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VERMONT

State CARE Act Program Profile

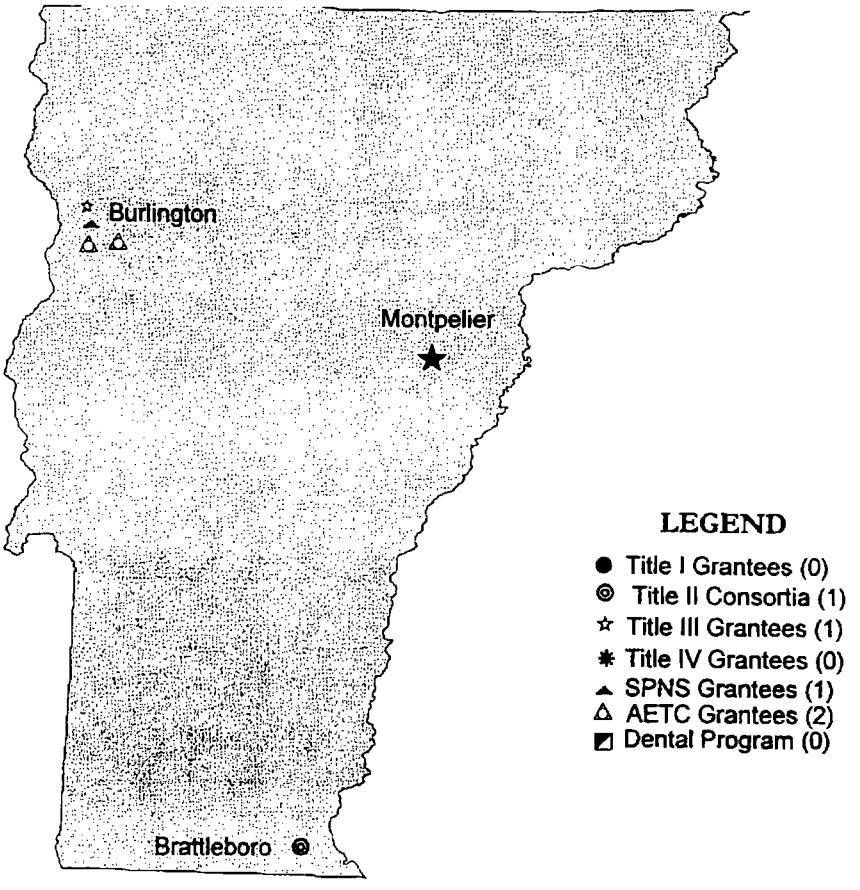
CARE Act Funding History Since 1996

Fiscal Year	1996	1997	1998	Total
Title I	$0	$0	$0	$0
Title II (including ADAP)	$279,529	$342,140	$404,394	$1,026,063
ADAP	($29,529)	($92,140)	($154,394)	($276,063)
Title III	$0	$0	$250,310	$250,310
Title IV	$0	$0	$0	$0
SPNS	$434,652	$431,720	$89,977	$956,349
AETC	$31,000	$24,531	$31,000	$86,531
Dental	No Data	$0	$0	$0
Total	**$745,181**	**$798,391**	**$775,681**	**$2,319,253**

Number of CARE Act-funded Grantees in State (in addition to Title II and ADAP grants)

	1996	1997	1998
Title I	0	0	0
Title III	0	0	1
Title IV	0	0	0
SPNS	1	1	1
AETC (grantee or subcontractor)	2	2	2
Dental	0	0	0

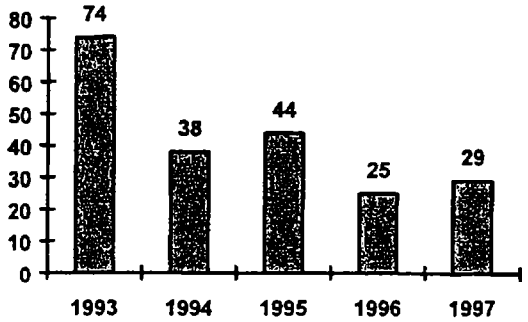
Location of FY 1998 CARE Act Grantees and Title II Consortia



HIV/AIDS Epidemic in the State: Vermont (Pop. 588,978)

- Persons reported to be living with AIDS through 1997: 145
- State reporting requirement for HIV: No HIV reporting
- State AIDS Cases (cumulative) since 1993: 210 (<1% of AIDS cases in the U.S.)

- New AIDS Cases by Calendar Year, 1993-1997



Demographics of AIDS Cases Reported in 1997

	State-Specific Data	National Data
Men (13 years and up):	100%	78%
Women (13 years and up):	0%	22%

	State-Specific Data	National Data
<13 years old :	0%	1%
13-19 years old :	0%	1%
20+ years old :	100%	98%

	State-Specific Data	National Data
White:	90%	33%
African American:	7%	45%
Hispanic:	0%	21%
Asian/Pacific Islander:	0%	<1%
Native American/Alaskan Native:	3%	<1%

	State-Specific Data	National Data
Men who have sex with men (MSM):	59%	35%
Injecting drug user (IDU):	14%	24%
Men who have sex with men and inject drugs (MSM/IDU):	21%	4%
Heterosexual contact:	0%	13%
Other, unknown or not reported:	7%	24%

Co-morbidities

	State Cases per 100,000 Population	U.S. Cases per 100,000 Population
Chlamydia (1996)	68.1	194.5
Gonorrhea (1996)	8.0	124.0
Syphilis (1996)	0	4.3
TB (1997)	1.0	7.4

Statewide Coordinated Statement of Need (SCSN)

- **Gaps:** medical and dental care; financial support; housing; culturally-competent services; access to information about locally-available resources; and access to uniform, quality HIV services for PLWHs across the State

State Medicaid Information

Medicaid Income Eligibility Requirements

Eligibility Category	Income
Adult Aged/Blind/Disabled*	75% FPL
Pregnant Women	200% FPL
Medically Needy	81% FPL

*Income eligibility for State's ADAP program is 200% FPL.

