Vermont HIV/AIDS Community Advisory Group Meeting
Tuesday, January 28, 2014

In Attendance: Tom Aloisi, Department of Education; Peter Jacobsen, Vermont CARES; Grace Keller, Howard Center; Roy Belcher, PWA Coalition; Chris Fletcher, PWA Coalition; Miriam Cruz; Chuck Kletecka; Paul Redden III; Paul Redden IV; Sue Conley, APSV; Karen Peterson, APSV; Laura Byrne, H2RC; Jose Negron; John Harris; Dan Chase

via Telephone/Teleconference: Kim Fountain, RU12; Jo Schneiderman, Twin States; Pat Gocklin, DHMC; Deborah Kutzko, Fletcher Allen

Department of Health: Daniel Daltry, Erin Larose

Center for Health & Learning: Alexander Potter

The meeting was opened at 11:03 a.m.

I. Welcomes and Introductions

II. COMMUNITY TOPIC – VERMONT NEEDS

A. Daniel reviewed the steps CAG has taken in examining the prevention funding picture in Vermont. Discussion has been held on:

1. CDC expectations.
2. What we are currently doing.
3. What is needed in Vermont.
4. Today, Daniel asked members to think again about core needs specific to the state, that we may not have thought about yet – what is needed that isn't happening right now.

B. The next phase following that is to discuss the actual Request for Proposals that the Department of Health will be generating. Daniel has specific ideas he would like to go over with the CAG regarding the RFP.

C. Discussion was opened for concepts and ideas on needs that are not currently being met, either reemphasis of what has been stated in the past, or new ideas that have come up since our previous "needs" discussion. Daniel reminded members to not limit their thinking only to needs specifically targeted by the current CDC-approved interventions.

1. Vermont is currently funding CLEAR and WILLOW. Three grantees are implementing CLEAR across the state. One grantee is implementing WILLOW for women and HIV. These are both CDC approved Evidence Based Interventions.
2. Hepatitis C is not a strong theme in the WILLOW workshop.
3. Roy stated that in having run WILLOW a couple of times, he has really seen the benefit of the peer-to-peer aspect of the program. In a rural setting like Vermont, we know how much fragmentation can happen among our populations. He would like to see EBIs/DEBIs that prioritize peer connections as prevention. If peer-to-peer models were expanded to make the most of new technologies, this

could potentially really help a dispersed, rural population. In terms of adherence, the use of technology can be very helpful. Adherence really benefits from peer-to-peer models – consumers are taking to other consumers about their struggles with adherence, encouraging each other, etc. There is a role that an agency can play in emphasizing and supporting adherence, but consumers connecting with other consumers – utilizing technology and the internet – can be very helpful.

4. Chuck mentioned that in a small state, we see many of the interventions get "tapped out" – people have taken the intervention, gone through the workshops, and there are not a lot of other people to be reached by the programs. Others agreed this can present real problems – both Healthy Relationships and WILLOW have experienced a lot of difficulty in getting enough people together for regular groups. Also, physically getting a group together that can meet more than once is very challenging in Vermont. People often have to travel a long distance to the group – another instance where interventions can thrive very differently in urban settings than in rural. Also, there appears to be much less motivation for people to come together than there was in earlier times in the AIDS crisis. Chuck stressed that for an intervention to be chosen for Vermont, it would be really necessary to prove that providers can actually get people to attend it/become involved in it.

5. People discussed the pros and cons of individuals taking the same intervention over again. There was definitely a benefit to be seen from going through some groups more than once – new learning, a new group of different people, better recall of material. If an intervention was focused on the Retreat, and people could participate again and build on the work that was done the previous year perhaps there would be more interest. Laura stated that Healthy Relationships has been offered for so long as a model that there are people who simply won't do it any more, even though people can participate new each year.

6. It was also mentioned that group interventions simply will not reach everyone – there are people who don't do groups, and those people will not do groups! How can we try to meet their needs?

7. It was asked what is coming out new in models around promoting adherence. Daniel responded that there are five new prevention for positive adherence DEBIs being released for the next RFP round. Four are up online, and can be reviewed. Of these, two *may* have a fit with Vermont. Daniel is not encouraged.

