Idaho Advisory Council on HIV and AIDS

Meeting Report

February 7-8, 2014

Submitted by:
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Opening Remarks & Introductions

Chris Bidiman, Community Co-Chair and Aimee Shipman, DHW Co-Chair welcomed the membership and guests and facilitated introductions of those present.

New members Gina Holt and Ryan Gilles were welcomed and introduced to the membership.

Sherry Dyer, Meeting Facilitator, referred participants to the agenda as a guide for presentations and discussions of the members for the 1 ½ day meeting. Group members and technical advisors introduced themselves, and, where appropriate, disclosed relationships of their organizations with funding sources.

For the benefit of current and new members, Sherry explained the consensus process for making decisions and reaffirmed the IACHA Operating Agreements.

Overview: Community Planning and Preparing for the New Comprehensive Plan

Bebe presented some initial thoughts related to the 2015 planning cycle. While there have not been any details provided by national funding agencies at this time, it is important to prepare by reviewing our current progress and identifying new information and new challenges for future planning.

The State's HIV Prevention and Care Programs are required to complete a statewide planning process that results in a comprehensive written plan aimed at achieving an ideal continuum of care system. The Idaho Advisory Council on HIV and AIDS is the community planning group that plays a key role in this effort. The Council works to ensure a parity, inclusion and representation—continuing diverse and broad representation of people in the statewide community who are serving and dealing with HIV. The Continuum of Care Circle encompasses HIV Testing, Linkage to Care, HIV Primary Care, HIV Medications – ADAP, Prevention with Positives as well as many other services and needs.

The National HIV/AIDS Strategy was released in 2010. This Federal plan established 3 primary goals:

- Reduce the number of people who become infected with HIV
- Increase access to care and optimize health outcomes
- Reduce HIV related health disparities.

Idaho incorporated the national strategy components into its community planning committee representation and into the goals and actions of the 2012-2015 Comprehensive Jurisdictional Plan. Key to this effort is the vision for an ideal, high quality, comprehensive continuum of care.

The planning process incorporates information from many sources within the State, including the epidemiological data, a statewide needs assessment and gaps analysis of existing resources such as transportation and geographic resources.

Future focus will need goals related to HIV negative individuals, people unaware of their status, people aware but not in care. Our efforts should be directed toward ensuring solutions for closing the gaps in the continuum of care.

It is time now, in 2014, to begin thinking about 2016 and beyond. There are still many questions about CDC and recent HRSA guidance. The Prevention budget has been cut again and there are many questions yet to be answered in both Care and Prevention.

A preliminary calendar of events includes:

- September, 2014 IACHA meeting – identify the target populations for a needs assessment. (we will need to determine if this assessment will be required)
- October, 2014 – January, 2015 – Contract for the needs assessment, if required
- February 2015 IACHA meeting – needs assessment contract in place
- April/May 2015 IACHA meeting – review results from Center for AIDS Research Project
- By summer, 2015 Prevention and Care Programs should have a clearer picture of direction from CDC and HRSA.

HIV Prevention Discussion – Tobie Barton, Rebecca Schliep, Rafe Hewett

Rebecca provided an overview of the Idaho HIV Prevention Program, and referred participants to the HIV Prevention Update handout that was distributed by email before the meeting.

The Prevention Program had hoped for improved funding levels in year 3 of the 5-year CDC grant cycle. However, funding has been reduced in each year of the current grant cycle; program funding for 2014 ($731,030) was reduced by over $90,000 compared to last year. Other low incidence and middle incidence states have also experienced loss in funding over previous years. Program adjustments included eliminating funds for social marketing, media or mobilization.

