

SECTION 9: VERMONT DEPARTMENT OF HEALTH ACTIVITIES

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Section 9A: Community Planning

2004 Community Planning Group Process

At present, the CPG consists of 18 members, including 2 non-voting members who are State employees. In preparation for current appointments that began in October of 2003, applications were circulated widely to HIV prevention provider organizations, peer-based HIV advocacy groups and professionals from various disciplines. Selected members were appointed to staggered two-year terms to facilitate continuity of membership. In the Fall of 2003, two Community Co-Chairs were elected by the CPG; and the Health Department Co-Chair position continues to be held by the HIV/AIDS Program Director.

Four CPG committees convened this year:

Steering: Steering Committee, comprised of the CPG co-chairs and other committee chairs, meets monthly to formulate agendas for upcoming meetings, develop strategic work plans, facilitate communication among the membership, and to address any other related CPG business.

Membership: The Membership Committee meets on an as-needed basis, to plan and implement the creation of a CPG membership application; the recruitment of new members; the screening of new membership applications; and the planning of the new member orientation, which will take place this year in October.

Policies and Procedures: The Policies and Procedures Committee has continued its work, updating existing policies and procedures to govern the CPG's process. A new Policies and Procedures manual is expected to be

finished and available to the members by the end of 2004. It will also be made available through the CPG's website at <http://www.nvtredcross.org/cpg>.

Heterosexual: This committee was formed recently, and will continue its work in the coming year, examining the HIV prevention needs of people at increased risk through heterosexual contact; deciding upon a specific direction within that goal; and implementing a needs assessment process for this target population, or for some sub-population(s).

In addition to the regular CPG committees in 2004, there was also a Prevention for Positives work group, comprised of CPG members, other community members and consumers, and service providers from around the state. This group focused on the prevention needs of people living with HIV/AIDS in Vermont, and also reviewed potential HIV prevention interventions for this population. The work group's final recommendations were passed onto the CPG and became the basis of Section 4 of this Comprehensive Plan: Prevention For Positives.

All CPG committee meetings were typically held by conference call, to facilitate participation among members around the state. The full CPG met in person monthly, with additional special meetings scheduled as necessary. Full CPG meetings were held in geographically central locations to reduce barriers to participation. Members who are not state employees or employees of an agency receiving federal HIV prevention funding were eligible for stipends and travel expense reimbursement

2004 CPG Membership and Participation

The CPG strives to reflect the epidemic in its membership. In 2004, five of the CPG's 18 members were MSM. Two members were either current or former users of injection drugs. Two members were African American, and another two were Native American. In terms of gender, the CPG membership included eight females, nine males, and one transgender person. At least four members were people living with HIV/AIDS.

An overview of 2004 CPG membership demographics appears on the following page.

2004 CPG Membership

	County	New/ Return	Term Expires	Target Pop.	Gov't Vote	Grantee Provider	Ally	MSM	IDU	Hetero	Ally	Gender	Race Ethnicity	Age	Youth	People of Color	Woman	PLWA/HIV
1	Caledonia	Returning	2004			X					X	F	W	15	X			
2	Washington	Returning	2005	X				X				F	W	50+			X	
3	Chittenden	Returning	2005	X				X				M	W	40+				X
4	Calendonia	New	2006	X						X		F	W	40+			X	X
5	Bennington	Returning	2004	X				X				M	W	30+				
6	Chittenden	New	2005			X					X	T	W	25+	X			
7	Windsor	New	2006			X					X	F	W	40+				
8	Orleans	Returning	2005	X					X			M	NA	50+				
9	Orleans	Returning	2004				X				X	M	NA	20	X			
10	Caledonia	Returning	2004	X						X		F	W	40+			X	X
11	Chittenden	New	2005	X		X		X				M	W	25+	X			
12	Chittenden	Returning	2005			X					X	M	AA	50+				
13	Windsor	Returning	2005	X				X				M	W	50+	X			
14	Windsor	Returning	2004				X				X	F	W	25+	X			
15	Orange	Returning	2004	X				X				M	W	30+				
16	Chittenden	Returning	2005			X					X	F	AA	25+	X		X	
17	Chittenden	Gov't.			X							F	W	30+				
18	Caledonia	New	2006	X						X		M	W	40+				X
				10	1	5	7	5	2	3	7	8 F 9 M 1 T	14W 2AA 2N	(2)<24(25) 330(5)40	7	3	4	4

CPG Future Goals and Areas of Concentration

The Community Planning Group has identified the following areas for further discussion and/or concentration in the coming four-year work cycle.

