LOS ANGELES COUNTY COMMISSION ON HIV

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COMMISSION ON HIV
MEETING MINUTES
January 12, 2012

MEMBERS PRESENT	MEMBERS PRESENT *(cont.)*	PUBLIC	PUBLIC (Cont.)
Carla Bailey, *Co-Chair*/Kevin Lewis	Karen Peterson	Herman Avilez	Lambert Talley
Michael Johnson, *Co-Chair*	Juan Rivera	Neland Butler	Brigitte Tweddell
Sergio Aviña	Stephen Simon	Kirk Collins	Sharon White
Al Ballesteros	Carlos Vega-Matos	Tracey Cumberland	Melvin Wilson
Cheryl Barrit	Tonya Washington-Hendricks	Phil Curtis	Jason Wise
Joseph Cadden	Kathy Watt	Michelle Enfield	
Whitney Engeran-Cordova	Jocelyn Woodard/Robert Sotomayor	Jonathan Fielding	
Lilia Espinoza	Fariba Younai	Susan Forrest	**DHSP STAFF**
Aaron Fox		Larry Gonzales	Kyle Baker
Douglas Frye		Shawn Griffin	Rhodri Dierst-Davies
David Giugni	**MEMBERS ABSENT**	S. Randal Henry	Amy Wohl
Terry Goddard	Anthony Braswell	Tim Hughes	Juhua Wu
Joseph Green	Thelma James	Miki Jackson	
David Kelly	Lee Kochems	Jackie Jones	
Bradley Land	Jenny O'Malley	Ayanna Kiburi *(by phone)*	**COMMISSION STAFF/CONSULTANTS**
Ted Liso		Luke Klipp	
Anna Long		Patricia McGowan *(by phone)*	Dawn McClendon
Abad Lopez		Karen Mark *(by phone)*	Jane Nachazel
Elizabeth Mendia		Vicky Pulatian	Glenda Pinney
Quentin O'Brien		Tania Rodriguez	James Stewart
Angélica Palmeros		Ricki Rosales	Craig Vincent-Jones
Mario Pérez		Jill Somers *(by phone)*	Nicole Werner

1. **CALL TO ORDER**: Mr. Johnson called the meeting to order at 9:10 am.
   - **A. Roll Call (Present)**: Ballesteros, Barrit, Cadden, Engeran-Cordova, Frye, Giugni, Green, Johnson, Kelly, Land, Lewis, Liso, Long, Lopez, Pérez, Peterson, Rivera, Simon, Sotomayor, Vega-Matos, Washington-Hendricks, Watt, Younai

2. **APPROVAL OF AGENDA**:
   MOTION 1: Approve the Agenda Order with Motion 4 revised to, "Elect Executive Committee At-Large members, as nominated" **(*Passed by Consensus*)**.

3. **APPROVAL OF MEETING MINUTES**:
   MOTION 2: Approve minutes from the 12/8/2011 Commission on HIV meeting **(*Passed by Consensus*)**.

4. **CONSENT CALENDAR**: Motion 4 was pulled for the election and Motion 5 for a presentation and deliberation.
   MOTION 3: Approve the Consent Calendar with Motions 4 and 5 pulled for deliberation **(*Passed by Consensus*)**.

5. **PARLIAMENTARY TRAINING**: There was no training.

6. **PUBLIC COMMENT, NON-AGENDIZED OR FOLLOW-UP**: Mr. Talley, a nurse for 30 years, said most clients do not know their rights or how to fight insurance companies to meet needs.

7. **COMMISSION COMMENT, NON-AGENDIZED OR FOLLOW-UP**: Mr. Engeran-Cordova said AIDS Healthcare Foundation's (AHF's) Los Angeles City initiative requiring use of condoms as part of an adult film permitting process was adopted by the Los Angeles City Council. AHF continues gathering the 200,000 signatures needed for a Los Angeles County initiative and plans a State measure.

8. **CO-CHAIRS' REPORT**:
   A. **Executive Committee At-Large Member Elections**: Mr. Stewart reported an initial six candidates for the five seats: Messrs. Aviña, Engeran-Cordova, Liso, Rivera and Mses. O'Malley and Peterson. Mr. Johnson reported that Mr. Aviña had withdrawn his nomination so the remaining five were elected.
   MOTION 4: Elect Executive Committee At-Large members, as nominated ***(Passed by Consensus)***.
   B. **Miscellaneous**:
      - Mr. Johnson noted that Dr. Frye, Mr. Pérez and Ms. Watt now had voting status following enactment of LA County Code 3.29.
      - He reported the Co-Chairs chose to make committee assignments in February rather than January following the election of Executive At-Large members.

9. **EXECUTIVE DIRECTOR'S REPORT**: There was no report.

10. **PUBLIC HEALTH/HEALTH CARE AGENCY REPORTS**:
   A. **Department of Public Health Priorities**:
      - Dr. Fielding, Director, Department of Public Health (DPH), re-affirmed DPH's commitment to working with the Commission. He thanked the Commission for its valuable work, including its support for program integration in DHSP to improve synergy, spearheading integrated HIV prevention and care planning, and leadership in acquiring the HUD grant which will better integrate HIV planning across housing, public health, health care delivery and mental health services.
      - One aspect of this era of change is a shift in the public perception of HIV, which feeds the view that HIV can easily be integrated into general health care. It is necessary to fight to retain the best elements of the HIV care system. Policy makers must be educated, e.g., about the importance of an undetectable Viral Load in reducing transmission. About 75% of clients in the Ryan White system of care have undetectable viral loads while only about 25% of other clients do.
      - He felt the Commission recognized the need for new paradigms in the response to HIV and STDs. Integrated local planning must occur across a continuum among multiple modalities including HIV, STDs, viral hepatitis and perhaps TB, which has developed more antibiotic-resistant strains. He recommended capitalizing on opportunities to prevent HIV through improved STD prevention and treatment, especially regarding syphilis and gonorrhea.
      - Spatial analysis helps to identify the four key spatial clusters that account for a high percentage of HIV cases and overlap strongly with, e.g., gonorrhea, chlamydia and syphilis. It is important to think differently at a geographic and geopolitical level than is the case countywide, e.g., mobilizing local communities and targeting resources.
      - HIV treatment as prevention is also a key trend. *Science* magazine chose HIV Prevention Trials Network Study results as the top 2011 breakthrough across all health care and prevention fields. County treatment and viral suppression levels are better than the national average, but work remains to meet goals of the National HIV/AIDS Strategy (NHAS).
      - Dr. Fielding was impressed with Gardner's care continuum and treatment cascade. DHSP will quantify the information locally. Community partners also need to know how to help clients move consistently forward through the continuum.
      - The HIV prevention portfolio needs to be re-set based on new CDC guidance and focus on evidence-based interventions which Dr. Fielding has supported for years. It is fair that individual/group interventions show reach and effectiveness needed to meaningfully change the HIV prevention trajectory. DPH must demonstrate effectiveness for all prevention interventions and health promotion efforts, not just those for HIV, as responsible stewards for public funds.
      - Even so, treatment and prevention alone cannot sufficiently reduce new infections. Case finding efforts must dramatically improve, including acknowledgement of social and economic factors affecting the disease burden, e.g., racism, homophobia and poverty. One of four County children live in poverty and the household poverty rate is about 15%.
      - Policy and structural interventions must also play a key role in identifying the estimated 13,000 HIV+ individuals who do not know their status, as well as bringing those who know their status but are not in care into care.

