



LOS ANGELES COUNTY COMMISSION ON HIV

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While not required of meeting participants, signing-in constitutes public notice of attendance. Presence at meetings is recorded solely based on sign-in sheets, and not signing-in constitutes absence for Commission members. Only members of the Commission on HIV are accorded voting privileges, thus Commissioners who have not signed in cannot vote. Sign-in sheets are available upon request.

COMMISSION ON HIV MEETING MINUTES September 18, 2014

**Approved
11/13/2014**

COMMISSION MEMBERS PRESENT	COMMISSION MEMBERS PRESENT (cont.)	COMMISSION MEMBERS ABSENT	DHSP STAFF
Michael Johnson, Esq., <i>Co-Chair</i>	Miguel Martinez, MSW, MPH	Joseph Cadden, MD	Kyle Baker
Ricky Rosales, <i>Co-Chair</i>	Ismael Morales	Dahlia Ferlito, MPH (<i>pending</i>)	Rhodri Dierst-Davies, MPH
Alvaro Ballesteros, MBA	José Munoz	Suzette Flynn	Sonali Kulkarni, MD
Alex Castillo	Mario Pérez, MPH	Lynnea Garbutt	Carlos Vega-Matos, MPA
Raquel Cataldo	Gregory Rios	David Giugni, LCSW	
Kevin Donnelly	Juan Rivera	Grissel Granados, MSW/Maria Roman	
Michelle Enfield	Jill Rotenberg	Joseph Green/Eric Sanjurjo, MPH	COMMISSION STAFF/CONSULTANTS
Lilia Espinoza, PhD	Sabel Samone-Loreca/ Susan Forrest	Kimler Gutierrez (<i>pending</i>)	
Aaron Fox, MPM		AJ King, MPH	Dawn McClendon
Terry Goddard, MA	Shoshanna Scholar	Patsy Lawson	Jane Nachazel
Ayanna Kiburi, MPH (by phone)	Terry Smith, MPA	Marc McMillin	Craig Vincent-Jones, MHA
Lee Kochems, MA	LaShonda Spencer, MD	Victoria Ortega	Nicole Werner
Mitchell Kushner, MPH, MD	Will Watts, JD	Angélica Palmeros, MSW	
Bradley Land		Monique Tula	
Rob Lester, MPP		Terrell Winder	
Ted Liso/Lantis, MBA, Douglas		Fariba Younai, DDS	
Abad Lopez		Richard Zaldivar	
PUBLIC			
Robert Aguayo	Traci Bivens-Davis	Efren Chavez	Edd Cockrell
Thelma Garcia	Jesus Gaspar	Sherry Gonzalez	Laura Gutierrez
Miguel Gutierrez	Miki Jackson	Uyen Kao	Joseph Leahy
Kiesha McCurtis	Steve Mercieca	Andy Mills	Darrell Nichols
William Paja	Jose Paredas	Michael Pitkin	Craig Pulsipher
Yaniva Reyes-Lopez	Martha Ron	Camilo Rosas	Natalie Sanchez
Raquel Sanchez	Kevin Stalter	Brigitte Tweddell	Jason Wise

1. **CALL TO ORDER:** Mr. Johnson opened the meeting at 9:35 am and welcomed new Commission member Will Watts, JD.
 - A. **Roll Call (Present):** Ballesteros, Donnelly, Enfield, Espinoza, Goddard, Johnson, Kiburi, Kochems, Kushner, Land, Liso/Lantis, Lopez, Martinez, Morales, Munoz, Pérez, Rivera, Rosales, Rotenberg, Samone-Loreca/Forrest, Smith, Spencer, Watts

2. APPROVAL OF AGENDA:

MOTION 1: Approve the Agenda Order with Item 12.C.1., DHSP's report on biomedical interventions, moved after Item 13. A., the Planning, Priorities and Allocations (PP&A) Committee report (***Passed by Consensus***).

3. APPROVAL OF MEETING MINUTES: This item was postponed.

MOTION 2: Approve minutes from the Commission on HIV meetings, as presented (***Postponed***).

4. PUBLIC COMMENT (*Non-Agendized or Follow-Up*):

- Mr. Nichols, Peer Advocate, Exodus, thanked Mr. Leahy, Janssen Therapeutics; Eduardo Martinez, AIDS Healthcare Foundation (AHF); and Ms. Tula, AIDS United for responding to his call to assist Exodus' heterosexual support group. A flyer for the group was on the resource table. It lists Walgreens as a sponsor, but sponsorship ended recently without notice. Support for the group has been rare and he encouraged people to keep its support in mind.
- Ms. Garcia, Los Angeles Subcommittee on the United States Conference on AIDS (USCA) 2014, reported a community member received a Subcommittee mentorship and will present to the community afterwards. The opening plenary will be live streamed 10/2/2014, 8:00 am, at the California Endowment. To RSVP, text USCA 2014 to 313131. The Subcommittee will also host a film night at USCA on 10/4/2014. Both events offer free "Normal Heart" DVDs while supplies last. The live stream will be available at <http://www.ustream.tv/channel/usca-2014> or www.ustream.tv by searching for the USCA2014 channel. Live stream event flyers were on the resource table. Ms. Garcia thanked Subcommittee members for their work.
- Mr. Pitkin suggested increased attention to identifying ways to fill service gaps across systems. He also urged an increased effort to redress differences with the County through negotiation rather than litigation to reduce legal costs.
- Ms. Jackson, AHF, noted AHF did not object to being mentioned by name. She said the County audit did not contend that services were not performed but, rather, that the process for billing was invalid so some monies paid should be returned.
- She reported a day in the life of AHF includes: 4,363 patients seen in 34 countries, 3,361 HIV tests with 174 persons diagnosed with HIV, and 87,251 condoms distributed. AHF seeks to provide cutting edge medicine and advocacy regardless of ability to pay including some 40,000 patients in Uganda and eight clinics in Cambodia. The first publicized death of a physician from Ebola was an AHF physician and AHF has been at the forefront of advocating for a stronger Ebola response.
- Mr. Stalter reported the Thrive Tribe Brotherhood, a social group for HIV+ men, holds a pot luck monthly. The next pot luck will be 9/27/2014 in West Hollywood at a member's home. Contact him for information.

