Idaho Advisory Council on HIV and AIDS

Meeting Report

September 21 & 22, 2012

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Opening Remarks and Introductions

Chris Bidiman and Bebe Thompson, IACHA Co-Chairs, welcomed everyone to the regular September meeting of IACHA. Sherry Dyer, the meeting facilitator, reminded the members of the guidelines for success and the method for decision-making.

New CDC HIV Planning Guidance – Erick Seelbach

Erick distributed material that provided a summary of the CDC HIV Planning Guidance, comparing the 2004-2011 Guidance to the current HIV Planning Guidance released July 2012. The Guidance sets standards and a framework for how community planning organizations must function and collaborate. Plans must align every program with the National HIV/AIDS Strategy.

The Health Department's new HIV Prevention Guidelines shift a little away from pure prevention to a more comprehensive collaborative approach with prevention and care resources across communities. The focus needs to be on high impact prevention interventions tailored to communities. There is a shift to helping health departments get interventions out and collaborate with programs and providers in geographic areas.

Several members agreed that, while IACHA's focus has been forward thinking, there is understanding of the need to formalize action/activities and to resolve any possible disconnects and for ensuring collaboration to keep people in HIV care.

The 52 monitoring and evaluation indicators have been reduced to 4 questions. The role of HIV planning groups is to ensure plans, activities, and actions move toward this comprehensive, integrated approach.

Lisa Kramer, the IACHA representative from the Idaho Department of Education, asked to what extent education has a role in the guidance. Education is not mentioned in the National HIV/AIDS Strategy and schools are mentioned once. However, everyone knows schools must be represented and involved.

Relationships need to be strengthened among HIV care, prevention and surveillance. Community planning needs to address how we use the surveillance data we have to inform our questions and to inform our plans. A key focus of the changes is to take down silos across all services for the best impact and to do more with less, which requires greater collaboration.

The HIV planning process includes stakeholder identification, a results oriented engagement process and jurisdictional plan development, implementation and monitoring. It is important we ensure we are addressing how we best engage all of the providers, programs, and client representation in order to ensure comprehensive care services.

New CDC Guidance for Comprehensive Plan – Lynsey Winters Juel

With the publication of the CDC HIV Planning Guidance, there are three areas that IACHA must address and/or consider. These include: new monitoring questions, new requirements for the letter of concurrence/non-concurrence/concurrence with reservations and the membership profile.

1. Monitoring Questions: CDC issued new guidance monitoring questions that IACHA needs to be able to respond to.

   Question 1: To what extent did HIV service providers and other stakeholders who can best inform the coordination and collaboration of HIV prevention, care, and treatment services participate in the planning process*?*

   Response: In the Plan, we covered at length the extensive involvement of IACHA and our process for plan development.

   Question 2: To what extent did the engagement process achieve a more coordinated, collaborative, and seamless approach to accessing HIV services for the highest-risk populations?

   Response: We covered how we engage stakeholders and prioritized populations. We also stated the impact of that engagement. Dr. Blue suggested a results orientation be included in our response. "How did each of these pieces add to the needed and expected results"?

   Question 3: To what extent was input from HPG members, other stakeholders, and providers used to inform and monitor the development and implementation (or update) of the Jurisdictional HIV Prevention Plan?

   Response: We stated in the Comprehensive Plan that the IACHA Data Committee will create a monitoring tool.

   Question 4: To what extent were surveillance and service data/indicators utilized to inform and monitor the development and implementation (or update) of the jurisdictional plan?

   Response: We included our Epi Profile summary and attachment along with prioritized populations as determined by health districts and RPG's. The monitoring tool will be applied for this purpose. Additionally, we included the following service indicators/ data:

   - *Number of individuals in care in each health district*
   - *Performance measure outcomes*
   - *The gaps analysis tool of services available in each health district*

   The IACHA Data Committee will develop a monitoring tool.

   Lynsey queried the group regarding what is best process to go through these questions to keep data relevant. Members agreed that these 4 monitoring questions need to be asked and answered at each meeting. Additionally, the process of developing the Plan must be documented in our meeting minutes.

