LOS ANGELES COUNTY COMMISSION ON HIV

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COMMISSION ON HIV
MEETING MINUTES
July 14, 2011

MEMBERS PRESENT	MEMBERS ABSENT	PUBLIC *(cont.)*	OAPP/HIV EPI STAFF
Carla Bailey, *Co-Chair*	Anthony Braswell	Cara O'Connor	Kyle Baker
Michael Johnson, *Co-Chair*	Fredy Ceja	Jose Ramos	Juli-Ann Carlos
Sergio Aviña	Nettie DeAugustine	Daniel Rivas	Julie Cross
Al Ballesteros	Jeffrey Goodman	Sonia Rivera	Mike Jansen
Whitney Engeran-Cordova	Mario Pérez	Tania Rodriguez	Jacqueline Rurangirwa
Douglas Frye		Natalie Sanchez	Dave Young
David Giugni		Anthony Schillaci	
Terry Goddard	**PUBLIC**	Patricia Serna	
Joseph Green	Darrin Aiken	Brigitte Tweddell	**COMMISSION STAFF/CONSULTANTS**
Thelma James	H. Avilez	Jason Wise	
Lee Kochems	Annette Briceno	Maria Zepeda	Erinn Cortez
Bradley Land	Joe Cadden		Dawn McClendon
Ted Liso/James Chud	Monique Center		Jane Nachazel
Anna Long	Zoyla Cruz		Glenda Pinney
Abad Lopez	Bruce Edwards		James Stewart
Elizabeth Mendia	Bill Flores		Diane Tan
Quentin O'Brien	Susan Forrest		Craig Vincent-Jones
Jenny O'Malley	Aaron Fox		Adrianne Wynn
Alberto Orozco/David Kelly	Marie Franins		Nicole Werner
Angélica Palmeros	Shawn Griffin		
Karen Peterson	Tim Hughes		
Juan Rivera	Miki Jackson		
Stephen Simon	Craig Jones		
Robert Sotomayor	Mitchell Katz		
Tonya Washington-Hendricks	Darnell Levingston		
Kathy Watt	Kevin Lewis		
Fariba Younai	Mary Madrigal		

1. **CALL TO ORDER**: Mr. Johnson called the meeting to order at 9:10 am.
   - **A. Roll Call** (**Present**): Ballesteros, Engeran-Cordova, Giugni, Green, Johnson, Land, Liso/Chud, Long, Lopez, Mendia, O'Brien, O'Malley, Orozco/Kelly, Peterson, Rivera, Simon, Sotomayor, Washington-Hendricks

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

3. **APPROVAL OF MEETING MINUTES**:
MOTION 2: Approve minutes from the 6/9/2011 Commission on HIV meeting with Item 16, Bullet 2, Line 2 corrected from "U.S. citizen for five or more years" to "U.S. citizen or legal resident for five or more years" **(*Passed by Consensus*)**.

4. **CONSENT CALENDAR**:
MOTION 3: Approve the Consent Calendar with Motions 4 and 5 pulled **(*Passed by Consensus; 1 Abstention, Motions 7 and 8*)**.

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

6. **PUBLIC COMMENT, NON-AGENDIZED OR FOLLOW-UP**:
- Dr. Madrigal, Substance Abuse Foundation of Long Beach, Minority Health Outpatient Clinic (MHO), said the five-year Substance Abuse and Mental Health Services Administration (SAMHSA) grant is concluding, which will force the clinic's closure in two months without new funding. Dr. Madrigal said she had sought Federal, State and local help without success.
- The three major HIV/AIDS Long Beach providers – City of Long Beach, Harbor UCLA and St. Mary Medical Center CARE Program – all refer clients to MHO and have provided letters of support.
- Ms. Center, a transgendered person, said MHO is the first effective mental health therapy she has found.
- Mr. Jones, USAF Retired, said MHO services exceed those of the Veterans Administration (VA) which will only see him quarterly. With MHO he has addressed his HIV+ diagnosis for the first time in 25 years and has become an advocate.
- Mr. Schillaci, HIV+ since 1989, said he did not know how to live after prison. MHO saved his life after others did not help.
- Ms. Rivera, Latina wife and mother, spoke through a translator. She said many Latinas rely on HMO for individual and group services. Both she and her husband are HIV+. Families depend on HMO services to be normal and active in society.
- Mr. Ramos said he came to MHO in 2006. He was suicidal and homeless after his family rejected him due to addiction. He has now been sober six years, has two jobs, pays taxes, helps others with HIV and has a reason to live.
- Ms. Briceno, staff, has worked at MHO since the start of the grant. Clients have seen such growth that they wanted to donate excess CAB meeting funds to help maintain services rather than hold an event for themselves.
- Mr. Levingston worked on HIV/AIDS in the Oakland community from 1988 until retiring here 18 months ago. A PBS airing of "Bad Blood" prompted his return to the fight. It explores Federal Drug Administration, Red Cross and CDC inaction that facilitated the HIV and hepatitis C epidemics and suggests prevention approaches. He is African-American, heterosexual and HIV-, but has worked across all communities including the gay community. He urged Commissioners to review the DVD.

