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6/8/2000 5th National ADAP [AIDS Drug Assistance Program] Educational Forum DC

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T II
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The Title II Community
AIDS National Network

1775 " T " St. NW
Washington, DC 20009

Ph: (202) 588-1775
FAX: (202) 588-8868
Web Site at: www.t2cann.org
eMail: weaids@ix.netcom.com
Christopher D. Phipps, Esq.
Counsel

Service Projects:

CANAN
(Community AIDS National Alert Network)
National fax & eMail Alerts
CANAN_DC@AOL.com

The Title II T.A. Corps
Peer & Technical Assistance for Title II Community needs.
1. High Risk Insurance Pools
2. Disability/Benefits & "Back to Work"
3. SERCA (Southern Emergency Response Coalition for AIDS) Primary care access

TAEP
(The Treatment Access Expansion Project.)
New Tools for needs projection and policy development

The Voice of Title II
A newsletter for Ryan White funded service providers and clients

→ Cheryl

Citation —

TX'S Bill

2 Pages.

TII CANN
1775 T STREET NW
WASHINGTON, DC 20009
202-588-1775

FAX COVER PAGE

TIME: **4:32:34 PM**

DATE: **5/2/00**

TO: **Sandra Thurman**

FROM: **Bill Arnold**

SUBJECT: **5 National ADAP Educational Forum**

MESSAGE:

Sandy...

Invitation to participate in this year's National ADAP Educational Forum.

It's here in DC at The Monarch Hotel (former ANA) June 8-9-10. Would you like to "show the flag" as it were? If so, let me know and we'll work you in where you would like.

Regards, *Bill

William E. Arnold

TII CANN

1775 "T" Street, NW
Washington, DC 20009
Ph 202-588-1775
Fx 202-588-8868
Weaids@ix.netcom.com

Thursday, June 8, 2000

6:30 - 7:30 p.m. **Welcoming Reception**

7:30 - 9:30 p.m. **Dinner & Awards Presentation**

Friday, June 9, 2000

9:05 - 9:25 a.m. **Panel: "Ryan White & ADAP, Access to Treatment - A Bipartisan Model"**

9:25 - 10:45 a.m. **Challenges for Public Health HIV Providers & The Future of Care**

Treatment Update

40 Minutes

John Bartlett, MD, Professor of Medicine & Chief of Infectious Diseases
The Johns Hopkins University University School of Medicine
Ross Research Building, Room 1159
720 Rutland Avenue
Baltimore, MD 21206
(410) 614-3631
(410) 955-7889

This session presents an update on the many issues confronting clinicians, and the public health system in the care of individuals with HIV disease. An emphasis is placed on the challenges of reaching out to those individuals who are traditionally underserved - women, communities of color, and the multipally-diagnosed. An overview of the current treatment guidelines is presented as well as a step-wise approach to treatment with discussion of treatment failure, salvage therapy and the use of resistance testing.

30 Minutes

Drugs in Development

Richard Elion, MD
Washington, DC Private HIV Practice
1737 20th Street, NW
Washington, DC 20009
(202) 833-1222
(202) 332-2794
drrelion@aol.com

As presented in the previous talk by Dr. John Bartlett, HIV care providers must not only develop initial therapy

regimens, consistent with treatment guidelines, but also anticipate treatment failures and look at appropriate salvage therapy options. The development and availability of additional medications greatly enhances a clinicians ability to do this. This session presents an overview of current medications available, those drugs in the near-term (1-2 year pipeline) and offers some additional perspective on the possible future therapeutic options beyond that time.

Friday, June 9, 2000

11:00 - 12:00 p.m. **Medicaid, ADAPs & Entitlement Programs Utilization & Access to Care**

Jeff Levi, Ph.D.
Center for Health Policy Research
George Washington University
2021 K Street, NW, Suite 800
Washington, DC 20006
(202) 530-2363
(202) 296-0025
ihojxl@mail.gwumc.edu

Medicaid, ADAPs, Ryan White, and Medicare are the principal public health programs that finance care for individuals with HIV/AIDS. The interdependence of these programs in assuring continuity of care and treatment is crucial. This session presents the work of researchers in examining the utilization and access of these programs.

12:00 - 1:00 p.m. **Lunch**

1:00 - 2:00 p.m. **Health Care Financing Administration Initiatives**

Tim Westmoreland, JD
Director, Center for Medicaid and State Operations
Health Care Financing Administration
7500 Security Boulevard, Room C5223
Baltimore, MD 21244
(410) 786-3870
(410) 786-0024
twestmoreland@hcfa.gov
Assistant: Louvenia Anderson

The Health Care Financing Administration (HCFA) is the largest payor of HIV/AIDS care through both the Medicaid and Medicare programs. HCFA is also the agency which

works with states interested in demonstration waivers to expand eligibility for Medicaid, which several states are in the process of pursuing. The agency will also play an important role in the implementation of the Work Incentives Improvement Act. Meeting attendees will hear how HCFA is working on these and other issues which in turn impact state Medicaid, ADAPs and other public health programs.

2:00 - 3:30 p.m. **Caucus Sessions**

Corrections Caucus
Moderator: Dave Doolen
Tri County Community Health Center
P.O. Box 227
Newton Grove, NC 28366
(910) 567-6194
(910) 567-5678
mdoolen@aol.com

ADAP Caucus
Michael Montgomery, Moderator
Chief, HIV Care Branch
Department of Health Services
P.O. Box 342732
Sacramento, CA 94234
(916) 323-7357
(916) 327-3177
mmontgomery@dhs.ca.gov

Title II Caucus
Lanny Cross, Moderator
ADAP Director
NYS DOH/AIDS Institute
P.O. Box 2052
Empire Station
Albany, NY 12220
(518) 459-1641
(518) 459-2744
ltc02@health.state.ny.us

Medicaid Caucus
Annette Hanson, M.D.
Medical Director, Medical Assistance
Commonwealth of Massachusetts
600 Washington Street
Boston, MA 02111
(617) 210-5682

(617) 210-5865

or

Kathy King
State of Maryland
Medicaid

Caucus sessions provide an opportunity for conference participants to come together for discussion of issues of mutual concern. This session focuses on identifying challenges faced in program administration and begins to explore potential solutions.

3:30 - 3:45 **Break**

3:45 - 5:15 **Concurrent Breakout Sessions**

1. Medicare Drug Benefit Proposals
Jeff Crowley
National Association of People With AIDS (NAPWA)
(202) 898-0414

&

Patricia Newman
Kaiser Family Foundation

This session provides an overview of the various proposals for the Medicare program to be expanded to include prescription drug coverage; an assessment of the likelihood of legislative action, and the impact that these would have on people living with HIV/AIDS.

2. Work Incentives Improvement Act
Lisa Cox
AIDS Action Council
1906 Sunderland Place, NW
Washington, DC 20009
(202) 530-8030 Ext. 3077
(202) 530-8031
lcox@aidsaction.org

The Work Incentives Improvement Act (WIIA) is a major initiative which will positively impact the return to work of individuals with HIV/AIDS whose health status has improved by preventing the loss of health care benefits to these

individuals. This session gives an overview of the WIIA and examines the relationship of WIIA with state Medicaid and ADAPs.

3. Medicaid & Medicare: Opportunities and Challenges

Thomas P. McCormack
Programs, Policy, Legislative & Training Consultant
Title II Community AIDS National Network (T II CANN)
611 G Street, SW
Washington, DC 20024
(202) 479-2543
(202) 479-1169 FAX

Navigating the Medicaid and Medicare entitlement programs is critical for individuals with HIV/AIDS, their providers and other public health programs such as ADAP and Corrections. This session examines ways in which to fully benefit from these programs as well as the unique challenges faced in moving through the system.

4. Pennsylvania Medical Society Initiative

John Folby
Administrator, Pennsylvania ADAP
Department of Public Welfare
P.O. Box 8021
Harrisburg, PA 17105
(717) 772-6057
(717) 772-6179

Pennsylvania like many other states is interested in reviewing the appropriateness of physician prescribing habits to conformity of the NIH treatment guidelines for individuals who are ADAP clients. The Pennsylvania ADAP has teamed up with the State medical society and University of Pittsburgh-based AETC to develop a program which sets out to review utilization data and make provider-to-provider communication in cases where therapy appears to deviate from standard of care.

5. Michigan's Ryan White Corrections Planning District

Jacki Miller
HIV Case Management Coordinator
Michigan Department of Corrections
Bureau of Health Care Services
Grandview Plaza

PO Box 30003
Lansing, MI 48909
(517) 241-7123
(517) 335-0871
millerjk@state.mi.us

The State of Michigan has established a separate Ryan White planning district which not only coordinates input from HIV-infected inmates within the corrections setting, but facilitates communication with the other community-based consortia and community providers. The session provides an opportunity to learn about this initiative and how it has increased the awareness of corrections as well as community stakeholders and patients/inmates alike.

