# HIV/AIDS Community Advisory Group Meeting Minutes

January 17, 2017; Three Stallions Inn, Randolph VT

**Attendees:** Laura Byrne, H2RC; Rick Dumas, APSV Board; Jonathan Heins; Peter Jacobsen, Vermont CARES; Chuck Kletecka; Zpora Perry, CCC; Karen Peterson, AIDS Project of Southern Vermont; Amy Tatko, VT PWA Coalition
**Remote Attendees:** Grace Keller, SafeRecovery
**VDH:** Erin LaRose, Daniel Daltry
**Caracal Consulting:** Alex Potter

Meeting opened 11:06 a.m.

I. **Introductions:**
   A. Daniel announced that the new Commissioner of Health is Dr. Mark A. Levine, succeeding Dr. Harry Chen. Dr. Levine was a Professor of Health Medicine at the University of Vermont and an adult health specialist.
   B. Daniel announced that the role of CAG coordination is now filled by a new vendor – Caracal Consulting. This is Alex's new independent business. VDH and Caracal are excited about the partnership!

II. **Vermont Epidemiological Maps:** Daniel reviewed three slides of new epidemiological maps regarding syringe exchanges, HIV/HCV rates, and opiate deaths.
   A. Gentleman out of Baystate is doing a two-year study under an NIH grant on how opiates impact New England, focusing on Maine, New Hampshire and Vermont. He is mainly working with the ADAPs in the states but Daniel was fortunate to be on the call with him and the ADAP representatives. Notably, Vermont was held up as a model. We always focus on where the continued need is in the state, but in comparison to our New England neighbors we are held up as what the "baseline" should look like!
   B. Regarding the first map on syringe exchanges and HCV/HIV rates, Jonathan asked about the county of Essex. Daniel said that when the CDC looked at areas of vulnerability to HCV/HIV outbreaks, they assessed "indicators that are predictors that an outbreak could happen." Both Windham and Essex Counties were in the top ten of 250 sites noted. However, in discussions with colleagues in Kansas, they noted that very few people live in one of the highest risk counties designated in their state. Low resident numbers can skew outcomes. Jonathan said he was thinking about the prison systems, location in Newport, closeness to Canadian border.
   C. Regarding HCV data, Daniel noted there are a host of limitations. The system does not maintain good addresses. Only two populations – 30 and under, and 65 and older – are actively investigated. The middle age range is not followed cases are just marked as Chronic and reviewed, and demographic data is not available unless it is collected and sent by the initial doctor – the doctors are not

contacted if all information is not present. Currently we do know that acute infection is most likely to be seen in the age cohort of 30 and under. Age 65 and over are being highlighted due to CDC recommendations regarding this age range, and our state epidemiologist wants to stay closely on top of risk of outbreak in long term care facilities..

D. Source of these data are NEDSS and EHARS.
E. Regarding the Opiate Deaths and Treatment rates map, there was discussion on the high death rate in Rutland. Grace noted that she thinks part of it may be they do not have as much Narcan. Peter noted that while VT CARES has Narcan at their exchange, they are mostly asked to send people to Woodbridge, as that is the "official" distributor. Anything placing an additional referral in the process can lead to problems. Daniel asked Zpora about any information from the medical front in Rutland. Zpora reported that they do now have an Infectious Disease doctor there. Further conversation raised the following possible factors:
    1. Jonathan noted that Rutland is a gateway community from out of state. As Brattleboro is a gateway to drugs from Connecticut, Rutland is a gateway from lower Manhattan and other locations. The source of the drugs coming in could be tied to death rates based on numerous issues such as purity and level of Fentanyl present. Fentanyl can make a big difference.
    2. Grace noted that Fentanyl overdose is much harder to overcome. Narcan works on heroin but not as much on Fentanyl. A patient who overdosed was brought to the exchange, and in the ten minutes between when the ambulance was called and when it arrived, she needed to administer 4 Narcan doses and still do rescue breathing. One dose usually will bring someone around.
    3. Are there limits on how many Narcan can be distributed to an individual? There are not hard and fast limits. The Health Department would like exchanges to distribute one to an individual at one time. The exchanges understand this and are careful, but they do assess and give out what is needed by the particular clients.
    4. Peter noted a big thank you to Grace – for saving a life. She noted it is very scary and has happened a number of times – 8 to 10 times since 2013, and three times she has needed to do rescue breathing. It had been five months since one had occurred before this incident. She also stressed that **this incident really emphasizes the issue of time, and the need to call 911 from wherever the overdose occurred.** This is a message that needs to be **strongly reinforced for clients of the exchanges**.
    5. Jonathan inquired about communication and collaboration with Vermont opiate administrators, especially as relates to epidemiological data. Daniel noted that Jackie Corbally is the Opiate Policy Director in Burlington (as head of CommunityStat, a team of community representatives in health, law enforcement, housing, social services)

and Tom Dalton has been working closely with the Burlington Opiate Task Force.