- Dr. Fielding acknowledged concern about patient migration to Healthy Way LA (HWLA) and changes anticipated with full Affordable Care Act (ACA) implementation. The County is a leader in this migration, though he would prefer more time and fewer State savings assumptions. The Commission is a valuable planning and advocacy partner in helping ensure a benefits program is available before people migrate. DPH, the Department of Health Services (DHS) and the Department of Mental Health (DMH) are working to develop a seamless system and negotiating timing with the State.
- Mr. Kelly was interested in work towards a cure. Dr. Fielding noted work continues on vaccines and more effective medications. Vaccines currently appear to be the most promising approach, but progress is not dramatic.
- Mr. Johnson noted three County departments working together has always been challenging and offered Commission assistance. Dr. Fielding replied both need and personalities have produced the closest working relationship he has seen in his 14 years. Situations beyond HWLA migration are also pushing cooperation, such as the AB 109 release of State prisoners to counties, which requires a broad range of services. Commission support for efforts is helpful.
- Mr. O'Brien, Los Angeles Gay and Lesbian Center, asked about PEP and PrEP efforts. Dr. Fielding said DPH was studying feasibility. So far, there is a low seroconversion rate of about 2 to 280. Need can be reduced by lowering viral loads.
- Mr. Land noted Federally Qualified Health Centers (FQHCs) are successful, but there can be up to a three-month wait to get in and up to a three-hour wait for a scheduled appointment. He asked about proportioning services especially in areas such as SPA 3 not in top spatial clusters. Dr. Fielding noted that is a DHS issue as it manages the HWLA contracts, but there will be some disruption in so large a change. Clusters are meant only to help in apportioning service to need.
- Ms. Watt thanked Dr. Fielding for responding to her letter on LGBT drug and alcohol services. Substance Abuse Prevention and Control said their County investment was $542,101 for treatment and prevention – grossly inadequate. Dr. Fielding noted services at clinics not LGBT-specific and some evidence LGBTs use them. Ms. Watt said most of her clients had tried such clinics, but were uncomfortable discussing who they were, sexual behaviors and causative factors. Dr. Fielding affirmed DPH's LGBT commitment, but it must maximize what is left after funding reductions.
- Mr. Giugni requested an update on methamphetamine treatment funds from District 3. Dr. Fielding said funding ends in February, but some was set aside. Outcome results were below expectations so DPH plans an enhanced model RFP.

➲ Dr. Cadden and his colleagues will develop a presentation for the Commission on work towards a cure.

11. CALIFORNIA OFFICE OF AIDS (OA) REPORT:

A. OA Work/Information:

- Ms. Kiburi, Chief, HIV Care Branch, reported OA completed and submitted its Ryan White Part B 2012 application. The application has not normally been posted, but OA will provide it to anyone asking to see it.
- She introduced Patricia McGowan, the new HIV Care Program Policy Specialist, who will liaison with Part B contractors and increase OA planning council representation. Jennie Lee Paris, the new Minority AIDS Initiative (MAI) Policy Specialist, will liaison with MAI contractors. She was unable to join the call. Both positions have long been vacant.
- 2012 contract monitoring has begun, but HRSA just sent clarification on how OA can collaborate with contractors to share in subcontractor monitoring. 2012 national standards require annual contractor and subcontractor monitoring. The clarifications ease addressing the large number of agencies to be seen. Negotiations for 2012-2013 will start soon.
- Low Income Health Program (LIHP) implementation guidance for non-legacy counties is being prepared. The draft will be distributed for feedback once completed, much as the Legacy County guidance was previously.
- The Medi-Cal Waiver and 10% reduction in provider reimbursement was discussed at the November Commission meeting. The Department of Health Care Services (DHCS) soon after included the Waiver as an exempted program so providers will continue at the current 1% reduction rather than 10%. OA sent out an announcement on the change.
- HRSA sent a notice the prior week that the Federal ban on use of funds for syringe service programs has been re-instated. OA sent the notice to all OA contractors and noted the policy is not retroactive. OA will assist any providers that need to remove funds for future services from budgets.
- Jill Somers, Chief, ADAP Branch, reported OA mailed 15,000 ADAP-only clients information on the OA- Pre-Existing Condition Insurance Plan (PCIP) with eligibility requirements and how to contact a local OA-PCIP enrollment worker.
- Mr. Engeran-Cordova felt it important for providers to be aware of such letters in advance to prepare for questions. Ms. Somers did not know about such notice, but contractors were informed previously about program development and those interested in doing so reviewed materials, such as letters being prepared for distribution. All counties also received information about training for OA-PCIP enrollment workers. The list was of those trained.
- Mr. Land called attention to the 2012-2013 Governor's Budget's New Major Assumptions that include a new ADAP cost-sharing proposal which will force PLWH into LIHP. He found it completely unacceptable.

