Vermont Department of Health HIV/AIDS Community Advisory Group Meeting Minutes
March 27, 2018; 10:00 - 2:00pm
Gifford Medical Center, Randolph VT

CAG MEMBERS PRESENT: Tom Aloisi, Vermont Agency of Education; Mike Bensel, Pride Center of Vermont; Laura Byrne, H2RC; Daniel Chase; Chris Fletcher, Board Member, People with AIDS Coalition; Pat Gocklin, DHMC; Weslee Hyslop, Consumer Advocate, VT People with AIDS Coalition; Grace Keller, Howard Center Safe Recovery; Chuck Kletecka, Board Chair, Vermont People with AIDS Coalition; Zpora Perry, UVM CCC; Karen Peterson, AIDS Project of Southern Vermont; Donna Pratt, Twin States; Paul Redden III; David Shein, ED, VT People with AIDS Coalition
REMOTE ATTENDANCE: Peter Jacobsen, VT CARES
GUESTS: Derek
VDH: Roy Belcher, Daniel Daltry, Erin LaRose, Jonathan Radigan, Vermont Department of Health
C^2: Alexander B. Potter

Meeting opened at 10:04 a.m.

INTRODUCTIONS: Weslee Hyslop, Consumer Advocate, and David Schein, Executive Director, of the Vermont People With AIDS Coalition were introduced and welcomed.

I. DISCUSSION ITEMS

A. Dashboard – 2017 Year in Review *[Dashboard attached]*

1. Alex reviewed full year Dashboard 2017, including syringe exchange data and revised display of data.
2. Discussion noted specific measures needing alteration from cumulative to weighted percentages.

B. 2018 VDH RFA and TRL: Presentation

1. Daniel, Roy and Jonathan presented successively on: PS18-1802 Required Strategies & Activities; Review of TRL/HIV Testing in 2017; and TRL Funding under the upcoming RFA, including TRL program budget considerations. ***[PowerPoint slides attached.]***
2. **Strategies Review:** 75% of prospective $1 million in combined prevention and surveillance funding must go to **11 required activities** and **15%** must go to **HIV Surveillance** specifically.
    a. More focused activity outcomes, reviewed at previous CAG meetings.
    b. Program Improvement Plans (PIPs) and potential for funding decreases if programs are not performing.
    c. Strategies 2, 4, 5, and 7 and their accompanying Activities were reviewed. ***[See attached Slides 4 - 11.]***
        i. S2. Identify persons w/HIV infection and uninfected persons at risk for HIV infection
        ii. S4. Provide comprehensive HIV-related prevention services for persons living with diagnosed HIV
        iii. S5. Provide comprehensive HIV-related prevention services for HIV-negative persons at risk
        iv. S7. Conduct community-level HIV prevention activities
3. **2017 Testing Review:** 447 total VDH-Funded HIV Tests; 379 total Network HIV Tests.
    a. 44% of Network Tests were MSM.
    b. Of 4th Quarter 2017 MSM Tests within Network, 67% assessed for PrEP.
4. **TRL Funding Structure:** Funded services based on TRL priorities of *testing HIV+ individuals unaware of their status*, *targeting* Vermonters at *highest risk for infection*, *recruiting targeted populations*, *providing bio-medical referrals* to all TRL clients regardless of HIV status.
    a. New structure will be funding ***Prime Vendors*** and ***Prime Vendors Enhanced***.
    b. **Prime Vendor:** Any organization wanting to deliver TRL must submit **Prime Vendor Application**.
        i. Reimbursed on per-client basis, rates based on priority populations, additional reimbursements for priority referrals. ***[Reimbursement rates – Slides 20 & 21; sample report form – Slide 22]***
        ii. If 100 tests conducted with no HIV positivity, grantee must cease testing and consult with VDH.
    c. **Prime Vendor Enhanced:** Must be approved **Prime Vendor**, target 100 MSM tests, and will be awarded additional funding for Recruitment & Outreach, Advertising, Incentives, and Salary.
        i. Applicants must detail how enhanced funds used across four domains.
        ii. Held accountable to goals set in application, with funded reductions if standards not met.
    d. RFA Budget Categories line-by-line review of allowable expenses ***[Slides 26 - 32]***

C. 2018 RFA and TRL: Q & A

- Clarification of 75% and the TRL domains – is any percentage required to be targeted on TRL?