Needs Assessment:

- Incarcerated populations
- Sex workers/people who trade sex for resources
- Communities of Color
- People who are intermittent/casual drug injectors
- MSM/IDU; also MSM who are Crystal Methamphetamine users
- People who are Transgender
- All sub-populations within our existing definition of People at increased risk through Heterosexual Transmission.
- Youth who are substance users, including alcohol

Examining specific issues related to HIV prevention:

- Alcohol-related risk, across all populations
- Geographically specific HIV prevention issues in Vermont. Which areas, and which populations in specific areas, are underserved?
- The intersection of Prevention for Positives efforts and prevention efforts targeting at-risk populations. In what ways should these programs be distinct? In what ways should they be cooperative?
- HIV and Hepatitis coinfection. Create recommendations for prevention efforts that address this issue.

Planning and Prioritizing:

- Long-range planning for the CPG (i.e., 5-10 year projections)
- Move toward a more targeted list of priority populations (and moreover, address the disparity between the small amount of prevention funding available in Vermont and the relatively large number of people we are currently trying to reach with prevention services)
- Continue to collaborate with the HIV/AIDS Services Advisory Council (HASAC); continue to seek appropriate linkages between HIV prevention and care services.
- Evaluation of HIV prevention program effectiveness – determining the CPG's options in this regard.

Section 9B: **Partner Counseling and Referral Services (PCRS)**

The Vermont CPG concurs that PCRS in Vermont should continue to be planned and implemented by Vermont Department of Health (VDH) staff, as has been the case thus far. Plans for improving PCRS in Vermont were provided to the CPG by VDH as follows:

- 1) Vermont Department of Health personnel will attend a formal CDC-sponsored training in December 2004
- 2) PCRS implementation is anticipated in early 2005. Plans are to begin implementation with private physicians/providers who are diagnosing newly infected individuals (including those with AIDS).

VDH will integrate PCRS information into a training already in development between VDH and key HIV medical providers. There will also be a one-page overview of PCRS and its availability in a quarterly newsletter sent by VDH to all medical providers statewide, by June 2005

3) Concomitant with implementing PCRS among private providers, VDH will work with ASOs to develop their capacity to implement PCRS activities in a way that is skills-based, practical, and will protect the confidentiality (and anonymity) of the HIV-infected person. ASOs will be limited to the partner elicitation component of PCRS; VDH will manage the partner notification.

4) VDH will also investigate the possibility of implementing PCRS activities in high prevalence settings such as corrections.

5) VDH will develop guidelines around PCRS implementation among prevalent cases of HIV/AIDS (i.e., HIV/AIDS cases that were diagnosed before the implementation of HIV reporting in Vermont).

Note: PCRS activities can be implemented without requiring names since Vermont does not have a named system for HIV reporting.

Other plans regarding PCRS in Vermont include the following:

- Promote PCRS within Vermont's CTR system by providing current testers with an overview of PCRS, and by integrating PCRS information into CTR training curricula.
- Maintain information in the Vermont Consent Form for Confidential and Anonymous Testing in regards to the availability of PCRS.
- Create a client brochure for PCRS, available to anyone visiting a medical or non-medical setting who is interested in learning more about PCRS.

Section 9C: Capacity Building

The following overview of capacity building plans in the coming four-year work cycle was presented to the CPG by the Vermont Department of Health in April 2004, and subsequently approved the CPG for inclusion here.

