Illinois HIV Integrated Planning Council (IHIPC) Webinar Meeting Minutes
Final

9:00 am: Welcome; Introductions; Moment of Silence; Meeting Agenda and Process; Instructions

IHIPC Co-chairs

Co-Chairs J. Nuss and N. Holmes welcomed all members/guests to the meeting. Webinar and housekeeping instructions were reviewed. Following this, the group was led in a moment of silence for all people living with HIV past and present and for all those working to end the epidemic in Illinois.

All present IHIPC members were announced, and the attendance of guests was recorded.

The Co-Chairs reviewed the meeting objectives, meeting agenda, and the IHIPC concurrence checklist.

The following announcements were made at the meeting:

- Minutes from all IHIPC standing committee meetings continue to be posted on the IHIPC webpage: http://www.dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/hpg/meetings.
- The release of the Summer issue of the IHIPC newsletter has been delayed due to COVID response priorities. It will be released once approved by IDPH Communications.
- Member updates: After resignations from voting members, R. Jimenez and C. Montgomery have transitioned from at-large members into the vacant voting positions.
- The meeting survey will be available for completion until November 2nd at the following link:http://bit.ly/IHIPCmeetingsurvey .

9:15 am: Regional Care/Prevention Lead Agent Updates

The following individuals gave updates for their respective regional programs. Successes and challenges, especially those related to COVID-19, were discussed. Please see the meeting recording for details (https://www.train.org/illinois/course/1094397/):

Region 1: Care update by T. Abrams; Prevention update by M. Maginn.
Region 2: Care update by L. Roeder; Prevention update by M. Maginn.
Region 3: Care update by D. Hunt; Prevention update by C. Wade.
Region 4: Care update by S. Rehrig; Prevention update by J. Erdman.
Region 5: Care update by P. Clark; Prevention update by C. Wade.
Region 6 : Care update by G. Dunn; Prevention update by J. Erdman.
Region 7: Care update by B. Olayanju; Prevention update by J. Erdman.
Region 8: Care update by B. Olayanju; Prevention update by W. Allen.

There were no questions or discussion regarding the material presented.

10:00 am: IDPH and Liaison Updates

The following individuals gave program/liaison updates. Please see the meeting recording for details:

IDPH HIV Section update by A. Perez.
IDHS Substance Use Prevention and Recovery update by J. Kowalsky.
IDPH STD Section update by L. Choat.
IDPH HIV Corrections by M. Gaines.
There was no report from the Illinois Primary Health Care Liaison.
The CAHISC Liaison position is vacant, so there was no report.
The St. Louis Planning Council Liaison and the IDPH Center's for Minority Health Liaison will provide in-depth presentations at the October 27 meeting, so there were no

reports (see October 27 meeting minutes for more details).

Discussion (Q: Question, C: Comment, A: Answer):
Q: For the Corrections Liaison: Are there any further update on SIU medical services for people housed in IDOC facilities? Could you share the DOC positivity rates for HIV, HCV, and Syphilis if available?
A: M. Gaines responded: This information is not available at this time, but I will share more information on these topics in future reports.
Q: For the IDPH SUPR Liaison: Has Naloxone distribution by mail been affected by the USPS changes this year? Could you share which agencies are able to mail Naloxone kits?
A: J. Kowalsky responded: There have been some delays reported by providers regarding bulk orders of Nalaxone, but Naloxone distribution by local agencies to clients through the mail has not been impacted by USPS changes. Any agency registered with the Drug Overdose Prevention Program can send Naloxone by mail (this includes pharmacies). To see a full listing of these agencies (referred to as Overdose Education and Naloxone Distribution (OEND) Providers) and for other related information, please visit the following websites:
Drug Overdose Prevention Program (DOPP) Homepage: https://www.dhs.state.il.us/page.aspx?item=58142
• Includes a link to the map of designated OEND providers funded by IDHS/SUPR:
https://www.dhs.state.il.us/OneNetLibrary/27896/documents/Illinois_Funded_Overdose_Prevention_Programs_IPDO_and_SOR_by_County.pdf
Illinois Helpline, "Stay Safe" page for harm reduction resources: https://helplineil.org/app/staysafe
• Includes a link to a map and search feature of all OEND programs registered with DOPP:
https://helplineil.org/app/account/opa_result/incident_id/NTAyMzY=#description
Participants may also contact J. Kowalsky at james.kowalsky@illinois.gov for follow-up information/further questions.

