State of Vermont Integrated State Plan for HIV Care & Prevention

including the

Statewide Coordinated Statement of Need



2016

Vermont Department of Health
Department of Health & Human Services
Health Surveillance Division
HIV, STD & Hepatitis C Program
Burlington, Vermont



Letter of Concurrence between the Vermont HIV/AIDS Community Advisory Group and the Vermont Department of Health

DATE: September 2016

TO: CDC/HRSA Project Officers as named below

RE: Vermont's Integrated HIV Prevention and Care Plan

Rita Volipitta
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Dear CDC & HRSA Project Officers:

The Vermont HIV/AIDS Community Advisory Group (CAG) concurs with the following submission by the Vermont Department of Health in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

The Vermont HIV/AIDS CAG has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. This planning body concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

The Vermont CAG provided input into the development of the Integrated HIV Prevention and Care Plan through oversight, assisting coordination, and direct participation in the consumer-driven Needs Assessment process that contributed substantially to the Statewide Coordinated Statement of Need and to the larger body of the Integrated Plan. The Vermont CAG meets seven times per year and gives input into assessment and planning for HIV/AIDS Services in Vermont. The CAG reviewed and approved the Integrated HIV Prevention and Care Plan for Vermont through the process of individual review and group vote for concurrence.

The signatures below confirm the concurrence of the planning body with the Integrated HIV Prevention and Care Plan.

| Signature: | Date: | | | | | | | | |
|---|-------------------------|--|--|--|--|--|--|--|--|
| Peter Jacobsen, Community Advisory Group Co-Chair | | | | | | | | | |
| | | | | | | | | | |
| Signature: | Date: | | | | | | | | |
| Daniel Daltry, Vermont Depart | ment of Health Co-Chair | | | | | | | | |

SECTION I. Statewide Coordinated Statement of Need/Needs Assessment

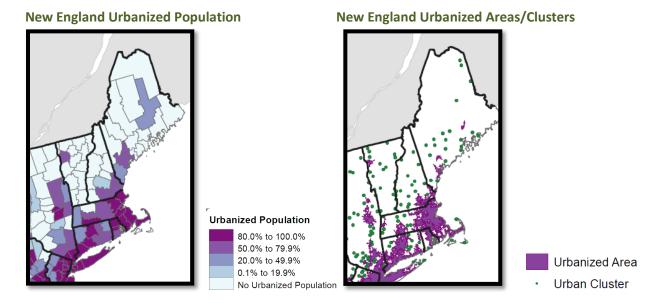
A. EPIDEMIOLOGIC OVERVIEW

a. Describe (map and/or narrative) the geographical region of the jurisdiction with regard to communities affected by HIV infection.

The geographical jurisdiction of this Statewide Coordinated State of Need is the state of Vermont, with an estimated total population of 626,042 individuals. [Census July 2015] Vermont is comprised of 14 counties, only one – Chittenden County in the northwest corner of Vermont – is classified as an "urban area" by census definitions. The maps below demonstrate Vermont's urban/rural characteristics, contrasted with the surrounding New England states.

The map on the left indicates the location and placement of Chittenden County, while the one on the right represents the additional locations in Vermont that can be defined as "urban clusters," of which Vermont has 15. The Census Bureau identifies two types of urban areas:

- Urbanized Areas (UAs) of 50,000 or more people;
- Urban Clusters (UCs) of at least 2,500 and less than 50,000 people.
- "Rural" encompasses all population, housing, and territory not included within an urban area. [https://www.census.gov/geo/reference/urban-rural.html]



In these visual representations, of note is Vermont's placement – closely surrounded by "urban" and "urbanized" areas in other states. Unlike other largely rural areas with low population numbers, residents can easily access urban centers in a few hours. The interstate highway system in New England provides fast, unobstructed access to the much more populous areas of Boston and Provincetown, MA; Providence, RI; Manchester and Portsmouth NH; the Maine Seacoast from NH to Portland, ME; Albany and New York City, NY. Montreal, Canada, is also an easy drive from all of Vermont.

A small, rural state with a relatively small overall population, Vermont residents nonetheless interact with out-of-state communities and individuals to a great degree, affecting aspects of HIV risk.

- This expedient access to populous urban areas is a factor in Vermont's HIV risk demographics.
 Given the lack of gay infrastructure in Vermont, these are all destination locations for Vermont men seeking social outlets.
- These same routes have historically been singled out for making drug trafficking easier, bringing drugs that can be bought cheaply in larger cities into Vermont, where they can be sold at higher profit.
- The limited summer months in Vermont turn specific swimming holes in the state into destination locations for gay men from other surrounding areas, which serve as recreational, social, and sexual gathering locations. Vermont is known for a relaxed approach to swimming areas.
- Vermont is the site of Faerie Camp Destiny, in Chester, VT, a gathering location for the nationally-networked gay, bisexual, and transgender men's group, the Radical Faeries.
- b. Describe (table, graph, and/or narrative) the socio-demographic characteristics of persons newly diagnosed, PLWH, and persons at higher risk for HIV infection in the service area, including Demographic data and Socioeconomic data as available

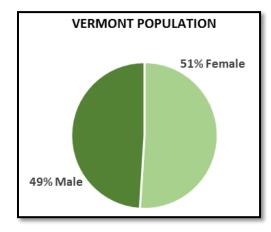
Vermont has the following majority demographic features: of the estimated total population of 626,042 individuals, 95% are categorized as White [Census July 2014]; 50.7% female; 63.7% between the ages of 18 and 65 [Census 2014]; and 91.6% having a high school diploma. Vermont has 665 documented individuals living with HIV/AIDS.

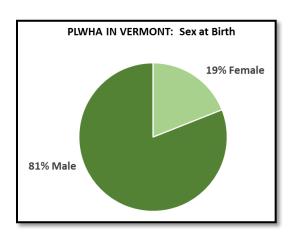
DEMOGRAPHICS:

Sex/Gender Identity:

Vermont's population is 50.7% female and 49.3% male. The table and charts contrast the proportion of Vermont's PLWHA population. Sex at birth as a graph demonstrates that the Vermont HIV epidemic represents a primarily cisgender population.

| GENDER | % of VT PLWHA | % of VT POP |
|--------|------------------|----------------|
| MALE | 81% | 49% |
| FEMALE | 19% | 51% |



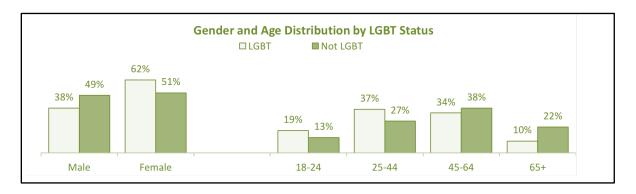


Sexual Orientation:

Gay, bisexual and other men who have sex with men are at significantly higher risk for HIV/AIDS. The transmission category of male/male sexual contact accounts for the highest HIV transmission rates in Vermont, representing 55.5%, with "male/male sexual contact *and* IDU risk" accounting for another 5%. All other transmission risks fall below 20%, including the next highest, heterosexual contact, at 17.1%.

Demographic information broken out along sexual orientation lines is not widely available given it has only begun to be collected more recently in programs such as Healthy People 2020 and Behavioral Risk Surveys. According to LGBT data that is available for Vermont, five percent of Vermont adults identify as either lesbian, gay, bisexual, transgender, or other sexual identity (LGBT). Unfortunately, this data is not broken out by gender within the demographic categories.

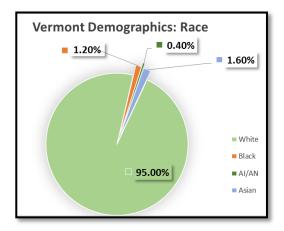
Four in ten (38%) Vermont LGBT adults identify as male. [BRFSS] More than half of Vermont LGBT adults are ages 18-44 (56%), versus 40% of Vermont's non-LGBT population, and overall are more likely to be a racial or ethnic minority, compared with non-LGBT adult Vermonters (10% vs. 5%).

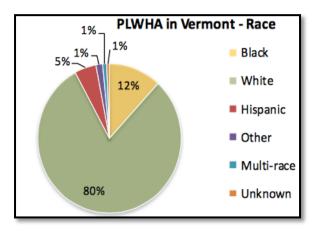


Race:

Of PLWHA in Vermont, the majority are White, at 80.2%, followed by Black at 11.9% and Hispanic at 4.9%. This is in contrast to Vermont's overall population, which is predominately White.

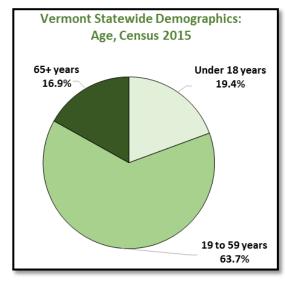
| DEMOGRAPHIC | % OF VT PLWHA | % OF VT POP |
|-------------|------------------|----------------|
| BLACK | 11.9 | 1.2 |
| HISPANIC | 4.9 | 1.8 |
| WHITE | 80.2 | 93.8 |

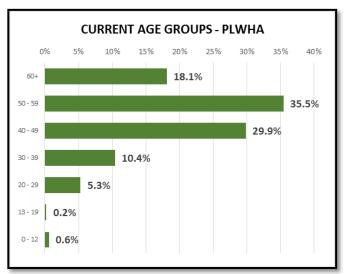


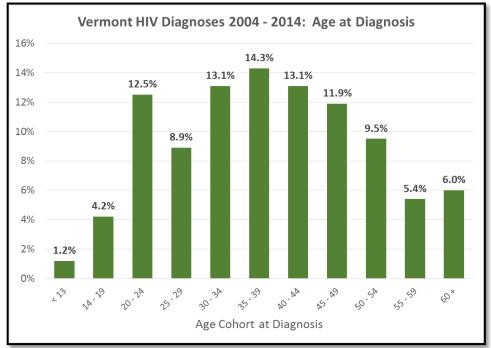


Age:

The age profile of the state as a whole and the PLWHA community is contrasted below, followed by a graph of age at diagnosis.

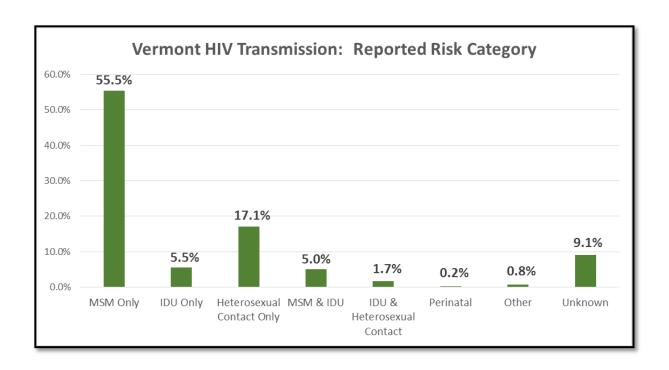






TRANSMISSION CATEGORY:

Transmission data indicates that the majority of Vermont's PLWHA's fall into the men who have sex with men risk category, at 55.5%. All other risk categories register below 20%, with heterosexual transmission the next highest at 17.1% and injection drug use at 5.5%. It is important to note that while "IDU only" stands at 5.5%, the category of MSM and IDU transmission risk accounts for an additional 5%.



SOCIOECONOMIC DATA:

The most current Census data reports that 12.2% of Vermont residents live below the federal poverty line. The median household income is \$54,447 and the per capita income is \$29,535. Median housing rates are \$1,541 per month for homeowners with mortgages, and \$889 monthly gross rent for renters.

There are no statistically significant differences between the LGBT and non-LGBT adult population in Vermont by education status, annual household income level, employment status, or the presence of children in the home. The vast majority of Vermont residents (91.6%) have a high school diploma, with approximately one third of residents having a bachelor's degree or higher.

Of the state's PLWHA, 76% are below 500% adjusted gross federal poverty level.

A total of 24% of Vermont residents, and 9.8% of the population under 65, are living with a disability, a number that likely crosses over with the PLWHA population of Vermont. Of Vermont residents below 65, 5.9% are living without health insurance. [BRFFS]

All Vermonters living with HIV have access to health insurance with assistance from the Vermont Department of Health.

c. Describe (table, graph, and/or narrative) the burden of HIV in the service area using HIV surveillance data and the characteristics of the population living with HIV (i.e., number of PLWH, rates, trends, populations most affected, geographic concentrations, deaths, etc.).

Contrasting Vermont population demographics with Vermont's HIV/AIDS burden, the following emerges:

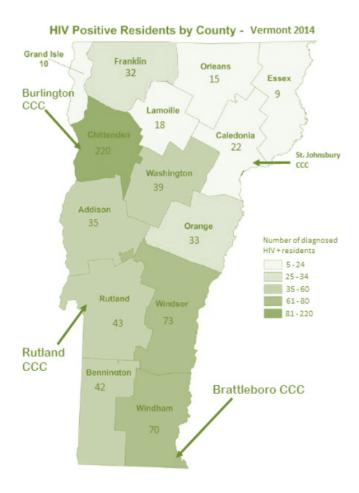
1. 665 individuals were known to be living with HIV/AIDS in Vermont as of December 31, 2014, resulting in a case rate of 106 per 100,000.

- 2. Two factors indicate immediately that men who have sex with men remain the most heavily affected population in Vermont. A statewide sex ratio of 50.7% female and 49.3% male, and an HIV/AIDS burden of 19% female and 81% male, is complemented by a 55.5% identified transmission risk of "MSM only" among PLWHA.
- 3. People of color specifically Black/African American individuals are disproportionally represented in Vermont's epidemic. While comprising only 1.2% of Vermont's population, they comprise 11.9% of Vermont PLWHA.
- 4. In the ten-year period of 2004 to 2014, the majority age at diagnosis fell between ages 30 and 45, together accounting for 40% of HIV diagnoses.
- 5. Vermont's HIV/AIDS burden generally follows its population spectrum, with by far the largest number of PLWH 220 residing in Chittenden County, the most populous county. The only notable anomaly to this pattern is Windham County, with a PLWHA population of 70, and a total population of 43,386 representing a larger percentage of PLWHA per overall population.

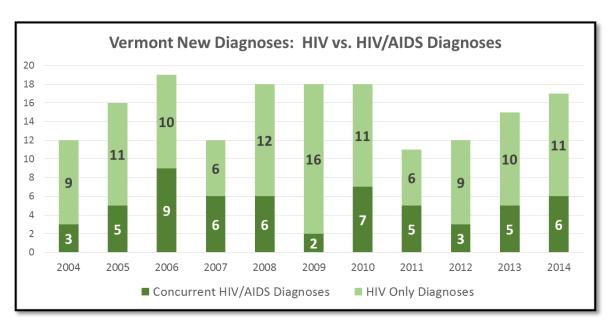
Vermont's fourteen counties are displayed in the chart below, with the total 2015 Census population estimates in column one, and the total number of Persons Living With HIV in column two, from the Vermont Department of Health data. The third column reflects that county's percentage of Vermont's PLWH.

| | TOTAL | | % VT |
|------------|------------|------|------|
| COUNTY | POPULATION | PLWH | PLWH |
| Addison | 37,035 | 35 | 5% |
| Bennington | 36,317 | 42 | 6% |
| Caledonia | 30,780 | 22 | 3% |
| Chittenden | 161,382 | 220 | 33% |
| Essex | 6,163 | 9 | 1% |
| Franklin | 48,799 | 32 | 5% |
| Grand Isle | 6,861 | 10 | 2% |
| Lamoille | 25,235 | 18 | 3% |
| Orange | 28,899 | 33 | 5% |
| Orleans | 27,100 | 15 | 2% |
| Rutland | 59,736 | 43 | 6% |
| Washington | 58,612 | 39 | 6% |
| Windham | 43,386 | 70 | 11% |
| Windsor | 55,737 | 73 | 11% |

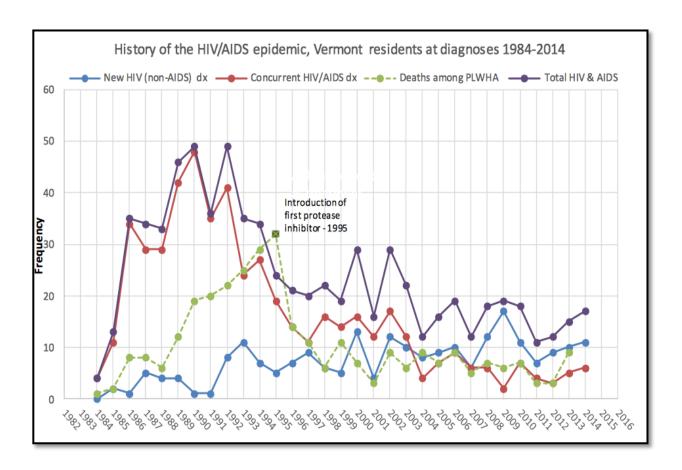
The following map provides a visual accompaniment to the table.



The graph below indicates the diagnoses patterns in Vermont, over the decade of 2004 – 2014. Overall, Vermont diagnoses have come before the individual has progressed to AIDS, but a number of diagnoses per year continue to locate individuals who have not discovered their HIV infection until after full disease progression.



The following graphic representation of the overall history of Vermont's experience with HIV/AIDS indicates that the state has followed the national curve of the epidemic, with deaths greatly decreasing following the introduction of protease inhibitors and the continued advances in treatment.



d. Describe (table, graph, and/or narrative) the **indicators of risk** for HIV infection in population area.

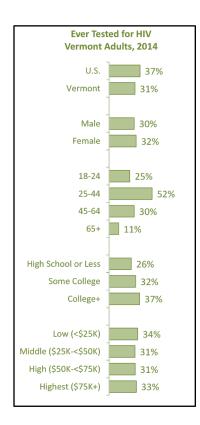
HIV Risk Indicators: BEHAVIORAL SURVEILLANCE DATA

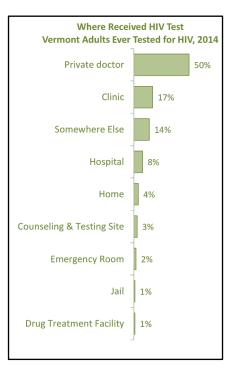
HIV Testing Patterns/Deterrents

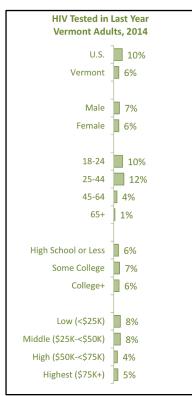
HIV testing data from 2014 indicates that Vermonters are somewhat less likely to have ever been tested for HIV than the national average, 31% to 37%. This has been statistically stable for the last ten years.

While rates of testing are fairly equally distributed over income ranges, higher education and younger age are indicative of higher rates of having been tested, with the age range of 25 – 44 accounting for 52%, far outpacing all other age ranges, and "college educated" accounting for 37%, in excess of those with "some college" (32%) and well in excess of those with "high school or less" (26%). The majority (50%) of Vermonters who ever tested for HIV were tested at their private doctor's office, with only 3% testing at a counseling/testing site.

Similar to the rates of "ever tested for HIV" the rates of "tested in the last 12 months" have remained stable over the last ten years, at 8% for the 18-64 age range and 6% averaged over all ages. This is, once again, lower than the national average.



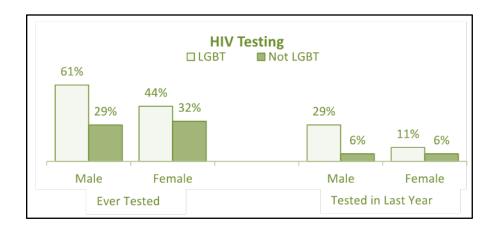




Vermont's most recent Youth Risk Behavior Survey data on HIV Risk and Testing indicate that 10% of students in grades 9 through 12 report being ever tested for HIV, with females and older students more likely to report testing.

Vermont's LGBT Health Data Brief [November 2015] indicates that significantly more LGBT adults have ever been tested, and more in the past year, than their heterosexual counterparts. Half of the Vermont adult LGBT population report having ever been tested for HIV, and 18% report testing in the last year. LGBT men are significantly more likely than non-LGBT men to have received HIV testing, both "ever" and "in the last year." These totals – 61% having ever tested and 29% testing in the past year – indicate Vermont is doing well at targeting testing to its highest risk populations.

LGBT women are also significantly more likely than their heterosexual counterparts to have "ever" been tested.



From the most recent Vermont Needs Assessment, roughly 55% of men participating report getting tested for HIV and other STDs on a yearly/almost yearly basis.

Lower levels of testing in the general population is theorized to reflect both a lack of overall awareness of HIV and a correlating sense of safety from infection conferred by living in a small rural state – a consistent theme with higher risk populations (MSM and heterosexual females) in the Needs Assessment process.

The high rate of testing at doctors' offices supports further findings from the Needs Assessment, in which respondents indicated an increasing willingness to test at a doctor's office. The 29% of men identifying as part of the gay and bisexual community reporting testing in the past year indicate that further efforts are needed to increase testing in this higher risk community, as is planned in the 2016 state granting process for increased targeting testing with MSM.

Substance Use

Substance use is a significant indicator of HIV risk in multiple ways, from compromised decision-making under the influence to shared needles for intravenous drug use. Vermont has higher than average adult alcohol use, high rates of marijuana use particularly among young adults, and a significant injection drug crisis.

From high school youth, to young adults, to adults, the alcohol data is as follows.

Over half of Vermont high school students report drinking alcohol (56%) during their lifetime. Lifetime use increased significantly over age, but overall youth drinking rates have decreased since 2005, and again since 2013.

- 30% drank in last thirty days.
- 16% reported binge drinking with males significantly more likely to report binge drinking.

Of note is this correlating statistic:

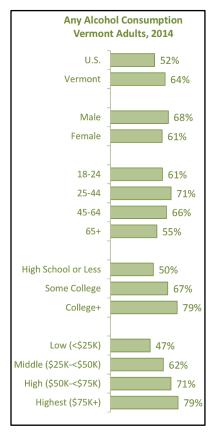
• Of the 31% of high school students reporting *current* sexual activity (within the past three months), 18% reported using alcohol or drugs prior to sex.

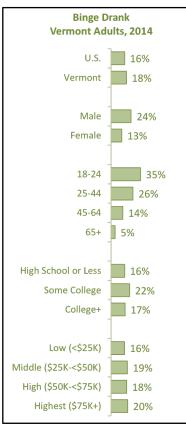
Young adults (college students):

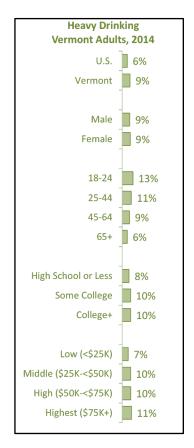
- Over half (55%) of young adults reported binge drinking in the past 30 days.
- Narrowing the age range to 18 to 20 below Vermont's legal drinking age still yielded a result

of approximately half (49%) reporting binge drinking.

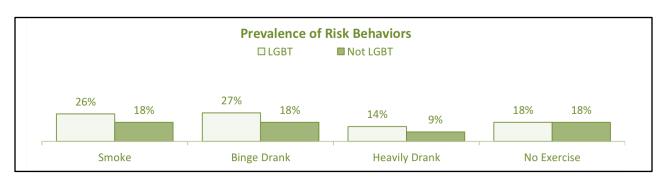
For adults, Vermont has higher than national average drinking, binge drinking, and heavy drinking.







Additional health status data concerning gay and bisexual men – is also available through Vermont's LGBT Health Data Brief [November 2015], which reviewed Vermont BRFSS data specific to the LGBT adult population, and this population has been demonstrated to experience higher participation in risk behaviors such as alcohol use. Vermont LGBT adults are significantly more likely than their heterosexual counterparts to report binge drinking (27% vs. 18%). Heavy drinking rates are also elevated among the LGBT population.



Other substances,¹ including marijuana in the area of compromised decision-making and heroin in the area of shared needle risk, are present in Vermont.

Vermont has a higher than national average use of marijuana. [VDH Data Brief, with data from 2011/2012 National Survey on Drug Use and Health]

Across drug use in the high school age range, males are significantly more likely to report harder drug use, and rates rise with student age.

- 11% of students report taking a prescription pain reliever or stimulant not prescribed to them, and while high, this number does indicate a decrease from 2013 to 2015 though stimulant use remained the same.
- 5% report using cocaine.
- 7% report using inhalants.
- 3% report using methamphetamines.
- 2% report using heroin.

Among young adults, one study of 4,300 college students found:

- 17% reported misusing a prescription drug within the past year.
- Among prescription drug categories, the highest prevalence of past year misuse was for stimulants (11%), followed by pain relievers (7%) and sedatives (4%).
- 37% report using marijuana, and half of marijuana users report using it daily or almost daily (20 or more days a month).