Session 6: Rural/Border Issues
HRSA (?); Title IV Clinic in Texas; Alabama

The importance and uniqueness of programmatic and treatment challenges in rural and border communities is presented.

Session 7: HRSA Update
HRSA Staff

Program updates and guidance from HRSA staff.

6:30 - 7:30 p.m. **Reception (Location to be determined)**

7:30 - 9:30 p.m. **Dinner**

Saturday June 10, 2000

7:45 - 8:30 a.m. **Continental Breakfast**

8:30 - 9:00 a.m. **Adherence Panel (Name)**
Guillermo Santos, D.O.
Medical Director
Betances Health Unit
280 Henry Street
New York, NY 10002
(212) 227-8401
(212) 227-8842

9:00 - 9:45 a.m. **Hepatitis-C Panel**
Jay Hufnagel, NIH, Mark Sulkowski, Johns Hopkins
(Cathy Mulligan, UCSF?)

Mark Sulkowski
(410) 614-4172
msulkowski@jhmi.edu

Hepatitis-C Co-infection represents one of the most challenging aspects in the clinical treatment of HIV. This session presents an overview of the crucial clinical considerations in treatment of individuals with Hepatitis-C and HIV coinfection, current standard of care, and issues for state ADAPs, Medicaid and Corrections to address when making formulary and eligibility decisions. It also presents a look forward at future treatments and research in this area.

9:45 - 11:00 a.m. **Concurrent Breakout Sessions**

1. **Maryland Transitional Assistance Program**
   Coy Stout, LCSW-C
   MADAP Administrator
   Maryland AIDS Administration
   50 North Calvert Street, 5th Floor
   Baltimore, MD 21202
   (410) 767-5685
   (410) 333-2608
   stoutc@dhmh.state.md.us

2. **Indiana's High Risk Insurance Pool Experience**
   James Carr & Pat Reid
   5555 North Takoma Ave. #109
   Indianapolis, IN 46220
   (317) 251-8327
   (317) 251-8328 (FAX)
   jmcarr @ameritech.net

   Indiana has had great success in looking at its high-risk insurance pool as a means to take pressure off the state ADAP. This has resulted in solving many problems with access and enrollment in ADAP and offers other states a lesson on how to proceed in similar situations.

3. **Medicaid Expansion - Massachusetts Experience & Other State Initiatives**
   Annette Hanson, M.D.
   Jennifer Kates, M.A., M.P.A.
   Senior Program Officer
   Kaiser Family Foundation
   2400 Sand Hill Road
   Menlo Park, CA 94023

(650) 854-9400
(650) 854-4800\
jkates@kff.org

Many states have been examining Medicaid expansion waivers as a way to bring both pharmaceutical and other medical coverage to HIV-infected non-AIDS populations. Maine became the first state to have a Medicaid waiver conditionally approved by HCFA. Other states including Massachusetts are in the process of developing waivers, each of which must demonstrate "budget neutrality". This session presents an opportunity to dialogue with both the Kaiser Family Foundation, which has been assisting many states with their process and one of those states, Massachusetts.

4. **Targeted Outreach Strategies to Minority & Traditionally Underserved Populations**
   Social Marketing/Communications Consultants

   State ADAPs, Medicaid programs, health departments, community-based providers are increasingly concerned with the need to establish effective and responsive communications and outreach initiatives to underserved populations, focusing on women and communities of color. This session seeks to establish a general level of understanding among participants of the strategies employed when initiating social marketing strategies of this nature. An emphasis will be placed on understanding cultural differences, beliefs, barriers to treatment-seeking behavior, and other factors to be addressed.

5. **Corrections & Community Collaborations**
   Barry Zack, Centerforce
   1 - 2 of the 7 CDC-funded Corrections Initiatives

   Collaborations between community-based organizations and the correctional setting are critical to ensure both continuity of care and the appropriateness of that treatment. This session examines the efforts of one community-based organization in that regard and also presents information on the efforts of CDC-funded community-corrections partnerships.

6. **Side Effects Management**
   Johanes Koch, M.D.
   San Francisco General Hospital
   1001 Potrero Ave., 3D-5, SFGH
   San Francisco, CA 94110
   (415) 206-4753

   The longer-term management of HIV-disease coupled with the side effects of many component drugs utilized in HAART have led to a number of side effects which must be managed clinically. State ADAPs need to be aware of the frequency and importance of these complications as they make formulary and other decisions which can be responsive to client needs and the reality of the complexity of combination therapy and the management of HIV disease. Metabolic, GI, CNS and other complications manifest themselves in the clinical management of patients.

11:00 - 11:15 a.m. **Break**

11:15 - 12:15 p.m. **HIV Quality Care Network Presentation**
Christine Lubinski & Richard Moore, M.D.
Christine Lubinski, Staff Director
HIV Quality Care Network
Infectious Disease Society of America
(703) 299-0200
clubinski@idsociety.org

This session presents an overview of the HIV Quality Care Network, including program and data findings. The Network offers many lessons for state ADAPs, Medicaid programs and others to learn how to more effectively address both program management and enhance access to care, ensuring that appropriate standards of care are met.

12:15 - 1:30 p.m. **Lunch**
Speaker, Ryan White CARE Act Reauthorizaton

1:30 - 3:00 p.m. **Caucus Sessions**

1. **ADAP Caucus**

2. **Title II Caucus**

3. **Medicaid Caucus**

4. Corrections Caucus

Caucuses will reconvene to continue their identification of issues and action steps. This session focuses on using material presented during the conference to identify other challenges in program administration and opportunites to address these.

3:00 - 3:15 p.m. **Break**

3:15 - 4:00 p.m. **Panel: Where Do We Go From Here?**
Report From Caucuses to Conference Participants
Caucus Moderators

4:00 p.m. **Wrap-Up & Conclusion**

PAREXEL

June 28, 2000

Dear Colleague:

On behalf of our sponsors, I would like to thank you for your attendance and participation in the 2000 ADAP National Educational Forum. We believe that this year's conference was one of our most successful, as evidenced by the level of participant involvement in the discussions and workshops.

As was mentioned during the conference, one of the main goals of this year's educational forum was to produce a resource document which would summarize the various challenges and solutions discussed during the general sessions and the workshops. We anticipate that this document will be ready for distribution sometime by early fall.

In the meantime, we wanted to make sure that everyone had received copies of the presentations that were not included in the conference book and which were not readily available at the registration desk. Copies of those presentations are enclosed for your information. We are also enclosing a copy of the conference evaluation form. If you have not already done so, we urge you to complete the form and submit it no later than July 7. The comments that you provide to us are critical in securing sponsorship for the conference, as well as in helping to ensure that the educational venues that we provide are structured to meet your needs.

Lastly, we remind you that all reimbursement forms must be received no later than July 7. Please remember to submit all original receipts with your reimbursement requests.

Again, thank you for your participation in this year's conference. If you have any questions, please contact me at 703-535-5048 or Cathy Townsend at 703-535-5007.

Sincerely,

Veronica Ayala-Sims

Veronica Ayala-Sims
Project Manager

PAREXEL INTERNATIONAL MEDICAL MARKETING SERVICES, INC.

1101 King Street, Suite 600 • Alexandria, VA 22314 • Main Telephone: 703-739-0200 • Fax: 703-683-2239

RYAN WHITE REAUTHORIZATION

ISSUES OF NOTE
IN SENATE AND HOUSE BILLS

- SUPPLEMENT -

Humberto Cruz
New York State Department of Health
AIDS Institute

2000 National AIDS Drug Assistance Program Educational Program
June 8-10, 2000
The Washington Monarch Hotel, Washington, D.C.

SENATE AND HOUSE RYAN WHITE BILLS
PROVISIONS OF NOTE AND COMMENTS

ISSUE	SENATE BILL (S.2311 Passed 6/6/00)	HOUSE BILL (6/9/00 Specs)	NYS POSITION
Competitive component of Title II	Fifty percent of new Title II funds will be used for "supplemental" portion to be awarded to states for emerging communities, defined as areas with ***500*** to 1,999 cases of AIDS in the last five years. ***New Title II funds will be awarded as follows:*** ***a. 50% awarded to all states based on existing formula*** ***b. 25% or $5 million, whichever is greater, awarded to states for communities with 500 to 999 cases in the last five years;*** ***c. 25% or $5 million, whichever is greater, awarded to states for communities with 1,000 to 1,999 cases in the last five years.*** ***For purposes of awarding funds under b and c, the non-EMA component of the formula is removed. At least $20 million in new base funding must be available before b and c become effective.***	***Adds supplemental component of Title II for areas within states that are not eligible for Title I. Indicates that competitive funds will be available for development and care activities, primary care and social services. Eligibility criteria include: severe need; and evidence of disparities in access and services among affected subgroups and low income, historically underserved communities.***	Support competitive component of Title II supported by a portion of new funds. Do not support the use of Title II supplemental funds to create more Title I-like awards. ***House eligibility criteria re "evidence of disparities in access and services among affected subgroups and low income, historically underserved communities" will be difficult to document and appears to punish states that are doing well in this area by making them ineligible for funds.*** Recommended options: (1) All states should be eligible for the competitive awards to address priority unmet needs in all non-Title I areas; or (2) The competitive portion could be split into two components: non-Title I states would be eligible for one component based on a formula rather than based on the definition in the Senate bill; and all states would be eligible for the other component to address needs in non-Title I areas.

