LOS ANGELES COUNTY COMMISSION ON HIV

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JOINT COMMISSION ON HIV/ PREVENTION PLANNING COMMITTEE (PPC) MEETING MINUTES

April 12, 2012

COMMISSION MEMBERS PRESENT	COMMISSION MEMBERS PRESENT (*cont.*)	COMMISSION MEMBERS ABSENT	COMMISSION STAFF/ CONSULTANTS
Carla Bailey, *Co-Chair*/Kevin Lewis	Stephen Simon	Anthony Braswell	Claire Husted
Michael Johnson, *Co-Chair*	Carlos Vega-Matos	Joseph Green	Dawn McClendon
Sergio Aviña	Kathy Watt*	Angélica Palmeros	Jane Nachazel
Al Ballesteros	Fariba Younai	Karen Peterson	Glenda Pinney
Cheryl Barrit		Tonya Washington-Hendricks	James Stewart
Joseph Cadden		Jocelyn Woodard	Craig Vincent-Jones
Whitney Engeran-Cordova	**PPC MEMBERS PRESENT**		Nicole Werner
Lilia Espinoza	Michael Green, *Co-Chair*		
Aaron Fox*	Anthony Gutierrez, *Co-Chair*	**PPC MEMBERS ABSENT**	
Douglas Frye	Ricki Rosales, *Co-Chair*	Trevor Daniels	**DHSP STAFF**
David Giugni*	Sophia Rumanes, *Co-Chair*	Jeffrey Goodman	True Beck
Terry Goddard	Scott Campbell	Brian Lew	Kyle Baker
Thelma James	Juli-Ann Carlos	Victor Martinez	Elizabeth Escobedo
David Kelly	John Copeland	Jill Rotenberg	Jennifer Felderman
Lee Kochems	Michelle Enfield	Terry Smith	John Mesta
Bradley Land	Aaron Fox*	Enrique Topete	Pamela Ogata
Ted Liso/James Chud	David Giugni*	Timothy Young	Cheryl Williams
Anna Long	Grissel Granados		Juhua Wu
Abad Lopez	Heather Grant		
Elizabeth Mendia	AJ King		
Jenny O'Malley	Milton Smith		
Mario Pérez	Kathy Watt*		
Juan Rivera			
PUBLIC			
Darrin Aiken	Ernesto Aldana	Erika Alvarez	Victor Ashly
H. Avilez	Danny Bado	Reginald Batiste	Heidi Booth
Troy Canen	Tracey Cumbarland	Susan Forrest	Marie Franios
William Furois	Thelma Garcia	Shawn Griffin	Kimler Gutierrez
Richard Huff	Miki Jackson	Jaye Johnson	Alejandrina Jurado
Kimberley Kisler	Luke Klipp	Joseph Leahy	Esperanza Moniz

PUBLIC (*cont.*)			
Lerenia Navarro	Laura Ramos	Greg Rios	Daniel Rivas
Martha Ron	Lambert Talley	Tia Thames	Miguel Topete
Jason Tran	Brigitte Tweddell	Kevin Weiler	Sharon White
William White	Jason Wise	Gregory Wilson	Melvin Wilson

* *Indicates dual Commission and PPC membership*

1. **JOINT MEETING CALL TO ORDER**: Mr. Johnson called the meeting to order at 9:20 am.
   - **A. Roll Call**:
     Commission (**Present)**: Aviña, Bailey/Lewis, Ballesteros, Barrit, Cadden, Engeran-Cordova, Frye, Giugni, Goddard, James, Johnson, Kelly, Kochems, Land, Liso/Chud, Long, Lopez, Mendia, O'Malley, Pérez, Rivera, Simon, Younai
     PPC (**Present)**: Campbell, Carlos, Copeland, Fox, Giugni, Granados, Grant, Green, Gutierrez, King, Rumanes, Milton Smith

2. **APPROVAL OF AGENDA**:
   MOTION 1: Approve the Agenda Order **(*Passed by Consensus*)**.

3. **PUBLIC COMMENT *(Non-Agendized or Follow-up)***:
   - Mr. Leathers, Owner/President, West Hollywood Medical Management and Marketing, Inc., noted his firm has served non-profits for 10 years with a special focus on chemical dependency and HIV. Services include lobbying and are inexpensive.
   - Mr. Klipp reported the State Department of Health Care Services (DHCS) just issued a coordinated care initiative proposal for dual eligibles in four demonstration counties, including Los Angeles. Clients enrolled in the AIDS Healthcare Foundation (AHF) program will not be passively enrolled in the demonstration project, but PLWHA not in AHF's plan remain subject to passive enrollment. The deadline for public comments on the DHCS proposal is 5/4/2012.

4. **COMMISSION/PPC COMMENT *(Non-Agendized or Follow-up)***:
   - Mr. Kelly reported the next Life Group LA POZ Life Weekend Seminar will be 4/28-29/2012 in the Long Beach area. The Seminar is open to those infected and affected by HIV. For more information, go to www.thelifegroupla.org.
   - Mr. Giugni noted difficulties in assisting people with migration from Medi-Cal to Medi-Cal managed care and Ryan White to Healthy Way LA, or appeals to maintain current care. He requested DHSP offer a list of the pertinent migration/appeal contact people at each of the 13 contracted benefit specialty agencies as agencies are now simply referring to each other.
   - Mr. Fox reported Commissioner testimony at the Senate and Assembly hearings in Sacramento personalized the issue of ADAP cost-sharing. The Senate rejected the ADAP cost-sharing proposal, but the Assembly left it open. He thanked AHF for funding the trips.
   - ➲ Refer migration and migration appeal issues to Consumer Caucus and DHSP.

