Idaho Advisory Council on HIV and AIDS

Meeting Report

April 12 & 13, 2013

Submitted by:
Sherry G Dyer
Management & Organization Consultant
sherry@sherry-dyer.com
208-724-7049

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Opening Remarks and Introductions

Chris Bidiman and Bebe Thompson, IACHA Co-Chairs, welcomed everyone to the April face-to-face meeting of IACHA. The members, TAs and guests introduced themselves and, where applicable, provided brief updates related to personal or professional events.

Meeting Overview and Guidelines for Success – Sherry Dyer

Sherry Dyer, facilitator, provided a general overview of the meeting arrangements and announced that a public comment segment had been set aside on the agenda at 2:20 p.m. for guests to ask questions or provide information. Sherry then covered background regarding the new, recommended IACHA Guidelines for Success. It has been several years since the guidelines had been revised and there have been many changes within the IACHA membership and structure. The guidelines had been reviewed and were being recommended by IACHA's Administrative Committee. Sherry asked for discussion from the group. The general sense was that everyone liked the new, streamlined set of Guidelines.

Decision: Sherry called for the question and the new Guidelines for Success were unanimously accepted by all members.

Nominations for Community Co-Chair

Frances Nagashima and Chris Bidiman were nominated. Frances stated that if Chris was willing to serve a second term, she would prefer to withdraw her nomination. Chris said he was willing to serve a second term.

Decision: Sherry called for the question and Chris Bidiman was re-elected for a 2nd term as IACHA Community Co-Chair.

HIV Disclosure/Criminalization – Kaden Sinclair

(contact for Kaden Sinclair: KadenSinclair@gmail.com)

Guest presenter, Kaden Sinclair had approached IACHA requesting the opportunity to present his views and concerns regarding the Idaho HIV Statute that makes it a crime for a person to not disclose to relevant parties that they have HIV. The statute dates back to the mid 1980's. There is lack of public awareness of the Idaho statutes that criminalize the lack of communications to partners regarding HIV status. There is also lack of awareness for many people regarding personal health/HIV status and the need for testing.

We have come a long way since the early days of the HIV disease. Many Idaho lawmakers are not sufficiently knowledgeable of the advances made in the last 27 years.

In order to change the statutes, new legislation will be required. Kaden expressed his interest in having IACHA members engage in efforts in support of repealing the law.

Dr. Blue agrees with Kaden and others that the law is outdated. He also stated that the rationale used by the law's founders is outdated and not based upon current science and medical understanding. Other laws, such as the negligent endangerment laws, could address the issue, where there is one.

Options briefly discussed were to contact people involved in the original writing of the law and help ensure current information and insight. The recommendations would need to come into the House Judiciary Committee. The Idaho Medical Association could provide some backing for nonbinding resolutions. Healthcare Reform might be an opportunity to discuss this, related to progressive HIV Care.

In matters of policy, IACHA does not have a sufficient voice. The effort must be handled carefully so as to avoid getting conversation locked up in a legislative committee or of ending up with deeper restrictions. Bebe advised that the Department of Health and Welfare cannot initiate this legislation/policy/etc. but can come out and support it.

Actions:

- Gary Rillema will run this by each of the 7 Health Districts to determine their willingness to engage. The Districts are typically willing to champion initiatives and often work with lobbyists.
- Dr. Blue and Kaden Sinclair will form a team to work with the Idaho Medical Association.
- DHW Care and Prevention staff will alert DHW, who will come on board as needed.
- IACHA assigned the issue to the team responsible for Focus Area 1: Reduce HIV Incidence in the IACHA Jurisdictional Comprehensive Plan.

Part B and ADAP Update – Bebe Thompson

Bebe presented a status report and 3-year trends (2010 – 2012) on ADAP and current challenges. Enrollment in ADAP has increased each year. However, the ADAP waitlist has declined slightly in 2012 with 76 people on the waitlist compared to 79 in 2011. This could be due to the transient nature of people on ADAP. The total number of clients served per grant year reflect an overall increase, from 195 in 2010 to 230 in 2013.

Overall, the ADAP budget from federal and state dollars has not increased over the 3 year period. The ADAP expenditures have increased from $3.1 million in 2010 to $4.2 million in 2012. The prices for drugs are increasing and we have more people on more drugs. The average cost for drugs per year per person is $13,800 after rebates. ADAP rebates are up substantially. Projected rebate income should be enough to sustain the level of spending with no new federal funds. Rebates will be 60% of our budget, an improvement over past years. So, the ADAP Program is likely to be OK regardless of the availability of emergency funds.