Capacity building around HIV Prevention in Vermont will include:

- Training – workshops, conferences (in-state and out of state), courses, public speakers
- Cross-training and collaboration – between grantees and VDH, among grantees, between grantees and other health or human service providers, between VDH and other states' HIV/STD programs
- Technical Assistance – includes both in-state and out of state providers, national organizations, CDC, NIH, other governmental organizations
- National Conferences and regional meetings – National HIV Prevention Leadership Summit, U.S. Conference on AIDS, National HIV Prevention Conference (biannual), regional STD conferences
- Distance learning opportunities – phone conferencing, satellite broadcasts, Web-casts and video conferencing

Target audiences for HIV Prevention capacity building include:

- CPG
- VDH grantee staff and volunteers
- VDH staff
- Other health or human service providers
- Communities at risk and the larger community

Resources directed toward HIV Prevention capacity building come from:

- Vermont's CDC HIV Prevention grant
- CDC's training and technical assistance
- CDC and/or other state's distance learning efforts (satellite and Web-casts)
- New England AIDS Education Training Center (AETC)
- Other state government agencies or departments (Alcohol and Drug Abuse Programs, etc.)
- Expertise/experience at Vermont CBO's, ASO's, and communities

Capacity building needs are determined through:

- CPG surveys, evaluations
- Prevention grantee provider surveys, dialogue with grant monitors and training evaluations
- CDC initiatives and directives
- Analysis of other data collection

Key areas of HIV Prevention capacity development include:

1. HIV Prevention Community Planning Group
 - a) CPG Orientation
 - b) Introduction to the CPG Guidance
 - c) Vermont Epidemiological Profile Presentation
 - d) Vermont Counseling and Testing System Update
 - e) Community Planning Leadership Summit
 - f) Prevention for HIV Infected Persons – Report on Guideline Development
 - g) CPG Priority Setting Technical Assistance

2. HIV Prevention Counseling, Testing and Referral (CTR)
 - a) Anonymous Oral Testing Training
 - b) Anonymous Blood Testing Training
 - c) Fundamentals of HIV Prevention Counseling and Testing Training of Trainers
 - d) Routine HIV Testing in High Prevalence Medical Settings Training
 - e) Updated CTR Reporting Tool and Prevention Evaluation Monitoring System (PEMS) Training
 - f) Introduction to the Updated CTR Reporting Tool (bubble form) Workshop
 - g) Making Referrals Work Training

3. Partner counseling and Referral Services (PCRS)
 - a) CDC Sponsored PCRS Training of Trainers
 - b) Utilizing the VDH PCRS System Training for Current CTR Providers

4. Prevention for HIV Infected Persons
 - a) Prevention for HIV Infected Persons – Guideline Development Meetings
 - b) Prevention for HIV Infected Persons – VDH Staff Training
 - c) Prevention for HIV Infected Persons – Grantee Staff Training

5. Health Education and Risk Reduction (HERR)
 - a) American Red Cross Basic HIV Program Training
 - b) Annual HIV/AIDS Updates
 - c) Annual HIV/AIDS Public Nurse HIV Designee Updates
 - d) Outcome Monitoring – Initial Results and Program Improvement
 - e) US Conference on AIDS
 - f) Intervention Design Trainings
 - g) National HIV Prevention Conference
 - h) Effective Outreach Training for VDH Staff
 - i) Effective Outreach Training for Grantee Staff
 - j) Making Referrals Work Training for VDH Staff
 - k) Making Referrals Work Training for Grantee Staff

6. Public Information Programs

- a) VDH HIV/AIDS Hotline Training for VDH Staff
- b) National HIV Testing Day Orientation / Public Health Nurse HIV Designees
- c) World AIDS Day Orientation for Public Health Nurse HIV Designees

7. Perinatal Transmission Prevention

- a) Medical Providers Offering Perinatal Care Training
- b) Perinatal HIV Screening Programs for Community Public Health Staff and Public Health Nurses

8. Quality Assurance

- a) Quality Assurance Standards Guideline Development Meetings
- b) Quality Assurance Standards Implementation Training for VDH Staff
- c) Quality Assurance Standards Implementation Training for Grantee Staff

9. Evaluation

- a) Evaluation Training for VDH Staff
- b) Evaluation Training for Grantee Staff
- c) Evaluation Tools for Outcome Monitoring Training
- d) Prevention Evaluation Monitoring System (PEMS) Training for VDH Staff
- e) Prevention Evaluation Monitoring System (PEMS) Training for Grantee Staff

10. Capacity Building Activities

- a) Cultural Competency Training for Grantee Staff
- b) Cultural Competency Training for VDH Staff