Medicaid Prescription Drug Benefits Limits

Co-payment:	Yes
Limit on Rx per month:	No
Refill limit:	Yes
Quantity Limit:	Yes

Waivers

1115 waiver: Yes

Beneficiary groups: All current Medicaid eligible groups, except dual eligibles, individuals receiving long term care services and those spending down to become eligible for the Medically Needy Program. Poor adults and children with incomes up to 150% FPL and Medicare beneficiaries with household incomes below 150% FPL (prescription drug benefit only).

1915(b) waiver(s): No

Title II: Vermont

Funding History

Fiscal Year	1996	1997	1998	Total
Title II Formula Grant	$279,529	$342,140	$404,394	$1,026,063
ADAP (included in Title II grant)	($29,529)	($92,140)	($154,394)	($276,063)
Minimum Required State Match	$0	$0	$0	$0

Allocation of Funds

	1998
Health Care (State Administered)	$250,000/62%
Home and Community Care	($0)
Health Insurance Continuation	($0)
ADAP/Treatments	($250,000)
Direct Services	($0)
Case Management (State Administered)	$0/0%
Consortia	$62,000/15%
Health Care*	($27,000)
ADAP/Treatment	($0)
Case Management	($35,000)
Support Services**	($0)
Administration, Planning and Evaluation (Total State/Consortia)	$30,529/8%

* includes: diagnostic testing, preventive care and screening, prescribing and managing medication therapy, continuing care and management of chronic conditions, and referral to specialty care.
** includes: counseling, direct emergency financial assistance, companion/buddy services, day and respite care, housing assistance, and food services.

Consortia Activities, FY 1997

Number of consortia in State: 1

Consortium Name	Location	Service Area	Title II Funding, FY 1997
Vermont HIV/AIDS Care Consortium	Brattleboro	Statewide	$71,728

Accomplishments

Improved Patient Access

- The State-administered ADAP expanded from 60 clients in 1996 to 74 in 1997 (23%). As of May 1998, the total number of enrolled clients increased another 50%. Monthly utilization is approximately 90 clients.

- The number of clients receiving triple combination therapy has increased from approximately 34% of ADAP participants in 1996 compared with almost 80% by mid-1998.

- New services designed to improve access for HIV-infected women to primary health care, treatment, and support services were established in 1997 in cooperation with the Twin State Women's Network, serving both New Hampshire and Vermont.

- In 1997, for the first time, service coordination and care management became available in all 14 counties, improving access to local and state services, especially in rural areas.

- In 1997, the comprehensive care clinic in Burlington opened three satellite offices in Rutland, Brattleboro, and St. Johnsbury, through CARE Act funding under the SPNS program. All Title II-funded programs expanded their service areas. As a result, it is estimated that over 90% of all HIV-infected persons in the state are accessing medical care and treatment.

- To better reach individuals who have been incarcerated, ADAP information began being distributed to case managers with the corrections system in 1997.

Cost Savings

- In 1997 and 1998, the ADAP negotiated voluntary manufacturers' rebates from pharmaceutical companies.

Other Accomplishments

- The grantee conducted cultural competency training for service providers during 1997.

- A new computerized information database was developed in 1997, with information on more than 600 providers statewide. The database is now available to consumers on the Internet as well as via a hotline through a cooperative effort with other CARE Act-, CDC-, and State-funded HIV-related programs.

- An ADAP Advisory Committee was formed in 1997 that includes four consumers and four physicians as well as a medical ethicist. The committee's recommendations are reviewed by the State Epidemiologist and the Commissioner of Health, in consultation with the Chief Financial Officer for the Department of Health, to establish if the recommendations are medically sound and financially feasible for the program.

- The grantee held two statewide training conferences for medical providers.

AIDS Drug Assistance Program (ADAP): Vermont

Funding History

Fiscal Year	1996	1997	1998	Total
Title II Funds	$118,529	$249,980	$312,234	$680,743
State Funds	$0	$200,000	$200,000	$400,000
Total	**$118,529**	**$449,980**	**$512,234**	**$1,080,743**

Program

- Administrative Agency: Dept. of Health
- Formulary: 40 drugs, 4 protease inhibitors, 8 other antiretroviral drugs.
- Medical Eligibility
  - HIV Infected: Yes
  - CD4 Count: No
- Financial Eligibility
- Asset Limit: No
- Annual Income Cap: No
- Co-payment: No
- PLWH involvement in advisory capacity: A subcommittee comprised of physicians, PLWH, and a medical ethicist makes recommendations on the formulary to the program's Advisory Committee.
- Enrollment cap: No
- Waiting list as of 10/98: No
- Waiting list for protease inhibitors as of 10/98: No