The costs for the Community Planning joint contract have been shifted to HIV Care which has the capacity to increase their share. Contracts for 2014 with Health Districts were reduced 11%. Significant reductions were made to CBO contracts – 20% to 50% reductions compared to previous years. To address the HIV prevention performance metrics, we realigned funding and revised agency contracts through revamping the scope of work, refining reporting requirements and revising performance metrics. New HIV testing criteria has been developed. HIV test allocations have been lowered each year of the current contract and are budgeted at 1,888 in 2014, a 52% reduction compared to 2011. Over the next several months, Prevention will be reviewing the HD and CBO testing work plans and will work with contractors to revise strategies and testing locations aimed at increasing the HIV testing positivity yield.

With these funding changes, we are looking for new ways to approach our testing strategy. We want to demonstrate to CDC that we are utilizing resources to develop new strategies. For example, in pursuit of our Social Networking Strategy, we are looking for someone connected to drug users who can approach that community to gain knowledge and provide an inroad to bring

HIV testing to individuals who are not currently being reached. We will need to adapt our criteria toward higher risk for Alternate Site testing.

Tobie, Rebecca and Rafe opened the floor to questions/comments about the budget reduction and the impact on community-based organizations. Following is a summary of group input and responses during this segment of the meeting.

- We are doing better at referring clients to health departments. Doing so, we show lower numbers of reactives in the CBO setting, which impacts our future funding and opportunities to provide assistance. This creates a downward spiral of service and discovery.
- Need to look at what are other states doing? For example, the use of "house parties" for providing screening.
- How can we increase the rates of testing for organizations that depend upon conducting testing for their funding?
- Need to know the characteristics of late tester groups so we can effectively target them for earlier testing. Need better understand of the profile of late testers.
- Define the focus for each District, based upon population and resources.
- Develop a public campaign (note: money targeted for social marketing is gone at the State (Prevention) level).
    - Facebook and Twitter are ineffective for social marketing. We need access where we are most likely to find our target audience. Grind-r Advertising is effective, but costs $1000 for 6 weeks of advertising.
    - Drug treatment and methadone centers are not effective.
- How do we build trust and get people engaged – people who don't have access to the standard approach for testing?
- Our funding issue is related to being a low prevalence State. We will never match the numbers in high prevalence states.
- When we limit testing to MSM and injection drug users we create stigma.
- Standard resources for testing, e.g. District Health Centers, should still be recognized and referred to.
- Idaho's numbers may not be high, but the impact is still critical.
- Pinpointing a certain high risk, e.g. hepatitis, can help with identifying HIV

Key conclusions/take home ideas:

1. People do come to events, but many for the wrong reasons. We need to change the environment of the events and the expectations.
2. Explore back page ads: e.g. adult entertainment and Craigslist.
3. Consider use of coupons for the baby boomer age group for HCV testing.
4. Educate and train primary care doctors regarding "who should be tested". This is not typically on a doctor's mind when they see a patient. Talk with them and help them know how to talk to people about testing.
5. All adults should be tested once regardless of risk. That is the model. Need to help doctors buy in.
6. Work with free clinics that have ties to homeless shelters.

7. Use Hep C as an inroad. Also STD testing, etc. Apply for a grant to do this.

RWPB and ADAP Update – Bebe Thompson

Bebe reviewed the timing of each of the HIV Care annual funding cycles. The cycles have been changed to coincide with the grants. Federal Grant: April 1 – March 31; State General Funds: July 1 – June 30; ADAP Emergency Relief: April 1 – March 31; and Manufacturer Rebates: ongoing by quarter.

The Ryan White Formula Grant at $746.452 for Part B Earmark and ADAP Supplemental is roughly level for the last 2 years. The ADAP Emergency Funding received an additional $200,000 this year. The State General Funds of $801,800 remained level with the previous year. Drug Rebates were $2.1 million in FY2012 and are estimated at $3.3 million in FY2013. Total Funding for FY13 is $5,618,547.

ADAP expenditures between April 1, 2013 and December 31, 2013 totaled $4,249,927. Total scripts were 3,974 and total clients served were 241. The predominant race and age groups are white and 25-44 respectively. 77% are under the 138% poverty level. It is expected the needs for funds for medications will go down as more people get on affordable care. The annual medication cost per client averages $20,000; with the annual rebate that number drops to $9,256 per client. Insurance assistance averages a profit of $2,911 per client. Any surplus goes back into ADAP.