- Dr. Mark, Interim Chief, OA, reviewed the Governor's Budget. Three OA programs receive State General Funds. There is no change to the HIV/AIDS Surveillance Program's $6.6 million. A small increase is proposed for insurance assistance programs to pay private health insurance premiums for OA-Health Insurance Premium Programs (OA-HIPP) clients co-enrolled in Medi-Cal with a Share-Of-Cost (SOC). Ryan White cannot be used for Medi-Cal co-pays.
- Reductions are proposed for ADAP. The FY 2011-2012 enacted budget was $503.6 million for local assistance funds with $82.6 million in General Funds. The revised FY 2011-2012 budget is $477.3 million. The proposed FY 2012-2013 budget is $395.1 million. The two major changes are transition of eligible clients to LIHP and implementation of share-of-cost.
- LIHP covers those 19-64 years-of-age with incomes up to 200% Federal Poverty Level (FPL) as determined by each county. Some ADAP clients are expected to shift to LIHP. In FY 2011-2012, OA estimated savings of $19.9 million due to that shift. In FY 2012-2013, OA estimates savings of $106.8 million.
- The revised share-of-cost policy will begin 7/1/2012. For ADAP-only, Medi-Cal share-of-cost and Medicare Part D clients, the share-of-cost will be 5% for those with incomes between 101%-200% FPL or an average of $70 per month; 7% for 201%-300% FPL, an average of $150/month; and 10% for >300% FPL, an average of $312-$385/month. Private insurance clients at >100% FPL will have a share-of-cost equal to 2% annual income or $28-$77 per month for co-pays/deductibles. The 2% share-of-cost was chosen to retain private clients in ADAP as they generate rebates. There will be no share-of-cost below 100% FPL, for Medicare clients reaching catastrophic coverage or those who qualify for full subsidy Medicare and for Medi-Medi clients with no Medi-Cal share-of-cost.
- OA estimates $16.5 million in savings from share-of-cost with administrative costs of $2 million to implement the program, for a net savings of $14.5 million.
- It is assumed clients eligible for LIHP and subject to share-of-cost will act in their financial best interests and migrate to the LIHPs. Mr. Johnson said it is unrealistic and shocking to expect this population to have the financial skills to evaluate their best interests.
- Mr. Fox was on the Health and Human Services call on the budget and felt the Department of Public Health and OA were devalued by not participating. Dr. Mark said OA was there, but the set-up did not allow direct question response.
- Mr. Fox asked if the savings estimate assumed Los Angeles County would begin LIHP screening in March 2012. Dr. Mark replied the assumption was that, on average, the ten Legacy Counties would begin LIHP enrollment 1/1/2012 and enroll one-twelfth of clients per month. It was the best available estimate at the time and can be re-evaluated for the May Revise. The same is true of using ADAP screening for LIHP screening. Many counties may use that approach while others may not.
- Mr. Fox said Governor Brown proposed the cost-sharing proposal last year, but the Legislature dismissed it as reckless. It was troubling this proposal implicitly forced vulnerable people into another program. Dr. Mark said Ryan White is the payer of last resort so those with options must use them. He countered Federal, State and county governments agreed to a thoughtful process with time to migrate people. This was not thoughtful and used finances as the sole threshold.
- Mr. Engeran-Cordova felt it unfortunate in a $500 million program to cause so much pain for $15 million in savings and hoped the Legislature would dismiss the proposal. Worse, he felt it unrealistic to assume $82 million in General Fund savings and worried there would be massive swings in estimates for ADAP by May. He hoped there were internal discussions on that.
- Mr. Ballesteros noted the State was simultaneously pushing people to migrate to LIHP while cutting the Prospective Payment System (PPS) rates for community health centers. He asked how that was reconciled. Dr. Mark said OA was not involved with PPS rates. This is the Governor's Budget and it is the Administration's role to coordinate proposals.
- Mr. O'Brien stated some 20% of ADAP clients will not be eligible for the LIHP so will have to choose between medication or food. He stated estimates were neither accurate nor tenable. He hoped the Legislature would reject this, but was concerned there was now an estimate that had become a target. He sought to work with OA for a better estimate. Dr. Mark said, as an Administration employee, she must support the Budget, but also supports better estimates for the May Revise.
- Mr. Klipp, AIDS Project Los Angeles, noted he already contacted OA and Dr. Mark by email on estimated savings of $32 million from LIHP migration prior to 7/1/2012. He asked how many people were expected to migrate. He added most LIHPs only accept people up to 133% FPL while the 5% share-of-cost covers those at 101% to 200% FPL. He asked if the estimate accounted for that. Also, estimates vary between migration spread over twelve months and a faster one. Dr. Mark said varying county caps on FPL for LIHPs was accounted for in estimates. She will follow-up with email on other items.

- Mr. Pérez felt New Major Assumptions in the Governor's budget raised issues of county size differences. Los Angeles County shoulders the plurality of California's HIV burden so delays in its LIHP implementation influence savings. DHSP immediately realized the $107 million estimated ADAP savings for FY 2012-2013 was unrealistic as it assumes a March implementation in Los Angeles County. DHSP has advised State partners to expect a lower May Revise estimate. The County does not expect to transition sooner than 7/1/2012, has discussed that with OA, and is available to assist OA in any way possible.
- Shared cost was raised for the last budget cycle. Questions arose over implementation, timing, financing and logistics that have not been resolved. Little is saved. Gardner's Treatment Cascade estimates, being modeled in the County, clearly show that every possible barrier must be eliminated to ensure people get and stay in care and on medications to reach suppressed viral load levels. Co-payments of $70, $150 or $300+ just add another barrier.
- He asked if OA proposed investing any of the planned savings in HIV prevention. Dr. Mark said the Governor's Budget is as it is. She welcomed DHSP assistance within the given State rules. She understood Ms. Kiburi and Ms. Somers continued to work with DHSP on an accurate estimate for LIHP implementation with monthly updates. She understood the public health imperative of getting people on medications, but Governor Brown is responding to fiscal pressures.
- Mr. Liso stressed estimates were unrealistic, penalized the poor and were not fiscal solutions. They will be fought.
- Mr. Vincent-Jones understood that OA is part of the Administration and must support the Governor's Budget. What disconcerts him is that OA is responsible for developing estimates. This year they are unrealistic, erroneous and use a poor methodology. He noted Dr. Mark said the prior week the estimate assumed the County would begin LIHP implementation in March, to which the County had not committed, and that day said it uses an average January implementation for Legacy Counties though data that was not presented.
- May Revise estimates must be done better, but the current poor estimates have already targeted ADAP. It is always harder to roll something back, even if first estimates were done poorly, than to avert problems in the first place. Dr. Mark said estimates take months. The Administration appreciates estimates must be updated for the May Revise.
- He noted the cost-sharing proposal for those at 101%-200% FPL, or about $12,000-$14,000 per year, represents nearly 10% of their personal budgets if they still have to rely on ADAP. That is not manageable. The Administration should know that.
- The Governor's Budget includes formation of an Office of Health Equity. While everyone supports health equity, he found it ironic when the same budget puts such equity in peril. Dr. Mark replied that the Office is not new, but a re-organization of existing offices for improved coordination and hopefully savings.
- Mr. Johnson said he is HIV+. These programs and medications saved his life. He knows what choice he would have made when he was living at that income level. He would have chosen to eat and keep a roof over his head. He would have gone without medication. This proposal will kill already marginalized and stigmatized populations. The loud and clear message from the Governor is that they do not matter. He was horrified that estimates and following a process can be discussed without the emotion of the impact of what it will do to human beings and expected more.
- ➲ Dr. Mark will follow-up by email on how varying county caps on FPL for their LIHPs were accounted for in estimates.