➲ Mr. Vincent-Jones will link Dr. Madrigal to Long Beach area Commissioners to discuss strategies.

7. **COMMISSION COMMENT, NON-AGENDIZED OR FOLLOW-UP**: Mr. Simon introduced Mr. Edwards, Director, Community Planning, Department of Public Health, City of Chicago. Mr. Edwards appreciated the opportunity to experience another community planning process. He noted Chicago also has separate bodies for care/treatment and prevention, but is discussing how to address the move toward streamlining and welcomes the opportunity to share information with other bodies.

8. **CO-CHAIRS' REPORT**: Mr. Johnson reported Robert Butler has resigned and moved to Palm Springs. He was Co-Chair of the Joint Public Policy (JPP) Committee and the Commission/PPC Integration Task Force and previous Operations Committee Co-Chair. Additional recruitment in the Long Beach area is planned for his successor. Suggestions are welcome.

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

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

11. **OFFICE OF AIDS PROGRAMS AND POLICY (OAPP) REPORT**:

A. **Spatial Cluster Analysis of HIV/STD Disease Burden**:
- Mr. Jansen, Chief, Research and Evaluation, reported on preliminary data they started analyzing six months earlier that will ultimately provide a better understanding of prevention trends, given that arbitrary SPA or census tract boundaries do not explain geographical disease burden differences. A separate study is evaluating the most effective HIV prevention strategies.
- Spatial analysis uses Geographic Information Systems (GIS) with a set of quantitative statistics on numerical-spatial relationships. HIV and STD surveillance and HIV testing data are being used for a clearer picture of disease burden.