The RWPB Base Award after 5% sequestration is $534,516. Medical Case Management contracts are $205,033. For Part C clinics, labs are funded at $62,000 and staff funding totals $19,500. The Community Planning budget is $45,843 and the ADAP Database Rebuild is funded at $69,233.

Looking at FY2014, overall funding for Ryan White Programs was increased over 2013. ADAP Emergency Relief funding begins April 1 -- $770,295 was requested. ADAPs across the country returned some of their money, which may provide for additional funds for 2014. Formula Grant contracts will be funded at 2013 levels. We are working on two additional MCM contracts – the RFP for those services is in the final stages of development. We anticipate approximately $80,000 additional for Medical Case Management, including support services.

The legislature is expected to pass the requested ADAP increased spending authority for 2014. The rebate spending authority will be $3.3 million per state fiscal year. The impact of the Affordable Care Act on ADAP is unknown. Clinics will be paying close attention to the ACA trends. If you have insurance coverage, current rules do not allow you to be on ADAP. Fewer clients on ADAP will impact the amount of rebate receipts during the fall of 2014.

Several questions remain regarding national level decisions yet to be made, much of them related to the impact of the ACA. ADAP will not go away but the status of coverage is unknown, creating concerns for many states regarding the impact on the future of planning. ADAP covers undocumented people; ACA does not. Reauthorization of Ryan White remains on hold.

Pharmaceutical manufacturers are uncertain about future rebates. HRSA took the lead with a posted letter on the NASTAD website, providing the opportunity for states to give input on the impacts to the state program.

Youth Risk Behavior Survey Results – Lisa Kramer

The survey is funded by CDC. It was administered in spring, 2013; the report was released January, 2014. The survey involved 1,600 students, male and female, in grades 9 through 12. It covered topics such as bullying, suicide, drug usage and sexual activity. A few highlights of the consolidated report follow:

- 38% of students have had sexual intercourse compared to 40% in the 2011 survey. For seniors, 60% have had intercourse, compared to 53% in 2011.

- The use of condoms during sexual intercourse is a new question in the 2013 survey. 58% of those saying they have had sexual intercourse said they used condoms. 37% of male students and 46% of female students reported they did not use a condom the last time they had sexual intercourse.

- In the 2011 survey, 83% of students said they received teaching on HIV/AIDS. Less than half of the students say they have talked about HIV/AIDS infection with their own parents or other adults in the family.

- As of January 2014 the State Department of Education no longer receives HIV Prevention funding from CDC (we may still be able to do a limited amount of work with funding from DHW).

- 30% of students have used marijuana one or more times compared to 19% in the previous survey.

- 29% of students said they experienced bullying due to weight, size or physical appearance compared to 26% in the 2011 survey. 25% experienced bullying on school property, up from 23% last survey.

- Students who felt sad or hopeless almost every day for a period of 2 weeks or more and stopped doing usual activities reached 29% compared to 27% in the previous survey. 15% seriously considered suicide; 13% made a plan to commit suicide.

Lisa urged consideration of using this information to inform IACHA's planning and program development, particularly HIV/AIDS prevention. The data is available going back to 1991. The CDC website provides data from other states for comparison purposes.

IACHA also discussed "vaping" as a potential growing risk behavior among youth (vaping referring to the use of adding substances to electronic cigarettes).

ACA in Idaho – Dieuwke Spencer

1. Legislative updates (Medicaid or other programs)

There has been a vocal thumbs down to Medicaid expansion because leaders don't want more of the same, but to improve what we have. Director Armstrong has presented before the legislature regarding Medicaid reform/transformation. The hoped for outcome is for funds to implement reform. There are indications of openness to restoring funds for cuts made in 2011, such as dental service for adults with disabilities.