6. Jonathan inquired if there was a matter of cost in the limitations. Laura said that yes, it is "not cost effective" to give more than one per person, but as stated, the exchanges give as best fits client needs. Jonathan asked about more money can be obtained to support this, and Laura said that in giving out what is needed, they report on their numbers to the state, and no one has come back to say they cannot distribute as they have been.

## III. HRSA Site Visit: August 17 – 19, 2016

A. The HRSA site visit was significantly different this year than at any time in the past, and much more intensive and detailed. There was a team of 8 to 10 individuals where in the past there were usually two. Daniel said it was a very thorough and intense visit, and Peter agreed – Vermont CARES was the community partner that was visited by HRSA as part of their visit. The evaluators conducted full days of investigation, and were very focused and targeted. The Findings of the visit were written up in the document distributed prior to the meeting.

B. There was a strong theme throughout the visit that the representatives saw that Vermont does not have enough money to operate as it has been operating and the financial investigator in particular was not encouraging about continued operation as is. He spoke strongly that he did not see how Vermont could continue without integration and consolidation of community services.

C. Daniel highlighted five items from the Findings to review in more detail.

1. **Consolidation/Integration:** HRSA's finding regarding their strongly expressed view that consolidation and integration of community services is an Improvement Option Finding. The various findings were Programmatic, Legislative, identified Strengths, and Improvement Options. This Improvement Option Finding is a mandate to keep talking about the issues raised and HRSA's recommendations. Programmatic Findings were places where HRSA guidance was not being met that need to be addressed in an Action Plan reported within 30 days of the report being delivered to VDH. Legislative Findings are those that could result in the state being placed on "draw down" if the state does not address and comply. Therefore, there is no immediate mandate to take action on consolidation/integration questions. It must continue to be a topic of regular discussion and careful consideration, and HRSA will be assessing to see that this discussion is happening. The current Vermont Project Officer is a great partner and very supportive.
2. **Site Visits:** Site visits to the community agencies from the VDH will now include a finance representative.
3. **Subrecipient Payment:** HRSA stated that the advance payment method currently used to fund grantees must be changed from

advancing one quarter payment, and instead to limit disbursement to "minimum amount needed," timed to match the "actual, immediate cash requirements for Subrecipient" to carry out grant duties. Erin and Daniel are assessing rebate income as a potential route to assist Subrecipient's performance of duties that have historically been advance-funded. This requirement is limited to HRSA grantees, and does not affect CDC and rebate funded programming. Tied to this was the HRSA Findings noting that Vermont was not meeting distinctions between Medical Case Management and Non-Medical Case Management, and advanced funds used to cover non-medical case management duties funded services that were not allowable as medical case management.

4. **Procurement and Contracting:** The concern HRSA represented here was that the current 30-day required notice to clients, et al, of an agency about to close, was insufficient and could significantly disrupt care and care adherence. This will be changed to 60 days. Discussion ensued about the difficulty for clients when any agency closing its doors, and no amount of pre-notice will be perfect or prevent all disruptions. Peter noted that this feels like it represents the fear on the HRSA representatives part that the community agencies are in danger of closing at a moment's notice – as reflected in other areas of the findings. VDH and community agencies are aware this is not the case, and that Vermont has been functioning well and strongly on this model for 30 years. At the same time it is recognized that this is certainly an area where as much notice as possible is needed and ideal.
5. **Service Definitions:** This references the categorizing of services to match HRSA requirements, specifically around Medical Case Management. VDH can no longer fund Early Intervention Services. HRSA wants active engagement by case managers with the medical providers, and the Care Provider must be looped in on Case Manager and Client conversations. This is happening, but not consistently, and documenting it is currently problematic. As we move to real-time CAREWare updating, this will involve HIPAA considerations as well. A release signed by client is enough for the Case Manager and Care Provider to have a conversation, but accessing medical records is a very different situation.

D. Follow-up Questions & Discussion:
    1. When will HRSA be coming back for their next site visit? Three to five years.
    2. What is the timeline for implementation? We need to set timelines for specific changes that will take time and be phased in, but much has already been addressed to bring VDH into alignment with HRSA requirements as noted in the Findings. The Improvement Option Findings are to be discussed and assessed during the 3 to 5 year period

and acted upon as result of, and in the time frame of, the conclusions arising from ongoing consideration.

3. CAG members thanked VDH for their hard work during the site visit, and expressed appreciation for Erin and Daniel filtering the Findings out to the CAG, and highlighting/breaking down important information.
4. Amid all the discussions about HRSA's concerns about continued functioning, on the broader scale is there any information or speculation on major changes in HIV/AIDS funding? Daniel is keeping in close touch with NASTAD (National Alliance of State and Territorial AIDS Directors) and NCSD (National Coalition of STD Directors), and all are watching very carefully to ascertain as much as possible as soon as possible. Everyone needs to stay tuned, and continue to monitor, and NASTAD and NCSD are both very active in this. Daniel is also going to be chairing the NCSD Public Policy Committee.