5. **CALIFORNIA OFFICE OF AIDS (OA) REPORT**: There was no report.

6. **COMPREHENSIVE HIV PLAN (CHP)**:
   - **A. Presentation of the CHP:**
     - Mr. Rosales reviewed the history that preceded this first combined comprehensive care and prevention plan. In 2008, the Commission and PPC created the Collaboration and Integration Task Force to improve comprehensive service delivery. Consequently, the Joint Public Policy (JPP) Committee was reformed and, in 2009, the PPC held a one-and-one-half day seminar with Doc Klein, Commission consultant, to develop a PPC continuum of prevention.
     - The CDC released Testing and Linkage to Care/Treatment Plus (TLC+) in 2010. In response, the Task Force explored how each body was addressing it and presented results to both bodies. The CDC released Enhanced Comprehensive HIV Prevention Planning (ECHPP) in 2011 with care as a prevention intervention and prevention integrated into care. The bodies held a Joint Annual Meeting in 10/2011 at which time they voted to develop a joint CHP.
     - DHSP hired Ms. Husted as a consultant in 2011 to assist with the Plan, and the Task Force reformed into the CHP Task Force. One work group continues development of the continuum of care and prevention while another is finalizing goals and objectives consistent with the National HIV/AIDS Strategy (NHAS). Both bodies have been updated routinely.
     - Ms. Husted has worked in HIV/AIDS since 1991 starting in training and capacity building in upstate New York. She participated in writing the Title I application for the then Office of AIDS and Program Policy in 1998 and 1999 and has

written the Prevention Plan three times, as well as Inland Empire's Title I/Part A application the last seven years. Mr. King assisted in developing the Plan including drafting several sections and work on several tables.

- She stressed that it is important to listen to community input while recognizing that HRSA and the CDC require a jurisdictional plan which reflects ECHPP and other initiatives over the past three years, such as NHAS.
- The Task Force requested a truly integrated, user-friendly CHP. The last Prevention Plan was about 200 pages and the last Care Plan was 296 pages so an integrated Plan that meets requirements and is user-friendly is challenging.
- The Plan's Introduction highlights catalysts for change, such as NHAS, and reviews the reassessment of the County's HIV epidemic, the reconfiguration of programs into DHSP, the evolution of the County's HIV/AIDS planning, the County's Continuum of HIV Prevention and Care, and an overview of the 2012-2014 Comprehensive HIV Plan.
- Section II. Epidemiologic Overview, is not meant to replace the HIV Epidemiology Report, but does update 2009 data. The Overview reviews data in light of the Continuum of Care's flow of populations, i.e., from those who are HIV- low-risk through to those who are HIV+ and adherent to care. The section also reviews social determinants of health, such as homelessness and the expanding role of syndemic planning with geospatial analysis.
- High-risk/high-burden populations are examined by race/ethnicity, age, gender, risk category and SPA, including prevalence, disproportionate impact and emerging epidemic/populations. HRSA has asked about the emerging epidemic in its last several Part A applications. Ms. Husted used 2008-2011 prevalence data to identify trends. Dr. Frye added data collection began in 2007, so 2008 represents the first viable data, but trend data will increase over time.
- DHSP is one of the rare jurisdictions that adjusts data to reflect the actual age of reported cases over time. Trending data shows an increase in prevalence among those 50-59 and 60+ as expected with an aging population. More troubling is a slight increase in prevalence among those 20-29, but with a striking increase in incidence of 30.4% of the newly diagnosed versus 7.9% of total PLWHA. Those 30-39 have an incidence rate of 29.1% versus 18.2% overall.
- Ms. Husted noted true prevalence data cannot be calculated for populations, such as transgenders, IDUs and MSM because the total population number is needed to calculate the denominator and only estimates are available. However, trends can be calculated from the percentage of incidence versus the total prevalence, e.g., MSM and MSM/IDU prevalence overall is 76.4% and 6.4% respectively and have increased by 13.1% and 2.7% respectively.
- Those who are HIV+ but unaware of their status references a Part A application section on early identification of PLWH. The CDC provided a formula to Part A/B jurisdictions to calculate the estimate two years ago, the Estimated Back Calculation (EBC) Methodology, which uses a 21% nationwide estimate. More recent work indicates 21.5%. Ms. Husted used the 21.5% estimate with incidence data as a surrogate to explore demographic data for the unaware.
- HRSA also requires an unmet need population estimate defined as those aware they are HIV+ but not in medical care. DHSP develops the estimate using HRSA's methodology with data sets such as CaseWatch. The estimate has declined over time: 2008, 37.1%; 2009, 35.2%; and 2010, 33.9%. Data and demographics are from the 2011 application.
- PLWHA who are accessing care and adherent to their care plan are addressed jointly since a means has not been developed to identify those not adherent. Consequences of poor adherence are explored.
- Ms. Husted said data on late testers who test and convert to AIDS in the same calendar year will be added by May.
- Section III. Addressing Community Needs, Gaps, and Barriers, provides a population flow map of HIV+ populations needing services: 12,800, unaware; 18,800, aware but not accessing services; 27,900, accessing public or private services and adherent to care. HIV- low-risk and high-risk populations are noted, but data is insufficient for an estimate.
- The section reviews HIV prevention, testing and linkage to care; care and treatment of PLWHA; and capacity development needs in key areas of outreach, oral health care, monitoring Viral Load, Healthy Way LA transition, and improved coordination with Federally Qualified Health Centers (FQHCs) and Indian Health Service Centers (IHSCs).
- Individual components address discrete populations from the flow map of: HIV- individuals at low- or high-risk; and HIV+ individuals unaware of their status, those aware but not in care, and those accessing care and adherent to care.
- Los Angeles County Coordinated HIV Needs Assessment-Care (LACHNA-Care) data for 2011 is used to reflect needs, gaps (needed and not received) and barriers for the top ten needed Ryan White services. Medical outpatient is the top listed need, but is not among top service gaps. Oral health was the second most needed service and had the highest gap at 34.2%.
- Barriers are defined as structural, such as red tape; organizational, such as provider insensitivity; or individual, such as lack of awareness of service or location. Barriers are noted for six of the top ten needed services in the table.
- The section also provides tables that break out the top ten needed services by racial/ethnic populations and by selected populations of youth, transgender, homeless and IDU. Rankings are similar overall, but some differences emerge, e.g., medical outpatient is first for all groups, except youth, which ranks it third. Likewise, oral health is ranked second overall, but ranked seventh by whites, fifth by Latinos, third by homeless, and first by youth.