5. COMMISSION COMMENT (*Non-Agendized or Follow-Up*):

- Ms. Forrest reported the HV Drug and Alcohol Task Force will present a two-part training on the intersection of HIV, substance use and domestic violence. Part one, 11/12/2014, will offer an overview. Part two, 12/10/2014, will address interventions. Flyers were on the resource table. Go to <http://hivdatf.org> and click on 2014 trainings for more information or to register. Providers with domestic violence services who would like a resource fair table should contact Ms. Forrest.
- Dr. Kushner announced the Long Beach Gay Men's Health Summit, "Come Out, Be Out, Be Healthy," 10/11/2014, 8:30 am to 4:30 pm, Courtyard Marriot, 500 East First Street, Long Beach, CA 90802. The free Summit is being held in conjunction with National Coming Out Day and focuses on gay men's sexual and general health. Flyers were on the resource table.
- Mr. Munoz reported Commission members attending Spanish-speaking support groups are often asked about the Commission. He usually receives 10-15 minutes to summarize Commission work, but that often spurs additional questions.
- He added Patricios Soza now runs a Spanish-speaking educational group without institutional support. The group has a proven fellowship with an average of 35 attendees per meeting and a social network of over 200. The group is also nearly self-sustaining. He suggested the Commission designate it as an ad hoc group to improve Commission outreach to the Spanish-speaking community. Commission members could present once a month on the Commission and how it can help meet consumers needs. While the Latino Caucus would remain in English, this group needs to be in Spanish.
- Ms. Scholar said Governor Brown signed a bill 9/16/2014 that decriminalizes syringe possession regardless of number starting 1/1/2015. Past restrictions chilled accessing syringes at pharmacies and physicians as well as needle exchange usage. Restrictions remain for those on parole or probation, but efforts are ongoing to include them.
- Governor Brown also signed a bill 9/16/2014 that allows pharmacists to dispense Naloxone without a standing order from a physician. Naloxone reverses opioid overdoses. The Board of Pharmacists will still need to develop a regulatory process to implement the bill. Previous bills allowed Naloxone administration by emergency responders. On 1/1/2014, a new law permitted community programs addressing substance issues to have lay people operating under a physician's order provide Naloxone and training directly to people at risk of overdose and their family and friends.

- AIDS Project Los Angeles (APLA) will host a grand opening for its new Gleicher/Chen Health Center on 10/1/2014, 9:00 am to 12:00 noon. The Center is located at 3743 S. La Brea Avenue at Coliseum in the Baldwin Hills Shopping Center. This is part of APLA's expansion into medical services for the LGBT community and will include primary medical and dental care, mental health counseling, HIV specialty care and PrEP. Cards were on the resource table.
- Mr. Ballesteros reported the Department of Health Services (DHS) together with community clinics will roll out a new program, My Health LA, on 10/1/2014 to replace the previous unmatched indigent care program. It will be able to serve some 146,000 uninsured people, including the undocumented, below 138% of the Federal Poverty Level. It is not for PLWH, but offers an opportunity for prevention programs to enroll uninsured people in the LGBT community. My Health LA is a medical plan, not insurance, that includes medical care, laboratory work, x-rays, specialty care and other services commonly covered by insurance. He noted primary care is a critical HIV prevention component. He was available for assistance.
- Ms. Rotenberg reported the next SPA 4 Service Provider Network meeting will be 9/25/2014, 12:00 noon, at the LA LGBT Center, 1625 N. Schrader Blvd., Los Angeles CA 90028. There will be a presentation on Project MedNet which focuses on how social networks impact the health of African-Americans living with HIV. RSVP to 213.484.1186, extension 3029.
- ➡ Agendize for next Executive Committee: Consider Patricios Soza's Spanish-speaking educational group as a Commission ad hoc group with monthly reports from Commission members to improve outreach to the Spanish-speaking community.

6. CONSENT CALENDER:

- A. Policy/Procedure #08.2107: Consent Calendar:** Remaining Motions 4 and 5 withdrawn for discussion.
MOTION 3: Approve the Consent Calendar, with agenda motions revised or removed as necessary (*Withdrawn*).

7. CO-CHAIRS' REPORT: There was no report.

8. PARLIAMENTARY TRAINING: There was no report.

9. CALIFORNIA OFFICE OF AIDS (OA) REPORT:

A. California Planning Group (CPG):

- Mr. Rivera reported the CPG is planning its second in-person meeting on 10/1/2014 in San Diego coinciding with the USCA. CPG members have reviewed California's Integrated Surveillance, Prevention and Care Plan developed in 2012 by the previous CPG body. Members submitted questions and feedback to OA which will respond at the meeting.
- CPG members are also reviewing the governance documents for finalization at the San Diego meeting.
- CPG Community Co-Chairs signed the Letter of Congruence for the State's current legislative plan. The letter was submitted with OA's Prevention Branch 2014 Interim Progress Report as required by the CDC. CPG members reviewed the Integrated Plan and then chose whether they wanted the Community Co-Chairs to sign the Letter of Congruence, Letter of Non-Congruence or Letter of Congruence with Reservations.

B. OA Work/Information:

- Ms. Kiburi, Chief, HIV Care Branch, reported management memorandum 1401 was re-released with revisions and is posted on the OA website. It addresses OA's expectations of contractors in pursuing comprehensive coverage for all eligible clients. Revisions updated Covered California open enrollment dates and clarified an answer to one of the Frequently Asked Questions. OA also updated HCPN ADAP Covered California client information and acknowledgement form, available in English and Spanish on the OA website.
- HRSA's San Francisco Office of Regional Operations hosted a California Ryan White cross-Parts meeting on 9/3/2014 in San Francisco. The meeting assisted California Ryan White HIV/AIDS program grantees to prepare for the next ACA open enrollment period with an outreach and enrollment focus. The meeting's video will be on the OA website soon.
- Mr. Stalter said the three Blue Shield problems reported the prior month have not been resolved: check match-ups with batch numbers, cancellations and delayed reimbursements. In addition, it is no longer accepting payments using Social Security Numbers, but instead requires a member identification number which can take two to three months to obtain. Last year many people left clinic care for OA-HIPP, but then lost care. That may recur if problems are not fixed.
- Mr. Johnson added he has both heard and experienced having to personally call to request an OA-HIPP check or the request goes through the day payment is due and the check arrives two or three weeks later. The insurer then needs at least a week to match it up properly. Check requests should be made 30 days before the due date so they are on time.
- Mr. Rivera regularly helps consumers with OA-HIPP. He tells them they will likely have to front Covered California or COBRA premium payments for up to three months. Some consumers are able to do that, but others are not. If they are

able, it is time to apply for another three months by the time the first check is cut. He advises them to watch their payments carefully and apply at least six weeks before renewal. OA-HIPP is a great program, but can be improved.