8. Chuck brought attention back to the Treatment Cascade, and how clearly it shows that at each point along the way, people are being lost to the system. We said we need to look at where people are getting lost in Vermont – where do they fall off – and then try to find out why, and address those issues. It is amazing that we lose so many people along the way.

9. It was agreed that we need to use our data to drive our programs, to figure out what our populations need. It would be very important to have a thorough needs assessment done, to interview people, talk directly to those living with HIV, record their voice directly, to partner with the numerical data.

    a. Daniel noted that the Department of Health has recognized this need and has just recently contracted with Center for Health & Learning for Alex to conduct exactly this – a statewide need assessment.

    b. We will continue to refine our own data gathering, and have needs assessment results this year.

10. Paul (IV) mentioned that there are not a lot of public awareness and media campaigns anymore. Those who are involved keep each other in the loop, but more information needs to get out to others. Daniel reported that Vermont currently has three public relations efforts: one around CTR and testing, one around Viral Hepatitis Month, and one around World AIDS Day. In particular, this year we could publish our Care Continuum on World AIDS Day, and if we are at 80%, that will catch headlines much broader than just in Vermont!

11. Roy mentioned the Speaker Bureaus that have been created and used in the past, and his surprise that there is not more attention to the bureaus and use of them. It is such a beneficial thing to hear directly from a consumer. He noted that he thinks these are very effective.

    a. Daniel stated that this is something that if we deem important, we need to find a way to make it happen – with our CDC dollars or in other ways. Can we organize to have HIV positive speakers go out and talk to various groups – it is a very effective prevention tool in a state like ours.

    b. Chris noted that there is a stumbling block with the schools not wanting to bring anyone in to speak about HIV, in some communities. He took the training, and in Central Vermont was not called to speak once in four years. This is of additional concern because he knows from his niece who is in school that some of the local teachers are giving false information. He would like to see it be mandatory that someone external to the school goes in and presents the facts.

    c. It was agreed that even if we had a speakers bureau fully trained and vetted, we would need to put effort into establishing and promoting it, and getting the speakers in to communities and areas that still experience a lot of stigma.

12. Tom mentioned incentivizing people to get their viral load checked three times per year in an effort to monitor health and keep people in touch with care. A $100 incentive could be offered. Paul (III) stated that incentivizing is definitely the most successful way of getting some out to participate.

13. Chris commented on the benefits of doing a regular care diary, and collecting information that way, such as the program at UVM. That research project is wrapping up, but giving consumers a reason to do a diary and use that as a way to get information on their care is a great program.

    a. Daniel said that while Sondra Solomon's current work is indeed wrapping up, perhaps she could be approached and it could be inquired if there are next steps that could be pursued.

    b. Unfortunately, the CDC has strict guidelines on not using prevention funding for research.

    c. Can we help find funds for continued research?

    d. Can we expand knowledge of how people are getting to tell their stories?

14. Is there a way to follow the TB model, of going out and testing? What about going out and doing testing in homes, for viral levels, and getting psycho-social

information at the same time? Peter inquired if that service could possible go into a van.

III. CDC GUIDANCE VIDEO VIEWED OVER LUNCH – Discussion resumed.

A. Daniel described how from the video we can see that "scaleable" is a new focus.

1. Can an intervention go up and down depending on population size, and remain effective?
2. If there is a base cost to running an intervention and a base cost assigned to an HIV diagnosis, is the "scale" of the intervention "cost effective?"

3. Daniel noted that Vermont's funding is at the lowest possible level, and if we save one infection, we have met the "threshold of cost effectiveness." Nothing funded in Vermont reaches the levels of funding that outweighs potential effect.

4. However, we do need to answer to the CDC with our own cost effectiveness. What is the math science behind what we are doing?

5. A big positive about the new paradigm they are moving to is that there is much more talk of adaptations of interventions, which was not at all the case previously.