In 2013, there will be a lot of uncertainty. The effects of sequestration will impact funding with an expected 5% cut in the budget. Plus ADAP Emergency Relief funds were not included in the Federal budget. HRSA is looking for sources of funding to supplement this reduction and Idaho will apply for supplemental funding. The Health Exchange will be required to include essential health benefits. It is still unknown whether or not there will be Medicaid expansions in Idaho in 2014. It is unclear what the deductibles will be for medical and pharmacy in exchange plans. Participants in the Idaho Health Insurance Exchange will have premium subsidies and out of pocket spending limits. Medical and pharmacy deductibles will still be high and on the front end. Co-pays are usually 30-50% of retail costs on brand name drugs.

With the transient nature of people on ADAP, low prevalent states like Idaho experience significant impact, with fewer numbers of clients, on availability of funds and, therefore, on our ability to identify needs and to provide care.

(To access the original presentation of this report, contact Lynsey.)

HIV Prevention Update – Rebecca Schliep

Year 2 Funding Update

Prevention was awarded their 2013 budget allocations of $877,151. 40% is allocated to the required core components of the program; 36% to required activities and 24% to recommended components. There is an anticipated reduction of the 2nd year budget award which would impact the $49,800 earmarked for a social marketing campaign. The remaining shortfall of $11,500 would be taken from funds earmarked for comprehensive prevention with positives.

Funding allocations for required core components include allocations in support of the 7 Health Districts: $100,000 for Clinic Based Testing and $134,000 for Community Based Testing. Under Prevention programs $29,835 has been allocated for Partner Services in the Health Districts. However, CRCS is no longer funded and IACHA will need to consider how we will incorporate needed strategies for accessing and implementing intervention for at-risk discordant couples. Agencies will be required to report monthly on dollars and targets for condom distribution. We will need to roll out a program to ensure implementation of strategies to address the gap in routine HIV testing among pregnant women.

Recommended components will be addressed through evidence-based prevention programs which were funded with a total of $158,506. Following is a summary of the programs and contractors by Health District: HD 3 – Cuidate/CCJ; HD 4 – Personalized Cognitive Counseling & Empowerment BOI/alpha; HD 6 – Mpowerment GP/ISU. Social Marketing support will be provided for each Health District to agencies that provide HIV testing at community-based sites. The Statewide Marketing effort will be cancelled if funding is not provided.

Year 1 Progress Report

Rebecca provided details regarding year 1 test events, positives and outcomes in both the Healthcare and Non-Healthcare settings. This information is important to show that results are being attained from the dollars received. Rebecca also provided updates on condom distribution efforts involving the 7 District Health Departments and 4 CBOs – the total number of condoms distributed in 2012 was 236,103. Prevention provided Capacity Building and Technical Assistance in response to requests involving 5 agencies. Prevention also provided support for 5 Effective Interventions: Partnership for Health, Text Messaging, ARTAS, Together Learning Choices and Healthy Relationships.

(To access the original presentation of this report, contact Lynsey.)

Dr. Blue stated that early treatment and relationship building with a provider also contributes to greater prevention effectiveness. We need to be encouraging people to stay connected to care.

Action: Following discussion, the Reducing HIV Incidence workgroup was asked to evaluate and incorporate goals and actions related to this opportunity of ensuring early treatment and provider relationship building.

Social Media Update

On Saturday morning Rebecca was asked to provide an update on the HIV Prevention blog titled IDPreventHIV.org. The goal was to have two articles per week published on Monday and Wednesday but the project has been put on hold. The Bureau Chief is not comfortable with the Department having a blog as there are currently no other bureaus with a public access blog. If/when this project is resumed, the HIV Prevention program will notify IACHA.

Policy Update Regarding ADAP – Dieuwke Spencer

Dieuwke responded to the following questions (as developed and provided by the Administrative Committee prior to the meeting):

1. What technical assistance has the Department requested from our federal partners, HRSA and/or NASTAD, or anticipates requesting in the coming year?