Clients Served

Clients enrolled, 10/98:	125
Number using ADAP each month:	90
Percent of clients on protease inhibitors:	90%
Percent of active clients below 200% FPL:	100%

Client Profile, FY 1996

Men:	100%
Women:	0%

<13 years old:	0%
13-19 years old:	0%
20+ years old:	100%

White:	100%
African American:	0%
Hispanic:	0%
Asian/Pacific Islander:	0%
Native American/Alaskan Native:	0%
Other, unknown or not reported:	0%

Title III: Vermont

Funding History

Fiscal Year	1996	1997	1998	Total
Number of Programs Funded in State	0	0	1	
Total Title III Funding in State	$0	$0	$250,310	$250,310

Accomplishments

- **Improved Patient Access**

- The four Comprehensive Care Clinics of Fletcher Allen Health Care, which are the only HIV specialty clinics in the State, provide complete medical care for PLWH. Between 1993 and 1996, the number of clients served increased by 19%. In 1998, Fletcher Allen Health Care was awarded a Title III grant to establish an early intervention program.

Title III Grantees, FY 1998

Grantee Name	Location	Service Area	Type of Organization
Fletcher Allen Health Care	Burlington	Statewide	Hospital/University-based Medical Center

Special Programs of National Significance (SPNS): Vermont

Funding History

Fiscal Year	1996	1997	1998	Total
Number of programs funded	1	1	1	
Total SPNS Funding in State	$434,652	$431,720	$89,977	$956,349

Project Descriptions

▸ **University of Vermont**
Location: Burlington
Project period: 10/94 - 9/99
Population Served: HIV-infected individuals
Description of Services: The Rural HIV project establishes a model for expanding and improving HIV service delivery in Vermont's rural areas. Prior to this effort, HIV-positive persons from remote parts of the state often had to travel several hours over mountain roads to access specialty care. Because nearly half the clients in this population have an AIDS diagnosis by the time they receive care, increasing their access to services is a high priority. The University of Vermont project established three state-of-the-art HIV clinics throughout the state to improve access to comprehensive medical care and psychosocial services. The project model also includes an education component to improve knowledge of HIV care among local health care providers.

Project Highlights

- The project established three rural HIV specialty clinics in regional hospitals in Rutland, Brattleboro, and St. Johnsbury, each staffed with an HIV/AIDS specialist, nurse practitioners trained in HIV care, a hospital social worker, and regional AIDS Service Organization representatives.

- The clinics provided services to 114 HIV-positive clients, almost half of whom had AIDS at the time of their initial visit. The clinics performed 460 follow-up visits.

- Satellite sites have had a significant impact on two fronts, dramatically decreasing clients' travel time and increasing the likelihood of PLWH pursuing care. Previously, 50% of clients reported having to drive more than an hour to reach a clinic, and 55% said travel time was a major barrier to their seeking treatment. Now, 85% live within 30 minutes of a clinic.

- The project strengthened Vermont's provider base by initiating an HIV/AIDS training program for local primary care doctors.

AIDS Education and Training Centers: Vermont

- New England AETC
- States Served: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
- Primary Grantee: New England AETC, Brookline, MA
- Subcontractors in State: University Health Center - Burlington
  Vermont HIV/AIDS Care Consortium - Burlington

Funding History

Year	1996	1997	1998	Total
Total AETC Funding for State	$31,000	$24,531	$31,000	$86,531

Training Highlights from FY 1997

- To provide information on PHS treatment guidelines, the AETC offered sessions designed to address the diverse training needs of health care providers, depending upon their clinical settings. Offered in one-, two-, or three-hour modules, program sessions were held at community health centers, regional meetings or professional provider associations, at in-service or grand rounds sessions, and as training programs open to all interested providers.

- To help providers understand that challenges of treating individuals with a dual diagnosis of HIV and addiction, the AETC developed a comprehensive two-day course. The curriculum featured the full scope of patient-clinician interactions and the course included lecture presentations, case discussions, and roundtable and panel discussions featuring people living with HIV

- "HIV/AIDS Updates and Case Discussion: A Program for Community Health Center Providers" is a monthly series that brings together a variety of clinicians experienced in HIV care and treatment issues from sites throughout the Boston area. Each month's session features an expert who presents a topic relevant to HIV/AIDS care, treatment and research. Participants are invited to bring cases from their own practices, which are then discussed by participants.

- To highlight the needs of women living with, or at-risk of, HIV disease and the challenges faced by their providers, the AETC developed a three-hour program titled "Women, HIV, and Reproductive Care." The goals of the program include: to describe current knowledge of HIV transmission and treatment; to identify the medical, social and emotional issues faced by women with HIV; to demonstrate skills for incorporating counseling patients about reproductive decision-making, HIV disease, and HIV testing into the providers' clinical settings; and to identify strategies to provide effective counseling and testing for women while considering cultural health practices, beliefs, and linguistic differences.

- The AETC developed an interactive program that allows participants to examine new and emerging therapies. "HIV Resistance, Treatment Sequencing, and Adherence Issues: A Roundtable Forum" features multidisciplinary, participatory roundtable discussions in which participants examine clinical case scenarios and propose treatment options in an informal group setting. The three-hour program begins with a presentation that is followed by roundtable discussions. Each roundtable is facilitated by a clinician. Participants are assigned to tables so that in each discussion a variety of disciplines are represented.

