Idaho Advisory Council on HIV and AIDS

Meeting Report

February 22, 23 & 25, 2012

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Thursday, February 23rd Presentations

IACHA members gathered for a special meeting Thursday evening, February 23, to receive and discuss key data reports in preparation for Friday's (February 24) Breakout Group Work (Consumer Perspective, Provider Prospective, Service Gaps and IDU Survey). Reports reviewed were extensive and included the following:

1. 2012 PLWH/A In Care Data
2. 2011 HIV Quality Management Data Results
3. 2012 HIV Providers Survey Results
4. 2012 Idaho Priority Populations Report
5. Statewide Income Eligibility for Various Programs Report Based Upon 2011 Federal Poverty Levels
6. 2010 Epi Profile Tables

IACHA Regular Meeting, Friday, February 24-25

IACHA members met Friday and Saturday according to the regular schedule.

Opening Remarks and Introductions

Chris Bidiman and Bebe Thompson, Co-Chairs of IACHA, opened the meeting with a welcome to all members and guests. Members introduced themselves. Facilitator, Sherry Dyer overviewed the agenda and the meeting process.

The annual disclosure process was reviewed which requires members to identify agencies they are associated with that may have vested interests in the outcomes of the decision-making processes of IACHA. Statements were completed by members and submitted to Lynsey.

YRBS Update (Youth Risk Behavior Survey) – Department of Education

Lisa Kramer presented an overview of the 2011 Idaho Youth Risk Behavior Survey. This information is collected biannually for grades 9 through 12. It is a random survey of 1500 students statewide.

This was the first year that the questions related to condom use and "sexting" were included in the survey. Generally, the data was consistent with previous trends. Marijuana use was the only area that took a significant jump from last year. This could be that it was easier information to get due to fewer stigmas about marijuana as it is used nationally for medical use. The data on Unintentional Injury, especially suicide, is the only area we see Idaho higher than national data. The National YRBS has 88 standard questions; Idaho is able to add additional questions that are unique to Idaho.

HIV Prevention Report

Rebecca Schliep and Rafe Hewett presented reports about Comprehensive Plan HIV Prevention Programs Grant Funding and about CDC's Technical Review Recommendations and the Department's Response.

Please Note: The details of these reports have been posted of the MSG website. Following are a few summary statements:

The focus of the five-year funding opportunity for HIV Prevention is on reducing new infections, increasing access to care, improving health outcomes for people living with HIV and promoting health equity.

Idaho's 2012 CDC Prevention grant award was $71,288 (8.65%) less than requested in the grant application. The state office budget was reduced by $38,237 (as a result, the state was not able to add a new position). Service provider contracts were reduced by $33,051.

The 2012 *Required* Funding Categories in the Comprehensive Plan include:

- HIV Testing
  - Clinic-Based HIV Counseling, Testing and Referral Services (CTRS)
  - Community-Based HIV Testing (increased the amount agencies can bill by an additional $10 per test)
- Comprehensive Prevention for HIV Positives
  - Partner Services (Epi Investigation Field Records) for the 7 district health departments increased from $150 to $195 from 2011 to 2012. Based on a formula involving things such as district size, incidence, etc., each district had an allotted number of epi field records that the State will pay for throughout the contract year. Each time they complete an epi field record (partner services on a positive case), they can then bill $195 per field record (or in other words - per partner service for positive person)
  - CRCS (HIV+ and high risk HIV-)
- Condom Distribution
- Policy Initiatives
  - HIV Prevention will work with the Department of Education (the state has not defined the initiatives at this time)
- Community Planning contract through Mountain State Group
- Capacity Building and Technical Assistance
  - Training contract through Judy Thorne, the NWAETC Coordinator
- Program planning, monitoring, evaluation, quality assurance, data collection and management, and reporting will be done at the state level through the State HIV Prevention Program

The 2012 *Recommended* Program Components include:

- Evidence-based HIV Prevention Interventions for HIV-negative persons at highest risk
  - Personalized Cognitive Counseling (PCC)
  - ¡Cuídate!
  - Mpowerment (the 2011 pilot with a.l.p.h.a. is funded through May 2012).
- Social Marketing, Media, Mobilization

IACHA membership discussed the options for submitting its letter to CDC's Division of HIV/AIDS Prevention regarding the HIV Prevention Application. Members agreed by consensus to submit a Letter of Concurrence with Reservations. Primary concerns related to the following:

- The shift of funds towards Care and the related impact on reducing funds in Idaho for Prevention
- The focus of testing in high prevalence areas will impact Idaho's ability to identify outbreaks in the rural areas
- Reduced funding limits for IACHA meetings and for member attendance at conferences
- The reduced funding for Health Communications/Public Information (HCPI)

Decision: A Letter of Concurrence with Reservations was developed by Chris Bidiman and Lynsey Winters Juel. It was presented to the membership for decision. By consensus, the membership approved the Letter of Concurrence with Reservations.