- He noted SPA 8 appears to have high overall HIV density. In fact, a 2009 HIV case density map reveals a high density cluster of >42 cases per 2 square miles in the downtown Long Beach area while Palos Verdes has a very low <0.5.
- Planning is also moving toward a syndemic model which focuses on connections among disease co-factors, considers connections in developing policy, and aligns with multiple avenues of social change. This syndemic spatial analysis uses 2009 HIV, syphilis and gonorrhea incidence data. Other co-factors, such as hepatitis, will be added in future.
- 1,858 (91.2%) of the 2,036 HIV cases provided an address. Of those, 1,731 (93.2%) could be geocoded to an exact location and were used in analysis. 127 could be geocoded to zip code mainly due to homeless clients who used cross streets or PO boxes. These were not used in preliminary analysis, but may be incorporated later.
- 2,641 syphilis cases were geocoded by residence. Of these, 39.5% self-reported HIV co-infection and 60.5% reported no HIV co-infection. There were 7,918 gonorrhea cases geocoded by residence with HIV results to be added as available.
- Cluster analysis first determines whether cases are clustered or dispersed. The Average Nearest Neighbor (ANN) statistic calculates the mean distance between cases and compares it to a hypothetical random distribution. All three diseases are strongly clustered, so spatial characteristics are a proven factor in HIV and STD cases.
- Nearest Neighbor Hierarchical Clustering (NNH) is then used to identify and locate clusters. Single-level clusters are large clusters at the County level while multi-level clusters are more specifically identified, e.g., zip code or census tract.
- This analysis uses a minimum 1% of cases to qualify as a cluster and uses single-level analysis for SPA-level planning.
- Preliminary HIV results show seven clusters representing 68.2% of all cases. The Central Cluster represents 42.5%, a high percentage, with other clusters in the South, two towards the East, two towards the Northwest and one far North.
- Clusters for 68.2% of syphilis-HIV co-infection and syphilis without HIV cases are similar. Overlaying the three reveals cluster groups: Central, East, Northwest, South and far North. 83.9% of HIV cases are within 32% of square miles.
- The Central Cluster is relatively small geographically, but represents cases for: HIV, 46.3%; syphilis and HIV, 58.5%; syphilis without HIV, 44.6%; and gonorrhea, 42.1%. Demographically it is similar to the County as a whole.
- The South Cluster represents cases for: HIV, 18.4%; syphilis and HIV, 9.0%; syphilis without HIV, 13.9%; and gonorrhea, 20.4%. It is also demographically similar to the County as a whole.
- The Northwest Cluster, within the San Fernando Valley, represents cases for: HIV, 9.2%; syphilis and HIV, 8.6%; syphilis without HIV, 12.0%; and gonorrhea, 8.0%. Demographically it has a higher proportion of Latinos, at 51.5%, than all but the East cluster.
- The East Cluster, much of the San Gabriel Valley, cases are: HIV, 6.6%; syphilis and HIV, 5.8%; syphilis without HIV, 7.4%; and gonorrhea, 5.5%. It has the highest percentage of Latinos, at 52.0%; African-Americans are 11.5% with a high proportion of those who are women, 58.3%.
- The North Cluster, Lancaster-Palmdale, represents cases for: HIV, 1.3%; syphilis and HIV, 0%; syphilis without HIV, 1.0%; and gonorrhea, 3.0%. Demographically it represents a wide distribution of race and gender.
- Additional spatial factors planned for analysis are meth use, alcohol use, poverty and Community Viral Load (cVL).
- Hot spot analysis identifies income group clusters. Overlaying them with HIV cases reveals correlations with poverty clusters especially in the Central, South and Northwest, but more analysis is needed to clarify its predictive impact.
- CVL is a population-based measure of viral burden. This analysis uses most recent viral load for Ryan White (RW) system clients with viral loads averaged for the mean. Potential biologic indicators of effectiveness are antiretroviral treatment and HIV prevention. CVL data is dispersed, but adding poverty to the equation improves the predictability of clustering, especially along the 110 Fwy.
- Testing and medical outpatient sites align with clusters, but resources are being analyzed. There is a cVL/medical outpatient site correlation with provider variations now being studied to see if they are provider- or population-based.
- Limitations include cases only from 2009, lack of some HIV co-infection data and the assumption that infection occurs within residential clusters rather than, e.g., at a separate location.
- Recommendations are: include multiple years of new and previous cases to address trends; match all HIV cases with STD case data; and use multi-level clustering to identify smaller clusters within the larger ones to pinpoint service need.
- Work continues on spatial regression analysis to identify co-factor contributions to HIV and STD cases in specific areas.
- Mr. O'Brien asked about sexual orientation demographics. Mr. Jansen replied all census data would be used as available. Some data was used from the 2000 census, but 2010 data was not yet available in a downloadable form.
- Ms. Watt noted that while meth use is prevalent, alcohol use is spiking. Mr. Jansen replied it is easier to evaluate the HIV risk of meth use as HIV testing forms only ask if alcohol was used in the last twelve months. Ms. Watt said from about 1994 to 2005, those using meth avoided alcohol as interfering with their high, but now combine meth with vodka and Red Bull. They often use "a couple drinks to get out the door," so asking what it takes to "get out the door" could help. A new trend is to combine meth with GHB, especially troubling as clients cannot remember their activities.

- Mr. Levingston urged review of crack in the African-American community. Mr. Jansen noted data on crack use is collected.
- ➲ Mr. Jansen will review re-introducing GHB to the drug section interview and how to better analyze alcohol use data.

B. Miscellaneous:
- Mr. Baker reported there was still no word on the Part A notice of grant award.
- Mr. Engeran-Cordova noted the FY 2010 RW Part A Certification of Aggregate Administrative Cost shows subcontractors used 5.48% of the allowable 10%. He felt it important to explore reasons, e.g., regulatory limits or agency underspending.
- ➲ Refer 5.48% subcontractor aggregate administrative costs for FY 2010 to P&P Committee for review.

12. HIV EPIDEMIOLOGY PROGRAM (HEP) REPORT:
- Dr. Frye, Director, HEP, noted HEP is helping enhance spatial cluster analysis data by developing more automated and reliable matching of the HIV surveillance with testing and RW care databases. Previous matching has been done on a limited basis.
- About 42,600 HIV and AIDS cases have been reported by name: 35%, white; 21%, African-American; 40%, Hispanic; 3%, Asian; 0.4%, American Indian/Alaskan Native. Some 5,000 cases in the laboratory database are pending investigation. HEP has been unable to convert about 3,200 cases in the coded database to names.
- HEP processes over 100,000 laboratory reports, mostly viral loads, and 100,000 CD4 reports annually for the database.
- Several HEP staff will attend the CDC HIV surveillance workshop in Atlanta the week of 7/18/2011. Work will start in August with the State and San Francisco to migrate the physical eHARS server to Sacramento by the end of the year.
- A large five-month supplement for electronic laboratory reporting to the surveillance award is expected. Due to the short time span, funds will be contracted to SAS Corporation, Atlas and Honeywell. Identified projects are: transition laboratories that now use electronic reporting to HL7 messaging to report all diseases on the same port; build out a restricted access website to view updated matched databases; and improve DPH IT security to facilitate data sharing.