2. Health Insurance Exchange

There is a big push in February because of the enrollment deadline in March.
30 Ryan White clients have signed up which is encouraging. It is important to get people into comprehensive coverage.

3. Prevention Funding Cuts – will the Department be able to request or provide funding to make up for the cuts?

We anticipate carry-over of unused federal funds in the amount of $67,000. To access State funds we need to move early – prior to the start of the legislative session. Dollars will be very targeted. The State does not give much money to Prevention. How can we make people understand that prevention is better than the cure? We must be very targeted in our "ask".

4. ADAP

ADAP is accessible for those who elect to enroll for insurance. A person can appeal for consideration. ADAP may be used to cover a medication that may not currently be covered on an insurance formulary. The patient will have to appeal the insurance company to add the medication to the formulary but we will cover it with ADAP funds in the interim. If one's insurance company covers only certain medications, one may not be able to try for a "better" medication. There is no movement in the department regarding wrap around for ADAP. It is considered the patients responsibility. There are still a lot of unknowns. There has been talk of the possibility of privatizing.

5. Election to Not Enroll

If a person elects not to enroll they will have to take the penalty. It must be documented that an individual "vigorously pursued" enrollment. What does that mean? Individual, personal circumstances will be considered. No direction has been provided. NASTAD is working for clarity on this matter. The level of co-pay is a factor for many clients who can barely afford the premium. We would go to bat for this person.

In 2014, there will probably be no impact on eligibility for ADAP assistance. This is probably more likely to be addressed in subsequent years. This year is a transition year. The State is doing the best they can to ensure people will continue to receive their medication and care.

What is Happening with A.L.P.H.A.? – Jonny Walker

ALPHA experienced a 20% cut in funding for testing. We don't want to change the "walk-in" approach. We need to explore new/unique funding sources. It has been suggested we apply for additional funds. We also may reach out to our community partners for test materials and other services. We should know more soon about our overall funding situation. We provide support to help clients who are navigating the insurance process.

We are committed to post-exposure advocacy. We go with the client to the ER to ensure testing and treatment in a timely manner and that our clients are treated well through the process . . . that they are getting the appropriate drugs based upon their need. We will do all we can to locate the necessary drugs. We have had 7 client successfully navigated through this effort.

We work with the Idaho Food Bank and Food Pantries to help clients who are infected and affected by HIV. In January we districted 2400 lbs of food. We operate on the premise that clients will take what they need and do not abuse the services. The food distribution in the first month of 2014 amounted to as much as 9 months distributed last year. We have an regular scheduled HIV related film night, followed by discussion. We are in the process of updating our website. We estimate that we will distribute 50,000 condoms in 2014. Community Partners and our own client base experienced training on how to save the lives of friends. We are working on a means to continue the Chlamydia and Gonorrhea testing and are looking for sources for Hep C test kits.

Mpowerment is expecting a funding cut in 2014. They have had great success and involve their clients in providing services.

Russ Duke of District 4 is working with us and the Ada County Jail for testing for injection drug clients. We are working to get into the Ada County jail, hopefully by the 2nd quarter, for HIV, Hep B and Hep C testing.

Viral Hepatitis Update – Rafe Hewett

The Viral Hepatitis Prevention Program is in year 2 of the 3-year grant cycle. Idaho has been awarded $19,904 for year 2 which covers salary, conference attendance and test kits. The CDC has released 50% of the total year two award. All jurisdictions have a Viral Hep coordinator.

Rafe attended the NASTAD Hepatitis Technical Assistance meeting in October, 2013. Coordinator training was held in conjunction with this meeting. The CDC now has 3 project officers covering different regions throughout the country and Rafe was able to meet Idaho's new Project Officer, Rachel Cabral, for the first time at the meeting.