   Answer: Technical Assistance is given when a program is at the implementation phase. During a February 22, 2013 call with NASTAD, the NASTAD representatives indicated surprise at Idaho's challenges. During this call, it was made clear that Idaho is not ready for technical assistance (related to health insurance premiums and cost sharing). Several factors figured into this decision: politics (as the legislature is unwilling to support), low levels of DHW staffing and funding resources.

2. Protecting the $800k in state general funding was cited as one reason not to pursue purchasing insurance (cited during the September 2012 IACHA meeting). Now that the funding is openly cited in the Milliman report on the analysis of healthcare expansion what does the Division of Health plan to do?

   Answer: The suggestion to fund ADAP from the general funds of the Department for purchasing medications was not well received. It would change the use of funds and could result, ultimately, in a loss of funds. This is the single largest chunk of money and does renew annually, so it is conspicuous and vulnerable. It was clearly stated that if Medicaid is expanded, the $800K is vulnerable and could go away – it would be like suggesting "we don't need this anymore".

   We need to continue protecting the $800K. We cannot get more; we do not want to get less. The $800K in State General Funds are restricted in that they may only be used to purchase medications. Using these funds to purchase insurance would change the use of funds and possibly jeopardize the funds being available. However, if lost,

Maintenance of Effort (for the Ryan White Part B Grant Application) could be provided through Corrections and Medicaid.

At this point, Katy Kujawski asked "what if the payments to insurance were only for prescription co-pays?" Diuwke responded that would be a potential area to look into further.

3. Who specifically at the Department is currently involved in the decision making process as it relates to ADAP?

   Answer: This matter went all the way to Dick Armstrong.

4. How can IACHA assist the Department in making ADAP sustainable given the pending cuts to funding?

   Answer and Action:
   The Department needs to research the cost effectiveness of transitioning to insurance purchase (in response to this answer, Katy asked if this was the information that the IACHA Research Committee has already provided. No answer was provided by Dieuwke).

   Dieuwke suggested that the Department needs to develop a pilot project for those who cannot afford their deductibles/co-pays and identify what rules we are working with now. She said that Idaho ADAP rules are woefully out of date and not in alignment with federal standards.

   Dieuwke will help to provide the framework to help brainstorm and form a plan, including details about what leeway we have and what parameters we can work with. Dieuwke's organization will provide the necessary information by May 10, 2013. Additionally, she committed to Chris' request to identify next steps, responsible parties and timelines.

   IACHA will develop a response by the end of May in preparation for the June 5, 2013 videoconference meeting.

5. Will Idaho be applying some of ADAP's or State funds toward paying for deductibles and co-pays now (as a more efficient use of funds)?

   Answer: We cannot answer this question yet. The Governor has created a Task Force for the Insurance Exchange. A big piece of this program involves personal (shared) responsibility (note: Dieuwke did not clarify what accounts for this shared responsibility). Taking any dollars to pay in full for one group of people is not going to happen. It is difficult to work things out to achieve equity. But this will be a part of it with Medicaid Expansion and other changes. We may need to involve more people to help us address implications of Medicaid Expansion.

   Regarding the undocumented – we don't know how this will be addressed. The State can decide to limit funding to undocumented people.

In addition to answering the above questions, IACHA and Dieuwke had the following discussion:

Dr. Blue asked Dieuwke what her thinking is regarding the shrinking funds and increasing costs. Specifically, he stated there will still be a big gap between the Exchange and Medicaid. Dieuwke stated that case management is underway and efforts will be to optimize rebates. The administration and infrastructure is being set up to use the State General Funds for drug assistance aide only. She stated that "we should not give up and throw in the towel." Legislators are not in favor of expanding Medicaid, so proposals must be conservative.

According to Dieuwke, those at HRSA who participated on a conference call were amazed at the reach of our legislators into the management of H&W. H&W has to get support from the legislature for a great deal of what they want to do. Legislators are very interested in the return on investment. We can effectively care for HIV/AIDS with the money we have – a lot can happen.

Starting in April 2013, a 6-month Medicaid Transformation grant begins. This project is charged with reviewing, improving and expanding Medicaid. There will be 56 focus groups throughout the state. Decisions from this process will influence Medicaid in Idaho (thus, the Idaho ADAP Program).

Key to any proposal for changes to the ADAP program is a stated partnership between the client and the department; there must be personal responsibility of clients (Dieuwke did not clarify what accounts for "personal responsibility of clients").

