



LOS ANGELES COUNTY COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
www.hivcommission-la.info



PLANNING, PRIORITIES & ALLOCATIONS (PP&A) COMMITTEE MEETING MINUTES March 18, 2014

PP&A MEMBERS PRESENT	PP&A MEMBERS PRESENT (cont.)	PUBLIC	COMM STAFF/ CONSULTANTS
Al Ballesteros, MBA, <i>Co-Chair</i>	LaShonda Spencer, MD	Joseph Green	Jane Nachazel
Brad Land, <i>Co-Chair</i>	Monique Tula	David Kelly	Craig Vincent-Jones, MHA
Michelle Enfield		Rob Lester	
Michael Johnson, Esq.		Scott Singer	
Abad Lopez	PP&A MEMBERS ABSENT	Terry Smith	DHSP STAFF
Marc McMillin	Lynnea Garbutt	Sharon White	None
Mario Pérez, MPH	Sharon Holloway/Ismael Morales	Jason Wise	
Juan Rivera/Rev. Alejandro Escoto, MA			

CONTENTS OF COMMITTEE PACKET

- 1) **Agenda:** Planning, Priorities & Allocations (PP&A) Committee Meeting Agenda, *3/18/2014*
- 2) **Policy/Procedure:** #09.5203: Priority-and Allocation-Setting Framework and Process, *5/12/2011*
- 3) **Graphic:** CDC Due Dates, *March 2013*
- 4) **Program Background:** CDC's New High-Impact Approach to HIV Prevention Funding for Health Departments, *June 2011*
- 5) **Letter:** Regarding an Integrated HIV Plan
- 6) **Table:** Appendix E: HIV Planning Group (HPG), HPG Membership and Stakeholder Profile, *1/1/2013-12/31/2013*
- 7) **Table:** County of Los Angeles, Department of Public Health, Division of HIV and STD Programs, Centers for Disease Control and Prevention (CDC) HIV Prevention Cooperative Agreement (PS12-1201), Due Dates, *1/1/2012-12/31/2016*
- 8) **Guidance:** HIV Planning Guidance, *July 2012*
- 9) **Table:** Priorities and Planning (P and P) Committee FY 2010 Work Plan, *2010*

1. **CALL TO ORDER:** Mr. Land called the meeting to order at 1:10 pm.
2. **APPROVAL OF AGENDA:**
MOTION #1: Approve the Agenda Order with Item 9 moved up after Item 6 (*Passed by Consensus*).
3. **APPROVAL OF MEETING MINUTES:**
MOTION #2: Approve the Priorities and Planning (P&P) and Planning, Priorities and Allocations (PP&A) Committee meeting minutes, as presented (*Postponed*).
4. **PUBLIC COMMENT (Non-Agendized or Follow-Up):** There were no comments.
5. **COMMITTEE COMMENT (Non-Agendized or Follow-Up):**
 - Mr. McMillin, Ms. Scholar and Ms. Tula attended a 3/17/2014 City Council Finance Committee meeting. Some 20 speakers addressed the three-month HIV funding gap. The budget was not agendized, but Council members were supportive.
 - Speakers included Miguel Santana, Chief Budget Analyst, and Jerry Miller, Chief Legal Analyst. City finances are improving, but have not yet recovered from 2009. They recommended capping current salaries and reducing new hire salaries.
 - Ms. Tula said approximately 70% of the General Fund supports public safety and 5% supports miscellaneous programs such as health and culture. She was concerned HIV programs could become buried in the General Fund and become unstable,

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- Mr. Vincent-Jones has talked with the City. The General Fund is still low so prior one-time fixes are no longer available.
- Ms. Tula said the City's cut equals one-third of the budget for Ms. Scholar's agency. She cut all salaries to avert lay-offs. Some agencies may lack that option or choose not to use it. Agencies may not recover even if funds are later restored.
- Mr. McMillin spoke as a consumer. Noting the National HIV/AIDS Strategy, he said people who drop out of care generally become harder to re-engage. That would reflect poorly on the City. Ms. Tula supported activism if the loss is not replaced.