The use of heavier drugs, specifically heroin, presents a greatly increased risk of HIV infection through use of needles, and has been raised as a specter of increasing concern in Vermont. All trends and data points indicate a significant crisis in opiate abuse in Vermont that has been escalating. Starting in 2013, heroin and fentanyl related fatalities rose sharply, and currently more than 50 Vermonters die from opioid poisoning every year.

Vermont has seen this problem grow consistently over the past 16 years, and prosecution shifts indicate changing patterns of drug use.

- By the late 2000s, the opiate OxyContin was already a significant problem in Vermont: more
 people were prosecuted in federal court in Vermont in 2010 for illicit trafficking in prescription
 opiates than for any other drug.
- At that time, Vermont already ranked second in the country in per-capita admissions for treatment for addiction to prescription opiates.
- When OxyContin's delivery system and regulation was changed in 2010, making it resistant to crushing and considerably more expensive, many users switched to heroin, estimated to be only 1/8th as expensive as OxyContin.
- In 2013, there were twice as many federal indictments against **heroin dealers** than in the prior two years, and over five times as many as had been obtained in 2010.

The shift in use to heroin is also indicated in changing treatment patterns.

¹ Other Drug data is compiled from: Vermont Department of Health, Data Brief of June 2014; and "The Scope of the Opiate Crisis in Vermont," by the Vermont Association for Mental Health and Addiction Recovery, 2014.

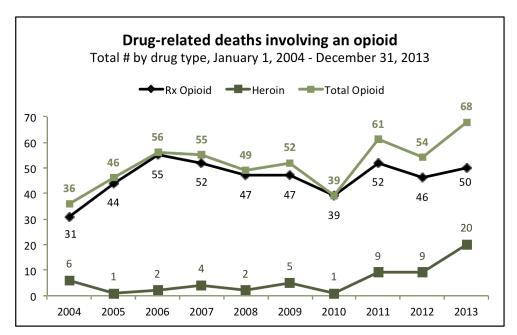
- Since 2000, Vermont has seen an increase of more than 770 percent in *treatment for opiate addictions*, up to 4,300 people in 2012.
- Vermont has seen a 250 percent increase in people receiving *treatment for heroin addictions* since 2000, with the greatest percentage increase, nearly 40 percent, in 2013.

The shift from prescription painkillers to increased heroin use continues to be of concern, with Vermonters aged 18-25 having one of the highest rates for non-medical use of painkillers in the country, coupled with the fact that nearly half of young people who inject heroin report having abused prescription opioids before starting to use heroin. Vermont's opioid issues clearly indicate increasing risk of HIV exposure through potential needle-sharing.

The results of the increase in availability and use of both prescription opioids and heroin have been dire.

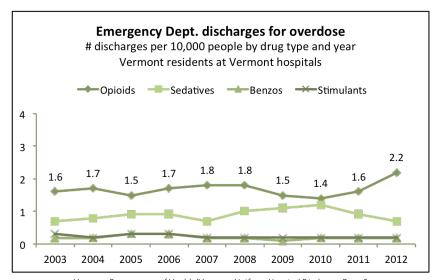
- Deaths from heroin doubled in Vermont in one year, from 2012 to 2013.
- Rutland, Vermont, has the highest rate of opiate-addicted pregnant women in the United States.
- Close to 80% of the state's inmates struggle with addiction or are in prison because of their addiction.

Heroin is reported as being one of the easiest drugs to obtain in Vermont. Vermont's convenient highway system that feeds into large cities such as Montreal, Boston, New York, and more make targeting the state an easy undertaking, with higher profit margins: dealers can sell drugs in Vermont at a price 500% higher than in nearby major cities. An estimated \$2 million in heroin is trafficked every week in Vermont.

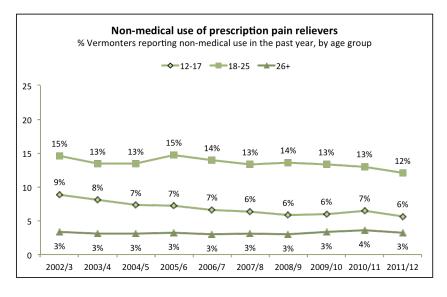


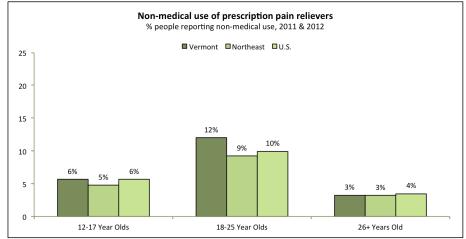
Vermont Department of Health/Office of the Chief Medical Examiner

NOTE: Total opioid includes unidentified opioids. Heroin and prescription opioids are not mutually exclusive



Vermont Department of Health/Vermont Uniform Hospital Discharge Data Set





Substance Abuse & Mental Health Services Administration/National Survey on Drug Use & Health (NSDUH) 2012

Prevalence Rates for Substance Use Behaviors, by Gender: Vermont Young Adult Survey

| Substance Use Behavior | Female | Male | Total |
|---|--------|------|-------|
| Alcohol Use: | | | |
| Any alcohol use in past 30 days | 71.9 | 77.3 | 74.7 |
| Binge drinking in past 30 days | 49.4 | 61.0 | 55.3 |
| Driving after having too much to drink in past 30 days | 2.5 | 4.8 | 3.7 |
| Marijuana Use: | | | |
| Any marijuana use in past 30 days | 31.0 | 43.1 | 37.3 |
| Consumption of edible marijuana in past 30 days | 3.3 | 5.9 | 4.6 |
| Driving after using marijuana in past 30 days | 10.1 | 20.4 | 15.4 |
| Prescription Drug Misuse: | | | |
| Misuse of any prescription drug (in the categories listed below) in past year | 15.8 | 18.8 | 17.3 |
| Misuse of prescription pain relievers in past year | 6.9 | 8.1 | 7.4 |
| Misuse of prescription sedatives in past year | 4.3 | 5.0 | 4.6 |
| Misuse of prescription stimulants in past year | 9.1 | 13.3 | 11.3 |
| Misuse of methadone in past year | 1.8 | 2.2 | 2.0 |
| Other: | | | |
| Any use of heroin in past year | 1.6 | 2.7 | 2.1 |

Sexual Behavior, Unprotected Sex, Sexual Orientation and Gender Identity

Sexual behavior data on adults is not widely collected in Vermont, and the BRFSS reports only provide insight into HIV testing, specifically, and general risk factors that influence HIV risk, such as alcohol use and IV drugs. Data on sexual risk taking is not regularly collected or reported for the populations at higher risk for HIV transmission in Vermont.

From the Needs Assessment conducted by Vermont Department of Health in 2014/2015, the data that was gathered indicated the following concerning sexual risk among MSM.

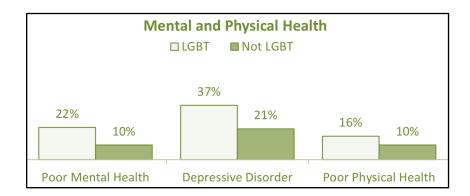
- 61% report having more than one sexual partner in the past 12 months
- 17% report having a sexually transmitted infection in the past two years
- Vermont men express a generally high level of knowledge of biomedical prevention models
 including Treatment as Prevention (72%) and PreExposure Prophylaxis (76%) and a fairly high
 level of willingness to use as a prevention method 69% willing to use TasP, and 58% willing to
 use PrEP

General respondents, which included men and women (by and large gay men and heterosexual women participated in the Needs Assessment) the following results emerged as pertains to sexual risk indicators.

- Knowledge of where to find free condoms is high in some counties, lower in others, but for the most part above 50%
- Only 2% of respondents agreed that "men I have sex with refuse to use condoms," but an
 additional 13% mostly agreed with the statement, 27% mostly disagreed, and 33% disagreed
 completely
- For "ability to insist on safer sex with partners," only 5% mostly disagreed, indicating they did not feel able to do so; 30% mostly agreed; 55% agreed completely that they felt able to do so.

An additional note concerning sexual behavior and sexual orientation related indicators of risks, involves the impact of mental health and personal support systems. The Vermont BRFSS notes that Vermont LGBT adults are twice as likely as non-LGBT adults to report poor mental health (22% vs. 10%) and are also significantly more likely to have been diagnosed with a depressive disorder (37% vs. 21%). While LGBT adults reported that they generally get the emotional and social support they need, results

indicate they get this support less frequently than their heterosexual counterparts. LGBT adults are *more likely* to 'usually' get supported emotionally and socially, and significantly *less likely* to 'always' get support. Mental health challenges and a lack of emotional and social support contribute to higher risk for HIV infection.



One large population where questions concerning sexual behavior and use of condoms <u>is</u> asked on a clear and consistent basis is high school students, through the YRBS. The most recent Vermont YRBS data indicates:

- 41% of students report having had sex, with the number rising significantly with each grade level, and 44% report having no sexual contact.
 - 42% report having oral sex, again rising with each grade level, with no difference between males and females
 - 50% of those reporting having engaged in sex, report sexual contact with the opposite sex only
 - 1% report same sex sexual contact only
 - o 5% report sexual contact with both sexes
 - 3% report having sex before 13 years of age
 - 10% report having four or more sexual partners
- Orientation:
 - 88% identified heterosexual
 - o 6% identified bisexual, with females more likely to identify as bisexual
 - 2% identified as gay or lesbian, with females again more likely to report a same-sex identification
 - 4% identified as unsure of sexual orientation
- 58% of students reported using a condom at last sexual activity, with the rates <u>decreasing</u> significantly over the increasing age/grade levels, including a drop in reported use from 65% to 54% an 11% decrease between 9th grade reporters and 12th grade reporters
- 55% of females and 62% of males report using condoms at last sexual activity, both of which are decreases (3% decrease in both cases) from 2013 to 2015

Anti-Retroviral Adherence

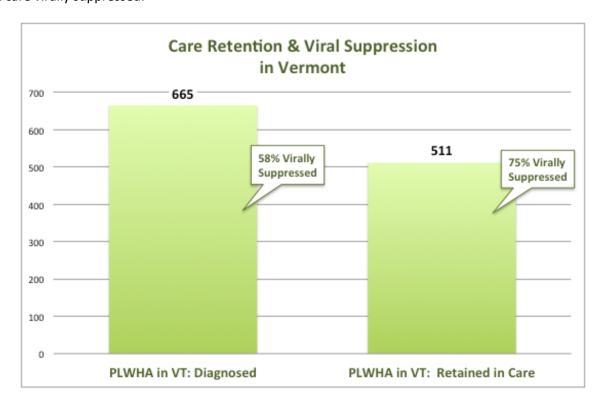
The levels of viral suppression reported in Vermont provide a picture of anti-retroviral adherence. A high level of viral suppression would indicate high adherence. Of the 665 diagnosed PLWHAs, 58% are virally suppressed, and therefore likely to be highly adherent. Of the 511 PLWHAs with a confirmed medical care visit in the past year, 75% are virally suppressed, indicating high adherence. Additional assessment of adherence in Vermont is noted in the Needs Assessment section of this report.

HIV Risk Indicators: HIV SURVEILLANCE DATA - TESTING & CLINICAL DATA

Vermont's HIV testing program conducted 883 tests in 2015.

The state of Vermont does not collect CD4 counts as this test result cannot be extracted on the basis of diagnosis only, and would therefore reflect an inaccurate picture of HIV CD4 data. Available data would include all Vermont residents with CD4 count tests, rather than just Vermont PLWHA.

Viral load suppression is collected and reported when it is below 200 copies/mL and is reflected in the chart below, with 58% of Vermont's 665 PLWHA virally suppressed, and 75% of the 511 PLWHA who are in care virally suppressed.



HIV Risk Indicators: RYAN WHITE HIV/AIDS PROGRAM SERVICES REPORT; ADAP DATA REPORT

HIV Risk Indicators: OTHER RELEVANT DEMOGRAPHIC DATA

(Hepatitis B or C surveillance, STD surveillance, Tuberculosis surveillance, and Substance use data)

The following chart provides *Hepatitis*, *STD* and *tuberculosis* surveillance data.

Infectious Disease News



Guidance • Support • Protection • Prevention

Division of Health Surveillance - Infectious Disease Epidemiology Section - January 2015

Vermont – Selected Reportable Diseases – 2014 (Data through MMWR Week 53 1/3/2015) – Provisional

| | Campylobacter | Cryptosporidium § | E. coli* | Giardia | Group A Strep Inv | Hepatitis A | Hepatitis B - Acute | Hepatitis B – Chronic | Hepatitis C - Acute | Hepatitis C - Chronic | Legionellosis | Listeriosis | Lyme § | Meningococcal Inf. | Pertussis | Salmonella | Shigella | Tuberculosis | Varicella § |
|--|---------------|-------------------|----------|---------|-------------------|-------------|---------------------|-----------------------|---------------------|-----------------------|---------------|-------------|--------|--------------------|-----------|------------|----------|--------------|-------------|
| Age | | | | | | | | | | | | | | | | | | | |
| <5 | 17 | 7 | 2 | 13 | 1 | 0 | 0 | 1 | 0 | 2 | 0 | 0 | 23 | 0 | 6 | 10 | 0 | 0 | 33 |
| 5-14 | 10 | 8 | 4 | 25 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 94 | 0 | 20 | 9 | 0 | 0 | 71 |
| 15-24 | 26 | 15 | 3 | 25 | 0 | 2 | 0 | 6 | 2 | 93 | 0 | 0 | 47 | 0 | 12 | 12 | 0 | 0 | 7 |
| 25-39 | 28 | 4 | 3 | 15 | 3 | 0 | 1 | 11 | 2 | 363 | 1 | 0 | 75 | 0 | 2 | 16 | 3 | 1 | 6 |
| 40-64 | 57 | 2 | 1 | 44 | 9 | 0 | 3 | 15 | 0 | 394 | 3 | 1 | 223 | 0 | 2 | 24 | 0 | 1 | 0 |
| 65+ | 40 | 4 | 2 | 15 | 11 | 0 | 0 | 1 | 0 | 44 | 3 | 0 | 119 | 0 | 0 | 22 | 1 | 0 | 1 |
| Unknown | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total (YTD) | 178 | 40 | 15 | 137 | 25 | 2 | 4 | 34 | 4 | 896 | 7 | 1 | 581 | 0 | 42 | 93 | 4 | 2 | 118 |
| 5-yr Median (YTD) | 184 | 50 | 18 | 183 | 20 | 2 | 2 | † | 4 | † | 12 | 1 | 581 | 4 | 95 | 85 | 5 | 5 | 118 |
| County of Residence | | | | | | | | | | | | | | | | | | | |
| Addison | 12 | 9 | 1 | 7 | 2 | | 0 | 1 | 0 | 34 | 1 | | 41 | 0 | 0 | 4 | 0 | 0 | 4 |
| Bennington | 9 | 0 | 0 | 6 | 1 | | 1 | 1 | 0 | 38 | 0 | | 105 | 0 | 0 | 1 | 0 | 0 | 10 |
| Caledonia | 8 | 6 | 2 | 8 | 0 | | 0 | 1 | 0 | 52 | 1 | | 7 | 0 | 0 | 4 | 0 | 0 | 6 |
| Chittenden | 35 | 3 | 2 | 56 | 9 | | 0 | 18 | 0 | 214 | 2 | | 57 | 0 | 4 | 32 | 3 | 1 | 18 |
| Essex | 0 | 0 | 0 | 3 | 0 | | 0 | 0 | 1 | 5 | 0 | | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| Franklin | 17 | 2 | 1 | 5 | 0 | | 0 | 1 | 0 | 69 | 0 | | 13 | 0 | 1 | 4 | 0 | 0 | 2 |
| Grand Isle | 1 | 2 | 0 | 0 | 1 | | 0 | 0 | 0 | 11 | 0 | | 8 | 0 | 0 | 0 | 0 | 0 | 0 |
| Lamoille | 11 | 3 | 0 | 9 | 0 | | 0 | 0 | 1 | 20 | 0 | | 7 | 0 | 1 | 3 | 0 | 0 | 11 |
| Orange | 4 | 1 | 0 | 2 | 0 | | 1 | 0 | 0 | 23 | 1 | | 28 | 0 | 0 | 6 | 0 | 0 | 1 |
| Orleans | 8 | 2 | 0 | 3 | 1 | | 0 | 3 | 0 | 38 | 0 | | 1 | 0 | 0 | 2 | 0 | 0 | 5 |
| Rutland | 25 | 3 | 1 | 9 | 3 | | 1 | 4 | 1 | 163 | 1 | | 98 | 0 | 1 | 11 | 0 | 0 | 5 |
| Washington | 23 | 6 | 5 | 12 | 1 | | 0 | 1 | 0 | 56 | 0 | | 24 | 0 | 0 | 12 | 1 | 0 | 46 |
| Windham | 15 | 0 | 1 | 7 | 1 | | 0 | 3 | 0 | 81 | 0 | | 83 | 0 | 34 | 7 | 0 | 0 | 7 |
| Windsor | 10 | 3 | 2 | 10 | 6 | | 1 | 1 | 1 | 92 | 1 | | 108 | 0 | 1 | 7 | 0 | 1 | 3 |
| Unknown | 0 | 0 | 0 | 0 | 0 | | 0 | 0 | 0 | 0 | 0 | | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total (YTD) | 178 | 40 | 15 | 137 | 25 | 2 | 4 | 34 | 4 | 896 | 7 | 1 | 581 | 0 | 42 | 93 | 4 | 2 | 118 |
| (802)863-7240 1(800)640-4374 (VT) FAX: (802)865-7701 | | | | | | | | | | | | | | | | | | | |

*Shiga toxin-producing Escherichia coli (STEC)

§ Includes both confirmed & probable cases

†No 5-year median available

Columns may be partially obscured to protect patient confidentiality

For questions & comments, please contact Patsy Kelso at (802) 863-7240

A great deal of substance use surveillance data was presented in the *Alcohol and Other Substances* portion of the *HIV Risk Indicators*.

Briefly, the available surveillance data indicates that Vermont is experiencing a significant opiate and heroin crisis, with drug-related arrests and deaths increasing, and need for treatment far outpacing the state's ability to provide.²

HIV Risk Indicators: QUALITATIVE DATA

An extensive Vermont HIV/AIDS Needs Assessment was conducted across the state of Vermont with data gathering from May 2014 – May 2015, and analysis and reporting through January 2016. The assessment was conducted on two arms of inquiry – Care and Prevention – and considerable qualitative data was gathered through interviews with HIV positive individuals, focus groups with HIV positive individuals, and focus groups with individuals at higher risk for infection.

Much of the Needs Assessment qualitative data has been summarized and reported in **Section I. Part D. Assessing Needs, Gaps and Barriers**. An overview follows here of Needs Assessment qualitative data that reflects on this **Epidemiologic Overview**, for the purpose of describing the *Indicators of Risk for HIV Infection* in the Vermont Service Area.

Specific "indicators of risk for HIV infection" gathered from <u>interviews and focus groups with HIV</u> positive individuals included the following.

- Disclosure Assumptions: In interviews, a minority of Vermont PLWHA said they do not disclose
 HIV status, while the majority do disclose their positive status prior to sexual activity. Noted
 were instances of brief sexual encounters among MSM, wherein respondents characterized the
 expected norm is "protect yourself." A small minority said that knowing their viral load is
 undetectable, they do not disclose HIV status and do not use condoms unless requested by the
 sexual partner. More notably, this information contributed to the conclusion from the Needs
 Assessment that widespread and incorrect assumptions exist throughoutear the Vermont MSM
 community about pre-sex disclosures of HIV status that may impact condom use.
- Adherence Issues: Many Vermont interviewees have some troubles taking their medication, usually due to forgetfulness, "brain fog," resistance to thinking about HIV every day, depression or other mental health conditions, and occasionally due to not having the medication for a variety of reasons (incarceration, inability to pay, inability to pick up the prescription).
 Depression was a consistent common barrier. Interviewees were by and large very aware that incomplete adherence to medication would affect undetectable viral loads.

Specific *indicators of risk for HIV infection* gathered from <u>interviews with providers of services to HIV</u> positive individuals included the following.

• Adherence Concerns: Providers expressed concerns that not all patients/clients who report being in care and maintaining treatment are actually doing so. Providers note that patients sometimes claim adherence to try to please providers. Providers spoke of patients suffering

² Vermont Department of Health, Data Briefs of February and June 2014 and July 2016; and "The Scope of the Opiate Crisis in Vermont," by the Vermont Association for Mental Health and Addiction Recovery, 2014.

- with co-occurring mental health diagnoses that diminished their ability to adhere to treatment regimen, of concern given the high percentage of <u>co-occurring mental health diagnoses in Vermont PLWHA population</u>.
- Active Addiction: Providers with a high caseload of individuals with a co-occurring substance abuse disorder expressed concerns for the continued risk that active addiction or relapse creates for their patients – of particular concern given Vermont rates of addiction and Vermont's long waiting lists for addiction treatment.
- **Incarceration:** Providers with a high caseload of patients experiencing or in danger of incarceration in Vermont expressed concern that this presents high risk for HIV transmission, either through interruption of care or exposure to transmission risk in prison, with the <u>Vermont correctional system</u> not well-versed in HIV prevention or care.

Specific *indicators of risk for HIV infection* gathered from focus groups with <u>individuals at higher risk of infection</u> included the following.

- **Knowledge:** On a very basic level, HIV knowledge in Vermont is demonstrably higher among MSM of all ages than their heterosexual counterparts. Knowledge of HIV among female and male heterosexuals is significantly lower, and like the widely varying knowledge among queer youth, it is very dependent on school sexuality education that is frequently lacking in Vermont.
- Disclosure Assumptions: Confirming the information shared in interviews with PLWHA,
 participants in MSM focus groups spoke to the issue of not discussing HIV status before
 engaging in sex, even if condoms were not used. The general consensus was that HIV negative
 men in Vermont social circles <u>assume</u> a partner will tell them if he is HIV positive, with the result
 that the conversation usually or often does not occur.
- **Stigma**: Respondents in all focus groups spoke of HIV stigma in Vermont, and the difficulties involved in bringing up HIV and talking about it with prospective Vermont partners. This was described as having considerable impact on self-protective behaviors, with the result that participants acknowledged higher risk sexual activity does happen due to inhibitions about talking about HIV and condoms.
- **Personal Risk Perception**: Despite wide response that HIV <u>is</u> a health concern in Vermont, the majority of respondents ranked their own <u>personal</u> risk as very low, and expressed in numerous ways the belief that they are less likely to contract HIV because they lived in Vermont.
- **Travel**: Despite the belief that living in Vermont is safer on a personal risk level, MSM spoke of regularly traveling to nearby urban areas for sex and relationships, entering areas where their potential risk of infection could be much higher.

HIV Risk Indicators: OTHER RELEVANT PROGRAM DATA

Much data has been shared above concerning the status of drug use, and injection drug use specifically, in Vermont, but it is considered relevant program data to make specific note hear of the services Vermont is providing to try to address the high HIV risk inherent in the state's drug crisis.

Vermont has been identified by the CDC as a site of potential outbreak of HIV due to high rates and concentration of injection drug use, and has submitted a **Determination of Need** application to the CDC for permission to utilize funds for staffing and non-needle supplies for syringe service programs.

Vermont has six syringe exchanges, in Burlington, Rutland, St. Johnsbury, White River Junction, Brattleboro and Richmond, and two mobile syringe exchanges in Springfield, and in the Montpelier/Barre area. All sites have a high rate of usage and need additional support. The Needs Assessment received many reports of a high need for additional exchanges, including one in Windham County (Brattleboro's location), which is one of the counties singled out by the CDC. The expansion of services from four exchanges and one mobile, to six exchanges and two mobiles, is one of the many ways the state of Vermont began to immediately address concerns highlighted in the Needs Assessment.

The exchanges offer additional services to combat HIV transmission, including educational information, treatment referrals, risk reduction counseling, overdose reversal kits (Narcan/Naloxone), free safer sex materials (condoms, etc.), and testing for HIV & Hepatitis C.

The Vermont Department of Health HIV/AIDS, STD, and Viral Hepatitis Department and the Vermont HIV/AIDS Community Advisory Group maintain a high level of attention and concern on this issue, and regularly feature syringe exchange and additional services at CAG meetings, including informational presentations, reviews of statistics and needs, discussion of state resource allocations, and strategize concerning the shortage of treatment beds available at recovery centers.

