HIV/AIDS Community Advisory Group Meeting Minutes – May 11, 2016; Randolph VT

Attending:

- Tom Aloisi, VT AOE; Mike Bensel, VT Pride Center; Laura Byrne, H2RC; Dan Chase; Sue Conley, APSV; Miriam Cruz; Rick Dumas, APSV Board; Chris Fletcher; Kim Fountain, VT Pride Center; Pat Gocklin, DHMC; Peter Jacobson, VT CARES; Chuck Kletecka; Deb Kutzko, CCC; Zpora Perry, CCC; Karen Peterson, APSV; Donna Pratt, Twin States; Paul Redden III; Paul Redden IV; Amy Tatko, PWAC
- Daniel Daltry and Erin LaRose, VDH
- Alexander B. Potter, CHL

Meeting opened at 11:04 am.

I. RFP – PREVENTION

A. Daniel opened the discussion on the Prevention RFP, following last meeting's review of Care. He reminded members that this would not be their last chance to offer feedback. The June 14 meeting will discuss scoring: panelists, scoring criteria, etc. He will share what has been used and CAG will have a chance to weigh in.

B. This will be a two-year RFP, for 2017/2018. The CDC has not released the new iteration of funding yet, so there is one year left on 12-1201, and the next will be under the new release. This next iteration of funding may have new or different guidance. If the changes are severe or drastic, we can meet as a body to discuss changes to our funding for 2018.

C. Daniel reviewed the restrictions on funding uses, e.g. the 75/25 split.

1. **Category A** – at least 75% must be allocated to required domains
2. **75% Required Core Components**
   - *a. HIV Testing*
     - i. Support routine testing in medical settings
     - ii. Promote routine, early HIV screening of pregnant women
     - iii. Facilitate testing for other STDs, hepatitis & TB
     - iv. Goal of 1% positivity rate from non-clinical sites
   - *b. Comprehensive Prevention with Positives*
     - i. Linkage to care & treatment
     - ii. Retention or reengagement into care
     - iii. Partner Services
     - iv. Risk Reduction – may be broadly defined; goal is to remove barriers to HIV prevention without lobbying
   - *c. Condom Distribution – to focus on PLWHA first*
   - *d. Policy Initiatives*
3. **75% Required Activities**
   - *a. Jurisdictional Planning Group - CAG*
     - i. Needs Assessment
     - ii. Jurisdictional HIV Plan required
       - Align with NHAS
       - Letter of concurrence
       - Needs assessment, resource inventory, gap analysis, prevention interventions/strategies
     - iii. "Engagement Process" – addresses coordination across all HIV programs (prevention, care & treatment
   - *b. Capacity Building and Technical Assistance*
     - i. Internal Training Needs (within VDH)
     - ii. Perform official needs assessment internal & external
   - *c. Program Planning, Monitoring, Evaluation*
     - i. Additional reporting on funds used in an area with 30% or more HIV cases
4. **No more than 25%** can be used for:

a. *Evidence Based Interventions for High Risk Negatives*
b. *Social Marketing, Media, Mobilization*
c. *Pre-Exposure Prophylaxis and nPEP (no $ for meds)*
d. *SSP services*

D. **SSP:** HRSA and CDC just released guidance for funds for running syringe service programs – the funds can pay for staffing and supplies, just not needles/syringes. They have not indicated, if an applicant gets approval, if it is part of the 75%. VDH applying by end of May. Any funds received must be spent by the end of 2016. The CDC has said that decisions made at this time are **precedent setting**, so once approved, **it stands going forward**. Vermont being approved now would prepare us well for 2017 funding.