B. California Planning Group (CPG): Ms. Kiburi noted a member poll was underway to schedule an all-member meeting before the end of January. The meeting will finalize work group activities for the plan in order to complete the draft in April. The draft will be distributed for feedback via the Advisory Network and/or direct emails. The HRSA deadline is June 2012.

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

A. HIV Epidemiology Report:

- Dr. Frye, Chief, HIV Epidemiology Division, reported all end of year data was submitted to the State. There were 3,135 new HIV/AIDS cases for 2011, including 2,293 named HIV cases and 752 AIDS cases. That is a reduction from 3,476 HIV/AIDS cases in 2010, including 2,364 named HIV cases and more than 1,000 AIDS cases.
- There were 2,062 cases diagnosed in 2011 though data is not wholly accurate as there is a reporting delay. Numbers are similar to 2009 and 2008 with a slight decline from 2008.
- 2011 saw significant data migration and database consolidation, which should facilitate meet new data requirements.

B. Administrative Agency Report:

- Mr. Pérez reported DHSP has been working for a year on integration into one division of the three public health programs: HIV Epidemiology Program, STD Program, and Office of AIDS Programs and Policy. The structure is nearly complete which will answer questions about, e.g., nomenclature, sections and units.

- He noted both HRSA and the CDC have sent notices that Federal funds can no longer be used for needle exchange. The ban includes Prevention Cooperative Agreement dollars. The County has worked with the City of Los Angeles to fund these programs so should not be impacted, but it is a symbolic step back from effective prevention approaches.
- Regarding the Low Income Health Program (LIHP), the Departments of Health Services (DHS), Mental Health (DMH) and Public Health (DPH) have worked with the Commission and community partners to develop a smooth migration roadmap to the County LIHP, Healthy Way LA (HWLA). OA has been told migration will start no earlier than 7/1/2012.
- Two major things must be in place for migration. RW-eligible clients go to fill a prescription at their local pharmacy, but then there is a separate interaction between the pharmacy and the State's Pharmacy Benefit Manager (PBM) overseeing ADAP. Under HWLA, a similar system must be in place to facilitate a transaction between the HWLA provider and DHS, which manages HWLA, to reimburse the provider which will have purchased medications under 340B pricing.
- DHS has not yet identified the PBM system. It is a major undertaking considering the client numbers and funds involved. It is also key to easing pressure on providers and pharmacies concerned about slow reimbursement.
- Second, the County has always said HWLA enrollment would be tethered to the annual ADAP eligibility exercise. HWLA eligibility screening would occur as clients come forward based on birth month. Trainings for screeners are scheduled.
- Mental health is another area of concern. RW clients access a range of mental health services, but HWLA-eligible clients will receive either a DMH-delivered service for the acutely mentally ill or, more commonly, an existing community mental health provider delivering services via a DMH-DHS transaction. Provider education is needed and ongoing, e.g., Mr. Vega-Matos will meet with mental health provider partners on 1/18/2012.
- DHS updated the Board on HWLA on 12/20/2011 and will do so in January. The County reported to State partners in November. The next report was due the week of 1/16/2012. Updates are on the DHSP website.
- The Medical Outpatient fee-for-service transition will be coupled with HWLA migration around mid-2012.
- Mr. Land suggested involving consumers in pharmacy management system development. Mr. Pérez said Commission and Consumer Caucus feedback has been relayed to the coordinating committee. Mr. Vincent-Jones said the Caucus had not identified a consumer strategy due to rapid changes, but work may have progressed enough to begin.
- Mr. Fox thanked Mr. Pérez for participating in a California Primary Care Association call to address RW population pharmacy issues with LIHP migration. He asked if the pharmacy management system will be countywide. Mr. Vega-Matos said the RFP will be countywide to avert multiple transitions going forward towards 2014.
- Ms. Watt said providers should track current client addresses. Her agency has received information packets for former clients. Mr. Johnson noted Dr. Mitchell Katz, Director, DHS, hopes to improve the system, but it is a complex issue.
- Mr. Engeran-Cordova reiterated concern that providers be advised about letters in advance to assist clients. Mr. Vega-Matos said DHSP tries to coordinate, but does not always know. DHSP advised OA in November that letters were sent indiscriminately with misinformation that worried those unaffected by the transition. DHSP was focusing on education via the website, provider and SPA network meetings, is discussing a warm line, and is drafting a patient letter with DHS.

➲ The Consumer Caucus will begin developing HWLA strategies.
➲ Mr. Vincent-Jones will get the 12/20/2012 HWLA update to the Board by DHS and forward it to Commissioners.
➲ Mr. Vincent-Jones will strategize with the Consumer Caucus and Mr. Baker, DHSP, on a letter to State offices higher than OA regarding concerns about client communications and misinformation.

14. STANDING COMMITTEE REPORTS:

A. Priorities & Planning (P&P) Committee:

1. ***FY 2011 LACHNA-Care***:

- Dr. Wohl, HIV Epidemiology, DHSP, presented on the Los Angeles Coordinated HIV Needs Assessment-Care (LACHNA-Care). It was developed to complete a needs assessment of the Ryan White (RW) system in the County by interviewing a representative client sample to evaluate awareness of services, service needs, services received, services needed and not received (gaps), accessibility of services, barriers to services and satisfaction with services.
- Its purpose is to: evaluate if existing HIV services are sufficient; prioritize relative importance of different service categories for funding across regions and populations; and guide funding when a range of options is available.
- The stratified probability-based proportional-to-size sampling methodology was modified from previous studies to meet LACHNA-Care needs. The sampling design is in two stages – first for sites and then for clients. Agencies were grouped into medical, support services, residential, oral health and substance abuse types before sampling to ensure a representative sample from each type, yielding 46 sites of 100. A sample size calculation was performed

on the previous year's 18,545 clients for a sample size of 400 to which 50 were added for underrepresented groups.