- The "Nurse Practitioner/Nurse Practitioner Student Clinical Site Training" is a clinical training program that has offered up to 98 hours of clinical experience over 13 weeks to students in a practice that focuses solely on HIV disease. The clinical practicum takes place at the clinic and during home visits, providing an opportunity for participants to experience a full spectrum of HIV-related treatment and care strategies and interventions

Office of HIV/AIDS Policy

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Fax. (202) 690-6584
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TO: Sandy

FAX:

FROM: Deborah von Zinkernagel
Deputy Director

(This fax contains _____ page(s) + cover)

Per M. Richard -

Here's some stuff you can draw from.

XOXOX to you -

Deb

If there are any problems with this transmission, please call Terrie Alvarez at (202) 690-5560

I. OVERVIEW

The mission of the Department of Health and Human Services is to enhance the health and well-being of Americans by providing for effective health and human services and by fostering strong, sustained advances in the sciences underlying medicine, public health and social services. In keeping with this mission, the Department has played a leadership role in combating the HIV/AIDS epidemic through research and Federally funded health care and preventive health services. Over the first two decades of experience with the HIV/AIDS epidemic, major advances have occurred, and new challenges have arisen, in the arenas of research, HIV prevention and delivery of care. This Framework provides a brief overview of the US HIV/AIDS epidemic in the year 2000, and provides a set of broad goals and principles to guide the Department's response to HIV/AIDS over the next several years. Specific and measurable goals and objectives congruent with these overarching goals and principles have been developed within the Department's agencies, and these are provided as an Appendix to the Framework. These are consistent with the Core Values set forward in the Departmental Strategic Plan.

Introduction

Over 734,000 cases of the acquired immunodeficiency syndrome (AIDS) have been reported in the United States since the time this disease was first recognized and reported in 1981. There have been over 430,000 deaths due to infection with the human immunodeficiency virus (HIV) which causes AIDS, and approximately 800,000 - 900,000 persons are living with HIV/AIDS in the United States. Worldwide, the HIV/AIDS epidemic has been characterized by explosive growth, particularly in the nations of sub-Saharan Africa and of Southeast Asia, with an estimated 34.3 million persons living with HIV/AIDS.

Since the earliest days of the HIV epidemic, the response of Federal, State and local public health systems in the U.S. has centered on conducting basic and clinical research to understand the biology of HIV, develop effective therapies, and design prevention interventions; conducting accurate surveillance of the magnitude and characteristics of this epidemic; defining and delivering prevention messages to reduce individual risk; and providing care and treatment to persons infected or affected by HIV/AIDS. These efforts have been implemented and enhanced through the development of community-based responses, stimulated both through public health mechanisms and within highly affected groups responding to the impact of the epidemic.

Over time, the demographic characteristics of the HIV epidemic have changed, as has the natural history of HIV infection among persons receiving appropriate treatment. HIV/AIDS in the developed world has been transformed from a rapidly fatal infection diagnosed at a late stage of disease to a chronic progressive illness that affords many years of productive life under complex treatment regimens. Public health efforts to address the HIV/AIDS epidemic have been effective in reducing morbidity and mortality associated with AIDS, but an estimated 40,000 new HIV infections continue to take place annually in the United States. These new infections occur

disproportionately among racial and ethnic populations, and among marginalized or low income groups that are not embraced within traditional systems of health care and prevention services.

Over the span of two decades, important lessons have been learned that are central to an effective response to HIV/AIDS. This knowledge provides the foundation for a strategic Framework to guide a sound public health response to curtail the HIV/AIDS epidemic in this country. This conceptual approach is grounded in the importance of understanding the dynamics of risk and social factors that increase vulnerability to acquiring HIV, and on an appreciation of the range and quality of health care services that are needed to assist persons living with HIV disease to enter and remain in appropriate care. Other factors central to this Framework for overcoming the HIV epidemic are continued progress in research, including the development of prevention interventions, such as vaccines and topical microbicides; therapeutic research to develop drugs and drug regimens that are more effective, less toxic, cheaper, and easier to use; and behavioral research to continually inform effective prevention strategies. These elements, when combined and implemented in a coordinated plan of action, offer a real hope for reducing the number of new HIV infections in this country and ending the enormous toll of suffering this epidemic has imposed on individuals and communities across the nation.

HHS Strategic Framework

The Department of Health and Human Services has developed this *Framework for Enhancing the HHS Response to HIV/AIDS in the United States* to inform the national public health response to the HIV/AIDS epidemic over the next several years. The Framework provides a broad overview of the HIV/AIDS epidemic in the USA, and anchors prospective federal HIV prevention, treatment and research efforts within the context of lessons learned over the past two decades. The overarching goal of the Framework is to effectively position the Department's programs ahead of the moving edge of the epidemic (among populations where new infections are occurring) with appropriate prevention and care and treatment services that curtail its expansion in the population.

To guide the Department's response, the Framework puts forward a set of overarching principles that are translated into specific goals and objectives defined at the level of individual agencies within the Department. Accountability for progress on specific objectives can be tracked through the strategic planning processes at both the agency and Department level. The efforts at the Federal level represent only a portion of the nation's overall response to HIV, as these are complemented and enhanced by efforts at the State and local level and within the private sector.