HRSA's reaction to our yearly waiting list is "you have to fix this." What is our contingency plan when they challenge us regarding our programs/outcomes? According to Dieuwke, a key barrier is that the Department is woefully understaffed. When asked, "will HRSA give up on us?", she responded, "there is a lot they can do before they take away the funding. They have never pulled dollars away from a State."

One aspect of ADAP is to pay for co-pays for Medicare Part D (through the donut hole). Dieuwke expressed that H&W will not pay for anything else within the system other than co-pays. She stated that we need to identify which group has the highest need. Twice, Katy asked than once about using the general funds to purchase medications through a non-Medicare insurance plan as a wrap-around program, similar to what the Department is already doing with Medicare Part D and IDAGAP. Dieuwke was unable to answer this or really address using these funds in any capacity other than full insurance purchase.

Finally, Dieuwke encouraged IACHA to keep putting ideas forward, stating that she will help wherever she can. IACHA's workgroups are encouraged to work with Dieuwke or others in the Department.

Viral Hepatitis Prevention Program Update – Rafe Hewett

Rafe provided a funding update for the Viral Hep Program – the funding cycle is November 2012 through the end of October 2013. For the 3 year grant cycle, we anticipate $19,000 in the

first 2 years and $17,000 in the 3rd year. About $1000 (5-10%) covers program costs (travel and rapid HCV test kits); the remainder covers salaries, benefits and indirect costs.

As VHP Coordinator, Rafe will oversee the Viral Hep Task Force. The Task Force is co-chaired by Judy Thorne and Rafe and will meet 3 times per year to track progression of the VH prevention goals, to plan and coordinate activities and to identify improved collaborations. Our task force will provide recommendations to IACHA regarding statewide VH goals. Members of the Task Force are IACHA members, Stacie Lechot, Chris Bidiman and Jonny Walker, as well as representatives of other district health offices around the State. Our 2013 timeline includes the development of a task force charter and preparation for our first meetings in late spring and in the fall. Our theme is "KNOW MORE Hepatitis". May is "Viral Hep Month" and we will provide testing opportunities plus a tool kit and we will sponsor a related workshop.

In our efforts to understand best practices for securing funding, we determined that jurisdictions that were able to keep an adult hepatitis vaccine project were funded through their state, primarily due to identified high incidence of Hep B. A toolkit was developed and distributed to a select group of clinicians in November 2012. We plan to expand distribution in 2013. Sections in the toolkit include: Who to Test; Patient Self-Administered Risk Assessment, Testing and Serology, and Billing and Diagnosis Codes.

Our Task Force will be working on a plan, including funding, for sustainability of the program after this 3 year funding cycle.

Public Comment Period

Time is set aside during IACHA meetings for guests, members, RPGs, etc. to make comments on any matter appropriate to IACHA. No comments were offered during this period.

Committee Work to Update Strategic Plan Goals

Each of the three subcommittees (Reducing HIV Incidence Committee, Increasing Access to Care and Optimizing Health Outcomes Committee, and Reducing HIV-related Health Disparities Committee) worked to provide updates to the Strategic Plan Goals as they relate to the Jurisdictional Comprehensive Plan. Updates to the goals have been integrated into the plan and are included as an attachment to the meeting minutes.

IACHA Administrative Updates – Lynsey Winters Juel

IACHA Policies and Procedures: Lynsey overviewed the recommended changes to the IACHA Policies and Procedures and provided the rationale for each change. Most of the changes addressed organization updates:

- Regional Planning Groups were eliminated from the IACHA process due to IACHA budget reductions.

- Role changes were made for the Administration Committee including folding in the responsibilities of the Membership Committee (the Membership Committee no longer exists as a separate entity).
- New subcommittees have been formed that support each of the 3 sections of the IACHA Comprehensive Plan.
- Viral Hep was added in reference to the Comprehensive Plan
- Minor changes were made to the Membership Slots for clarification and more specificity.

Decision: The changes to the IACHA Policies and Procedures were approved unanimously.

Heartland Alliance: Lynsey advised that, after further consideration regarding earlier discussions about the Mission of Heartland Alliance for Human Needs & Human Rights out of Chicago, this group was probably not a good fit for TA on behalf of IACHA. They are an impressive organization but their focus is different than IACHA. They do have some very good materials that could be beneficial to the IACHA workgroups and Lynsey will attempt to get more copies or access online.