- Mr. Lantis said he received OA-HIPP COBRA payments for slightly over a year, but lost coverage because the last quarterly payment was one month short. He did not catch the problem within the dispute period and his insurance coverage was retroactively cancelled back to the end of June 2014. He is now in the dispute process with the insurer.
- Mr. Pérez invited OA to work with him and Mr. Vega-Matos in the next 72 hours to develop a one- or two-page summary response to help people navigate this system with its multiple options to cover and finance health care. If a document cannot be completed in that time, he urged at least caucusing to develop a framework to help people struggling month to month to piece together payments while facing cancellations. What is known can be consolidated and troubleshooting recommendations offered to consumers perhaps with the Commission's assistance.
- Mr. Stalter suggested a one-page best practices sheet detailing consumer responsibilities as an OA-HIPP enrollee. A second sheet could identify specific issues with particular insurers such as Blue Shield and how to address them.
- ➡ Ms. Kiburi was unable to provide the written OA report for the meeting, but would email it to the Commission office.
- ➡ Ms. Kiburi said she, Dr. Karen Mark, Division Chief, and Niki Dhillon, Chief, ADAP Branch which includes OA-HIPP are very concerned about the issues and have been working to allay them. She was sure they would be willing to caucus on them. She, Dr. Mark or Ms. Dhillon will contact Mr. Pérez by 9/19/2014.
- ➡ Mr. Pérez requested consumers help develop English and Spanish documents. The Consumer Caucus will address that.

10. TASK FORCE REPORTS:

A. Comprehensive HIV Planning (CHP) Task Force:

1) 2014 Annual Meeting:

- The CHP Task Force is working on the Annual Meeting, An HIV-Free Generation, 10/30/2014, 8:30 am to 5:00 pm.
- Mr. Smith reported the intention is to re-invigorate Commission planning efforts to bring the theme to life in the County. Attendees at past annual meetings were often observers, but this Annual Meeting will emphasize attendee participation to use the expertise of the people in the room.
- The agenda is still being finalized, but will open with a review of the year's Commission accomplishments. A consumer panel will offer their perspectives, e.g., on top future priorities. Members are also asked to review other jurisdiction's principles/plans such as those in the packet: The Atlanta Principles, New York's Plan to End AIDS and Decreases in Community Viral Load Are Accompanied by Reductions in New HIV Infections in San Francisco.
- These various perspectives will inform discussion on developing a County plan. Small group discussions and directed conversations will help to develop key themes going forward.

B. **Community Task Forces:** There were no other task force reports.

11. CAUCUS REPORTS:

A. Transgender Caucus: Trans Summit:

- Mr. Vincent-Jones reported the Caucus has formed a Steering Committee with the Transgender Service Provider Network to oversee and plan the one-day Summit for consumers and practitioners.
- The Caucus met with the Steering Committee and decided to postpone the Summit until January. Originally it had planned to hold it in conjunction with the Transgender Day of Remembrance which is November 20th, but the group felt a delay would improve planning, acquisition of desired speakers and promotion for a better event.
- A separate activity will be developed at the next meeting to highlight the Transgender Day of Remembrance.

B. **Consumer Caucus: Caucus "Consumer" Participation:** Mr. Liso reported the Caucus will meet after the Commission. The meeting will address OA-HIPP issues as discussed earlier and continue the discussion on the definition of "consumer."

C. **Youth Caucus: Update:** There was no report.

D. Latino Caucus:

- Dr. Espinoza said the Caucus has not met, but she is in talks with Mr. Vincent-Jones about its challenges.
- Mr. Pérez asked about discussion on his earlier proposal to coordinate with the effort to re-invigorate Alianza. A synergistic approach rather than two competing bodies could be more effective.
- ➡ Agendize the proposal for the Caucus to work with Alianza for the next Executive Committee.

12. DIVISION OF HIV/STD PROGRAMS (DHSP) REPORT:

A. Research/Surveillance:

1) Medical Monitoring Project (MMP) and Related Research Activities:

- Mr. Dierst-Davies, Epidemiologist, presented "LAC HIV Cascades by Demographic Factors and Results from Projects to Improve Linkage and Re-engagement in HIV Care." It addressed Commission requests for treatment cascade information by demographic groups developed through various ongoing programs. Data can suggest both how various groups are progressing across the continuum, but also what strategies contribute to success.
- LAC trends in HIV linkage, retention and viral suppression, 2009-2012, is based on data from the HIV surveillance database. HRSA definitions are: linkage, Viral Load (VL) test within three months of diagnosis; retention, two medical visits within a 12-month period at least three months apart or a VL and CD4 count; and viral suppression, viral load no greater than 200 copies/ml. From 2009 to 2012, rates slightly increased for linkage, 78% to 81%, and viral suppression, 51% to 56%, while retention rates were essentially stable, 57% to 58%.
- The CDC-funded MMP is a continuous supplemental HIV surveillance study to produce nationally representative data on PLWH receiving care in the US. The County was among the first to pilot the study in 2005-2006 and began serial surveillance in 2007. A new group of PLWH are interviewed and their medical records reviewed each year.
- The County collaborates with state and local health departments, the CDC, National Institutes of Health and HRSA. The CDC has 23 MMP project areas including California as a whole and separate Los Angeles County and San Francisco jurisdictions. Jurisdictions annually submit a list to the CDC of providers who saw HIV patients within the previous six months. The CDC randomly selects a sample of providers based on their size and then selects patients from those providers. Lists of selected patients are sent to the jurisdictions for follow-up.
- The County uses MMP data to help meet RW reporting requirements, in epidemiology profiles, evaluation of prevention programs and resources for care and treatment, and information on access to care and prevention. DHSP has also written manuscripts based on MMP data and has collaborated with other jurisdictions.
- Nationally, MMP data influenced Healthy People, documented the impact of RW CARE Act care and informed treatment guidelines. It is considered a large, national, randomized study of PLWH in care. The CDC helps weight the data for several large jurisdictions including the County so the assumption is that the sample is representative.
- MMP data can help answer questions on whether patients receive care/treatment consistent with US Public Health Service guidelines, barriers to receiving care/treatment and behaviors engaged in by PLWH in care.
- DHSP is using MMP and HIV surveillance data to develop a treatment cascade model for the County and then to use it to review data by such factors as race/ethnicity, age and gender. Eventual publication is planned.
- DHSP estimates of those aware of their HIV diagnosis in the County there are: 77% linked to care, 56% retained, 50% on ART and 42% virally suppressed. Linked and retained data are from HIV surveillance. On ART and virally suppressed data are weighted MMP 2009 data. It is important to note that these denominators are not consistent across the treatment cascade. CDC estimates 15-17% of PLWH are unaware of their status.
- African-Americans had the lowest rates across the board per proportion of population of all races/ethnicities reviewed. African-Americans, Latinos and other race/ethnicities had lower linkage rates compared to whites. African-American retention rates were also much lower compared to whites, but Latino and other race/ethnicities had slightly higher rates compared to whites. Rates of those on ART were lower among non-whites than whites.
- Women had slightly lower rates of linkage and suppression versus men while other rates were fairly consistent.
- Rates overall were inversely proportionate to age with improvement as populations aged. Those 18-29 had the lowest rates of any group with: 71% linkage, 50% retention, 31% on ART and 25% virally suppressed.
- DHSP is unable to conduct multivariate analysis to examine all factors simultaneously due to methodological limitations, primarily because data denominators were drawn from different data sets. Another limitation is that data is from 2009 and is likely to be different in 2013 or 2014.
- DHSP initiated Project Engage and Navigation Program demonstration projects to improve linkage and re-engagement. Both seek to identify PLWH aware of their status, but not in medical care. Methodologies differ.
- Project Engage seeks to identify hard to reach HIV+ persons who are Out Of Care (OOC) and link them back into care. It primarily uses a social network approach, the snowball sampling method, used for some 50 years to find hidden populations. A person ("seed") is identified in the population and incentivized to find another person in the population ("alter"). The alter is then incentivized and so on developing multiple recruitment waves.
- The initial concept was to test the snowball approach method rather than an intervention per se. DHSP learned and adapted as Project Engage progressed, e.g., expanding the OOC definition. A major finding was the need for a navigation program to include outreach with community workers to help identify hard to reach populations in locations such as parks. Fliers/pocket cards are also helpful, but the outreach component is very important.