11. STD Prevention Activities

- a) STD/HIV Updates

12. Collaboration and Coordination with Other Related Programs (non-governmental)

- a) HIV Risk Assessment for Medical Providers Training
- b) Making Referrals Work Training for Mental Health Service Providers

13. HIV/AIDS Epidemiological and Behavioral Surveillance

- a) Orientation to the Epidemiological Profile for VDH Staff
- b) Orientation to the Epidemiological Profile for HASAC
- c) National CDC-Sponsored Evaluation Training for VDH Staff

14. Prevention Case Management

- a) Prevention Case Management Training for VDH Staff
- b) Prevention Case Management Training for Grantee Staff

Section 9D: **Counseling, Testing and Referral Services**

An overview of HIV Counseling and Testing in Vermont, including future directions for counseling and testing in the state, was presented by Vermont Department of Health to the CPG in April, 2004, and subsequently approved by the CPG for inclusion here:

Vermont's Counseling, Testing and Referral Program (CTR) presently includes a total of 40 locations statewide. These sites are a combination of AIDS Service Organizations, publicly-funded health clinics, hospitals, private medical providers, family planning clinics, minority-based community organizations, youth-based community organizations, drug treatment facilities, and correctional facilities. Of these 40 sites, 17 offer free anonymous oral testing, 14 offer free anonymous blood testing, and 13 offer free confidential blood testing. The anonymous oral sites are customized to reach those most at risk in non-medical and outreach settings.

In 1998, Vermont tested a total of 898 individuals and identified one HIV-positive person. In 2002, Vermont tested more than 2,400 individuals and identified 18 previously unidentified HIV infections. While Vermont remains a low-prevalence state for HIV, it is anticipated by the Department of Health that numbers will continue to increase for both testing and the detection of HIV within our communities.

Improving efforts to identify newly infected persons

- Increase availability of free anonymous tests: Add two oral and/or rapid test sites yearly, increasing the number testing sites by ten by 2008
- Increase the number of trained counselors who perform anonymous oral testing outside of medical settings: Hold a minimum of 2 trainings yearly to attain a maximum of 24 new counselors per year.
- Increase the number of trained counselors who perform anonymous blood testing within medical settings: Hold one training per year to reach nurses, physician's assistants, and physicians.
- Train 1-2 individuals per year to teach the CDC Fundamentals of HIV Prevention curriculum.
- Hold three trainings by the end of 2005 of medical providers in HIV risk assessment and symptom recognition.

- Provide two trainings to medical providers from high-prevalence medical settings as well as the Vermont Department of Corrections, around the need for routine HIV-antibody testing in their medical settings.
- Increase the availability of anonymous testing in correctional facilities: Have anonymous testing available in all 10 of Vermont's correctional facilities by 2006, with the addition of providers able to offer testing.
- Increase Partner Counseling and Referral Services, as outlined above.

Improving Provision of Test Results

In 2000 when national post-test counseling rates for HIV-positive results were at an average of 58.2%, Vermont's rate was 100%. Similarly, Vermont's post-test counseling rate for HIV-negative test results was 90%. In 2002, the rates were 95.5% and 87.5%, respectively.

Plans for maintaining these rates are as follows:

- Increase the number of anonymous test sites available to individuals statewide, in geographically diverse areas.
- Emphasize high-quality training for counselors, including many opportunities to practice role-playing for pre- and post-test counseling sessions, and placing an emphasis with clients on the importance of returning for test results.

Providing and Tracking the Completion of Referrals for Persons with Positive Test Results

Until this time, Vermont has not tracked referrals in its system. Given the rural nature and low prevalence of HIV here, the Department of Health plans to examine ways in which other states have addressed this issue. Plans at this time include:

- Develop a conversion system for anonymous HIV positive test results by which the anonymous test result becomes a confidential test result. Issues of implementation, feasibility, and confidentiality must be examined and addressed before this can take place.
- Explore possibilities of developing an inter-agency referral tracking system.
- Explore new opportunities for referral tracking using PEMS and CTS data collection forms.