B. HIV CARE CONTINUUM

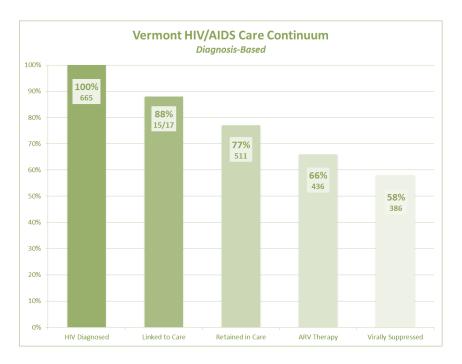
- Use either the HIV prevalence-based continuum and/or the HIV diagnosed-based continuum; explain why
- Graphic depiction and descriptive narrative on the HIV Care Continuum of the jurisdiction; definitions of numerator and denominator clearly stated for each step

Continuum Chosen: The state of Vermont utilizes a diagnosed-based continuum.

The *HIV diagnosed-based continuum* was chosen due to the state population size as the only method applicable to Vermont's circumstances, and the best method of maintaining the most accurate data.

Vermont does not have prospective data on unknown infections – nationwide calculations and projections for undiagnosed infection are less useful and less accurate when applied to a small rural state. As is noted by the CDC, "estimates for jurisdictions with <60 diagnoses per year (average) over the most recent 5 years (2008–2012) are considered numerically unstable." [Prevalence of Diagnosed and Undiagnosed HIV Infection — United States, 2008–2012, Morbidity and Mortality Weekly Report, June 26, 2015 / 64(24);657-662]

a. Provide a **graphic depiction** and a descriptive narrative of the HIV Care Continuum of the jurisdiction using the most current calendar year data. The definitions of the numerator and the denominator must be clearly stated for each step.



i. HIV-Diagnosed:

There are 665 known, reported cases of HIV infection, for a rate of 106 cases per 100,000 people. [VDH Annual Report, 2014 data, reported May 2015]

Numerator: 665 diagnosed/reported HIV/AIDS cases

Denominator: 626,042 Vermont population **Case Rate:** .00106223 * 100,000 = 106.222905

ii. Linkage to Care

88% (15 of 17 people) of individuals diagnosed with HIV in Vermont in 2014 were linked to care within one month.

Numerator: 15 diagnosed individuals in 2014 linked to care in one month

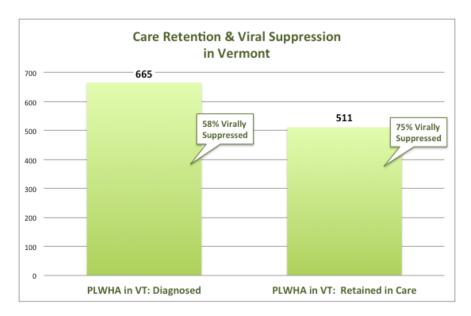
Denominator: 17 diagnosed individuals in 2014

iii. Retained in Care

77% of PLWHA in Vermont (511 individuals of 665 diagnosed individuals) are in care, having had a care visit in the last year that would include a viral load test or a CD4 test.

Numerator: 511 diagnosed individuals with one care visit in last 12 months

Denominator: 665 diagnosed individuals in Vermont



iv. **Antiretroviral Use**: The number of people receiving medical care and who have a documented antiretroviral therapy prescription in their medical records in the measurement year.

66% of PLWHA in Vermont (436 individuals of 665 diagnosed individuals) are receiving medical care and are taking antiretroviral therapy.

Numerator: 436 diagnosed individuals on ARV **Denominator:** 665 diagnosed individuals in Vermont

v. **Viral Load Suppression**: The percentage of individuals whose most recent HIV viral load within the measurement year was less than 200 copies/mL.

58% of all PLWHA in Vermont have achieved viral load suppression.

Numerator: 386 diagnosed individuals virally suppressed

Denominator: 665 diagnosed individuals in Vermont

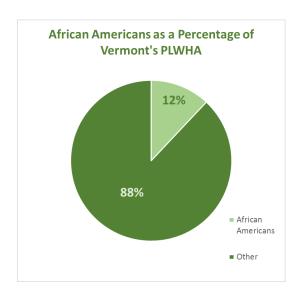
75% of PLWHA in care have achieved viral load suppression.

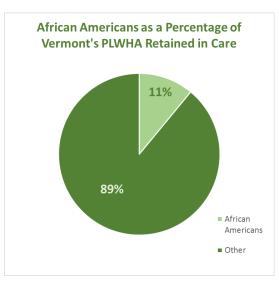
Numerator: 386 diagnosed individuals virally suppressed **Denominator:** 511 diagnosed individuals in Vermont in care

b. Provide a narrative (and graphic, if available) description of **disparities in engagement** among key populations along the HIV Care Continuum (e.g., young MSM, IDU, African-American heterosexual women, etc.).

To the best of Vermont's data gathering ability, no significant disparities in care engagement emerges. While MSM and African American individuals are overrepresented in the overall demographics of the HIV epidemic in Vermont, both populations appear to be engaged in care at similar rates.

Vermont's HIV epidemic is 12% African American, and African Americans make up 11% of PLWHA retained in care.





- c. Describe how the **HIV Care Continuum** may be or is **currently utilized** in
 - planning, prioritizing, targeting, and monitoring available resources in response to the needs of PLWH in the jurisdiction, and
 - 2) **improving engagement and outcomes** at each stage of the HIV Care Continuum.

Vermont Department of Health HIV/AIDS, STD and Viral Hepatitis Department and the Vermont HIV/AIDS Community Advisory Group utilize the state's HIV Care Continuum as the basis for assessing response to Vermont's HIV epidemic. Since the introduction of the Continuum of Care (originally the Cascade) Vermont state officials have been working diligently to address gaps in data collection and reporting, and have significantly improved internal and external systems. Simultaneously VDH HASH has worked closely with the CAG and the state medical providers to address their concerns regarding confidentiality of HIV positive individual's personal medical data – an issue that has been of high priority for the CAG, medical community, and the community at large over the years of the epidemic, to the

extent of Vermont legislation on how personal data must be collected and recorded, and the maintenance of separate data servers by HASH department for HIV/AIDS-related data.

The HASH department has worked consistently and respectfully to improve systems with full disclosure of changes, and explanations as to the safeguards that remain in place whenever a change is implemented. The department continues to work with the community to advance use of confidential rather than anonymous systems, with the goal of better surveillance for epidemiologic and response improvement, including a higher trust in the medical and reporting structures in Vermont among testing clients and communities reached, to better engage both in the overall linkage model promoted by the Care Continuum.

Vermont HIV data reporting is the most up-to-date and fully analyzed as possible, as represented by the detail and analysis of the Vermont Care Continuum available in this document, to provide the department and the community the clearest picture of where Vermont services are most needed, and where Vermont must prioritize its extremely restricted resources.

The HASH department is highly confident of improved accuracy and detail.

NHAS requirements and the Care Continuum are regularly brought to CAG meetings and discussed in the light of how best to prioritize, target and monitor available resources. In analyzing the allocation of resources throughout care and prevention, significant focus has been placed on prioritizing linkage to and engagement in care, from HIV Testing Models to Prevention with Positives, care retention efforts, and outreach to higher risk populations. The continuum allows for state officials and community members to accurately assess successes and challenges – such as the high rate of success Vermont experiences in linking those testing positive to care, the high rate of success in retention in care Vermont experiences due to high-quality and well-liked medical professionals, and the areas where Vermont needs to place more resources and focus, such as finding higher risk social circles to access with testing and reengaging individuals who may become estranged from care.

The well-documented Vermont continuum clearly demonstrates these trends: with 88% of positive testees linked to care within one month, 78% of diagnosed "confirmed in care," but also noting that while 75% of those in care are virally suppressed, with 22% of diagnosed cases outstanding as potentially not in care, this drops the overall community viral suppression efforts to 58% of all diagnosed.

The discussions and analysis based on the Vermont continuum findings assist in:

- <u>Planning, and prioritization/targeting of funding resources, for testing models</u> that will be most likely to find potential positives, given Vermont's proven efficacy in bringing these individuals into care – even if this shifts long-held patterns/previous priorities in Vermont HIV testing.
- <u>Planning, and prioritization/targeting of funding, for prevention with positive models</u> that
 emphasize support for staying closely linked with medical care, and emphasize adherence to
 treatment to advance viral suppression an area that needs continuous creative planning from
 community providers, given Vermont's prior and current experiences with interventions often
 designed for a larger, more urban population.
- <u>Planning, designing and implementing the statewide Needs Assessment</u> to focus heavily on
 information most pertinent to the challenges identified on the continuum, including a strong
 focus on assessing individual and community barriers to getting into/remaining in medical care,
 assessing the relationships between ASOs and medical providers, and assessing the Vermont
 PLWHA experiences of HIV medications and PLWHA community norms around treatment.

As described, all of these areas of focused planning have as a goal <u>improving engagement and outcomes</u> at each stage of the continuum. Vermont services currently in place, and the designing of future services through the release of the current Request for Funding Proposals, are now all viewed through the lens of how each will influence one or more of the five points on the continuum. The submission of the Designation of Need application and the continued focus and prioritization of planning and funding around targeted work with injection drug users is directly aimed at increasing the testing of higher risk populations and linkage to care in numerous ways.

C. FINANCIAL AND HUMAN RESOURCES INVENTORY

a. Provide in a table format a jurisdictional HIV Resources Inventory

At a minimum, **the table** should contain the following information:

- i. Funding Sources
- ii. Funding Amount
- iii. Funded Service Provider Agencies
- iv. Services Delivered
- v. HIV Care Continuum Step(s) Impacted

| | JURISDITIONAL HIV RESOURCES INVENTORY | | | | | | | | |
|--------------------|---|---|---|---|--|--|--|--|--|
| FUNDING SOURCES | FUNDING AMOUNT | FUNDED SERVICE PROVIDER AGENCIES | SERVICES DELIVERED | HIV CARE CONTINUUM STEP(s) IMPACTED | | | | | |
| Part B | ~\$3,000 | Vermont Department of Health HIV/AIDS/STD & Hepatitis C Program | VDH Early Intervention Program: Pays for initial doctors' visits & baseline medical tests, including viral load screening. Also included in the EIP is Genotype and Phenotype Testing: Financial assistance to underinsured and uninsured Vermonters living with HIV in need of this specific lab work. Funded services include: lab fees, purchase and administration of vaccines not covered by VMAP. | Linkage to Care Retention in Care | | | | | |
| Part B; Rebate | 370,000 (Part B); \$600,000 (rebate) | | VDH Vermont Medication Assistance Program: Financial assistance for the purchase of prescription medications to low income PLWHA in Vermont. | Retention in Care Medication Adherence Viral Suppression | | | | | |
| Part B; Rebate | \$54,000 (Part B); \$20,000 (rebate) | | VDH HIV Dental Care Assistance Program: Financial assistance to underinsured and uninsured Vermonters living with HIV. Funded services include: diagnostic procedures (x-rays and evaluations); preventative care (cleanings, restorative treatments, root canals), removable prostheses including complete and partial dentures, and necessary oral surgery including extractions. | Linkage to Care Retention in Care | | | | | |
| Part B | \$40,000 | Comprehensive Care Clinic System UVM Medical Center, Burlington Rutland Regional Medical Center, Rutland Brattleboro Memorial Hospital, Brattleboro | Medical Nutrition Therapy: Nutritional counseling and support from a licensed nutritionist for the purpose of providing nutritional screening to HIV positive patients at nutritional risk. Includes follow-up visits for patients with high-risk scores every 3-6 months, and monitoring and evaluation of outcomes for patients with high cholesterol and/or elevated glucose levels. | Retention in Care Medication Adherence Viral Suppression | | | | | |
| Part B | \$63,000 | Northeastern Vermont Regional Hospital, St. Johnsbury | Mental Health Therapy: Mental health services to HIV positive Vermonters, to prescribe medication for a variety of mental health issues, and to help address issues around HIV and medication adherence. | Linkage to Care Retention in Care Medication Adherence Viral Suppression | | | | | |
| Part B | \$62,000 | | Medical Case Management including Treatment Adherence: CCC nurses to provide medical case management, including assistance with treatment adherence for those experiencing barriers to HIV therapy. | Retention in Care Medication Adherence Viral Suppression | | | | | |
| CDC | \$200,000 | | HIV Testing Services | Diagnosis Linkage to Care | | | | | |
| Part B; Rebate | \$195,000 | AIDS Service Organizations/ Community Based Organization • AIDS Project of Southern Vermont: Brattleboro and Bennington | Medical Case Management: three community-based organizations provide core HIV case management services for people in Vermont living with HIV/AIDS, consistent with | Linkage to Care Retention in Care Medication Adherence Viral Suppression | | | | | |

| | | H2RC: Lebanon and White River Junction Vermont CARES: Burlington, Rutland, and St. Albans | HAB/HRSA's service delivery policies and the State's Quality Assurance Standards for HIV Case Management. | |
|---------------------|-----------|---|---|--|
| Rebate | \$600,000 | ASOs AIDS Project of Southern Vermont, Windham and Bennington Counties Association of Africans Living in Vermont, Chittenden County H2RC, Windsor County Safe Recovery, Howard Center, Chittenden County Twin States, Windham County Vermont CARES, Chittenden, Rutland, and Caledonia Counties Vermont People with AIDS Coalition, Washington County | Basic Needs Support: SEVEN organizations provide childcare, respite care, nutritional support, transportation, and financial assistance, as well as services for those struggling with substance use. | Retention in Care Medication Adherence Viral Suppression |
| CDC | \$300,000 | ASOs/CBOs AIDS Project of Southern Vermont, Windham and Bennington Counties Association of Africans Living in Vermont, Chittenden County H2RC, Windsor County Safe Recovery, Howard Center, Chittenden County Twin States, Windham County Vermont CARES, Chittenden, Rutland, and Caledonia Counties Vermont People with AIDS Coalition, Washington County Pride Center of Vermont, Chittenden County | Prevention Services: CLEAR MPowerment Willow Social Network Testing | Diagnosis Linkage to Care |
| VT State General | \$250,000 | ASOs/CBOs Howard Center Safe Recovery, Green Mountain Needle Co-op, Chittenden County Rutland Syringe Exchange, Vermont CARES, Rutland County St. Johnsbury Needle Exchange, Vermont CARES, Caledonia County | Syringe Exchange Services: Needle/Syringe Exchange, Case Management, HIV/HCV Testing, Resource Referral | Diagnosis Linkage to Care Retention in Care |

| | | Mobile Syringe Exchange, Vermont CARES, Washington County Good Neighbor Clinic, HIV/HCV Resource Center, White River Junction, Windsor County Windham County Syringe Exchange, AIDS Project of Southern Vermont, Windham County Springfield Mobile Exchange, H2RC Richmond Exchange, Richmond Rescue | | |
|--------|--|--|---|---|
| CDC | Included in \$200,000 referenced above for HIV testing, under CCC Services | Vermont Department of Health ASOs CBOs CCCs | Anonymous and Confidential HIV Counseling, Testing and Referral (CTR) Sites: Vermont has 37 sites and a total of 60 current HIV counselor/testers, in all regions of the state, performing oral testing, or a combination of oral and blood testing. VDH has implemented a rapid testing program that supports nine ASO, CBO and CTR sites throughout the state to conduct rapid oral HIV testing, including a clinic offered by VDH. | Diagnosis Linkage to Care |
| HUD | APSV: \$29,136 H2RC: \$10,791 VTCARES: \$490,672 | AIDS Project of Southern Vermont, Windham and Bennington Counties H2RC, Windsor County Vermont CARES, Chittenden, Rutland, and Caledonia Counties | Housing Opportunities for People With AIDS (HOPWA): A variety of HUD programs and projects provide assistance to persons living with HIV/AIDS and their families who may require emergency, transitional, or long-term affordable housing solutions. HIV/AIDS housing assistance includes short- and long-term rental assistance, live-in medical facilities, and housing sites developed exclusively for people living with AIDS. | Retention in Care Medication Adherence Viral Suppression |
| Rebate | \$55,000 | Twin States Network (TSN) | Peer Support: Provides ongoing peer and volunteer support to HIV+ Vermonters via e-mail, phone and face-to-face contact, in compliance with Peer Natural Leader service provision standards in Vermont's Quality Assurance Standards | Linkage to Care Retention in Care Medication Adherence Viral Suppression |
| CDC | \$30,000 | Planned Parenthood NNE | Confidential HIV Testing Services | Diagnosis Linkage to Care |
| Rebate | \$60,000 | Vermont PWA Coalition | Advocacy and Health Care Referral Support | Linkage to Care Retention in Care Medication Adherence Viral Suppression |

b. Provide a narrative description of the HIV Workforce Capacity in the jurisdiction and how it impacts the HIV prevention and care service delivery system. (e.g. licensed providers, community health workers, paraprofessionals).

The primary capacity issues faced by Vermont's HIV workforce are an outcome of its rural geography, with many areas of low population – and correspondingly few local services. Larger practices and service organizations are located in populations centers such as Burlington, Rutland, Brattleboro, White River Junction. Hospitals and medical centers located in more populous areas create long drives with attendant expenses for individuals living in smaller towns without resident services.

Medical Workforce:

Four Comprehensive Care Clinics based around the state, each associated with a hospital or medical center, offer the services of a social worker, nurse practitioner, and infectious disease physician.

These are located in the following sites, towns/cities, and corresponding quadrants of the state:

- Northeastern Vermont Regional Hospital, St. Johnsbury Northeast
- **UVM Medical Center**, Burlington Northwest
- Brattleboro Memorial Hospital, Brattleboro Southeast
- Rutland Regional Hospital, Rutland Southern Central West

Additional Infectious Disease services are available at:

- Southwestern Vermont Healthcare, Bennington Southwest
- **Dartmouth Hitchcock Medical Center**, Lebanon, New Hampshire, bordering White River Junction, VT Southern Central East Vermont.

<u>Impact on Care and Prevention in Vermont:</u>

Numerically, there are enough Infectious Disease doctors and nurse practitioners to serve the population of PLWHA in Vermont – no one has been turned away or put on a waiting list for lack of an available infectious disease specialist. Patients report the ability to get an appointment quickly when they need one. This positively impacts Vermont's care an prevention efforts, helping positive individuals stay in care and maintain treatment.

Access can be a greater issue. Many PLWHA have to drive an hour or more to get to doctor's appointments, without the aid of public transportation given the significant limitations Vermont has in the area of public transportation. This transportation issue is exacerbated by poor road conditions that are possible-to-likely for six months of the year.

Another issue that increases the travel time and hardship for some PLWHA is the limited choice of Infectious Disease specialists in a given area. The size of Vermont hospitals leaves patients with little choice but to seek another hospital if they have significant conflict with the available ID professionals closest to them. Vermont is fortunate to have high quality, highly ranked professionals who are serving the PLWHA community well.

The availability of knowledgeable primary care physicians in Vermont has increased but is still expressed as a concern by PLWHA in less-populated areas of the state. The impact of this is that PLWHA without

knowledgeable/sensitive primary care still access their Infectious Disease Specialist office for most medical needs.

<u>AIDS Service Organization/Community Based Organization Workforce:</u>

Three community-based ASOs offer medical case management with social workers, prevention services with positives and with higher risk populations, HIV testing, Hepatitis C testing, condom distribution, and other services such as housing assistance, food shelves, transportation assistance, and emergency assistance:

- **HIV/HCV Resource Center** (H2RC): FTE Executive Director/Prevention Specialist, FTE Vermont Case Manager, FTE New Hampshire Case Manager.
- AIDS Project of Southern Vermont (APSV): FTE Executive Director, Two .8 FTE Case Managers, Three PT Direct Services Support positions, One FTE Prevention Specialist/CLEAR Provider, 1 Administration Position.
- Vermont Committee for AIDS Resources Education and Services (Vermont CARES): FTE
 Executive Director, 1 FTE Services Director, 6 FTE Case Managers, 1 FTE Prevention
 Specialist/Case Manager, 2 Administration Positions.

Additional HIV/AIDS services are available through the following community-based agencies:

- Vermont People With AIDS Coalition: PT Executive Director and PT Consumer Advocate.
 Serving HIV positive Vermonters with support services such as an annual retreat with educational and support services, informational resources, consumer advocacy, representation of consumer concerns at the statewide Community Advisory Group.
- Twin States Network: PT Executive Director and PT CLEAR Provider. Serving people impacted by HIV/AIDS and Hepatitis C with Client Advocates, One-on-One Counseling, Women's Retreat, Support Groups.
- Association of Africans Living in Vermont: HIV-related Positions Outreach Worker/Program Specialist, Health Educator. Serving new Americans with a variety of support services, including HIV/AIDS prevention services.
- **Pride Center of Vermont**: FTE Prevention Specialist (Mpowerment Coordinator). Serving the LGBTQ community of Vermont with a variety of services, including an Mpowerment HIV prevention program for MSM, with one full FTE. The Mpowerment staff member also provides HIV testing.
- **Outright Vermont**: Serving Queer Youth of Vermont with a variety of support services, including condom distribution, HIV testing and HIV educational resources.
- **Planned Parenthood of Northern New England**: Offering HIV testing, STD testing, educational resources and condom distribution.

Syringe Exchange Workforce:

Syringe Exchange Services are available through the following five organizations, providing free clean needles, HIV and Hepatitis C Testing, condom distribution, case management, and referral to additional resources:

- Howard Center Safe Recovery: Burlington
- **H2RC:** White River Junction and Springfield, VT/Lebanon, NH
- **Vermont CARES:** St. Johnsbury, Rutland, Montpelier/Barre, Frankin County, Grand Isle County, Addison County.

• AIDS Project of Southern Vermont: Brattleboro

• Richmond Rescue: Richmond

Impact on Care and Prevention in Vermont:

The available AIDS Service Organizations provide good coverage of the state of Vermont regionally, with availability of case management services. However, the case management system is frequently strained with large caseloads per number of case managers available, long waits for appointments with case managers in areas with higher numbers of PLWHA, and difficulty reaching and connecting with ASO case managers by both PLWHA and medical providers due to reduced operating hours. Vermont ASOs consistently hover on the edge of needing additional case management services and additional support services due to funding cuts and lack of financial resources, but thus far continue to offer high quality services that meet the needs of the majority of PLWHAs in Vermont.

As with medical providers, there is limited choice by region, and if a PLWHA has a conflict with a specific agency and/or case manager, it can be difficult to be assigned to a different case manager, and can be impossible to access another ASO without physically moving to another area of the state.

The limited number of prevention service workers in the state of Vermont reflects the changes in funding streams that have eliminated much of Vermont's ability to conduct prevention with higher risk negative populations. This has a large impact on prevention in Vermont.

Positions and programs have been eliminated as federal cuts for prevention programming were followed by private funding sources choosing to redirect their funding to the federal model. Mpowerment is now offered in only one location in the state, rather than three as offered prior to 2013, and testing and prevention efforts with the MSM community – consistently the highest population represented in the Vermont HIV epidemic – have been reduced as a result.

The limited number of syringe exchange programs and the consistent battle for funding has a large negative impact on Vermont prevention and testing/linkage to care efforts. The need for additional syringe exchange locations and services in the state has been a consistent, recognized issue in the state for many years and expansion is underway.

Substance Abuse Treatment Workforce:

The Pew Charitable Trust special report "How Severe is the Shortage of Substance Abuse Specialists?" of April 1, 2015, records Vermont as having the most substance abuse professionals per 1000 people with substance use disorder, at a rate of 70 professionals per 1000. However, this data is credited to 2012 statistics from SAMHSA and US Bureau of Labor, and the prior review of the substance abuse issues increasing in Vermont, indicate the years of 2012 and 2013 were explosive years in the growth of number of people receiving heroin treatment, and that numbers seeking treatment are rising. The pertinent data points:

- In 2010 Vermont ranked *second in the country* in per-capita admissions for treatment for addiction to prescription opiates.
- Since 2000, Vermont has seen an *increase of more than 770 percent* in <u>treatment for opiate</u> addictions, up to 4,300 people in 2012.

- Vermont has seen a 250 percent increase in people receiving <u>heroin treatment</u> since 2000, with the greatest percentage increase, nearly 40 percent, in 2013.
- Deaths from heroin doubled from 2012 to 2013.

By February 2016, Pew Charitable Trust *Stateline* reported:

- "Almost 500 people in Vermont are on waiting lists to receive medication to treat their opioid dependence, Stateline reports. More than half will wait almost a full year."
- "Vermont has 248 doctors licensed to prescribe buprenorphine, the article notes. Most treat only their existing patients who have opioid dependence."
- "In October [2015], the average wait time to get into the opioid treatment program here in Chittenden County was 358 days. But because the number includes pregnant women who by law must be treated within 48 hours and intravenous drug users who must be treated within 14 days, the wait is much longer for everyone else."

Waiting lists for substance abuse treatment continue to be an issue of dire urgency in Vermont.

In addition to treatment providers and treatment beds, additional syringe exchange personnel are needed around the state.