Letter of Concurrence: The Letter of Concurrence with Reservations was written in February 2012 did not meet the requirements set in the new CDC HIV Planning Guidance (the letter referenced programs that are no longer funded and did not address the process of the IACHA involvement in the development of the Plan). The letter must identify whether or not the planning body concurs with the Comprehensive Jurisdictional Plan as written by the Health Department. In addition, the letter must describe the process by which stakeholders were involved with guiding the development of the Plan.

Decision: The members indicated full concurrence with the Jurisdictional Comprehensive Plan.

A letter was drafted and presented to the members.

2. Membership Profile (as submitted to CDC)
Lynsey presented the IACHA Membership Profile that will be sent to CDC along with the Jurisdictional Comprehensive Plan. This profile was based on the members that were surveyed in January 2012.

What is AHEC? – Lynda Bennett

Lynda Bennett of AHEC (Area Health Education Center) provided an overview regarding the Center. AHEC works through Mountain States Group. It is federally funded through HRSA. AHEC works through the WWAMI (Washington, Wyoming, Alaska, Montana and Idaho) Program to increase and retain primary care providers in rural and underserved areas of Idaho. AHEC works with children and young people to encourage them to become medical providers and come back to rural Idaho. We need doctors, nurses, dentists to help people make healthy choices and to support chronic disease management.

Many of the people living in Idaho's rural areas are age 60 and over – one of highest age demographics in the U.S. There is a lack of sufficient primary care providers for rural areas. The question was posed: Are people living with HIV/AIDS living in urban areas due to lack of services in rural? If we provide more services in rural areas, would more people live or stay in those areas? We need more primary care providers in our rural areas.

Lynda will be working to promote the IACHA goals in other groups she is affiliated with. IACHA had an article in the September, 2012 AHEC publication and we will do more in the future.

Epi Presentation: Syphilis and HIV – Jared Bartschi

In the past, Jared has shared information about the epidemiological interaction between STD and HIV (co-infection). Inflammation also compromises the immune system and increases the potential for transmission between syphilis and HIV.

Co-infection of syphilis and HIV is not thought to alter the progression of primary and secondary syphilis, but it has been shown to affect other aspects of syphilis.

Complexities of HIV/syphilis co-infection include the difficulty of lab testing, the more frequent and rapid progression to neurologic (mental) involvement, which can happen at any stage), the more rapid progression to tertiary manifestations and treatment failure (relapse).

There was a resurgence of syphilis in the late 1990s due to changes in sexual behavior, in particular, those behaviors of men having sex with men. Incidence of syphilis is highest in the upper Midwest, Montana, Idaho and Oregon.

In Idaho, over the last two years we are seeing a significant increase in syphilis outbreaks. Since June 2011, there have been 46 cases, mostly in districts 3 and 4, involving 44 men and 2 female. The median age is 35 with an age range of 30 - 56, including MSM, MSMW, and WSM.

HIV Prevention Update – Rebecca Schliep

IDU Risk Assessment

We started our contract with Closed Loop Marketing and Advertising (CLM)in September 2012. CLM will be implementing the survey by conducting participant recruitment, survey distribution, and processing the results. CLM will begin by piloting the survey to obtain feedback on survey length, flow of questions, understanding and language before beginning statewide survey implementation.

HIV Post Award Site Visit Assessment

CDC conducted Idaho's PS12-1201 HIV Post Award Site Visit Assessment September 19 0 20, 2012. The purpose was to assess grantees redirection of prevention programs to align with NHAS. The site visit was conducted by Idaho's project officer Odessa Dubose and the acting team leader of the Division of HIV/AIDS Prevention, Melanie Sovine. The site visit was designed to be a high level 'snap-shot' to identify the programs deficiencies. CDC should be providing a follow-up report that summarizes their findings.

As an example of the specific feedback from CDC, looking at social marketing and how we are currently tracking and monitoring this is by looking at agency reports of events with respect to event date, the key message, the target audience, and the estimated exposure. Local campaigns have focused on testing event promotion, reduction of HIV risks, and encouraging people to know their HIV status.

Social Marketing activities will need to change from advertising for services (awareness days) to targeted key messages encouraging behavior change and to encourage people to get tested. The social marketing activities needs to address the local epidemiology.

Our new funding opportunities must be aimed at yielding results. We are below the CDC benchmark of 1% positivity. CDC does recommend 'Know Your Status' but it was pointed out that we are diluting our seropositivity with all of the HIV screening. It's time to change our focus from general awareness testing to very targeted testing. Prevention efforts must be high impact.