The Department recognizes the staggering impact of the AIDS pandemic on countries and communities around the world and is an active partner in supporting research, prevention, care and treatment initiatives to address it. Nonetheless, this Framework is specifically focused on the epidemic in the U.S. and does not fully reflect additional efforts undertaken within the Department to respond to the global HIV/AIDS pandemic beyond the borders of the United States.

Role of Specific Agencies

Within the Department of Health and Human Services, individual agencies play a leadership role within specific areas of programmatic expertise: HIV prevention activities (Centers for Disease Control and Prevention); HIV-related health care services (Health Services and Resources Administration); prevention and treatment of substance abuse and mental health disorders (Substance Abuse and Mental Health Services Administration); biomedical and behavioral research, including prevention and therapeutic research (National Institutes of Health); and licensing and regulation of therapeutics and devices (the Food and Drug Administration). In addition, the Health Care Financing Administration supports a continuum of HIV prevention and health care services for individuals enrolled in the Medicaid and Medicare programs, and the Indian Health Service supports all health care services for Native Americans. Each of the Department's agencies with defined areas of programmatic responsibility for HIV/AIDS (i.e. CDC, HRSA, NIH, SAMHSA and HCFA) has developed a strategic plan with goals and measurable objectives pertinent to HIV/AIDS consistent with that agency's mission. These are provided in the Appendix.

Other agencies and Offices within the Department also play an important role in the overall response to HIV/AIDS. The work of the Food and Drug Administration (FDA) is inclusive of many important review and oversight functions related to drugs, biologics and medical devices for the prevention and treatment of HIV/AIDS and related conditions. The Agency for Healthcare Research and Quality (AHRQ) has supported numerous studies of the impact of HIV disease on the cost, quality, and access to care of persons with HIV disease. AHRQ sponsors HIV/AIDS research and quality of care initiatives in multiple areas, as well as ongoing data collection on health services cost and utilization. The Indian Health Service (IHS) works in partnership with Tribal Governments to provide health care and social services to American Indian and Alaska Native people. These services include HIV prevention, education and care and treatment. Additional information on the HIV/AIDS activities of these agencies is also provided in the Appendix. Other programs supported through the Administration on Aging (AoA) and the Administration for Children and Families (ACF) also serve populations affected by HIV/AIDS and provide additional opportunities to promote HIV prevention and linkages to health care. Finally, the Office of Civil Rights (OCR) has an important role in addressing issues of discrimination as these affect the ability of individuals to access and receive appropriate services related to HIV/AIDS.

Coordination of Effort

Coordination of activities across major areas of program focus is vital to utilizing limited resources effectively and achieving mutually held or interdependent goals. As an example, years of experience in addressing the HIV/AIDS epidemic has illustrated the interrelated nature, and overlapping domains, of HIV prevention and care. Prevention efforts include primary prevention of HIV infection, as well as lifelong risk reduction among persons receiving care and treatment for HIV disease. Appropriate treatment of HIV disease with antiretroviral agents that

lower viral load, treatment of other sexually transmitted diseases, and the regular provision of messages supporting behavioral risk reduction by a trusted provider, enhance HIV prevention efforts. Both HIV prevention and treatment efforts must be tightly integrated with programs addressing addictions in order to serve populations with substance abuse disorders. The need for coordination also extends to translating research advances in prevention and therapeutic interventions into HIV prevention and care/treatment programs. The Framework highlights the essential role that inter-agency coordination must play as part of a comprehensive national response, and identifies mechanisms to achieve this coordination.

Other Federal HIV/AIDS Planning Efforts

The Department of Health and Human Services has established a number of prevention goals to improve the health of the U.S. population, as put forward in *Healthy People 2010 Objectives for Improving Health*. These objectives reflect a broad spectrum of professional and consumer input. Specific objectives related to the goal of HIV prevention are included in *Healthy People 2010* as part of a national goal to prevent new HIV infections and reduce related mortality and morbidity. This Framework incorporates and builds on these prevention objectives, as the objectives and the research informing them are also reflected in the strategic plans of agencies provided in the Appendix.

Agencies within the Department of Health and Human Services have conducted independent planning processes in the course of developing strategic plans of action. Most of the agencies within the Public Health Service have developed in depth strategies to address HIV/AIDS, and have incorporated processes to include expert and consumer input into the development of appropriate goals, objectives, and strategies by which to meet these.

The National Institutes of Health (NIH) is Congressionally mandated to develop an agency-wide plan for HIV-related research. The Office of AIDS Research at the NIH uses a consensus development model with representation from experts within and external to Government including experts from academic, foundations, industry, and community representatives. In addition, in 1996, the NIH initiated an extensive review of its entire AIDS research program to identify new research priorities and directions.

The Federal Biomedical Research Plan and Budget for HIV and AIDS At the request of the President, the Office of AIDS Research at the NIH coordinated a government-wide AIDS research plan. (NIH - please provide year of report)

The Substance Abuse and Mental Health Services Administration (SAMHSA) completed an HIV Strategic Plan in May 2000, capping a 2 year process involving consultation with a broad range of national organizations and State agencies, and public meetings on substance abuse, mental health and HIV/AIDS issues.

The Centers for Disease Control and Prevention (CDC) is currently finalizing a CDC strategic plan for HIV prevention. The planning process has involved a broad spectrum of national and local organizations, representatives from State and local health departments, expert providers and consumers.

