Vermont HIV/AIDS Community Advisory Group Meeting Minutes
Tuesday, November 4, 2014
Wilder Center, Wilder, VT

Attending Members: Tom Aloisi, AOE; Roy Belcher, PWA Coalition; Laura Byrne, H2RC; Dan Chase; Miriam Cruz; Jonathan Heins, PWA Coalition; Grace Keller, Howard Center; Michelle Kiefer; Karen Peterson, APSV; Paul Redden IV; Jo Schneiderman, Twin States; Amy Tracy

Guests: Mike Bensel, Pride Center of Vermont; John Chagnon, Pride Center of Vermont; Zpora Perry, Comprehensive Care Clinic

Vermont Department of Health: Daniel Daltry; Erin LaRose

Center for Health & Learning: Alexander B. Potter

I. DISCUSSIONS:

A. **Needs Assessment** Update

1. The data collection period has been extended into the new year, with the final Needs Assessment to be delivered to the Department of Health on June 30, 2015.
    a. Interviews: 38 care interviews conducted thus far, majority in person (as opposed to phone).
    b. Surveys: 55 Care surveys and 83 Prevention surveys have been collected.
    c. Focus Groups: Two have been conducted, and three more are scheduled prior to December 31, 2015. Heterosexual 20 somethings; LGBTQ 20 somethings; two PLWHA; one northern MSM.
2. **LARGEST OUTSTANDING NEEDS:**
    a. Individuals not in care. 99% of consumer respondents (interviews, focus groups and surveys) report being in care. While this is great news, we are not accessing individuals not in care, and therefore we have a data gap. **PLEASE OFFER ANY AND ALL SUGGESTIONS/FEEDBACK FOR METHODS OF REACHING HIV+ PEOPLE NOT IN CARE, through any means possible.**
    b. Focus Groups. Could use more focus groups for regions not as fully represented.
    c. Additional hard to reach populations for interviews – IDU.
3. Alex provided a brief overview of the new numbers in the Needs Assessment, and a raw data overview. *Due to the preliminary nature of these assessments based on raw data, neither assessments nor data are being released for even limited distribution at this time.*
4. Preliminary report will be provided at the 4/28/15 CAG meeting to allow for CAG member feedback prior to final report compilation.

B. Alex provided an overview of the **Summary Document** that distills Vermont needs identified at CAG meetings throughout 2014 in the CDC-fundable areas of **Policy**, **HIV CTR**, **Prevention with Positives**, and **additional needs** not reflected in CDC-defined categories, in preparation for the RFP in 2015.
    1. *Summary document attached here.*
    2. Question was posed for final input = "What are the additional needs for the RFP?"

C. Discussion of RFP needs as follows.

1. MENTAL HEALTH:
    a. CDC funding doesn't address mental health. Can RFP work this into models? CDC sees funding for mental health as provided through HRSA.
    b. If cannot be linked through prevention RFP can other funding sources be pursued? Mental health is a big concern for HIV+ people.
    c. Medication and/or counseling? Yes – counseling definitely but possibly moving clients toward medication as needed; could need assistance with medication cost.
    d. Anecdotally **depression is a big cofactor in adherence difficulties**. Circular cause and effect: when people do not take their HIV medication, there is data indicating that increased viral load is linked to worsening depression.
    e. Clients like an HIV+ counselor. Many clients report having to explain HIV circumstances to their mental health provider and providers do not have a good grasp of issues that come with disclosure and other psychosocial affects. In women's groups, women have repeatedly reported that they spend more time educating their therapists and trying to explain the unique needs/problems that come with HIV.
    f. HIV+ community is aging, and there are significant depression risks around that as well. Individuals getting older, who have HIV, often have parallel processes driving them toward depression.
    g. Current prevention funded intervention is the CLEAR intervention. Hybrid of mental health and prevention skills building. CLEAR provider not counselors, are not required to be licensed therapists, and are instructed to clarify that CLEAR sessions are not therapy sessions.
        i. Some are concerned about CLEAR saturation. Have we reached the people who want to do CLEAR?
        ii. Others believe saturation has not been reached, particularly with high risk negatives. Additionally high interest and good value for clients in retaking it.
    h. Support group at Pride Center is a good mental health option, helping people be part of a community of HIV positive folks. Hard to get off ground in other areas of state.
    i. What is keeping folks out of mental health services? Age; poverty; stigma of HIV & stigma of mental illness (small towns, office staff); mental illness can be its own obstacle; having to educate counselors repeatedly; cannot refer self into care such as Brattleboro Retreat; much be referred by a medical provider; isolation; lack of transportation; lack of choice of providers.
    j. Some have only entered mental health care through court order after entering the criminal justice system – has often had a positive effect. Anecdotally/needs assessment interviews have supported this as a positive intervention with clear results.
    k. Stepping stone would be to support another form of peer support for those who cannot get to an in-person support group. Got an approval to allow CLEAR to be practiced through Skype. More like that?
    l. A lot of young people are reaching out through social media – things they won't tell family/friends they will post in a forum that feels anonymous. Look to a media arm for prevention, provision of services?
2. POLICY
    a. VDH updates:
        i. While Vermont is in a good position on syringe exchanges, there is no good news on lifting the federal ban.