14. PREVENTION PLANNING COMMITTEE (PPC) REPORT:

A. Enhanced Comprehensive HIV Prevention Plan (ECHPP):
- Ms. Rurangirwa, OAPP, reported on the CDC-funded initiative to enhance HIV prevention in 12 Metropolitan Statistical Areas (MSAs) that represent 44% of the epidemic. Grantees are expected to align prevention strategies with NHAS and develop a plan that addresses gaps and better supports strategies with the greatest impact on reducing HIV incidence.
- ECHPP does not replace the community prevention planning process, but is designed to enhance it by incorporating all available DPH resources, those that can be leveraged from other areas and structural interventions for the high risk.
- There are 14 required and 10 recommended strategies. Among required strategies are: routine opt-out testing in clinical settings, testing in non-clinical settings, condom distribution for PLWH and high risk HIV-negatives, PEP, TLC+, access and adherence to ARV, integrated HIV and STD testing, behavioral risk screening and interventions for PLWH.
- Among recommended strategies are: condom distribution for the general population; social marketing; behavioral risk screening and intervention for high risk HIV-negatives; integrated hepatitis, TB and STD testing; partner services; vaccinations; and treatment for PLWH, high risk HIV-negatives and IDUs.
- ECHPP is a two-phase process with the first focused on planning and attention to some local prevention strategy gaps.
- The first phase grant was received at the end of September 2010. Prevention strategy assessment and planning produced an ECHPP draft submitted 2/15/2011. The final plan was submitted 3/15/2011 and approved 5/19/2011.
- The County formed two work groups to inform ECHPP: an internal DPH group with representatives from OAPP, STD Programs, HEP and Health Assessment; and ECHPP Scientific Advisory Committee. PPC Co-Chairs were on both groups.
- The goal was to assess current HIV programs with a focus on syndemic planning and the optimal mix to achieve NHAS goals, including collaboration with RAND Corporation on robust decision-making to choose the best interventions for various populations. Integration of OAPP, STD Programs and HEP was not a result of ECHPP, but facilitated the process.
- Activities targeted for increase are: routine screening in clinical settings, condom distribution, PEP, targeted multiple morbidity screening, enhanced linkage to and retention in care, partner services, adherence counseling and social marketing. Increases or decreases to other activities will be determined by modeling results and syndemic planning. These decisions will be made by the end of the funding year in September 2011.
- ECHPP allowed a streamlined process that resulted in an evidence-based HIV prevention plan tailored to the County.

- Local ECHPP challenges included: a very short timeline; staff to meet the timeline and CDC program requirements, such as work books on all 24 interventions and on goals, objectives, funding sources, data systems and a plan at a glance; connecting ECHPP with local community planning; and coordination with Federal partners to share agency information.
- The County applied for the two-year Phase II with an expected award in September 2011. Meanwhile, the modeling methodology and results are being shared and the Prevention Plan is being refined to align with ECHPP and NHAS.
- Ms. Rurangirwa noted work books are at http://www.publichealth.lacounty.gov/aids/PPCpresentation.htm and the CDC website can be accessed at http://www.cdc.gov/hiv/nhas/echpp/index.htm.
- Mr. Engeran-Cordova asked about ECHPP alignment with the Prevention Plan. Ms. Rurangirwa said ECHPP came first, so is being incorporated. Ms. Watt noted multiple tracks moving at once, e.g., the Commission/PPC Continuum Integration Task Force has been aware of ECHPP while working on TLC+, and the Comprehensive Care Planning Task Force has been aware of it while developing the Comprehensive Care Plan.
- The PPC has stepped back slightly from its timeline to incorporate ECHPP, and the Prevention Planning Guidance is expected soon. The name of the guidance was changed from Community to Prevention Planning Guidance, underscoring the need to include all partners who participate in any way in prevention activities to best leverage resources.
- Ms. Watt added ECHPP differs from the 12 Cities Project in which a Washington DC community education group, UCHAPS and other partners developed The Road to End AIDS 2012 leading up to the 7/22-27/2012 XIX International AIDS Conference in Washington DC. The 12 Cities Project raised funds to pressure partners to meet the NHAS goals.