- DHSP began with HRSA's OOC definition, but felt it too restrictive for PLWH in need. Eligibility was expanded to: no primary HIV care visit for 6-12 months and last VL >200 copies/ml; no primary HIV care visit for more than 12 months; newly diagnosed and never in care; less than two HIV primary care visits at the same provider in the prior six months; or recently released from jail, prison or other institutionalized setting and no regular HIV care provider.
- DHSP first identified seeds and alters within medical facilities, but expanded to direct community recruitment, e.g., Health Education/Risk Reduction (HE/RR) programs such as a crystal meth support group and distributing fliers/pocket cards where people with high HIV rates may congregate such as agencies, parks and outdoor settings.
- Seeds/alters receive \$40 for completing a baseline survey and an additional \$40 after linkage to care.
- Project Engage continues actively enrolling participants. Seeds are mainly meant to drive recruitment by enrolling alters. There have been 118 seeds and 171 alters screened, 61 seeds and 68 alters enrolled and 13 alters enrolled as recruiters. Eligibility is verified via HIV surveillance data with 50% to 70% ineligible due to a recent medical visit.
- Of the 68 OOC participants, 50 (74%) were homeless in the past six months, 19 (28%) engaged in sex work in the past 12 months, 33 (49%) were incarcerated in the past 12 months and 13 (22%) reported injection drug use in the past three months. Most participants had been out of care approximately one year and had elevated VLs. Approximately 35% were African-American and 40% Latino, The median age was approximately 30.
- For those linked to care, it took approximately one month including, e.g., assessments, assistance with structural barriers such as lack of identification, navigating the system to find a clinic, setting up the first appointment and possibly help with the financial screening. Staff time required varied, but the mean was 6.5 hours. Of the 68 OOC participants, 50 (74%) were linked with 23 retained six months post enrollment and 19 of those remain in care.
- The 68 OOC participants reported their top five unmet service needs in declining order as: medical care, dental care, case management, mental health counseling and medication support. Individual barriers were the most common reason for not accessing services, e.g., not knowing where to go, substance abuse or feeling too sick. The second most common reasons were structural, e.g., confusing system, long wait times, not available in area, transportation, ineligibility/denied service, immigration status concerns. There were also some organizational barriers, e.g., did not complete paperwork, financial difficulties, language barrier, disrespect/mistreatment by staff.
- DHSP also did an acceptability survey for the program. Of the 41 alters who took the survey, 100% agreed/strongly agreed that they were satisfied with the program and would recommend it to others, 95% agreed/strongly agreed that it helped them get into care and 78% agreed/strongly agreed they would not have entered care without it.
- Both incentivized snowball sampling and direct recruitment are effective at locating marginalized, hard-to-reach OOC PLWH. Recruitment seems most effective in a non-medical agency setting or at public park/outdoor settings.
- Regarding implementation, HIV surveillance screening was effective in confirming OOC status. The social network approach yielded shallow recruitment waves of only one to two persons deep since being HIV+ and not in care is generally not discussed socially. Addition of direct recruitment, however, successfully expanded enrollment.
- DHSP also found not all facilities had the necessary infrastructure to serve this population with multiple needs. Project Engage coincided with the start of ACA so providers were addressing many new clients and structural changes. It is possible some providers unable to address multiple needs clients then will be able to do so in future.
- The Navigation Program mainly reviews clinic records to identify OOC persons. Once identified, a strengths-based case management intervention is utilized to re-engage them into care. The intervention was adapted for an OOC population from CDC's Antiretroviral Treatment Access Study (ARTAS) for newly diagnosed HIV patients.
- ARTAS uses five visits before moving on while the Navigation Program uses 10 and includes feedback loops so a person who does not reach all ARTAS goals can be re-enrolled into the program or into a different aspect of it. Incentives were specifically eliminated for this program.
- The Navigation Program was a DHSP pilot project with APLA. Outreach workers went to seven HIV clinics across Los Angeles to identify potential OOC participants. The HIV surveillance database was used to determine if people actually were OOC, were receiving care at another facility or returned to care on their own.
- 1,010 patients were identified. Of those, 28% were in care elsewhere, 23% returned to care independently and 11% were located/enrolled with 56 patients returning to care with a phone call and 75 enrolled in the program. The median age was approximately 34.
- There was an average of seven visits over 15 meeting hours with 98% linked, but just 48% retained at six months. There is an incentive for completing a survey and for linking to care.
- The top reported barriers to HIV care reported by 47 participants were in declining order: 30%, other life priorities, e.g., childcare, work; 13%, lack of money; 6%, transportation; 4%, homelessness; 4%, drinking/using drugs.