Impact on Care and Prevention in Vermont:

Waiting lists drastically increase the loss of individuals ready to enter treatment, compromising potential diagnosis of HIV, linkage to care, and multiple opportunities for prevention of further transmission – to the individual, and to that person's drug network and sexual partners. Every individual who cannot access treatment stays in the network of a higher risk state for HIV infection and transmission.

c. Provide a narrative description of how different funding sources interact to ensure continuity of HIV prevention, care, and treatment services in the jurisdiction.

The HIV/AIDS/STD/Hepatitis Program at the Vermont Department of Health works with other state and local agencies, community planning groups, hospitals, rural medical providers, case managers and social workers to streamline the continuum of care and ensure services from various funding sources interact smoothly.

Given the limited resources the state has to provide prevention interventions for those at high risk of infection, the focus is on funding one Mpowerment program in Chittenden County for MSM and CLEAR programs for IDU populations around the state. The primary link between the stream of funding for these programs and other services along the continuum is the blend of prevention services for positives. Many of the same individuals trained to deliver the CLEAR intervention to high risk populations (IDU), also deliver CLEAR as a prevention-for-positives intervention. The national founders of Mpowerment continue to work with the program to establish additional ways in which the program can serve HIV positive MSM.

In addition, all prevention programming offers HIV testing and Hepatitis C testing, and the integrated nature of prevention in care result in individuals testing positive being linked directly with care as quickly as possible.

Vermont's rural geography and limited resources contribute to challenges in meeting the needs of HIV positive Vermonters, but service providers are for the most part able to link people from all populations and cohorts to needed essential services. Agency relationships enable people to access services from multiple venues. This referral network ensures that someone living with HIV is provided with the following:

- Immediate linkage to medical care if newly diagnosed, or estranged from care.
- Outreach and advocacy to recently diagnosed and non-symptomatic HIV positive individuals to
 ensure that they and their families are connected to supportive services that will best support
 continued health and quality of life.
- A liaison with existing HIV Comprehensive Care Clinics and other HIV/AIDS service providers to identify needs and generate referrals to services.
- Education and materials to all HIV positive clients and their families regarding the availability of supportive services and entitlement programs (i.e., AMAP, DCAP, Insurance Continuation Program, Social Security, VHAP, Medicaid, HOPWA, PWAC special services funds, subsidized housing, fuel assistance, substance abuse treatment, etc.).
- Timely updated treatment to clients.
- Anonymous/confidential oral HIV Counseling, Testing and Referral (CTR), including voluntary oral HIV antibody testing for family and drug/sexual partners of HIV positive individuals.
- Hepatitis C Testing.
- Proactive treatment care plans and supportive counseling to assist clients in addressing lifestyle changes as needed to maintain stable health.
- Access to early intervention services, including vaccinations and HIV geno- and phenotype testing services.
- Information on treatment advocacy and adherence.
- Partner Services.

When an individual is diagnosed as HIV positive, the current system in operation places the responsibility of coordination of resources on HIV case managers and social workers located within one of Vermont's three AIDS Service Organizations, or four Part C Comprehensive Care Clinic sites. Medical social workers meet with newly diagnosed HIV positive clients to discuss HIV prevention needs, create an HIV prevention plan, and provide referrals to needed medical or social services. Newly diagnosed individuals may access medical services through Vermont's early intervention services free of charge (e.g. first two physician's visits, labs, vaccinations).

The Part B program strives to meet the diverse needs and challenges of providing services in geographically underserved areas of the State, including allocation of resources to meet the needs where no other resources are available. The goal is to further promote linkages between existing CBOs and state and federal level entitlement programs. In order to ensure that appropriate linkages are made, the VDH offers trainings and educational opportunities to case managers, social workers, and medical providers throughout the state. Case managers and social workers are also encouraged to attend educational trainings through Dartmouth Hitchcock's Part D clinic and the Hood Family Center for Children and Families. The National AIDS Education and Training Center for New England is based in Massachusetts, and has Regional Partners in all states.

Case managers and social workers have a comprehensive knowledge of state and federal entitlement programs for people living with HIV. Upon intake a client's psycho-social needs are assessed. Care Plans

are then designed with the client, which outline goals for accessing services and care. Referrals are made to appropriate agencies and programs, based on the needs of the client, such as Housing Opportunities for People with AIDS (HOPWA), Department of Developmental and Mental Health Services (DHMS), Aid to Needy Families and Children (ANFC), Commodity Supplemental Food Program (CSFP), Women Infants and Children (WIC), and the Low-Income Home Energy Assistance Program (LIHEAP). Case managers and social workers assist clients in application processes for these programs. State and federal programs are always accessed first, before using Part B funding.

Coordination with substance abuse and mental health treatment services currently occurs through referrals from CBOs or through the CCCs. During intake and assessment and through the development of care plans, clients' needs are assessed and ranked. If it is determined that substance abuse treatment is needed, referrals are made to local or regional counselors or treatment centers. Individuals can also be referred to drug and alcohol services through the Health Department's Divisions of Mental Health and Alcohol and Drug Abuse Programs as well.

Screening for eligibility of state and federal entitlement and benefit programs occurs during the intake process. Case managers and social workers are required to initiate intake processes for services that have not been accessed for which the client may be eligible. Direct services funded by Part B are provided to any HIV positive Vermont resident showing proof of sero-status, who is at or below 500% federal poverty level and is un- or under-insured, providing assistance with medical co-pays and deductibles. Intake and assessment and financial verification are completed before services are rendered and it is confirmed that Ryan White funds are always the payer of last resort.

d. Provide a narrative description identifying any needed resources and/or services in the jurisdiction that are not being provided, and steps taken to secure them.

The extensive Needs Assessment conducted over the past two years identified high satisfaction with available Vermont services, and specific resources/services that were lacking. The full summary of the Needs Assessment findings is below, in **Section I, Part D – Addressing Needs, Gaps, Barriers**. A brief overview of identified resources/services needed include:

- Financial Assistance additional financial assistance is an ongoing need.
- Transportation public transportation services, reliable and affordable transportation options, assistance with affordable reliable automobile purchases/maintenance
- Housing affordable housing options, additional emergency assistance, advance deposits
- Nutrition Assistance additional funding for Vermont's Three Squares/SNAP program
- Substance Abuse Treatment Services more availability
- Syringe Exchange Services full state coverage, stable funding
- Mental Health Services affordable service from HIV-knowledgeable providers
- Dental expansion of dental services to include dentures and plates

Steps taken to address these needs include continued work with various state agencies on availability of housing vouchers (with success) and substance abuse treatment availability; exploration of potential support to ASOs for additional transportation services; prioritization of needs identified as matched with upcoming funding opportunities.

In reference to prevention services not currently provided, due to limited resources there is only one prevention program for high risk negative MSM in the state. This programming is based in Chittenden

County, with the highest population of MSM and PLWHA in the state. Serving the MSM population statewide is challenging though this organization – Pride Center of Vermont – is established as a statewide organization and is focused on expanding its reach.

Ongoing public education needs around HIV/AIDS are high, such as standardization of HIV education throughout the state in schools, and anti-stigma education in communities and workplaces.

Steps taken to expand syringe exchange services include advocating for state funding, and applying for a Determination of Need to the CDC, given the identification of two separate Vermont counties as at high risk for an HIV outbreak related to needle sharing. Safe Recovery, run out of the Howard Center in Burlington, has had a long running syringe exchange, and has worked with the ASOs in forming a working group that has planned for the syringe exchange expansion now taking place. These new startups will be guided by the experience of Safe Recovery and the ASOs that have been conducting syringe services.

D. ADDRESSING NEEDS, GAPS, BARRIERS

- This section will describe the process used to develop a collaborative and coordinated needs assessment that will result in greater alignment and access to prevention care and treatment services
- Goals of NA are: 1) ID and describe HIV prevention and care services that exist and those needed; 2) enhance the quality of services
 for persons at higher risk for HIV and PLWHA based on stakeholder feedback; 3) id barriers that impede access to existing services
- a. Describe the process used to identify HIV prevention and care service needs of people at higher risk for HIV and PLWH (diagnosed and undiagnosed)

As a base for the identification of prevention and care service needs, the Vermont Department of Health begins with review of state epidemiologic data, continuum of care data, surveillance data, reporting and data collection from current grantees and service providers, and consultation with the stakeholders represented by the HIV/AIDS Community Advisory Group.

Upon this base, a formal Needs Assessment process is initiated on a five year cycle, to gather further data directly, in a number of different avenues, from consumers of care and prevention services, state residents affected by HIV/AIDS who may not currently access services, and community and medical service providers.

In 2014, the VDH HASH commissioned the Center for Health and Learning (CHL), a health and education agency serving the state of Vermont, to conduct this most recent statewide HIV/AIDS Care & Prevention Needs Assessment. The Needs Assessment's defined functions:

Comprehensive Functions

- Provide reference framework for Vermont's HIV epidemic as the state strives to make the
 best use of limited resources, while simultaneously addressing the required activities of the
 Centers for Disease Control and Prevention (CDC) and the Health Resources and Services
 Administration (HRSA).
- 2) Inform the revision and writing of the HIV/AIDS Statewide Comprehensive Plan.
- 3) Deliver direct feedback to service providers, as well as demographic and lived experience data, to inform service efforts and quality improvement.

Vermont's diverse Community Advisory Group members include consumers of HIV/AIDS services, representatives of Vermont Department of Health grantee organizations, AIDS Service Organizations, the Vermont Consumer Advocate, community-based organizations with a role in HIV care and/or prevention, Vermont's Comprehensive Care Clinic system – the primary HIV care delivery system in Vermont, Vermont Agency of Education staff, and VDH staff. The CAG assisted greatly with advising and implementing this Needs Assessment process.

CAG members assisted in compiling, then reviewed and made recommendations on, survey and interview format and questions; participated in both surveys and interviews; recruited additional participants and advertised the Needs Assessment process throughout the state.

This assessment divided the areas of Care and Prevention into two separate arms of investigation, with separate data gathering tools used and different populations targeted for participation. However, with the increased emphasis on **High Impact Prevention** and **Prevention with Positives**, the line between care and prevention services is not as distinct as if prevention services were defined solely as "serving higher risk HIV negative populations."

Additionally, while HIV negative individuals are not in a position to provide feedback on HIV care services, HIV positive individuals are in a position to provide feedback on prevention services. To this end, HIV positive individuals were welcomed and encouraged to provide feedback in all arms of study.

Selected Population Cohorts

The process of selecting participant cohorts was discussed at CAG and confirmed by the VDH. The cohorts sought included:

- 1) HIV positive individuals living in Vermont
- HIV negative individuals living in Vermont representing populations at higher risk for HIV infection
- 3) Individuals accessing the services of Syringe Exchange programs in Vermont
- 4) Service Providers
 - o AIDS Service Organizations administration, prevention, and direct services staff
 - Medical staff of Comprehensive Care Clinics
 - o Community medical professionals serving HIV positive patients

Data Gathering Process

The data gathering process included:

- 1) Care Survey available on paper and online
- 2) Prevention Survey available on paper and online
- 3) Syringe Exchange Clientele Survey available on paper card
- 4) Service Provider Survey for ASO/CBO staff available on paper and online
- 5) Service Provider Survey for Medical Professionals available on paper and online

Additional data gathering methods included:

- 1) Focus Groups in person
- 2) Individual interviews via telephone
- 3) Individual interviews in person

Recruitment Process

Participation was sought through a number of avenues, across population segments.

- 1) Direct CAG Recruitment
 - The researcher appealed to the Community Advisory Group for participation themselves, and referral of others, with strong results in reaching diverse populations.
 - Staff members of AIDS Service Organizations and Community Based Organizations were asked to solicit participation in all avenues of the needs assessment from their staff, clients and volunteers.
 - Medical staff members at the Comprehensive Care Clinics were asked to solicit participation from their patients in the care surveys and interviews.
 - Consumer-members of CAG were asked to solicit participation in all avenues of the needs assessment from friends and associates.

2) Incentives

- Incentives of \$25 gift cards were offered to participants in interviews and focus groups.
 Gift card venues included primarily gas stations, grocery stores, and pharmacies.
- Incentive of a \$100 gift card drawing was offered for filling out a survey, with two separate drawings for Care and Prevention. Individuals received one entry for filling out the survey, and could receive additional entries if they referred friends.

 No incentives were offered to service providers for filling out surveys or participating in interviews.

3) Large events

- Tabling was conducted at large events with a relevant population in attendance, for instance Vermont Pride Event in Burlington, VT, with a large attendance of men who have sex with men. Surveys were available in hard copy, on iPad, and business cards with links to the surveys were handed out.
- Outreach workers attending large events handed out business cards with survey links.
- Researcher attended PWA Retreats and held scheduled focus groups and interview sessions, and made surveys available.

4) Advertising

- Online advertising was conducted via paid targeted ads on Facebook and Grindr, and unpaid promotion using two Facebook pages that routed to two websites – one for each arm of the project. Additional unpaid online advertising included relevant interestgroup email listservs (e.g. Tri-State Gay Men, a social listserv) and Facebook groups.
- o Business cards were printed with links to the online surveys, and information about the incentives. Contact information was given for follow-up if an interview was desired.
- Articles in newsletters were written and distributed by both researcher and staff of ASOs/CBOs promoting participation in all aspects of the assessment.
- Word of mouth advertising was strongly promoted throughout the assessment process.

The Needs Assessment process produced the following number of unique participants:

- o 132 individuals in the Care assessment
- o 245 individuals in the Prevention assessment
- 50 individuals in the IDU postcard survey
- b. Describe the HIV prevention and care SERVICE NEEDS of persons at risk for HIV and PLWHA.
- c. **Describe the SERVICE GAPS** identified by and for persons at higher risk for HIV and PLWH.
- d. **Describe the BARRIERS** to HIV prevention and care services

The prevention and care services for PLWHA and those at higher risk of HIV infection do overlap, but often fall along different continuums of service. The category of IDU data captured at syringe exchanges also crosses over with both areas, yet can be starkly different. Therefore **Section I. Part D.**, letters **b.**, **c.** and **d.** will be discussed for *PLWHA* first – as identified by PLWHA and by Care Providers. Then, **Section I. Part D.**, letters **b.**, **c.** and **d.** will be discussed for *those at higher risk of infection*, and then again for IDU-specific issues from participants of *Syringe Service Programs*.

I.D.b. SERVICE NEEDS. CARE: PLWHA, Community Providers, Medical Providers

The Needs Assessment brought information on needs of PLWHA from two sources – <u>PLWHA</u> and <u>Community and Medical Service Providers</u> working with PLWHA. Consumer perspectives are discussed first, followed by Community, then Medical, Service Providers, for each of b., c. and d.

CARE NEEDS: Consumer [PLWHA] Primary Findings

- 1) PLWHA in Vermont experience the following five life challenges in common, at high rates.
 - > 90% of respondents experience Financial Instability.
 - > 85% of respondents experience Stigma in various forms.

- ~ 75% of respondents experience Isolation in various forms.
- ~ 75% of respondents experience Public Ignorance (lack of HIV/AIDS awareness and rampant public misinformation).
- > 50% of respondents experience **Depression** and/or other **Mental Health Conditions**.
 Over half of positive Vermonters are struggling with their mental health, with depression identified as the most common co-occurring diagnosis with HIV.
- 2) Many PLWHA in Vermont have little to no difficulty accessing *services* and getting *certain needs* met.
 - Over 50% "are getting" services they need, with 38% "mostly getting" needed services.
 - Identified needs by many PLWHA that are being well-met:
 - Appropriate, high quality medical care, including assistance with expense.
 - Appropriate, high quality ASO services, including case management.
- 3) By contrast, the following *needs* are experienced by many PLWHA living in Vermont as not being met, and are further identified as the *most difficult* needs to meet.
 - **Financial**: Significant majority identify financial concerns of varying intensity, *even those reporting their needs as "being met."* ³
 - Housing: Cost and availability.⁴
 - Food: Cuts to Vermont's Three Squares program (food stamps) are reported as devastating.
 - Transportation
 - Dental Care: DCAP is helpful but many need dentures or plates.
 - Mental Health Care
- 4) Despite high isolation, PLWHA are firmly divided on need for and type of additional supports in Vermont stigma often played at least some role in resistance to accessing additional forms of direct support.
 - HIV-Specific Peer Activities/Support Groups.
 - 47% express a need for peer groups/peer activities/support groups but 34% expressed disinterest, and another 18% expressed no opinion.
 - It can be theorized that the almost one fifth of PLWA not expressing a preference are unlikely to attend or be interested in peer groups, or they would have expressed some level of interest.
 - HIV-Specific One-on-One Counseling Support.
 - 40% expressed interest, but 30% expressed no interest, and an even greater number 30% gave no opinion on the matter.
 - Again, it is safest to expect that those not expressing any opinion would be less likely to be interested in counseling, or they would have expressed interest.
 - Prevention-with-Positives Interventions. Participation in and satisfaction with initiatives such as CLEAR demonstrate similar split.

³ While this data may appear contradictory to the large percentage of PLWHA stating their needs are met, respondents were hugely grateful and at times visibly overwhelmed by the support and help that had been provided to them by Vermont services. Many were clearly inclined to report that their "needs are met" as part of their expression of gratitude toward their agency. Further interaction throughout research consistently brought to the surface that many of these same individuals still experienced a great deal of financial insecurity.

⁴ VDH HASH Department responsiveness during the time period of the Needs Assessment actively reduced this need, a fact respondents recognized and immediately identified to researcher. Housing is still flagged as a top concern, even as it improves.

- PLWHA who have participated in these initiatives found them useful and enjoyable.
- PLWHA who have not yet participated expressed resistance to "interventions."

PWA Retreat.

- A majority two-thirds of respondents attend every year and find the Retreat highly valuable.
- A minority one-third have either never attended a Retreat, or have attended once, and in either circumstance do not intend to go in future (reasons vary).

DISCUSSION: PLWHA

By age cohort, unmet housing need was a much greater struggle for the cohorts 30 - 39 years and 40 - 49 years than for any other. Similarly, these two cohorts also had greatest unmet need in the categories of transportation and food.

Unmet mental health needs were ranked significantly higher in the 40 - 49 age group than in any other. An inability to get services for these specific needs appeared to be lowest among the age cohort 50 - 59.

Through a racial lens, the unmet need in areas of housing, transportation and food existed at a higher <u>rate</u> per respondent for Black participants. The ratio of Black to White participants over all in the assessment process was approximately 1 to 8.

In the realm of dental and eye care, dentures and glasses were identified repeatedly as difficult to obtain.

While most PLWHA respondents had access to emergency food shelves and grocery cards from ASOs, food was mentioned repeatedly in the context of "there isn't anything left for food by the end of the month." Also, people spoke of not wanting to keep asking for grocery cards from their ASO – due to embarrassment, a sense of having "asked for too much," and out of gratitude for what had already been provided by their agencies. These people identified that in some months this reluctance caused them to wait too long before eventually having to ask, and by then the grocery cards available for that month were often gone.

All of the foregoing underscores the prominent theme running throughout the entire Needs Assessment, as will be seen: the **financial difficulties experienced by the majority of the HIV positive individuals** have many expressions in descriptions of other needs, but **by far, financial assistance was the highest unmet need identified**.

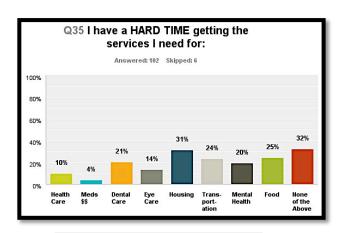
The difficulties of earning money while on SSI and receiving state and federal food assistance were particularly complicated for PLWHA. A substantial subset of respondents described being physically able to work and wanting desperately to do so, but often unable because they could not survive on the income from a job alone, and SSI and government food assistance both cut off at too early of an earning point, causing them to tumble directly back into financial crisis. Both of these outcomes of the system were hard emotionally and psychologically on PLWHA who experienced them, often repeatedly as they continued to struggle for self-sufficiency and were caught in the income/benefit loop over and over.

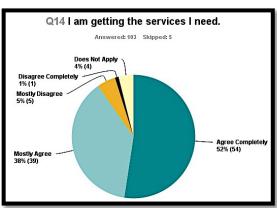
Breaking free of a sudden spiral can be difficult in the extreme, and ASO providers report that they are often unable to provide the amount of financial assistance that would help truly <u>stabilize</u> a family or an individual experiencing this.

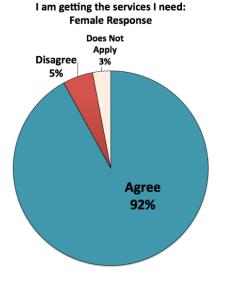
'It's a situation where you get finances balanced and you feel good physically – mostly – and your medication is stable and circumstances align <u>just right</u>, and life functions well. And you breathe a big sigh of relief. But you know... it is vulnerable to the <u>least</u> little bump in the road, or emergency, or instability. That feeling... it usually lasts about a week.' Survey Respondent

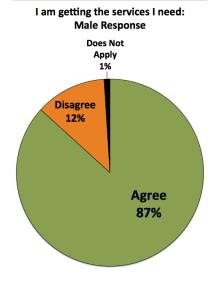
Mental health itself was raised by PLWHA as an unmet need, from a financial perspective (not having the money to afford mental health care), availability of mental health care workers able to see them at all, and finding mental health providers experienced in working with HIV-positive individuals and the specific issues that raises.

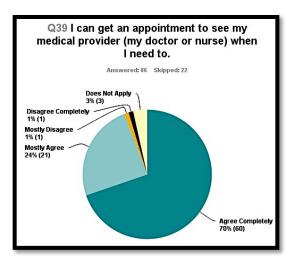
The following charts provide graphic accompaniment to responses from PLWHA.

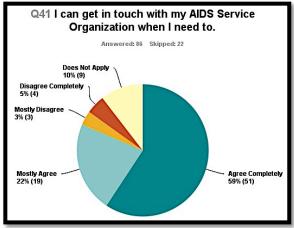










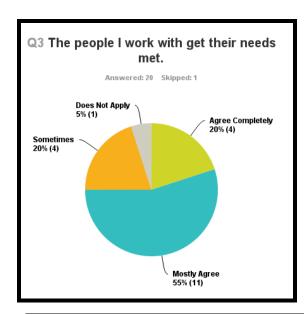


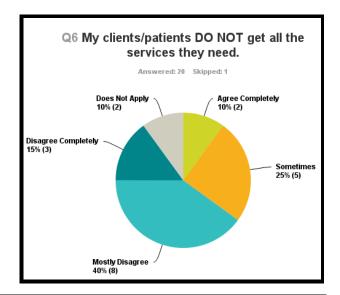
CARE NEEDS: Community Provider [ASO Staff] Response Primary Findings

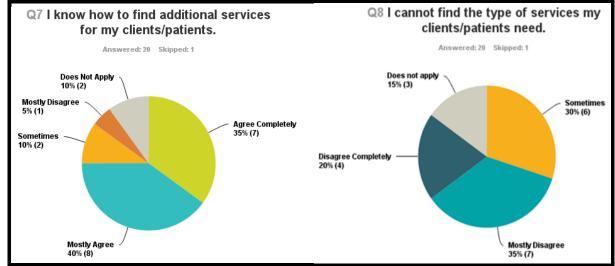
Needs identified by community and medical providers directly echoed those identified by PLWHA.

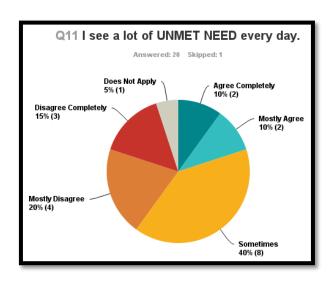
- 1) The following four issues are identified as the most prominent needs providers encounter in working with PLWHA.
 - Housing
 - Mental Health
 - o **Resources** (financial, physical infrastructure, and emotional)
 - Transportation
- 2) <u>Poverty</u> and <u>illness</u> are raised as overriding concerns that are <u>never addressed well enough</u>, with illness referencing the co-occurring diagnoses that often come with HIV.
- 3) The majority of community care providers believe clients' needs are mostly being met.
- 4) A significant minority of providers feel their clients do not get all the services they need.
- 5) A strong majority stated they *usually* know how to find additional services for their clients.
- 6) One fifth of respondents stated that they see *a lot of unmet need* on a regular basis, and an additional 40% expressed they sometimes do.
- 7) Providers reported a majority of clients do have co-occurring physical/mental health conditions.