## IV. CAG Housekeeping

a. November 22, 2016 Minutes:
    1. Michelle O'Donnel of the PWA Coalition *was* in attendance.
    2. Page 2 (I.B.4.) – "VDH was previously funded nine agencies…" Strike "was" to read "VDH previously funded…"
    3. A question was raised about the statement that "testing was the biggest area of ask and biggest area of awards." This was surprising. Daniel clarified that yes, this statement is accurate, as this reflects the *prevention* dollars only, not all prevention & care.
    4. Page 2 (II.D.) – Strike "Two different work plans are advisable."
    5. Karen made a motion to approve, and Rick seconded. The minutes were passed with one abstention.
b. 2017 Meeting Details: Alex reviewed meeting details and the 2017 dates were confirmed.
c. Public Comment:
    1. Peter announced that VT CARES got the van! Following much work over many years, they will move forward with a mobile syringe exchange. A smaller van was identified as a better option based on client needs, and Peter anticipates the van beginning service in spring or early summer. Please let Peter know if there are particular hot spots for testing or Syringe Exchange that would be good for the van to visit – he will review any suggested places with VDH and move forward from there.
    2. Peter announced they are in the home stretch of the clinical trials they have been participating in, looking at a new HIV and syphilis combined rapid test, that is now going through FDA approval. They are currently looking for two or three individuals who are HIV+ and have EVER had syphilis. The trial is working out of only the Burlington office; a $40 stipend is provided for participation.

3. Peter announced that a group of organizations was able to effect change in how Hepatitis C will be treated in VT, with some exciting changes. Following written advocacy, good language changes were made that will hopefully battle the stigma around drug use.
    a. If the administration moves forward with the proposed language, specific restrictions to accessing Hepatitis C treatment have been lifted. It is no longer necessary that the candidate for treatment be abstinent from drugs/alcohol, and a much less severe level fibrosis to will now qualify individuals. Language requiring patients to see a specialist for Hepatitis C was not altered – in Vermont this can be hard to access, but the committee thought that was still a good idea and important to leave in place.
    b. Zpora expressed that while she thinks the changes are great, she is still concerned about providers not wanting to provide treatment, often out of a concern for adherence, as opposed to being punitive to certain candidates. Peter agreed and suggested that we can do work with the providers we know and do more education. It was noted that it is important to have a good conversation with treatment candidates about whether or not it is the right time for them to enter treatment. If they do not adhere or discontinue completely, it is much harder to get insurance to approve treatment a second time.
4. AIDS Awareness Day at the legislature will be March 21, 2017.

**V. VDH Update**

a. Song Nguyen began work as the Viral Hepatitis Prevention Coordinator on December 5th. She is a Vermont native who has been working in DC for the past 10 years. She has a strong passion for addressing health conditions that affect certain populations, with considerable prior work in healthcare justice. She comes into the position at a time when the grant has changed considerably.
    1. The grant is much more focused on care continuum, with both situational assessment looking at policy gaps, and also micro-level assessment, specific to community health centers, how many nurses are available, how many patients are screened, etc.
    2. A site setting or organization must be in the highest area of morbidity – it must be a concentration of at least 30% of the Hepatitis population. Overall, grantees must focus on 70% of their HCV positive population, with the geographic area representing a concentration of at least 30% being the focus in year one, and then in years two and three expanding to work with other areas that encompass the other 40%.
    3. Song is starting out in Chittenden county as prescribed by the grant.
b. Syringe Exchanges

1. Daniel announced that while the Barre Syringe Exchange is in place, the police chief there strongly favors a 1 to 1 exchange and this is how this exchange will start out. This is concerning in that 1 for 1 exchanges do not appear to be current best practice. There is concern that a 1 for 1 exchange creates more likelihood of an individual using a single needle repeatedly. In addition, *any* additional barriers in getting clean needles have historically affected client willingness to utilize an exchange. For now the positive aspect is the Barre exchange is open! It will hopefully evolve beyond a 1 for 1 policy.
2. Dr. Perez in Morrisville is very excited about running an exchange.
3. Dr. Richard Bernstein had first exchange day this past Sunday in Richmond.
4. Grace noted that it is important to keep in focus that 1 for 1 exchanges are not a solution – the goal is often that people are concerned about finding used syringes in the community, but in distributing between 700,000 - 800,000 syringes, their area has seen only 140 found in the community, with 75 of those found at one site. It's a place to start but it is important that as a syringe exchange community we always need to keep the option to NOT limit exchanges to 1 for 1 – the long term the message should be "is not a solution". Overall, communities with SEs find fewer syringes in their community. Grace has more data regarding this if people would like to see it.

c. New state Health Commissioner, Dr. Levine, begins in March.
d. The new QSRs for the new grant cycle are in the final stages of review and they will be out to grantees by end of month. The focus has been staying very close to the language awarded in the grants.

Meeting Adjourned 1:40pm

Respectfully submitted,
Alexander B. Potter