- As an example of combination High Impact Prevention (HIP) Testing – Clinical and community based

Partner Service –District Health Departments

- Linkage to Care – MCM
- Behavioral Interventions* – Mpowerment, Cuidate,CRCS

*Behavioral Intervention (cannot be done as standalones)

Change considerations for IACHA include: Regional planning groups need to be viable for the Health District. They were impressed with the community planning efforts and products we are supporting. We must support health districts for more targeted testing and worked toward prevention with positives. Any requests for general projects and specific projects must meet the needs of the health department.

Northwest AIDS Education Training Center Update – Judy Thorne

We are receiving more requests for technical assistance such as policy and procedure formation. In FY12 we trained 413 people – 27% medical doctors and 36% nurses.

We are increasing our focus for training to pharmacists and Physician Assistants. Attendees for the training represent several employment settings, the largest being college academia 18%, mental health/substance use – 16%, and non-health/not working – 21%.

Our long term training model is to:

- Identify sites where rapid test training can be expanded and supported
- Build capacity in districts where there is low provider support

We support the HIV fellowship at the Wellness Center through education opportunities and preceptorships. We are working to decrease provider stigma through cultural awareness in support of a key IACHA objective.

We will increase HIV/HCV capacity building and incorporate Hepatitis C. We are training ISU faculty to teach students in P.A./Pharmacy/Nursing. ECHO telehealth exists in three sites

Lynsey raised questions regarding education options for coordinators of Drug and Mental Health Courts – Ada County Drug Court. Judy stated that support would require being able to draw a direct correlation to the goals and guidance of NWAETC.

Affordable Care Act/Health Care Reform – Corey Surber

As Director of St. Alphonsus' Community Health Initiatives, Corey's role is to educate consumers, advocates, etc. on the rationale of the Affordable Care Act. Three components that need to be addressed: access, cost, and quality. Shifts in one of these areas affect the others.

The drivers for Health Care Reform include:

- "Access" for seniors, low income, and severe health issues. Currently 50 million people are uninsured
- The cost of health care nationwide represents 17.6% of Gross Domestic Product. 20% of families experienced financial difficulty due to medical bills.

There has been a dramatic per capita escalation in health care expenditures. 5% of Americans covered one half of the total health care costs – mostly related to end of life care.

Goals of the Affordable Care Act are:

- Make insurance accessible and affordable
- Delivery and reform of health care provision
- Ensure the program can pay for itself

Corey reviewed the multiple aspects of Health Care Reform including what is being done, what the costs could be, what the long term goals are of the Reform Act and how states, particularly Idaho, are addressing this.

Ryan White Part B Pharmaceutical Coverage – Dieuwke Spencer

A letter in support of ADAP purchasing PCIP insurance for clients was sent to the Division of Public Health Administrator, Jane Smith, and the Chief of the Bureau of Clinical and Preventative Services, Dieuwke Spencer, on behalf of IACHA.

Dieuwke Spencer, now in a new position as Deputy Administrator, Division of Public Health, stated that Director Armstrong must make the decision. There is not a lot of support to pay insurance for any group. Legislators make the distribution of state funds decision. Dieuwke stated that if we have no state funding from the legislature, we have no Ryan White Program due to the Federal Maintenance of Effort requirement. With the legislature, we have one opportunity to make the proposal for this change. If we get it wonderful, if we lose it, we risk losing it all.

On January 1, 2014, the Affordable Care Act will be fully in force. According to Dieuwke, there will not be any decisions until after the election in November. During the last three years, ADAP Emergency Relief Funds have been accessed in order to sustain the program and meet the ever increasing need. During the site review in April, a statement was made by the review team that there will be no more emergency funds beginning in April 2013.

Jonny raised the question, "What will we do for the 50-60 people who will not receive money for drug coverage? Who do we have to talk to?" Dieuwke stated that while DHW totally gets this issue, we must act cautiously and judiciously. We need a contingency plan? How do you take services away from people?

Rick asked whether we need to address philosophical issues within the Department, or is it purely legislative.

Dr. Blue said we should take this concern to every voting person in the State to gain support for increased funds to cover the gap. The Legislature could help us get more general funds. We need to become the voice of Idaho and connect with communities in Idaho.