The Health Resources and Services Administration (HRSA) prepared a HRSA-wide strategic plan in 1997 encompassing objectives for HIV/AIDS services under broad health care goals. The HIV/AIDS Bureau within HRSA is in the process of developing a strategic plan for HIV/AIDS care for Fiscal Years 2002-2005, with an expected completion date of Fall 2000.

White House Office of National AIDS Policy In 1997, the Office of National AIDS Policy released the White House HIV/AIDS Strategy paper. This document reviewed the record of accomplishment and future opportunities for progress in five broad areas: prevention, care and services, international activities, civil rights, and translating research advances into practice.

II. TRENDS IN THE HIV/AIDS EPIDEMIC

EPIDEMIOLOGY

HIV/AIDS remains a significant cause of illness, disability, and death in the US despite recent advances in effective treatments and prevention interventions. Since the epidemic was first defined in 1981, there have been over 733,000 cases of AIDS, and more than 430,000 deaths, reported to the Centers for Disease Control and Prevention (CDC). In 1999, 46,400 cases of AIDS, and 21,419 cases of HIV infection (not yet advanced to AIDS), were newly reported to the CDC. Overall, the estimated number of new HIV infections occurring annually has been stable at approximately 40,000 for several years.

Despite stable incidence, the prevalence of HIV/AIDS continues to rise, as more people are living longer with the disease. Improvement in treatment of HIV/AIDS, including new antiretroviral therapies, has resulted in fewer deaths from AIDS since 1996. In 1998, there were 16,432 reported deaths due to AIDS, compared with 49,677 deaths in 1994. A reported 299,944 persons with AIDS, and 113,167 with HIV disease, were living in the US at the end of 1999.

The AIDS epidemic in the US is composed of multiple diverse subepidemics that vary by region and community. Trends in gender, race/ethnicity, age, and exposure risk categories have had a major impact on planning for the delivery of HIV prevention and care. Summary statistics presented below provide a context for a national response to HIV/AIDS, but successful prevention and care services must be tailored to the demographic trends and needs of local communities.

Race and Gender

The demographic characteristics of HIV/AIDS epidemic in the US have shifted significantly since the early 1980's, when the disease emerged most prominently within communities of white gay men. The proportion of new AIDS cases reported among women ≥ age 13 years has risen from 7% in 1985 to 23% of new cases in 1999. An even greater proportion of newly reported HIV infections (32%) were among women in 1999, in those States with confidential HIV infection reporting. Women who acquire HIV through heterosexual transmission are one of the fastest growing segments of the AIDS population.

The disproportionate impact of HIV/AIDS on racial and ethnic communities has been steadily increasing. In 1999, Whites represented 32% of newly reported AIDS cases, and 44% of cumulative AIDS cases. [**INSERT**: By comparison, one decade ago, in 1990, Whites accounted for XXX% of AIDS cases.] In 1999, African Americans accounted for 47% of new AIDS cases, and 37% of cumulative AIDS cases, although they comprise only 12% of the US population. Persons of Hispanic origin represented 19% of new AIDS cases in 1999, and 18% of cumulative AIDS cases. Persons of Asian/Pacific Islander descent, and of American Indian/Native American heritage, have consistently accounted for 0.8% and 0.3% of reported AIDS cases, respectively.

A diagnosis of AIDS comes during the latter stages of HIV disease, and is indicative that an individual has lived on average 8 - 10 years with HIV infection. A more timely snapshot of the dynamics of the epidemic can be gained from data on HIV infections, in terms of populations who have more recently seroconverted, and who also require health care for their HIV disease. Recent estimates of new infections by the CDC indicate 55% of new HIV infections are among African Americans and 20% are among Hispanics, resulting in three quarters of all new infections occurring within racial/ethnic minority populations. These data have important implications for targeting HIV prevention efforts and developing adequate capacity for services in heavily impacted communities.

The racial disparities in HIV/AIDS are even greater when gender is considered. African American women account for 67% of all reported HIV infections, and 57% of cumulative AIDS cases, among women. Women of Hispanic descent represent 20% of cumulative AIDS cases. Although African American and Hispanic women comprise only one quarter of the female population in the US, they make up three quarters of all the AIDS cases among women. Three out of every five women diagnosed with AIDS in 1998 were African American, and one of every five was Hispanic. AIDS was the second leading cause of death among African American women between the ages of 25 - 44 in 1997 (update this). There are also prominent racial disparities in patterns of HIV/AIDS among men. In 1999, 43% of new AIDS cases were among African Americans and 19% were among Hispanics. HIV/AIDS has been the leading cause of death among African American men between the ages of 25 - 44 since XXXX.

Exposure Groups/Transmission Categories

The design of effective prevention strategies relies on an understanding of the nature of risk, and the social and biological contexts in which persons are exposed to, and become infected with, HIV. For many years, the AIDS epidemic in the US was predominantly recognized among men who had unprotected sex with men. The association with substance abuse, particularly injection drug use and cocaine preparations, became prominent in the 1990's along with rising numbers of HIV infections acquired through heterosexual contact. Substance abuse, including the use of alcohol and non-injection drugs as well as injection drugs, now plays a critical/central role in the expansion of the HIV epidemic. There are substantial differences within HIV exposure categories across racial and ethnic groups and within age groups, requiring different prevention strategies to reach individuals at risk.