Facts about Condoms Video: Lynsey provided information and showed a demo of the website for Facts About Condoms videos. The website is www.factsaboutcondoms.com/videos.php.

AHEC Newsletter: Gary Rillema wrote an article (*The Benefits of Early Identification of HIV*) which will be included in the May AHEC Frontier Footnotes. The intent is to continue to have articles submitted by IACHA members that will have wide distribution in Idaho.

CDC Monitoring Questions: Lynsey had emailed to IACHA membership the responses developed by Rebecca and Lynsey to the CDC Monitoring Questions. Members were asked to provide feedback on the responses. It was suggested that information regarding the cycle of subcommittee work and how it is reported to IACHA be added to the document. It was also stated that the document would be placed on the IACHA website. Lynsey will attach the responses of the CDC Monitoring Questions to these April meeting minutes. Members are asked to review the responses and provide feedback.

HRSA: Lynsey advised of a request for information (under the Freedom of Information Act). The request includes all correspondence to and from HRSA and H&W regarding the Ryan White Part B Program and the ADAP Program between January 12 and March 13. There are 20 working days to comply with this request – the response is due April 19, 2013.

Membership Updates: Lynsey presented a summary of the Membership Survey conducted earlier in the year. The Membership Survey provides important demographics regarding the membership of IACHA and helps to identify where there might be gaps in membership representation on IACHA's Membership Matrix. Two members did not respond to the survey. The report reflects the results of those members who responded to the survey.

The Administrative Committee previously discussed the importance of considering adding a slot for viral hepatitis. An earlier decision of IACHA integrated Viral Hepatitis into the

Jurisdictional Comprehensive Plan, but no membership slot was created. Chronic infectious disease is becoming a CDC focus. We also need to consider gender balance. Other areas that might need considerations for slots, or at least representation include Homeless, Elderly, Migrant/Immigrant and Veterans/VA. The Youth slot needs to be better defined. There is a need to recruit new members to fill 8 slots that are currently not filled.

Decisions:

- It was agreed to combine the Corrections and Criminal Justice slots into 1 and to add Viral Hep as a new slot.
- The membership will consider the suggested possible changed or added slots at the June 2013 meeting.

New Member Application

An application for membership was received from a guest attending this April meeting. Maria Flores is from District 5.

Decision: Maria Flores application for membership was accepted by a unanimous vote of the membership.

IACHA Leadership and Committee Membership – April, 2013

Administration Committee:

Bebe Thompson (State Co-Chair)
Chris Bidiman (Community Co-Chair)
Whitney Holman-Ginder (Reducing HIV Incidence co-chair)
Frances Nagashima (Reducing HIV Incidence co-chair/split with Alex)
Alex Zamora (Reducing HIV Incidence co-chair/split with Frances)
Katy Kujawski (Increasing Access to Care and Optimizing Health co-chair)
Stacie Lechot (Increasing Access to Care and Optimizing Health co-chair)
Jonny Walker (Reducing HIV-Related Health Disparities co-chair)
Rick Pongratz (Reducing HIV-related Health Disparities co-chair)
(Limited to summer)

Technical Assistance provided by:

Rebecca Schliep (HIV Prevention)
Rafe Hewett (HIV Prevention)
Lynsey Winters Juel (IACHA Coordinator)
Sherry Dyer (IACHA Facilitator)

Reducing HIV Incidence Committee

a. Whitney Holman-Ginder
b. Alex Zamora
c. Frances Nagashima
d. Darlene Burke
e. Chris Bidiman
f. Shane Anderson
g. Marie Florez

Technical Assistance: Rebecca Schliep

Increasing Access to Care and Optimizing Health Outcomes Committee

a. Kathy Kujawski
b. Stacie Lechot
c. Linwood Fraser
d. Kituta Asimba
e. Gary Rillema

Technical Assistance: Rafe Hewett & Jamie Perry Strain

Reducing HIV-related Health Disparities Committee

a. Jonny Walker
b. Rick Pongratz
c. Lynn Opdyke
d. Mary Linn
e. Bebe Thompson
f. Mercedes Walser