Casey stated Medicaid is paying for insurance for kids. We need to know "How do they do this and how can we do likewise?".

Jonny stated that Wyoming and Iowa doing this – funding for gaps in coverage. How do we do likewise in Idaho? Dieuwke responded that initial discussions have been underway with Director Armstrong.

The question was asked whether there are conversations with drug companies to support the gap in 2013.

Dieuwke Spencer stated that she would look into the insurance laws to be able to better understand the requirements and/or restriction. Additionally, she stated that she would be happy to come back and talk about this again and keep people updated for moving forward. But we need to be realistic – this is not an easy sell in this state.

Idaho Department of Education – Lisa Kramer

The Idaho Department of Education budgets $140,000 annually for school health initiatives.

The new comprehensive Sex Ed Training video, "Sex, etc." is available to elementary school teachers and administrative staff. This program is designed for elementary level classes focusing on risk reduction. We have completed this training for educators with the Nez Perce Tribe. This is a six hour course.

Jurisdictional Comprehensive Plan: A work in progress – Lynsey Winters Juel

Lynsey Winters Juel prepared the Council for the continuing work of finalizing the Jurisdictional Comprehensive Plan. Regarding the goals, do we have enough information? Do we have what we need to move forward toward achievement?

Lynsey overviewed the goals and strategies of each of the three focus areas of the Jurisdictional Comprehensive Plan:

1. Reduce HIV incidences
2. Increase access to care and optimizing health outcome
3. Reduce HIV related health disparities

She identified work groups and group leaders. Lynsey challenged each group to review their section of the plan and make suggested changes and improvements as needed in order to expand and refine the goals and strategies/action steps.

A fourth work group (the Data Committee) was tasked with developing a Plan monitoring tool to assist IACHA with evaluating progress of and developments for the goals and strategies over the life of the Plan.

The 4 work groups spent 2 hours working separately to develop edits and additions to the goals and strategies.

Ryan White Part B and ADAP Updates – Bebe Thompson

Bebe provided an update on the ADAP numbers for FY2011, April 1, 2011 thru March 31, 2012. For the 12 month period, 231 clients were enrolled, 55 of whom were new clients. 210 clients received at least one medication. 3,866 scripts were filled. Compared to FY09 and FY10, ADAP enrollments in FY11were up in all 3 tracked categories of Clients Served, New Clients Enrolled and Clients on the Wait List. ADAP expenditures have also continued to increase in each year of the last 3. Bebe gave detail breakdowns of clients receiving direct services.

Bebe presented a summary of the eight goals developed as a result of the April 2012 RWPB site visit. Strengths of the program include:

- Well organized and easy to follow administrative procedures and documents
- QM plan in place with systems to track and report data
- Several programmatic and fiscal areas were given ratings of excellence
- Relationships with contractors were assessed as open and productive

The Recommendations for improvement involved areas of ADAP recertification, site visits, contractor quality assurance reviews and monitoring programs and policy development.

A key recommendation included the formation of an ADAP Advisory Committee through IACHA for the development of ADAP rules and procedures. The

following members and technical advisors agreed to serve on the Committee: Dr. Sky Blue (infectious disease specialist), Chris Bidiman (Medical Case Manager), Gary Rillema (Idaho Public Health District Representative), Stacey Lechot (Medical Case Manager), and Jamie Strain (Wellness Center/Case Management).

Bebe advised that pharmacist, Dave Hachey, has agreed to serve. Bebe will be rounding out the membership with the addition of a consumer, a nurse and a Spokane-based pharmacist.

IACHA Administrative Updates – Lynsey Winters Juel

Lynsey reviewed the following updates for IACHA members.

1. Conference Attendance: Bebe Thompson attended the NASTAD Annual Meeting and Chris Bidiman attended USCA. Due to extra funding from Mountain States Group, two additional members will attend conferences this year: Francis Nagashima and Jonny Walker. IACHA will have funds in 2013 for one person to attend a conference.

2. Regional Planning and Funding Report:
   - District 1 received $1000 for a World AIDS Day event to build capacity.
   - District 5 received $1000 for their efforts to build capacity. Funds covered meals and brochures related to their efforts
   - District 7 received $1000 for education presentations to youth in their area.