Ryan White Part B Report

Bebe Thompson reviewed concerns about theRyan white FY2012 funding levels for ADAP, which will be based upon the Emergency Relief Funding grant proposal. The state has not received guidance for the proposal and do not know when it will come out. They have submitted two requests for emergency funding. Currently, they are pulling money from 5-7 sources for ADAP. The ADAP waiting list has been reduced, which it good news. Bebe has presented a Concept Paper for technical assistance to help write the Health Insurance Continuation Program. It is currently with leadership in the review stage.

Perhaps a letter from IACHA would help. The letter would need to go to the Bureau Chief with a copy to the Director of Idaho Health and Welfare (Dick Armstrong).
Idaho would propose an option to pay premiums, co-pays and deductibles for insurance with ADAP funding. The discussion centered around the idea that using these funds to pay for this insurance are too close to Health care Reform. There is a larger political undercurrent going on regarding the National Health Care agenda.

Dr. Skye Blue made comments regarding the Affordable Care Act, the upcoming elections will advise what will happen with the Act. Any efforts for intervention between now and the election may not have value or impact.

Community Planning and the National HIV/AIDS Strategy

Erick Seelbach, HIV/AIDS Regional Resource Coordinator (AK, ID, OR, WA) of the US Department of Health and Human Services presented regarding aligning goals at the Regional/State level with the NHAS Vision.

The vision statement was framed in July 2010 and states*: The United States will become a place where new infections are rare and when they do occur, every person, regardless of age, gender identify, or socio-economic circumstances, will have unfettered access to high quality , life-extending care, free from stigma and discrimination.* At the National Level, the goals for HIV/AIDS are as follows:

1. Reduce new incidence of infection.
2. Increase Access to care – Optimize Health Outcome.
3. Reduce HIV-related Health Disparities

Achieving these goals will require increased coordination and decreased silos at all levels across the U.S. We are working to increase partnerships at the National, State and Community levels and to decrease stigma by ensuring people's voices are heard through public leadership.

Erick reviewed the HHS 12 City Demonstration Project involving cities with the greatest representative population of people living with HIV/AIDS. These 12 jurisdictions represent 44% of all AIDS cases. They are working together to develop a plan to address gaps and prevention strategies that have the biggest impact on reducing HIV incidence.

This 5-year Project is currently in the planning process and engages HRSA, SAMHSA, NIH, HIS, CMS along with other federal partners, to leverage departmental resources and assets to support coordinated planning and implementation of HIV prevention, care and treatment in these 12 jurisdictions. When this new approach is fully implemented, HIV prevention resources will closely match the geographic burden of HIV.

The CDC comprehensive HIV focus will be to broaden the group of partners and stakeholders engaged in prevention planning and targeting resources to those communities at the highest risk for HIV transmission and acquisition. The effort will enhance collaboration and coordination of HIV prevention, care and treatment.

Two questions were raised by IACHA members:

1. How does this strategy consider low-prevalence states?
2. Why are we not also looking at the healthy communities to understand their strategies?

It was agreed we need better coordination and more critical focus across all programs.

The question being asked of all states and all initiatives is: What would it take to greatly reduce the numbers of new HIV/STI/VH infections, to keep greater numbers of HIV positive people from development AIDS, and to support healthy lives for people living with HIV/VH/STI?

There is a new paradigm for HIV prevention with a focus on High Risk Negative People – who know their status, get into care, reduce transmission and increase suppression. Testing is to help people know their status so they can get into care. The focus on intervention is to increase testing to decrease transmission.