Working with Medical Care Entities to Encourage and Support Routine HIV Screening in High Prevalence Settings

- Provide trainings to medical providers from high-prevalence medical settings as well as the Vermont Department of Corrections, around the need for routine HIV-antibody testing in their medical settings.
- Communicate with other medical entities that possibly see high-risk individuals: veterans' hospitals, refugee health clinics, and others.
- Encourage routine risk assessment at medical facilities who largely see low-risk clients.

Supporting Providers of CTR Services

- Certify oral testing counselors only following a successful five-day training and pre-test counseling role-play evaluation.
- Provide annual training for CTR providers in medical settings who perform blood testing.
- Provide training to medical providers from high-prevalence medical settings around the need for routine HIV-antibody testing.
- Provide training to medical providers from low-prevalence medical settings around the need to HIV risk assessment and symptom recognition.
- Hold quarterly conference calls with all CTR providers, to inform them of new guidelines and recommendations, changes to procedures, etc. It is also an opportunity for providers to exchange information, offer support, and share learning experiences.
- Continue to offer each counselor one-on-one support, to answer questions and concerns, thus making CTR services more effective for both the CTR provider and his/her clients.
- Hold three trainings concerning the updated CTR reporting tool (bubble form) and how to correctly administer it.
- Create a media campaign, comprised of posters and pamphlets, directed at pregnant women, with the goal of increasing the number of women who choose to receive HIV CTR services as part of their family planning services, and to help physicians and clients share the responsibility of universal voluntary CTR for pregnant clients.

Section 9E: Surveillance and Research

HIV/AIDS Surveillance

HIV/AIDS surveillance is the process of collecting, analyzing, and interpreting data on individuals infected with HIV and/or who have an AIDS diagnosis. These data are used to plan and evaluate treatment and support programs for people in Vermont living with HIV and AIDS. Surveillance data also assist in the development of programs to prevent infection with HIV. AIDS surveillance has continued since 1982, with names of cases reported confidentially. In March 2000, the HIV surveillance system was implemented using a coded unique identifier system. Recent treatment advances have slowed the progression of HIV to AIDS and as a result, people are living longer with HIV. The HIV surveillance system was implemented because AIDS data alone cannot offer a reliable estimate of the HIV epidemic.

Any physician, nurse, or other institution required to report results of HIV tests must have written policies in place to ensure the confidentiality of the information. The Vermont Department of Health ensures the security and confidentiality of HIV/AIDS data and meets strict security requirements outlined by the Centers for Disease Control and Prevention (CDC).

Surveillance/Research Activities - Ongoing

Vermont's small population, low incidence, and rural nature often limit our state's eligibility for participation in larger-scale studies. However, the Vermont Department of Health is committed to additional research that may further our understanding of HIV prevention, and specifically, HIV prevention in Vermont, and looks forward to participating in these studies when invited to do so.

The following research activities are ongoing.

Behavioral Risk Factor Surveillance System (BRFSS)

The BRFSS collects state-level data on personal health behaviors using a standard core questionnaire so that data can be compared across states. It is a population-based random digit-dialed telephone survey of adults. A sexual behavior module was added to the survey in 1994, 1995, 1996, 1998 and 2000. In this module, adults (ages 18-49) were asked about their number of sexual partners, condom use, and treatment for STDs.

Youth Risk Behavior Survey (YRBS)

The Vermont YRBS collects information on health-risk behaviors among youth and young adults in each of the following categories: behaviors that contribute to unintentional injuries and violence; tobacco use; alcohol and other drug use;

sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases, including HIV infection; unhealthy dietary behaviors; and physical inactivity. The survey has been conducted among a representative sample of Vermont students in grades 8-12 every two years since 1985.

Sexually Transmitted Disease (STD) Surveillance

Chlamydia trachomatis infection, gonorrhea, and syphilis are reportable under Vermont's Communicable Disease Regulations. Demographic information is entered into the NETSS system and transmitted to the CDC (without identifiers) on a weekly basis.

Drug Treatment Surveillance

The Alcohol and Drug Abuse Program (ADAP) of Vermont Department of Health maintains substance abuse treatment admissions from facilities that receive State funding. The data offer another way to indirectly measure the prevalence of injection drug use in Vermont. The admissions data may not represent unduplicated individuals, but rather they may represent multiple admissions within a calendar year for an individual.