10:30 am – 10:40 am: Brief break

10:40 am: Present/Vote on Proposed Changes to the IHIPC Bylaws and New IHIPC Membership – 40 minutes

Janet Nuss, IDPH IHIPC Coordinator/Co-chair and Marleigh Andrews-Conrad, IDPH HIV Community Planning Program Specialist

M. Andrews-Conrad presented the proposed changes to the IHIPC Bylaws and Procedures for 2021 on behalf of the Membership Committee. It was explained that the Membership Committee had completed their yearly review of the Bylaws and Procedures and were proposing changes on the following topics: changes related to the new IHIPC committee structure for 2021 (including restructuring process, new committee descriptions and general committee information, workgroup-specific language, and redistribution of Membership Committee tasks) and technical changes /update. It was noted that because of this amount of new material in the Bylaws and Procedures, this presentation was a condensed version. A more comprehensive version was sent to voting members before the meeting for their review before voting.,
In order to adopt the new recommendations, Bylaw revisions required a 2/3 vote, and Procedure revisions require a majority vote.

There were no questions or discussion regarding the material presented.

Vote: At 11:00 am, the motion was made by C. Hendry and seconded by J. Nuss to adopt the changes to the By-laws as recommended and presented by the Membership Committee.
Result: The motion carried with 29 in favor, 0 opposed, 0 abstentions, and 5 absent/no vote cast.

Vote: At 11:05 am, the motion was made by L. Meyer and seconded by J. Filicette to adopt the changes to the Procedures as recommended and presented by the Membership Committee.
Result: The motion carried with 28 in favor, 0 opposed, 0 abstentions, and 6 absent/no vote cast.

M. Andrews-Conrad presented the 2021 IHIPC Membership Applications Review, Ranking, and Selection Process on behalf of the Membership Committee. Participants were reminded of the 2021 Membership Gap Analysis process and the identified priorities:

- Highest priorities: Region 5; Representative of a CBO that is directly funded by CDC for High Impact Prevention
- Second priorities: Region 2 and 7; MSM of all races (but especially those who are Black or Hispanic); Hispanic HRH

- Third priorities: Region 1, 4, and 6; Black or Hispanic young people (aged 18-24)

After the application and scoring process was reviewed, the recommended slate of eight elected voting members and six new at-large members for 2021 was presented. The following is true of the proposed members in the slate, thus fulfilling several identified gaps:

- Eleven are people of color:
  - Seven identify as Black.
  - Four identify as Hispanic.
  - Three identify as being of more than one race or of another race.
- Eight identify as members of a prioritized population.
- Ten represent MSM, with eight representing MSM of color.
- Ten fill regional gaps: 1, 2, 4, 5, and 7.
- Three are young adult (aged 25-29).

Gaps not filled by these proposed members will be prioritized in the next recruitment and selection cycle.

Discussion (Q: Question, C: Comment, A: Answer):

Q: Do at-large members vote?

A: M. Andrews-Conrad responded: At-large members do not vote. They are, however, trained and held to all of the same membership standards as voting members. In the event of a voting member exiting the group unexpectedly, an at-large member can then easily transition into the vacant voting role.

Vote: At 11:20 am, the motion was made by J. Nuss and seconded by M. Williams to accept the recommended slate of voting and at-large applicants for 2021 IHIPC membership as presented on behalf of the Membership Committee

Result: Votes were cast via ballot. The motion carried with 23 in favor, 1 opposed, 2 abstentions, and 8 absent/no vote cast .