ISSUE	SENATE BILL (S.2311 Passed 6/6/00)	HOUSE BILL (6/9/00 Specs)	NYS POSITION
Competitive component of dedicated ADAP funds	***Three percent*** of dedicated ADAP funds will be used for a competitive component to assist states unable to provide treatments to all PLWH/A. Requires 25% match. ***These funds are to be used to serve individuals at or below 200% of poverty level.***	Two percent of dedicated ADAP funds will be used for competitive component to assist states in need. Requires 25% match.	Support House language with the exception of the match requirement. ***Do not support restrictions on eligibility for services in Senate bill.***
Formula	No change in formula, ***with the exception of the formula associated with the "emerging communities" component.*** Authorizes a study concerning appropriate epidemiologic measures and their relationship to financing and delivery of services.	***Retains existing 10-year weighted AIDS case count until 2005. In 2005, the tenth year of the case count will be based on HIV cases for the most recent one-year period for which data are available. This change takes effect only if the Secretary determines by 7/1/04 that HIV case data are sufficient for this purpose.*** Requires IOM study of surveillance based on HIV and whether it is adequate for use in formula awards.	A hold harmless provision is required if the legislation mandates a change in formula. ***Continuing to base the allocation of funds on AIDS is most likely detrimental to states that are making treatments available to PLWHA, as fewer people progress to AIDS.***
Hold harmless provisions	Changes Title I hold harmless provision so that formula awards will be no less than 98 percent of the amount received in the preceding fiscal year.	Changes ***Title I and Title II*** hold harmless provision so that formula awards will be no less than ***95 percent*** of the amount received in the preceding fiscal year.	Do not support House language. Could result in drastic reductions in awards and disruptions in services. ***Could lead to a maximum 25% reduction in the fifth year.***
Allowable uses of ADAP funds:			

ISSUE	SENATE BILL (S.2311 Passed 6/6/00)	HOUSE BILL (6/9/00 Specs)	NYS POSITION
(a) Use of ADAP funds for treatment adherence, medical monitoring, and lab testing	Allows ADAP funds to be used for treatment adherence and medical monitoring, but imposes a 10 percent cap on the use of ADAP funds for these activities.	Does not address the use of ADAP funds for treatment adherence, medical monitoring or lab testing.	Strongly support the use of ADAP funds for treatment adherence, medical monitoring and lab testing. There should be no cap on the use of ADAP funds for these activities. Medical monitoring, lab testing and treatment adherence support are essential components of the provision of treatments and should not be capped. Senate bill requires deletion of language regarding 10 percent cap. House bill requires addition of language allowing the use of funds for treatment adherence, medical monitoring, and lab testing.
(b) Use of ADAP funds for continuation of health insurance	Does not address the use of ADAP funds for continuation of health insurance.	Allows ADAP funds to be used for continuation of health insurance.	Strongly support the use of ADAP funds for continuation of health insurance. Senate bill requires addition of language allowing the use of funds for health insurance continuation.

ISSUE	SENATE BILL (S.2311 Passed 6/6/00)	HOUSE BILL (6/9/00 Specs)	NYS POSITION
Early intervention services	Allows for the use of funds for early intervention services, but limits the entities eligible for such funding to medical care settings and certain types of settings that are considered to be access points for medical care.	Allows for the use of funds for early intervention services in a variety of settings, including all entities receiving Title I or Title II funds. ***June 9 House specs indicate that the House provisions must be consistent with Senate provisions.***	Support ***May 11*** House bill. ***Do not support limitations in Senate bill.*** There should be no limitation on the types of settings that can use funds for early intervention services. All funded entities must be eligible to use funds for these services. CBOs that serve minority and other underserved communities may be the ideal settings in which to conduct early intervention activities. Limiting the settings in which early intervention services can be provided is not consistent with the new emphasis in both versions of the bill on identifying and serving persons not currently in care.

ISSUE	SENATE BILL (S.2311 Passed 6/6/00)	HOUSE BILL (6/9/00 Specs)	NYS POSITION
Support services must be health related	Requires that support services facilitate or enhance the delivery, continuity, or benefits of health services.	Requires that support services directly support or sustain the delivery or benefits of health care.	Do not support a requirement that support services must be directly linked to care. We do not know how HRSA would implement such language. It may be difficult to demonstrate a definite link between some support services and health care. Some support services enhance quality of life. In addition, some affected populations, like women and children, require support services that might not be directly linked to care, such as permanency planning and legal services that assist families affected by HIV.
Cap on the use of funds for quality	Mandates additional requirements related to quality management, but imposes a cap on the use of funds for these activities. For Title II, the cap is part of an existing cap on evaluation.	***Refers to Senate provision and indicates that state strategies for improvement should be directed to making services consistent with PHS guidelines.***	Do not support a cap on the use of funds for quality management. Making the cap part of an existing cap would jeopardize our ability to carry out effective quality management activities. Support quality management as an important and allowable programmatic activity. We have recommended that this be clarified in conference to ensure that most expenses related to quality management are allowable programmatic expenses.

ISSUE	SENATE BILL (S.2311 Passed 6/6/00)	HOUSE BILL (6/9/00 Specs)	NYS POSITION
Requirements re identification of need and allocation of resources	Priority setting and funding allocation must consider the needs of individuals not currently receiving services, based on epidemiologic measures established by the Secretary; disparities in health services among affected subgroups; and demonstrated or probable cost effectiveness and outcome effectiveness. Consideration of individuals not currently receiving services won't be required until 2003.	For FY 2002 and later, allocations must take into account the number and demographics of all people not in care. States and cities must develop a plan for identifying individuals who are not in care, informing them of and ***encouraging them to utilize*** services. ***Plan is not a condition of grant. State applications must include a strategy, with discrete goals and timetable and an appropriate allocation of funds.***	Do not support a requirement to assess the needs of individuals living with HIV who are not receiving services (and who may be unknown to any system). Do not support disparities in health services, cost effectiveness and outcome effectiveness as priority setting and allocation factors. The legislation should not mandate activities that are based on information that may not be available and may be impossible to collect. Mechanisms for the collection of such data are not in place and would most likely be very expensive to produce. These activities are appropriate for special studies but would be very expensive and of limited utility if required of all states and Title I EMAs. In addition, the emphasis on identifying and serving those not in care is not consistent with the limitations on the use of funds for early intervention services in the Senate bill. Should this mandate remain in the legislation, it must be deferred until HIV reporting is required. ***The language in the House specifications regarding "an appropriate allocation of funds" is not clear. Does this language mandate that states devote a portion of their Title II funding to developing or implementing such a plan? We do not support a specific requirement related to how funds are allocated and the amount allocated for certain purposes. In addition, it appears that language allowing the use of Ryan White funds for this purpose is elsewhere in the bill (see "Surveillance and partner notification" on page 7).***

ISSUE	SENATE BILL (S.2311 Passed 6/6/00)	HOUSE BILL (6/9/00 Specs)	NYS POSITION
Title III - preference in awards	New language provides for preference in awarding new grants for applicants that will use funds to serve areas that are ***rural and underserved.***	Adds new subsection to Section 2653 which states that preference will be given to applicants that will serve underserved areas and rural areas.	Would support House language if the preference applied to ***newly appropriated*** Title III funds. If this preference applies to all Title III funds ***or to grant funding being re-solicited***, this language could be detrimental to New York, given that we do not know how "underserved" will be defined. ***Do not support Senate language, as it appears that only rural areas will be eligible for new Title III grants. This does not allow for the use of Title III funds to address needs in urban areas.***
Surveillance and partner notification	No provision.	Allows for the use of Title II funds for surveillance and partner notification. ***Appears that the 6/9 specs replace this with a new section enhancing CDC funding for surveillance activities. Authorizes the use of Title II funding for casefinding for purposes of identifying individuals with HIV who are not receiving services.***	Support the use of funds for these activities, but would prefer a cap of two percent of base Title II funds. ***Support 6/9 House specification authorizing the use of Title II funds for casefinding. This reiterates the importance of legislative language that does not limit the settings in which early intervention activities can be conducted. Question the language re enhancing CDC funding. Is this is an effective mechanism to increase CDC resources for surveillance activities as states move toward HIV reporting?***

ISSUE	SENATE BILL (S.2311 Passed 6/6/00)	HOUSE BILL (6/9/00 Specs)	NYS POSITION
Women, infants and children	Requires a change in the way grantees provide resources for infants, children and women to make resources available proportionate to the percentage that group singularly represents in the state's population of PLWA.	Adds "youth" wherever the legislation refers to women, infants and children.	Do not support the change in the Senate bill. This represents a change from an aggregate percentage of funds for all of these populations. That is, we will have to demonstrate the percentage of funds used for <u>each</u> of these populations. This could be problematic. Women, infants and children move to Medicaid quickly and are, therefore, a smaller percentage of the total number of persons served through ADAP. We continue to serve a large percentage of women and children through our base service funds, but as the dedicated ADAP pot continues to increase while the base does not increase at a similar rate, the percentage of total Title II funds targeted to these populations continues to decline. Would like report language to recognize that grantees might use resources from other sources to support services for these populations, in which case the Secretary may waive the requirement related to allocation of Title II funds that is proportionate to the percentage of PLWHA that these groups represent.