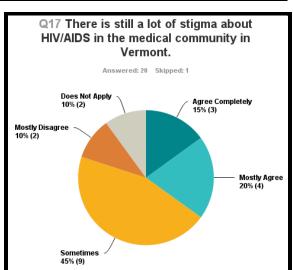
The following charts offer a graphic representation of the needs *community providers* encounter, in working with PLWHA:

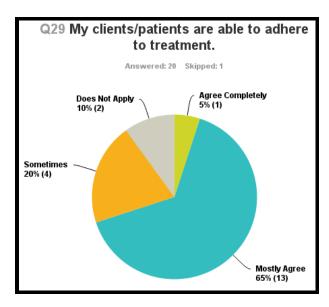








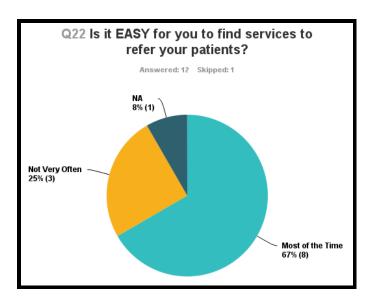




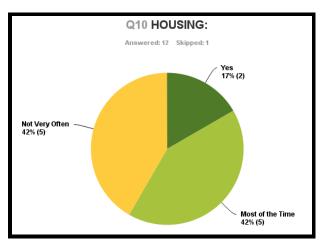
<u>CARE NEEDS: Medical Provider [Nurses, Nurse Practitioners, Physicians] Response Primary</u> Findings:

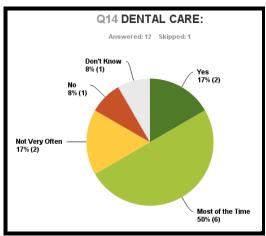
- 1) Medical providers expressed divided feedback on whether their patients can get assistance and services for what they need. (Food, housing, utilities, dental and eye care, and mental health and substance abuse treatment.)
 - o A majority of providers in all categories report patients can get services **most of the time**.
- 2) The majority of medical providers are confident that more than 75% of their patients do adhere to treatment.
 - A small number report adherence as much higher (in excess of 90% of patients).
 - A small number report adherence as lower (50 75% of patients).
- 3) A strong majority of medical providers do see patients with a co-occurring physical illness.
 - Most report a dual diagnosis in *over half* of their patients.
- 4) A majority do see patients with a co-occurring mental health condition, but at lower rates.
 - Most report less than half of their patients present with a mental health diagnosis.
- 5) A majority do see patients with a co-occurring substance abuse disorder, at lower rates still.
 - o Most report *less than one quarter* of their patients have a substance abuse disorder.

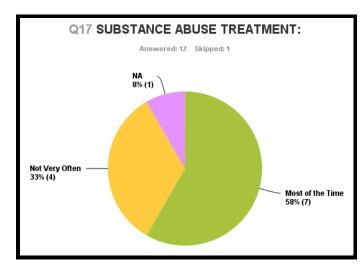
The following charts offer a graphic representation of the needs *medical providers* encounter, in working with PLWHA:

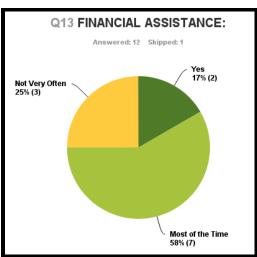


The following charts answer Yes/No to the question: "Can your patients get the help they need with..."









DISCUSSION: COMMUNITY & MEDICAL PROVIDERS

Once again, the overlap of identified needs is obvious, indicating the reliability of Needs Assessment findings. This speaks well to the quality and caring of Vermont service professionals, that they are deeply in touch with the needs experienced by their clients/patients.

The most common needs raised by service providers, by a significant margin, were:

- Housing
- Mental Health
- o Resources (financial, emotional, physical)

Housing concerns included the known statewide issues of shortage of affordable housing and high prices of rents overall, and additional mentions were made of the limitations on housing vouchers that can create long waiting periods for people even after they have been deemed eligible.

"More HOPWA funds." -Respondent 3

"Housing is a big issue for people who have relapsed and burnt bridges." -Respondent 8

"There are some needs - like housing, domestic violence support, that are unmet throughout Vermont regardless of how dedicated and hard working the staff are." -Survey Participant

Resources is a term that was used in different contexts, as one responder noted:

"More resources - financial, emotional, physical. There are many services but not enough to meet the gaping holes of poverty and illness."

-Survey Participant

Resources was used in the context of financial assistance, primarily, but also represented by numerous phrases, including: emergency assistance, assistance with meeting basic needs, poverty, resources to go about daily living, financial help for housing, food, food stamps, homeless shelter(s).

Mental health was also identified in different contexts, including: lack of mental health providers, inexperienced providers, need for experienced mental health *prescribers*, need for adaptation of provider services and supports to meet changing populations of PLWHA with increased mental health needs, increased substance abuse issues, and long waits.

"I have practiced HIV Medicine for over 23 years, in Albany, NY and Ft. Lauderdale, FL. This population in [Vermont town] is the most challenging I have ever experienced due to the combinations of dual diagnosis drug abuse and mental health."

-Medical Provider

"To have a waiting list to get into substance abuse treatment programs is crazy." -Respondent 5

"There is a lot of co-diagnosis with mental health conditions. There are self-destructive behaviors, some that led people to get infected... trauma, sexual abuse, addiction, anger, rage... TRAUMA just keeps showing up over and over again. And that just doesn't go away for people. We need mental health people who work with trauma, who know how to work with trauma. Good support groups around trauma."

-Respondent 3

"The main thing people I see need is better psychiatric care. For drug use, there needs to be more treatment. Getting a program that will help drug users to be more HIV care-compliant. Most people get

their meds paid for one way or another. It's the social psychological issues and the addiction that interferes with compliance."

-Respondent 6

"You need to watch out for mental health issues all the time. I'm seeing it more now, more co-occurring mental health disorders. More than half of the people I see. A few drop out of care every year because of mental health."

-Respondent 7

"We have clients dealing with mental health, substance abuse, and HIV. We have several clients that have pretty severe mental health issues and the community mental health system is not that accessible. People have to wait to get in for an appointment with [local designated mental health agency]. I had a client move to a different area and they moved out of the [DA's] catchment area, and had to transfer to another. And they said 'sorry, six month wait for an appointment.' And of course their mental health broke down! Six months?! The state mental health system has a lot of cracks and people ARE falling through. There is incredible need, people have overwhelming caseloads of clients. If our clients see a psychiatrist, that may be only for medication, not therapy. Many private therapists will not take Medicaid." -Respondent 5

One item that falls under resources needs separate mention – transportation. This was another common theme running throughout responses. While not mentioned as ubiquitously as housing/mental health/financial resources, transportation was raised both in the context of limited financial resources, and as its own barrier apart from financial need.

"Transportation is the second highest need behind housing. And it's a component of their medical care.

They can't get to their appointments without it. I have clients who have a round trip of 80 miles and don't have the income to pay for the gas... It's worse for people who live further out."

-Respondent 4

"Transportation. Transportation, and healthy food at a reasonable cost."

-Respondent 8

"The highest need? It's different for everyone... except maybe transportation. Transportation is a huge issue."

-Respondent 2

"I could not do what I do with the Case Managers getting people to their appointments. People are not able to make it in otherwise. Transportation is a big problem." - Medical Provider

The shortfalls and complications of government benefits were identified well by a Community Service Provider:

"We hit a wall when we have people who are engaged, wanting to pick themselves up, and there are certain expenses that people who are working to better their situations need to meet, that we just don't have. It isn't allowed. They need a vehicle. A down payment...

"Losing benefits is a huge problem and they fine you... [clients] need a lawyer they can't afford – if they have a savvy social worker MAYBE they can help, but sometimes they can't even deal with some of it. It is very difficult to navigate. They're extremely harsh on people. Look, it's not that the benefits aren't good. It's just... there are so many hurdles and demeaning tactics – maybe not on purpose but they end up being demeaning. People feel 'less than.' Their sense of self-importance, security, self-confidence is shattered because they can't make things happen. They feel they are doing something wrong but it is basically the system.

"In terms of resources, up to now we have been able to find some kind of way to make the situation better. We can't always do it the way the client WANTS, but we always try to do something. Now... with so many cuts... A big struggle is affordable housing. In the last couple years we have had three clients lose subsidized housing for various reasons. These are people living on SSI, disability, and they went from

paying 30% of their income per month for rent to 85% of their income. For some, the cost of an apartment is greater than their monthly income, not including utilities."

-Respondent 4

Of the many common and recurrent themes that emerged between the interviews with individual consumers and interviews with providers, addressing stigma and isolation was **one of the most prominent needs identified**. As part of the topic of stigma, for the purposes of this research "isolation" has been paired in this review due to the strong link between the two.

As noted above, providers mentioned mental health frequently, and depression in particular – as a <u>direct</u> corollary, the issue of stigma and isolation usually followed. Professionals described working with people who were so fearful of their HIV status becoming public that it had a significant effect on their willingness to leave their homes – to socialize, to attend medical appointments – and their general mental health overall.

"The top need? More community. Less isolation. For some people, they have me, a doctor... maybe a counselor, maybe a partner. It's a huge secret in their lives..." -Respondent 3

"We have people who... we are their contact with the world."

-Respondent 4

"Being a small town, there are people who will not come to [the medical] office because [it is] the infectious disease office. People only want to go to primary care because they feel that being in [the Infectious Disease] waiting room is a stigma.

-Respondent 6

"The stigma is HUGE, connected to the organization [ASO]. ...One person would not do medication. And it was stigma. [They]... said they 'weren't sick and didn't need them.' But it came out that the fear was if anyone found the medication... that would connect [them] to HIV. One person had someone walk [them] out of the office to block them from view. Another who had a best friend [they] told everything to... except that they were HIV positive. A third who was so afraid of someone finding out, [they] would make sure no one was in the office and no one was even coming to the office, even another client." -Respondent 2

"We have clients who are hesitant to go to food pantries because of the stigma. We can't always meet all their food needs. They want someone to provide them with companionship. They want someone who will be a friend and go do things. And that is not something we are able to provide."

-Respondent 4

Finally, when offered the opportunity to "fill in the blank" to express the highest and most common needs they encountered, the following list was generated by providers, with many answers appearing multiple times, and many individuals identifying in writing the same choices that had been offered in previous multiple choice questions, with qualifying details.

This list serves to provide additional detail on the general categories of need providers identified:

➤ Housing:

- Stable housing
- Housing affordability
- Emergency housing subsidies
- Housing clients with antisocial mental health issues
- Short/long term affordable housing
- Housing for those coming out of the Corrections system

Medical Services:

More HIV providers

- o Hepatitis C resources, education, services and treatment
- Dental care

> Financial assistance:

- More financial, emotional, physical resources
- Transportation
- Employment opportunities
- o Livable wages
- Nutritious food/food shelves
- Legal advocacy for PLWHA

➤ Mental Health:

- Isolation
- Social supports
- o Stigma
- o Mental health care for severe conditions
- Crisis intervention services
- Substance abuse treatment
 - More treatment options
 - Access to syringe exchanges in rural areas
 - Addiction services

Serving isolated areas:

- Social supports
- o Stigma
- o More HIV education/outreach through the state

Funding for Services:

- o More funds for staff and prevention
- More funds for ASOs to be open more hours
- Testing in isolated areas in VT

► <u>Inter-agency services coordination</u>:

- Referrals to other resources
- Domestic Violence services
- o Consistent case management across the state
- o Inter-organization communication

I.D.c. SERVICE GAPS. CARE: PLWHA, Community Providers, Medical Providers

There is much overlap between <u>needs identified</u>, and <u>gaps in services</u>. As would be expected, the issues raised fall within the same spectrum of themes discussed thus far.

- The following four services gaps are identified as the most common in Vermont.
 - Substance Abuse Treatment (including more syringe exchanges)
 - Affordable Housing
 - o **Emergency** and **Ongoing Financial Assistance**
 - Domestic Abuse Supports
- Community providers identify a large gap in community education and anti-stigma work, which is badly needed throughout Vermont.

PLWHA

Asked specifically about service gaps, PLWHA consistently mentioned services for financial assistance. It was clear that while many were happy with their medical care, happy with their ASO, and felt their HIV was largely managed, more than 90% of individuals interviewed spoke of the financial instability brought on as a consequence of living with HIV/AIDS.

Specific service gaps identified by PLWHA:

- Insufficient food assistance services from the state
- o Lack of transportation services, especially to medical appointments
- Dysfunctional SSI services/dysfunctional federal assistance services
- Lack of mental health services: waiting lists for mental health treatment, substance abuse treatment; lack of housing assistance for those with mental health conditions, etc.

A significant service gap that addresses an important aspect of self-care and well-being was consistently defined as "community education services." The large majority of PLWHA spoke of how stigma, inability to discuss their HIV status, and the sheer amount of general misinformation about HIV throughout the state in the general population had huge impact on their quality of life, and their ability to effectively manage care and meet their needs. This ranged from losing jobs due to HIV status becoming known, to being harassed at workplaces, and inability to get work; discrimination in housing from landlords and neighbors; and negative effects on mental health and social life.

Service Providers

Specific service gaps identified by service providers:

- DCAP was greatly appreciated but dentures services were noted as a significant gap.
- HOPWA was identified as experiencing significant service gaps in the amount of assistance available.
- Syringe exchange coverage have large gaps, and needed to be available around the entire state.
- Vermont state food assistance services (Three Squares, SNAP) have huge gaps.
- The Vermont Department of Corrections was singled out for concern, in the areas of Probation and Parole, lack of HIV education and knowledge within the prison system (prisoners, staff, officers), and lack of continuity of support services post-release.

- "Corrections staff need education in risk identification, what to look for, what puts people at risk. And education for prisoners – people need to be talked to in a way that respects them. Not lecturing, not talking above them, and using their vernacular."
- "We desperately need testing in the corrections system."
- "Probation and Parole are extremely difficult to work with. Addicts are addicts and they WILL push the envelope, but P&P will up the ante until it is impossible for the person to succeed."

I.D.d. BARRIERS. CARE: PLWHA, Community Providers, Medical Providers

In reviewing the **Service Needs** and **Service Gaps** experienced by PLWHA in the past pages, many of the **Barrier** categories identified in **Letter d.** have been already covered.

Social and structural barriers are large in Vermont, including poverty, stigma, and the rural landscape. The isolation of living in a small rural state with a struggling economy is exacerbated by the confining nature of living in small towns with small, interconnected social networks. Many PLWHA raised concerns about being seen in an Infectious Disease doctor's office, seen talking to other HIV positive people, or seen near AIDS service organizations, and of people seeing their HIV medications. The stigma and isolation further feed the depression and mental health challenges that can also interfere with care. In areas of the state with larger populations of new Americans, Vermont faces struggles with interpretation services, resources available in appropriate languages, and cultural barriers that can exacerbate stigma.

Program barriers and infrastructure barriers are largely captured within the lack of funding Vermont has access to for HIV/AIDS services, AIDS Service Organizations, and emergency assistance. The lack of transportation infrastructure is a huge barrier for getting to doctors' appointments, for those whom it affects. In addition, the spread-out nature of rural services with concentrations in the few larger towns and city, means that many PLWHA have long drives for numerous types of services and appointments.

Another infrastructure barrier more fully in the IDU section below is the lack of syringe exchanges throughout the entire state (only certain counties are covered), and lack of state capacity for substance abuse treatment, as detailed in the **Section I. Epidemiologic Overview, Part A., Letter d**. A shortage of available treatment placements/waiting lists put individuals struggling with addictions at huge risk.

Vermont's Health Connect services, fulfilling the national requirements of the healthcare exchange, have had structural delays, implementation difficulties, and technical problems, but ASO case managers have taken on roles as Health Care Navigators to help guide clients through accessing health insurance.

The state budget of Vermont is under severe strain. Many services have faced significant cuts, including state food assistance programs, and the state Department of Mental Health. The latter negatively affects the availability of quality, timely mental health care through the state's Designated Agencies.

Client barriers of housing instability, poverty, and mental health have been explored at length in **Needs** and **Service Gaps**. In examining client barriers, the consistent inability to reach individuals not currently in care for direct consultation, either through survey or interviews, has been a significant limitation. There is a lack of direct feedback from those most able to explain what is keeping them out of care. Due to this difficulty, the survey responses to "barriers to care" could not be statistically calculated.

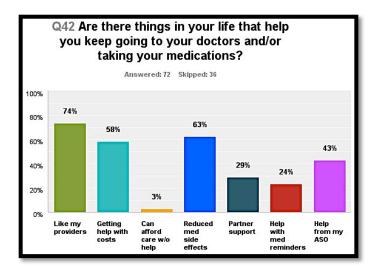
While HIV surveillance analysis indicates that as many as 22% of Vermont PLWHA are not in the state's care systems, from the perspective of community supports, it speaks highly to Vermont's current services that getting into and staying in care are clear "community norms" among PLWHA. None of the individuals interviewed could think of <u>anyone they knew</u> who was HIV positive and <u>not</u> in care. As this section moves into closer analysis of PLWHA-identified barriers, it is based in material from:

- Individuals in current care
 - o Barriers they experienced before getting into care, and those they still experience
 - Barriers they theorize may keep other PLWHA out of care, based on their experiences

• Service providers, both community and medical

It can be helpful to turn the question and examine what currently <u>supports</u> those who are in care, in order to examine what may be missing from the lives of those not in care. It is reasonable to assess that if there is a support that is strongly associated with keeping PLWHA in care, the lack of that support may well be a barrier to other PLWHA entering or remaining in care.

The following graph presents a range of responses that were offered in the survey, with the percentages of those identifying a given item as helpful to staying in care. Individuals could check as many supports as applied to their circumstances. Strong themes come through. The fact that Vermont is able to offer <a href="https://high.graph.com/high.gr



Other categories highlight the ongoing theme of financial instability:

- Almost two thirds of responding PLWHA selected "getting help with costs" compared to just 3% identifying "I can afford care without help."
- An additional 43% of PLWHA selected "help from my ASO" as a support, which is known to include assistance with linkage with medical care, assistance with applying for benefits for care, and assistance with transportation to and from care.

This juxtaposition of response indicates that when barriers are being identified, <u>financial instability</u> is highly likely to be a large barrier in getting into care and remaining in care.

Another data point of considerable interest is the two-thirds of respondents who selected "reduced medication side effects" as a primary reason they are able to stay in care. This is another theme that rises again in participant feedback, and by looking to the opposite side of this equation, a significant barrier to care for others may be an inability to physically tolerate HIV medication, dislike of taking HIV medication, or lack of knowledge/belief that HIV treatment has improved a great deal, bringing about an unwillingness to enter care.

The last two supports received lower responses overall, but still significant, with approximately one third choosing "partner support" and one quarter choosing "getting help with medication reminders." Both of these indicate additional themes that arose in interviews around important aspects of staying in care: being connected to others, feeling cared about and caring in return, and the issue of "brain fog" or forgetfulness. This last was an issue that was identified by many PLWHA as being a factor in struggles to

remain in care, and therefore the lack of connectedness, and the incidence of memory-effect of an individual's HIV infection, are likely to be barriers to care for others.

Some summary statements of general themes around barriers to care are possible to be gleaned from overall PLWHA responses across the range of the Needs Assessment, including responses to multiple questions and discussions with interviewees. Once again, significant consistency in issues raised appeared immediately.

- 1. <u>Four challenges/barriers to getting into and remaining in care are identified by PLWHA as most common.</u>
 - a. Transportation Barriers
 - b. Financial Barriers
 - c. **Precarious Life Circumstances** (unstable income, housing, emergencies)
 - d. Mental Health Barriers
 - i. Depression/mental health conditions are barriers to self-care/staying in care.
 - ii. Above barriers also exist to getting into/remaining in mental health care itself.
- 2. Three challenges are identified by PLWHA in care as most likely to influence a positive individual's ability and/or willingness to enter and remain in care.
 - a. **Mental Health** half of all respondents identify this as a likely cause of not getting care.
 - b. **Substance Abuse** *over one third* identify this as a likely cause of not getting care.
 - c. **Stigma/Fear** *one third* identify this as a likely cause of not getting care.

A total of **20 people** responded to the invitation to identify barriers/challenges to <u>their</u> participation in care, in their own words, while a further ten specified that they <u>did not</u> experience barriers to care. Primary themes identified once again included:

- Transportation
- Financial
- Mental Health
- Life Instability

The following table is a ranked list of reasons that respondents overall, in their experience, <u>believed</u> would be most likely to keep people out of care, with the percent identifying that barrier noted.

| POTENTIAL CARE BARRIERS – Respondents' Opinions | | |
|---|--|--------------------------|
| RANK | IDENTIFIED BARRIERS | % Identifying Barrier |
| 1 | Mental Health | 50% |
| 2 | Substance abuse | 35% |
| 3 | Stigma/Fear | 30% |
| 4 | Past Perceptions of HIV Care/Medications | ~ 20% |
| 5 | Financial Concerns (specific to health care) | ~ 20% |
| 6 | Life Circumstances – Maslow's Hierarchy | ~ 20% |
| 7 | Fear/Dislike of Doctors/Medical Environments | ~ 20% |
| 8 | Other: Anger, Self-blame, Feel Currently Healthy, Prefer to Ignore | < 5% |

In surveying and interviewing providers, they were asked to rank only **three to five services**, in an attempt to sift out large themes and prioritization. The results demonstrate that medical providers

believe the five most important services that PLWHA need in order to successfully overcome barriers to care are:

- Mental Health Care
- Addiction Services
- Case Management
- Housing Assistance
- Basic Needs Assistance

Direct provider responses on the topic of barriers include the following:

"There is a lot of fear around side effects. Even though the meds are so much better. I'm mostly seeing people who have had HIV for a while now. They remember AZT. ...While taking medication once a day makes it easier than it used to be, some people really struggle with the constant reminder. They think of it as a reminder of 'I'm a bad person.'"

-Respondent 7

"Fatigue definitely affects compliance."

-Respondent 7

"I hear 'I don't want to take my meds. I know I should, but I don't want to.' I think 15 – 20% of the people I see are not in care or are not taking their meds. They say they are in care, when you ask. But I get calls from the pharmacy – there are people who are not filling their prescriptions. Why? Disorganization, denial... I hear 'Taking my meds reminds me I have the virus.' I know someone, they [work in a health related field]. Really smart. Does not take [their] meds. It's total denial."

When providers focused in on the supports to staying in care question, they ranked the factors that support care retention in similar fashion to PLWHA.

- Improvement in medication.
 - o success of treatment
 - decrease in side effects
 - extended quality of life
- <u>Financial assistance for medication</u> played a large role in <u>treatment adherence</u>, given the extremely high cost of HIV medications.

I.D.b. SERVICE NEEDS: [THOSE AT HIGHER RISK OF INFECTION]

Needs Assessment Primary Findings:

- 1) HIV/AIDS is perceived as a health concern in Vermont by a vast majority of respondents both to the survey and in focus groups. However, other indications belie this specific answer.
 - Further investigation indicates that <u>wider education and awareness is actually needed</u>.
 Numerous participants exhibited high self-assessment of knowledge, but low *actual* knowledge.
 - MSM are the only group with consistent average to above average HIV knowledge.
 - Those responding had a perception their peers were less informed.
 - Queer youth/young adults had *mixed levels* of knowledge, with the *majority* expressing "I don't know anything;" "I've tried to find information on the internet."
 - Respondents expressed concerns of encountering lack of awareness and knowledge among peers, and peers who had significant misinformation.
 - Straight young adults had *very little* knowledge or understanding of HIV, even those who began the conversation <u>believing</u> their knowledge to be good.
 - Respondents perceived their peers as not knowledgeable or aware, reporting HIV is not discussed and encountering misinformation.
 - Respondents generally do not view themselves at risk of HIV, feeling "safe" in Vermont.
 - Participants ranking their *personal risk of getting HIV* and their *personal risk of getting an STI other than HIV* chose "Low" or "Very Low" risk at the same rates.
 - Twice as many people checked the Medium and High when ranking their risk for another STI versus their risk for HIV.
 - The number of people selecting "Does Not Apply" <u>decreased by two thirds</u> when assessing their *risk for another STI* versus *risk for HIV*. Three times the number of people indicated *risk for acquiring HIV* as <u>not even applicable to their lives</u>, while their *risk of acquiring another STI* was applicable.
 - Despite perceptions of safety and risk assessment, 61% of male respondents report having sex with multiple partners, and 17% report experiencing an STI in the previous 12 months.
- 2) <u>Just under half report testing for HIV on a yearly basis, and just over half report testing for other STIs annually, indicating a need for continued testing outreach.</u>
 - Individuals 50 and over are more likely to prefer anonymous test options while people under 50 are more likely to be willing to test confidentially with their doctor. This indicates a <u>potential</u> need for two targeted messages for testing campaigns, dependent on age.
 - Women reported testing for other STIs at twice the rate of testing for other STIs and HIV. Given heterosexual transmission is the second highest transmission category in Vermont this indicates a need for STI testing to be used as an opening for HIV testing for heterosexual women.
- 3) Generally, respondents are aware of how and where to find free condoms in Vermont.
 - This varied by county, indicating a need for geographically-targeted condom distribution.
- 4) A majority of respondents (60%) do not meet with "condom refusal" among the men with whom they have sex, and a strong majority (85%) state they can "insist on safer sex."
 - Written comments on surveys and focus group respondents expressed a different picture, speaking of widespread and persistent bias against condoms in the Vermont MSM community, including 'unspoken' pressure to not bring them up or talk about HIV, condom fatigue, etc.