Men ***The predominant risk factor for HIV/AIDS among men is unprotected sex with other men*** (56% of cumulative AIDS cases are attributed to this risk behavior). More recent figures for 1999 identify a lower proportion of new AIDS cases (44%) and new HIV infections (40%) as due to male-male sex. There is significant variation among racial and ethnic groups, as 75% of cumulative AIDS cases among White men are attributed to male-male sex, with lower proportions among Hispanic (43%) and African American (38%) men. Men of color represented 45% of new infections among gay and bisexual men in 1998. Recent reports have indicated an increase in high risk behaviors among young gay men, which has important implications for sustained and targeted prevention strategies. (Request CDC assistance with most appropriate data here.)

Exposure to HIV through injection drug use practices accounts for 22% of cumulative AIDS cases among men, but higher percentages of African Americans (34%) and Hispanics (36%) have contracted HIV directly through this mode of transmission. Recent data suggest that, particularly in the urban Northeast, injection drug use may have peaked and stabilized at a high rate.

There has been an increase in the number of men acquiring HIV/AIDS through heterosexual transmission, rising from 4% of cumulative AIDS cases to 8% of new AIDS cases in 1999. This trend is most evident among African American men, where 12% of new AIDS cases, and 13% of new HIV infections, in 1999 were attributed to unprotected heterosexual contact. The impact of HIV/AIDS acquired through transfusion of blood components or tissue donation primarily occurred prior to widespread screening of the blood supply, accounting for 2% of cumulative AIDS cases among men.

Women ***The HIV/AIDS epidemic among women has been predominantly due to injection drug use practices and unprotected heterosexual contact.*** Forty two percent of cumulative AIDS cases are attributable to injection drug use, and 40% to heterosexual contact, among women. Heterosexual contact is identified more frequently among women of Hispanic (47%) and Asian/Pacific Islander (49%) heritage as the mode of transmission among cumulative AIDS cases. There are critical differences within the category of heterosexual exposure with implications for HIV prevention strategies for women. Heterosexual exposure may result from sex with a current

or former user of injection drugs, sex with a bisexual male, or in many cases, a sex with a male for whom the HIV risk has not been identified. The role of other non-injection drugs, such as alcohol and cocaine, may also influence behaviors that increase an individual's risk of infection, but these are not captured within the category of injection drug use.

Age

Up to half of all HIV infections are estimated to occur among persons 25 years of age or younger. While 10% of cumulative AIDS cases have been diagnosed among persons ≥ 50 years of age, the majority of HIV infections continue to occur during adolescence and early adulthood. (Request CDC/NIH assistance characterizing unique risks and vulnerabilities /developmental stages common within this age group...) HIV is a particular threat among those already coping with multiple other major issues and stressors, such as homeless and runaway youth, youth who are the victims of abuse, and sexual minority youth.

HIV/AIDS Among Children Over the course of the epidemic, there have been dramatic changes in the impact of HIV/AIDS on children. To date, a total of 8,718 AIDS cases and 2,026 cases of HIV infection have been reported among children under 13 years of age. Over 75% of these have occurred under 5 years of age, and over 90% are the result of transmission from an infected mother to her infant. These children are disproportionately of African American and Hispanic background, mirroriing the patterns of HIV infection among women. One of the most significant research findings demonstrated that mother to child transmission of HIV could be substantially reduced through the administration of antiviral therapy to a mother and newborn. This finding has resulted in a 75% decline in HIV transmission from mother to child between 1992 and 1998, with fewer children identified each year. In 1999, there were only 263 newly reported pediatric cases of AIDS. Development and wide implementation of Public Health Service guidelines for HIV counseling, testing, and treatment with antivirals has greatly assisted in this reduction. Enhanced efforts to enter pregnant women in prenatal care, and additional research to identify alternate therapeutic regimens and methods to reduce perinatal transmission, are expected to further reduce the number of children born with HIV.

Geography

HIV/AIDS remains primarily an epidemic of urban areas, with over 80% of cumulative and new AIDS cases reported within metropolitan areas of ≥ 500,000 population. Ten percent of AIDS cases are reported in metropolitan areas with a population 50,000 ≤ 500,000, and roughly 6% reported from non-metropolitan areas. The initial epicenters of AIDS in the States of New York, California, and Florida continue to be highly impacted, but the epidemic has spread throughout the country particularly among states in the Northeast, South, and Southwest. In 1998, people living in the South accounted for 38% of AIDS cases, 31% were living in the Northeast and 21% in the West. The impact of HIV/AIDS on rural areas is often disproportionate to the actual number of cases, as these areas have limited health care infrastructure and services to address the needs of people living with HIV disease.

Registration Form

Breaking Down Barriers to Work:
HIV/AIDS and Employment

Name: _____

Agency: _____

Address: _____

_____

_____

Phone: _____

E-mail: _____

☐ Check here for a Vegetarian Meal.

☐ Describe any Special Needs:

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To accommodate any special needs, please let us know by August 15th.

Workshop Selections *(for planning purposes only):* AM _____ PM _____

Registration Fee: $30.00/$40.00 on site

Fee includes materials, continental breakfast and lunch.

Make check payable to: Vt. Dept. of Health. Send to: Lori Yarrow, Div. of Voc. Rehab., 103 So. Main Street, Waterbury, VT 05671

Due to space limitations, conference will be limited to 150 people. As long as space is available, consumers will be free. For confidential registration, contact Rob Larabee at 802-777-0235.