ISSUE	SENATE BILL (S.2311 Passed 6/6/00)	HOUSE BILL (6/9/00 Specs)	NYS POSITION
Plan re coordination with substance abuse programs	No provision.	Requires that states develop and implement a plan for coordination with drug abuse prevention and treatment programs two years after enactment. ***Plan is not a condition of grant. Instead, State application must include a strategy, with discrete goals and timetable and an appropriate allocation of funds.***	This is the second new plan required of states. While we support coordination, such coordination has always been a requirement, and we have had to demonstrate coordination in our applications for many years. This requirement is unnecessary and burdensome. ***The language in the House specifications regarding "an appropriate allocation of funds" is not clear. Does this language mandate that states devote a portion of their Title II funding to developing or implementing such a plan? We do not support such a requirement. Additional requirements and restrictions with regard to the use of Title II funds would be burdensome.***

ISSUE	SENATE BILL (S.2311 Passed 6/6/00)	HOUSE BILL (6/9/00 Specs)	NYS POSITION
Participatory planning process	***No provision.***	***6/9 specs indicate that a requirement will be added under 2617(a)(3) that states must demonstrate "such a participatory planning process exists and is utilized in decisions about needs assessment and priority setting for Title II funds."***	***This is not clear. There is no section 2617(a)(3). Section 2617(b)(3) relates to the SCSN. Cannot tell what the language "such a participatory planning process" refers to. Do not support any additional requirements regarding participatory planning. Existing requirements are sufficient (e.g., SCSN, consortia, public hearings, coordination requirements, etc.).***
Plans required of Secretary	No provision.	Requires the following plans: - Plan for improving coordination with Titles XIX & XXI of SSA and any other appropriate federal program - Plan for coordinating Title I and II disbursements - Plan for simplified application process. - Plan for medical case management of prison releasees - Determination re biennial applications	Support simplified application process and biennial applications. Coordinating Title I and Title II disbursements (i.e., having them on the same grant cycle) could be problematic in New York given the level of NYS and NYC involvement in each other's applications. No position on the other plans.

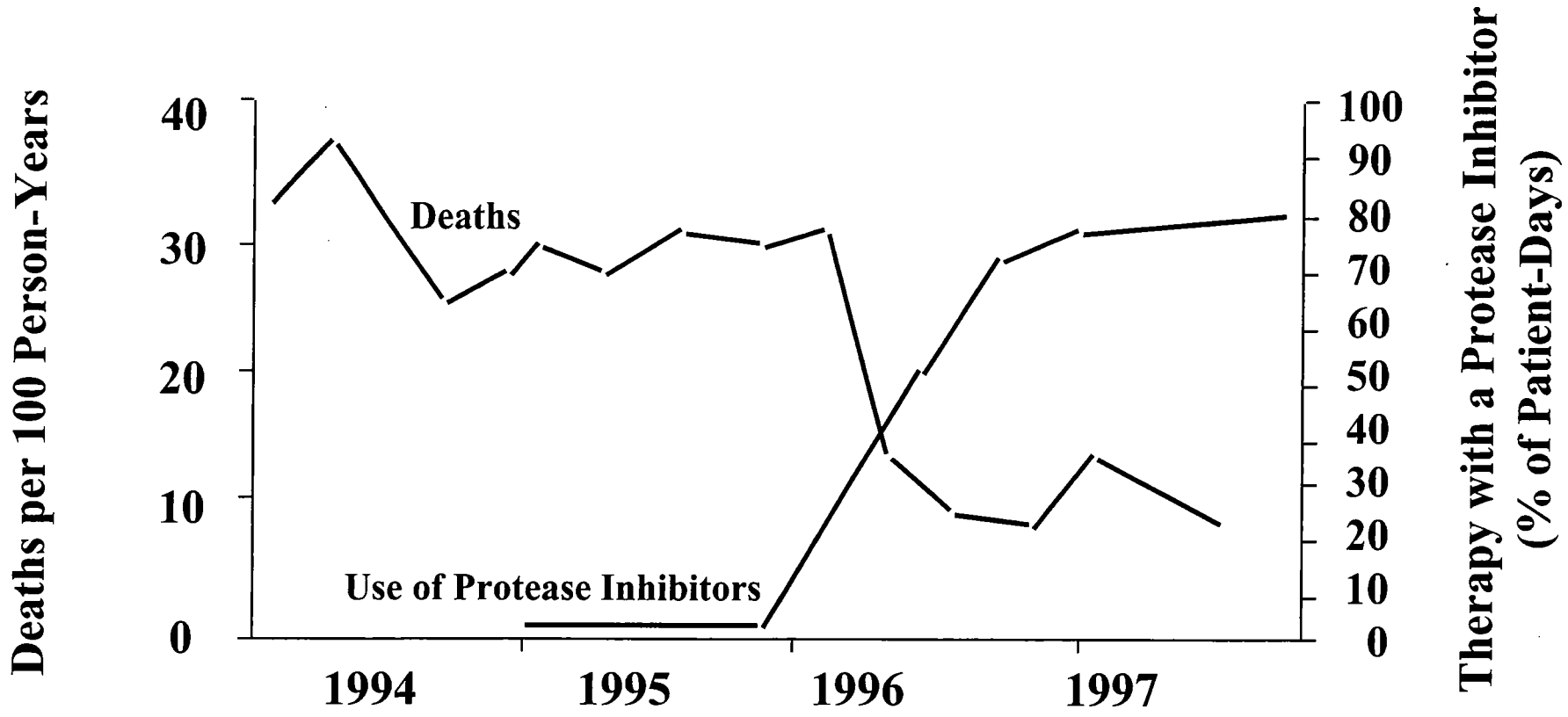
Morbidity and Mortality in HIV/HCV Co-infected Patients

Barbara McGovern, MD

Assistant Professor of Medicine

Tufts University School of Medicine

Declining Morbidity and Mortality in Patients with HIV



Palella, F. 1998 NEJM

HIV Modifies the Natural History of Chronic Hepatitis C

- Compared to patients who are HIV seronegative:
  - Coinfected patients progress faster to cirrhosis
  - Coinfected patients have higher rates of morbidity and mortality related to liver disease

Rapidly Progressive Liver Disease in Co-Infected Patients

1989 report of 3 patients with h/o transfusion related NANB hepatitis

All three patients developed cirrhosis within three years; two died.

Two patients found to be HIV seropositive. One patient was known to be HIV+ prior to symptomatic hepatitis