- Clients were sampled on a real-time basis with clients recruited as they arrived for services. The percentage of clients approached varied with site size, e.g., all might be sampled at a small site while every third or fifth might be sampled at larger sites. Youth, transgender and IDU special populations were oversampled. Special populations were restricted to three to maintain study generalizability. The three were chosen with Commission input.
- Response rate was excellent at 94%, which provides good generalization to the entire Ryan White population. Limited information was collected from non-responders. Representation was good across SPAs.
- Criteria were: 18 or older, HIV+, willing to provide written informed consent in English or Spanish, able to complete survey in English or Spanish, Los Angeles County resident, receiving a RW-funded service at a RW-funded facility.
- Data collection was via a 45-minute survey self-administered on a laptop in English or Spanish. The survey was confidential with no names attached. Surveys were completed between January and June of 2011. Participants who completed the survey received $30 Ralph's or Target gift cards.
- The presentation focuses on the service utilization survey topic which covers awareness, need, utilization, accessibility, gaps, barriers, and satisfaction with services. Other topics were: demographics, HIV testing and medical care history, overall health status, sexual behavior, substance use, and oral health.
- Dr. Wohl noted there are 47 service types funded through RW. These were combined into four service clusters for analysis purposes and to help organize the survey for those taking it. Service clusters identified in consultation with the Commission are: health-related, case management, housing/transportation, and other support services.
- Clients were asked if they: were aware of service, needed it, received it, needed but did not receive it, main reason they did not receive needed service, had trouble accessing it, main reason they did not access it, and were satisfied with service received. A service gap was defined as percent of those who needed but did not receive a service.
- Data is presented both by clusters and individual services. Individual services are presented by the top 10 services participants were aware of, expressed a need for, received, reported a gap, and barriers as well as those services participants were least aware of and reported the least need for, and smallest service gap.
- Participants reporting gaps were asked questions about specific barriers. Staff categorized these as: structural, e.g., too much paperwork or too many rules; organizational, e.g., provider insensitivity, length of wait time or wrong referrals; and individual, e.g., not aware of service availability, did not know location, or did not know who to ask.
- Logistic regression analysis was used to predict factors associated with gaps for the total study sample, clusters and individual service types, specifically Oral Health which had the greatest gap. Variables for the logistic model were based on significant results from the bivariate analyses. Results are represented as Odds Ratios (OR) and accompanied by 95% Confidence Intervals (95% CI) which indicates 95% confidence the true answer is within the given interval. Very wide intervals, e.g., 95% CI: 1.2-99.9, indicate poor reliability.
- Dr. Wohl noted study limitations: includes only PWH accessing RW services while those who do not access such services likely have the greatest barriers, extent of received services funded by other sources unknown; eligibility for services that respondents reported as needed unknown, e.g., housing has eligibility requirements.
- She noted DHSP is developing methods to better identify PWH who are not accessing RW services.
- LACHNA demographic distribution corresponds well to the 2009 RW client total with: 24%, African-American; 21%, White; 47%, Latino; 6%, other. Age and gender were also similar with males slightly underestimated and females slightly overrepresented. Transgenders were also overrepresented slightly because they were oversampled for sufficient data to analyze. Surveys were in English, 78%; Spanish, 22%. Sexual orientation was: 63%, gay/lesbian/ bisexual; 36%, heterosexual. Insurance status was: 56%, no insurance; 39%, public insurance; 3%, private insurance. Income distribution was: 64%, at/below 100% FPL; 12%, currently homeless; 12%, chronically homeless.
- Regarding awareness: 99.1%, RW-funded services, expected as respondents received them; 98.4%, health-related; 92%, case management; 90.4%, support; 80.4%, housing; 78.7%, transportation. Of individual services, Medical Outpatient, (89.1%) and Psychosocial Case Management (86.0%) were highest with Hospice (19.1%) and Rehabilitation (19.6%) lowest. Respondents were aware of an average 21.3 services.
- Regarding need: 99.7%, RW-funded services; 99.6%, health-related; 86%, case management; 84.0%, support; 75.6%, transportation; 64.9%, housing. Of individual services, reported need for Medical Outpatient (93.8%) and Oral Health (82.9%) were highest with Child Care (1.8%) and Substance Abuse Treatment (2.2%) lowest. All respondents reported need for at least one service with an average of 11.6 services needed.
- Most participants (98.9%) received RW-funded services especially health-related services (98.4%). Fewest (37.8%) received housing services. Overall satisfaction with (88.6%) and accessibility of (89.4%) service clusters was high

and was the same for individual services. Of individual services, receipt of services was highest for Medical Outpatient, 90.2%, and lowest for Hospice, 0.9%. Respondents reported receiving an average 7.5 services (16%, range 0-44).

- Regarding gaps: 80.6%, RW-funded services; 64.4%, housing; 60.6%, support; 59.8%, health-related; 35.0%, transportation; 29.2%, case management. Most participants (80.6%) reported at least one gap. Barriers reported for all RW-funded services were: 35.1%, individual services; 35.1%, structural; 26.6%, organizational. By cluster, individual barriers were highest from 63.2%, case management, to 44.1%, housing. Individual service gaps ranged from 34.2%, Oral Health, to 2.0%, Hospice with most barriers individual. An average 3.9 gaps were reported.
- Logistic regression analysis was used to identify gap predictors. Few demographic variables predicted reporting any gap except that currently homeless individuals were 3.7 times (OR=3.7; 95% CI: 1.1-12.4) more likely to report a gap though the CI indicates borderline significance. Few racial/ethnic variables predicted reporting any gap except that Latinos with a lower socioeconomic status were 3 times (OR=3.0; 95% CI: 1.4-6.7) more likely to report a gap. The most common Latino barrier was individual which might indicate a language issue.
- Gap predictors for clusters were:
  Health-Related: Those who reported substance use in the previous six months were almost twice as likely to report a gap (OR=1.9; 95% CI: 1.2-3.0);
  Housing: The uninsured (OR=3.4; 95% CI: 1.8-6.4), those infected with HIV for five years or less (OR=2.2; 95% CI: 1.1-4.7), or homeless in past 12 months (OR=2.6; 95% CI: 1.1-6.3) were significantly more likely to report a gap, but those at/below 100% FPL (OR=0.4; 95% CI: 0.2-0.8) were significantly less likely, probably due to housing eligibility;
  Transportation: Those incarcerated in the last 12 months were significantly more likely to report a gap (OR=2.3; 95% CI: 1.1-5.1), but those interviewed in Spanish were significantly less likely (OR=0.4; 95% CI: 0.1-0.9);
  Case Management: Those 25-49 year old were three times more likely to report a gap (OR=2.1; 95% CI: 1.8-5.3);
  Support: those at/below 100% FPL were three times more likely to report a gap (OR=3.1; 95% CI: 1.5-6.2), but the uninsured (OR=0.2; 95% CI: 0.2-0.5) or those infected with HIV for less than or equal to five years (OR=0.4; 95% CI: 0.2-0.9) were significantly less likely to report a gap.
- Predictors for Oral Health, the individual service with the highest gap, 34.2%, were: the recently incarcerated (OR=2.7; 95% CI: 1.2-6.1), the uninsured (OR=1.8; 95% CI: 1.2-2.9), or reported substance use in the last six months (OR=1.8; 95% CI: 1.1-2.8) were significantly more likely to have a gap.
- In conclusion, Dr. Wohl reported specific factors identified as predictors for service cluster and Oral Health gaps can be used for priority- and allocation-setting as data is generalizable to all clients in the system due to the sampling methodology and the high response rate of 94%.
- Mr. Pérez recommended oversampling data on Native Americans, who have a very high infection rate, and Asian Pacific Islanders for the next LACHNA. Mr. Vincent-Jones replied funds were limited and it was determined that oversampling would still not result in viable data. He suggested other approaches to consider such as focus groups.
- Mr. Pérez added language may not fully address individual barriers for Latinos. Other causes could be immigration status or acculturation. He expressed concern that some State policies, such as on co-payments, could discourage Latinos from accessing services if policies were misinterpreted to apply to RW. He felt it important to ensure good messaging to Latinos or gaps could worsen. Dr. Wohl noted immigration status was reviewed as a gap predictor.
- Dr. Younai asked how predictor variables were chosen. Dr. Wohl replied any factors that were significant in bivariate analyses were included in the gap predictor model. Those that remained significant were highlighted. Insurance was not reviewed as a predictor of Oral Health gaps, but could be in future.
- Mr. Sotomayor asked if any of those who identified gaps were assisted. Mr. Vincent-Jones replied that was not part of LACHNA though earlier surveys on unmet need did include referrals for those not accessing medical care.
- Mr. Simon asked how eligibility affects reported need. Ms. Pinney responded LACHNA uses self-reported need. Need is not defined nor is eligibility determined. He asked how need for Substance Abuse ranked low, but those with substance use issues had high need gaps. Dr. Wohl replied Substance Abuse Treatment need was for methadone. A small proportion of heroin users are HIV+. Some may also not be ready to acknowledge need.
- Mr. Aviña noted Mental Health, Psychiatry was the ninth highest listed need at 45.1% and asked about racial/ethnic differences, especially among African-Americans and Latinos. Dr. Wohl said only Oral Health was reviewed due to the size of the gap, but data can be mined for any of the other individual services.
- Dr. Henry asked if engagement/linkage to care was examined. An “appointments kept” variable with a tri-domain of effectively linked, mid-level linked, and not very well linked could generate odds of those more likely, e.g., to