   Planning Groups can still apply for funds this year. New guidelines have been established for regional planning groups which constitute a shift from how RPG funds can be used. We will receive guidelines that contain the new restrictions.

3. There will be 4 meetings in 2013. Two will be face to face meetings and 2 will be web-based. The typical 3rd annual face to face meeting had to be cut due to funding restrictions. We will test run the new web-based approach. Through group discussion, 2013 meeting dates were agreed upon:
   - January 16 videoconference format from 12 p.m. to 4 p.m.
   - April 12-13 Full meeting in Boise
   - June 5 videoconference format from 12 p.m. to 4 p.m.
   - September 27-28 Full Meeting in Boise

Membership Committee Report – Chris Bidiman

Chris Bidiman presented Lenny Linwood for membership on IACHA. Lenny would fill one of the HIV slots of the membership roster. Gary Rillema agreed to be Lenny's mentor.

Chris informed IACHA that Idaho Purce, long time IACHA member, had made the decision to resign her membership. This leaves the prevention slot of the member roster open. Other open slots were reviewed. Terms of most current members will expire during 2013. The membership committee will review the expiration guidelines and will be prepared to make membership recommendations in 2012.

There was also discussion about including a viral hepatitis slot.

Decision: IACHA membership agreed unanimously to approve Lenny Linwood as a new member.

HIV Prevention (Activity from January 1-June 30, 2012) – Rebecca Schliep

Our required core components are HIV Testing, Comprehensive Prevention for Positives, Condom Distribution and Policy Initiatives. For HIV testing, those agencies that we are funding will also receive complementary social marketing funds. From the first six months testing sites totaled 54. There were 2,440 test events resulting in 16 newly diagnosed positives and 2 previously diagnosed.

Almost 115,000 condoms were distributed with the highest proportions in the Panhandle District with almost 24,000 and Central District Health with 30,000 followed by South Central with 16,500 and Eastern Idaho District Health with almost 11,000. Agencies will report on who they are targeting for condom distribution. We are doing a good job with condom distribution.

It was difficult to get positives involved with CRCS. It could be that the agencies are not the right fit or that incentives need to be included. We will explore the possibility of offering incentives next year.

The Mpowerment Project/Genesis Project is successfully focusing on evidence-based interventions that mobilize young gay/bisexual men to shape healthy communities for themselves and to build positive connections. The Mpowerment Project – Outloud in Health District 4 is conducting group meetings that are community level interventions. Their marketing efforts have reached 908 high-risk negative individuals.

From January to June, 2012, Social Marketing campaigns have reached over 260,000 individuals in the State. Five DHDs and 4 CBOs receive funding from the HIV Prevention Program for social marketing activities. The social marketing

funding has been awarded to the contractors who are providing community based HIV testing.

Cuidate – The HIV Prevention program and the Adolescent Pregnancy Prevention Program has a joint contract with CCJ to provide Cuidate in health district 3. There has been a total of 76 students enrolled and 67 students have completed the program.

HIV testing needs to be much more targeted. The benchmark for CDC is 1% positivity. Looking at the first six months of 2012, our HIV testing from all contracted sites is 0.7%.

Through Mpowerment 1,436 high risk individuals have been reached. The Mpowerment project in Boise, Out Loud, just started their contract in June 2012 after finishing the pilot project.

Technical Assistance: Members were encouraged to work with Rebecca if their agency is in need of technical assistance.

During the post-award site visit assessment, CDC suggested that Idaho look at some additional intervention. During the next IACHA meeting, the group may be asked to review and provide recommendations for expanding interventions to include:

1. Artas - Anti Retroviral Treatment and Access Services. The focus is on strength based management with the goal of linking recent diagnosed persons to care.
2. CLEAR – Choosing Life Empowerment Action Results. The program provides skills for making healthy choices. May require some minimal credentialing – Rebecca will continue to evaluate.

New intervention recommendations will have to be made by June. We need to work with IACHA in 2013 to identify what behavioral interventions would work for Idaho.