Martin, P. 1989 Gastroenteroogy

Morbidity and Mortality in Hemophilia Patients with HIV/HCV

Multi-center Hemophilia Cohort Study

Prospective study 223 patients

70% with HCV; 44% coinfected with HIV

Eyster, E. 1993 J AIDS

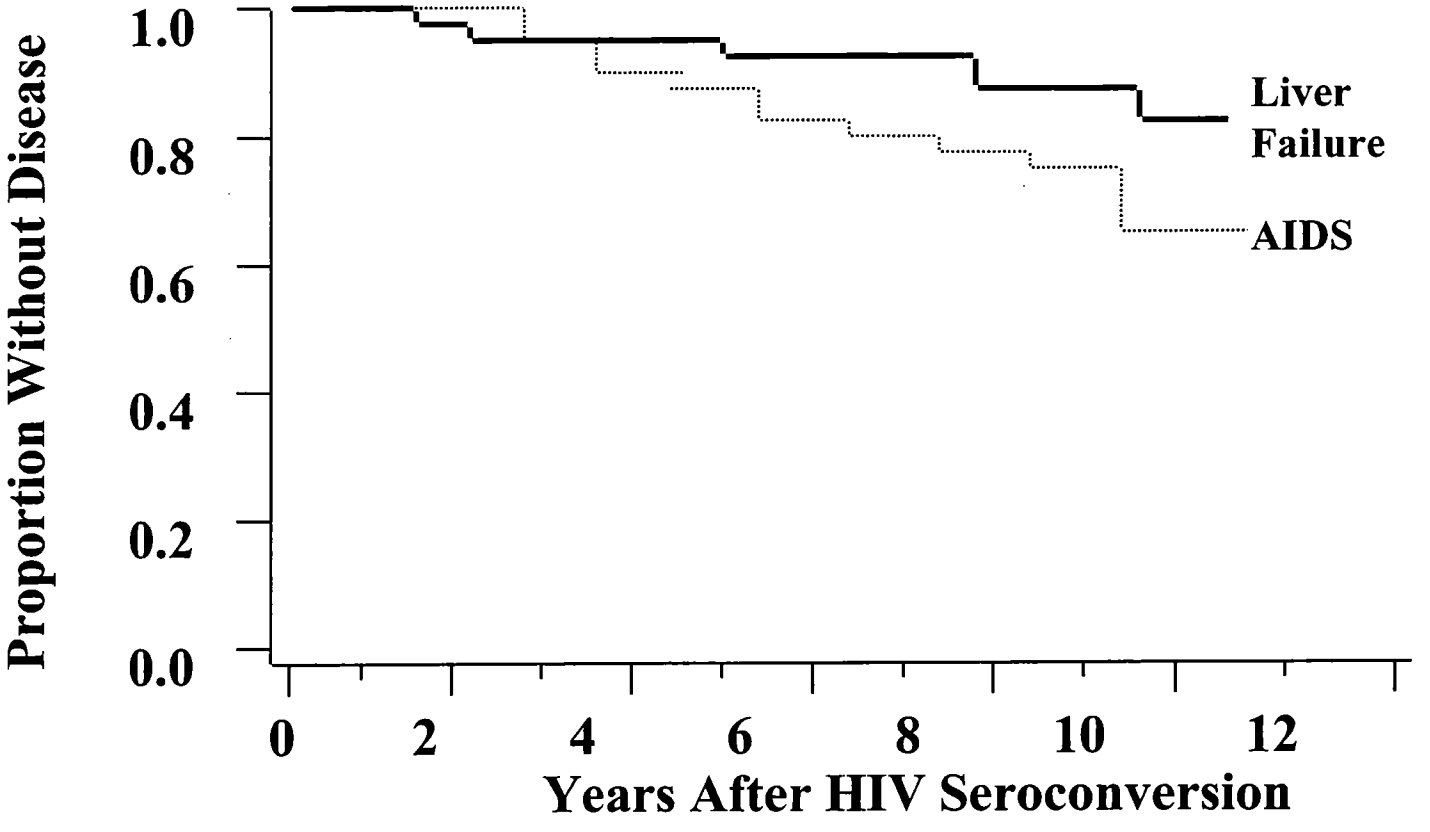
Morbidity and Mortality in Patients with HIV/HCV

Condition	HCV +/ HIV - vs. HCV - /HIV -	HCV +/ HIV + vs. HCV +/HIV -	HCV +/ HIV + vs. HCV -/HIV-
Hepatomegaly	1.6 (0.6, 3.8)	2.3 (1.2, 4.1)	3.2 (1.3, 7.7)
Splenomegaly	4.1 (1.1, 15.2)	2.5 (1.3, 4.9)	8.4 (2.2, 32.2)
Transaminitis	4.6 (1.7, 12.8)	1.0 (0.7, 1.5)	3.7 (1.3, 10.8)

[a] Excluded are subjects who had not received any type of blood products and subjects missing annual examinations.

Eyster E 1993 J. AIDS

Morbidity and Mortality in HIV/HCV



Kaplan-Meier actuarial analysis comparing cumulative incidence of liver failure and AIDS following HIV seroconversion among 97 HCV-infected subjects.

Eyster E. 1993 J AIDS

Morbidity and Mortality in Patients with HIV/HCV

Retrospective study in Royal Free Hospital hemophilia center (1979-93)

Cohort had known dates of exposure to cryoprecipitate. All study patients were HCVseropositive

40% also had HIV

Telfer, P.1994 Br J Haematology

Morbidity and Mortality in Patients with HIV/HCV

- 11 patients developed hepatic decompensation; 10 out of 11 were co-infected
- The median time from concentrate exposure to clinical demise was 16.5 years (7.7-22.9)
- The relative hazard of developing liver failure after HIV infection was 21.4

Telfer, P. 1994 Br J Haematology

Morbidity and Mortality in Patients with HIV/HCV

- Retrospective study of 145 patients in outpatient hemophilia clinic from 1990-95
- Question: Are patients with AIDS and declining immune function at increased risk to develop liver disease than HIV patients with stable immune function over time?

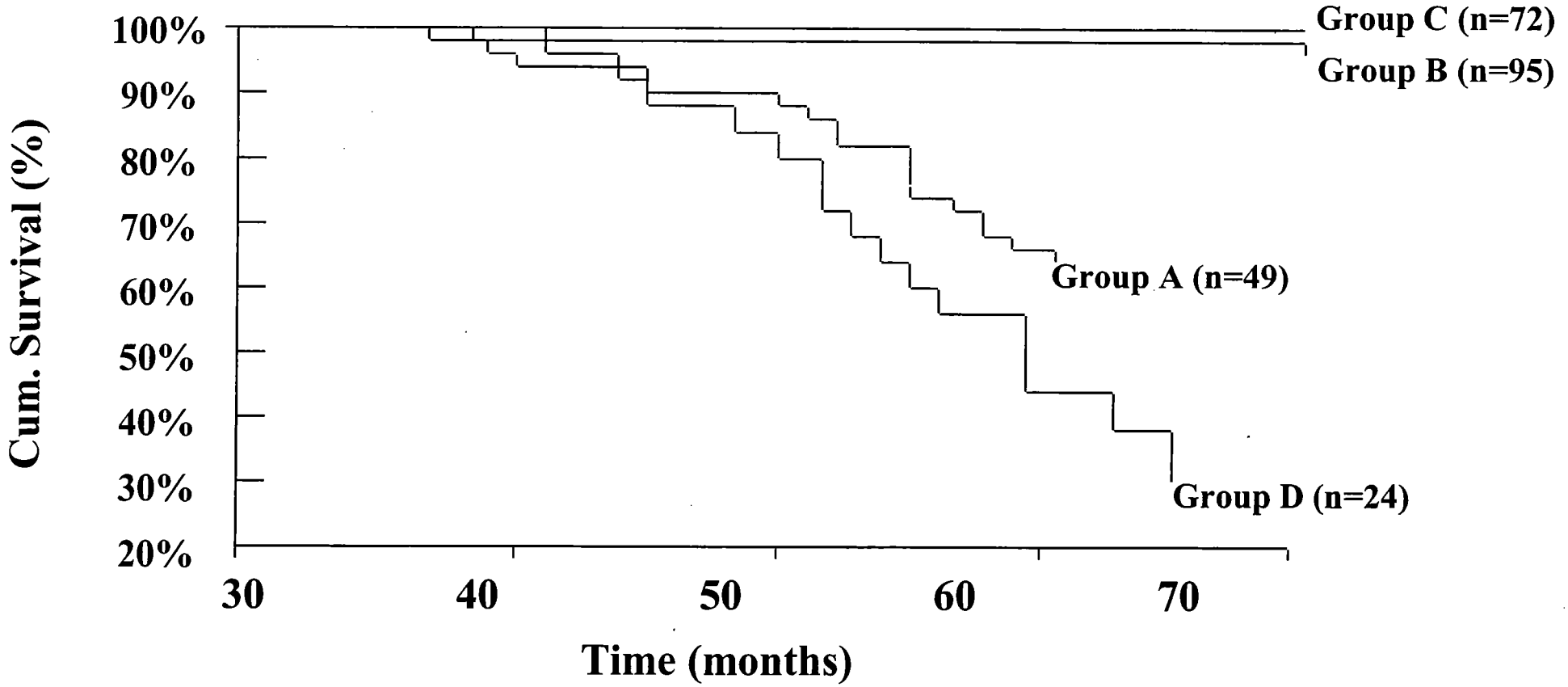
Rockstroh 1996 Am J Gastroenterology

Morbidity and Mortality in Patients with HIV and HCV

- 49 patients with AIDS or CD4 <100 had 10:20 deaths with liver failure
- 95 HIV patients with stable CD4 counts had 2 deaths with OIs/malignancies
- 72 patients with HCV alone had no deaths
- 24 HIV+/HCV-patients with CD4 <100 or AIDS had 16 deaths with OIs/malignancies;

