HIV Community Advisory Group Meeting Minutes
April 9, 2019; 10 a.m. – 2 p.m.
Gifford Medical Center, Randolph VT

Attendance: Dan Chase; Chuck Kletecka; Karen Peterson, APSV; Laura Byrne, H2RC; Grace Keller, Howard Center Safe Recovery; Peter Jacobsen, VT CARES; Pat Gocklin, DHMC; Paul Redden III
Remote Attendance: Zpora Perry, Paul Redden IV
Vermont Department of Health: Kelly Bachiochi, Daniel Daltry, Erin LaRose,
Caracal Consulting: Alexander B. Potter

The meeting was called to order at 10:11 a.m.

INTRODUCTIONS
Daniel introduced Kelly Bachiochi, new Viral Hepatitis Coordinator with the HIV/STD/Viral Hepatitis Program. Kelly comes to HSH Program from VDH's Emergency Preparedness office, having worked primarily in communications and with the Health Alert Network. Previously, she worked with the Massachusetts Department of Health, achieved her MPH in Massachusetts, and has experience with immunization and vaccine programs. Kelly has already gotten out on the road, visiting Brattleboro and working with the Immunization Clinic at APSV Syringe Services Program (SSP).

I. DISCUSSION ITEMS

A. 2018 PERFORMANCE DASHBOARD.

Alex and Daniel introduced discussion of the finalized **2018 Performance Dashboard**. Dashboard not reviewed in full, as all members have download access at **CAG website:** www.vthivcag.org The Dashboard is not locked, but as a reminder, the password to the CAG Member Portal is **VTHIVCAG** (case sensitive). Contact Alex with any difficulty accessing or downloading. Certainly bring questions and discussion items to our attention if you have them following your own review of the final Dashboard.

1. Focus of review and discussion: *Testing, Referral and Linkage*, including both *TRL-PrEP* and *TRL-ASO* programming.
2. Intent: **discuss challenges providers may experience with PrEP screening and referral, share ideas and successes, and address difficulties**. All numbers are presented in aggregate with no intent to call out any individual agency's performance, or criticize providers' hard work.
3. Alex presented two slides *[attached]* of all 2018 quarterly totals and performance-to-goal comparisons for TRL-ASO and TRL-PrEP, specifically,
    - total *number MSM tested* versus *number MSM screened with CDC MSM Risk Assessment Tool*, and
    - total *number MSM scoring 10 or higher* versus *number MSM referred to PrEP*.
4. Goal of "*50%+ of all HIV tests delivered to MSM"* met, but all other TRL categories well below goals. Results highlighted might indicate providers experience barriers. Encouraging upticks in performance did occur later in year, especially fourth quarter.
5. Men may not *accept* a referral to PrEP – providers **cannot control** this and **this is not** measured as a performance category. Providers **can control** all other performance-related measures by **always screening every client** with CDC MSM Risk Assessment Tool, and **always delivering a no-pressure PrEP referral** to every testing client scoring a 10 or higher on tool.

B. RESPONSES. Providers/CAG members invited to respond. Ideas, known/suspected barriers?

1. **Adapting to TRL.** May have taken early quarters for testers to adapt from CTR testing mindset to TRL, and required **use of CDC Community Health Assessment screening tool(s)**, first the MSM and then PWID.

2. **Perception of "client-centered service" by testers.** VT providers trained in harm reduction and no-pressure presentation of options. May have started 2018 with tendency to not conduct community health assessment screening if client "shut down" mentions about PrEP early in session. Testers may have perceived continued mention of or referral to PrEP as insensitive/contrary to "client-centered" service. Upticks in use of assessment screening in 4th quarter likely indicate testers better understanding how to integrate the screening with the client-centered service mode. As testers more familiar, numbers screened increased.
3. **Judgmental or significantly PrEP-averse client.** Forceful, negative reaction to any mention of PrEP may also increase tester concern that referral would be insensitive.
4. **Early, clear expression by client of desire for "just a test & result, not a lot of talk."** As community health risk assessment not explicitly advertised, "results-only" clients may experience "bait & switch" reaction, as though introduced to service they weren't expecting/don't want.
5. **Misunderstanding by tester of nuances of "referrals."** Wide agreement that testers value integrity in reporting, may have believed that if referral was "shut down" immediately by client, or client resisted PrEP discussion, that tester's efforts "didn't count" as formal referral. If client didn't leave *with a referral card*, tester may have interpreted that "no referral made." Nuances of offering versus accepting may underrepresent performance.