- Program evaluation found that HIV surveillance and other Department of Public Health (DPH) databases provide key locator/tracking information, but access is limited to DPH or DPH contract staff.
- It was also determined that a one size fits all intervention was inefficient and not client centered.
- DHSP is integrating lessons learned into the new iteration with a three-tiered strategy based on patient need. The first tier is a direct link to a medical appointment for someone expressing interest in one. The second tier is a one- or two-session motivational interviewing intervention. The third tier is the 10-session ARTAS intervention for those with greater barriers. DHSP is also now following patients for six months to support greater retention.
- Ultimately, DHSP is integrating best practices from this, Project Engage and other projects such as a jail study to create a County-based linkage to care program that will work with the Medical Care Coordination (MCC) model to help identify and re-engage OOC people and bring them back to a medical home.
- Ms. Samone-Loreca asked why the transgender population was not reflected in treatment cascades. Mr. Dierst-Davies replied DHSP collects transgender data for MMP and has mechanisms to identify such data for HIV surveillance. Proportions were likely too small to weight data reliably. Regarding linkage projects, the Navigation Program has enrolled no transgender persons and Project Engage just two. DHSP is working on improved outreach.
- He noted national data reflects more categories, e.g., transgender and other race/ethnicity census groups.
- Ms. Enfield suggested using snowball sampling and other outreach methods to specifically target the transgender population. Mr. Dierst-Davies said snowball sampling has been successful in past transgender recruitment efforts.
- Ms. Scholar asked if Project Engage and Navigation Program helped clients obtain identification. Mr. Dierst-Davies replied staff did, e.g., accompany clients to the DMV for identification or programs where discounted identification cards are available. Identification was also sometimes available at a facility a patient had attended in the past.
- Mr. Smith asked what were the "other" race/ethnicities referred to in treatment cascades. Mr. Dierst-Davies said race/ethnicities follow census categories, e.g., Asian/Pacific Islander and Native American/Alaska Native/Hawaiian. Some may self-identify as multi-racial. Numbers were too small to weight with confidence.
- Dr. Spencer appreciated the data despite its demographic limitations. It reflects how, despite all the efforts, one size does not fit all especially in retaining adolescents and youth. We need more creative thinking. Mr. Dierst-Davies added these were challenging studies, but did identify hard to reach populations and offered the opportunity to learn how methodology might be used in a different context or to augment existing programming.
- Mr. Goddard said New York reviews housing to improve indicators and asked about questions other than on homelessness. Mr. Dierst-Davies said the Project Engage and Navigation Program housing question asks about the person's current living situation, e.g., couch, hotel, apartment without a lease. Data can be expanded for review.
- ➡ Mr. Dierst-Davies will follow-up with DHSP on the lack of transgender treatment cascade data.
- ➡ Mr. Dierst-Davies will request treatment cascade break-downs by age for race/ethnicities.

B. HIV/STD Services: There was no report.

C. Administrative Agency:

- Mr. Pérez reported the County successfully submitted its CDC prevention application. The Ryan White (RW) application was due 9/19/2014. Staff was working to finalize it despite a number of power outages and surges in DHSP's building.
- The power outages and surges have required deploying hundreds of staff intermittently to other sites since 9/15/2014. He noted staff is prioritizing critical projects like the RW application so responses to questions may be delayed.
- He thanked the number of people who participated in PP&A's conversations on resources.

1) PEP, PrEP and Biomedical Intervention Implementation Strategies:

- Dr. Kulkarni noted the role of biomedical interventions has evolved. The concept originated to prevent mother to child transmission and evolved to include occupational Post-Exposure Prophylaxis (PEP). In 2005, the CDC released recommendations in a Morbidity and Mortality Weekly Report on non-occupational Post-Exposure Prophylaxis (nPEP) for those engaging in high risk sexual activity and IDUs. Some providers began to provide nPEP.
- DHSP was part of a 2010 nPEP demonstration project which became a permanent program, PEP LA. The 2011 HIV Prevention Trials Network 052 trial provided definitive treatment as prevention data by showing that treatment of PLWH reduced HIV transmission to others. The US Public Health Service released treatment guidelines in 2012 that recommended essentially universal ART treatment for PLWH.
- About the same time, DHSP created its testing and linkage to care framework with an increased linkage focus and rolled out MCC. Efforts focused on increased biomedical interventions for PLWH.
- Studies since then have shown a reduced risk for HIV infection among those taking Pre-exposure Prophylaxis (PrEP) especially for those who take their medication as directed. In May 2014, the CDC released their first PrEP clinical

guidance. It is a comprehensive set of documents for providers interested in offering PrEP including tools such as patient information sheets and an MSM risk assessment as well as informational handouts in English and Spanish.