6. CO-CHAIRS' REPORT: Mr. Land noted this meeting launches the start of integrated prevention and care planning.

7. HIV PREVENTION AND STD PLANNING: This item was postponed.

9. PP&A COMMITTEE 2014 WORK PLAN:

- Mr. Land recommended starting with a timeline to integrate prevention and care work in a timely manner to meet goals.
- Mr. Smith reported the last Prevention Planning Committee (PPC) planning process took approximately one year, but could have benefitted from 18 months. Task forces initially developed recommendations for specific populations or issues. There was significant data collection including a Data Summit. The process goal was to identify interventions and recommend percentages for them. The PPC and DHSP worked together closely and consensus was generally reached by process end.
- The PPC lacked independent authority to determine allocations. It focused on activities especially for highly funded services, e.g., Health Education/Risk Reduction. The CDC has revised its requirements so the process will likely differ.
- Ms. Tula served on the Massachusetts prevention planning council. It was similar to the PPC with a focus on interventions. She asked how that related to Standards and Best Practices (SBP) Committee work.
- Mr. Vincent-Jones replied PP&A and SBP work together. SBP is the evaluation Committee which includes Standards of Care which define services and interventions, minimum expectations for them, and service effectiveness once implemented. PP&A is primarily the planning Committee which determines the most needed services and allocates to them.
- Mr. Smith felt the prevention plan was primarily set so time might best be devoted to STDs. Mr. Vincent-Jones replied PP&A is responsible for prevention and care Priority- and Allocation-Setting (P-and-A) in a manner that will allow STDs to be incorporated eventually. STDs are, however, very complex so he felt it best to start with prevention and care.
- The CDC does not require prevention planning councils to do allocations, but HRSA does and the Commission's Board Ordinance provides that authority. A few people have commented that the Commission cannot do prevention allocations because the CDC now requires a 75%/25% split for allocations, but that has been the norm for care for some time.
- The Commission also allocates to "categories" while the PPC used "interventions," but he felt that was primarily semantic.
- Grant terms differ with one year for care and three years for prevention, but he felt it important to get ahead of the curve.
- Mr. Singer asked whether the Commission had received similar prevention financial information to that received on care. Mr. Vincent-Jones replied that information was not yet available, but DHSP will provide it.
- Mr. Ballesteros noted JWCH plans for both prevention and care. It has Community Health Centers (CHCs) which must do needs assessments of the community served, e.g., within a three mile radius of the CHC, at least every three years with ongoing assessment expected. JWCH describes the demographics of the area around a clinic site; health insurance data to help identify needed services; incidence of, e.g., chronic illness, mental illness, HIV and STDs; and illness outcomes compared to the County, State and nation. Data is used to align resources every three years with adjustments annually.
- Mr. Lopez asked how JWCH is funded. Mr. Ballesteros replied JWCH engages in fund-raising activities as well as applying for local, State and Federal grants. He is currently looking at how to build funding for prevention activities into the core funding cost structure of Medi-Cal, HMOs and insurance so JWCH is not as dependent on the grant system for reimbursement.
- He felt agencies will need infrastructure support and development to address funding issues. Agencies are paid for their number of patient visits multiplied by their rate. Cost reports must be submitted to the State at the end of the year. The State may accept a new cost as allowable. If so, it is added to the agency's rate for the next year. Agencies must float the cost for the first year, but can build costs such as for prevention activities into the rate over time.
- The State cost report lists allowable costs, e.g., Medical Care Coordination (MCC) and RN case management. JWCH has increased its rate to \$188 per visit by adding allowable costs. The rate includes everything such as rent, supplies and staff.
- Federally Qualified Health Centers (FQHCs) receive a grant for uninsured patients and a State enhanced rate for Medi-Cal patients. FQHC look-alikes only receive the rate. Most County patients are Medi-Cal so, as the number of uninsured declines, it is important to build costs into the rate. Community-Based Organizations (CBOs) are usually nonprofits, most often 501(C)3s, that have developed with the community. FQHCs and FQHC look-alikes must be nonprofits.
- Mr. Pérez noted more is learned daily about the changing health care financial landscape and its pressure points. DHSP has stated FQHCs will play an increasingly crucial role in care to people who were historically part of the Ryan White system, but

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activity will vary significantly. There are 170+ FQHCs, FQHC look-alikes and CHCs. FQHCs with a healthy Prospective Payment System rate should do well as will Ryan White Medical Outpatient agencies with a rate of \$330.12.