- Section IV. Los Angeles County's Continuum of HIV Prevention and Care Resources, provides a matrix of interventions/ services targeted to each population flow map group and indicates Ryan White or other funding. This matrix responds to HRSA's plan guidance which requests funding resource information. Both Ryan White service categories and the 24 ECHPP services are included and organized to reflect population flow from HIV- through to HIV+ accessing care.
- System-level services are listed first: structural/policy initiatives, perinatal transmission prevention, HIV/STD surveillance data to prioritize risk counseling/partner services, routine opt-out testing, antiretroviral treatment policies/ procedures. Community-level services follow: social marketing, community mobilization, community interventions that reduce risk. Individual or group level interventions are the third grouping.
- County service categories seek to serve PLWHA in a holistic manner and do not always match HRSA definitions. Tables 21 and 22 map corresponding HRSA and County core, requisite 75% of funding, and support categories respectively.
- HRSA requested information on how needs translate into prioritized services. Table 23 uses 2011 LACHNA-Care and FY 2012 priority rankings to indicate categories, services, ranking need and gap. LACHNA-Care was completed prior to consolidation of the prior 38 categories into the current 17 so Table 23 uses the 38 categories.
- Ryan White resources, "payer of last resort," are: Part A, County grant; Part B, state grant including ADAP; Part C, Early Intervention Services; Part D, Women, Infants, Children and Youth (WICY); Part F, AIDS Education and Training Centers (AETCs), and dental reimbursement to the UCLA and the UCLA.
- The section reviews other resources including Housing Opportunities for People With AIDS (HOPWA), County Department of Mental Health (DMH) and Substance Abuse and Prevention Control (SAPC), and providers such as Veterans Affairs and Kaiser Permanente. Major payers are: Medi-Cal, Medicare, Cal-Fresh, Healthy Way LA and Healthy Families.
- Capacity building and technical assistance resources are also reviewed. These include: CDC Capacity Building Assistance, DHSP, and the Center for HIV Identification, Prevention and Treatment Services (CHIPTS).
- HRSA guidance requests information on the County's response to fiscal uncertainty. That is taken from the application.
- The final two sections, Section V. Future Direction for Los Angeles County's HIV Services and Section VI. Measuring Results, are organized around NHAS goals: reduce new HIV infections; increase access to care and improve health outcomes for PLWHA; reduce HIV-related health disparities and health inequities; achieve a more coordinated national response to the HIV epidemic. Goals and objectives are still being finalized and will include challenges of the 2009 Plan.
- HRSA requested information on how Ryan White collaborates with ECHPP, discussed in Section V.G., and Ryan White alignment with national and state plans specifically the Affordable Care Act (ACA), Healthy People 2020, NHAS and the California Statewide Coordinated Statement of Need, which will be detailed in Section V.H.
- The Section VI. Measuring Results implementation component will be written after completion of goals and objectives. Ms. Husted noted ECHPP goals use one-year objectives. That approach could enhance Plan value as a living document.
- Section VI. C. Assessing Los Angeles County's Efforts to Address the Needs of HIV Positive Individuals who are Unaware of their Status has been adapted from the County's Strategy for Early Identification of Individuals with HIV/AIDS (EIIHA).
- Data usage in service utilization and clinical outcomes, Section VI.D., is also addressed per HRSA guidance.
- Current attachments are: CDC Required and Recommended Interventions, Evaluation of the 2009 Ryan White Comprehensive Care Plan, and Los Angeles County Ryan White Service Definitions. A list of acronyms will be added.
- Mr. Goddard suggested using a dashboard for monitoring. Mr. Vincent-Jones reported that has been discussed. While data would not support monthly updates, quarterly updates might be feasible eventually.
- Ms. Enfield suggested expanding references to discrimination beyond homophobia to include transphobia. She added "transgender" is an adjective, and should not be modified to a verb, such as with "transgendered."
- Mr. Gutierrez asked about data on AIDS-related deaths to inform data on those who are HIV+ but not in care. A low mortality rate could indicate many of those listed as HIV+ but not in care have left the County since lack of care increases mortality. Ms. Husted planned to request that data. She noted County domestic migration overall is net negative, but people continue to enter the County. Dr. Frye added death data has a two-year time lag due to reporting requirements. Annual deaths went up in 2008 to 707 from 647, but there is no major upward trend.
- Mr. Ballesteros asked about differences in data between Figure 1, page 5, and Table 8, page 47. Ms. Husted replied the former used data rounded to the nearest 100. Further, Table 8, C, 2010 HIV+ aware, 55,471, uses data drawn from the State database. It is close to the County reported 59,500 of aware and unaware in Figure 1 as Table 8 includes cases not reported in the County. Ms. Husted felt the County epidemic was larger than the standard methodology indicates as it does not allow use of the state unmet need database. Using that database results in an overall number of some 67,000.
- Mr. Engeran-Cordova suggested Activity 4.1.2. Integrated Care and Prevention Planning could be realized by continuing to meet jointly. Mr. Vincent-Jones responded neither body has a defined goal towards that at this time.