E. CDC is still holding Vermont to the goal of 1% positive rate from non-clinical testing services, which is one positive per every one hundred tests. One percent is likely not even a reality for Vermont. We are .008%. We very likely have 90% viral suppression, but the focus is still on this 1% positivity. CDC continues to push for increased number of testing, but the more tests we do, the more difficult it is to reach a 1% positivity, given our low incidence.
   1. Targeting for our testing numbers is important going forward. Currently 54% of gay men are positive, but only 22% of our testing is on gay men.
   2. Discussion of CD4 reporting/measures was had – the VT lab has not been able to provide assurance that they could break out the CD4 only of the HIV positive patients. Only 25 states have CD4 reporting in place. VDH prefers to stress "what is the PURPOSE of collecting a piece of data" and thus far, collecting CD4s has seemed intrusive and unnecessary, given the lack of a public health purpose for getting CD4 counts on people who are NOT HIV positive, which is currently the only way any CD4s could be counted.
   3. Tracking condom distribution continues to be something that is asked for in each report, and VDH has looked into this with community providers. Providing a number of condoms distributed to positive individuals is not something VDH will require.

F. Big changes in Prevention funding:
   1. Category C (HIP) is gone.
   2. There is no indication that there will be anything like a category C in the next iteration of funds.
   3. A list of eligible projects was released that looked much like HIP (High Impact Prevention) but ***no one*** in New England was eligible, even if we collaborated with other states and formed a New England Coalition.
   4. *Counseling, Testing and Referral* is now *Testing, Referral and Linkage*.
   5. HRSA and CDC are allocating for SSP's based on determination of need.
   6. PrEP medication still cannot be paid for out of these funds.
   7. Must demonstrate allocation is matched to geographic areas with 30% morbidity, as has been the case.

G. Daniel described his suggested plan, based on reviewing the Needs Assessment, NHAS, and the guidance.
   1. Brief Outline (*suggested*):
      a. 75% Distribution
         i. **In-house:** VDH Staffing; Condoms, TRL Supplies; Capacity Building; Travel
         ii. **TRL:** TRL* (embedded PrEP model); TRL ASO
         iii. **Other:** CLEAR, Peer Outreach, Other CDC EBI's; Transportation for Mental Health Services
      b. 25% Distribution
         i. Mpowerment
         ii. SSP
   2. This plan is suggesting two different models for testing: TRL and demonstration over two years with PrEP embedded in testing and linkage. Instead of ITPs, there would be one: TRL+.

3. Will not be funding three different CLEARs. Saturated population. See a possible future for one CLEAR provider for positives, serving statewide population.
4. Peer outreach: referral and linkage, monitoring and assessing referrals, how they are made and how they are linked. A Peer Outreach Linkage Specialist is a possibility. HIV Navigator Providers. Could be a standalone FTE or a portion of the FTE positions that currently exist.
5. Could look at other EBIs. Could identify ones that would meet a need.
6. Can see some of prevention funding going toward helping provide services Ryan White won't fund. Transportation other than just to HIV appointments is a high need. (e.g. mental health appointments)
7. **Question:** Is CDC moving away from CLEAR? It is hard to say. Their training schedule is not offering good opportunities to become trained in it. Right now, what is known is that there is a clear shift to biomedical interventions and less on counseling and sociobehavioral interventions. A striking example is in the movement from CTR to TRL. It is not clear what "EBIs emphasized and supported by CDC" will be this time around. Some originally approved have now been de-emphasized or removed.
8. **Question:** What will testing reimbursement look like? Potential to raise reimbursement level to $40, for anyone doing test in identified high-risk population. Anyone to be reimbursed for testing needs to put in short Targeted Testing Plan application - how they will recruit, monitor, link to care . RFA will have more.
9. **Question:** Positives referred to care, but where for high-risk negatives? PrEP; alcohol & drug services.
10. **Discussion:** Anonymous and confidential testing models. The CDC has endorsed a rapid on rapid algorithm – if two rapid reactives, that could indicate more strongly that test is a true positive. That would allow for anonymity until that person is linked to care. As a state of testers, we need to challenge ourselves to think further about the anonymous/confidential model we have in place. Currently we place a heavy stress on the anonymous model, and this may be working against ourselves. This may reinforce stigma. Anonymous options were critically important at a time, but as HIPPA has moved forward and changed somewhat, this may have changed – this is not a suggestion we do away with anonymous testing, but how can we introduce a confidential option into our testing regimen. General discussion among CAG members demonstrated support for the concept of reinforcing confidential testing as a fight against stigma, and clarified again that this is not a suggestion to move **AWAY** from anonymous testing, but a move to **ENHANCE** our confidential services. There is no hard cap on number of tests an agency could do, but at the 100 mark, VDH would need to check in. Concerns were expressed that we lose people to the testing process whenever testing becomes at all threatening to those who most need to be tested – Daniel stressed that we would not take away any anonymous services, that this is instead an effort to cultivate testers who have the ability to help the individuals getting tested to trust in the system, as we currently see with people who come to the CCCs for testing. Testing training will happen next year. Jonathan is thinking about our training. CAG will play a role in that.
11. Daniel described what the goals would look like for TRL+. The service would be based in Chittenden County and have the ability to reach around the state – would want to see someone with access to an ongoing recruitment model for MSM; at least one MOU with a medical provider; HepC offered at same time; ensure STI testing is happening. HRSA expects this level of care with positive individuals – this would be a system to do it with high-risk negatives. It meshes well with both the NHAS indicators and how Mpowerment is evolving. Mike noted that they have been beta testing the new Mpowerment curriculum and it is excellent. There is more emphasis on HIV positive men. He is waiting for the Mpowerment folks to launch the break down of what it will look like; they have said they should have something by end of summer/early fall. Kim noted that VT Pride Center is excited about collaborating with other organizations, and this new Mpowerment model opens up space for a collaborative model with these efforts. CAG members expressed the strengths and challenges they saw with this model. A discussion of referrals and tracking referrals raised concerns about best ways to do so; Deb K mentioned an important point, that interpretation services and more materials in languages in addition to English are needed. They are seeing more non-English speakers at CCC including Syrian, Swahili and Nepalese.

