INTEGRATED HIV/AIDS PLANNING IHAP TA CENTER

targetHIV.org/IHAP

Integrated HIV Prevention and Care Plan

Vermont 2016 Integrated HIV Prevention and Care Plan

REGION	Northeast
PLAN TYPE	Integrated state-only prevention and care plan
JURISDICTIONS	State of Vermont
HIV PREVALENCE	Low

Vermont's Integrated HIV Prevention and Care Plan section has very strong SMART objectives, which are specific, measurable, and timed, and align with the first three goals of the NHAS goals. The objectives are associated with specific quantitative measures, and will be measured against baseline data.

SELECTION CRITERIA: INTEGRATED HIV PREVENTION AND CARE PLAN

Exemplary Integrated HIV Prevention and Care Plan sections met the following criteria (based on the Integrated HIV Prevention and Care Plan Guidance):

- ☑ Comprised of SMART objectives, strategies to correspond to each objective, activities, targeted population, timeframe, resources needed, who is responsible for each task, covers time period 2017-2021
- ☑ Specific metrics to monitor activities
- ☑ Objectives and activities aimed at addressing gaps along the HIV Care Continuum.
- ☑ Objectives that align with the National HIV/AIDS Strategy (NHAS)
- ☑ Description of how the Integrated Plan was developed

Additional exemplary plan sections are available online:
www.targetHIV.org/exemplary-integrated-plans

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

GOAL #1 SMART Objective #1: By 2021, **reduce new HIV infections** in Vermont **by 20%** 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

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 of 2016	Service Providers	Respond to RFA with evidence-based interventions based on area's distribution of epidemic	Risk Pop. By Geography	VT Epidemiology 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 high-risk 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

GOAL #1 SMART Objective #2: By 2021, **reduce new HIV infections** 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).
  - ASO organizations to deliver targeted HIV testing services to populations greatest represented in Vermont's latest HIV annual report
  - 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
- **Strategy 2:** 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 of 2021	VDH	Support grantees in implementation of targeted testing programming, prioritizing geographic area of highest disease burden and higher risk population	Higher Risk Populations	Grantee Quarterly Reporting
By DEC of 2021	VDH	Monitor testing data through Evaluation Web.	Higher Risk Populations	EvalWeb Testing data
By DEC of 2017	VDH	Offer and provide technical assistance for retraining staff in TRL and support for (1) targeting of MSM testing and (2) attempts to reach 1% positivity	MSM	# MSM tested Testing positivity rate
By JAN of 2017	VDH	Provide test reimbursement model that prioritizes MSM testing, and matches overall the epidemiology of HIV in Vermont	MSM, Higher Risk Pops.	# MSM tested
By JAN of 2017	Service Providers	Realign testing efforts to TRL, TRL+, TRL ASO through compliance with state retraining of testing staff	MSM, Higher Risk Pops.	# MSM tested # IDU tested
By DEC of 2021	Service Providers	Implement highly targeted testing to ensure prioritized outreach to and testing of MSM	MSM	# MSM tested # MSM reached
By DEC of 2021	Service Providers	Enter all testing data in a timely manner into Evaluation Web.	Higher Risk Populations	EvalWeb Data
By DEC of 2021	Service Providers	Monitor testing results in comparison to MSM goals and realign efforts appropriately	MSM	EvalWeb Data
By DEC of 2021	Service Providers	Chittenden County – Implement TRL +, engaging in linkage to biomedical prevention for MSM through embedding in Mpowerment intervention	MSM	# MSM tested # 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

GOAL #1 SMART Objective #3: By 2021 **reduce new HIV infections** 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 programming throughout service area (eg. statewide).				
TIME	**RESPONSIBLE PARTIES**	**ACTIVITY**	**TARGET POPULATION**	**DATA INDICATORS**
By DEC of 2016	VDH	Allocate funding to statewide CLEAR provider to ensure full-state coverage and increase number of unique individuals reached.	PLWHA IDU	# enrolled in CLEAR # 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 of 2021	Service Provider	Prioritize locating and serving first-time CLEAR participants.	PLWHA IDU	# first-time participants enrolled 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

STRATEGY 3. Implement supports [peer support/access to mental health] to combat isolation, stigma and poor mental health among PLWHA.				
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

GOAL #2 SMART Objective #1: by 2021 **increase access to care and improve health outcomes** 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

STRATEGY 2. Ensure continuity of comprehensive health care coverage to support access to HIV 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

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

STRATEGY 2. As part of the Syringe Service Program, provide HIV testing and the CLEAR intervention to clients.				
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

STRATEGY 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

GOAL #3 SMART Objective #2: By 2021, **reduce HIV-related health disparities and inequities** 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.

STRATEGY 1. Promote 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

STRATEGY 2. Mobilize communities to reduce HIV-related stigma.				
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

STRATEGY 3. Promote public leadership of people living with HIV.				
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