B. Laura inquired if the 75/25 split will continue going forward. Daniel responded that yes, the CDC minimum requirement of 75% for Core Areas and Activities as defined by the CDC will remain in effect for the 4th and 5th years of this entire cycle. This means, at least 75% of a state's award has to go to these three areas and these four activities as mandated by the CDC:

1. AREAS:
    a. Monitoring and Evaluation – covered at the VDH.
    b. Jurisdictional Planning – covered at the VDH and CHL.
    c. Capacity Building and Technical Assistance – covered at the VDH through Jonathan Radigan.

2. ACTIVITIES:
    a. Policy – covered internally at the VDH and through CAG.
    b. Counseling Testing & Referral (now also known as Testing & Linkage to Care) – VDH will always ensure we have a component of testing.
    c. Prevention with Positives – covered in the interventions funded.
    d. Condom distribution – covered within the realm of the larger interventions/VDH regular activities. (Not applicable as an intervention on its own.)

3. The remaining funds can go to serving high-risk negatives.

4. The allocation of the remaining funds in Vermont has prioritized serving high-risk negatives, but this is not the CDC's priority with the 25% split. For CDC purposes, 100% could be allocated to the above activities. Daniel noted that in Iowa, they are putting all their federal allocation to care and testing. How did this get by their community group? Every state has to have a community planning body. It is unclear how this arrangement got through!

5. In looking at the allocation of the remaining amount for high-risk negatives, it must be allocated to a metropolitan service area with at least 30% of the state's

HIV positive population live. There is no area in Vermont that meets this requirement.

6. Currently Vermont's funding split is roughly 80/20 -- $150,000 to prevention with positives; $200,000 to CTR; and $100,000 to high-risk negative prevention ($130,000 if it is calculated with the high-risk negative work that is embedded in the CLEAR interventions). Apart from CLEAR, Mpowerment at RU12 is the prevention with high-risk negatives. CTR is a one-on-one intervention, and in Vermont, when we don't have any other resources for serving HIV negative people, we can look to CTR as a service.

7. Chris noted that Vermont CARES Testing Together couples testing model is a good prevention model. Daniel noted that we also have some providers who are doing Innovative Testing Programs that are based on "meeting people where they are at" in terms of prevention. We've also heard there is a mobile van that can do testing around the state! We are looking how to be creative and offer testing everywhere we can with ITPs.

C. Daniel asked for comments on/reactions to the video overview of CDC prioritization.

1. Chuck stated that it was very depressing. Others agreed. It is clearly a model of reducing everything to a number. Their math science is difficult to fully comprehend and buy into.

2. Daniel noted that he definitely understood that reaction. His hope in showing the video was to give everyone a good sense of where the CDC is coming from with their prioritization process, as we go into our RFP process in Vermont.

3. Daniel wants to have a document that spells out all the interventions, and when we go to the RFP, he will provide a paragraph on each with a link to more information. We are forming our discussion and process on what is needed, and what should be allowed for funding in Vermont, and in order to do so he felt it was important to have a clear view of how the CDC is making decisions.

4. Peter asked about any new information on new interventions. Daniel said that there are the five new ones that have been mentioned for adherence, of which two may possibly be useable in Vermont, but that no other interventions for IDU, for women, etc., are forthcoming.

5. Peter inquired about the amount of money we will be looking at. Daniel reported that the end of next year we will hit the rock bottom of CDC funding, meaning we have gone from 1.5 million in funding down to $750,000.

6. Daniel reported that the CDC recently had a conference call, and they are not completely done with their reductions in funds. The sequester hit, and that will have an impact, and there is an additional 15% cut the CDC has coming out of their budget. Vermont is at the floor now, but there is a further 15% cut that would impact year five.

IV. RFP – VERMONT'S RFP PROCESS AND OPTIONS.

A. The goal we have been moving toward is the release of the RFP this June, which all grantees would use to reapply for funding starting in January 2015. Ordinarily this would be a two-year RFP, to fund 2015 and 2016. At this time we could do that, but we do not yet know what the second year will look like, as we do not know for sure what the cuts may be that impact 2016.

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B. VDH has three options that Daniel would like to discuss with CAG.

1. VDH can release a 2-year RFP, with the knowledge on all sides that the first year of funding would be solid, but after that there would be a strong element of unknown as far as amount of funding.