- While people indicate they do not experience outright condom refusal, and are able to insist on safer sex, the additional context suggests they may not even be asking partners to use condoms and may not be raising the topic of safer sex at all.
- This discrepancy indicates a continued <u>need for prevention outreach in the MSM community</u>, and more specifically a <u>need for outreach with PrEP</u>.
- 5) Respondents expressed good knowledge of current biomedical prevention trends, including Treatment as Prevention and PrEP.
 - A solid majority agreed mostly/completely to both understanding TasP, and being willing to utilize it as a prevention method if they had an HIV positive partner.
 - While respondents express that they "understand" and "would use" TasP/PrEP, a significant majority would want to continue to use condoms as back up (79% for TasP; 72% for PrEP). This calls into question exactly how well respondents understand the biomedical interventions, the level of reliability, and the implications of an undetectable viral load. This indicates a potential need for more education and outreach around biomedical prevention.
- 6) A strong majority of responding individuals perceive a high level of HIV/AIDS stigma in Vermont.
 - MSM reported significant stigma toward HIV positive individuals in dating and social circles, and stigma toward discussing HIV or condoms, indicating a <u>need for continued efforts in the MSM</u> community to promote communication about HIV, personal risk, and sexual self-efficacy.
 - MSM report going out of state for sex and dating, due to the limited population of MSM in Vermont, indicating a <u>need to assess how out-of-state sex in higher incidence areas may affect</u> Vermont's epidemic.
 - These prevention findings echo care findings reported by PLWHA and providers, indicating a need for anti-stigma work.
- 7) HIV is not "seen" in the world at large, in communities, on college campuses, or in the news.
 - This universal reaction indicates a <u>need for higher profile that HIV infection does still happen</u>, <u>and in small states</u>.
 - Given the increasing awareness around drug use in Vermont, publicity and awareness efforts could link to efforts to increase awareness around HIV infection risk, indicating a <u>need for cross-agency/interdepartmental collaboration on awareness and education</u>.
- 8) All respondents universally express, with great emphasis and repetition, that sexuality education in high school is highly problematic and ineffective, indicating a need for greatly improved and increased sexuality education.
 - Participant reports of class experiences diverged widely, depending on location of class.
 - Given health class generally happens once during the high school years, respondents report that
 it happens too early, too quickly, without enough emphasis on sexual health, and needs to be
 taught twice and required of all students.

- Of particularly strong concern for respondents are: health classes taught by sports coaches, spending little to no time on sexuality education, focusing only on sexually transmitted disease, not covering HIV/AIDS or propagating misinformation, and relegation of health/sexuality education to "one ninth grade semester."
- Recommendations included having the health class in freshman year, and a second required 'refresher' health class in junior or senior year.

DISCUSSION – Those at Higher Risk:

Prevention needs and risks in Vermont are shaped in part by the rural nature of the state, and the relatively small, dispersed population.

Due to population size and overall low HIV incidence, prevention funding for high-risk negatives is severely limited, and focused in the northwest corner of the state, in the only community with a 30% of the state's HIV epidemic in their jurisdiction.

While Vermont's primary population at risk is MSM (representing 55% of the state's epidemic), this unfortunately means that the only MSM-focused prevention programming for high-risk negatives is in the northwest corner, focused in Chittenden County. The MSM population in Vermont is seeded throughout the state, and results of the Needs Assessment indicate that there is a strong sense of "protection from HIV" conferred by living in a small rural state, while at the same time there is a presence of condom fatigue and resistance to condom use, as identified by men participating in the assessment.

As noted in the summary above, perhaps of highest concern is that while assessment

"What do you HIV?"

Fill-in-the-blank identifying their or "Very High":

- Being on PrE I'm positive.
- Protection...
- Monogamy.
- Condoms, co

results indicate that Vermont residents across genders and ages do believe HIV is a health issue of Statewide Coordinated Statement of Need: 2016; PRONE Page 5

other gay gu

concern in Vermont, the majority of respondents simultaneously identified themselves as unlikely to be at risk for infection, presenting the exact frame of mind that is dangerous in small states with small social networks.

Further indication of this mindset comes when examining the data of those who acknowledged risk of acquiring HIV. Data indicates that approximately <u>one-third</u> of responding sexually active men who have sex with men, who self-assess good knowledge of HIV/AIDS, also self-assess that they are at <u>medium risk</u> or higher for acquiring HIV.

All respondents checking "High" or "Very High Risk" of personal HIV infection, chose "Agree Completely" or "Mostly Agree" to the statement "I know a lot about HIV/AIDS." These respondents were primarily gay identified males with an age range of 20s – 50s.

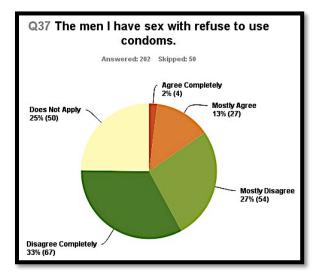
All but three respondents checking "Medium Risk" of becoming infected also chose "Agree Completely" or "Mostly Agree" to "I know a lot about HIV/AIDS." This group was also primarily gay-identified males, with ages ranging from 20s – 60s.

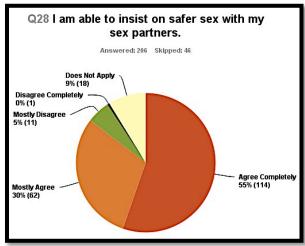
Further, most respondents choosing "High" or "Very High Risk" of acquiring HIV offered a fill-in-the-blank answer to the question "What do you think is the best way to prevent HIV?" —with accurate, thoughtful answers, confirming their self-assessment of their HIV knowledge. Similarly, the majority of those choosing Medium Risk for acquiring HIV also filled in accurate answers.

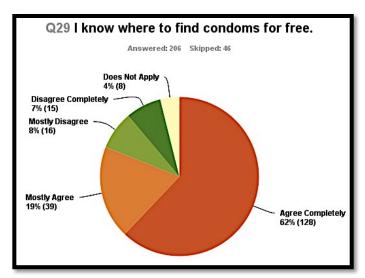
While the need for prevention services and programming is needed throughout the state, questions about **type of prevention services** desired receive mixed response.

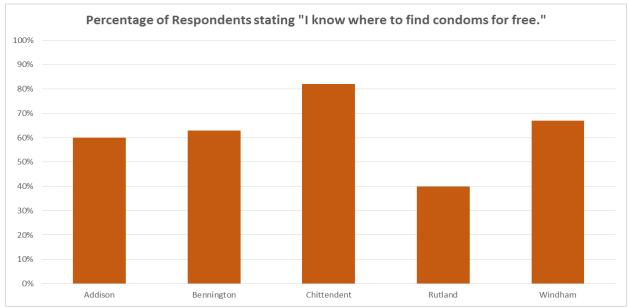
Questions asked about interest in **peer groups** and **one-on-one counseling settings** for talking about HIV and personal risk. Response varied significantly based on gender, with <u>males much more likely to agree that they would like to get together with peers</u>. This speaks well for the success of prevention programs such as Mpowerment that are rooted in social networks and peer groups.

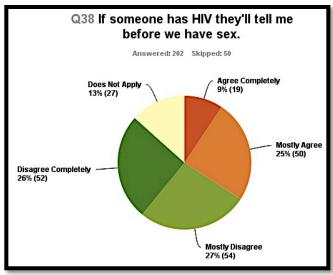
The following charts provide graphic accompaniment to the Needs Assessment findings around <u>prevention needs</u> in Vermont.

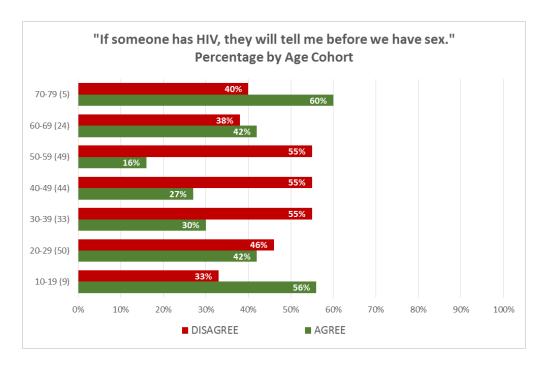


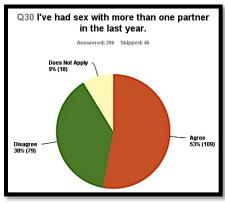


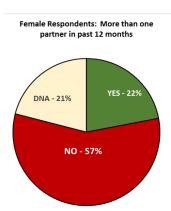


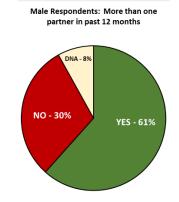


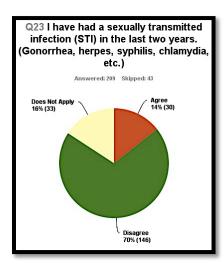


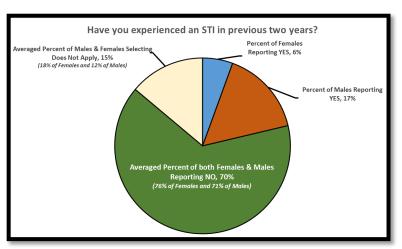


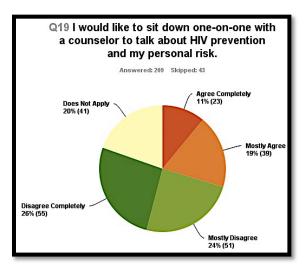


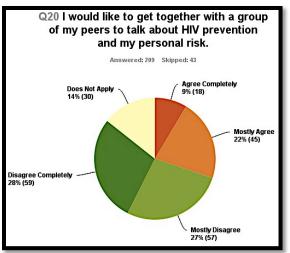


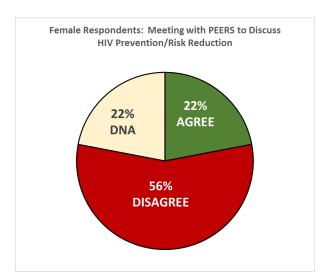


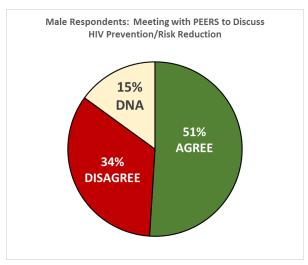


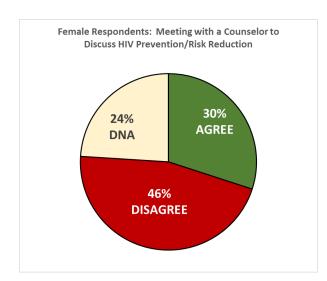


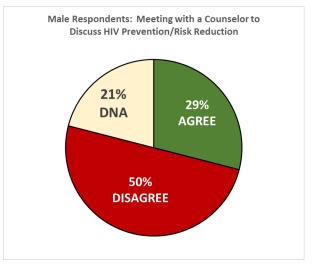


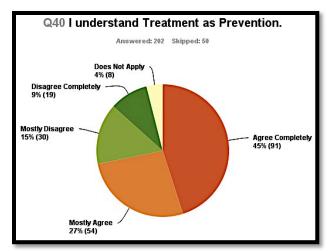


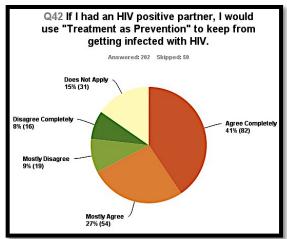


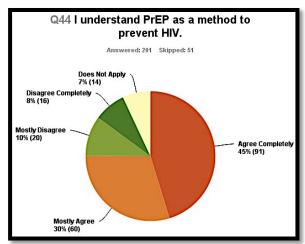


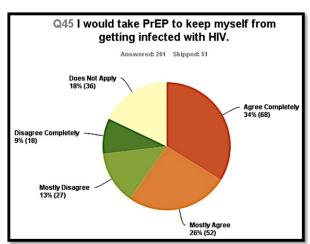


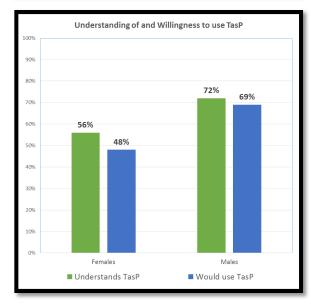


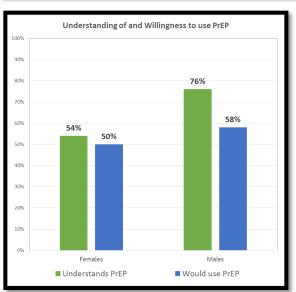


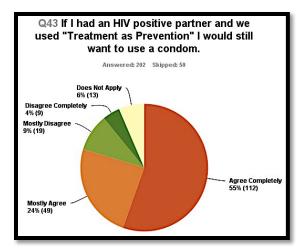


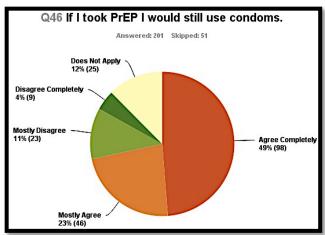












I.D.c. SERVICE GAPS: [THOSE AT HIGHER RISK OF INFECTION]

The Needs Assessment findings in the prevention arena indicate service gaps in the following areas, as identified by participants in the surveys and focus groups:

- While there appears to be a perception of HIV as a health concern in Vermont, the level of knowledge outside of the MSM community is low.
 - Gap No consistent service providing education and awareness to the broader population.
 - Gap No consistent anti-stigma services, especially in counties with high reported stigma experiences.
- Gap No consistent college/university HIV/AIDS awareness and prevention services for students, including a lack of orientation awareness sessions and lack of condom distribution.
- Gap Lack of attention to widespread feedback and <u>demand</u> for significant changes to high school health class services, especially those regarding sexual health and HIV/AIDS in particular.
- Gap Lack of free condom services visibility in more rural counties.
- Gap Lack of extended targeted prevention services for those at higher risk, especially MSM, throughout the state.
- Gap Low apparent linkage of testing for other STIs with HIV testing, especially for women.
- Gap Culturally appropriate services in native languages for new Americans.

I.D.d. BARRIERS: [THOSE AT HIGHER RISK OF INFECTION]

Barriers to HIV prevention services in the state of Vermont have been largely referenced above in the Service Needs and Service Gaps sections, and include:

- Insufficient prevention funding for higher risk negatives
- Insufficient state education requirements or adherence on health/sexuality education
- Insufficient attention to HIV in higher education
- Insufficient knowledge that HIV "still exists" and is still not "cure-able"
- High levels of stigma social and institutional (workplaces)
- High false sense of security in the "safety from disease" conferred by a small rural state
- Insufficient awareness of personal HIV risk
- Lack of free condom visibility (specific counties)

- Lack of integration of HIV into larger medical services for general population
- Insufficient culturally appropriate services in native languages for new Americans

I.D.b. & c. SERVICE NEEDS & SERVICE GAPS: [SYRINGE SERVICES]

The population sought and accessed was clients of the various Vermont syringe exchanges, and service providers. Fifty individuals were assisted by syringe exchange workers in filling out a short survey. They expressed the following needs, and service gaps.

Overall, participants reported that the top five items or services needed most were:

- 1. Clean needles
- 2. Medication-assisted drug treatment
- 3. Help finding housing
- 4. Basic toiletries
- 5. **Food**

Participant responses indicate clean needles and medication-assisted drug treatment were the two highest needs by a <u>significant margin</u>. A total of 42 out of the 47 participants who answered the question checked "clean needles" on the list of most needed services, indicating the syringe exchanges are <u>fulfilling a strong existing demand to help individuals struggling with addiction protect themselves from HIV and other bloodborne pathogens</u>. The overwhelming response indicates that the syringe exchange primary service is indeed the <u>most needed</u>.

This data indicates that syringe exchanges are indeed a stepping stone service, with individuals coming in for clean needles ranking "medication-assisted drug treatment" as second highest choice. Clearly there is interest in treatment among the clients of the exchanges, and there is strong support for the previously stated conclusion that the <u>largest service gap</u> is the <u>lack of availability of treatment service</u>.

The need for housing among the top five indicates again that there is a service gap in finding emergency housing for those most in need in Vermont, and as noted by service providers in the preceding section, housing options specifically for individuals who have been incarcerated or have an arrest record. "Food" and "basic needs" indicate that the majority of syringe exchange clients are at a survival-level of need — the very basics are the most needed, and overshadow much else. That medication-assisted treatment is ranked higher, speaks strongly to the existing gap in treatment services.

The following highest needs, with just over half of respondents selecting them, were:

- 6. Hepatitis services
- 7. Help finding work
- 8. Dental care

The second tier rankings indicate similar trends as are seen in prior investigation with PLWHA. This underlines that this population is exhibiting a drive for self-care, to reach out to protect themselves, and their fellows struggling with addiction, and <u>also</u> wants to improve their lives and <u>work</u> to do so, but are lacking the societal supports that will help them get past the first obstacles. Again, dental services arise as a service gap.

In a body of responses with equivalent numbers of participants from both genders, the data demonstrates that a greater percentage of male participants than female participants selected any of the items or services as most needed, with the one exception of mental health services. Thirty-seven percent of female participants selected mental health services as a most-needed service, compared to 33% of male participants.

While the small amount of participants in this survey prevents significant statistical analysis, a simple observation would note that male participants were more likely than female participants to identify their need for a particular item or service. Whether this is a result of females having a higher rate of finding these services, or of females being less willing to ask for assistance, is not possible to assess from this data.

Responses by age reveal that participants <u>under the age of 35</u> demonstrated a greater need for medication-assisted drug treatment, food, and hepatitis services, while participants <u>35</u> years and older demonstrated a greater need for help with housing, basic health care, and HIV/AIDS services.

The number of responses was limited for the fill-in-the-blank **Question 2:** "What else?" Hand written entries included:

- Assistance with the cost of transportation (fuel)
- Feminine health products
- Therapeutic support
- Help with maintaining sobriety

A small number of participants listed the following "urgent day-to-day needs" in response to the **Question 3** fill-in-the-blank:

- Housing
- Food
- Clean needles
- Transportation
- Medical care
- Employment
- Financial assistance
- Medical-assisted treatment
- Mental health care and treatment
- Safety

The repeated appearance of the primary needs that were indicated in **Question 1** underline the validity of these results, given individuals took the additional time to write them in again and emphasize that they are <u>urgent</u>. This underscores the high level of need in a high-risk population, and the harm done by huge waiting lists for treatment.

Question 4 asked participants to check off "items and services that would be MOST helpful for you to have right HERE at the syringe exchange." With the already-small pool of data, it should be noted that 15 of the 50 participants did not respond to this question. A response rate of 35 people (70%) is still indicative of solid information, given the strong trends of similar answers to the first questions.

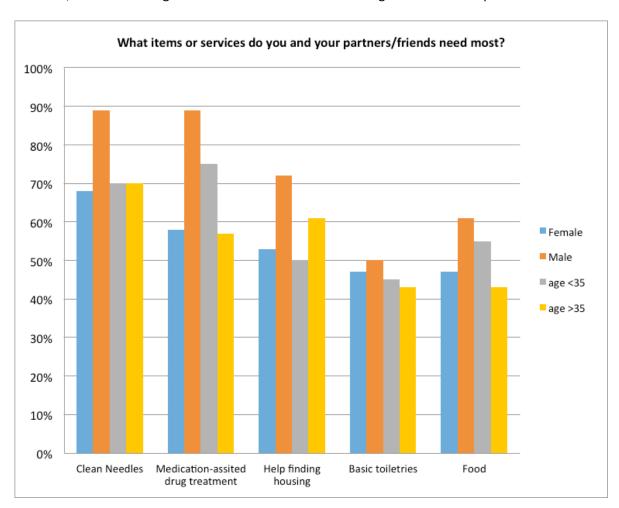
As seen in the following chart, participants indicated that the most helpful services to have located at the syringe exchange would be:

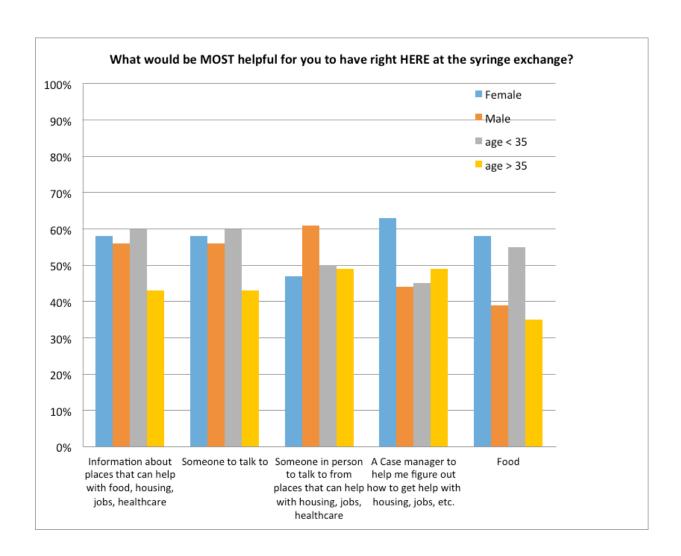
- 1. Someone to talk to
- 2. Information about places that can help with food, housing, jobs, healthcare
- 3. Someone in person to talk to from places that can help with housing, jobs, and healthcare
- 4. **A case manager** to sit with to help figure out how to get help with housing, jobs, etc.
- 5. Food

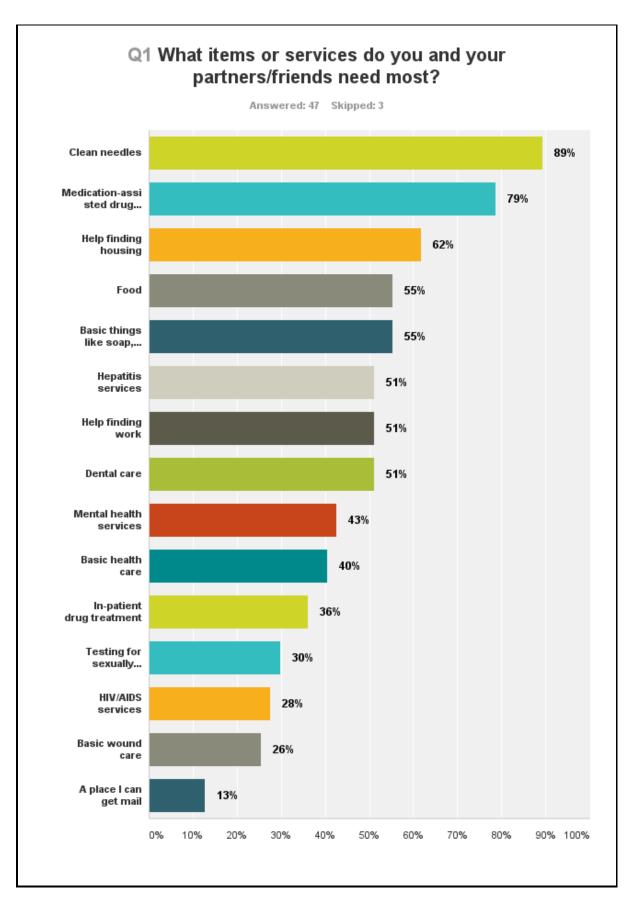
These results are telling, and highly suggestive of a <u>significant service gap</u> for this high-risk community. Beyond access to clean needles, many participants would like to be able to go to their syringe exchange and <u>talk to someone</u>. Three of the top four items focus on human interaction. While talking to someone who can <u>help them access other local services</u> is obviously a strong part of this picture, the fact that <u>all three</u> of these options identifying human interaction were so high on the list – with simply "someone to talk to" at the very top – implies a strong need for personal connection in the lives of these individuals, and speaks to an often underestimated essential service that syringe exchanges are providing.