HIV Counseling and Testing Data

The HIV Counseling and Testing System (CTS) was originally developed in 1988 to collect data on the population receiving counseling and testing services. The data are used to guide the development of HIV prevention programs and to estimate the need for early intervention service for persons with HIV infection. Demographic and behavioral data as well as HIV test results are reported to the Vermont Department of health by each of the state's testing sites. Data are entered into CTS software provide by the CDC and are transmitted to the CDC on a monthly basis. Data cannot distinguish multiple tests on the same individual and cannot be used to estimate statewide HIV seroprevalence.

Ryan White CARE Act Data

In 2002 the Vermont Department of Health HIV/AIDS Program established a standardized unique identifier reporting system with the state- and federally-funded AIDS Service Organizations and the Comprehensive Care Clinics in Vermont, in order to reduce duplication of services and to determine the number of people receiving services from these organizations. The HIV/AIDS Program reports on HIV-positive client utilization of Ryan White Title II services by service category. The data include individuals who are HIV-positive, as well as individuals who are not infected but who are directly impacted by immediate family members living with the virus. Unique identifiers are not reported for HIV-negative individuals.

The HIV/AIDS Program also uses unique identifiers reported to the Title II Coordinator to determine the number of individuals receiving case management services, where these services are received, and the percentage of duplication of services occurring across agencies.

Section 9F: Health Education/Risk Reduction (HE/RR)

The Vermont Department of Health (VDH) HIV/AIDS Program has taken several steps to ensure that HIV prevention grantees provide interventions based on scientific theory, program theory, and/or evidence of effectiveness. Existing and prospective grantees received information and training in 2004 on the DEBIs (Diffusion of Effective Behavioral Interventions for HIV Prevention) and CDC's Compendium of Effective Interventions. Grantee organization capacity to deliver interventions from DEBI and the Compendium was also discussed.

The use of scientific theory, and programs with evidence of effectiveness was further developed in Prevention with Positives meetings with grantees and community stakeholders. The VDH HIV/AIDS Program hosted a series of monthly meetings on Prevention with HIV Positives from December 2003 – April 2004 with grantees and people living with the virus. This Prevention with Positives Workgroup was an informal sub-committee to the Vermont CPG. They reviewed 14 evidence-based interventions for Positives taken from the Compendium, DEBI and PHIPP and made feasibility recommendations to the CPG. These interventions and recommendations are detailed in Section 8 of this Comprehensive Plan.

In 2004 the Vermont CPG approved all DEBI and Compendium interventions for use in Vermont. (These interventions are also detailed in Section 8 of this Comprehensive Plan.) Based on that CPG recommendation, the Vermont Department of Health's HIV Prevention RFP for 2005-2007 lists the DEBI and Compendium interventions as options for use by organizations submitting proposals. However, because both DEBI and Compendium interventions are largely developed for and tested within urban areas, it has been important to allow flexibility about which interventions are allowable in rural Vermont. For this reason, VDH did not require grantees to implement DEBI, and allowed other evidence-based and theory-based HIV Prevention interventions to be used.

It is anticipated that the majority of grantees in the coming three-year cycle will be using DEBI and/or Compendium projects, for which protocols are already developed. Organizations that are funded for interventions that do not fall within the DEBI or Compendium will be required to write intervention curricula and protocols that are appropriate to the behavior change theory or evidence-based intervention from which they are derived.

Section 9G: Evaluation/PEMS

The Center for Disease Control and Prevention (CDC) has been working to implement a new system that will help evaluate HIV Prevention programs. This system is called the Prevention Evaluation Monitoring System (PEMS).