- Ms. Mendia suggested adding case density per SPA, but Mr. Chud felt SPA data obsolete. Mr. Vincent-Jones noted the PPC is migrating from SPA data to data per the five clusters identified by geospatial analysis, but that the care side has not done because other factors are involved, not precluding it in the future. Care will have to develop a different analysis, as DHSP resources permit.
- Mr. Pérez noted references to the 104 FQHCs, but felt it also key to address the role of Community Health Centers.
- He also urged an emphasis on rates of Viral Load (VL) suppression, noted on page 51, by group and area. Data is limited, but increasing the rate of those with a suppressed VL will be critical to get ahead of the epidemic.
- Mr. Pérez noted the Public Health Figure 28 that inventories services. He felt capacity building resources should also be inventoried with goals identified, such as an increase in addiction health providers. Resources should be evaluated on how well they increase capacity to: do more tests; get people into care, virally suppressed and adherent; address holistic life issues and social determinants of health. He offered to work with Ms. Husted and others to develop data.
- He added federal partners increasingly expect researchers to engage local health departments. There is significant local research which could address, e.g., questions on disparities. He would like the Plan to support that engagement.
- Mr. Liso noted the NHAS goals listed do not specifically address housing. Mr. Vincent-Jones said the fourth goal, coordinated national response, has activity 4.1.4 which focuses on integrating housing services such as Ryan White and HOPWA. This Plan does not address individual categories per se, but it is hoped to include more on housing. Mr. Pérez noted NHAS does have a performance indicator tied to the number of people with stable housing. Mr. Vega-Matos added the Commission recently received a planning grant to coordinate the care and housing continuum for PLWHA, and it may be able to assist in the process.
- Ms. Watt noted the Plan was open for public comment until 4/26/2012 and urged all to review it in detail. The CHP TF will meet 4/27/2012 to incorporate public comment. The Plan will be presented to the Commission for approval on 5/10/2012. Stage 1 ends with HRSA submission prior to the 5/21/2012 deadline.
- Stage 2 will incorporate RAND priority modeling, other prevention planning elements, and care information updates. The Task Force will develop a dissemination strategy to elicit community input and raise Plan awareness. The final Plan will be presented to the PPC at the 8/2/2013 meeting, approved at the next meeting and then submitted to the CDC.
- In Stage 3, the Task Force will design and publish the final Plan then continue to ensure it is a "living document."

➲ Ms. Husted will correct data to note that 4 of 6 2010 perinatal cases treated in the County originated elsewhere.
➲ Ms. Husted noted some individual/group interventions were not included in Section IV, Table 20, but will be added.
➲ Ms. Husted will add Section 8 as a major service payer in Section IV.
➲ Ms. Husted will reverse the order of Section IV components E. Response to Fiscal Uncertainty and F. Capacity Building
➲ Ms. Husted will correct Table 8: G, PLWHA to PLWA; and H, PLWHA to PLWH.
➲ Ms. Husted will add insurance premium payment plans to other resources.
➲ Ms. Husted will incorporate references to transgender when referencing discrimination such as homophobia.
➲ Ms. Husted will develop a descriptive paragraph to clarify differences in estimates from the official reported base numbers versus unofficial most likely actual numbers and describe why the estimates are different.
➲ Ms. Husted will check inconsistent numbers for PLWHA who are aware of their status but not in care on page 55, Outreach, sentence 1, 18,800 and page 56, FQHCs, sentence 5, 16,800.
➲ Ms. Husted will replace the reference on page 98, D. Using Data, sentence 2, CDC's Program Evaluation and Monitoring System (PEMS), with the new evaluation system being rolled out by the CDC.
➲ Ms. Husted will clarify distinction of risks for heterosexual and sharing injection paraphernalia, page 40, sentences 1, 2.
➲ Ms. Husted will clarify the proportion of male and female (over 95%) heterosexuals in Table 7, top of page 40.