For more information, call: 802-651-1534, or 800-244-7639, TTY: 800-319-3141.

Please return by August 15th.

Conference Planning Committee

George Collier, University Affiliated Program of Vermont, University of Vermont
Lawrence Garrett, Vermont Department of Health, AIDS Program
Stacey Joroff, Esq., Disability Law Project, Vermont Legal Aid
Rob Larabee, Vermont People with AIDS Coalition
Carol Leech, Division of Vocational Rehabilitation
Samuel Lurie, Vermont AIDS Education and Training Center and Dept. of Health AIDS Program
MaryAlice Mowry, Vermont Work Incentive Initiative, Vocational Rehabilitation
Sally Redpath, Vermont Occupational Information Coordinating Committee, Department of Employment & Training
Lori Yarrow, Division of Vocational Rehabilitation
Kevin Veller, Office of U.S. Senator James Jeffords
Greg Voorheis, *(Chair)*, Department of Employment & Training
Lee Works, PhD., Vermont People with AIDS Coalition

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HIV AIDS
Returning to Work

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A Conference for:

- *Vocational Counselors*
- *Case Managers*
- *Advocates*
- *Employment Specialists*
- *Health Care Providers*
- *Social Security Representatives*
- *Consumers*
- *Employers*

Friday, August 25, 2000
Capitol Plaza Conference Center
Montpelier, Vermont

Hosted by:
Senator James Jeffords

Keynote Speaker

Sandra Thurman, Director of White House Office of AIDS Policy

"As we see more Americans living with AIDS, there is every reason to believe that we will continue to see more people staying in the workplace, getting into the workplace, or returning to the workforce. The discussions we have in Vermont will play a vitally important role in our ability to address these challenges on behalf of individuals, families, workers and all those living with HIV and AIDS across the country."

Reception - Thursday, August 24th

at the Radisson Hotel, Battery Street, Burlington, Vermont

Join us for a free reception with Sandra Thurman, Senator Jim Jeffords and others in the HIV/AIDS Community.

4:00 p.m.	Press Conference
5:00 - 7:00 p.m.	Reception *(Open to Public)*

Schedule - Fri., Aug. 25, Montpelier

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Workshops - *(Each workshop will run twice, once in the morning and again in the afternoon)*

A: Benefits and Insurance: Issues to Consider in Returning to Work

***Barbara W. Prine**, Esq., Staff Attorney, Disability Law Project; **MaryAlice Mowry**, Vermont Work Incentive Initiative, Division of Vocational Rehabilitation*

People considering returning to work who have been on disability have alot to consider. What are the trade-offs, what entitlements are lost or gained, is it worth it? Many questions need to be addressed and considered by each individual. This workshop will look at issues specific to Vermont and help familiarize participants with entitlement programs.

B: Accommodations: Employer and Employee Responsibilities

***Eileen Blackwood**, Esq., Attorney in private practice in Burlington*

The Americans with Disabilities Act requires that employers provide reasonable accommodations to its employees. Individuals with HIV/AIDS are covered by the ADA. This workshop will outline the legal obligations of employers and employees and provide information on employers' responsibilities to provide the accommodations. Examples will be presented.

C: Confidentiality, Disclosure and Privacy Issues in the Workplace Setting

***Jon Argenziano**, Esq., HIV/Drug Assistance and Health Insurance Initiative, Community Research Initiative, Brookline, MA*

Confidentiality issues for people with HIV/AIDS are extremely important and unique. This workshop will address laws, policies, and practical concerns regarding confidentiality, for both the consumer and the professional. Policies for employees' files and benefits information will also be discussed and case studies presented.

D: New Treatment, New Issues: Basic HIV Transmission, Therapy and Care

***Christopher Grace**, MD, Director, Comprehensive Care Clinic, Fletcher Allen Health Care, Associate Professor of Medicine, University of Vermont College of Medicine*

The HIV epidemic has changed dramatically over the past few years with the rapid improvement of medical care and treatment. These new therapeutics have changed the practice of HIV care as well as the prognosis for people living with the virus. How do these new medications work and what effects do they have on the quality of life, medical care, and work for people living with HIV?

E: Being the Right Resource: Vocational Counseling and Preparing People to Return to Work

***Jonathan Leite**, Career Counselor with Boston Career Link, Boston, Massachusetts*

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F: Employer Requirements, Supports and Resources

***Greg Voorheis**, Special Assistant to the Commissioner of the Department of Employment & Training; **Gary Barto**, Condominium Rental Manager for Killington, LTD, a person successfully managing a life with AIDS; **Deborah Lisi-Baker**, Executive Director, Vermont Center for Independent Living*

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Vermont AIDS Education and Training Center
Vermont PWA Coalition
Comprehensive Care Clinic, Fletcher Allen Health Care

State of Vermont:
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Dept. of Employment & Training/USDOL
Division of Vocational Rehabilitation
Vermont Occupational Information Coordinating Committee

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RECEPTION SPONSORS

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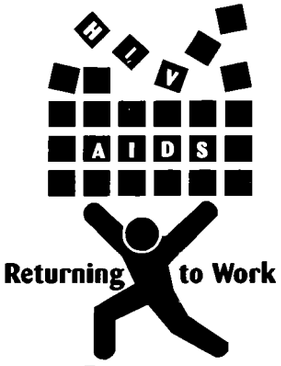

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