12. Specific concerns from specific agencies included having only one CLEAR provider for the state, defining a prevention role for the PWA Coalition with the phasing out of WILLOW due to saturation, the continued demand for Mpowerment in APSV's area. Daniel acknowledged that we are very challenged around group level interventions given the saturation issues we have been encountering with CLEAR and WILLOW. Chuck suggested PWAC could look toward peer outreach/peer navigator role. Daniel noted other than HIV navigator services we are hard pressed to find an EBI that is a direct match for our area.

II. NEEDS ASSESSMENT: Alex presented on the Prevention Section of the Needs Assessment.

III. VDH REPORT

A. Regarding applying for syringe exchange support, Vermont's project officer has said directly that VT should apply for the entire state. VT has two counties identified as high outbreak risk. Roy has assembled excellent data and is partnering on writing the application.

B. New testing guidance from CDC – distilled version is that there is an emphasis on a shorter test session, assess if we are using the right test, and assessment for appropriateness of PrEP. There is a movement away from oral rapid testing, toward the "fourth generation" test, a push toward using the rapid finger stick. Daniel and Hannah's assessment is that VT is currently using the right tool. To increase the rate of false positives is a greater concern than the current lag time. 30% of our tests are finger stick right now. Pat reported that the NH tester has been getting asked about the 4th gen rapid test, and people are going elsewhere for it. Daniel said that in interviewing about 100 MSM per year, he has not heard any asking for 4th gen. Mike reported that people who live outside of VT ask more, but otherwise he has not heard it more than once or twice.

IV. CAG HOUSEKEEPING

A. Minutes: Paul Redden III made a motion to approve the minutes. Chuck seconded. The minutes were passed with one abstention.

B. The change of date for the end of May meeting to June 14 was highlighted.

C. Public Comments: none

D. CAG Announcements:

1. Chuck noted that proposed language around syringe exchange does not include any reference to CAG as an advisory body and CAG is not identified as a body to be consulted in the syringe exchange programs. This is a continued concern that the CAG is not recognized as an important body to be consulted.
2. Kim announced that the Pride Center's biggest event of the year is Friday 5/13.
3. Amy distributed information on WILLOW and the PWA Retreat.
4. Rick noted that Brattleboro is having its AIDS walk on Saturday.
5. Peter announced that they have recently folded in social networks testing into the ITP in which they had been doing Testing Together -- it garnered 50 couples in two years, and now it's 60 tests in the last three weeks because of this change! Chiefly with the IDU population.

Meeting adjourned: 2:35 pm

Respectfully submitted,
Alexander B. Potter