ii. Daniel is doing a program on MSM and gonorrhea.
    a) Vermont has a small enough caseload of gonorrhea presently to be able to interview all. Biggest concern is watching for the resistant gonorrhea strain.
        1) Syphilis has an automatic protocol in place and VDH has prioritized getting those testing positive for syphilis an HIV test.
        2) Chlamydia does affect MSM but not as often. There is not as much interviewing possible with chlamydia, with over 2000 cases/year.
    b) We do not have site specific testing for gonorrhea. Undiagnosed rectal or pharyngeal gonorrhea increases the risk of contracting HIV two to three times. Part of the protocol is working with those testing positive to go back for additional cultures if they test positive again in 90 days. Can only identify antibiotic resistance through a culture.
    c) Desired protocol is to offer these individuals opportunity to determine HIV status, and if negative, look at the MSM risk index and talk to them about PrEP. CDC has six questions, and individuals scoring above 10 are considered a candidate for PrEP based on risk factors.

iii. Harmonizing chapter 18 to make sure there is sensitivity to the language and ensure there is no criminalization of HIV present or implied.

b. Discussion re: protocols on syphilis/gonorrhea. Who offers/refers for HIV tests? How many referral links does a client have to follow? VDH is the second link. The provider reports the positive test and Daniel calls the provider to ask if an HIV test has been conducted. If yes and positive, Daniel asks if a referral to services is in place. Important to be careful about how people are finding out they are HIV positive. Client's primary relationship is hopefully with their medical provider. Is HIV status linked to other STD status partner contacts? If Daniel learns person with other STD is also HIV positive, he asks if they want him to inform of HIV status as well. Does not automatically occur.

c. Condom policies. Tom Aloisi is working on condom provision in schools, and it would be great if VDH could come out in support of that work. Daniel agreed that VDH must partner more with AOE. Always working on increasing partnerships with other departments/agencies: Alcohol and Drug Abuse Programs, Maternal and Child Health, Mental Health. VDH continues to report to CDC that condoms are not tracked by individual number going out to HIV positive individuals, but rather distributed in a variety of ways and venues. Can individuals who are HIV positive get condoms mailed to them? Daniel said we could try it as a pilot. There are other states that do it. Mike reported that the Vermont Pride Center has had that request.

3. PREVENTION WITH POSITIVES
    a. Have discussed range of services available – we are now identifying the range of services that are needed.
    b. Mental health has clearly been identified.
        i. Vermont currently funding CLEAR.

ii. John noted that the Pride Center support group has provided a good gateway into CLEAR services. Most people who attend the group sign up for CLEAR.
iii. Additional needs – online, in-person, remote, individual and group services.
iv. VDH always comes away from CAG meetings with a strong sense that there is value in clients repeating CLEAR – one of the reasons for lifting the 13 month requirement. Maybe advocate with CDC about the need to repeat the program with consumers and how much they gain from that process.
v. Summary document noted that Treatment & Adherence module is not chosen by clients but the T&A topics come into all of the CLEAR modules.

c. While CDC has not recognized the need with funding/programming, there is strong benefit to providing services like CLEAR to partners – partners help people adhere to their medications, help with mental health, and a variety of supports. Partners could also use education. VDH has done its best to allow partner participation where possible, in order to foster partner-assisted prevention. Try to frame grants in a way that services provided to positives will also serve negative partners. From CDC perspective they are funding positive prevention and if they do not want to provide funding for services for negatives. But if we make it clear that it is part of Vermont's prevention approach as a whole, and programs do not count those individuals in their number goals, that may make a difference in what Vermont is allowed to do with funding.

4. CTR:
   a. There is now evidence that different modalities (testing in non-office environments, testing in homes, testing couples) are being used effectively in Vermont. Where is the VDH on allowing those services in grant applications? VDH absolutely agrees. Sees no reason to discontinue the ITPs that have been so successful. Hannah emphasizes guidance and has definitely allowed exploration of these new modalities. VDH wants to continue ITPs and Daniel and Hannah talking about how to take lessons learned and roll them into the CTR network of services. CTR will evolve but definitely going to keep ITPs alive. Our consumers and partners have brought us valuable lessons.
   b. Not wedded to OraSure as a kit provider. May be moving toward a 4th generation test. Currently VT using a 2nd generation test. Confident about moving to finger stick model. Easier to integrate Hepatitis C testing. Both specificity and sensitivity is improved with the 4th generation test. We know HIV is 750 times more infectious in the acute phase and this is something VDH is always staying up on any new advancements in this area and determining if advances should be integrated. Need to take a balanced approach to specificity and sensitivity – if we have too many false positives people will lose faith in the HIV test overall and will not get tested.
   c. CTR will be funded at same level going forward. Finger stick is cheaper option.
   d. CDC sees the ACA as providing everyone access to an HIV test through a medical provider. Should VT carve money out of HIV prevention dollars to make sure medical providers are doing this testing? Daniel feels no, because there is funding in place through the ACA to emphasize what

medical providers should be providing. But VDH nurses can be reaching out to providers in their catchment areas as part of their salaried positions.