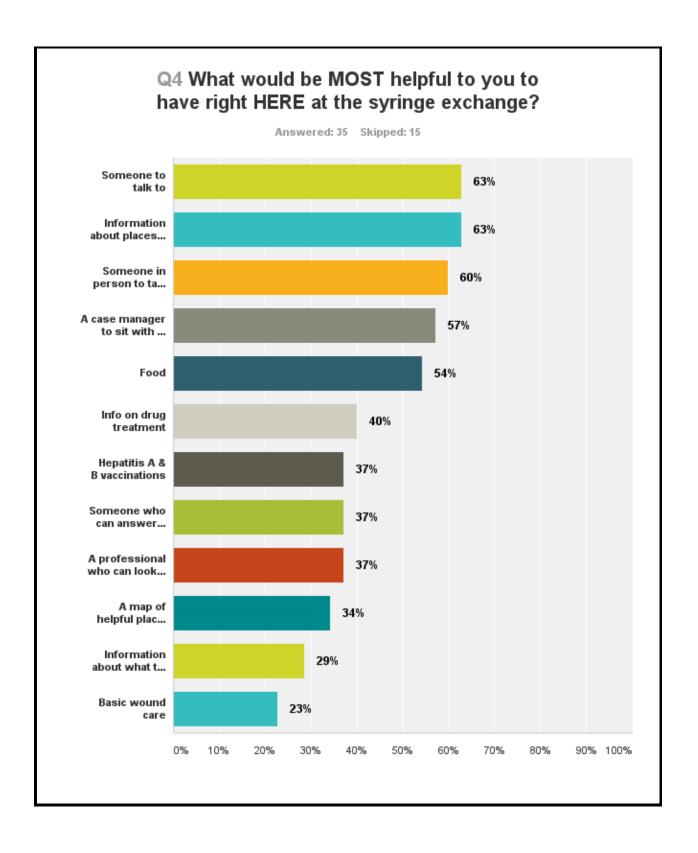
I.D.d. BARRIERS: [SYRINGE SERVICES]

Barriers for this population include homelessness, active addiction, and long waiting lists for treatment placements. A lack of statewide syringe exchange services is a barrier for individuals in protecting themselves, but the most significant barrier is the severe shortage of treatment options.









E. DATA: ACCESS, SOURCES, and SYSTEMS

a. Describe the **main sources of data and data systems** (e.g., CAREWare, eHARS) used to conduct the needs assessment, including the development of the HIV Care Continuum.

In conducting the overall assessment of needs for statewide planning, one of the data sources was the specific document of the Vermont 2015 HIV/AIDS Care and Services Needs Assessment referenced extensively in the preceding section: **Section I, Part D – Needs, Gaps, Barriers**. The main sources of data for that single document will be noted first, as much of the detail on those sources has already been covered, followed by the sources of data and data systems utilized for the Integrated Plan as a whole.

The Needs Assessment document's main sources of data were Vermont residents in the following categories: consumers of HIV care and prevention services, individuals at higher risk of infection, and community and medical service providers. These sources were accessed through surveying, focus groups, and interviews.

Beyond that document, the primary sources of data include:

- Community Advisory Group: Meetings, Minutes
- Behavioral Risk Factor Surveillance System
- Youth Risk Behavior Survey
- Census 2014
- Vermont Department of Health Surveillance Data Briefs: HASH, ADAP
- 2011/2012 National Survey on Drug Use and Health

Data systems used include:

- CAREWare
- eHARS
- NBS Electronic Data Surveillance system
- STD Management Information System
- VDH HIV Surveillance System
 - Early Identification of Individuals with HIV/AIDS for RWHAP Parts A and B Grantees
 - o Ryan White HIV/AIDS Program Services Report
- Vermont Medication Assistance Program

In developing the Care Continuum, specific use was made of the HIV Surveillance System to gather data on each segment of the continuum.

b. Describe any **data policies that facilitated and/or served as barriers** to the conduct of the needs assessment, including the development of the HIV Care Continuum.

CAREWare and eHARS have in past years been maintained on an off-network computer system at the VDH, due to concerns about confidentiality of HIV-related data. This policy has proved to be a barrier in full assessment of data. Both systems are in the process of being migrated to the network, with the support of the community, which will facilitate better and more up-to-date data surveillance going forward. Additionally, now HIV data is now being integrated into the NEDSS system. Between STDMIS, NEDSS, CAREWare, and eHARS Vermont will have be able to match across all reporting systems to verify histories of HIV, HCV and STI's.

c. Describe any data and/or information that the planning group would like to have used in conducting the needs assessment including developing the HIV Care Continuum and the plan, but that was unavailable

The planning group would have preferred a sample of PLWHA not in care for the Needs Assessment document. For a variety of reasons this was not possible, but would have informed the Needs Assessment in a completely different way. As with all data collection, a large sample response would always be preferred, in this case particularly with prevention respondents. Comparative data on the knowledge, understanding and experience with HIV/AIDS on the larger medical community in Vermont would provide excellent resources for examining the issues of stigma in medical care, but resource limitations did not allow for a survey of that magnitude.

In developing the Care Continuum, the data from the HIV Surveillance System provided all the necessary information from step to step.

##

SECTION II. Integrated HIV Prevention and Care Plan

A. INTEGRATED HIV PREVENTION AND CARE PLAN

Section II, the integrated HIV Prevention and Care Plan, should respond to the needs identified in Section I of the Integrated HIV SCSN/Needs Assessment guidance and align with the three NHAS Goals, (1) reducing new HIV infections, (2) increasing access to care and improving health outcomes for PLWH, and (3) reducing HIV-related disparities and health inequities

(A1) TARGETED NHAS GOAL: REDUCING NEW INFECTIONS

<u>GOAL #1 SMART Objective #1</u>: By 2021, <u>reduce new HIV infections</u> in Vermont <u>by 20%</u> of Vermont's five-year average from 2009–2014, from **15** to **12**.

- **Strategy 1:** Allocate public funding consistent with the geographic distribution of the epidemic.
- > Strategy 2: Allocate to grantees according to the latest epidemiological data so that funds reach areas with highest burden of disease.
- > Strategy 3: Focus on high-risk populations: Intensify HIV prevention efforts in communities where HIV is most heavily concentrated

| STRATEG | STRATEGY 1. Allocate public funding consistent with the geographic distribution of the epidemic. | | | | |
|-------------------|---|--|---------------------------|--|--|
| TIME | RESPONSIBLE PARTIES | ACTIVITY | TARGET POPULATION | DATA INDICATORS | |
| By DEC of 2016 | VDH | Allocate federal funds to match Vermont epidemic distribution through targeted RFA | Risk Pop. By Geography | VT Epidemiology Funding Allocation | |
| By SEP | Service | Respond to RFA with evidence-based interventions based on area's distribution of | Risk Pop. By | VT Epidemiology | |
| of 2016 | Providers | epidemic | Geography | Completed Proposals | |
| By DEC of 2016 | VDH | Prioritize funding/programming for MSM in Chittenden County, thereby matching: 1. Geographic region with highest rate of HIV 2. Population with highest concentration of transmission risk 3. Geographic region with highest concentration of risk population | MSM | Funding Allocation to Chittenden County for MSM Programming | |
| By DEC of 2021 | Service Providers in Chittenden County | Deliver intensified VDH-endorsed evidence-based prevention interventions (eg. TLR PrEP, Mpowerment) in communities with heaviest concentration of HIV infection | MSM | Grant Reporting, e.g. Appropriate EB intervention implementation # MSM reached # MSM tested | |

STRATEGY 2. Allocate to grantees according to the latest epidemiological data so that funds reach areas with the highest burden of disease.

| TIME | RESPONSIBLE PARTIES | ACTIVITY | TARGET POPULATION | DATA INDICATORS |
|-------------------|---------------------|---|--------------------------------------|-------------------------------|
| By JUL of 2016 | VDH | Establish priority target populations/geographic areas in state Request for Applications for funding | MSM PLWHA | VT Epidemiological Profile |
| By DEC of 2016 | VDH | Pursuant to state applications from Service Providers, ensure financial allocation of federal funding matches distribution of disease in Vermont in both geographic and population measures | MSM; PLWHA; Heterosexuals; IDU | VT Epidemiological Profile |
| By DEC of 2016 | VDH | Allocate to grantees based on intent and ability to deliver evidence based targeted programming including Prevention with Positives, MSM Services, Targeted Testing, and Syringe Services | MSM; PLWHA; Heterosexuals; IDU | VT Epidemiological Profile |

STRATEGY 3. Focus on high-risk populations: Intensify HIV prevention efforts in communities where HIV is most heavily concentrated

| TIME | RESPONSIBLE PARTIES | ACTIVITY | TARGET POPULATION | DATA INDICATORS |
|-------------------|----------------------|---|--|--|
| By JUL of 2016 | VDH | Establish priority target populations matched to geographic areas in Request for Applications for state funding | MSM: Chittenden County; PLWHA & IDU: Statewide | VT Epidemiologic Profile |
| By DEC of 2016 | VDH | Prioritize funding/programming for MSM in Chittenden County, thereby matching: 1. Geographic region with highest rate of HIV 2. Population with highest concentration of transmission risk 3. Geographic region with highest concentration of risk population1 | MSM in Chittenden County | VT Epidemiologic Profile |
| By JAN of 2017 | VDH | Deliver funding to organizations with approved evidence based programs focused on high-risk populations | MSM; PLWHA; Heterosexual; IDU | Funding Allocations |
| By DEC of 2021 | Service Providers | Utilize awarded funding based on epidemiologic patterns in respective geographic areas | MSM; PLWHA; Heterosexual; IDU | VT Epidemiologic Profile |
| By DEC of 2021 | Service Providers | Target human resources to programming for priority populations | MSM; PLWHA; Heterosexual; IDU | Quarterly Reporting |
| By DEC of 2021 | Service Providers | Deliver focused services/evidence based interventions that reach designated highrisk populations, including: TLR, TLR PrEP, Mpowerment, Prevention with Positives interventions, CLEAR | MSM; PLWHA; Heterosexual; IDU | Grant Reporting on funded programs, e.g. • # MSM tested • # PLWH in CLEAR |

<u>GOAL #1 SMART Objective #2</u>: By 2021, <u>reduce new HIV infections</u> by increasing the percentage of HIV tests conducted with MSM from 22% of all tests to at least 60%, in order to – find potential positives early, link positives and high risk negatives to effective biomedical prevention methods, and thereby prevent transmission.

- Strategy 1: Support and implement targeted testing efforts with MSM through state-structured testing programming [HIV Testing, Referral & Linkage (TRL, TRL+, TRL ASO)]. Testing, Referral & Linkage in non-clinical settings (formerly HIV Counseling, Testing, Referral).
 - o ASO organizations to deliver targeted HIV testing services to populations greatest represented in Vermont's latest HIV annual report
 - o Community based provider to deliver targeted HIV testing, linkage, & referral for Gay identified or Men Who have Sex with Men with embedded PrEP counseling component
 - Based upon Vermont's approved Determination of Need by the CDC fiscal support to operating comprehensive Syringe Service Programs
- <u>Strategy 2</u>: Standardize, support and implement the integration of referral and linkage to increased access to effective biomedical HIV prevention services, including PrEP and nPEP, through HIV testing services.
- **Strategy 3:** Standardize, support and continue ongoing effective implementation linking clients testing positive to medical care within 14 days of delivery of positive result from test provider, facilitating increased access to biomedical HIV prevention services including HAART, and PrEP for negative partners.

STRATEGY 1. Support and implement targeted testing efforts with MSM through state-structured testing programming. [HIV Testing, Referral, & Linkage (TRL, TRL+, TRL ASO)]. Testing, Referral & Linkage in non-clinical settings (formerly known as HIV CTR - HIV Counseling, Testing, Referral)]

| TIME | RESPONSIBLE PARTIES | ACTIVITY | TARGET POPULATION | DATA INDICATORS |
|---------|---------------------|--|-------------------|-------------------------|
| By DEC | VDH | Support grantees in implementation of targeted testing programming, prioritizing | Higher Risk | Grantee Quarterly |
| of 2021 | VUH | geographic area of highest disease burden and higher risk population | Populations | Reporting |
| By DEC | VDH | Monitor testing data through Evaluation Web. | Higher Risk | EvalWeb Testing data |
| of 2021 | VDII | Monitor testing data through Evaluation web. | Populations | Evalved resting data |
| By DEC | VDH | Offer and provide technical assistance for retraining staff in TRL and support for | MSM | # MSM tested |
| of 2017 | VDII | (1) targeting of MSM testing and (2) attempts to reach 1% positivity | IVISIVI | Testing positivity rate |
| By JAN | VDH | Provide test reimbursement model that prioritizes MSM testing, and matches | MSM, Higher | # MSM tested |
| of 2017 | VDII | overall the epidemiology of HIV in Vermont | Risk Pops. | # IVISIVI testeu |
| By JAN | Service | Realign testing efforts to TRL, TRL+, TRL ASO through compliance with state | MSM, Higher | # MSM tested |
| of 2017 | Providers | retraining of testing staff | Risk Pops. | # IDU tested |
| By DEC | Service | Implement highly targeted testing to ensure prioritized outreach to and testing of | MSM | # MSM tested |
| of 2021 | Providers | MSM | INICINI | # MSM reached |
| By DEC | Service | Enter all testing data in a timely manner into Evaluation Wah | Higher Risk | EvalWeb Data |
| of 2021 | Providers | Enter all testing data in a timely manner into Evaluation Web. | Populations | Evalvven Data |
| By DEC | Service | Monitor testing results in comparison to MSM goals and realign efforts | NACNA | FuelWeb Data |
| of 2021 | Providers | appropriately | MSM | EvalWeb Data |
| By DEC | Service | Chittenden County – Implement TRL +, engaging in linkage to biomedical | NACNA | # MSM tested |
| of 2021 | Providers | prevention for MSM through embedding in Mpowerment intervention | MSM | # Referrals |

STRATEGY 2. Standardize, support and implement the integration of referral and linkage to increased access to effective biomedical HIV prevention services, including PrEP, nPEP, and HAART (TasP) through HIV testing services.

| TIME | RESPONSIBLE PARTIES | ACTIVITY | TARGET POPULATION | DATA INDICATORS |
|-------------------|--|---|-------------------------------------|--|
| By DEC of 2021 | VDH | Support integration of referral and linkage to effective biomedical HIV prevention services in all testing efforts (TRL, TRL+, TRL ASO) | MSM, IDU, Heterosexual, PLWHA | Quarterly Reporting from Grantees # tested # referred # confirmed linkages |
| By DEC of 2021 | VDH | Prioritize and support TRL+, embedded in MPowerment intervention, in Chittenden County | MSM | # MSM tested # MSM referred # MSM with confirmed linkage |
| By DEC of 2021 | Service Providers – Chittenden County | Embed TRL+ into Mpowerment intervention | MSM | Quarterly Reporting # MSM tested # MSM referred # MSM reached by Mpowerment |
| By DEC of 2021 | Service Providers | Promote knowledge and understanding of PrEP, nPEP and HAART (TasP) among high risk populations | MSM, IDU, Heterosexual, PLWHA | # reporting high knowledge in Needs Assessment |
| By DEC of 2021 | Service Providers | Discuss PrEP and nPEP with high risk populations in testing sessions | MSM, IDU, Heterosexual, PLWHA | # testing sessions w/high risk individuals # documented discussions # referrals |
| By DEC of 2021 | Service Providers | Link appropriate testing clients with biomedical referrals | MSM, IDU, Heterosexual, PLWHA | # referrals |
| By DEC of 2021 | Service Providers | Track referrals to biomedical interventions | MSM, IDU, Heterosexual, PLWHA | # confirmed linkages |

STRATEGY 3. Standardize, support and continue ongoing effective implementation linking clients testing positive to medical care within 14 days of delivery of positive result from test provider, facilitating increased access to biomedical HIV prevention services including HAART, and PrEP for negative partners.

| TIME | RESPONSIBLE PARTIES | ACTIVITY | TARGET POPULATION | DATA INDICATORS |
|-------------------|----------------------|---|--|--|
| By DEC of 2021 | VDH | Ensure and support integrated network of Care and Prevention Providers to facilitate ongoing high success in linking clients testing positive with care within 14 days of receiving their positive result | Newly Diagnosed; Partners of Newly Diagnosed | # Positive tests # PLWHA in care # Days between diagnosis and care linkage # Partners referred for biomedical prevention # Confirmed partner linkage |
| By DEC of 2021 | Service Providers | Continue to engage in and support integrated network of Care and Prevention Providers to facilitate the linkage of clients testing positive within 14 days of receiving their positive result | Newly Diagnosed; Partners of Newly Diagnosed | # Positive tests # PLWHA in care # Days between diagnosis and care linkage # Partners referred for biomedical prevention # Confirmed partner linkage |

<u>GOAL #1 SMART Objective #3</u>: By 2021 <u>reduce new HIV infections</u> in Vermont by increasing by 10% the number of unique individuals living with HIV, that are at high risk for transmission of HIV, becoming engaged in evidence-based interventions offered by the Vermont Department of Health's 2016 RFA.

- > Strategy 1: Implement expanded prevention efforts with PLWHA, such as CLEAR programming throughout service area (eg. statewide).
- > Strategy 2: Implement the CLEAR intervention in the IDU community through embedding in Syringe Service Programs.
- > Strategy 3: Implement supports [peer support/access to mental health] to combat isolation, stigma, poor mental health among PLWHA.

| STRATEGY 1 | Provide expanded | prevention efforts with PLWHA | such as CLEAR nr | ogramming thro | uighout sarvice area | (abiwateta na) |
|-------------|------------------|-------------------------------|--------------------|----------------|-----------------------|--------------------|
| JINAIEGI I. | rioviue expanded | prevention enorts with FLWIA | , Such as CLEAN PI | ogranning uno | jugilout selvice alea | i (eg. statewide). |

| TIME | RESPONSIBLE PARTIES | ACTIVITY | TARGET POPULATION | DATA INDICATORS |
|-------------------|---------------------|--|-------------------|--|
| By DEC | VDH | Allocate funding to statewide CLEAR provider to ensure full-state coverage | PLWHA | # enrolled in CLEAR |
| of 2016 | VUH | and increase number of unique individuals reached. | IDU | # CLEAR sessions completed |
| By DEC of 2021 | VDH | Monitor continued high success rate of CLEAR completion by PLWHA. | PLWHA | Grantee Quarterly Reporting # PLWHA enrolled in CLEAR # CLEAR sessions completed |
| By DEC of 2021 | VDH | Monitor continued high success rate of PLWHA satisfaction with CLEAR services. | PLWHA | # PLWHA enrolled in CLEAR # PLWHA expressing satisfaction in Needs Assessment |
| By JAN of 2017 | Service Provider | Ensure access to full state population of PLWHA through strong networking among state community and medical service providers. | PLWHA | # outreach contacts made around state # PLWHA enrolled in CLEAR |
| By DEC | Service | Prioritize locating and serving first-time CLEAR participants. | PLWHA | # first-time participants enrolled |
| of 2021 | Provider | Frioritize locating and serving mist-time CLEAR participants. | IDU | in CLEAR |
| By JAN of 2017 | Service Provider | Report in a timely manner all CLEAR participation results. | PLWHA IDU | Quarterly Reporting |

STRATEGY 2. Provide the CLEAR intervention in the IDU community through embedding in Syringe Service Programs.

| TIME | RESPONSIBLE PARTIES | ACTIVITY | TARGET POPULATION | DATA INDICATORS |
|-------------------|--------------------------|--|-------------------|---|
| By JAN of 2017 | VDH | Pursuant to CDC decision on Determination of Need regarding Syringe Services, allocate sufficient funding to support provision of CLEAR services embedded in Syringe Services statewide. | IDU | # Syringe Services # Regions of State Covered # Clients Established # Syringes Collected # Syringes Exchanged |
| By DEC of 2021 | VDH/Service Providers | Expand Syringe Service programming statewide. | | # Syringe Services # Regions of State Covered # Clients Established # Syringes Collected # Syringes Exchanged |
| By DEC of 2021 | Service Providers | Expand recruitment of CLEAR participants through Syringe Services. | | # CLEAR Participants # Recruited through Syringe Services |
| By DEC of 2021 | Service Provider | Prioritize locating and serving first-time CLEAR participants. | | # First-time CLEAR Participants |
| By DEC of 2021 | Service Provider | Report in a timely manner all CLEAR participation results. | | # CLEAR Participants # CLEAR Sessions Completed |

| TIME | RESPONSIBLE PARTIES | ACTIVITY | TARGET POPULATION | DATA INDICATORS |
|-------------------|----------------------|---|-------------------------------|--|
| By DEC of 2016 | VDH | Ensure allocation of funding to organizations fulfilling provision of peer support through various means as designated through Needs Assessment with PLWHA, including organizations providing: Medical Case Management Non-medical Case Management Prevention Services CLEAR Support Groups PWA Education and Networking Events | PLWHA Partners of PLWHA | Final Funding Allocations Range of Services Provided by Funded Grantees |
| By DEC of 2021 | Service Providers | Provide services as designated through Needs Assessment, through programming best suited to provision. [e.g. Case Management linkage and transportation support; Prevention Services support programming; support for CLEAR participation] | PLWHA Partners of PLWHA | Dependent on Grantee Programming/Capacity, data as related to program implemented, e.g.: # PLWHA in Case Management # PLWHA referred for mental health support # Confirmed linkages to mental health support # Support groups held # Support services provided (e.g. transportation) |
| By DEC of 2021 | Service Providers | Utilize evidence-based social marketing tools and leverage digital tools and new technologies to reach target populations [e.g. Mpowerment providers = MSM] | PLWHA | # / Type social marketing tools # Reached through tools |
| By DEC of 2021 | Service Providers | Expand public outreach and prevention via networking and educating throughout related and intersecting services such as IPV, poverty services, etc. | PLWHA | # Service Organizations reached |

(A2) TARGETED NHAS GOAL: INCREASING ACCESS TO CARE AND IMPROVING HEALTH OUTCOMES FOR PLWHA

<u>GOAL #2 SMART Objective #1</u>: by 2021 <u>increase access to care and improve health outcomes</u> for PLWHA by increasing both care retention and viral suppression of PLWHA in care in Vermont by at least 14% of PLWHA retained in care (76% to 90%) and at least 32% of PLWHA experiencing viral suppression (58% to 90%).

- > Strategy 1: To get persons identified as HIV+ into medical care as early in the disease process as possible and facilitate entry into care.
- **Strategy 2:** Ensure continuity of high-quality comprehensive health care coverage to support access to HIV care.
- **Strategy 3**: To provide necessary core medical and support services to keep clients in medical care.
- **Strategy 4:** To track clients within and across medical care services, identify clients who have dropped out of care, find those clients, and work with them to get them back into care.