C. BRAINSTORMING. Suggestions, improvements?

1. Grace shared Jess' experience. Much easier to smoothly work in screening if she didn't think of it as **separate piece** to **add on** to the testing session, but rather as an **integrated part of risk assessment process** - just one more step in the unfolding session.
2. General agreement: Useful to clarify all testers **using same definition of offering a referral**. Ensure all testers know that their efforts count even if question is asked and refused.
3. Encourage testers to **think of PrEP similar to "other STD testing"** — referral to other STD testing always offered as standard part of process. PrEP is similar service.
4. Encourage testers to **use normalizing language** to help client think of PrEP conversation and referral as integrated part of testing risk assessment, and to help tester feel comfortable in a "client centered" approach. Possible statements such as "all the questions we ask help us look at overall risk", "given what you've described to me, I would offer anyone in your situation a referral to PrEP" and "as a service provider I want to offer you all the options available."
5. Grace said that she has found it extremely helpful to think of the mentioning of PrEP and referral to PrEP in very much the same way they approached Narcan, when people were mostly turning it down. **Treat it in your conversations as a chance to raise the topic with the knowledge that a refusal of the referral is not a failure** — it is an opportunity for the person to hear it, and **they may change their mind in the future**. They emphasized "if you change your mind you can let me know" when working through the barriers to accepting Narcan, and this helped a lot. Pairing the message of "this is what I would be saying to anybody" with a follow-up of "you can always talk to me if you change your mind" can help open the door to a future connection. Initially many people turned down Narcan, but now people are much more comfortable even just talking about it. Eventually we can reach a social norm tipping point with offering the changing services that are now available with biomedical prevention.

D. DASHBOARD FOLLOW-UP DISCUSSIONS

1. **CDC MSM Risk Index SCREENING TOOL.** Chuck asked about the CDC's tool, not having seen it. It is available online: http://www.healthvermont.gov/immunizations-infectious-disease/hiv/prevention. At the bottom of the page is information on PrEP and a link: *Click here for a brief clinical questionnaire for gay, bisexual, and other men who have sex with men, to help decide if PrEP may be right for them.*
2. **ADVERTISING MSM RISK ASSESSMENT.** Chuck suggested providers could clearly advertise "MSM Risk Assessment and referral" in promoting testing, to better prepare clients.

a. Concern: Clients may not readily distinguish the difference between "assessment" for services and getting services. Would people come in expecting screening *and* prescription? Testing network cannot prescribe. May frustrate clients more than introducing PrEP during risk assessment.
b. Concern: Advertising PrEP with testing may place *too much* emphasis on it; lead men to assume test session will focus on "getting on PrEP. " Tester reported experiencing clients reticent about PrEP who already feel pressured by their sexual partners who are on PrEP and do not want to use condoms. Would PrEP advertising keep men away from testing?
c. Chuck asked if VT does any targeted ads on PrEP itself, apart from testing. Daniel said VDH does not, but Planned Parenthood recently did limited-run full-page print ads in *Seven Days*. Pride Center may do online ads on apps, e.g. Grindr and Scruff, mobile apps that help men to locate other men nearby.
d. Grassroots advertising discussed, including informal, informational speaking tour based in libraries statewide. Response was positive. Donna said this could help outreach to friends and families of populations at higher risk, using example of parents learning about Narcan as a tool to help protect their children.
e. Daniel said communication department of VDH is looking at promotion and communication on a number of fronts regarding public health issues. Health Alert Network (HAN) - the VDH's existing tool for broadcasting information to medical providers statewide - is designated to be used only for emergencies and major announcements. However, VDH now using mobile formats - blogs, Twitter, Facebook. He said he has heard CAG's stated interest in more on-the-ground communication and advertising of PrEP to both medical network and public, it is noted, and he will be carry information back to VDH and advance in future discussions with Communications.