Principles of future work are to:

- Use data
- Understand the areas of greatest need – geography/communities
- Wider partner engagement
- Greater continuity across system
- Streamlining the approach

Regional Funding Picture – most recent data for people living with HIV/AIDS:

- Alaska 828 (as of 2008)
- Idaho 1254 (as of 2009)
- Oregon 5001 (as of 2009)
- Washington 10,842 (as of 2010)

More money will go into Care and less into Prevention – in support of the developing federal strategy of focusing High Risk. There will be more centralized planning, realignment of prevention services and a realignment of our thinking on what is the most effective thing to do. This will include leveraging connections and focusing on the best organizations/offices to do the work needed.

Work Group Tasks

The work groups were organized by into the following four focus

1. Consumer Perspective
2. Provider Perspective
3. Service Gaps
4. Update to the IDU assessment

Bebe Thompson provided the first three groups (all but the group focused on the IDU survey) with guidance to identify disparities in care, access to services and service gaps.

The results of each groups work will become a part of our Statewide Coordinated Statement of Need, which ultimately will be the Comprehensive Plan.

Group A Report (Consumer Perspective):

District	Needed & Did Not Receive	Needed & received	Average Rank	
1	1. Attend Support Group 2. Emergency Housing $ 3. Eye doctor 4. Food Voucher 5. HIV + Peer advocate	1. DX testing 2. $ for HIV drugs 3. Dr. or specialist 4. Dentist	1. HIV $ for ARV's 2. HIV medical care 3. MCM 4. Co-pays 5. DX and Lab $	Emergency Housing Support Groups
2	1. Emergency Housing $ 2. Apply for Medicaid 3. Apply for Medicare 4. Apply for Medicare drug plan 5. Apply private insurance, budgeting, utilities and Housing Assistance	1. DX testing 2. Dr. or specialist 3. HIV, MCM	No Response	
	1. Eye Doctor	1. DX Testing	1. Medical care	

3	2. Co-pays 3. Get Food	2. Dr. or specialist 3. HIV, MCM 4. Money for drugs	2. $ for ARV's 3. Co-pays 4. Labs	Eye Doctor
4	1. Eye Doctor 2. Dentist 3. Insurance premiums, utilities and housing (emergency)	1. DX testing 2. Dr or specialist 3. MCM	1. Medical Care 2. $ for ARV's 3. Mental Health 4. Housing/Utilites/Emergency Fund	
5	1. Eye doctor 2. Transport 3. Dentist	1. DX testing 2. Dr or specialist 3. $ for drugs	1. $ for ARV's 2. Medical Care 3. $ for medications	Dentist Eye Doctor Support groups
6	1. Dentist 2. Support Group	1. DX testing 2. Dr. or specialist 3. $ for drugs 4. MCM	1. Medical care 2. $ for ARV's 3. Other meds	• Provider availability barriers • Transportation barriers • Funding Eligibility barriers
7	1. Support Group 2. Eye Doctor 3. Applying for Medicare 4. Dentist	1. DX Testing 2. MCM 3. Doctor 4. $ for drugs	1. $ for ARV's 2. Medical Care 3. Other meds	

Discussion:

Barriers:

- Provider Availability
- Funding Eligibility
- Culturally Diverse Services
- Transportation
- HIV Stigma
- Hispanic Cultural Belief
- GLBTQI District 5
- Lack of (Substance abuse treatment) support
- Fear to engage??

Insufficient Access Points:

- Transportation
- Culturally Diverse Services

Capacity Development Need/Goals:

- Increasing Provider involvement through volunteer physicians Network in rural communities *AHEC Newsletter
- Increase Education to providers regarding HIV, GLBT, Hispanic, etc…

Group B Report Provider Perspective:

Group B referred to the National HIV/AIDS Strategy goals when reviewing the various documents. The goals are as follows:

1. Decrease new infections
2. Increase access to care
3. Decrease disparities

Gaps-

- Homeless Services
- Substance Abuse/ Addiction services
- Transportation
- Payment for Care services
- Number of primary care providers
- Assistance with Health Insurance premium/co-pay

Priority Services – Does not Address Geography

- Doctor Visits/labs
- HIV drug assistance
- MCM (Meets NHAS Goals #2 and #3)
- Transportation
- Mental Health

Providers Need:

- Community Resources
  - Addiction/Mental Health
  - MCM
  - Oral Health
- MCMs because MCMs provide the following:
  - connections to community for clients
  - Standardized training for all MCMs
- Reliable payer source
- Stable, affordable housing

Comprehensive Plan 3 yr: What do we want?