have gaps. Dr. Wohl noted the survey was limited to those accessing a site, but names were collected separately. It is hoped to use names to access CaseWatch appointment data for additional analysis when time permits.

- Mr. Giugni noted LACHNA originally went into the community to assess, e.g., RW awareness. While extensive, this iteration seems limited. Mr. Vincent-Jones replied this is the fifth LACHNA in six years. There has been a constant push for a more scientific, statistically reliable instrument. The Commission will work to disseminate it, but remains interested in more qualitative data--e.g., through focus groups--to supplement LACHNA as funds permit.
- He added RW legislation requires a regular needs assessment. LACHNA will be bi-annual. It mainly supports the Priority- and Allocation-Setting Process as priorities must be based on need. It supports planning and will be in the Comprehensive HIV Plan. Data also supports, e.g., standards, program modeling/best practices. Inclusion of Odds Ratios enhances data usability. The Priorities and Planning Committee plans extensive dissemination.

➲ Slide 35: Need for Services: Change "All Ryan White-Funded Services" to "Any Ryan White-Funded Service."

➲ Dr. Wohl accepted Mr. Goddard's invitation to present on LACHNA-Care at the next HOPWA/LACHAC meeting.

MOTION 5: Accept and file the FY 2011 Los Angeles Coordinated HIV Needs Assessment - Care (LACHNA-Care) report, as presented ***(Passed by Consensus)***.

B. Operations Committee:

1. ***Pol #07.2002: Duty Statement, Executive Committee At-Large***: Mr. Vincent-Jones noted this was presented in December. At-Large members will serve on both the Executive and Operations Committees.
   MOTION 6: Approve Policy/Procedure #07.2002: Duty Statement, Executive Committee At-Large Member, as presented **(*Passed as Part of the Consent Calendar*)**.
2. ***Ordinance Policy/Procedure Updates***: The Ordinance was passed in November and became effective in late December. The approved motion facilitates updating Commission Policies/Procedures for consistency.
   MOTION 7: Direct Executive Director to update approved Commission Policies/Procedures consistent with the revisions to Title 3 – Chapter 28 of the Los Angeles County Code approved and Commission Bylaws **(*Passed as Part of the Consent Calendar*)**.
3. ***Pol #06.1000: Commission Bylaws***:
   - Bylaws are the Commission's governing document. There are significant changes since the 2006 revision to reflect Commission evolution, different practices and the newly passed Ordinance though basic substance is the same.
   - HRSA must approve Bylaws and has submitted comments. Some were incorporated. Others are under discussion.
   - Revisions were reviewed and opened for public comment until 1/31/2012 and will be voted in February:
     - *Pg. 1:* Format was changed to conform to Policy/Procedure format as Bylaws are a Policy/Procedure.
     - *Article I. Name and Legal Authority:* Section 3 was added to identify where the Commission is located within the County structure and Executive Office. Section 4, Duties and Responsibilities, was edited to match the new County Code. Section 5, Federal and Local Compliance, verifies Ryan White, HRSA and County Code compliance.
     - *Article II. Members:* Section 1, Definition, was expanded from Commissioners and alternates to include community members who may vote on committees. Section 2, Composition, was edited to address the new membership structure as reflected in the County Code. Section 3, Term of Office, was edited to reflect differences among the types of members. Sections 4 and 5, "Reflectiveness" and "Representation," were added per HRSA request to emphasize the requirements. Section 9, Community Members, was added to address community members who are new to the Commission since the prior iteration.
     - *Article III. Member Requirements:* Essentially the same while adding more detail and explanation.
     - *Article IV. Nomination Process:* Updated to the process used for the last three or four years. The process is consistent with HRSA's open nominations process.
     - *Article V. Meetings:* Elaborates on HRSA's open meeting and California Brown Act requirements.
     - *Article VI. Resources:* New article to address Commission budgeting and its multiple potential sources of support. Distinction between Ryan White funds applied to planning council activities and other funding applied to activities consistent with the County Code. A section is also included on Commission staffing.
     - *Article VII. Policies and Procedures:* Essentially a new Article, policies/procedures are embedded with a link to the Policy/Procedure Manual. Section 2, HRSA Approval(s), identifies required Bylaws approval and specific approval for the Grievance (detailed in Section 3) and Conflict of Interest (Section 4) Policies/Procedures.
     - *Article VIII. Officers and Elections:* Definition has been expanded per current practice to include Commission and committee co-chairs, and At-Large Members including recent changes to the latter's membership.