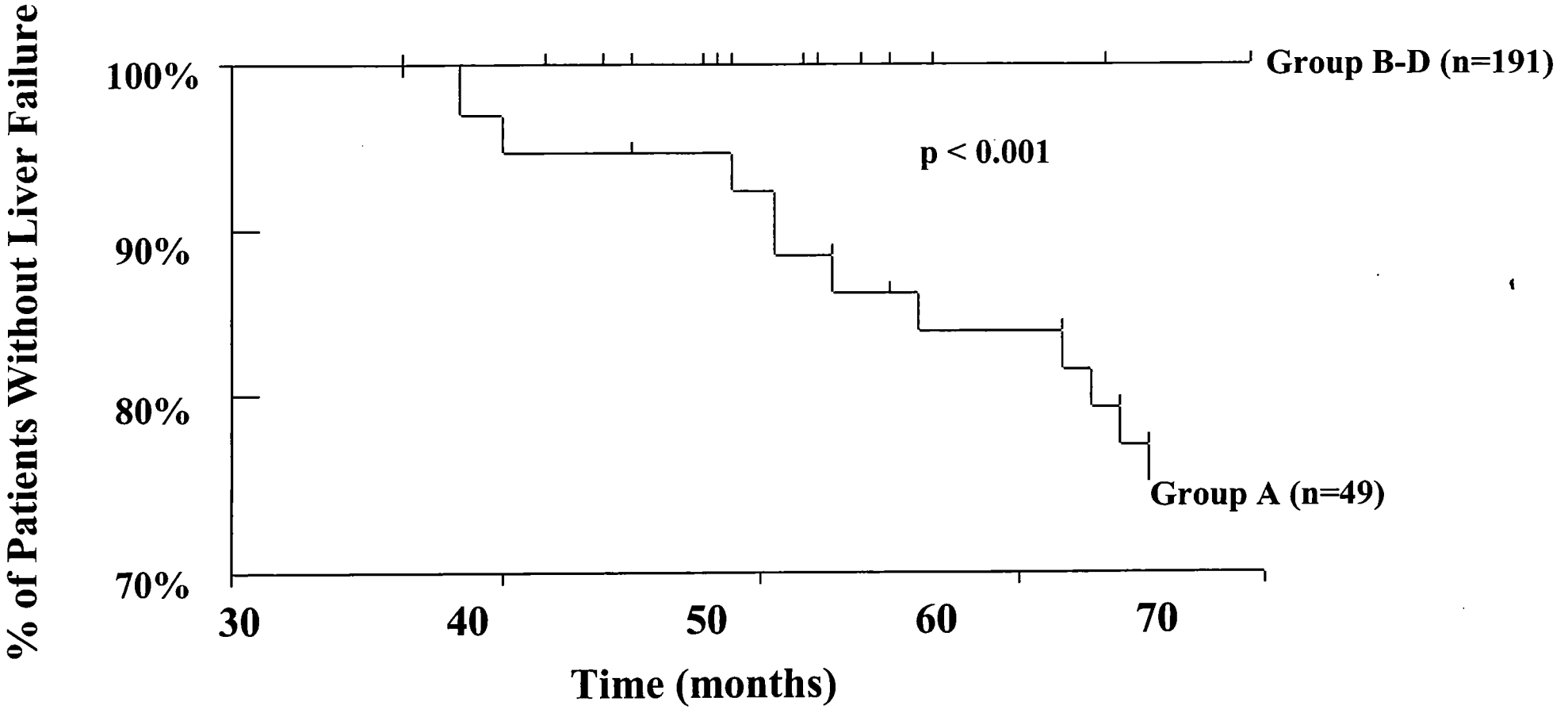
Rockstroh, JK 1996 Amer J Gastroenterology

Cumulative Survival for all Examined Groups



Rockstroh 1996 Am J Gastroenterology

Morbidity and Mortality in Patients with HIV and HCV



Rockstroh, JK 1996 Am J Gastroenterology

Morbidity and Mortality in Patients with HIV and HCV

Cohort study of mortality from liver cancer and liver disease in 4,865 patients with hemophilia from 1969 to 1992

1,218 were HIV seropositive

Review of death certificates with comparison to age-matched expected rates

Darby S, Lancet 1997

Morbidity and Mortality in Patients with HIV/HCV

Certified Cause of Death	Not Infected With HIV-1		Infected with HIV-1, All Severities of			
	Severe Haemophilia		Moderate/Mild Haemophilia		Haemophilia	
	0	O/E (95% CI)	0	O/E (95% CI)	0	O/E (95% CI)
Primary Liver Cancer*	2	19•7 (2•4-71•3)	2	5•5 (0•7-20•0)	1	15•1 (0•4-84•4)
Liver Disease†	7	19•8 (8•0-40•7)	6	5•6 (2•1-12•2)	28	94•4 (62•7-136•5)

Darby, S. 1997 Lancet

Morbidity and Mortality in Patients with HIV and HCV

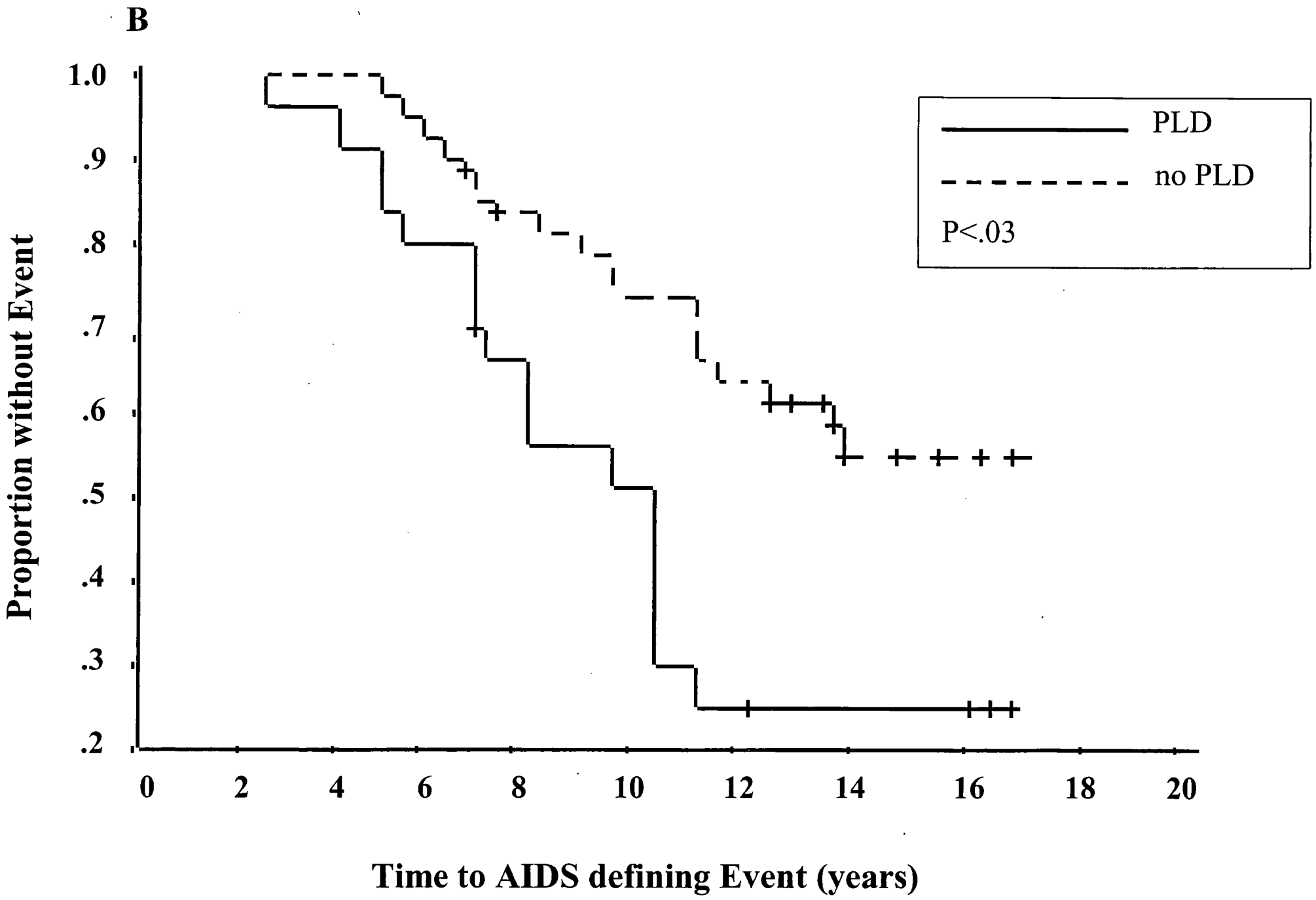
- Prospective study of 147 HCV+ hemophiliacs enrolled in the Montreal Hemophilia Center in 1982-1985
- 81 patients were coinfected with HIV/HCV
- Mean age at HCV infection was 19.7 years
- All were HCV seropositive

Lesens, O. 1999 JID

Morbidity and Mortality in Patients with HIV/HCV

	HIV -/HCV+	HIV+/HCV+
No.	53	81
PLD Occurrence	3/53 (5.6%)	22/81 (27%)

Lesens O. 1999 JID


B
1.0
.9
.8
.7
.6
.5
.4
.3
.2
Proportion without Event
0
2
4
6
8
10
12
14
16
18
20
Time to AIDS defining Event (years)
PLD
no PLD
P<.03

Morbidity and Mortality in Patients with HIV/HCV

Multicenter cross-sectional study from 1989 to 1994 in 547 patients with HCV secondary to percutaneous routes

116 HIV+ and 431 HIV-

Inclusion criteria: ALT elevations for 1 year; absence of ethanol intake; available biopsy; known duration of infection