When draft data variables were released by CDC, the Vermont Department of Health HIV/AIDS Program convened HIV Prevention grantees in order to review these draft variables and to provide comment to the CDC. Concerns that were stated during this comment period are also concerns shared by the Vermont Community Group. They include:

- Data system security and a lack of clarity around how client-related information will be shared via computer.
- The challenge of maintaining anonymity in a rural state like Vermont, where unique identifiers can be very identifying.
- Some of the client data is personal – including information about the number of sexual partners, the frequency of sex without a condom, HIV status, etc. Client discomfort with sharing this information may inhibit some from accessing good programs and necessary services.
- Clients may also be reluctant to provide the information necessary to create a unique identifier, and may have questions about what CDC will do with this information. This, too, could keep people away from good programs.
- Clients may not wish to be tracked when receiving and following up on referrals. There is a lack of clarity at the community level about who will be getting and using this information, and there is no way to guarantee clients that the information will be used in an honest way.
- The amount of time required to collect all variables will cut into the amount of time providers will have with clients for the actual interventions themselves. Clients may not be willing to spend the extra time required to do both.

The CDC has not yet released final data variables. However, they have conveyed that some of the individual client data variables will not be required in low-prevalence jurisdictions such as Vermont. Once the variables are released, the HIV/AIDS Program will share them with prospective HIV Prevention grantees. Recently, CDC expressed that the rules regarding safeguarding of PEMS information will be similar to, or stricter than, Surveillance data.

Concerns raised during the initial discussions about PEMS continue to be of issue to the HIV/AIDS Program, HIV Prevention grantees' staff, and to the Vermont Community

Planning Group. The CPG will continue to monitor these issues as PEMS implementation begins in 2005 and beyond.

How the Vermont HIV/AIDS Program will proceed with PEMS:

- In early 2005 the HIV/AIDS program will convene HIV Prevention grantees to help decide on an appropriate unique identifier for prevention clients. The Vermont Department of Health has committed to collect unique identifiers, and NOT names.
- The HIV/AIDS Program plans to offer training on referral tracking in 2005.
- Implementation of PEMS is expected to move forward according to the existing PEMS timeline.

Section 9H: Collaboration and Coordination

Collaboration among Vermont Department of Health programs, as well as between the Vermont Department of Health and other organizations that serve people at increased risk for HIV transmission, is key to the success of our state's HIV prevention efforts.

Internal collaboration at the Department of Health has included, and should continue to include, coordination of Counseling and Testing; Partner Counseling and Referral; and both the Prevention and Care Early Intervention Programs.

External collaboration, as well, should continue. In the past year, the Vermont Department of Health HIV/AIDS Program has collaborated with the agencies listed below, and anticipates that it will continue these collaborations in the future:

- The American Red Cross of Northern Vermont provides administrative services for Community Planning Group meetings on behalf of the HIV Program. These services include meeting organization, provision of mileage reimbursement, participant stipends, taking of meeting notes. The American Red Cross also provides three levels of HIV-related trainings to HIV Program prevention grantees to increase basic factual information about transmission, prevention and treatment of HIV.
- The Comprehensive Care Clinics, through a partnership with the AIDS Education Training Center (AETC), provides training on HIV/AIDS-related information to other Agency of Human Services programs such as Vocational Rehabilitation and Social Rehabilitation Services. Furthermore, the Comprehensive Care Clinics collaborate with the HIV Program to provide HIV-related training to incoming counselors as part of our CTR training. Objectives of these trainings include an increase in knowledge regarding

- serostatus awareness and the treatment and care systems for HIV. The HIV Program also collaborated with the Comprehensive Care Clinics in a research project designed to inform OB/GYNs about the need to conduct risk screening for HIV of all pregnant clients. This project allowed for oral testing to be provided to clients free of charge.
- The Vermont Department of Education works with the HIV Program to make training on HIV available to school staff members who deliver health curriculums, including school nurses. Also, an HIV prevention staff member sits on the DOE materials review panel for HIV and a DOE staff member sits on the HIV Program materials review panel. This exchange provides both organizations with a greater level of insight and expertise.
 - The Vermont Department of Health STD Program collaborates with the HIV Program in numerous ways. Both of Vermont's STD staff members are available to provide HIV PCRS on an as-requested basis. This collaboration will increase in 2005 following formal training in PCRS. A member of the STD Program sits on the HIV Community Planning Group as a non-voting member to share her expertise of STDs and populations at risk for infection. A member of the STD Program performs HIV testing to individuals who seek testing outside of an organizational setting. Furthermore, both STD Program staff members help to answer HIV hotline calls. As HIV is a sexually transmitted disease, this collaboration greatly helps the HIV Program to keep a broad focus when looking at factors that lead to increased risk of HIV infection. The wealth of knowledge and experience of Vermont's STD Program members is an invaluable entity to the HIV Program.
 - The University of Vermont's Dr. Sondra Solomon, a clinical psychologist, supports the Community Planning Group by sharing a research perspective, and by helping members to gain a greater understanding of how to use data. Dr. Solomon also helps the HIV Program by sitting on the HIV Prevention External Review panel and by providing training to incoming HIV testers on cultural competency. The HIV Program works as a conduit between Dr. Solomon and the HIV Surveillance branch for data collection needs. The HIV Program also hires a psychology graduate student who works in Dr. Solomon's HIV Stigma Laboratory to help with various evaluation needs. Furthermore, the HIV Program supports Dr. Solomon's research on HIV stigma in rural communities.
 - The Vermont Department of Health Alcohol and Drug Abuse Program (ADAP) supports the HIV/AIDS Program's work around creation of needle exchange guidelines and proposals. ADAP also supports the HIV Program's external review of prevention proposals. The HIV Program supports the ADAP's mobile methadone proposals. These collaborations allow for a sharing of resources to better reach substance users at increased risk for HIV infection.