3. **PLANNED PARENTHOOD REFERRALS.** Peter raised a topic related to barriers to PrEP referral involving misperceptions of Planned Parenthood (PP) among male clients - a possible barrier that can be easily addressed, but may not be recognized by testers. Rate of referral *acceptance and linkage* may be affected by potential stigma men carry regarding PP as service provider *for women*. PP is major prescriber for PrEP but Peter has seen stigma among men - lack of understanding that men get services at PP, feeling uncomfortable, expecting a negative experience. Providers can clarify how welcoming PP is and educate clients on services they make available for men. Offering to go with client to PP can increase comfort level exponentially. Grace emphasized that going with a client for an appointment does make all the difference - helping them make the call, giving a ride, walking them through the door.
4. **PERCEPTIONS ON CARE/MEDICATION**. Daniel inquired if members hear any indications of an increase in HIV positive individuals resisting starting medication or taking it at all. For many years with better medication and the news of "Undetectable = Untransmittable," standard of care has been consistent that positive individuals in care get on medication immediately upon diagnosis. For first time in some time Daniel hearing murmurs of individuals expressing they are "not ready" to be on medication, or don't want medication at all. Others?
    a. CAG members reported not hearing this often. Has come up, but more common themes members identified hearing were (1) people on medication for decades and extremely tired of it, and (2) individuals not adhering to, or not starting, HIV medication due to chaotic nature of their lives (addiction, homelessness, other pressing survival needs).
    b. Individual shared experience that they would be tempted to stop meds now, after 20 years on them, but for past experience going off medication and becoming very sick very quickly. The person explained they went into viral rebound within a week of discontinuing medication. Daniel said this is something for people to be very aware of the

danger of, as viral rebound resets the individual to their trigger point of infection (where it would be naturally at this point if not on medication) and viral load skyrockets.

c. Paul asked if individuals can scale back medication rather than stop completely, but this can actually be more dangerous. Fosters resistance to medication. On average, an individual can miss maybe up to four doses per month before risking developing resistance, which is why adherence so important.

d. Grace, Donna, Pat and Peter all agreed they mostly see issue of chaotic lives impacting ability to be on/stay on medication. Pat said she also sees patients who are young/in their late teens who don't want to deal with medication until they actually become sick.

E. HERE IN VERMONT: HOUSING.

1. Alex conducted research following last CAG meeting discussion of housing and the Here In Vermont campaign. Researched what other states used for needs assessment tools regarding homelessness/housing, and efforts and programs experiencing success.
2. Housing needs assessment tools from other areas proved underwhelming, but interesting growing national movement did surface - Community Solutions' Built for Zero.
3. Much of what was emphasized in Built for Zero efforts were thematically similar to items CAG members shared at last meeting:
    a. **"Real-time data" & coordinated service** - using tracking software and on-the-ground outreach, Built for Zero advocates finding homeless individuals, interviewing and assessing, maintaining complete list of people, and bringing all housing services provider organizations to a coordinated meeting. At meetings, list is reviewed, prioritized, and names are followed to the next meeting and on into the future until each is housed.
    b. **Streamlining process of applying for services**, including one point-of-entry into state service systems and maintaining coordination of services.
    c. **Dedicated housing services person/people** to track/follow individuals on waiting lists.
    d. **"Housing first" approach** - achieve placement of individual in housing before addressing any constellation of other needs; stabilization must come first.
4. Chittenden County is currently using Built for Zero model.
5. Not to say Vermont should adopt Built for Zero model statewide, and concerns exist about some best approaches. Chuck raised issue that with HIV positive individuals, housing service providers cannot use names. Grace said as long as client signs a release, they can be discussed by name, but also underlined concerns with confidentiality and privacy in seeing this model in practice. Same privacy and safety concerns flagged in research Alex conducted - in many communities using this model, police chiefs/other representatives of law enforcement sit at the table at housing meetings. Raises issues of great concern if names/other identifying information is used, especially for people engaging in a criminalized behavior, e.g. injecting substances.