Soto B. 1997 J Hepatology

Morbidity and Mortality in Patients with HIV and HCV

Demographic Characteristics	HIV-Positive (n=116)	HIV-Negative (n=431)
Sex (% male)	77	62
Age (years)	27.9± 5.9	37.3 ± 14.5
Blood Transfusion	4	213
Intravenous Drug Use	112	218
Duration (years) of HCV Infection*	7.6 ± 4.5	11.3 ±10.1

Soto B 1997 J Hepatology

Morbidity and Mortality in Patients with HIV/HCV

Time Intervals (years)	HIV + (n=116) Cirrhosis/Cases (%)	HIV--(n=431) Cirrhosis/Cases (%)	p-value
1-5	5/42 (11.9)	0/161 (0.0)	<0.05
1-10	13/87 (14.9)	7.272 (2.6)	<0.01
1-15	14/113 (12.4)	15/319 (4.7)	<0.05
>15	0/3 (0.0)	41/112 (36.6)	--

Soto B 1997 J Hepatology

Morbidity and Mortality in Patients with HIV/HCV

Retrospective chart review of all causes of death in HIV-seropositive patients in 1991, 1996 and 1998

The leading risk factor for HIV and HCV in all cohorts was IVDU

ETOH use history was reported more frequently in the 1998 cohort

McGovern B, Abstract IDSA Nov 1999

Morbidity and Mortality in Patients with HIV/HCV

- End-stage liver disease was the leading cause of death in the 1998 cohort
- One third of patients in the 1998 cohort had a recent history of discontinuation of HAART secondary to hepatotoxicity
- More than half of the patients who died with ESLD had either a NDVL or a CD4 >200 six months prior to death

McGovern B, Abstract IDSA Nov 1999

Liver Fibrosis Progression in Patients with HIV/HCV

122 HIV+/HCV+ patients and 122 HCV+/HIV- matched for age at infection, duration, sex, alcohol, routes of transmission

Fibrosis Progression Rates using age, alcohol and gender

Increased prevalence of higher scores of fibrosis and necro-inflammatory activity in patients with co-infection

Benhamou Y Hepatology 1999;30:1054-58.

Risk Factors for Fibrosis Progression

	ß	SE	OR	95% CI OR	P
Gender (men)	**0.01**	**0.049**	**1.010**	**0.916-1.113**	**.7**
HIV infection	**0.200**	**0.046**	**1.221**	**1.115-1.337**	**<.0001**
Severe immunosuppression*	**0.260**	**0.069**	**1.296**	**1.132-1.484**	**.0002**
Age at infection (>25 years old)	**0.497**	**0.054**	**1.643**	**1.476-1.829**	**<.0001**
Alcohol consumption (>50 g/d)	**0.499**	**0.048**	**1.647**	**1.496-1.812**	**<.0001**

NOTE: Variability of the fibrosis progression rate explained by the model: $r^2 = 0.53$.
Abbreviations: SE, standard error; OR, odds ratio; CI, confidence interval.
*CD4 $\leq$200 cell/μL, HIV-seronegative patients were considered to have more than 200 CD4 cells/μL.

Morbidity and Mortality in Patients with HIV/HCV

- HCV/HIV co-infection as serious problem facing clinicians and patients
- Need for testing of HCV antibody in all HIV infected patients
- Need to evaluate and manage both HIV and HCV infections concurrently
- Need for large treatment trials

As more effective therapies for HIV disease are developed, increased attention will need to be paid to the diagnosis and treatment of underlying HCV disease in persons with hemophilia and other risk groups with a high incidence of HCV infection.

-Elaine Eyster

The Forum for Public Health Financing and Access to HIV Treatment

2000 National AIDS Drug Assistance Program Educational Forum

New Millennium, New Strategies: Improving Access to Public Health Systems for HIV Treatment

June 8-10, 2000

The Washington Monarch Hotel

Washington, D.C.

We are interested in your reaction to this conference. Your response will be extremely important in future planning. Thank you for your cooperation in completing this conference evaluation.

I. General Participant Information

Please check the category that best describes your current professional position.

Discipline *(please check all that apply)*

- ❒ Physician
- ❒ Nurse
- ❒ Pharmacist
- ❒ Epidemiologist
- ❒ Social Worker
- ❒ Public Health
- ❒ Other (please specify) _____

Primary Professional Role *(please check one)*

- ❒ Program Administrator/Supervisor/Director
- ❒ Case Manager
- ❒ Care Provider
- ❒ Researcher/Analyst
- ❒ Faculty or Teacher
- ❒ Health Policy
- ❒ Other (please specify) _____

Please Indicate the Program You Represent *(select only one)*

- ❒ Medicaid
- ❒ ADAP
- ❒ Title II
- ❒ Corrections
- ❒ Community
- ❒ Other (please explain) _____

II. Faculty Evaluation

Please circle the response that you feel is appropriate. Rate each speaker in the categories indicated, on a scale of 1 (Poor) to 5 (Excellent).

General Session
Friday, June 9, 2000

Bill Arnold	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT
Knowledge of topic	1	2	3	4	5
Organization	1	2	3	4	5
Delivery	1	2	3	4	5
Value of Content	1	2	3	4	5
Objectives Met	1	2	3	4	5

Scott Hitt, MD	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT
Knowledge of topic	1	2	3	4	5
Organization	1	2	3	4	5
Delivery	1	2	3	4	5
Value of Content	1	2	3	4	5
Objectives Met	1	2	3	4	5

Gerald Friedland, MD	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT
Knowledge of topic	1	2	3	4	5
Organization	1	2	3	4	5
Delivery	1	2	3	4	5
Value of Content	1	2	3	4	5
Objectives Met	1	2	3	4	5

Tim Westmoreland	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT
Knowledge of topic	1	2	3	4	5
Organization	1	2	3	4	5
Delivery	1	2	3	4	5
Value of Content	1	2	3	4	5
Objectives Met	1	2	3	4	5

Christine Lubinski	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT
Knowledge of topic	1	2	3	4	5
Organization	1	2	3	4	5
Delivery	1	2	3	4	5
Value of Content	1	2	3	4	5
Objectives Met	1	2	3	4	5

Lydia Watts	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT
Knowledge of topic	1	2	3	4	5
Organization	1	2	3	4	5
Delivery	1	2	3	4	5
Value of Content	1	2	3	4	5
Objectives Met	1	2	3	4	5

Richard Elion, MD	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT
Knowledge of topic	1	2	3	4	5
Organization	1	2	3	4	5
Delivery	1	2	3	4	5
Value of Content	1	2	3	4	5
Objectives Met	1	2	3	4	5

Margaret Chesney, PhD	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT
Knowledge of topic	1	2	3	4	5
Organization	1	2	3	4	5
Delivery	1	2	3	4	5
Value of Content	1	2	3	4	5
Objectives Met	1	2	3	4	5

Lawrence "Bopper" Deyton, MD	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT
Knowledge of topic	1	2	3	4	5
Organization	1	2	3	4	5
Delivery	1	2	3	4	5
Value of Content	1	2	3	4	5
Objectives Met	1	2	3	4	5

Richard Moore, MD	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT
Knowledge of topic	1	2	3	4	5
Organization	1	2	3	4	5
Delivery	1	2	3	4	5
Value of Content	1	2	3	4	5
Objectives Met	1	2	3	4	5

II. Faculty Evaluation (cont.)

Please circle the response that you feel is appropriate. Rate each speaker in the categories indicated, on a scale of 1 (Poor) to 5 (Excellent).

Workshops Friday, June 9, 2000											
Dave Doolen	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT	**Lydia Watts**	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT
Knowledge of topic	1	2	3	4	5	Knowledge of topic	1	2	3	4	5
Organization	1	2	3	4	5	Organization	1	2	3	4	5
Delivery	1	2	3	4	5	Delivery	1	2	3	4	5
Value of Content	1	2	3	4	5	Value of Content	1	2	3	4	5
Objectives Met	1	2	3	4	5	Objectives Met	1	2	3	4	5
Lanny Cross	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT	**Michael Montgomery**	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT
Knowledge of topic	1	2	3	4	5	Knowledge of topic	1	2	3	4	5
Organization	1	2	3	4	5	Organization	1	2	3	4	5
Delivery	1	2	3	4	5	Delivery	1	2	3	4	5
Value of Content	1	2	3	4	5	Value of Content	1	2	3	4	5
Objectives Met	1	2	3	4	5	Objectives Met	1	2	3	4	5
Kathryn King	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT	**Johannes Koch, MD**	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT
Knowledge of topic	1	2	3	4	5	Knowledge of topic	1	2	3	4	5
Organization	1	2	3	4	5	Organization	1	2	3	4	5
Delivery	1	2	3	4	5	Delivery	1	2	3	4	5
Value of Content	1	2	3	4	5	Value of Content	1	2	3	4	5
Objectives Met	1	2	3	4	5	Objectives Met	1	2	3	4	5
Lisa Cox	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT	**Thomas McCormack**	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT
Knowledge of topic	1	2	3	4	5	Knowledge of topic	1	2	3	4	5
Organization	1	2	3	4	5	Organization	1	2	3	4	5
Delivery	1	2	3	4	5	Delivery	1	2	3	4	5
Value of Content	1	2	3	4	5	Value of Content	1	2	3	4	5
Objectives Met	1	2	3	4	5	Objectives Met	1	2	3	4	5
John Folby	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT	**Wayne Sauseda**	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT
Knowledge of topic	1	2	3	4	5	Knowledge of topic	1	2	3	4	5
Organization	1	2	3	4	5	Organization	1	2	3	4	5
Delivery	1	2	3	4	5	Delivery	1	2	3	4	5
Value of Content	1	2	3	4	5	Value of Content	1	2	3	4	5
Objectives Met	1	2	3	4	5	Objectives Met	1	2	3	4	5

II. Faculty Evaluation (cont.)

Please circle the response that you feel is appropriate. Rate each speaker in the categories indicated, on a scale of 1 (Poor) to 5 (Excellent).