7. ADJOURNMENT OF JOINT COMMISSION/PPC MEETING: Mr. Johnson adjourned the meeting at 11:30 am in memory of two individuals:

- Nicolas Ward, Robert Sotomayor's partner, who passed away at their home on 4/11/2012.
- Alexis Rivera, 34, who died on 3/28/2012 of complications of AIDS. Ms. Rivera was a 15-year Transgender Community activist including service as Policy Advocate, Transgender Law Center; Founding Member, League of Trans Unified Sisters (LOTUS); Chair, Transgender Service Provider Network; Founding Board Member, Female-to-Male Alliance of Los Angeles; Program Director, Tranny Rockstar, and Case Manager, Children's Hospital Los Angeles; Commissioner, Commission on HIV. She received several awards including the Latino Caucus HIV Prevention Leadership Award and Trans-Unity Spirit and Trailblazer Awards, and was a mother and grandmother.

A. PPC Roll Call (**Present)**: Campbell, Carlos, Copeland, Enfield, Fox, Giugni, Granados, Grant, Green, Gutierrez, King, Rosales, Rumanes, Milton Smith, Watt

9. COMMISSION MEETING CALL TO ORDER: Mr. Johnson called the meeting to order at 12:00 noon.

10. CONSENT CALENDAR:
MOTION 3: Approve the Consent Calendar **(*Passed by Consensus*)**.

11. PUBLIC COMMENT (*Non-Agendized or Follow-up*): There were no comments.

13. COMMISSION/PPC COMMENT (*Non-Agendized or Follow-up*):
- Ms. Mendia announced there would be a Condom Crawl that night starting at 6:00 pm at the Starbucks in downtown Whittier. Some 25 volunteers will go to four or five clubs to distribute condoms and information.
- Mr. Engeran-Cordova reported AIDS Healthcare Foundation (AHF) is sponsoring a 7/22/2012 march, "Keeping the Promise," prior to the XIX International AIDS Conference, 7/22-27/2012. AHF/Southern California will fund some 20 airfare and hotel scholarships for that first weekend. The return flight can be scheduled for after the end of the Conference should a scholarship recipient choose to provide alternate funding for additional hotel days and Conference delegate costs.
- AHF is expanding Out of the Closet Thrift Stores internationally. A store with testing will open 4/29/2012 in Amsterdam.
- ➲ Mr. Engeran-Cordova will provide applications for AHF "Keeping the Promise" march scholarships to Mr. Vincent-Jones. Those interested in scholarships should complete and return applications to Mr. Engeran-Cordova as quickly as possible.

14. CO-CHAIRS' REPORT:

A. Pol/Proc #06.1000: Commission on HIV Bylaws: Mr. Vincent-Jones noted the final Bylaws. Just one phrase was rewritten since Commission approval on 2/9/2012, per the Commission's direction. These are the Commission's governing rules so should be kept and referenced.

15. RYAN WHITE REAUTHORIZATION PRINCIPLES OF 2012:

A. Presentation of RW Reauthorization Principles:
- Mr. Simon noted that the Ryan White legislation should be reauthorized in 2013. It is critical to lead the discussion to ensure RW responds to major changes in the environment such as the Affordable Care Act (ACA) and the National HIV/AIDS Strategy (NHAS).
- The Work Group was created in the winter of 2011 with representatives from the Commission, the PPC, consumers, providers, DHSP, and participants from the Inland Empire. Public comment will close 4/27/2012. Comments will be incorporated for Commission approval at the 5/10/2012 meeting. The final document will be formatted, designed and published with an Executive Summary. Broad dissemination is planned.
- Many political allies are concerned about opening this discussion since funding is a contentious subject in Washington and they hope silence will protect existing funds. The work group feels, however, that without major restructuring many people will find RW irrelevant after ACA implementation and seek to end it. While there may be changes to the ACA before full implementation, the Principles are designed to address moving RW into the future regardless.
- The HIV epidemic has changed since RW was enacted and change will continue with ACA and NHAS. The County is uniquely positioned to respond to the ACA impact on PLWHA due to its experience with the 1115 Waiver.
- Many of the Commission's 2008 Reauthorization Principles have been incorporated in ACA and NHAS, such as coordination of HIV care/prevention/other programs, Early Treatment for HIV Act (ETHA) and portability of care.
- 2012 Principles recommend changes to RW to address NHAS goals of: reducing new HIV infections, increasing access to care/improving health outcomes, reducing health disparities/inequities, coordinated federal response to HIV. There is an emphasis on changes to increase RW effectiveness in meeting NHAS goals, especially coordinated federal response.
- The Principles support 2013 reauthorization with RW redesigned as a safety net consistent with ACA and public health principles that reform the federal response to HIV, close access/care gaps, and supports original RW legislative intent.
- Restructuring how RW resources can be used will allow policy makers to improve cost- and outcome-effectiveness. It will shed no longer useful program requirements while incorporating new components that reflect new/emerging tools and innovations to address treatment/care/prevention needs of people impacted by HIV. It will facilitate more effective ACA implementation and help ensure future federal funding for HIV services. There are eight principles:

1. *Ensure Continuity of Care:* Sizeable populations of PLWH will not be eligible for ACA for documentation or economic reasons. Maintaining continuity of care improves health outcomes and lowers treatment costs.
2. *Fully Integrate HIV Services:* RW can be a blueprint to integrate HIV service planning and delivery, e.g., by combining RW, HRSA, CDC, HOPWA and SAMHSA efforts, just as TLC+/ECHPP already view prevention as treatment. Dismantling "silos" will help prevent HIV transmission and improve access/health outcomes.
3. *Re-Define "Core Medical"/"Wrap-Around":*
   - Originally "wrap-around" services were for access/entry/retention in care, but became synonymous with supportive services in 2006 and now supplement services in other health systems. Under ACA, they will entail services not covered or capped under Medicaid or insurance exchanges, supplement cost-sharing and transitional support services or services to enroll patients in other systems.
   - "Core medical" and "support" definitions will not be as useful to many current clients who may need RW as supplemental, not primary, support. Expand "core medical" to include coordination with medical homes, linkage, transportation, co-payments/premiums, necessary non-formulary medications, capped services.
   - Modify 75% core medical/25% supportive service waiver process and expand "core medical services" to better address NHAS goals with HIV testing in care environments, linkage/care coordination with medical homes, PEP, outreach, retention in care, and benefits support/counseling.
4. *Re-Examine "Last Resort":* This key RW concept has been interpreted inappropriately to prevent the use of RW as supplemental payment sources, and is an obstacle to effective ACA-required changes, e.g., LIHP enrollees with limited formularies are forced out of ADAP or the inability to supplement Medicaid payments inadequate for high HIV care cost.
5. *Treat Basic HIV Care as Primary Care:* The shift to treating HIV with primary, rather than specialty, care is underway. Primary care can address diagnosis, respond to basic care needs and monitor health, but specialty care will still be needed in cases such as resistance and complications. AIDS Education and Treatment Centers (AETCs) must lead and shepherd the transition in all Part A/B areas through education and research.
6. *Restructure the RW Model:* Adjust RW for better efficiency/effectiveness:
   - Maintain Part A structures and resources;
   - Maintain Part B ADAP structure, but use community-based direct service funding in non-Part A jurisdictions with block grant funded community-based services to Part A jurisdictions within Part B areas;
   - Maintain Part C resources and providers, but shift to linkage and outreach and block grant resources to Part A/B jurisdictions;
   - Maintain Part D resources and providers, but allow local jurisdictions to determine WICY need outreach and block grant resources to Part A/B jurisdictions;
   - Maintain Part F AETCs and dental reimbursements;
   - Nationalize ADAP requirements by federalization or establishing formulary/financing/waiting list requirements for portability/equity across states;
   - Allow use of RW resources for surveillance data to identify unmet need and target linkage to care services;
   - Change Part A/B funding cycle from one to three years and use additional funds to stimulate effectiveness.
7. *Maximize Effectiveness:* Use additional RW resources to stimulate and incentivize effectiveness such as:
   - Cost effectiveness by using MOE to stimulate local investment, support for EMR development, resources for service/administration/operational/financing "best practices" and care/prevention integration;
   - Clinical effectiveness by broadening use of RW funds to supplement other ACA systems, rewarding jurisdictions that show increased access to care, rewarding supplemental funding that shows gains in reducing unmet need and increasing early diagnosis/entry into care, and expanding AETC training for primary care;
   - Comparative effectiveness by aligning RW research to help jurisdictions identify/implement most effective care/operational strategies, expanding comparative effectiveness framework to include operational efficiencies, award supplemental funds for more efficient treatment plans/drug regimens that improve outcomes, using RW resources for medical care visit components such as resistance and STD testing.
8. *Support HIV Community Planning:* Community health planning is a core public health function critical to adapt national strategies to local needs. RW should provide sufficient resources, empower bodies with decision-making authority, ensure national and local leadership support, reduce membership requirements and allow adaptation to local needs, support consumer involvement by reducing inequities of their participation.

- Mr. Engeran-Cordova applauded the work, but felt the Parts structure no longer made sense, especially in states such as Mississippi and Alabama where volume may be comparative low while need for resources and information is high.