- *Article IX. Commission Work Structures:* Essentially a new article, this expands from previous discussion of committees to work units as defined in Policy/Procedure #08.1102: Subordinate Commission Working Units which the Commission, approved about 18 months ago.
- *Articles X-XIV. Various Standing Committees:* Articles collectively replace one which addressed all committees. Each current article addresses one standing committee and details current responsibilities and membership.
- *Articles XV. Official Communications and Representation:* Standard language for Commission members/staff.
- *Article XVI: Amendments:* Standard language pertaining to Bylaws revision.

- Mr. Engeran-Cordova asked about resolution of HRSA's concerns regarding use of Ryan White Part A funds by the Joint Public Policy (JPP) Committee for policy and advocacy. Mr. Vincent-Jones noted HRSA has no definition of "policy and advocacy" and HRSA's guidance and planning responsibilities require it. As such, the Commission has found HRSA's assessment of this issue contradictory, counter-productive and undermines the role and responsibilities of the planning councils, and has stated so to HRSA staff multiple times.
- Nevertheless, DHSP has agreed to pay "policy and advocacy" costs with Net County Costs (NCC). The Commission will charge JPP costs to NCC as reflected in Bylaws Resources and JPP Bylaws Article. Mr. Vincent-Jones indicated that this solution is a good one, as the Commission no longer has to limit policy and advocacy conversations due to Ryan White restrictions. He added that while the Commission still vehemently disagrees with HRSA's intervention on this issue, the current arrangements resolve the issue effectively and it is time to move on.

4. ***Pol #08.3105: Ryan White Conflict of Interest***:

- M. Vincent-Jones said HRSA raised concerns in Fall 2011 that Commission conflicts-of-interest policy/procedures were inappropriate and inconsistent with HRSA's requirements. While the Commission disagrees, HRSA was particularly uncomfortable with the "safe harbor" provision. To address the issue, the policy/procedure was split into one pertaining only to Ryan White adherence and another pertaining only to State law adherence.
- Both policy/procedures were opened for public comment until 1/31/2012 and will be voted in February
- "Safe harbor" pertains to State conflict-of-interest laws which are more stringent than HRSA's. They could be interpreted by legal counsel to mean that no provider or administrator of service categories could talk, vote, or be in the room for discussion of priorities, allocations or service category planning. County Counsel designated "safe harbor" from State law to allow Commissioners to meet their Ryan White planning council duties.
- Declaring conflicts-of-interest or recusal when one service category is under consideration is consistent with Ryan White, but is only allowable under State law due to "safe harbor." Mr. Vega-Matos was concerned "safe harbor" does not cover Part B. Mr. Vincent-Jones replied that it covered all of Ryan White categories the Ryan White Part A planning council considers.

5. ***Pol #08.3108: State Conflict of Interest***: There was no additional discussion.

C. Joint Public Policy (JPP) Committee:

1. ***Governor's FY 2012-2013 State Budget***:

- In addition to ADAP proposals, Mr. Fox said the Governor's Budget proposes to remake the Federally Qualified Health Center (FQHC) Prospective Payment System (PPS). FQHCs now serve many PWH and that number will likely grow. The proposed PPS rate modification would set FQHC rates to see a patient.
- The proposal would need Legislature approval as part of the Budget, but would also need approval by the Centers for Medicare and Medicaid Services (CMS) because it represents a radical change to the Medi-Cal system.
- People nationwide are concerned since California is seen as a bellwether and many feel the rate unsustainably low. The Community Clinic Association of Los Angeles County, the California Primary Care Association and the National Association for Community Health Clinics are among organizations already working to defeat the proposal.
- Another Budget issue raised last year and dismissed by the Legislature is a one-year Medi-Cal managed care plan lock-in following open enrollment. Plans can now be changed monthly allowing flexibility to meet needs.

2. ***2012 Legislative Agenda***:

- JPP Co-Chairs Messrs. Fox and Simon, Mr. Vincent-Jones and Senate Health Committee staff discussed AB 491 to reduce testing barriers with the author, AIDS Healthcare Foundation, and the ACLU. Proposed language would: ease access to routine testing specifically in emergency rooms; reduce California barriers for a CLIA Waiver; and reduce training days required for counselor certification. A strategy to pursue linkages to care was also proposed.
- Conversation on the two-year bill was fruitful, but ACLU concerns were not resolved.
- Authors pulled AB 1327, blended Medi-Cal HIV/AIDS rate, as not needed. It is dropped from the Legislative Agenda.

3. ***Miscellaneous***:
   - Mr. Fox reported the State Department of Health Care Services (DHCS) has released a draft Request for Solutions (RFS) for California's Dual Eligibles Demonstration Project to develop better coordination. Dual eligibles are enrolled in both Medicare and Medicaid. The draft RFS excludes beneficiaries with HIV/AIDS, but comments were being accepted.
   - AIDS Project Los Angeles (APLA) spearheaded a letter signed by six other organizations which argues that PLWHA are a disproportionate number of those who access care as dual eligibles, so they should be included. At the same time, they argue against passive enrollment to ensure that people are not forced to leave long-term care providers.

D. Standards of Care (SOC) Committee:

1. ***Quality of Care Performance Measures***: Dr. Younai said the HIV Clinical Performance Measures for Adults and Adolescents use 21 measures developed by DHSP from HIVQUAL and other sources. The table identifies the measure, description, numerator, denominator, exclusions and benchmark. A Commission presentation is planned.
2. ***Miscellaneous***: Dr. Younai noted the HIV Discrimination in Dental Care study in the packet. Done in 2007-2008 prior to Denti-Cal cuts, it was presented at the International AIDS Conference, Mexico City, and published as a Williams Institute report in December 2011. Results show dental providers are less likely to refuse services to PWH than some other providers such as obstetricians, but a 5% refusal and/or discriminatory practice rate remains.

15. PREVENTION PLANNING COMMITTEE (PPC) REPORT:

- Mr. Pérez reported on the flagship CDC HIV Prevention Cooperative Agreement award–a new paradigm in three parts: 1) historical services with 75% for core services such as testing and prevention for positives and 25% for services such as Health Education/ Risk Reduction; 2) expanded testing with targeted countywide screening and a combined Part A/B $1 million increase from historical award; 3) competitive innovative activity or service awards to be announced in March.
- DHSP will RFP prevention this year and is working with its prevention partners to re-set prevention priorities and allocations.
- Ms. Watt reported the PPC discussed the award on 1/5/2012. The County should be congratulated on its increase as funding is re-aligned. Funding now follows the epidemic and may vary per jurisdiction over the next three years.
- The community is now looking at prevention, care and treatment across the spectrum. "Care and treatment providers" must consider the preventive aspects of their work, just as "prevention providers" have begun to address prevention in care and treatment. The NHAS and the Affordable Care Act presaged this change and CDC is now breaking down silos.