- Mr. Vega-Matos reported DHSP currently invests approximately \$671,000 in nPEP. There are also non-DHSP nPEP services delivered mostly through public and private health insurance. DHSP is working to quantify those services, e.g., many clinics provide nPEP for serodiscordant couples to prevent HIV transmission.
- Dr. Kulkarni noted most health insurance plans including Medi-Cal cover PEP costs including visits, laboratory tests and ARVs. PEP, however, should be initiated within 72 hours of exposure which can pose a challenge, e.g., to approve a prior authorization in time so the patient does not have to pay for the first few days of medication out of pocket. Some hospital emergency rooms provide a starter pack and then refer to a DHSP program.
- DHSP is part of a CHIRP-funded PrEP demonstration project in SPAs 4 and 6. Dr. Amy Wohl, Principle Investigator, works closely with UCLA. There are five PrEP studies in the County overall with eight sites. DHSP has disseminated the list to its contracted prevention providers as has the Los Angeles County PrEP Work Group.
- PrEP is also offered by many community providers, but consumers are often unaware of access points and their primary care physician may be unfamiliar with it and/or uncomfortable prescribing it. Like PEP, most health insurance plans cover PrEP, but the cost of co-payments and deductibles varies so cost may be an issue.
- Mr. Vega-Matos reported DHSP initiated an nPEP Work Group in 2007 with interested researchers and community stakeholders. That transitioned to the 2010 demonstration project and then PEP LA in Spring 2011 with the sites in SPAs 4 and 6. The SPA 4 site has seen high growth and is operating over capacity. SPA 6 uptake has been low.
- Dr. Kulkarni reported of clients presenting: 7% were diagnosed with Chlamydia, 10% with gonorrhea and 5% with syphilis. There were also 3% with previously undiagnosed HIV. Overall, rates are high and exceed rates for MSM at STD clinics confirming that high risk populations are being reached. One-quarter of clients also reported previous PEP use demonstrating that there is interest in using biomedical interventions.
- Mr. Vega-Matos said DHSP hoped to serve 601 patients with the approximately \$671,000 investment, but actually served 794 patients for the period ending February 2014. Overall SPA 4 program cost per patient is \$846 achieved by leveraging, e.g., patient assistance programs and other funding streams that cover administrative costs and sexual health staff providing adherence and risk reduction counseling. Lower patient volume at SPA 6, however, undercuts leveraging and economies of scale so that program cost is \$3,200 per patient.
- A key take-away is that leveraging is very important in maximizing cost efficiency of the program beyond average medication costs of \$383. There are significant staff costs for such activities as ensuring access to patient assistance programs, financial screenings and connection to other health plans if pertinent.
- Dr. Kulkarni said DHSP's nPEP delivery experience reflects the importance of providing biomedical interventions via comprehensive prevention programming. These include: medical visit follow-up; ARV laboratory testing, e.g., for renal disease; regular HIV and STD testing; adherence and risk reduction counseling; services such as care coordination follow-up and referrals for vaccination, e.g., for Hepatitis; and administrative support.
- DHSP funded the entire service when PEP LA started, but the importance of leveraging increased as more people became insured. That requires ensuring adequate financial screening along with help in applying for insurance, acquiring prior authorization and a starter pack of medication until insurance is active. Insurance and other programs should be able to address medical visits, ARV medications and, in most cases, HIV and STD testing.
- Care coordination, referrals, follow-up visits and vaccinations may be billed to insurance depending on coverage, the clinics' services and the provider's knowledge of billing. Adherence/risk reduction counseling may also be billable, but may not be fully reimbursed. Administrative functions such as financial screenings and prior authorization assistance are traditionally not reimbursed and may be a financial barrier for some providers.
- DHSP continues to fund all services for the uninsured, but providers are expected to access patient assistance programs where possible. Funding is more complex for the underinsured. Recently a patient interested in PrEP found his insurance had a \$300/month co-payment. A patient assistance program would have reduced that to \$200, but that was still unaffordable. DHSP is reviewing how to address such issues especially for high risk patients.
- DHSP convened an expert panel to help inform revision of its nPEP protocol. Occupational guidelines were recently revised to recommend three, rather than two, medications. nPEP protocols will likely be revised to follow suit and many providers are already following it which will increase the cost of medications. A standard two-drug regimen costs approximately \$400/month while the expected three-drug regimen will cost approximately \$1,000/month.
- Mr. Vega-Matos reported maintaining PEP LA investment for a two-drug regimen for 28-days as prescribed for the totally uninsured will require an increase from \$671,000 to \$821,000. Increasing the program by 25% will require

\$1,027,000. The cost to maintain services to the current number of patients with a three-drug regimen would be approximately \$1.3 million with a 25% increase in patients costing \$1.6 million.

- Applying available data to PrEP, a two-drug regimen with four medical visits per year at \$2,400 would represent an annual cost per patient of \$7,600, \$1.9 million for 250 patients or \$3.8 million for 500 patients. DHSP will be reviewing national data pertaining to infections averted versus lifetime cost.
- DHSP fully supports biomedical interventions as a critical part of the continuum of HIV services, but with a comprehensive approach. Interventions need to be structured, especially to ensure health plans provide timely and adequate coverage for all associated biomedical intervention services. Work force training is needed particularly for clinicians who regularly encounter patients needing biomedical interventions.
- DHSP also wants to work with emergency rooms in high prevalence areas where patients may need nPEP. DHSP programs often encounter patients who are victims of sexual assault, but it is challenging to ensure nPEP starts within the 36 to 72 hour recommended window when nPEP programs are generally not open on weekends.
- Social marketing is also important to help address: misconceptions about what biomedical interventions can and cannot do; provider and consumer resources as well as access; and stigma, e.g., of HIV-phobia and risk behaviors.
- DHSP would first like to recalibrate current services in SPAs 4 and 6 to include PrEP as well as nPEP. A second phase would deploy services to SPA 8 and a third phase would deploy services to SPAs 2 and 7.
- One key to deployment is recognition that, properly targeted and implemented, these are very valuable prevention tools that are, however, very expensive. The public health response should target those most at risk for HIV infection/exposure and those in high County prevalence areas. Services also need to be deployed at sites the community can access, e.g., current HIV medical homes or sexual health settings.
- Sites should be able to leverage funding streams regardless of the patient's situation, e.g., be able to bill Medi-Cal, LA Care, Health Net or Covered California plans. That ability will help contain costs.
- DHSP will work closely with the Commission and key stakeholders to refine cost projections and address other issues, e.g., it will participate in the CHIRP PrEP think take in November 2014. Dr. Kulkarni is talking with Dr. Mark about tailoring new CDC guidelines to address local epidemiology on high risk populations, e.g., transgender individuals. DHSP will likely develop a supplemental local guidance on which high risk populations to prioritize.
- Mr. Vega-Matos said DHSP plans a biomedical interventions advisory committee in coordination with AETCs, the Commission and stakeholders to leverage researcher, clinician, administrator, planner and consumer knowledge.
- Regarding demographic information, Mr. Vega-Matos said DHSP has data on DHSP-supported nPEP. DHSP is not now using County funds for PrEP so has no data, but is working with stakeholders who do support it to obtain data.
- Mr. Stalter, Thrive Tribe, urged more physician education. People often report primary physicians are reluctant to prescribe PrEP. Dr. Kulkarni replied DHSP is drafting an article for "Rx for Prevention," a DPH newsletter for County physicians. The piece will provide basic information and where to learn more for primary care physicians. DHSP is also using other communication channels, e.g., health advisory alerts.
- Mr. Stalter added there is a generational gap with those under 34 willing to take any medication while those over 34 are reluctant. He urged using social media, e.g., a Facebook page that can be easily referenced to both inform individuals and that people can reference at their physicians' offices. Mr. Vega-Matos replied DHSP wants to work with the Commission and other stakeholders to craft messages and develop strategies for different audiences.
- Mr. Fox reported the California HIV Alliance requested \$3 million for provider and consumer PrEP education statewide in the last budget year. It was not approved, but the ask will be renewed this year. OA also applied for CDC funds for PrEP education. It was not approved, but OA plans to apply again. He added PrEP has sparked LGBT community discussion about HIV and sexual health and more people are coming out to their physicians.
- Ms. Jackson asked about estimated PrEP outreach recruitment. Mr. Vega-Matos said DHSP has not engaged in full promotion of its nPEP program. A phone line has been promoted and distributed to police and the Sheriff's Department. Most people learn about the program by word of mouth yet DHSP has consistently exceeded goals.
- Mr. Pérez complimented the presentation's outline of a biomedical interventions option for the County as of September 2014. He cautioned that projections of costs for 500 patients were only to offer a sense of costs. There is a public health role that is largely as a safety net. It is important to capitalize on opportunities in the public and private health insurance markets, e.g., Kaiser, Medi-Cal and other health insurance plans are supporting PrEP now.
- There is more work to do in nPEP expansion and PrEP will continue to roll out. There needs to be strategic thinking on the public health role that compliments the public and private sectors insurance plans' adoption of PrEP.
- The County still has 1,900 new HIV infections annually. Biomedical interventions will not prevent them all. It is one of many prevention options in the toolbox. It is the best option for some and the County needs to make sure it is