11:20 am: Present/Vote on Interventions & Services Guidance Recommendations for 2021

Jeffery Erdman, IHIPC LTC, RRC, ART, & VS Committee Co-chair

J. Erdman presented the proposed changes to the Interventions and Services Guidance for 2021 on behalf of the LRAV and PP committees. The follow components of the Guidance were defined and reviewed: Recruitment Strategies; Key Public Health Strategies; Behavioral Risk Reduction Interventions; and Biomedical Risk Reduction Interventions.

The committees recommended the following additions for the 2021 Guidance, all of which are proposed to be appendices. Each of the recommendations was reviewed in detail (please see presentation slides for details):

- The 2020 HIV Care Compendium
- The 2020 HIV Prevention Safer Services Guidance
- List of 2020 Interventions and Strategies Most Commonly and Easily Implemented
- Guidance on Deprioritizing HIV Testing for PWID

Discussion (Q: Question, C: Comment, A: Answer):

Q: Thanks to all who contributed to the Interventions and Services Guidance, my question is while BIPOC face multiple factors that increase HIV vulnerability and impact viral suppression with HIV biomedical tools, can IHIPC explore incorporating social determinants of health into this guidance?

A: J. Erdman responded: Last year, the committees added a structural interventions section to the Guidance that focuses on things like social determinants of health and other structural interventions that are essential to providing prevention interventions. This will remain in the 2021 Guidance.

Q: For the changes with PWID, are there any other situations that may prompt HIV test? I'm thinking of reconnecting with syringe program after a long break (i.e. 1 year).

A: J. Erdman responded: I would hope that if a client had previously been engaged in a syringe exchange and had previously had a baseline test (which is one of the "prompts in the De-prioritization Guidance document) that this information would still be available when they returned. If they disclosed new exposures to HIV, however, a new test would be appropriate.

A: M Andrews-Conrad responded: I would also like to note that the De-prioritization Guidance document is meant to guide providers under the fee-for-service model. Anyone requesting an HIV test (regardless of identification with a prioritized population) will receive an HIV test if requested, but agencies will not be reimbursed at the prioritized rate for testing PWID if the client's situation is not listed in the "prompts".

A: C. Hicks responded: 3000 tests conducted with PWID over the past four years resulted in only 1 new HIV-positive result. These included clients who attended SSPs regularly and those who did not. If a PWID who has been away from the program returns and reports HIV exposures or tests positive for HCV, an HIV test would certainly be encouraged. The purpose of these guidelines is to encourage regularly HCV testing where 1 in 15 PWID currently test HCV+.

Vote: At 11:55 am, the motion was made by J. Filicette and seconded by T. Box to accept the Changes to the HIV Interventions and Services Guidance for 2021, as recommended and presented by the LRAV and Primary Prevention Committees

Result: The motion carried with 26 in favor, 0 opposed, 0 abstentions, and 8 absent/no vote cast.

12:00 pm: Break for Lunch

1:00 pm: Reconvene/Check Attendance/Review Afternoon Agenda

After the break, all present IHIPC members were announced, and the attendance of guests was recorded.

1:15 pm: Measuring Our Progress through Data: Updated State/Regional HIV Care Continua

Dr. Fangchao Ma, IDPH HIV Epidemiologist

F. Ma reported on the recently updated Statewide and Regional HIV Care Continuum. Steps of the Continuum (linkage to care, engagement in care, retention in care, and viral suppression) and their respective definitions were reviewed. Several data limitations were disclosed. F. Ma reviewed linkage to care, engagement in care, retainment in care, and viral suppression data by year (2014-2019); and then by sex at birth, age, race/ethnicity, transmission category for 2019 only. Regional data was reported for 2018-2019. Main findings from the presentation included the following:

- There was slightly increase in linkage to care (LTC) in 2019, but it was still below the peak level reached in 2016; still below 80%.
- Males had greater LTC across all intervals including within 30 days of diagnosis than females.
- Older patients (ages >=65) had lower rates of LTC relative to their counterparts in 2018, however this group had the highest LTC in 2019.
- Older patients (ages >=65) had lower proportions across all treatment cascade than other age groups.
- There were still noticeable regional differences in LTC, but regional differences for treatment cascades have further reduced.
- Rates of engagement in care, retained in care, and viral suppression further improved appreciably in 2019.
- African Americans still lagged behind across all HIV care continuum, this inequity needs to be addressed.