- He felt it also critical to emphasize oral health care as other resources such as Medicaid are capped at low levels.
- He urged defining RW as a "facilitating act" to coordinate resources from disparate parts of the system to identify and assist people throughout the continuum from testing through to care. It might even assume all testing from the CDC. He suggested adding case studies to show how RW catches people who fall through the cracks and keeps them in care.
- Mr. Vincent-Jones encouraged all to read the full document, e.g., oral health and identifying people throughout the process with testing are stressed, though perhaps not as strongly as Mr. Engeran-Cordova suggested.
- He noted the document does suggest shifting to a primarily Part A/B system, but may do so in too oblique a manner.
- Mr. Land complimented inclusion of co-payments which are a particular problem for people with co-morbidities. He also urged including case studies as understanding of the need for RW has declined since its inception.
- Mr. Pérez agreed with the focus on improving integration of HIV services, but felt it important to distinguish integration within a local system and integration of the broader health service delivery system. These may happen simultaneously or independently. One caveat in deconstructing the Parts structure is identifying how to hold jurisdictions accountable, e.g., how to hold Parts A and F accountable if a jurisdiction does well over all but is not meeting oral health goals.
- RW could also inherit a quality control/quality assurance role, e.g., RW local jurisdictions or grantees could work through the National Quality Center to ensure linkages, Viral Load suppression and retention rates are suitable. This would help ensure providers such as Kaiser Permanente, FQHCs and CHCs meet quality goals.
- Dr. Cadden felt Principles would be compelling for legislators as they emphasize cost efficiencies through ensuring effective care, but felt the argument would be bolstered by providing cost modeling.
- Mr. Chud felt it would be useful to address pharmaceutical company pricing negotiations. Mr. Vincent-Jones stressed that the Principles are designed to apply nationwide whereas ADAP, for example, varies from state to state.
- Dr. Younai noted Part F is dysfunctional nationwide. Each institution has a different formula with neither formulas nor numbers served public. Reimbursement takes two years. Originally it was about 50% of costs, but has dropped to about 35%. She recommended re-assessment. Ms. Watt agreed and added that could be one cause of service gaps.
- Mr. Engeran-Cordova said community planning was important, but Principles should acknowledge disparities among jurisdiction planning bodies in sophistication, capacity and undue provider influence. Mr. Johnson said most know which jurisdictions work. Those that do should be left to bring their local knowledge to bear.
- Ms. White noted not all consumers have internet access so sought a very inclusive dissemination plan.

➲ Mr. Vincent-Jones will work on how to incorporate case studies in a timely manner and review oral health and testing.

➲ Comments on the Principles and recommendations for dissemination should be sent to Mr. Vincent-Jones.

16. STANDING COMMITTEE REPORTS:

A. Standards of Care (SOC) Committee:

1. ***Mental Health Standards of Care***:

- Dr. Younai presented the new Standards integrating prior separate Standards for Psychiatry and Psychotherapy.
- Key themes are: provision of mental health services should be collaborative; "start where the client is"; decisions should be made collaboratively based on needs identified in the Mental Health Assessment; and providers must be experienced, well-trained and knowledgeable about needs of the culturally complex treatment population.
- Standards identify licensed practitioners and their pertinent services: psychiatrists, psychologists, Licensed Clinical Social Workers, Licensed Marriage and Family Therapists (MFT), Nurse Specialists and Practitioners. It also identifies unlicensed practitioners and pertinent services: MFT interns; Psychological assistants, interns; Post-Doctoral Fellows/Trainees; Social Work associates; MFT trainees and Social Work interns.
- Studies support the value of mental health services in improved primary care, utilization, retention and adherence to HAART and ARV. One-third of HIV clients in HIV primary care clinics meet criteria for one or more mental health disorders, but over 40% are not receiving psychiatric care.
- There are three core direct service components:
  - *Mental Health Assessment:* More in-depth than the Medical Care Coordination assessment, this includes presenting mental health problem; mental health treatment, including medications; mental status exam; five axis diagnosis, using most current version of DSM; reassessments as needed, but minimally at 12 months.
  - *Treatment Plans:* Statement of problems, symptoms or behaviors to be addressed in treatment; goals (desired outcomes) and objectives (change); proposed interventions; modalities to address identified problems; frequency/expected duration of services; service referrals.

- *Treatment Provision:* Interventions are described individually: counseling/psychotherapy for individuals, family or couples; group psychotherapy including closed psychotherapy groups, open psychotherapy groups and drop-in groups; psychiatric evaluations, medication monitoring and follow-up.
- Other service components include: documentation/informed consent, crisis intervention, triage/referral/ coordination, case closure, client retention, and case conferences.
- Use of interns, associates and trainees is defined with minimum orientation/training of 24 hours; no assignments projected longer than the internship; required clinical supervision; and termination/transition addressed in assessment. Monitoring and crisis care allowed are telephone contacts, transition groups and crisis counseling.
- Staffing requirements include a minimum of eight CEU hours in mental health in HIV and adherence to ethical standards/guidelines of the American Medical Association/American Psychiatric Association.
- Units of service are defined as units in each of the described categories and the number of clients served.
- Mr. Liso was concerned about caps. Mr. Vega-Matos replied RW has no caps. Healthy Way LA originally considered a cap of eight visits based on literature for an evidence-based intervention that indicates progress should be evident at that point. However, they agreed to remove the cap for the first few years and will instead review cases approaching eight visits with providers. Mr. Vincent-Jones said Standards address service content, not caps, which are more of an allocation issue.
- Public comment was opened until 4/27/2012. Comments can be sent to Mr. Vincent-Jones.

B. Operations Committee: There was no additional discussion.

1. ***Pol/Proc #07.1001: Duty Statement, Commissioner***:
   MOTION 3: Approve Policy/Procedure #07.1001: Duty Statement, Commissioner, as presented **(*Passed as Part of the Consent Calendar*)**.
2. ***Pol/Proc #08.2303: Voting Procedures***:
   MOTION 4: Approve Policy/Procedure #08.2303: Voting Procedures, as presented **(*Passed as Part of the Consent Calendar*)**.
3. ***Pol/Proc #08.3107: Consumer Definitions***:
   MOTION 5: Approve Policy/Procedure #08.3107: Consumer Definitions and Related Rules and Requirements, as presented **(*Passed as Part of the Consent Calendar*)**.
4. ***Pol/Proc #08.3303: Reimbursable Expenses***:
   MOTION 6: Approve Policy/Procedure #08.3303: Reimbursable Commission Expenses, as presented **(*Passed as Part of the Consent Calendar*)**.
5. ***Pol/Proc #09.7201: Consumer Compensation***:
   MOTION 7: Approve Policy/Procedure #09.7201: Compensation for Unaffiliated Consumer Commission Members, as presented **(*Passed as Part of the Consent Calendar*)**.