available for them regardless of ability to pay. Multiple sites with small enrollment is clearly not cost effective so the goal is to centralize the service in a way that has multiple elements and uses insurance where feasible.

- Mr. Martinez asked if the DHSP-funded HE/RR and MCC portfolio will be included in recalibration of SPA 4 and 6 services. Mr. Vega-Matos said DPH and some sister departments fund the critical services for the uninsured. DHSP is meeting with providers/stakeholders to identify services covered by other sources including codes and develop training on how to bill. RW cannot be used for nPEP or PrEP nor can CDC funds be used for drugs or medical visits.
- Dr. Kulkarni added DHSP with the Los Angeles County PrEP Work Group has held informational sessions. All DHSP-funded HE/RR providers were invited and will also be invited to a series of DHSP PrEP trainings starting in October.
- Ms. Kao asked about a roll out timeframe. Mr. Vega-Matos said DHSP has begun developing the plan to recalibrate SPAs 4 and 6. That can be done more quickly because services are in place. Phases 2 and 3 will require more conversation on efficient and accessible deployment mechanisms, e.g., whether through County facilities or community partners. It will take more time to deploy diligently and methodically as well as expeditiously.
- Mr. Smith said if the Commission wants PrEP to be a priority it must also advocate for and allocate to it.
- ➡ Mr. Johnson suggested, and the Commission approved, revising the agenda motion from approving a strategy to working with pertinent Committees and DHSP to draft a more specific strategy, timeline and suggested allocations.
- ➡ Messrs. Ballesteros and Land, Co-Chairs, PP&A Committee; Fox and Zaldivar, Co-Chairs, Public Policy Committee; and Johnson and Rosales, Co-Chairs, Commission will draft a structural approach for Executive presentation.

MOTION 4: Approve framework, as determined, for implementation of PEP, PrEP and other biomedical interventions and related services as necessary. Refer subject to Planning, Priorities and Allocations and Public Policy Committees to work with DHSP to develop more specific strategies, frameworks, timelines and allocations (*Passed by Consensus*).

13. STANDING COMMITTEE REPORTS:

A. Planning, Priorities and Allocations (PP&A) Committee: Commission members listed their conflicts of interest.

1) FY 2014 Allocation Modifications:

- Mr. Pérez reviewed the YR 24 Summary Report of RW Part A, MAI and SAM Care expenditures by service categories. DHSP received an increase of \$1.7 million tied to the RW award for approximately \$36.7 million in Part A supplemented by \$3.3 million in Minority AIDS Initiative (MAI) funds. The federal government also invests in states via RW. California uses its award largely to fund ADAP and separately to issue Single Allocation Model (SAM) grants to counties for care services. The County's SAM Care grant is approximately \$8.5 million.
- Overall, the County receives approximately \$48.5 million in RW funding managed by DHSP which supports services through a network of over 80 agencies with more than 250 contracts.
- The Commission annually uses a process to allocate resources to various categories by percentage of the grant. DHSP then converts the percentages to dollars as shown in the Summary, Column D.
- HRSA expects that 75% of resources invested in programs and services support core medical. The remainder may be used for supportive services. Jurisdictions that cannot expend 75% in core medical services must apply to HRSA for a waiver which includes an assurance that everyone in the jurisdiction has access to medical care.
- The Summary only reflects services supported by RW Part A, SAM Care or MAI. Some other services, such as Residential Services, are supported by other funding streams.
- Column E reflects Total Full Year Expenditure Projections which are expected to be approximately \$45.3 million out of \$48.4 million by 2/28/2015 leaving approximately \$3.1 million unspent. It should be noted that allocations may exceed expenditures for a variety of reasons, e.g., Oral Health providers may be unable to spend the full allocation.
- The second Summary sheet reviews the Calendar Year 2014 CDC Flagship award of approximately \$15.8 million. The Full Year Estimate of expenditures exceeds the award by \$275,370. Net County Cost (NCC) FY 2014-2015 funds, also on the Summary, cover remaining costs. The CDC STD Prevention grant was not reviewed at this time.
- The CDC Summary includes County Departmental Service Orders (DSOs). DSOs are used instead of contracts for services from other departments and go through a County review process. DSOs support field service workers for public health investigations and follow-up with partners of those recently testing HIV+. DHSP also has DSOs with DPH, Contract Monitoring Division, and the Auditor-Controller for fiscal audits as required by federal grantors.
- Some prevention service categories are split between CDC and NCC funding, e.g., the HE/RR portfolio.
- "Staffing Agency" refers to temporary workers who do data entry for a variety of contracts which is partially to relieve the burden on providers. "Consultant/Contractual Services" support routine testing contracts, an agreement with public health clinics for HIV testing and Public Health Laboratory HIV-related prevention activities.