Discussion (Q: Question, C: Comment, A: Answer):

Q: C. Ward asked the following questions to participants: Have any agencies implemented strategies to address the disparities between men and women as it relates to linkage, retention, and viral suppression?

Q: Do we know how the gender disparities compares to other states? Is this something that is common across the country?

A: F. Ma responded: I am not sure how it compares to national data, but I did see similar trends in some states. In the literature, it is noted that HIV stigma can more negatively impact women, so this might be playing a role in disparities across the continuum.

Q: Because people living with HCV are now less funded for HIV testing, can IDPH-funded providers use some fee-for-service dollars to link and retain PWID to HIV care? I ask this because the presentation indicates that they have low linkage to care and retention in care rates.

A: C. Hicks responded: Some grants allow for HCV linkage to care reimbursement through supplemental services. For HIV linkage to care, this can be achieved through prevention for positive interventions. For fee-for-service, CRCS would be the appropriate intervention to conduct this. As HIV incidence continues to lower among PWID, there most likely be a large demand for linking individuals to HIV care, especially in terms of new HIV diagnoses among PWID. Focusing linkage interventions on MSM and HRH might be more successful for funded agencies.

Q: Can Dr. Ma say anything about how the rate of viral suppression compares for people who are engaged in care vs. retained in care?

A: F. Ma responded: For retained in care, the viral suppression rate is over 85 percent. I don't know the engaged in care rate, but I believe it would be much lower than the rate correlated to clients retained in care (most likely lower than 70 percent). I will consider including this data in next year's presentation as it is a great question.

Q: Does this data include all people living with HIV (i.e. Ryan White engaged and those that are not engaged in RW services)?

A: C. Ward responded: Yes, the data includes all people living with HIV in Illinois (including Chicago).

C: F. Ma and C. Ward noted: If participants are interested in seeing more detailed regional data, please contact C. Ward to fill out a data request form.

Q: Are we tailoring strategies for black subpopulations, including persons who inject drugs and young males with acquisition attributed to heterosexual contact? It might be

needed to achieve improvements in linkage and retention in care.

A: F. Ma responded: Yes, if you examine that data into more specific sub-groups, you can see even more disparities when race/ethnicity &transmission categories are analyzed together. We need to continue to focus our efforts on increase linkage, retention, and viral suppression rates for the Black community as they have changed very little over time. In doing this, our rates for all transmission categories should increase as well.

Q: Given that downstate IL (outside of Chicago) has fewer Black/Latinx providers (staff & agencies) in the HIV health care system, should we be looking to accountability to deliver improved health outcomes for Black/Latinx communities?

A: C. Hicks responded: The disparities in this data is most likely and more prominently reflecting care of individuals outside of the Ryan White care system. If we compared Ryan White clients v. those not engaged in RW services, we would most likely see very different rates along the continuum. It might also be helpful to look at regional data to further evaluate this type of correlation. I will mention that the HIV section has been working to release Provider Report Cards for all providers (regardless of RW affiliation) to make them aware of disparities and continuum rates among their patients. We are hopeful this feedback will help improve outcomes. This will be discussed in more detail in the next presentation. Additionally, on the Prevention side, social marketing messages for specific populations can be used to engage and motivate clients to access Prevention and Care. We can continue to strategize to influence services outside of our networks as much as possible.