As a result of a recent reorganization of the Agency of Human Services in Vermont, ADAP now has its own deputy commissioner within the health department. This has allowed VDH to begin discussions about how to better collaborate in regards to HIV prevention programming for injection drug users and make HIV testing available in fixed sites and in mobile methadone treatment facilities.

- The Vermont Office of Minority Health (OMH) has one stream of funding which is for HIV prevention capacity-building among organizations that reach minority populations. As a result, the OMH and HIV Program fund many of the same community-based organizations for different but complimentary projects. The OMH and HIV Program support one another in the development of program work specifications, communication with community groups and strategic planning around HIV prevention for minority groups. Of special note is that the OMH is working with HIV prevention and care programs as well as HIV Surveillance programs on a needs-assessment among people of color and incarcerated populations. A report on this assessment will be available in the first quarter of 2005. Data collected from this assessment will likely effect future HIV prevention and care documents.
- Vermont Department of Corrections (DOC) collaborates with the HIV Program by supporting the work of HIV prevention grantees in corrections settings. Furthermore, the DOC supports the HIV program's needs-assessment research among people of color and incarcerated populations. The HIV program is assisting the DOC to enhance their existing medical services request for proposals to help ensure quality care and surveillance recording for people with HIV in the corrections system.
- The HIV/AIDS Services Advisory Council (HASAC) collaborates with the HIV Program by supporting coordination of quarterly meetings between the HASAC and the Community Planning Group. These meetings allow for shared training opportunities, shared data and projects that are appropriate for both care and prevention of HIV. The two groups have decided not to join into a single planning body at this time but have committed to reviewing the opportunity again in 2006.

Section 9I: Quality Assurance

Quality Assurance is an important aspect of any ongoing, comprehensive HIV prevention effort. The Community Planning Group encourages the Vermont Department of Health to continue its expansion of quality assurance measures for all HIV prevention programs and should assure that programs are run in an efficient and effective manner that supports clients in the best way possible.

Quality assurance should include monitoring efforts, as well as the development or updating of protocols. Some areas of note for quality assurance include, but are not limited to:

- the implementation of HIV prevention interventions by Community-Based Organizations;
- Counseling Testing and Referral (both in the training of providers as well as the actual provision of services);
- risk screening and testing of pregnant women;
- Partner Counseling and Referral Services (PCRS) as those efforts are expanded in the coming years.

Section 9J: Perinatal Transmission

With an increased focus on perinatal transmission under new CDC guidelines, the Vermont Department of Health HIV/AIDS Program should continue to collaborate with organizations that have funds with which to formally support perinatal transmission prevention.

Specific Department of Health plans in this area include

- working with the Women Infant Child (WIC) program to have health communication/public information about HIV and HIV testing available in all WIC clinics;
- reviewing 2000 Guidelines for Universal HIV Counseling and Voluntary Testing for Pregnant Women, and updating and distributing the guidelines should the need be present.

- END OF SECTION 9: VERMONT DEPARTMENT OF HEALTH ACTIVITIES -