Hepatitis C Update – Rafe Hewett

Rafe presented trends in Hepatitis C and related morbidity in the United States. Following are highlights of those trends: 2.7 – 3.9 million people in the U.S. are living with the Hepatitis C virus. There were 17,000 new infections in 2010. Hepatitis C is a major cause of liver disease. In 2007, 15,106 deaths in the U.S. were attributable to HCV. In the next 40-50 years it is possible that 1 million people will die from HCV-related complications. HCV related costs exceed $5 billion annually.

These statistics provide a strong rationale for the benefit of HCV diagnosis and care. It is important to ensure early clinical evaluation and ongoing monitoring, particularly given that treatment response decreases as liver disease progresses.

Protection measures, especially to avoid further harm, include vaccination against Hepatitis A and B, decrease or eliminate alcohol consumption and counseling to encourage weight loss for persons who have a BMI ≤ 25 and to help reduce the risk of transmission to others.

Recommendations for augmenting current HCV guidelines have come out because of concerns of limited effectiveness of current testing strategies and the increased morbidity and mortality of chronic HCV. Current data show that 45-85% of adults with chronic HCV are unaware of their infection.

New recommendations for prevention and treatment include one time testing for adults born between 1945 and 1965 who have not been tested for HCV risk factors. Baby boomers represent more than 75% of adults with hepatitis C. All persons with identified infection should receive alcohol screening and interventions as appropriate, including referral to appropriate care and treatment services based upon indications.

The Viral Hepatitis Prevention Program has received $29,000 for its new grant cycle for drug treatment and community settings. The Program goal is to: Increase the proportion of persons living with HCV infection who are made aware of their HCV infection through testing and ensure they are linked to prevention and clinical care services.

NASTAD Annual Meeting – Bebe Thompson

There are new (340 B) standards for registered entities and the OPA (Office of Pharmacy Affairs) will be performing site visits to ensure compliance. Idaho ADAP will not likely be on the list considering our small size. However, there are concerns regarding Idaho's ADAP method of medication distribution.. At present, there is no clear system in place to track a 340B purchased medication from manufacturer to intended ADAP eligible recipient. Several methods of ensuring compliance with the 340B and ADAP regulations have been considered. At present, the cost of returning medications to A-S is cost prohibitive with a 25% of cost restocking fee. Bebe discussed the potential for instituting a new web based system product labeling system through A-S that will link and accurately track medication distribution while ensuring that product labeling meets the requirements of the Idaho Pharmacy Board Rules.

Open Discussion Regarding Ryan White Part B ADAP Shortfall

Bebe opened the opportunity for discussion of the group. Points made were

- IACHA does not approve of the decision to put 100 people on our waiting list.
- Our ADAP Advisory Committee needs to learn about insurance laws and to determine what actions are needed.

- We need to determine where our advocacy effort is most useful

The ADAP Advisory Committee will further discuss the issue of how we address the ADAP short fall for coverage. Jonny Walker will participate with the ADAP Advisory Committee for this project.
IACHA will write a letter to the Department to further emphasize the support of purchasing insurance and identifying next steps and to encourage a decision from the Board of Health and Welfare. The advisory committee will need to determine what "plan b" is for 2013, if there is no additional emergency funding available and a decision on health insurance premium payments is delayed further. IACHA will need to write letter in support of ADAP Insurance to request a decision to come from the Administrative Board of Health and Welfare.

Update to Jurisdictional Comprehensive Plan

Updates to the Plan are reflected in the updated version of the HIV and Viral Hepatitis Jurisdictional Comprehensive Plan. This plan was submitted to CDC on September 28, 2012. The Plan is available on the following websites:

Safesex.idaho.gov (click on HIV & AIDS)
http://www.mtnstatesgroup.org/IACHA.htm (*please note, this site is being updated, so it may not be as reliable for up to date documents*)

Data Committee Report– Katy Kujawski

The Data Committee developed a template Data Monitoring Tool for evaluating progress of the goals and work being done by the committees. Lynsey and Katy will complete this work in the coming months.

Quarterly, the IACHA Coordinator will complete two matrices (one condensed; one detailed) to track the progress of the strategies as they are associated with the three focus areas and viral hepatitis goals. Progress will be noted with a simple color scheme: green indicates that the strategy was successfully completed; yellow indicates that challenges are being met and timely success is not likely; red indicates that the deadline has passed and the strategy was not met. If a strategy went into the "red," but later the activities were completed, it may move into the "green."