2:00 pm: <u>Measuring Our Progress through Data</u>: NHAS 2020 Indicators Overview/2020 Progress

Patricia Murphy, IDPH HIV Evaluation Administrator

P. Murphy presented an Overview of the NHAS Indicators with an update on Illinois's progress. Each of the 13 NHAS indicators was presented with the following information: Illinois baseline data for measuring the indicator as well as yearly outcomes, targets, and overall goals through 2020. Each indicator was also accompanied by points of consideration for future progress on the goal. Please see the presentation slides for specific information about each indicator.

Discussion (Q: Question, C: Comment, A: Answer):

C: Regarding comprehensive health education for young gay or bisexual men, FLASH (Family Life and Sexual Health) is an excellent curriculum used in Peoria High schools (FRIEND, Peoria School District collaboration). It is inclusive and is being evaluated for evidence-based outcomes.

Q: When did MMP shift from sampling Care clients to sampling all Surveillance-reported clients?

A: P. Murphy responded: That sampling changed in 2015, and all of the data in the MMP-related metrics have been reanalyzed to account for this.

Q: Is there a national report on these NHAS indicators? How is Illinois comparing?

A: P. Murphy responded: I was not able to find a national report, so I am not sure.

Q: Do you think a comprehensive approach to reducing/eliminating stigma may address multiple metric objectives? A structural focus will be necessary to make progress.

A: P. Murphy and C. Hicks responded: I believe this could be the case. Although it is difficult to measure outcomes in this context, it would be plausible that people with less internalized stigma and less provider-related stigma experiences would be more empowered to seek needed services. In our current national climate, this might be more difficult to achieve. This is all the more reason for us to work to reduce stigma.

C: IPHA's HIV Care Connect is currently running an anti-HIV stigma campaign on our website and social media platforms.

C: Dr. Ma is nearly finished with the more developed stigma analysis. He is making some final revisions before we submit for permission to publish on the IDPH website.

Q: U=U is in conflict with HIV criminalization laws. Eliminating such laws should help.

A: M. Andrews-Conrad: Yes, this is another component of stigma and how it trickles down through the continuum.

Q: Is COVID-19 taken into consideration when comparing percentages or expected outcomes?

A: P. Murphy responded: Because this data set is through 2019, COVID would not have impacted the information in this year's presentation. Next year, however, we will need to determine a way to evaluate this. I will share that the IDPH Medical Director is interested in conducting studies to showcase the impact of COVID on people living with HIV, so that might lend us some insight.

C: I think a significant campaign to reach HIV providers outside our Ryan White system is warranted. Perhaps engaging IPHCA and the FQHCs? This could improve our continuum-related indicator numbers.

A: P. Murphy responded: Yes, I agree. I think our Provider Report Cards will have a significant impact on this as well.

2:25-2:40 pm: Brief break

2:40 pm: Integrated Plan Concurrence Overview, Discussion, and Vote

J. Nuss presented the Integrated Plan Concurrence Overview, Discussion, and Vote. The presentation began by briefly reviewing the 2020 updates to the Integrated Plan which

had been presented previously and at this meeting. With these updates completed, the IHIPC's role in the Integrated Plan's concurrence process was discussed. Through review of the concurrence process, participants were reminded that concurrence letters from planning groups are only required with the submission of a new Integrated Plan (concurrence letter for 2017-2021 plan was submitted in September 2016), or if major changes are made to the Integrated Plan mid-cycle. J. Nuss then asked IHIPC members to discuss if they believed that a new concurrence letter related to this year's updates was necessary.

There were no questions or comments at this time.

Vote: At 3:01pm, the motion was made by N. Holmes and seconded by J. Erdman for the IHIPC to continue to support the existing letter of concurrence with the Integrated Plan.

Result: The motion carried with 25 in favor, 0 opposed, 0 abstentions, and 9 absent/no vote cast.