In year 1(11/12 – 10/13) of the Program, the Rapid HCV Screening Project included ISU Meridian, Intermountain Hospital and Port of Hope in Caldwell. 337 tests were performed in this 12 month period. 17 tests were reactive. These 17 clients were referred to confirmatory testing. An additional CBO HCV screening site (NIAC) was added in District 1. The Idaho Viral Hepatitis Advisory Council established 4 key recommendations for District Health Departments to address. All District contracts now include recommendations involving viral hepatitis related activities.

The Idaho Viral Hepatitis Advisory Council met 3 times in 2013. They also met on January 23, 2014. The Council serves in the same role as the IACHA sub-committees, focusing on statewide hepatitis prevention planning. The plan can be accessed on the IACHA site www.mtnstatesgroup.org.

Administrative Update – Lynsey Winters Juel

- Members were provided with the applications for review of 2 potential new members – Diane Shelman (District 2) and Jennifer Seaich (District 6).

  Following the meeting, via email contact, Rick Pongratz agreed to be the mentor for Jennifer and Chris Bidiman agreed to be the mentor for Diane.

  Decision: IACHA members agreed unanimously to accept the applications of Diane and Jennifer.

- The Resource Directory has been updated and can be accessed at http://www.healthandwelfare.idaho.gov/Health/FamilyPlanning,STDHIV/HIVPrevention/tabid/390/Default.aspx and http://www.mtnstatesgroup.org/programs/idaho-advisory-council-on-hiv-aids-iacha/

- The IACHA Responses to the CDC Monitoring Questions was updated January, 2014 and copies of the report passed out to members.

  Decision: IACHA members approved unanimously the monitoring questions update of January, 2014.

- Lynsey provided information on conferences available to members to attend in 2014. There is funding for 3 members to attend a conference in 2014. Members were requested to review and advise Lynsey as soon as possible of their interest to attend. *Applications are due to Lynsey by February 28, 2014. The approval decisions will be made the first*

week of March. Note: All Ryan White providers are required to attend The Ryan White All Grantees Meeting.

- Regarding the HIV Criminalization update, a group (consisting of Idaho Medical Association staff and lawyers, Dr. Blue, Kaden, Christine Hahn (H&W) and Lynsey) met in November, 2013. They decided not to pursue changes in the law through the legislature in 2014. A partial change could potentially preclude any additional changes being considered in the future. The group has chosen to wait and ensure there is sufficient support within the legislature before asking for changes.

  Follow up Note: On February 10, Lynsey joined Idaho Medical Association staff, Chris Hahn of IDHW, Dr. Blue and Ada County Prosecutor Jean Fisher to discuss legal and public health perspectives. There was agreement to continue to work toward options to revise the law. The agreement was to move forward methodically and not rush. IMA's lawyer and the prosecuting attorney will review the draft of proposed changes and explore points of agreement related to routes of transmission and penalty phases. They will also explore ways to integrate intent to harm language that can possibly allow for more disease neutral language.

- Lynsey will mail out the Membership Survey in February. Results will be presented at the May meeting.

Public Comment Period

Sheri Cook of HOPWA recently notice of potential changes being made to the program. Changes could include the requirement of greater coordination with the local homeless service system. More coordination and collaboration may be required. Health services including dental and vision may no longer be available effective November, 2014. Budget changes may impact the ability to spend money for health services, requiring those services to be redirected to other provider systems. Sherry will provide an update at the May IACHA meeting and will address potential next steps.

Committee Work

At this point in the meeting, IACHA members and support staff adjourned into Strategic Plan focus groups for the remainder of the meeting day: Reducing HIV Incidence, Access to Care and Optimizing Health Outcomes, and Reducing HIV-related Health Disparities. Committees were charged with continuing the review of progress and updates of their respective Strategic Plan goals and strategies.

Conference Report – Gary Rillema

In 2013, Gary attended the American Public Health Association Conference (HIV/AIDS section). Gary introduced his presentation indicating he wanted the group to discuss ways the

conference input could influence IACHA direction and decisions. He provided a few key takeaways from the conference, and then invited individuals to share their thoughts.