- Maintain HIV Drug Assistance (Meets NHAS Goals #1 & #3)
- Maintain, support, and train MCM (Meets NHAS Goals #1, #2 & #3)
  - Expand in underserved areas
  - Flexible billing opportunities.
- Shift resources and reallocate resources to MCM for the shrinking few (Meets NHAS Goals #1,#2, and #3) (Ensure that Medical is number 1)
- Better data (Meets NHAS Goals #1,#2 and #3)

5. Comprehensive Plan Needs

- Statewide Coordination of Services by Payors Available
  - Target/Identify priority services towards the areas that lack services or create the connections

6. Support MCM (Meets NHAS Goals #1,# 2, & #3)
   - Build capacity/relationships with community resources
   - Part B support of Resource Coordination (211 Careline)

Group C Report (Service Gaps/Unmet Needs)

	District	Hub	State
1	1. Peer group 2. Emergency Housing 3. Emergency Food 4. Peer advocate	1. Emergency Housing 2. Peer Group 3. Emergency Food 4. Peer advocates 5. Utility assistance	Provider • Transportation • Substance use/abuse • Homelessness • Lack of funding for core & support services • Lack of community partnership Source: Community Survey 1. Eye doctor 2. Dentist 3. Housing/Food/Utility 4. Support Group 5. Applying for Health insurance/SSI/Medicaid Note: Not present in survey but identified gap: • Cultural Competence • Language Services
2	1. Assistance applying 2. Emergency Housing 3. Utility assistance		
3	1. Eye doctor 2. Health insurance plan 3. Food	1. Eye doctor 2. Dentist 3. Utility assistance 4. Health Insurance premium 5. Food, Housing	
4	1. Eye Doctor 2. Dentist 3. Utility 4. Emergency Housing		
5	1. Eye doctor 2. Applying for meds/dis 3. Utilities 4. Transportation		
6	1. Dentist 2. Support groups 3. Housing 4. Utilities	1. Eye doctor 2. Support groups 3. Dentist 4. Apply SSI/Medicaid 5. Utility	
7	1. Support group 2. Eye doctor 3. Dentist 4. Applying for Medicaid		

Discussion: Goals

-Provider, consumer, funder partnerships to increase collaboration and communication
-Peer linkages, peer health and navigation for accessing services
Increase self-efficacy to lower cost of care
-Increase access to dental and eye care
-Increase access to basic needs: Food, utilities, clothing, shelter, etc…
-Language of understanding a collection of data, funding, education
-Revise surveys – clarify gaps provider and consumer synchronized
-TA: peer services in insurance environment guidance to reestablish peer support group

Group D Report:

Based on feedback from the work group, Rebecca developed several options. The members of the workgroup have been contacted and are discussing the following options.

Option 1: Needs assessment conducted via paper copy – participant required to mail in survey.

The response rate for mail in survey may only be 5 – 10%, the methodology for selecting participants is to work through substance abuse providers and asking them to hand the survey out to their clients. To get access to the providers, we would try to work through a contact at health and welfare's Substance Use Disorder program. The goal is to get surveys out to all parts of the state.

Option 2: Interview/focus groups - work with treatment providers to arrange a block of time to use a room on-site to conduct the survey either 1 on 1; or approach this as focus group if a large room is available (many treatment facilities have patients are doing things in groups anyway) and simply collect the survey as they finish. This may result in more completed surveys than the mail-in route but we would be limited to region 3 and 4.

Option 3: We could change the approach from a survey more qualitative approach where the emphasis is on gathering more details on types of drugs used, how sharing happens, and types of risk behaviors from 20-30 knowledgeable individuals via more open-ended interviews (on Q's in current survey) and then use this data later on to construct a survey to gain an idea of the prevalence of these mentioned behaviors in the large IDU population.

With all options, there will still be a contract with Closed Loop Marketing to have them approach the providers, hand out surveys or conduct focus group, collect responses, and analysis the responses and provide us with a report.

In addition, the members are discussing adding questions regarding the following topics:

- How people get clean syringes/injection equipment
- the level of difficulty encountered in obtaining them, and
- perceptions on the danger in carrying drug equipment on them (i.e., are police regularly stopping and searching people for paraphernalia)

2010 HIV Surveillance Update: Recent Data & New Testing Algorithms for Diagnosis

Jared Bartchi presented and discussed the 2010 data providing the following details:

2010 New Diagnoses:
21 HIV defining conditions
23 AIDS Cases

HIV/AIDS new diagnosis

2004-2005	67
2006-2007	68
2008-2009	100
2010	44

The outbreak in District 7 in 2008 caused numbers to be higher.