F. HOUSING/HOMELESSNESS FOLLOW-UP DISCUSSIONS

1. **NEEDS ASSESSMENT.** Longer discussion evolved about what Vermont needs assessment regarding housing and homelessness would look like/could accomplish. Daniel raised self-selection concerns. If we utilize Retreats' evaluation forms and add one or two questions, it reaches a self-selected population – people who are willing/able to attend one of the Retreats. Is this representative of the issues among the most in need? Key informant interviews could still be conducted, but quality of data is a concern with small numbers, especially with hard to find-and-reach populations such as homeless.
2. **DATA GATHERING.** General discussion concerning quality of data gathered at the Retreats (TSN's Women's Retreat and VTPWAC's PWA Retreat) included the following considerations:
    a. Retreat bring in wide variety of people with many experiences.
    b. One hears stories of range of housing/homelessness issues all the time at the Retreats.

c. Even if cannot reach “currently homeless” at Retreat, will reach people who have had problems in past, providing valuable information that is worth collecting.
d. A multi-prong approach would be best, similar to the previous full needs assessment, whereby the Retreats are utilized as a location for information gathering but other methods are employed as well; there is likely a “silent population” of people who are not necessarily found through service providers at all.
e. Past experiences described by Retreat attendees can offer excellent perspective on housing retention and supports needed, if they are currently succeeding.
f. Current attendees can represent how stable they feel their housing is at this “point in time”. May be people “just barely getting by” right now.

3. **OTHER POPULATION OUTREACH?** Ideas for ways to reach additional people, homeless or at risk of becoming homeless, for a circumscribed needs assessment? (Possibly five or six questions, utilizing a multi-prong approach - key informant interviews, online/hard copy survey, small focus group.)
    a. Review current list of folks not virally suppressed. Reach out, check in on housing issues, ask if willing to talk to Alex.
    b. Any info on HOPWA applications that might contribute interesting data points to gather? We already have access.
    c. Incentives - even a $10 gift card does wonders.
    d. Case managers could give good information, they have many stories and examples.

II. VDH UPDATE

A. HRSA PART B SUPPLEMENTAL NOFO. Last meeting during housing discussion Daniel spoke about a fall release of a Notice of Funding Opportunity (NOFO) from HRSA, that VDH would be utilizing to apply for initiatives, including housing services. In an unexpected move, NOFO released a week ago, and due in May. Work has commenced. Initiatives include:

1. **VDH HOUSING COORDINATOR.** Creation of new position at VDH - centralized Statewide Housing Coordinator. Lead policy person at VDH was excited as this fits with VT’s *State Health Improvement Plan* (SHIP) regarding “access to housing for disenfranchised populations.” There have been inquiries of this position conducting work for HSH Program for PLWH populations, and potentially spending some time in generalized housing world, as part of state’s investment in “equitable housing for all.” This is very preliminary as grant has not been written yet.
2. **HOME-BASED HEALTH SERVICES.** Support for Dr. Devika Singh’s home-based services. An infectious disease physician at the University of Vermont, Dr. Singh has been providing services specifically to HIV positive individuals and it has been an incredible boon to our population. She conducts multiple services to hard-to-reach populations, including some folks seen in Vermont’s recent HIV cluster, who are unable to make it into the clinic.
3. **MEDICARE PART D SUPPLEMENTAL GAP COVERAGE.** Vermont’s insurance coverage plan covers HIV positive clients well, but a growing number of people are aging into Medicare, and must switch at age 65. Unfortunately, moving on to Medicare creates a 20% coverage gap, specifically in the area of Part D, prescriptions. HSH’s current coverage picks up the Medicare Part B portion already, and will apply to also cover the Part D 20% copay gap. As majority of HIV+ Vermonters are middle-aged, this issue will increase in coming years.
4. **HOUSING VOUCHERS.** Create availability of additional housing vouchers to ameliorate wait time for HOPWA vouchers.