- DHSP supports 41 patient-centered medical homes distributed across the County with a relatively good overlay between disease burden and site location, but there are very different utilization patterns countywide. Studies show some half of South Los Angeles patients seek care elsewhere, e.g., for anonymity or due to a perception of better care at another site.
- Not all 41 Ryan White medical homes are FQHCs. Those that are not have less ability to compete for resources, e.g., they might see Ryan White-eligible, private and Medicaid-eligible patients, but the Medicaid Fee-For-Service rate is low.
- The question for the overall health of the system is whether it would be beneficial or not if, e.g., a quarter of FQHCs chose to serve PLWH. The County's Ryan White system is the most responsive in the country and provides PLWH the best chance to thrive. Many PLWH are migrating out of Ryan White, but Medicaid does not support HIV specialists with performance indicators that drive Viral Load (VL) suppression, an RN-social worker team to address psychosocial issues, and an option for services such as Medical Transportation, food and a case manager to help get and retain people in care.
- In the context of ACA, DHSP is working to understand how to leverage its position in DPH to create structural change that forces providers including, e.g., health plans, FQHCs, LA Care, Health Net and Kaiser to behave in concert with Ryan White system goals. DHSP has no leverage over FQHCs or Medicaid as the State sets rates, but there are pressure points.
- Mr. Pérez also urged considering the evolution of Ryan White. Arguments can be made that Ryan White should expand to support the prevention needs of PLWH in a way that ensures they do not put their partners at risk of transmission.
- It is not possible to argue now that Ryan White should support biomedical interventions because they serve HIV- people. DHSP is considering how to address other payer systems that could support them, e.g., the CDC, Medicaid and the State.
- The Commission should consider how to best utilize all funding streams, e.g., how to use State Part B dollars to shape the system or how to create incentives to shape provider behavior. Providers primarily respond to incentives, mandates and HEDIS, a national quality tool, which evaluates health plans by their ability to meet concrete measures which could be, e.g., universal tuberculosis screening or syphilis screening for gay men twice a year. Plans are scored for each measure.
- Ms. White pointed out not all non-Ryan White providers are comfortable addressing HIV. She currently receives care under the ACA and initially had to educate her physician. Many PLWH encountering that situation are likely to drop out of care.
- Ms. Tula asked about the ACA prevention carve out. Mr. Ballesteros said HIV providers can coordinate with FQHCs to provide services. He suggested the Commission educate providers about the opportunities for coordination.

A. Committee Work Priorities:

- Mr. Vincent-Jones noted the last Work Plan was done in 2010. It addresses what the Committee will do, when and how. Committee plans roll up into the Commission's Work Plan. Section I pertains to work common to all Committees.
- Section II addresses each Committee's specific responsibilities. PP&A has three core responsibilities: Needs Assessment, the Comprehensive HIV Plan and P-and-A. Other work is primarily supportive of those three areas.
- The Commission will be working with DHSP on the Los Angeles Coordinated Needs Assessment (LACHNA). A work group is coordinating with Dr. Amy Wohl in revising LACHNA to incorporate prevention and care as well as adding questions to elicit different information. LACHNA is unlikely to begin until fall.
- The Comprehensive HIV Plan does not need to be redone, but PP&A does need to begin monitoring it.
- The main issue will be P-and-A. He did not see major differences between what has been done in the past for care and what will need to be done to incorporate prevention though there will be adjustments. There are similar timelines, a 75%/25% split and interventions are consistent with services. SBP will define interventions as they do services.
- Mr. Pérez said PP&A should address planning around funding streams. Planning has traditionally focused on Ryan White Parts A/B and MAI. System wide planning should address Ryan White Parts C and D especially pertaining to substance abuse. Regarding prevention, the Commission should address CDC's HIV Prevention Cooperative Agreement, the largest source of prevention funding. Finally, STD control is funded by the CDC with a County contribution.
- Previously the CDC allowed jurisdictions to develop their interventions mainly as they saw fit. It is now much more prescriptive and requires expending 75% of funds, or approximately \$15 million annually for the County, on High-Impact Prevention (HIP) activities, i.e., HIV testing, comprehensive prevention for PLWH, condom distribution and policy initiatives to align structures, policies and regulations to enable optimal HIV prevention, care and treatment.
- The prevention planning cycle is five years, but it is not necessary to wait until 2018 to make adjustments.
- The first question is the correct mix of services, e.g., prevention, biomedical, testing, Prevention for Positives.
- DHSP is identifying high HIV burden communities so capacity can be increased in those areas. Risk also differs by race/ethnicity so it is crucial to tailor the mix of interventions and cultural messaging. The high HIV burden among gay men is well known, but other groups are emerging. African-American women are at increased risk, but it is harder to identify which of them are at risk. Transgender people are easier to identify, but are a small population with minimal data.