There has been no specific trend unique to a particular age group.

District 4 – has the highest percent because it has the highest population.

The Office of Epidemiology added a new transmission category (which is Idaho-specific , not CDC-required): "Presumed Heterosexual" as a mode of exposure. Presumed Heterosexual is selected only if all of the following criteria apply:

- Female only – who answer the survey
- Sex with male
- "No" drug use

Reporting is now done completely by electronic reporting which should improve our data. We have added a new algorithm for HIV diagnosis - 4 specific ways to diagnose.

Other changes identified by CDC

- HIV care definition – Stages 1-3 and unknown stage
- Expanded lab reporting all levels of VL and CD4 results will be reportable
- 2013 New grant cycle/funding format changes
- Death ascertainment (2012) matching electronically HIV/AIDS data with death certificate records
- Improved ability to provide more granular analysis – county level analysis

Details regarding the STD/HIV co-infection in 2010

- Most STDs were early syphilis – rising in Treasure Valley
- Mostly Treasure Valley
- All MSM or MSM/IDU
- Districts 3, 4 and 7

Syphilis:

- 13 early syphilis cases in 2011 (D3 and D4)
- 4 cases under study
- 8 HIV+ contacts in this group

Conference Report

Jesse Tellez attended the USCA Conference. Lynsey presented the report as submitted by Jesse.

- The USCA conference in Chicago was an awesome educational experience. The theme of this year's conference is "Make Change Real: Unite, Speak, Act" and the target population is gay and bisexual men.

- Some of the programs he participated included:
  1. Latino Institute: This program focused on how to identify successful, scalable and cost effective home grown prevention strategies for HIV/AIDS prevention in both the rural and urban Latino communities
  2. The AIDS institute: The goal of this program is to emphasize the importance of HIV testing and to pin point effective strategies to increase HIV testing. I learned that one of the main goals of the National HIV/AIDS strategy is to increase from 79 to 90 the percentage of people living with HIV who know their serostatus by 2015.
  3. Health HIV Institute: The discussion stressed the importance of the patients centered medical home (PCMH) model as the primary provider of HIV care. The core concepts of the PCMH model was reviewed and how to incorporate them into other primary provider services.
  4. Lunch Plenary: Gay men and HIV/AIDS. This was a sit down lunch in where many active HIV advocates spoke about what they are doing to bring attention to HIV/AIDS. Mondo Guerra, one of my favorite Project Runway contestants was one of the speakers. He and Jack Mackenroth has partnered with Merck to form a unique HIV education campaign "Living positive by design" to help people living HIV to have a positive outlook in life.

Administrative Updates

Lynsey Winters Juel overviewed several topics for the Administrative Update.

Communication Concerns: Lynsey raised her concerns that some people were not responding to email. She asked everyone to advise her of the best way to reach them and then to be sure to respond to her emails.

RPG Update: Lynsey reviewed the RPG Funds Report for each of the Districts requesting funds.

- District 1 received $350 for World AIDS Day events
- District 2 received $900 for World AIDS Day events
- District 4 received $1000 for its Regional Planning Group meetings and for World AIDS Day materials
- District 5 received $1000 for their June and August meetings
- District 6 received $875 for World AIDS Day events
- District 7 received $1500 for World AIDS Day presentations to roughly 350 students at 6 high school classes, a juvenile detention center, an alternative high school and a local university.

Conference Opportunities: Lynsey reminded members that there have been funding cuts that will affect the number of people who can attend conference. IACHA can send 1-2 people for 2012 conferences. The Administrative Committee will review applications to determine priorities.