- The approximately \$17.8 million in NCC is the County General Fund contribution to the HIV response. NCC funds a variety of services including Residential Services and PEP. It also covers miscellaneous expenses, e.g., some grants have administrative cost caps which may not cover costs of grant administration. "Transfer in of costs from various grants" covers other expenses that grants cannot support due to rules or over-expenditures. NCC fills such gaps.
- No variance is listed for NCC because the entire amount must be spent each year.
- Mr. Pérez noted several things happening simultaneously. Migration from RW to other payers for HIV medical care consistent with ACA and Medicaid Expansion philosophy continues to increase monthly. Medical care now uses the most RW funds but, going forward, increasing funds to other services should be considered.
- Some service categories are also consistently under spent. There is, for example a great and growing need for mental health services, but providers find it very hard to hire, or often even keep, mental health professionals.
- Oral Health projections are uncertain as recent Denti-Cal expansion has complicated estimates, e.g., a provider may accept a patient ostensibly for RW services who is ultimately Denti-Cal eligible.
- Finally, the \$1.7 million increase in funding was late in a grant year when flat or decreased funding was expected.
- Dr. Kushner asked if any County CDC prevention funds support providers in the Long Beach jurisdiction. The City of Long Beach does receive funds from the state. Mr. Pérez noted Long Beach has the second highest concentration of HIV in the County and has relied for about four years on state funding for most of its prevention.
- The CDC changed financing rules a few years ago to require California, Los Angeles County and Long Beach to coordinate as documented by letters from each party. Previously the CDC funded Long Beach directly. California now receives \$700,000 more in its CDC award, taken from the County award, which it allocates to Long Beach. This approach is used since the County has no mechanism with Long Beach to fund prevention. The County also funds providers in the City of Long Beach and greater Long Beach areas that complement City of Long Beach services.
- Mr. Ballesteros noted item 2 of Motion 5 provides PP&A time to review and enhance the MAI plan.
- Ms. Jackson expressed concern about requesting a HRSA waiver from the requirement to use 75% of program and service funds for core medical services when linkage, retention and viral suppression issues remain. She felt it would also be difficult to demonstrate to HRSA that everyone in the County has access to medical care.
- ➡ Mr. Land suggested, and the Commission approved, deleting agenda motion items 3 and 5 as strategy discussions on combined Parts A/B funds are ongoing (3) and FY 2015 allocation revisions will be revisited at a later date (5). Consequently, item 4 is renumbered as item 3.
- ➡ Refer Mr. Pérez's suggestion that public speakers state conflicts of interest to Operations Committee.

MOTION 5: Approve the following strategy for making mid-year adjustments to FY 2014 Ryan White (RW) Parts A/B allocations to accommodate savings resulting from the enrollment of former Ryan White patients into Medi-Cal or Covered California:

- 1) With the consent of Health Resources Services Administration (HRSA), carry over up to 5% of FY 2014 RW Part A formula funds into FY 2015 without penalty;
- 2) With consent of HRSA, absorb the cost and continued delivery of FY 2014 MAI-funded services into the FY 2014 RW Part A services budget, and carry over the balance of FY 2014 MAI funds into FY 2015; and
- 3) Request a waiver from the RW Part A 75% core medical services threshold requirement in 2015 (**Passed: 22 Ayes; 0 Opposed; 1 Abstention**).

2) **Unmet Need Technical Assistance (TA):** There was no report.

3) **FY 2015 P-and-A Pledge Forms:** Forms were in the packet for Commission members who had not yet submitted one.

B. Operations Committee: There was no report.

C. Public Policy Committee: Mr. Fox reported Governor Brown continues to sign bills. Those not yet addressed include some Medi-Cal bills and AB 336 pertaining to use of condoms as evidence. Bills must be signed by the end of September 2014.

D. Standards and Best Practices (SBP) Committee: There was no report.

15. **EXECUTIVE DIRECTOR'S REPORT:** This item was postponed.

16. **HOPWA REPORT:** This item was postponed.

17. **CITY/HEALTH DISTRICT REPORTS:** This item was postponed.

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18. SPA/DISTRICT REPORTS: This item was postponed.

19. AIDS EDUCATION/TRAINING CENTERS (AETCs): This item was postponed.

20. COMMISSION COMMENT: Mr. Johnson acknowledged Miguel Gutierrez, Director, Care Program, Long Beach.

21. ANNOUNCEMENTS:

- Ms. Enfield announced a PrEP forum on transgender individuals, 9/25/2014, 6:30 pm, LA LGBT Center on McCadden.
- The Department of Mental Health and APLA will host a Mental Health Symposium, 9/26/2014, 12:00 noon to 4:30 pm, Metropolitan Community Church on Prospect. Mental health stigma and LGBT Native American issues will be discussed.
- Mr. Smith noted AIDS Walk is 10/12/2014. It lifts spirits to see 30,000 people supporting work on the HIV epidemic.

22. ADJOURNMENT: The meeting adjourned at 1:30 pm.

A. Roll Call (Present): Castillo, Cataldo, Donnelly, Enfield, Fox, Johnson, Kochems, Land, Lester, Liso/Lantis, Lopez, Martinez, Morales, Munoz, Pérez, Rios, Rivera, Rosales, Rotenberg, Samone-Loreca/Forrest, Smith, Watts

MOTION AND VOTING SUMMARY		
MOTION 1: Approve the Agenda Order with Item 12.C.1., DHSP's report on biomedical interventions, moved after Item 13. A., the Planning, Priorities and Allocations (PP&A) Committee report.	<i>Passed by Consensus</i>	MOTION PASSED
MOTION 2: Approve minutes from the Commission on HIV meetings, as presented.	<i>Postponed</i>	MOTION POSTPONED
MOTION 3: Approve the Consent Calendar, with agenda motions revised or removed as necessary.	<i>Withdrawn</i>	MOTION WITHDRAWN
MOTION 4: Approve framework, as determined, for implementation of PEP, PrEP and other biomedical interventions and related services as necessary. Refer subject to Planning, Priorities and Allocations and Public Policy Committees to work with DHSP to develop more specific strategies, frameworks, timelines and allocations.	<i>Passed by Consensus</i>	MOTION PASSED
MOTION 5: Approve the following strategy for making mid-year adjustments to FY 2014 Ryan White (RW) Parts A/B allocations to accommodate savings resulting from the enrollment of former Ryan White patients into Medi-Cal or Covered California: 1) With the consent of Health Resources Services Administration (HRSA), carry over up to 5% of FY 2014 RW Part A formula funds into FY 2015 without penalty; 2) With consent of HRSA, absorb the cost and continued delivery of FY 2014 MAI-funded services into the FY 2014 RW Part A services budget, and carry over the balance of FY 2014 MAI funds into FY 2015; and 3) Request a waiver from the RW Part A 75% core medical services threshold requirement in 2015.	Ayes: Ballesteros, Cataldo, Donnelly, Enfield, Fox, Johnson, Kochems, Land, Lester, Liso, Lopez, Martinez, Morales, Munoz, Pérez, Rios, Rivera, Rosales, Rotenberg, Samone-Loreca, Smith, Watts Opposed: None Abstention: Kushner	MOTION PASSED Ayes: 22 Opposed: 0 Abstention: 1