Technical Assistance: Treena Clark, Sheri Cook & Lisa Kramer

IACHA Meeting Attendee List – April 2013

Members
Shane Anderson
Kituta Asimba
Darlene Burke
Chris Bidiman
Sky Blue
Linwood Fraser
Whitney Holman-Ginder
Katy Kujawski
Stacie Lechot
Mary Linn
Frances Nagashima
Cynthia Lynn Opdycke
Gary Rillema
Bebe Thompson
Jonathan Walker
Mercedes Walser
Rick Pongratz
Alex Zamora

Technical Assistance Providers
Sheri Cook
Treena Clark
Sherry Dyer
Rafe Hewett
Lisa Kramer
Rebecca Schliep
Eric Seelbach
Lynsey Winters Juel

Guests
Marie Florez
Diane Zhitlovsky
Kaden Sinclair
Dieuwke Spencer
Aimee Shipman
Kris Spain

Idaho Advisory Council on HIV and AIDS Meeting
April 12-13, 2013

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 (4) 5 (11)

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 (13)

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

Meeting Rooms:	1	2	3 (7)	4 (3) (+1 for Friday)	5 (4) (+1 for Saturday)
Meals:	1	2	3 (3)	4 (5)	5 (7)
Hotel Rooms:	1	2	3	4 (3)	5 (9)

Comments:

- Meals you bring in are better than the hotel's
- Meals seem to be the best when Lynsey brings them in.
- Normally the meeting rooms are great, but this Red Lion had a very noisy group next door- it was hard to hear and concentrate.
- May have sandwiches with condiments on side
- I did not like being sat on the inside of the tables. For that meeting room, we should try a different configuration
- Union building: difficult to see/engage with entire group

4. On a scale of 1-5, with five being the highest score, how do you rate the facilitator?
   1 2 3 4 (1) 5 (13)

   Comments:
   - Excellent, outstanding!!

5. Which parts of the meeting did you find the most useful?
   - Committee work and program updates
   - The information of the changes that are going on in the state
   - Presentation on decriminalization, time clarifying with DHW
   - Small group work
   - Both formal and informal interactions
   - Guests bringing new ideas
   - Subcommittees as well as introduction to guests and welcoming, plus filling in a membership spot for HIV positive (wonderful young lady)
   - ADAP meeting with head of department
   - Specific questions open to dialogue, updates, subcommittee work groups

6. Which parts of the meeting did you find least useful?
   - Non-answers from the DHW Bureau Chief
   - Some break-out parts of meeting (ADAP funding)
   - This time I found the viral hepatitis update least useful
   - Committee reports were good, but felt a bit long. I suspect this may be because of the re-alignment and changes in committees
   - Discussion on criminalization. He was high on passion, but lacked facts.
   - I am also concerned about the conflict with Dieuwke

7. What additional types of information, training or technical assistance would you like to receive at future meetings?
   - I like the ICON idea; great way to get the message beyond this meeting
   - I think we need more direction on what needs to be addressed in the committees based on work plan
   - More presenters like Kaden to find concerns which this board may be able to help
   - Continued updates on Health Care Reform, possibly more often than our meeting times
   - How could we include and reach out to the minority group? What does the Wellness Center do to address specific refugee populations?
   - HRSA updates on what they expect from our ADAP program
   - Viral Hep

8. Do you have any other comments regarding the meeting and/or accommodations?
   - Update the committee report forms to be on a paper with the work plan
   - I would like the board to invite one of the congress members to an IACHA meeting so that they can acknowledge our achievements and value what we are doing!
   - Food was somewhat a bummer this time around.
   - Other than the issues with my room, I found the rest of the accommodations were great. The food in the bar is much improved. My hotel room was not clean. I found shampoo and conditioner (used) bottles in the shower, an open bar of soap on the sink, a fork next to the coffee pot and old coffee in the pot. The rest of the room appeared to be clean, but it was hard trust that room being clean.
   - Thanks for all your hard work!
   - ADAP presentation was somewhat revolving or very confusing to not having answers
   - As a side note, I would like to re-present the idea of moving to a message board type system for some discussions. I would be happy to put together a presentation for a future meeting if that is something we wanted to pursue (Shane)
   - Hard to hear speakers on the second day
   - Union Hall: 1. Wi-Fi didn't work; 2. Very bad glare off white board
   - Red Lion: Can we get a portable microphone and speaker in case we need it?
   - 1st day room was uncomfortable (hot and weird seating arrangement)
   - Great as always! Thank you.