C. Joint Public Policy (JPP) Committee:

1. ***2012 Legislative Agenda***: Mr. Fox said JPP continues to gather more information on some bills from authors' offices.
2. ***Proposed FY 2012-2013 ADAP Reductions***:
   - The Senate Budget Health Subcommittee rejected the ADAP cost-sharing proposal, but the Assembly Budget Health Subcommittee chose to leave the issue open. They left it open last year as well and rejected it after the May Revise.
   - Ms Bailey and Mr. Vincent-Jones are scheduling a meeting with Assembly Budget Health Subcommittee Chair Holly Mitchell to ensure she is well-informed from her constituents on the issue. There will be further hearings after release of the May Revise.
   - Mr. Engeran-Cordova noted ADAP estimates were grossly inaccurate. He was concerned the Legislature will be surprised at a significantly different number and revisit the cost-sharing proposal to make up the difference.
   - Mr. Fox said the Office of AIDS was grilled at the Assembly hearing on estimates by both Democrats and Republicans. All know numbers were wrong. Additional Commission action may be needed after the May Revise.
   - Mr. Vincent-Jones said the Consumer Caucus would launch a letter-writing campaign for the May revise with a focus on personal stories targeted to Subcommittee Chairs and the Governor.

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

- Mr. Land reported P&P began discussing service priorities at its last meeting and identified several initial rankings. Final rankings should be developed at the 4/24/2012 meeting, after further discussion especially regarding Vision Care.

- Mr. Vincent-Jones thanked DHSP for submitting the Service Utilization Report needed for allocation-setting. It is a difficult and long report that was prioritized for P&P despite a heavy work load of other priorities.

1. ***Pol/Proc #05.4001: HIV Service Definitions***:
   - Definitions for the revised list of 17 HIV service categories will be open for public comment until 4/27/2012. Comments can be sent to Mr. Vincent-Jones.

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

A. HIV Epidemiology Report:

- Dr. Frye, Chief, HIV Epidemiology Division, reported the new Annual Report has been released and is on the website. He will bring some printed copies to the May meeting though the trend is toward electronic copies.
- New tables reflect HIV cases as data is now mature. California data is now in the National HIV/AIDS Surveillance Report.
- HIV Epidemiology is working with STD and TB Programs and Acute Communicable Disease Control on uniform security and confidentiality standards to improve data-sharing. The new supplemental funding FOA is expected by June.

B. Administrative Agency Report:

- Mr. Vega-Matos reported the 5/1/2012 Board Agenda includes an item to approve phase 1 of the oral health expansion. DHSP has begun work on phase 2 which should be ready by late spring or early summer.
- DHSP continues to work closely with the Departments of Health Services (DHS) and Mental Health (DMH) on implementation of Healthy Way LA. The Board has approved the contract negotiated by DHS to handle provision of pharmacy services, a key component. Mental health services are still being finalized.

18. COMMISSION COMMENT:

- Agendize discussion of integration of the Commission and PPC.

19. **ANNOUNCEMENTS**: Mr. Johnson announced that the Consumer Caucus would meet following the Commission meeting.

20. **ADJOURNMENT**: Mr. Johnson adjourned the meeting at 1:45 pm in memory of Alexis Rivera and Nicolas Ward.

A. Roll Call (Present): Aviña, Bailey/Lewis, Ballesteros, Cadden, Engeran-Cordova, Espinoza, Frye, Giugni, Goddard, James, Johnson, Kelly, Kochems, Land, Liso/Chud, Long, Lopez, Mendia, Rivera, Simon, Vega-Matos, Watt, Younai

MOTION AND VOTING SUMMARY		
MOTION 1: Approve the Agenda Order.	***Passed by Consensus***	**MOTION PASSED**
MOTION 2: Approve the Consent Calendar.	***Passed by Consensus***	**MOTION PASSED**
MOTION 3: Approve Policy/Procedure #07.1001: Duty Statement, Commissioner, as presented.	***Passed as Part of the Consent Calendar***	**MOTION PASSED**
MOTION 4: Approve Policy/Procedure #08.2303: Voting Procedures, as presented.	***Passed as Part of the Consent Calendar***	**MOTION PASSED**
MOTION 5: Approve Policy/Procedure #08.3107: Consumer Definitions and Related Rules and Requirements, as presented.	***Passed as Part of the Consent Calendar***	**MOTION PASSED**
MOTION 6: Approve Policy/Procedure #08.3303: Reimbursable Commission Expenses, as presented.	***Passed as Part of the Consent Calendar***	**MOTION PASSED**
MOTION 7: Approve Policy/Procedure #09.7201: Compensation for Unaffiliated Consumer Commission Members, as presented.	***Passed as Part of the Consent Calendar***	**MOTION PASSED**