Membership Survey Results: Lynsey presented information from the 2012 Membership Survey that provides demographics to help ensure IACHA membership represents the demographics of

the State. Three members did not yet complete the survey. All Membership Objectives of IACHA received member agreement ranging from 87% to 100%

Overall Comprehensive Plan Goals
(based on Friday Committee Work & Reports)

The IACHA members brainstormed what would it take to attain the following:

- Decrease new infections
- Reduce number of people progressing to AIDS
- Increase access to care
- Reduce health disparities

Reduce HIV incidents

- Increased access to MCMs
- Maintain education public awareness of HIV epidemic (especially in rural Idaho).
- Maximize and fine tune existing programs (prevention interventions).
- Build capacity of providers: Dental and Vision
- Testing without connection to intervention.
- Include HIV/condom education in schools – include the indirect care environment (dentist, vision, etc.)
- Increase behavioral interventions.
- Reduce stigma to GLBTI: "Add the Words" – legislature.
- Develop a Public Speakers Bureau.
- Utilize social media, e-based media (You tube) "let's go viral."
- Maintain ADAP money/access to meds
- Ensure integration of viral Hep with HIV
- Increase peer navigation
- Focused HIV testing – social network, face-to-face, online network
- Advocate standardized form for patient assistance
- Help people establish health relationships

Increase Access to Care/Optimize outcomes

- Maintain Ryan White Part B dollars for people with intensive needs.
  - Transportation
- Educate providers on consumer needs
- Increase provider base
  - Dental
  - General
  - Vision
- Statewide access to MCM
- Educate/Advertise resource availability.
- Address stigma, homophobia and confidentiality among all provider staff.
- Increase money for partner services.
- Write to providers – utilize existing resources (Substance Abuse newsletter, AHEC)
  - Statewide
  - District specific
- Consumer/provider surveys – Align so we can better analyze.
- Housing focus = Adherence.

BIG Picture : Increase providers

Reducing HIV–related Health Disparities (Rural Idaho)

- Normalize HIV testing (reduce health disparity and reduce stigma)
- Real picture of living with HIV – increase motivation for living healthy
  - Speakers Bureau
- Late testers/diagnosis – Who are they?
  - Population groups
  - Review prioritized pops.
- Understand why people are testing late and develop strategies to reach them earlier.
  - Increase equal access

  Focus: Districts 2 and 5.
- Involve RPGs
- Connect/focus on minorities and refugees
- ID (D7) – white men
- Legislator Sponsor for "Gay Men's Health Act"

IACHA in the Future: Keeping up the Good Work

IACHA Members brainstormed what is needed for the future success and continuity of work (considering the shift of national funding)

Explore funding alternatives

- Walgreens (invite representatives to our meetings)
- Idaho-based companies

  INL – Micron – HP (Both "gay friendly")
- ADAP Rebate money.
- Universities (money resources)
  - ISU has rooms that are like a hotel.
- Educational Conferences
  - Could provide funding resources
- Elton John Grant
- Levi Strauss Grants
- Private Hospitals

Action Steps

1. Determine budget needs for the future
2. Evaluate RPGs
   - More money to fund their work and provide improved guidance to RPGs

   AND/OR
   - Less money to utilize for IACHA meetings
3. Form committee to take these ideas under review and develop/implement actions: Long term and Short term
4. Evaluate means to work in small groups/committees to reduce costs and eliminate need for 3rd meeting
5. The Administrative Committee and Finance Committee will review options

Membership Recruitment

1. Gaps in membership - Faith Based, Corrections, Criminal Justice, HIV+ and Hispanic.
2. Mercedes questioned why she was reflected as representing the General Population. Lynsey advised that since people have the opportunity to reflect 3 slots, the Membership Committee selected each person based upon gaps in the Matrix.
3. Slots- Members will have a chance to reevaluate the slot they fill each year. The Membership Committee will work with Lynsey to determine how to coordinate this process. The next review/reevaluation of the matrix will occur in early 2013
4. Recruitment- Jonny provided potential members for the following slots: faith, corrections, Hispanic. The Membership Committee will follow up with potential members.

Decision: the IACHA membership approved the 2012 Membership Matrix by Consensus

Quality Management Committee Update

The QM Committee met in February 2012 to discuss 2011 data results and quality improvement projects and to update the QM Plan for 2012. The Committee agreed that the In-Care Retention Goal had been met. Quality Improvement projects for 2012 include increasing medical visits rates, increasing recertification rates, track clients who do not have medical appointments during the measurement period.

Meeting Evaluations

1. On a scale of 1 – 5 with five being the highest score, how do you rate this meeting?

   1 **2** **3** **4 (6)** **5 (7)**

2. According to the CDC Guidance, IACHA must ensure parity in community planning meetings (*parity* implies that all members have equal opportunity to provide input and have equal voice voting and in decision-making). With this in mind, how do you rate degree to which you felt you had the chance to voice your opinion and be a part of the decision-making processes in this meeting (with 1 being the least amount of parity and five being the highest degree of parity)?