B. CDC HIV PREVENTION CONFERENCE

1. National CDC HIV Prevention Conference occurred in March. Largest topic was administration’s “AIDS Initiative," ten-year plan to eradicate HIV in the US by 2030.

2. While the Obama Administration's *National HIV/AIDS Strategy* is officially no longer in use and this is presented as a new initiative, it has not truly changed much in practical application and reads more as an adaptation/update of the work the field has already been doing. The same four primary goals are the same, and the just-released HRSA NOFO confirmed this in the way it was written.

C. TOBACCO MONEY

1. Regarding the tobacco settlement funds that are being directed to syringe services, the Governor's opioid council plan initially called for expanded hours and locations for syringe exchanges throughout the state. However, the SSP Working Group convened in spring 2018 provided feedback that the number one priority would be sustaining existing services and filling in the current gaps, before expanding. Therefore, the money is being targeted to both reinforce existing programming and expand in some locations.
2. Examples include:
    a. APSV: Expanding hours at Brattleboro exchange, increase staffing (to .5 FTE), and open new exchange in Bennington.
    b. H2RC: Expanding hours, and potentially (1) opening location in Windsor and (2) increasing staff to .5 FTE.
    c. Safe Recovery: Expanding staffing and support of FTE to provide clinical intervention with clients. SR will also be able to use funds to offset deficits.
    d. VT CARES: Expanding hours, and potentially (1) new partnership with Barre connected to drug treatment, and (2) development of low barrier treatment model.

D. RESEARCH PROJECTS REACHING PWID POPULATION

1. The results of the research projects discussed previously at CAG are coming in, in preliminary fashion. Slides of presentations to VDH are not yet available to be passed along. Reports will continue going forward as the projects work toward completion. The DISCERN project is heading into Phase II, and PIRE is still looking for more consumer participation, so both research groups continue to gather data.
2. Daniel reviewed a number of statements that arose in ***both*** the PIRE ***and*** DISCERN presentations, that caught his attention. It can be difficult to ascertain how much certain DISCERN findings apply specifically to Vermont, as they studied VT, NH and MA, without separating out some findings based on state residency. However, it is important to review the findings with a mind to the fact that Vermont consumers were part of the study. PIRE studied Windham, Rutland and Franklin Counties.
3. All items noted were themes and statements that came up in *both* presentations. Daniel asked CAG members to share their thoughts on these reported indicators of community interest/experiences/challenges.
    a. Respondents indicate high interest in expanded days and times of exchange operation, including weekend and night hours.

    PROVIDER RESPONSE:

    - Laura said it is a good idea and clients would love it, but would prove very difficult to have evening/weekend staff coverage. Good Neighbors - the location of one of the exchanges - is closed on weekends, and nights would not be an appropriate time to run the exchange at that location due to other programming. Would benefit clients and ideally would like to be able to offer. Other providers agreed.
    - Grace said SR looks at possibility of night hours regularly, but recent focus has been shoring up current staffing and maintaining safe staff ratio during present open hours. Adding evening/weekends has not been an option with staff salaries uncertain, but with more secure staff funding it is something they will likely revisit. Current focus is on expanded services with low barrier treatment.

b. *In key informant interviews, the following statement was made in narrative: I wouldn't be injecting if I didn't have access to clean syringes." Comment indicated person would choose to snort or smoke, if unable to acquire syringes. By contrast, other respondents said that syringe exchanges should be more heavily and publicly advertised.*
PROVIDER RESPONSE:
- Significant concern expressed among providers about this finding and how it could be twisted and used against syringe services programs by individuals opposed to the SSP concept and cherry-picking data.
- Providers present reported they do not see representation of this statement and dynamic among their clients — once individuals move to injecting they generally express they would choose injecting, and would find a way to get syringes whether or not an exchange existed rather than use the drug in a different way.
- It was noted this was obviously a valid and real response for the individual quoted, and while it was impossible to tell based on one statement, Grace posited that internalized stigma could potentially play a role in a statement of this nature. Many individuals struggle with self-perception when it comes to their drug use, and may be invested in believing that they could stop injecting easily, or that they haven't "fallen that far" into addiction.
- One consumer noted that in their own experience, from the first time using a needle, they hated to go back to any other form of ingestion of drugs, and would in fact use a dirty needle before resorting to snorting. The drug simply did not work the same when not injected.
- Regarding advertising, there were number of responses, including struggles with funding staff roles preventing advertising from becoming a priority, potential for advertising to provoke drama/protest from community, and fact that clients asked "where did you hear about us?" always answer "from a friend." Karen said APSV provides fliers and cards around town, but word of mouth and peer referral trumps formal advertising every time.