3:05 pm: GTZ Implementation Council Update
Mike Benner, IHIPC Liaison to the Council

M. Benner presented the GTZ Implementation Council Update. Announcement included the following: recent GTZ events/speaking engagements; upcoming GTZ webinars; GTZ workgroup updates (including the STI Workgroup and Older Adults and Long-Term Survivors Workgroup); and virtual community engagement sessions. The schedule for the virtual community engagement sessions is as follows:

October 21 from 3:30-5:00 PM - Region 3
October 29 from 3:30-5:00 PM - Region 7
November 4 from 3:30-5:00 PM - Region 8
November 10 from 3:30-5:00 PM - Region 2
November 11 from 3:30-5:00 PM - Region 1
November 12 from 3:30-5:00 PM - Region 4
November 18 from 3:30-5:00 PM - Region 5
December 8 from 3:30-5:00 PM - Region 6

Discussion (Q: Question, C: Comment, A: Answer):

Q: I am wondering if GTZ has incorporated some of the pillars of the Black AIDS Institute's We the People Plan into their work? These pillars really speak to a lot as it relates to communities of color. Ig it has been adopted by GTZ, should IHIPC revisit this and incorporate it into its work?

A: J. Dispenza responded: Yes, the We the People Plan Pillars are to be incorporated into the GTZ Plan.

A: J Nuss responded: The IHIPC HIV Health Equity Workgroup intends to review this plan and to incorporate its principles into its work. Additionally, we are expecting to review Integrated Plan guidance from HRSA/CDC very soon. The GTZ plan, We the People Plan, and other plans will be reviewed and considered for inclusion in the 2022-2027 Integrated Plan.

C: All participants were encouraged to participate in GTZ community engagement sessions as able.

3:25 pm: Public Comment/Parking Lot Period

There was one request for Public Comment, but it was decided that it would be shared at the October 27 meeting.

Parking lot items:

Q: Are there any planned changes to fee-for-service grants in COVID times?

A: At this time, we are allowing agencies to use capacity building and federal funds to affect hiring and to make adaptations to programs as needed. We also will continue to urge agencies to adapt practices according to the Safer Service Protocol. We realize that this is a big shift for providers and will continue to support them in these endeavors. Finally, we are looking into adding new language into our grants that allows for flexibility in budget revisions during public health emergencies.