- The faith community is fostering AIDS initiatives that heal. There is positive work being done in this sector.
- Conference speaker, Randy Newman, stated planning groups need to talk about and share data. Unless we make an impact, planning groups are not doing anyone any good. Need greater emphasis related to lack of housing and the issue of mental illness.
- The AIDS Project in Los Angeles is working to identify why people are dropping out of care.
- We are seeing more studies and conversation about bi-sexuality.
- Latinos are critical care issues.
- Comic heroes for outreach are very positive
- 50% of people with AIDS will die.
- In Idaho, 50% of people in Idaho live at the poverty level. Per capita income is $23,000. The rural nature of our state has an impact on prevention, care and stigma
- Own the conversation.
- Contact with a real person is essential to linkage and adherence. There is a benefit in going to the person rather than asking the person to come to agency for services.
- Need to determine and share the community viral load, and determine how to share data with the public in a meaningful way.

General Discussion:

Gina Holt commented there is a need to have better communications within and across agencies related to community-based services. Idaho needs to do a better job of teaching about HIV/AIDS in the schools. We also need to address the issue of people staying in Care in Idaho.

Mercedes Walser raised the issue that some parts of the State have transitory populations, e.g. Mountain Home Air Force Base. This makes it difficult to keep track of people needing care across the State. Plus, women are often less likely to remain in Care.

Lynsey Winters Juel stated we are not tracking or reporting the community viral load consistently. The last time the data was tracked was 2011. The Quality Management Group has discussed this issue, but now they are not meeting.

Dr. Gilles stated that we don't know what the true community viral load is. We need to find people who know and are out of Care. We need private doctors to test as well as community-based doctors. Tobie Barton raised the question regarding what method of sharing is most effective. Dr. Gilles responded that we need to get on the agendas of community meetings; become an IMA partner through the IMA State Conference and through their newsletter. Also, we need to seek out relationships with County Medical societies.
Other suggestions included involving Judy Thorne; reaching out to big hospitals that employ many physicians; and starting a grass roots effort to get the word out.

Decision:

We will use the May meeting to review the QM status to help provide targeted, narrow data regarding the Viral Load versus multiple benchmarks.

- Get the data (CD4 and Viral Load) updated through CAREWare and through other sources.
- Prepare to present at the 2015 legislative session.
- Obtain the University of Washington study regarding getting people into Care (Dr. Giles)
- Reach out to physicians. Get input from members regarding who and how.
- Review data available through the Reducing HIV Incidence Committee (Whitney Ginder)

Gary summarized the discussion by stating the expressed view of the group: Medical Case Management is critical!

Regional Planning Group Updates

Whitney noted that the Flying M in Boise was holding Valentine for AIDS event February 6-16. The effort will benefit SNAP (Safety Net for AIDS Program)

Chris noted that the CHAS Clinic in Moscow is celebrating its 1-year anniversary. Also, Inland Oasis is celebrating its 10-year anniversary and it is currently developing a plan for celebration throughout 2014.

Gary stated that Breaking Boundaries is preparing for World AIDS Day with a Black Tie Dinner. They are hoping to net $40,000 this year.

Committee Reports

This section of the IACHA meeting record provides a brief overview of committee comments. For plan update details, see the Strategic Plan document on the Mountain States Group website under Idaho Advisory Council on HIV and AIDS.

- Reducing HIV Incidence: Whitney Ginder

    1. Updates are being made to this section of the plan including the following inclusions: utilizing ACA; promoting provider awareness of preventive health screening and networking with providers

    2. Some Health Departments in the state are not as active as others. At the College of Southern Idaho, they are limited on staff and, by policy; they do not allow non-CSI people to be test resources. Organizations have the resources, but cannot get some testing facilities to collaborate.

    3. In District 5, Positive Connections has been used to store supplies. Jonny noted that ALPHA is in early talks about getting test kits. They are working to get the paperwork done to get into Magic Valley.