STRATEGY 1. Link persons identified as HIV positive to medical care as early in the disease process as possible to facilitate entry into care.

| TIME | RESPONSIBLE PARTIES | ACTIVITY | TARGET POPULATION | DATA INDICATORS |
|-------------------|----------------------|--|--------------------------|--|
| By DEC of 2016 | VDH | Allocate funding to support: Ongoing high quality medical case management that facilitates those testing with CCCs to enter care directly Navigation Services through community based testing to assist in linking those receiving positive results to care Testing services that embed linkage to effective biomedical interventions (PrEP, nPEP, HAART) | Newly Diagnosed PLWHA | Final Funding Allocations |
| By DEC of 2021 | VDH | Monitor and report through HIV Surveillance Systems on linkage to care | Newly Diagnosed | # Linked to Care |
| By DEC of 2021 | Service Providers | Continue to provide ongoing high quality medical case management and range of services that encourage newly diagnosed to participate in care | Newly Diagnosed PLWHA | # Linked to Care # Retained in Care |
| By DEC of 2021 | Service Providers | Provide navigation services to newly diagnosed to ensure linkage to care | Newly Diagnosed | # Linked to Care |

| TIME | RESPONSIBLE PARTIES | ACTIVITY | TARGET POPULATION | DATA INDICATORS |
|-------------------|----------------------|--|--------------------------|--|
| By DEC of 2021 | VDH | Continue ongoing assistance to Vermont PLWHA to ensure all PLWHA known to the state remain covered by health insurance | Newly Diagnosed PLWHA | # PLWHA in VT # PLWHA covered by Health Insurance |
| By DEC of 2021 | VDH | Maintain and enhance ongoing relationship with Department of Vermont Health Access and Vermont Health Connect to ensure knowledge of potential changes and impacts on PLWHA. | Newly Diagnosed PLWHA | Successful Communication of Changes, if applicable |
| By DEC of 2021 | Service Providers | Maintain current knowledge and skills to provide Navigation Services to PLWHA to access state health insurance if needed | Newly Diagnosed PLWHA | # PLWHA, in need of Navigation Services, reached w/Services # PLWHA covered by Health Insurance |
| By DEC of 2021 | Service Providers | Provide Navigation Services to individuals accessing community based HIV testing to ensure newly diagnosed have access to insurance for needed health care | Newly Diagnosed MSM | # Newly Diagnosed, in need of Navigation Services, reached w/Services # PLWHA covered by Health Insurance |

| STRATEG | STRATEGY 3. To provide necessary core medical and support services to keep clients in medical care. | | | | |
|-------------------|---|--|-------------------|---|--|
| TIME | RESPONSIBLE PARTIES | ACTIVITY | TARGET POPULATION | DATA INDICATORS | |
| By DEC of 2016 | VDH | Continue allocation of funding and support to the network of Vermont providers of core medical and support services | PLWHA | Final Funding Allocations | |
| By DEC of 2021 | Service Providers | Continue to provide high quality core medical services, medical case management and support services as needed to retain clients in care | | % of PLWHA completing one medical appointment and one blood draw/lab work each year % of PLWHA served with confirmed undetectable viral load | |

STRATEGY 4. To track clients within and across medical care services, identify clients who have dropped out of care, find those clients, and work with them to get them back into care.

| TIME | RESPONSIBLE PARTIES | ACTIVITY | TARGET POPULATION | DATA INDICATORS |
|-------------------|--------------------------|--|-------------------|---|
| By DEC of 2021 | VDH | Monitor eHARS to ensure that all consumers complete HIV viral loads tests at least once every six months | PLWHA | # PLWHA in care # PLWHA completing viral load tests/six monthly |
| By DEC of 2021 | VDH/Service Providers | Develop ongoing tracking systems for identifying patients leaving care, including monitoring VMAP for prescription refills | PLWHA | Departure from Care Tracking System development # PLWHA ending Care # PLWHA ending Care identified # VMAP missed refills # VMAP missed refills tracked and resolved |
| By DEC of 2021 | VDH/Service Providers | Develop ongoing system for contacting patients to determine barriers to care retention | PLWHA | Departure from Care Contact System development # PLWHA ending Care contacted Reporting of identified Care Barriers |
| By DEC of 2021 | VDH/Service Providers | Connect patients with services that will support care retention | PLWHA | # PLWHA in Care supported in retention # PLWHA ending Care # PLWHA reconnected to Care |
| By DEC of 2021 | Service Providers | Collecting, reporting and tracking CD4 and Viral Load tests to monitor client health outcomes | PLWHA | # PLWHA in Care # PLWHA successfully monitored for health status |

GOAL #2 SMART Objective #2: Increase access to care and improve health outcomes for PLWHA by 2021 by decreasing by at least 10% the number of PLWHA identifying that they have a hard time getting services for basic needs, and increasing by at least 10% the number of PLWHA identifying that they are getting all services needed.

Decrease:

Health Care Need: from 10% to 0%
Housing Need: from 31% to 20%
Transportation Need: from 24% to 14%
Mental Health Need: from 20% to 10%

• Food Need: from 25% to 15%

Increase:

All Needed Services Achieved: from 52% to 62%

- > **Strategy 1:** Support comprehensive, coordinated patient-centered care for people living with HIV, including addressing HIV-related cooccurring conditions and challenges meeting basic needs, such as housing.
- > Strategy 2: Strengthen the current provider workforce to ensure access to and quality of care.
- > Strategy 3: Address policies to promote access to housing and other basic needs and supportive services for people living with HIV.
- > Strategy 4: Support screening for and referral to substance use and mental health services for people living with HIV.

STRATEGY 1. Support comprehensive, coordinated patient-centered care for people living with HIV, including addressing HIV-related cooccurring conditions and challenges meeting basic needs, such as housing.

| TIME | RESPONSIBLE PARTIES | ACTIVITY | TARGET POPULATION | DATA INDICATORS |
|-------------------|----------------------|---|-------------------|--|
| By DEC of 2021 | VDH | Through RFA, prioritize allocation of funding to organizations applying for Medical Case Management that are able to provide medical transportation services, when not available by other entities, and that are eligible to apply for HOPWA funding. | PLWHA | Final Funding Allocation |
| By DEC of 2021 | VDH | Encourage and promote the continuation of patient-centered services by providers in Vermont that address basic needs as prioritized by HIV CAG. | PLWHA | Reporting from Providers Reporting from PLWHA through Needs Assessment |
| By DEC of 2021 | VDH | Support and encourage existing network of high quality community and medical providers working as teams to address multiple needs. | PLWHA | Reporting from Providers Reporting from PLWHA through Needs Assessment |
| By DEC of 2021 | Service Providers | Allocate human resources and adjust job duties as required to assist in addressing basic needs such as transportation. | PLWHA | Reporting from Providers Reporting from PLWHA through Needs Assessment |

STRATEGY 2. Strengthen the current provider workforce to ensure access to and quality of care.

| TIME | RESPONSIBLE PARTIES | ACTIVITY | TARGET POPULATION | DATA INDICATORS | |
|---------|---------------------|--|-------------------|------------------------------|--|
| By DEC | VDH/Service | Assess staffing abilities to assist with basic needs in culturally competent | PLWHA | Quarterly Reporting | |
| of 2021 | Providers | manner (racial, gender, sexual orientation, socioeconomic, disabilities) | | Quarterly reperting | |
| By DEC | VDH/Service | Provide technical assistance/professional development opportunities as | PLWHA | # Professional Development | |
| of 2021 | Providers | needed to address cultural competency deficiencies | FLVVIIA | Opportunities provided | |
| By DEC | Service | Ensure all staff maintain currency in all related services for referrals and | PLWHA | Quarterly Reporting | |
| of 2021 | Providers | supports | FLVVIIA | Quarterly Reporting | |
| By DEC | VDH/Service | Coordinate statewide Case Manager training/workshops to routinize and | PLWHA | # Offerings to Case Managers | |
| of 2021 | Providers | standardize all offerings of referrals and assistance by all ASOs to all clients | FLVVIIA | # Case Managers attending | |

STRATEGY 3. Address policies to promote access to housing and other basic needs and other supportive services for people living with HIV.

| TIME | RESPONSIBLE PARTIES | ACTIVITY | TARGET POPULATION | DATA INDICATORS |
|-------------------|---------------------|--|-------------------|-------------------------------|
| By DEC of 2021 | VDH | Continue ongoing efforts to coordinate with Vermont State Housing Authority and the Burlington House Authority on meeting high demand for housing vouchers | PLWHA | # of PLWHA in need of housing |

| STRATEGY 4. Support screening for and referral to substance use and mental health services for people living with HIV. |
|---|
|---|

| TIME | RESPONSIBLE PARTIES | ACTIVITY | TARGET POPULATION | DATA INDICATORS |
|-------------------|--------------------------|--|-------------------|---|
| By DEC of 2021 | VDH/Service Providers | Promote and continue to implement screening of PLWHA clients/patients for substance use/abuse and mental health needs | PLWHA | # Screenings conducted # PLWHA identified for substance abuse treatment and/or mental health referral |
| By DEC of 2021 | VDH/Service Providers | Work in partnership with other state agencies and providers to express pressing need for: Additional substance abuse treatment services Additional state mental health treatment services Bridging of the gaps in the existing state networks | PLWHA | # Community Partnerships Efforts conducted |
| By DEC of 2021 | Service Providers | Work in partnership with community organizations addressing stigma of mental illness and mental health treatment | PLWHA | # Community Partnerships Efforts Conducted |

(A3) TARGETED NHAS GOAL: REDUCE HIV-RELATED HEALTH DISPARITIES AND HEALTH INEQUITIES

GOAL #3 SMART Objective #1: Reduce HIV-related health disparities by increasing the number of Syringe Services Program in Vermont from 3 to 5, thereby adopting a successful structural approach to reduce HIV infections and improve health outcomes in high-risk communities statewide.

- > Strategy 1. Target geographic areas of Windham County, Springfield, and Richmond for adoption of Syringe Service Programs modeled on programming in central and northern Vermont a successful structural approach to reduce infections and improve health outcomes.
- > Strategy 2. As part of the Syringe Service Program, provide HIV and Hepatitis C testing, and the CLEAR intervention to clients.
- > Strategy 3. Support engagement in care for groups with low levels of viral suppression, including persons who inject drugs.

STRATEGY 1. Target high-risk geographic area of Windham County for adoption of Syringe Service structural approach, modeled on successful programming in central and northern Vermont.

| TIME | RESPONSIBLE PARTIES | ACTIVITY | TARGET POPULATION | DATA INDICATORS |
|-------------------------|----------------------|---|-------------------|---|
| By end of 2021 | VDH | Pursuant to Determination of Need from CDC, allocate funding to Syringe Service Programming as aligns with burden of disease and target population, ensuring statewide coverage | IDU | # Syringe Service locations |
| Current & Ongoing | Service Providers | Organize statewide Syringe Services Working Group to plan for and facilitate statewide coverage | IDU | Working Group Meetings |
| By end of 2017 | Service Providers | Conduct training for new programs two new programs (Richmond, and Brattleboro in Windham County) | IDU | Quarterly Reporting Training Conducted |
| By end of 2021 | Service Providers | Deliver Syringe Services Programming including culturally competent services to collect used syringes, dispense Naloxone kits for overdose prevention, and provide navigation services to clients as needed for additional services | IDU | # Unique participants served # Syringes collected # Syringes dispensed # Naloxone kits dispensed # Referrals made |

| TIME | RESPONSIBLE PARTIES | ACTIVITY | TARGET POPULATION | DATA INDICATORS |
|-------------------|----------------------|--|---------------------------|---|
| By DEC of 2016 | VDH | Align funding allocation of HIV testing with geographic coverage of Syringe Service Programs | IDU | # of Syringe Service Programs |
| By DEC of 2021 | Service Providers | Provide culturally competent HIV testing services | IDU/High Risk Negative | Quarterly Reporting # IDU tested |
| By DEC of 2021 | Service Providers | Provide referrals to CLEAR programming | IDU/High Risk Negative | # IDU referred to CLEAR # IDU enrolling in CLEAR # CLEAR sessions completed |
| By DEC of 2021 | Service Providers | Provide referrals for additional services as appropriate to clients including substance abuse treatment, STI testing, IPV, mental health, and other services | IDU/High Risk Negative | # referrals made # confirmed linkages |
| By DEC of 2021 | Service Providers | Maintain current knowledge of and networking with service referral network | IDU/High Risk Negative | # Community Partners # referrals made |
| By DEC of 2021 | Service Providers | Track and maintain all record keeping and reporting in an accurate and timely manner | IDU/High Risk Negative | Quarterly Reporting |
| By DEC of 2021 | VDH | Monitor reporting on a regular basis and offer technical assistance as needed | IDU/High Risk Negative | Quarterly Reporting |

| STRATEG | TRATEGY 3. Support engagement in care for groups with low levels of viral suppression, including persons who inject drugs. | | | | | |
|-------------------|--|---|---------------------------------|---|--|--|
| TIME | RESPONSIBLE PARTIES | ACTIVITY | TARGET POPULATION | DATA INDICATORS | | |
| By DEC of 2016 | VDH | Allocate funding for TRL and Navigation services aligned with geographic distribution of Syringe Services | IDU | | | |
| By DEC of 2021 | VDH | Ensure statewide CLEAR Provider grantee offers access to CLEAR services to clients who inject drugs | IDU | Quarterly Reporting # IDU enrolling in CLEAR | | |
| By DEC of 2021 | Service Providers | Provide CLEAR to clients who inject drugs and offer Navigation services to clients to engage in HIV Care | IDU Newly Diagnosed PLWHA | # IDU enrolling in CLEAR # CLEAR sessions completed # PLWHA, in need, receiving Navigation Services | | |

<u>GOAL #3 SMART Objective #2</u>: By 2021, <u>reduce HIV-related health disparities and inequities</u> by reducing the percent of PLWHA reporting significant experiences with HIV stigma when accessing services from 27% in the 2015 Needs Assessment to less 20% in the 2020 Needs Assessment.

- > Strategy 1. Promote evidence-based public health approaches to HIV prevention and care.
- > Strategy 2. Mobilize communities to reduce HIV-related stigma.
- > Strategy 3. Promote public leadership of people living with HIV.

| | | evidence-based public health approaches to HIV prevention and care. | | |
|-------------------|--|--|--------------------------------------|--|
| TIME | RESPONSIBLE PARTIES | ACTIVITY | TARGET POPULATION | DATA INDICATORS |
| By DEC of 2016 | VDH | Through state RFA, require utilization of evidence-based public health approaches of all grantees, including those that address stigma in various ways. | PLWHA MSM Heterosexuals IDU | Final Funding Allocations |
| By DEC of 2021 | Service Providers | Provide high quality services delivering evidence-based public health approaches, with a strong awareness of stigma and the need for cultural competency. | PLWHA MSM Heterosexuals IDU | #/Name EBIs Quarterly Reporting |
| By DEC of 2021 | Service Providers – Chittenden County | Deliver Mpowerment programming: reduce stigma against HIV positive men, to promote evidence-based approaches such as PrEP, and to reduce stigma against PrEP and those who use it. | MSM | # MSM reached through MPowerment #/Type Stigma-reduction activities |
| By DEC of 2021 | Service Providers – Chittenden County | Deliver TRL +, Testing Linkage and Referral with PrEP navigation, embedded in Mpowerment intervention | MSM | # MSM tested # MSM referred # confirmed linkages |
| By DEC of 2021 | Service Providers | Deliver CLEAR | PLWHA IDU | # CLEAR participants # CLEAR completions # CLEAR sessions completed |

| TIME | RESPONSIBLE PARTIES | ACTIVITY | TARGET POPULATION | DATA INDICATORS |
|-------------------|--------------------------|--|--------------------|---|
| By DEC of 2021 | VDH | Continue to promote and encourage service provider involvement in national promotion days such as National HIV Testing Day | Community- wide | Quarterly Reporting #/Type national promotion days w/provider participant |
| By DEC of 2021 | Service Providers | Continue to promote ongoing community activities in geographic region of service | Community- wide | #/Type activities |
| By DEC of 2021 | VDH/Service Providers | Consider education campaign in specific geographic areas highlighted in Needs Assessment as experiencing high levels of stigma | Community- wide | Education Campaign Designed Education Campaign Conducted Lower levels of stigma reported by PLWHA in Needs Assessment |

| TIME | RESPONSIBLE PARTIES | ACTIVITY | TARGET POPULATION | DATA INDICATORS |
|-------------------|--------------------------|--|-------------------|---|
| By DEC of 2021 | VDH | Promote, recruit for, and assist HIV positive individuals in participation on the Community Advisory Group | PLWHA | # PLWHA active on CAG # recruitment efforts [e.g. PWA Retreat] |
| By DEC of 2021 | Service Providers | Promote, recruit for, and assist HIV positive individuals in participation on the Community Advisory Group | PLWHA | # PLWHA active on CAG #/Type supports offered to clients for participation |
| By DEC of 2021 | VDH/Service Providers | Continue to empower CAG's role in coordinating and participating in the statewide Needs Assessments | PLWHA | # CAG Members directly involved with Needs Assessment Process Type of CAG participation in Needs Assessment |

B. COLLABORATIONS, PARTNERSHIPS and STAKEHOLDER INVOLVEMENT

a. Describe the specific contributions of stakeholders and key partners to the development of the plan

This integrated plan was developed from the foregoing data and analysis, and the wealth of stakeholder information available through the Needs Assessment – care consumers, both community and medical service providers, and prevention consumers.

The Community Advisory Group, with representatives from a wide array of stakeholders and partners, participated in, and contributed to the recruitment of participants for, the Needs Assessment process from start to finish, and their involvement has ensured a high quality representation of the needs present in Vermont.

The CAG also reviews the integrated plan and advises its development.

b. Describe stakeholders and partners not involved in the planning process, but who are needed to more effectively improve outcomes along the HIV Care Continuum

The primary stakeholders who were less involved in the planning process than desired were PLWHA not currently in care and/or connected to services. The Needs Assessment process had great difficulty accessing a population of PLWHA not in care, and therefore the assessment of barriers to care have been gleaned from those experienced and theorized by PLWHA currently in care. A greater representation of direct voices of individuals not in care would have informed the planning process a great deal.

A second gap identified is the lack of full representation of participation in the Needs Assessment from all Vermont counties of consumers of care and prevention services. Service providers were accessed from all over the state, but certain counties had very low participation – voices which could have assisted planning around numerous issues that have appeared more pressing in smaller, rural towns/counties.

c. Provide a letter of concurrence to the goals and objectives of the Integrated HIV Prevention and Care Plan from the co-chairs of the planning body and the health department representatives (*Appendix B*)

Letter of Concurrence attached.

C. PLWH and COMMUNITY ENGAGEMENT

a. Describe how the people involved in developing the Integrated Plan are <u>reflective of the epidemic</u> in the jurisdiction.

The Vermont Community Advisory Group has solid representation of consumers of HIV care, from a variety of communities. As the primary group assisting in the planning process, this group has a membership that is reflective of Vermont's epidemic.

The Needs Assessment on which much of the planning process is based brought in a wide range of participants, with the result that the Vermont epidemic was well-represented. The demographics of age and race participation in the care arm of the process were excellent, with a slight gender imbalance (women were slightly overrepresented, men slightly underrepresented). The largest variation in representation of the Vermont epidemic was in geography, with Bennington County overrepresented and Chittenden County underrepresented.

In the prevention arm, participants originated from all over the state, and the two prime high risk groups represented in Vermont's epidemic – MSM and heterosexual females – were the audiences widely reached. The third high-risk group in Vermont's demographics, IDU, were well-represented in the assessment, with individuals participating from separate syringe exchanges around the state.

b. Describe how the inclusion of PLWH contributed to the plan development.

The inclusion of PLWHA in the Needs Assessment contributed a great deal to the solid base of data from which this planning document is drawn. The Needs Assessment reached a statistically significant number of PLWHA in Vermont (20%) and a statistically significant percentage of PLWHA in care in Vermont (24%).

The PLWHA participating were exceedingly generous in sharing their experiences and their lives in the assessment process. The 44 interviews conducted with PLWHA formed a basis of deeper detail and background information for the overall findings based on 132 total care participants. Trends and patterns of need were clearer and more easily analyzed due to the depth and richness of the information shared.

The strong voice of PLWHA in the Needs Assessment provides a broad, solid foundation for true representation of need in the development process for the Integrated Plan, and lends a great integrity to the conclusions reached.

Beyond the Needs Assessment, the PLWHA on the CAG review and advise on the actual plan document, and are therefore able to correct and clarify issues during the plan development process.

c. Describe the <u>methods used to engage communities</u>, people living with HIV, those at substantial risk of acquiring HIV infection and other impacted population groups to ensure that HIV prevention and care activities are responsive to their needs in the service area.

As the Needs Assessment represents a large portion of the community engagement in the plan process, the following is a description of how participation was sought through a number of avenues, across different population segments.

1. Direct CAG Recruitment

• The researcher worked closely with the Community Advisory Group for participation themselves, and referral of others, with strong results in reaching diverse populations. AIDS Service Organizations, Community Based Organizations and Medical providers all assisted in garnering wide participation through numerous arms of outreach.

2. Incentives

• Incentives of \$25 gift cards were offered to participants in interviews and focus groups. Incentive of a \$100 gift card drawing was offered for filling out a survey, with two separate drawings for the two surveys – Care and Prevention.

3. Large events

 Tabling was conducted at large events and direct outreach was conducted at gatherings of PLWHA.

4. Advertising

- Online advertising was conducted via paid and unpaid promotion. Business card ads were
 distributed, articles in newsletters were written and distributed, and word of mouth
 advertising was of great assistance.
- d. Describe <u>how impacted communities are engaged</u> in the planning process to provide critical insight into developing solutions to health problems to assure the availability of necessary resources.

As noted above, the Vermont Community Advisory Group has solid representation of impacted communities and the Needs Assessment had excellent representation of impacted communities. The engagement of these communities is sought regularly for CAG participation, always with intent to involve impacted community representatives in analyzing and providing feedback on Vermont efforts, and providing insight on solutions.

SECTION III. Monitoring and Improvement

a. Describe the process for regularly updating planning bodies and stakeholders on the progress of plan implementation, soliciting feedback, and using the feedback from stakeholders for plan improvements.

The Vermont CAG meets seven times each year, for a full day meeting, with numerous updates from the state and from service providers as to progress on implementation of all prevention and care efforts. Feedback is sought at these meetings, and it is stressed at the meetings that feedback is also welcome between meetings. The Vermont Department of Health is accessible and responsive to the community and is always striving for quality assurance and service improvement.

The VDH HASH issues periodic informational memos, letters, and resources to all CAG members that update stakeholders on items that may influence plan implementation, including such items as state and federal announcements, webinars and training opportunities, reports from national conferences and professional organizations such as NASTAD and NCSD.

Once the Integrated Plan is completed, submitted, and response is received, it is revisited at CAG meetings to assess implementation process. The state's Care Continuum and progress on meeting goals is a topic at each meeting.

b. Describe the plan to monitor and evaluate implementation of the goals and SMART objectives from Section II: Integrated HIV Prevention and Care Plan.

VDH has in place numerous methods for monitoring and evaluating implementation of the Integrated Plan, including provider reporting, surveillance systems, and data systems.

VDH monitors and evaluates all activities for Part B and Prevention funded programs. VDH has instituted various monitoring and evaluation programs and methods, based on HRSA guidance, which provides a comprehensive view of service utilization, expenditures, and barriers to care.

CAREWare is implemented at VDH and the four ASO agencies that receive Ryan White Part B funds along with the Comprehensive Care Clinics (Part C clinics) in order to collect program input and output data that enables the Department to measure the impact of its Part B programs.

Outcomes evaluation looks at impacts, benefits and changes to clients/patients during and after their participation in funded programs, in the short, intermediate and long-term. The impact on clients may vary depending on the type of service, program goal, and acuity and functioning of the client/patient, and in order to evaluate the efficacy of program work activities, the VDH has designed and conducts evaluation activities which:

- Track changes in utilization patterns of medical care and support services within each of the Part B funded service categories
- Document changes related to medical practices among primary care providers
- Examine, through client satisfaction surveys conducted by ASOs and CCCs, the extent to which services are being provided in a timely, culturally competent manner

All Part B sub-grantees are required to submit quarterly budget reports that reflect expenditures for the previous quarter. Budget reporting items include expenditures for personnel and fringe, travel, and financial assistance broken down by service category. Sub-grantees are also required to submit program reports every six months along with unique identifier reports of all current active clients. Grant

monitors within the VDH are in direct contact with all service providers, and follow up on questions or discrepancies in the reports immediately, offering and providing technical assistance if needed.

The Part B and State program report forms require sub-grantees to supply the Department with standard socio-demographic information on all clients who accessed services during the reporting period as well as program indicators such as utilization of services; specific uses of Part B funds; the number and types of contacts with clients; number of referrals and where they were made; number of appointments kept; Women, Infant, Children and Youth expenditures; and service units. Lastly, all Part B sub-grantees are required to submit the Care Act Data Report. VDH performs annual audits of Medical Case Managers files.

VDH has conducted continuous quality improvement on surveillance systems, and become more active with surveillance over the past three year, as detailed below. This greatly supports timely, accurate, high quality monitoring of results and outcomes. VDH works closely with the network of providers at all stages of the care continuum to continually improve systems and efforts for the collection of appropriate levels of information to provide thorough evaluation of programs.

c. Describe the strategy to utilize surveillance and program data to assess and improve health outcomes along the HIV Care Continuum that will be used to impact the quality of the HIV service delivery system, including strategic long-range planning.

VDH has made great strides in streamlining and improving surveillance over the past three years, and worked closely with the community during the changes to and evolution of these systems. Surveillance and program data is reviewed regularly in comparison to the state's Care Continuum, in order to address in a timely fashion any concerns and identify any areas in need of attention, technical assistance, and support in working toward improved health outcomes for PLWHA.

HIV testers throughout the state are networked into Evaluation Web, the online testing reporting system into which each tester enters their individual data as it is collected. Data is entered directly into the CAREWare system by ASOs and CCC medical providers. VDH reviews this data regularly, both in the form of ongoing evaluation of the demographics of Vermont's epidemic, and to evaluate progress on goals for care engagement and retention.

Through the VMAP system the VDH currently passively monitors medication refills. This monitoring can assist providers in evaluating adherence and assisting PLWHA who may need additional support with their medication.

The collecting of viral suppression data, conducted through direct reporting from the CCC system, allows for regular evaluation of this data point in the continuum.

Until this year, CAREWare and eHARS in Vermont have been maintained on an off-network computer system, due to prior arrangements addressing community concerns about confidentiality of data. Both are now being migrated onto the network, with the support of the community, and once the process is completed VDH will have access to more complete and real-time data, and be able to filter for individual information in a manner that will enhance evaluation and monitoring immediately, and greatly enhance planning processes going forward.

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