16. AIDS EDUCATION/TRAINING CENTERS (AETC) REPORT:

- Dr. Espinoza, Assistant Director, USC-AETC, noted hers in one of three County AETCs in the County.
- The Charles Drew University-AETC will host "HIV and Psychotropic Medications," 1/31/2012, 9:00 to 10:30 am. It is creating an instrument to evaluate HIV provider use of psychotropic medications, e.g., how often are they prescribed.
- The UCLA-AETC is developing the "Coping With Hope Conference," 5/17/2012, at the California Endowment.
- The USC-AETC works with HIV and primary care providers in the County. Kathy Jacobson, Medical Director, is currently working with some providers at the LAC+USC Emergency Department to help implement opt-out testing.
- It began working with the County Jail about six years ago initially providing care with HIV Medline faculty. Recently a small MAI grant allowed expansion to work with corrections officers and providers to improve quality of care, e.g., HIV Medline faculty provide clinical consultations, a monthly training series was implemented for providers in the inmate reception center, and a corrections fellowship was initiated last year. The first Corrections Fellow is now on the HIV Medline and the second is in training. A meeting is also being planned with DHSP and the County Jail to coordinate efforts.
- The USC-AETC general fellowship is in its seventh year. Fellows train with faculty and rotate through local HIV care sites.
- Both fellowships are now interviewing for the next fiscal year. Applicants should be in their third year of residency.

17. TASK FORCE REPORTS:

A. Comprehensive HIV Planning Task Force (CHP TF):

- Ms. Watt reported the 1/5/2012 PPC devoted most of its meeting to discussion of the new integrated care, prevention, treatment plus plan being developed. It stresses that prevention is treatment and treatment is prevention.
- The prevention plan has long been used actively by stakeholders. The Comprehensive HIV Plan goal is for a document equally user-friendly for prevention, care and treatment stakeholders that will lead in integrated community planning.
- The draft Table of Contents was in the packet for review. All are welcome to attend Task Force meetings.

B. Community Task Forces: There was no report.

18. CAUCUS REPORTS:

A. Consumer Caucus: The Caucus met following the Commission meeting.

B. Latino Caucus: There was no report.

19. **SPA/DISTRICT REPORTS**: Ms. White, SPA 6, thanked Mr. Vega-Matos and Julie Cross for accepting the invitation to address the community on 2/6/2012. She will send out a flyer to the Commission and PPC so anyone interested can attend.

20. COMMISSION COMMENT: Mr. Pérez acknowledged Ms. Watt's work on the Prevention Cooperative Agreement Funding Opportunity Announcement. He also expressed appreciation for the addition of the AETC Report to the Agenda.

21. **ANNOUNCEMENTS**:

- Ms. Woodard, SPA 1, announced Tarzana Treatment Center is no longer providing transportation for clients to access food at the Catalyst Foundation. The Consumer Advisory Board is asking for suggestions to help.
- Mr. Simon noted the City of Los Angeles uses HUD Federal block grants to support syringe exchange-related wrap-around services, e.g., linkage to care and social services. Funds are not used to purchase syringes, but contracts are likely to be modified to clarify that. Those wrap-around services will continue to be funded in the second and third contract years.
- The City is, however, facing a possible 20% cut to its prevention block grant. The AIDS Coordinator's Office will advocate to the Mayor and City Council to backfill funds. He urged Commission support.
- Mr. Simon will leave the AIDS Coordinator position in the next two months. The Mayor has been asked to expedite hiring his replacement with community input. He will join a public policy advocacy firm working to grow its Los Angeles office.
- Mr. Land acknowledged Ms. Bailey's 10-year Commission anniversary and Mr. Ballesteros and Dr. Long for years of service.
- Mr. Kelly noted Life Group LA's Poz Life Weekend, 1/28-29/2012, Plummer Park, West Hollywood, www.LifeGroupLA.org. He thanked Life Group LA and AIDS Healthcare Foundation who each named him Volunteer of the Year.

➲ Refer SPA 1 lack of transportation to access food to DHSP.

22. **ADJOURNMENT**: Mr. Johnson adjourned the meeting at 1:50.

A. Roll Call (**Present)**: Aviña, Bailey/Lewis, Ballesteros, Barrit, Cadden, Espinoza, Green, Johnson, Kelly, Land, Liso, Long, Lopez, Mendia, Pérez, Peterson, Rivera, Simon, Vega-Matos, Washington-Hendricks, Watt, Woodard, Younai

MOTION AND VOTING SUMMARY		
MOTION 1: Approve the Agenda Order with Motion 4 revised to, "Elect Executive Committee At-Large members, as nominated".	***Passed by Consensus***	**MOTION PASSED**
MOTION 2: Approve minutes from the 12/8/2011 Commission on HIV meeting.	***Passed by Consensus***	**MOTION PASSED**
MOTION 3: Approve the Consent Calendar with Motions 4 and 5 pulled for deliberation.	***Passed by Consensus***	**MOTION PASSED**
MOTION 4: Elect Executive Committee At-Large members, as nominated.	***Ayes:*** Aviña, Bailey, Ballesteros, DeAugustine, Engeran-Cordova, Giugni, Green, James, Johnson, Kochems, Land, Liso, Lopez, Mendia, O'Brien, O'Malley, Orozco, Page, Palmeros, Peterson, Rivera, Simon, Sotomayor, Vega-Matos, Washington-Hendricks ***Opposed:*** None ***Abstention:*** None	**MOTION PASSED** **Ayes**: 25 **Opposed**: 0 **Abstention:** 0
MOTION 5: Accept and file the FY 2011 Los Angeles Coordinated HIV Needs Assessment - Care (LACHNA-Care) report, as presented.	***Passed by Consensus***	**MOTION PASSED**
MOTION 6: Approve Policy/Procedure #07.2002: Duty Statement, Executive Committee At-Large Member, as presented.	***Passed as Part of the Consent Calendar***	**MOTION PASSED**
MOTION 7: Direct Executive Director to update approved Commission Policies/Procedures consistent with the revisions to Title 3 – Chapter 28 of the Los Angeles County Code approved and Commission Bylaws.	***Passed as Part of the Consent Calendar***	**MOTION PASSED**