    - DD: No. TRL falls under the funded activities of the 75%
- Is 100 negative tests too high before requiring a performance review?
    - DD: Still have 1% positivity requirement and still must target based on morbidity. If all agencies were doing testing, that would be greater than 700 tests done statewide. A greater population is being tested and that does not match state morbidity. Prior to 100 tests would likely be too soon.
    - Roy: VDH does review QSRs and enter discussions regarding performance.
- Are other states paying by referral? Why paying for staff to do job they should be doing already?
    - DD: No, some do not even pay at all. VDH believes staff wear lots of hats in Vermont organizations and are to be commended and rewarded for performing as needed.
- Do Network testing sites offer additional STD screens and if not, when might they be able to?
    - DD: Not currently. Investigating the technologies that would allow this.
- Wouldn't Prime Vendors be doing all the tasks that Prime Vendor Enhanced are getting more funding for?
    - DD: Not necessarily. There are entities that may have straightforward testing services that do not require advertising, recruitment, targeting, etc. For example, agencies with syringe exchanges may be able to test exchange members without significant additional costs.
- Focus on 100 MSM tests; are there expectations/objectives for reaching heterosexual populations?
    - DD: There are not set goals, but there are reimbursement rates set.
    - Roy: While goal is for 50% of ALL tests be MSM, do want vendors to test high risk heterosexuals, e.g. partners of people living with HIV. Want to refer lower risk testing to medical providers but recognize some agencies may have a good into high risk heterosexual populations. Additional populations need to be justified, as VT morbidity is gay men.
- How many vendor awards for PVE will be available? Will more than one be awarded?
    - DD: No set limit on vendors, and this is for a 5-year funding period. VDH will look to balance the applications and determine how many vendors are ideal for reaching state needs.
    - Jonathan: For example, a funding structure may be something like four .3 FTEs to be targeted around state. No agency should be applying for a full FTE just for a testing vendor. Realistically, if every agency is granted, it would hobble grantees in reaching their specified goals.
- Are there any ways for following up PrEP referrals/compliance?
    - DD: Experience thus far has been the folks linked to PrEP have not wanted additional follow up/support. CDC is interested and VDH may be asked about it, but our data has not indicated this is a warranted activity. CDC would love ongoing monitoring, but if folks do not want the service, there are limited options. VDH will entertain it as a service if an agency would like to tackle it.
    - Roy: We cannot surveil PrEP. We get viral load testing data but don't know if they are on PrEP, and should not know, as it is not reportable. Anecdotally, can say prescribers have been good about keeping folks using PrEP engaged.
    - DD: Planned Parenthood is prescribing to over 350 individuals on PrEP.
- Twin States does not test or intend to, but curious - why is heterosexual risk higher priority than IDU risk?
    - DD: It is based on state prevalence data.
- 'No out-of-state travel' mentioned in budget review – can training money be used for out-of-state travel?
    - Jonathan: Should be no need for VT testers to be trained/provide services out-of-state.
    - ***Clarification:*** Training/out-of-state travel money for TRL versus for other interventions.
    - Jonathan: That training/travel money (for interventions) held for staff/volunteers to be trained in funded model of intervention. Understood that may involve travel out of state for training.
- There is a large group of men who do not identify as gay or who do not come out as gay, but who engage in sex with men and risky behaviors. Some are married. They are hard to reach with testing services that are targeting gay men. They may want to get tested but won't go to Planned Parenthood, won't ask their doctor, and won't show up as MSM because they will not come out or share that they have sex with men.
    - DD: Yes, this is ongoing recognized issue. Also came up during the Needs Assessment. How can we assess the needs of people we cannot find, talk to, or reach with services? We recognize we may not access all populations, but still want to target testing to at least 50% MSM.
    - Mike: Good news is that we (Pride Center) **do** see a lot of men who meet the described profile. They tend to use hook up apps, and Pride Center advertises regularly there, and reach them that way.

D. 2018 RFA Timeline

1. RFA distributed to CAG members for **May 29 CAG Meeting.**
2. **May CAG Meeting** focused on RFA discussion and questions.
3. Planned RFA official release for applicants is **July**, likely to be due in **September** for funding decisions in **October.**

II. VDH REPORT

A. Close Out PS12-1201: Final report to close out the prior funding cyle has been submitted. Speaks to the duration of work for the last six years.

B. Comprehensive Syringe Services Programs Working Group

1. Working group founded by Governor's Opioid Coordination Council, with VDH assigned to take the lead and ensure representation of those running Syringe Service Programs.
2. Group has met twice, established bylaws, and is currently working on a Logic Model and selection of indicators.
3. Will produce a document on recommendations related to expansion and case management services.
4. Questions & Answers
    a. Any discussion of safer injection sites? No, not at this time. This was deemed a "not for now" topic, with a focus instead on what could be done first. Conversations about the entire topic of syringe exchanges have changed and the group is feeling encouraged.
    b. What products will this group produce? Initially the charge was to provide an implementation plan, but this was revised by the supervisors at VDH given the state is already implementing syringe service programs. Instead, the group will provide final recommendations, by June, on indicators for measuring success, reach of SSPs, locations for SSPs, and infrastructure needed.

III. CAG HOUSE KEEPING

A. Minutes: January 31, 2018

1. No changes or corrections.
2. Karen moved that the minutes be passed as written. Dan Chase seconded the motion.
3. Minutes passed with no one opposed and one abstention.

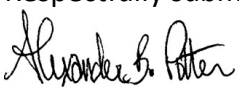
B. Announcements

1. Donna: Women's Retreat is May 31 – June 3. Twin States has hired Penny Cleverly as a part time Executive Director to complement Donna's role. Penny will focus on peer support and peer advocacy.
2. David: The PWA Retreat will be July 19 – 22, for anyone who is positive, or the partner of someone positive. David distributed a copy of the mailing going out and can provide more for anyone wanting to send them out.
3. Pat: Peggy Villars has retired. The new person, Julie Bardales, can be reached the same way Peggy has been in the past.

C. Upcoming Meeting Topics

1. May – RFA Review/Questions
2. July & September – Populations of Interest including trans populations in July; and in September showing Etched in Granite film with a potential Vermont Panel
3. November is open and welcome requests. Suggested panel regarding People Who Inject Drugs.

Meeting adjourned at 1p.m.
Respectfully submitted,



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