2. VDH can release a 1-year RFP, so that organizations can apply for one solid year of funding, and not have to try to project forward for two years, when 2016 is an unknown quantity.

3. VDH can determine to NOT release an RFP at all this summer. In this instance, everyone who is currently doing an intervention would continue as is, and all grants that are currently in place would be extended for one more year, through 12/31/2015.

4. In conjunction with number three, an additional option would be for VDH to change the requirements for the third year of the grant, softening the rules on some client requirements that would apply to all interventions based on what we have learned during years one and two.

5. Daniel asked for feedback from the CAG and clarified that he would be speaking personally with all executive directors who were not currently at the table. We would need the support of the CAG and all EDs to go with option three.

6. Daniel added that in considering this, CAG think about the following.

    a. What data will we be using in terms of the care continuum to look at what we most need to best serve our constituents? Currently we don't have this set up. If we do a one or two year RFP, we are projecting without the data we would ideally like to have.

    b. VDH has contracted with CHL to complete a Needs Assessment, with the original intent of having it wrapped up in the early part of the year. If the Needs Assessment instead had the full year to run, it could be more thorough.

C. Daniel asked members for their gut reactions and encouraged people to be very blunt and ask questions.

1. Members responded very positively to option number three.

2. Roy asked if Daniel could speak to what might happen if a grantee was running WILLOW and might be interested in adding another intervention. For instance, if the PWA Coalition wanted to shift to an adherence intervention, would the target audience need to be women, since they were running WILLOW? Daniel clarified that the coalition was funded to serve positives. If the change in intervention would serve positives on a group level, that would be fine. Grantees have had shifts in interventions in the past during grant periods due to experiences along the way that have necessitated a change in direction for better service.

D. The group discussed a motion that Option Three be supported by the CAG body, to the effect that "the current grant period would extend through 12/31/2015 and a new RFP would be released mid-2015." Laura and Karen both seconded. Discussion of the motion ensued.

1. What would happen for year three of a new RFP in 2017 is it would be part of a whole new cooperative agreement from the CDC, and would be part of an entirely new grant cycle with the CDC.

2. Would we need to write in individual changes with agencies to any motion? No, this is very similar to what the VDH did at the end of 2011, with the year 2012 funding. VDH extended funding for one more full year to the then-current grantees, and allowed the funded programs to continue uninterrupted through 12/31/2012, when they would otherwise have been impacted a full year sooner.

3. Are we sure there will be a project announcement after this one? Yes, VDH is sure.

4. Discussion came to a close.

E. Vote was taken and the CAG **unanimously approved the motion** to support the extension of the current grant period through 12/31/2015, with a new RFP to be released mid-2015, with full consideration of the additional information that has been gathered.

F. Daniel will talk with all the Executive directors and report back at the March meeting.

V. CAG BUSINESS

A. Previous Meeting Minutes:

1. CORRECTION: on page six in Announcements – "PWA Coaltion is planning to host with Vermont CARES"

2. Chuck moved the minutes as corrected.

3. Paul (III) seconded.

4. The minutes were unanimously approved as corrected.

B. Announcements:

1. PETER: Based on feedback from other statewide leaders, adjusted/revised goals. Peter distributed the invitation to the statehouse event on February 7. This is a big annual gathering of PWAs, advocates, social workers, hopsitals, etc., and all are encouraged to attend. There will be no meeting with the governor this year. Potentially a meeting with someone from the Governor's cabinet.

2. ROY: February 15 is the annual drag ball and all are invited!

C. VDH Announcements:

1. Update on revision of Statute 18 – Gail (lobbyist) is working on modernizing the language. In passing it through to Gail it was stressed we wanted it modified and it could be part of lobby day but that the CAG needed to see it back again before it could be finalized. It missed a specific deadline to be introduced on its own, but it could be attached to another issue. This could mean another year of having to do a workaround with CDC's reporting system.