4. We are considering developing a directory of resources for testing events. We want to do this statewide.

5. STD funding has been decreased. Districts are looking at prioritizing and clarifying: who to test. Health screens will not include STDs as a general rule due to funds.

- Increasing Access to Care and Optimizing Health Outcomes: Stacie Lechot

1. The committee is sending out brochure mailers to providers and consumers regarding toolkits. The mailer will include billing codes as an added resource. The mailer will represent IACHA to promote awareness of IACHA as a local resource. We will need to develop a letter to go with the brochure. Bebe's funds will cover the costs. The Administrative Committee will continue this discussion between February and the May IACHA meeting (and consider ways to include IMA and Judy Thorne in the discussion).

   We are considering how to increase access to PEP in ERs on weekends. We plan to pilot with ALPHA and the Wellness Center.

2. We are developing ICONS for links to HIV Care testing sites. Rafe will send out the information within the next 2 weeks. IACHA members are being asked to add the ICONS to their websites. We will also approach community partners to add to their websites.

3. HIV Care Messages: developing 16 topics "Did you know . . . . .?" We will email IACHA members when the messages come out.

4. Lynsey stated the Stacie's team needs a co-chair and asked members to volunteer. **Linwood Fraser agreed to be the co-chair.**

- Reducing HIV-Related Health Disparities: Jonny Walker

Goal 1 is a significant data request to the state. There is uncertainty regarding how to sift through the size of this effort. The Committee is in a re-evaluation phase: What does the Health Disparities Committee want to look at? What do we mean by *Health Disparities?* We have not received the data requests we asked for earlier. The EPI Profile may be a source to drive the discovery.

The committee will have a conference call with the Data Committee and get Bebe's input. Lynsey will arrange a committee conference call before the next IACHA meeting.

Attachment 1: IACHA Meeting Attendee List

Members:
Shane Anderson
Kituta Asimba
Christopher Bidiman
Darlene Burke
Linwood Fraser
Ryan Gilles
Whitney Ginder
Gina Holt
Stacie Lechot
Gary Rillema
Aimee Shipman
Jonathan Walker
Mercedes Walser
Alex Zamora

Technical Assistance Providers:
Tobie Barton
Sheri Cook
Sherry Dyer
Rafe Hewett
Lisa Kramer
Rebecca Schliep
Bebe Thompson
Lynsey Winters Juel

Attachment 2: Meeting Evaluation

Idaho Advisory Council on HIV and AIDS Meeting
February 7-8, 2014
MEETING EVALUATION

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

   1 2 3 4(5) 5 (5)

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 3 4(2) 5 (7)

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 (5) 5(5)**

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

   Hotel Rooms **1 2 3 4 (3) 5(4)**

   Comments:

   - On lunch sandwiches could we please have condiments on the side instead of on the sandwich? Breakfasts were great.
   - Room was kind of cold
   - Great meals and new venue

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 (6)

   Comments:

   - Good redirect and focus

5. Which parts of the meeting did you find the most useful?

   - Prevention conversation was great

- Alpha update
- The prevention discussion a
- Committee meeting and setting goals/action items
- All info was great
- Discussion of community VL- Gary's report
- Tobie, Rebecca and Rafe's combined presentation
- Program updates and work groups
- The whole meeting and meeting of new members
- The Epi information discussed and updates from partners about fiscal changes

6. Which parts of the meeting did you find least useful?
    - Disparities group discussion- the group needs better momentum and goals. If the group continues to struggle (and it's a hard task) maybe just have 2 groups and more people on each to accomplish goals there.
    - Dieuwke Spencer
    - Prolonged statistical updates- These should be brief and focus on the most relevant issues
7. 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.)
    - Harm reduction /overdose prevention
    - Mental health, rural areas, women of color in small communities
8. Do you have any other comments regarding the meeting and/or accommodations?
    - Please set up tables so that group is facing one another- maybe tables in a horseshoe or tighter group?
    - Good meeting
    - Quality management updates and updates on IMA letter/ physician communication
    - Re-set room facing dark wall and window