The more detailed matrix will be used as a reference for IACHA and funders to better ascertain the exact activities that have or have not been successful at any point during the three years as identified in the Jurisdictional Comprehensive Plan.

The following is the condensed matrix (note that all strategies are “in the green” to begin):

		Strategy 1	Strategy 2	Strategy 3	Strategy 4	Strategy 5	Strategy 6
Focus Area #1	Goal 1	x of 3	x of 3	x of 3	x of 1	NA	NA
	Goal 2	x of 1	x of 2	x of 1	x of 1	x of 1	x of 1
Focus Area #2	Goal 1	x of 4	x of 5	x of 3	x of 3	NA	NA
	Goal 2	x of 3	x of 2	x of 1	x of 1	NA	NA
Focus Area #3	Goal 1	x of 1	x of 1	x of 1	x of 1	NA	NA
	Goal 2	x of 3	x of 3	x of 2	x of 2	x of 1	x of 3
Viral Hepatitis Goal #1		x of 4	x of 3	x of 2	NA	NA	NA
Viral Hepatitis Goal #1		x of 2	x of 2	NA	NA	NA	NA
Viral Hepatitis Goal #1		x of 2	NA	NA	NA	NA	NA

Idaho Advisory Council on HIV and AIDS Meeting
September 21-22, 2012

Meeting Evaluation

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

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

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 (10)**

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

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

Comments:

- It's hotel food- what I do expect ☺
- Yipee! No potato bar! Eggs are good too!

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

1 **2** **3** **4 (4)** **5 (8)**

Comments:

- Sheri is great. I'd like her to be more forceful with keeping us on schedule.

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

- Workgroups, Affordable Care Act, Prevention updates
- Prevention grant
- Judy Thorne
- Syphilis/HIV info
- Insurance/Obamacare 2014
- ACA presentation
- AHEC and laws of health insurance
- Workgroups. Some presentations (Jared, Corey and Lisa)
- Committee work/interaction is good

- I feel like we were able to more fully discuss and understand topics, issues, goals in this meeting that in previous. I liked the agenda and speakers- especially bringing the Deputy Director in to address insurance concerns and scheduling 2013.
- Corey Surber-ACA- we need to continue to look at/consider how health care reform is affecting services and funding streams, ADAP and Prevention/STD contracts

6. Which parts of the meeting did you find least useful?
    a. The guest's questions and use of time for personal questions/stories
    b. AHEC
    c. ADAP wraparound discussion
    d. Extended discussions- which were minimized this time
    e. Idaho Dept of Ed update
7. What additional types of information, training or technical assistance would you like to receive at future meetings?
    a. Information on what CBOs need to move towards with the new Obamacare 2014… how to survive the shift
    b. H&W grant apps, partner engagement and involvement
    c. Make more time for groups- breakout sessions
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.)
    a. I miss having the stated goals of each presentation (IACHA action needed) being on the agenda… but I'm weird like that.
    b. Knowledge of youth at risk- options for referring to seek information and modes of exposure with behaviors and risk
9. Do you have any other comments regarding the meeting and/or accommodations?
    a. Guest comments were disruptive and off topic
    b. Please have other options for meals
    c. We needed more time to work on our focus groups
    d. The room was very cold again. I also thought the food was lacking this time.

e. The breakfast on Saturday was pretty skimpy—yogurt and granola would have helped to make it more filling. For those who done eat bread, this meal ended up being just cheese and juice.

Attachment 2: IACHA Attendee List

Members
Shane Anderson
Kituta Asimba
Mary Beaver
Chris Bidiman
Sky Blue
Darlene Burke
Lisa Kramer
Katy Kujawksi
Stacie Lechot
Frances Nagashima
Cynthia Lynn Opdycke
Gary Rillema
Bebe Thompson
Jonathan Walker
Mercedes Walser
Rick Pongratz
Alex Zamora

Technical Advisors
Crystal Bastin(sitting in for Sheri Cook)
Treena Clark
Sherry Dyer
Casey Moyer
Erick Seelback
Jamie Strain
Judy Thorne
Lynsey Winters Juel

Guests
Jared Bartschi
Lynda Bennet
Corey Suber
Michael Pitman
Diane Zhitlovsky

Absent Members
Whitney Holman
Mary Linn
Alisha Rogers
Denielle Townsend