c. *Opposing viewpoints on treatment were represented by statements such as "I wish people were harder on me when I was in treatment" versus "you slip up once and you're kicked out and treated like garbage."*
PROVIDER RESPONSE:
- Laura has heard mixed reports on various counselors and programs, that there is lack of consistency in approaches to relapse.
- Karen noted that our panelist at the SSP panel in December said he started a program taking 9 drugs, and was kicked out of it because he tested positive for one of them, without consideration to the fact that he was no longer using the other 8.
- Grace said SR experiences best results with programming that emphasizes no punishment or ejection from program for relapse.

d. *Only 45% of population surveyed heard of PrEP, but 84% had been tested for HIV.*
PROVIDER RESPONSE: Providers said this depends a great deal on location individual tested, as many people get tested elsewhere before accessing services in Vermont.

E. HIV/HCV MONITORED THERAPY. Chittenden Clinic, in coordination with the CCC, has begun conducting monitored therapy for HIV and HCV.

1. Interested in doing daily dosing for HCV, but providers must consult with a hepatologist to do so. Two hepatologists have been teaching the doctors at the clinic. Exciting to think that those accessing treatment at Clinic are now getting HCV medication.
2. Donna asked if there were any contraindications for taking medications for HIV and HCV at the same time, and there are not.

3. The concept is a "one stop" for all dosing. Grace said that this one-stop concept can help encourage providers to take on higher risk clients, knowing they have a daily dosing structure.

F. PAYMENTS. Grantees said state payment of invoices was much faster and thanked Erin.

III. CAG BUSINESS

A. MINUTES: Karen moved the minutes and Donna seconded. Chuck commented that they are very thorough. The minutes were approved unanimously.

B. ANNOUNCEMENTS:

1. Chuck announced they will soon have fliers for the Coalition's PWA Retreat, July 25 - 28.
2. Donna announced that the Women's Retreat will occur on the weekend of May 30.
3. Karen announced that APSV experienced a new bump with their insurance coverage about which she wanted to give other agencies a head's up. On a phone call alerting the insurance company that they had neglected to add "syringe exchange services" to APSV's coverage, as requested, the fact that ***HIV testing*** is provided onsite came under question. While adding exchange services onsite would have no effect on their insurance, APSV conducting HIV tests *and providing the results onsite* resulted in an unspecified increase in cost of insurance policy, that will be calculated when it is next due for payment.
4. Karen asked if a staff safety policy had been developed by other organizations running exchanges. Peter said they are still developing one. Donna said she would be interested to see what agencies decided on. Their main concern at TSN is safety while out in the community and meeting at private homes. Their cardinal rule is that if *anything* seems unusual or out of place, to trust their instinct and simply leave. Grace said they had brought in a safety consultant. In 18 years of work at Safe Recovery they had never had to call the police, but six months about there was an act of aggression against a staff member that got violent. One issue that arose immediately was that there did not have good access to easy exit — it is important not to let an individual get between you and the door. Donna said that working in Corrections, they are always very conscious of safety issues, and are trained to always remain out of direct arms reach.
5. Laura announced that the Claremont syringe exchange will be opening the first week of May and staffed by Dartmouth medical students. The exchange is being funded by a local philanthropist that the students approached. H2RC was brought in to supervise.

Meeting adjourned 1:25 p.m.

Respectfully submitted,

Alexander B. Potter
Caracal Consulting