5. JURISDICTIONAL PLANNING: addressed through salaried positions, contract with CHL.

6. CAPACITY BUILDING AND TECHNICAL ASSISTANCE: Jonathan Radigan, addressed through salaried position.

7. MONITORING AND SURVEILLANCE: have begun having people enter their own data, and give folks access to data in real time. How have providers experienced this? Providers really like it.

8. Last note on RFP – VDH would like to delay first CAG meeting until February in 2015. February 10&11 NASTAD is meeting on evolving HIV prevention in MA, RI, NY, CT, ME, NH. Would like to have that information on the table before RFP is issued.

D. Conference Updates
    1. Grace reported on Harm Reduction Conference in Baltimore.
        a. Good to go and see that Vermont is ahead of the curve in many respects, even as conference is very inspiring to do more. Great to see where we could go, where we may not be able to go.
        b. There were sessions on PrEP at the conference – not specific to PrEP and IDU, but more "PrEP overview."
        c. Any talk on the federal ban? Yes, but no movement and people feel very defeated about it.
        d. Sessions on safe injecting, injecting in bathrooms/in communities? Yes. All exchange are work with the problem of people injecting in bathrooms. Does not happen often at our exchange but does happen and must deal with it when it does – track it, it happens, it is not increasing. Presents realization that people have NOWHERE to go to safely inject. Difficult to find a balance between not wanting to encourage but still help find a safe place. Lot of talk at conference about this.
        e. Could this be a possible policy issue? Getting sharps containers into restrooms? Restrooms at Department of Health? Tom is indeed working on that. Maybe something to try to put up at rest areas in state? VDH website also has information on how to make an effective sharps container.
    2. Alex and Laura reported on attending the Global and Local Plagues conference in NH.
        a. New England overview of data and trends was excellent. Vermont's Alex Goode was a great presenter and has fantastic reports.
        b. Bryan Marsh from DHMC emphasized the commonness of concurrent diagnosis of HIV and AIDS.
    3. National Coalition of STD Directors Meeting. Daniel reported.
        a. NCSD is to STDs generally what NASTAD is to HIV specifically. Coalition votes on core component document that outlines what every STD program should do.

b. Daniel talked about gonorrhea control program he is doing, and how that might impact HIV. Several other individuals spoke about programs that will have an impact on HIV.
c. Heavy emphasis on third party billing and what public health programs doing on third party billing as federal money is being reduced. VDH is accredited – one of the first 3 accredited in US for third party billing. Would need names to get reimbursed. Doing just under 1,000 tests, and therefore not worth the money to bill third party for that number of tests. Even those doing 16,000 tests, the billing does not support the service being funded.
d. Insurance plans want to start screening women 24 and under for chlamydia. They are also being screened for gonorrhea but not site specific.
e. Douglas Brooks, policy czar, spoke – emphasized importance of integration, and talked about the impacts of trauma. He spoke to the issue that something that is not monitored by CDC is the level of trauma people are in when they get this kind of diagnosis.
f. Presentation on PrEP – looked at the Hopkins Self-Assessment tool. May not be the best document, but more than the CDC's current 6 question assessment. Good tool to give consumers if they want to consider PrEP, and advocate for themselves.

II. BUSINESS:

A. Minutes: In the section on Safe Recovery, Alex recorded significantly incorrect numbers, and Grace will update these. Jonathan moved the minutes, Jo seconded, there was no discussion, and the minute were unanimously accepted.
B. Daniel's updates: Final funding for Part C at last meeting was not known. Current statement is "for fourth year of grant, you will be awarded up to $100,000 to complete this project" but still did not specify how much would be awarded. They have issued the statement that "no new activities can be delivered under this intervention, and it should be wrapped up" but after that, it is uncertain what will happen. It was asked, what is this Part C project? Multi-prong intervention serving IDU using a combination of testing, syringe exchange, case management, and trying to evaluate what is most impactful.
C. Public Comment: None.
D. Announcements:
    1. Roy announced Focus Group for Needs Assessment in Burlington.
    2. Roy distributed posters for World AIDS Day event, December 1 in Montpelier.
E. Community Concerns/Cheers and Fears: The lack of cookies is still extremely problematic.

Respectfully submitted,

Alexander B. Potter