   1 **2(1)** **3(1)** **4 (2)** **5 (10)**

   - I think we are doing good. Could always increase # of PLWHA, but big improvements have occurred.
   - Some people seem so concerned with getting their opinion heard that they don't stop to listen or let others speak

3. On a scale of 1-5 with five being the highest score, how do you rate meeting location?

Meeting Rooms	**1**	**2**	**3**	**4 (10)**	**5(6)**
Meals	**1(1)**	**2(1)**	**3 (4)**	**4 (5)**	**5 (4)**
Hotel Rooms	**1**	**2**	**3 (3)**	**4 (3)**	**5(7)**

   Comments:
   - Liked Jenny's Lunch line
   - I'm OK going somewhere cheaper
   - Liked the hall
   - Dirty towel and hair in bathroom after it was clean. Shuttle from airport was extremely slow with a 35 minute wait.
   - Potato bar ☹

4. On a scale of 1-5, with five being the highest score, how do you rate the facilitator?

   1 **2** **3** **4 (3)** **5 (12)**

5. Which parts of the meeting did you find the most useful?
   - I really enjoyed our groups. When we do that I understand what it going on, which is good.
   - Group work
   - Epi update
   - Small Group: data review and planning
   - Work group, various presentations were very helpful
   - Good to hear from Erick: Region X Cross-over liaison
   - The open forum aspect of the meeting made voicing ideas or opinions very comfortable
   - Breakouts
   - Find all of it useful

- Sharing information
- Everything
- Working in groups. I hope finding additional funding sources will work too

6. Which parts of the meeting did you find least useful?
   - The Thursday night presentations on survey results was important, but needed to be more organized. I'm in favor of making us work hard (on evenings), but presentations need to be concise.
   - I learned from every aspect of the meeting whether it was a little or a lot. It was all useful.
   - Nothing. Everything was useful.

7. What additional types of information, training or technical assistance would you like to receive at future meetings?
   - I am still wanting to be a face of AIDS and be a guest speaker. Not sure what to do about it. Want to speak at school.
   - Women of color, stigma, mental health and care being in District 2
   - Fundraising strategies (grant writing training)
   - Information about ways to increase funding
   - I would like to receive IACHA emails (Shane Ames)

8. What expertise can you offer to the IACHA meetings in the way of presentations, trainings, etc? (Please include your name so that we can contact you.)
   - I can write grants!
   - Mental/behavioral health
   - Social work policy/involvement

9. Do you have any other comments regarding the meeting and/or accommodations?
   - Thanks Lynsey. I really had a good time. Food was great outside of Red Lion.
   - Liked the meeting room on Friday although more room at Red Lion
   - Great job
   - Thank you. You're all great.
   - While I have not had a prevention program in my area for women, I still feel that importance of this is needed as well as reaching out to those at risk in the Lewiston area and where those at risk can receive resources and assistance for these behaviors aside from what I give in my case management load.
   - The only thing I would change about the accommodations is when ordering sandwiches for the group, please have condiments on the side.
   - Red Lion left a little bit to be desired this time.
   - Looking forward to see some potential donors or private donors on IACHA next meeting
   - No more potato bars. The Red Lion food is really becoming dreadful. Lipstick on unused coffee cup…ew. Also, do we <u>need</u> to put a credit card on file for incidentals at the hotel if it is direct bill?

IACHA Attendees List

Shane Anderson
Asimba Kituta
Christopher Bidiman
Sky Blue
Darlene Burke
Whitney Holman
Katy Kujawski
Stacie Lechot
Mary Linn
Cynthia Lynn Opdycke
Rick Pongratz
Gary Rillema
Alisha Rodgers
Joe Swartz
Bebe Thompson
Denielle Townsend
Jonathan Walker
Mercedes Walser

TA
Lynsey Winters Juel
Sherry Dyer
Rebecca Schliep
Casey Moyer
Sheri Cook

Guests
Jamie MacDonald
Lisa Kramer
Shane Ames
Erick Seelbach
Annabeth Elliott

Absent Members
Idaho Purce
Frances Nagashima
Mary Beaver