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- In addition, there are co-factors such as multigenerational poverty, substance abuse, child sexual abuse, mental illness.
- DHSP will be releasing RFPs over the next few years based on need and capacity rather than large groups of prevention or care. RFPs require significant time and resources for DHSP and providers so subjects will be selected deliberately.
- DHSP is likely to begin with RFPs to meet the needs of African-American and Latino gay men. Other RFPs under consideration are for the transgender community, care approaches to integrate substance abuse and mental health, Home-Based Case Management and issues pertaining to transportation.
- DHSP used a CDC grant a few years ago for the RAND Corporation to study how best to reduce new infections. RAND used a robust decision-making model to examine the entire prevention response. The most cost effective intervention was to ensure optimal care leading to VL suppression for PLWH who know their status but are not yet receiving optimal care. Pertinent services include retention, physician management and psychosocial. That does not mean shifting prevention funds to care, but prevention funds should supplement and complement care prevention opportunities.
- Mr. Pérez said 65,000 STDs are reported in the County annually of which 48,000 are Chlamydia. STDs have increased steadily for approximately 12 years. Syphilis rebounded, particularly among gay men, in the late 1990s and early 2000s. The CDC funded a two-year Syphilis Elimination Project in eight cities, but funding ended and services closed down.
- Mr. Pérez said considerable STD research has already been done. He recommended increasing capacity in high burden zip codes. Sexual health community norms need to change so it is not alright to have gonorrhea or continually return to one's physician with syphilis. Annually, 50% of gay men in the County's Ryan White system present with syphilis.
- There is some divergence between those at risk for HIV and those at risk for STDs. Few young women are being diagnosed with HIV, but many are being diagnosed with STDs particularly Chlamydia and gonorrhea. That is especially true among young women of color. There are programs that target young women, but they are not sufficient especially in South Los Angeles, Long Beach, and the San Fernando and Antelope Valleys where STDs are raging.
- The Metro SPA also has high STD rates, but has existing resources that can be marshaled to do more STD work.
- The CDC has directed all grantees to use 2014, the first year of a five-year STD prevention cycle, as a retrospective, reflective planning year. DHSP is reviewing data on interventions. It is also working to improve testing availability in Men's Central Jail, K6G, where many gay and transgender inmates are housed, as well as a facility that houses women. There are now eight hours each of HIV testing and STD testing, but that is changing to 16 hours of HIV/STD testing.
- Condoms are now available in K6B once per week. DHSP is seeking agreement with the Sheriff for continuous availability. One-third of K6G inmates are diagnosed with HIV, syphilis or gonorrhea, but continue to be sexually active.
- Mr. Pérez supported encouraging FQHCs and Title X (family planning) clinics to increase their focus on STD screening.
- HIV and STD funds cannot address racism, stigma, multigenerational poverty or other social determinants. Other resources must be leveraged to address them. He felt the County HIV response is likely ahead of the rest of the country by 10 years, but its STD response is likely 10 years behind. There have been demonstrations and pilots, e.g., the Syphilis Elimination Project that targeted hot spots with good results, but services were not sustained after projects ended.
- It is important to thoughtfully consider how to sustain interventions, e.g., people will begin to phase out of the PrEP studies in May 2014. DHSP is trying to develop a continuing PrEP option for those clients.
- Mr. Land said, in terms of the Work Plan, it appears that care and prevention are symbiotic. Mr. Pérez replied systems were changing around us at their own pace – not ours. DHSP is trying to adapt to those fiscal realities and financing opportunities. DHSP seeks input on what services to support so there is time to implement them.
- Ms. White noted many African-American women are infected via heterosexual activity. Mr. Pérez said the epidemic among women is very different from that among men. Of PLWH, 86% are men. Of those, 85% are gay men and most are gay, gay men who are also IDUs or bi-sexual men. Exposure for women is overwhelmingly heterosexual.
- DHSP previously did a Supplemental HIV Survey for everyone diagnosed with HIV to enhance epidemiological data. It was not uncommon for someone to say he only slept with women in 2001, but identify as MSM by 2011.
- Mr. Smith noted there was an existing HIV prevention plan. He asked if STDs should garner the first focus since more planning was needed. Mr. Pérez replied the entire prevention portfolio will expire 6/30/2014. DHSP has requested the Board extend current contracts for 18 months for time to develop a better response. The Commission can inform RFPs.
- Historically, two large CBOs have been funded to provide STD screening and treatment. He would like to RFP services that will provide better countywide coverage. DHSP is also recommending an 18 month extension for STD contracts.
- Mr. Lopez asked whether HIP comprehensive prevention for PLWH is funded with CDC or Ryan White funds. Mr. Pérez said the Ryan White system is creatively using its 41 medical homes staffed with MCC teams to do more prevention.
- Mr. Vincent-Jones noted VL suppression lowers the community VL, but asked whether there was information on the effect of a lower community VL on transmission rates. Mr. Pérez said the community VL measure is often a measure of diagnosed PLWH who are consistently in care so there are limitations on how the data can be used.