3:30 pm: Adjourn

2020 Illinois HIV Integrated Planning Council (IHIPC) Vote Log _ October 26-27, 2020 IHIPC Meeting_updated 10.28.20

Member Name	Member Type	Date: 8/10/20	Date: 8/28/20	Date: 10/26/20	Date: 10/26/20	Date: 10/26/20	Date: 10/26/20	Date: 10/26/20
		Motion 1: A motion was made by M. Maginn and seconded by N. Holmes on 8/4/20 at 9:45 am to adopt the agenda for the 10/26-10/27/20 IHIPC Meeting as approved by the Steering Committee. The motion was sent to members 8/10/20 at 8:00 am; they were given until 8:00 am 8/17/20 to submit votes.	**Motion 2:** A motion was made by J.Nuss and seconded by J. Charles on 9/23/20 at 11:17 am to adopt the revised agenda for the October 26, 20 IHIPC meeting. Members were given until noon on 9/28/20 to submit their votes.	**Motion 3:** A motion was made by C. Hendry and seconded by J. Nuss at 11:00am to adopt the changes to the By-laws as recommended and presented by the Membership Committee.	**Motion 4:** A motion was made by L. Meyer and seconded by J. Filicette at 11:05am to adopt the changes to the Procedures as recommended and presented by the Membership Committee.	**Motion 5:** A motion was made by J. Nuss and seconded by M. Williams at 11:20am to accept the recommended slate of voting and at-large applicants for 2021 IHIPC membership as presented on behalf of the Membership Committee	**Motion 6:** A motion was made by J. Filicette and seconded by T. Box at 11:55am to accept the Changes to the HIV Interventions and Services Guidance for 2021 as recommended and presented by the LRAV and Primary Prevention Committees.	**Motion 7:** A motion was made by N. Holmes and seconded by J. Erdman at 3:01pm for the IHIPC to continue to support the existing letter of concurrence with the Integrated Plan.
IHIPC Voting Members								
Benner, M.	Voting	Y	Y	Y	Y		Y	Y
Box, T.	Voting	Y	Y	Y	Y		Y	Y
Bradley, W.	Voting	Y	Y	Y	Y		Y	Y
Carabello, F.	Voting	Y	X	Y	Y		Y	Y
Carter, D.	Voting	X	Y	X	X		X	X
Charles, J.	Voting	Y	Y	X	X		X	X
Choat, L.	Voting	Y	Y	X	X		X	X
Crause, C.	Voting	Y	Y	Y	Y		Y	Y
Dispenza, J.	Voting	TS	Y	Y	Y		Y	Y
Erdman, J.	Voting	Y	Y	Y	Y		Y	Y
Filicette, J.	Voting	Y	Y	Y	Y		Y	Y
Gaines, M.	Voting	Y	Y	Y	Y		Y	Y
Hendry, C.	Voting	X	Y	Y	Y		Y	Y
Holmes, N.	Voting	Y	X	Y	Y		Y	Y
Hoots, C.	Voting	Y	Y	X	X		X	X
Howard, T.	Voting	Y	Y	Y	Y		Y	Y
Hunt, D.	Voting	Y	Y	Y	Y		Y	X
Jimenez, R.	Voting	Y	X	Y	Y		Y	Y
Johnson, R.	Voting	X	Y	Y	Y		Y	X
Jones, S.	Voting	X	X	Y	Y		X	X
Kowalsky, J	Voting	Y	Y	Y	Y		Y	Y
Laskowski, C.	Voting	Y						
Lewis, K.	Voting	Y	Y	Y	Y		Y	Y
Maginn, M.	Voting	Y	Y	Y	Y		Y	Y
Meirick, A.	Voting	X	Y	Y	Y		X	Y
Meyer, L.	Voting	Y	Y	Y	Y		Y	Y
Montgomery, C.	Voting		Y	X	X		X	X
Nuss, J.	Voting	Y	Y	Y	Y		Y	Y
Olayanju, B.	Voting	Y	Y	Y	Y		Y	Y
Rehrig, S.	Voting	Y	Y	Y	X		X	Y
Roeder, L.	Voting	Y	Y	Y	Y		Y	Y
Wheeler, R.	Voting	Y	Y	Y	Y		Y	Y
Williams, M.	Voting	X	Y	Y	Y		Y	X
Williamson, M.	Voting	Y	Y	Y	Y		Y	Y
Zamor, S.	Voting	X	X	Y	Y		Y	Y
Type of Vote:		**electronic**	**electronic**	**roll call**	**roll call**	**ballot**	**roll call**	**roll call**
Results: Carried/Defeated		**carried**	**carried**	**carried**	**carried**	**carried**	**carried**	**carried**
Results: Vote Count		26 in favor, 0 opposed, 0 abstentions, 7 members absent or "no vote cast/received", 1 TS	29 in favor, 0 opposed, 0 abstentions, 5 members absent or "no vote cast/received", 0 TS	29 in favor, 0 opposed, 0 abstentions, 5 members absent or "no vote cast/received", 0 TS	28 in favor, 0 opposed, 0 abstentions, 6 members absent or "no vote cast/received", 0 TS	23 in favor, 1 opposed, 2 abstentions, 8 members absent or "no vote cast/received", 0 TS	26 in favor, 0 opposed, 0 abstentions, 8 members absent or "no vote cast/received", 0 TS	25 in favor, 0 opposed, 0 abstentions, 9 members absent or "no vote cast/received", 0 TS

Y: In favor; N: Opposed; A: Abstain; X: Absent or No vote cast/received TS: temporarily suspended