Workshops Friday, June 9, 2000											
Jo Ann Spearmon, PharmD	**POOR**	**FAIR**	**GOOD**	**VERY GOOD**	**EXCELLENT**	**John Palenicek, PhD**	**POOR**	**FAIR**	**GOOD**	**VERY GOOD**	**EXCELLENT**
	1	2	3	4	5	Knowledge of topic	1	2	3	4	5
Knowledge of topic	1	2	3	4	5	Organization	1	2	3	4	5
Organization	1	2	3	4	5	Delivery	1	2	3	4	5
Delivery	1	2	3	4	5	Value of Content	1	2	3	4	5
Value of Content	1	2	3	4	5	Objectives Met	1	2	3	4	5
Objectives Met											
Coy Stout	**POOR**	**FAIR**	**GOOD**	**VERY GOOD**	**EXCELLENT**						
Knowledge of topic	1	2	3	4	5						
Organization	1	2	3	4	5						
Delivery	1	2	3	4	5						
Value of Content	1	2	3	4	5						
Objectives Met	1	2	3	4	5						

II. Faculty Evaluation (cont.)

Please circle the response that you feel is appropriate. Rate each speaker in the categories indicated, on a scale of 1 (Poor) to 5 (Excellent).

General Session Saturday, June 10, 2000											
Jeff Levi, PhD	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT	**Barbara McGovern, MD**	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT
Knowledge of topic	1	2	3	4	5		1	2	3	4	5
Organization	1	2	3	4	5	Knowledge of topic	1	2	3	4	5
Delivery	1	2	3	4	5	Organization	1	2	3	4	5
Value of Content	1	2	3	4	5	Delivery	1	2	3	4	5
Objectives Met	1	2	3	4	5	Value of Content	1	2	3	4	5
						Objectives Met					
David Bernstein, MD	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT	**Humberto Cruz**	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT
Knowledge of topic	1	2	3	4	5	Knowledge of topic	1	2	3	4	5
Organization	1	2	3	4	5	Organization	1	2	3	4	5
Delivery	1	2	3	4	5	Delivery	1	2	3	4	5
Value of Content	1	2	3	4	5	Value of Content	1	2	3	4	5
Objectives Met	1	2	3	4	5	Objectives Met	1	2	3	4	5

II. Faculty Evaluation (cont.)

Please circle the response that you feel is appropriate. Rate each speaker in the categories indicated, on a scale of 1 (Poor) to 5 (Excellent).

Workshops Saturday, June 10, 2000											
James Carr	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT	**Pat Reid**	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT
Knowledge of topic	1	2	3	4	5	Knowledge of topic	1	2	3	4	5
Organization	1	2	3	4	5	Organization	1	2	3	4	5
Delivery	1	2	3	4	5	Delivery	1	2	3	4	5
Value of Content	1	2	3	4	5	Value of Content	1	2	3	4	5
Objectives Met	1	2	3	4	5	Objectives Met	1	2	3	4	5
Gary Rose	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT	**Jeff Levi, PhD**	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT
Knowledge of topic	1	2	3	4	5	Knowledge of topic	1	2	3	4	5
Organization	1	2	3	4	5	Organization	1	2	3	4	5
Delivery	1	2	3	4	5	Delivery	1	2	3	4	5
Value of Content	1	2	3	4	5	Value of Content	1	2	3	4	5
Objectives Met	1	2	3	4	5	Objectives Met	1	2	3	4	5
Wilburt Jordan, MD	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT	**Tim Tinker, DrPH**	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT
Knowledge of topic	1	2	3	4	5	Knowledge of topic	1	2	3	4	5
Organization	1	2	3	4	5	Organization	1	2	3	4	5
Delivery	1	2	3	4	5	Delivery	1	2	3	4	5
Value of Content	1	2	3	4	5	Value of Content	1	2	3	4	5
Objectives Met	1	2	3	4	5	Objectives Met	1	2	3	4	5
William Pick	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT	**Dawn Broussard**	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT
Knowledge of topic	1	2	3	4	5	Knowledge of topic	1	2	3	4	5
Organization	1	2	3	4	5	Organization	1	2	3	4	5
Delivery	1	2	3	4	5	Delivery	1	2	3	4	5
Value of Content	1	2	3	4	5	Value of Content	1	2	3	4	5
Objectives Met	1	2	3	4	5	Objectives Met	1	2	3	4	5
Cassandra Newkirk, MD	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT	**Jeff Crowley**	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT
	1	2	3	4	5	Knowledge of topic	1	2	3	4	5
Knowledge of topic	1	2	3	4	5	Organization	1	2	3	4	5
Organization	1	2	3	4	5	Delivery	1	2	3	4	5
Delivery	1	2	3	4	5	Value of Content	1	2	3	4	5
Value of Content	1	2	3	4	5	Objectives Met	1	2	3	4	5
Objectives Met											

III. Overall Conference Evaluation

To what extent do you agree/disagree with the following statements? Please circle one number to indicate your response, on a scale of 1 (Strongly Disagree) to 5 (Strongly Agree).

		Strongly Disagree				Strongly Agree
1.	The content was relevant to the announced topics.	1	2	3	4	5
2.	The time allotted for each presentation was adequate.	1	2	3	4	5
3.	There was adequate time for discussion.	1	2	3	4	5
4.	The program content was presented in a clear and easily understandable manner.	1	2	3	4	5
5.	The audiovisual materials effectively supplemented the content.	1	2	3	4	5
6.	The quality of the audiovisual materials was good.	1	2	3	4	5
7.	The handouts appropriately complemented the content.	1	2	3	4	5
8.	The content presented will be professionally useful to me.	1	2	3	4	5
9.	The breakout exercises were useful and educational.	1	2	3	4	5
10.	I found the opportunity to talk with representatives of other states and other programs very valuable.	1	2	3	4	5
11.	The physical environment was conducive to my learning.	1	2	3	4	5
12.	The quality of the food and beverages was good.	1	2	3	4	5

13. Do you feel the length of the conference was sufficient?
___yes, length was sufficient
___no, shorter would be better
___no, longer would be better

14. How do you plan to incorporate the information shared at the conference into your daily work?

_____

_____

_____

15. Has this conference met your professional objectives?
Check one_____Yes _____No

If not, please explain:

_____

_____

_____

_____

16. What types of educational assistance would be most useful to you (please check all that apply)

- ❒ Newsletters
- ❒ Educational Materials
- ❒ Focused Workshops
- ❒ National Meetings
- ❒ Regional/Local Meetings
- ❒ Continuing Education Symposia
- ❒ Internet Based Services/Materials
- ❒ Other

Please elaborate: _____

_____

_____

_____

17. Please specify in which of the following technical and training opportunities you participate and rate their value to you. (please check all that apply and rate on a scale of 1 [not at all valuable] to 5 [extremely valuable])

Participate	Rating	
❒	_____	Professional society meetings
❒	_____	State-sponsored workshops
❒	_____	Local ASO/CBO sponsored meetings
❒	_____	Regional ADAP forums
❒	_____	National meetings (please specify)
		_____
❒	_____	Other (please specify)
		_____

18. What topic(s) or theme(s) would you like to see included in future conferences?

_____

_____

_____

_____

19. What critical issues/challenges are you facing in administering your program? (Please check all that apply and add comments as desired)

- ❒ Funding
- ❒ Outreach to special populations
- ❒ Collaboration with other programs
- ❒ Care/treatment
- ❒ Other

_____

_____

_____

_____

20. Do you plan on sharing the conference information with others? (If yes, please list) ❒Yes ❒No

_____

_____

_____

_____

21. General comments/suggestions:

_____

_____

_____

_____

_____

_____

_____

Thank you for completing this evaluation form. Please return the completed evaluation form to the registration desk or mail to:

2000 National AIDS Drug Assistance Program Educational Forum
Attn: Veronica Ayala
1101 King Street
Suite 600
Alexandria, VA 22314
703/535-5048
703/683-2239 fax