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- Mr. Vincent-Jones noted the care P-and-A process was molded over 10 years. It can be revised to incorporate the new prevention and STD responsibilities, but he recommended full review prior to changing tested procedures.
- Prevention, care and STD planning are now all part of the Commission's charge. The time to step into the process for prevention and STDs will never be perfect, but it would help to start now so PP&A develops familiarity with the process. The Ordinance specifically includes HIV prevention starting with FY 2015. STDs can start this year or next.
- The P-and-A care schedule was developed from the endpoint backwards to ensure DHSP has time to RFP and implement requested new or revised services by the March start of the grant year. Care P-and-A has normally started by June based on DHSP's request for 9-12 months for that work. Prevention will likely require a similar timeframe.
- PP&A will need to review a variety of factors for both care and prevention, e.g., unit costs and how they contribute to service and cost effectiveness; geographic distribution of services; priority services for specific populations and individual population outcomes; other sources of funding; and, most recently, social determinants of health.
- The Commission and PPC each had strengths in their processes. The Commission did significant work regarding geographic distribution of services while the PPC did more work with population-specific needs.
- The Commission advocated for Fee-For-Service because unit cost for a particular service can be combined with frequency and patient outcomes to open up full service and cost effectiveness analysis.
- It will not be necessary to push as hard to complete FY 2015 decisions as was necessary to complete FY 2013 and 2014 allocation modifications. Ordinarily, at this point, the Committee would be determining priorities, the third to last step in the process, but sufficient time for the decision-making process is important while moving ahead with deliberation.
- The Committee previously used a one to two day process but, if the Commission rejected one decision, it needed to start over from that point. The current process is in steps with Commission approval for each one. The stepped process also ensures PP&A has time to review often complex information. The final two steps are directives to shape the allocations, e.g., for specific populations, and service evaluation. Ryan White legislation states the planning council may add additional information or instructions on how best to meet the need and other factors to be considered.
- P-and-A usually starts in November. LACHNA is done every two years and usually presented in November or December. It addresses needs, barriers and gaps. The statute calls for the planning council to determine the most needed services. LACHNA is critical for priority-setting since priorities are based on needs. In turn, allocations are based on priorities.
- The Committee chooses Paradigms and Operating Values to guide the process, e.g., the Commission has regularly chosen utilitarianism, the greatest good for the greatest number, as a paradigm to inform decisions.
- Epidemiological data is presented next. That can include treatment cascade data for particular populations.
- DHSP then presents the Service Utilization Report (SUR) which includes data for all services including services funded by NCC. The SUR breaks down data by population and geography.
- HRSA requires prioritizing services by need. That is generally done in March. It can be more complex than it appears, e.g., five people may rank Hospice as their first priority while 3,000 rank Oral Health Care as their third priority.
- Priorities need to be ranked prior to allocation-setting as a guide, but there are other considerations. Ryan White is funding of last resort so other resources are considered as well as migration to ACA, the SUR and cost effectiveness.
- ➡ Mr. Pérez will review the RFP timeline and provide an updated iteration.
- ➡ Staff will email links for the RAND Corporation report and the Prevention Plan.
- ➡ Dr. Amy Wohl will review community VL data and break it out by race/ethnicity.
- ➡ Mr. Vincent-Jones will work with DHSP to obtain financial data for prevention and STDs.
- ➡ Mr. Vincent-Jones will update the LACHNA and Comprehensive HIV Plan sections of the Work Plan.

B. Scheduling and Timeline(s): There was no additional discussion.

10. NEXT STEPS: There was no additional discussion.

11. ANNOUNCEMENTS: There were no announcements.

12. ADJOURNMENT: The meeting adjourned at 4:10 pm.