2. VDH & CHL are excited about the Needs Assessment process that will begin soon. If it is determined that there will be no RFP issued this year, the time

frame will be extended. Alex will be spearheading the process and will be contacting all CAG organizations and will be soliciting CAG feedback on tools. There will be incentives for participation. There will be focus groups as well as individual interviews, as well as written options for those who do not like groups and do not want to talk in person. Peter asked how short feedback forms could be made, because it would be great to have input from the syringe exchanges, but the clientele would need to have a very SHORT way to participate. Alex said he is very happy to adapt the tools to fit the needs of the prioritized populations, as CAG members and ASOs/CBOs identify them.

3. Hannah recently sent out an email to the CTR network that Planned Parenthood does *site specific* testing for chlamydia and gonorrhea. Just testing orally does not help at all if the individual has a rectal infection. In fact, if the testing had not been done in three sites – urine, throat, rectum – 95% of gonorrheal infections would have been missed completely. The CCC has provided this service. The test needs to go through a lab that has been specifically approved to process these results. Planned Parenthood is using a lab that is able to do so, and the VDH lab will be getting validated to do so as well. Currently "site specific" tests have not been approved by the FDA, and some providers do not want to do a non-FDA approved test because they cannot get reimbursed for the services. All of this information taken together suggests that there are a lot of unidentified cases of gonorrhea across the entire country. There is a significant health disparity with men who have sex with men and rectal gonorrhea. Current findings indicate that 60% of gonorrheal infections are acquired out of state. Notably, Montreal is one of the areas where the treatment-resistant strain has been found, an area frequently visited by men from Vermont. San Francisco had a good information campaign around "check your butt" regarding site specific testing.

4. Erin and Daniel went to a NASTAD training on ACA and how to look at prevention and how to look at funding streams. Not a lot of it applied to Vermont. Pre and post-test counseling *with a lab test* is approved for reimbursement for providers. The cost effectiveness of this for providers is still low, however, as a percentage is lost just in the billing process. New York state has approved reimbursement of syringe exchange services. They have a proposal in front of their Medicaid board right now, and VDH is eager to see their materials and see what we can learn/apply to Vermont. The current climate in Vermont may be good for this type of movement.

5. There was a technical review for HIV and STD services. Nothing significant was returned on HIV. Other areas had "corrective action plans" if they did not hit their 1% positivity rate. It was noted that Vermont did not hit 1%, but it was not listed a corrective action. The items that were identified for corrective action were easily addressed through VDH documentation.

6. Erin and Mary have been working very hard on healthcare reform and VMAP. In March we hope to have a presentation on HCR and VMAP, hopefully with a representative from the Exchange, but Erin will be able to provide it if we don't have an Exchange rep.

7. Paul (III) asked if VDH thought the governor speaking about heroin helped the case for syringe exchanges. Daniel replied that he was hopeful. NASTAD inquire about advocates of syringe exchange in Vermont. At the same time the Drug Policy Task Force has been putting pressure on Bernie Sanders to prioritize lifting the ban on syringe exchanges. Usage of the exchanges in Vermont is way up, and membership is up 50% all while operating on a shoestring budget.

D. Delta/Plus

1. New space: Some liked it, some did not. We have a contract for the year. Please let Alex know if there are challenges but we may not be able to change. Temperature was a problem and we will work on this. We will also need to be careful to stick to our meeting schedule this year rather than move dates around.

2. Go To Meeting: One user had bad experiences with being able to hear. One user had good experiences but stressed that SOME MEMBERS NEED TO SPEAK UP! ☺ It was agreed that anyone calling in on Go To Meeting must mute themselves until they wish to speak about an issue – muting and non-muting created consistent problems. Alex strongly encouraged everyone to go to the Go To Meeting website to take a look at a sample Go To Meeting screen shot. We will continue to try to improve.

3. COMMUNITY CONCERN: A new CAG attendee raised a concern about HOPWA. Having been on the long-term assistance list for four year, they have used the short term funding a few times but have seen no movement at all in the four years. Is there any leeway on the short term for those who have been waiting for so long? They have written Bernie Sanders but there is no additional funding right now – both Section 8 and HOPWA have been cut. But this is a very restrictive list that does not see much turnover, so people wait a very long time. Daniel and Erin responded that this is on the VDH's radar. AHS is pushing a big housing initiative across the state, and are asking for input. Erin will take this feedback to them.

Respectfully submitted,
Alexander B. Potter