B. Miscellaneous:

- Ms. Watt reported the CDC Cooperative Agreement funding announcement was released. She urged all to read the FOA, which has strict guidance on matching funds to the epidemic. There is also a 75%/25% funding split: 75% for Testing and Linkage to Care/Treatment Plus (TLC+), evaluation and monitoring, policy work to break down activity barriers, PEP and PrEP; and 25% for Health Education/Risk Reduction (HE/RR) with proven effectiveness for high-risk populations and syringe access.
- The FOA noted a three-year process to shift funds to high need areas to meet National HIV/AIDS Strategy (NHAS) goals. States with low HIV prevalence and incidence will lose funding, but retain a basic allocation to continue prevention work.
- Mr. Giugni noted the PowerPoint in the packet from the PPC colloquia by Dr. Raphael Landovitz, UCLA Center for Clinical AIDS Research and Education, on the NEXT-PrEP study. He suggested it would be a valuable Commission presentation. Ms. Watt noted two more PrEP studies discussed on the CDC website. They were so successful, the studies were halted early.
- Ms. Watt reported the PPC elected Ricky Rosales as Community Co-Chair. He joins continuing Co-Chair Terry Smith.

15. **SPA/DISTRICT REPORTS**: Mr. Aikin said he and Heather Bowlan are the new SPA 6 Co-Chairs. The last meeting agendized remaining work for 2011. Meetings are the second Tuesday of the month, 10:00 am to 12:00 noon, at a new location: Planned Parenthood, 8520 South Broadway, Los Angeles 90003. All are welcome to attend.

16. CAUCUS REPORTS:

A. Latino Caucus: There was no report.

B. Consumer Caucus: Mr. Liso reported the Caucus met 6/23/2011 and would meet following the Commission.

1. ***HIV Services Roundtable***:

- The SPAs 4/5 Roundtable on 6/29/2011 at Plummer Park went very well. Mr. Liso thanked all those who helped.
- The next Roundtable will be for SPA 7, 8/4/2011, 5:30 to 9:00 pm, Belvedere Park, Los Angeles. English and Spanish flyers were distributed by email, included in the packet and on the resource table. Mr. Liso urged everyone to help spread the word. There will be a conference call for additional planning closer to the Roundtable.

2. ***Medical Exemption Requests (MERs)***:

- Mr. Liso noted the letter in the packet to Toby Douglas, Director, California Department of Health Care Services (DHCS) regarding random denial of Medi-Cal managed care exemption requests (MERs).
- Mr. Vincent-Jones noted the randomness appears to be due to a difference between Federal and State definitions.

3. ***Pol. #08.1306: Adherence to HIPAA Principles***:

- Mr. Johnson noted the policy was revised per Commission comments and was in the packet.

- Mr. Vincent-Jones noted if a consent calendar is used, then all action motions are included on it. Agendas go out 72 hours in advance and orientation discusses the consent calendar. People may pull items at the meeting or call staff to pull an item prior to the meeting. He added that the Commission decided to use a consent calendar and could similarly suspend its use.

➲ Staff will update the Commissioner contact list and distribute it subsequently.

MOTION 4: Approve revisions to Policy/Procedure #08.1306 [Adherence to the Principles of the Health Insurance Portability and Accountability Act (HIPAA)], as presented **(*Passed by Consensus*)**.

17. STANDING COMMITTEE REPORTS:

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

1. ***FY 2012 Priority- and Allocation-Setting (P-and-A)***: Next meetings will be 7/19/2011 and 7/26/2011, 1:30 to 4:30 pm.
2. ***FY 2010 Financial Expenditure Reports***: Mr. Ballesteros reported Mr. Young, Chief, Financial Services, OAPP, presented on Expenditure and Annual Reports. Materials were in the packet. There will be a Commission presentation 8/11/2011.
3. ***FY 2008-2010 Annual Reports***: There was no additional discussion.

B. Standards of Care (SOC) Committee:

1. ***Housing Case Management Standard of Care***:
   - Dr. Younai reported the one comment submitted was to change the name of the service category to Housing Specialty due to confusion among clients with Psychosocial Case Management and consistency with the Los Angeles Housing Department.
   - The Co-Chairs felt the name should remain as proposed since Psychosocial Case Management is transitioning to Medical Care Coordination and use of case management terminology is used throughout the standards.
   - The decision can be revisited by the full Committee if the Commission has serious objections.

   MOTION 5: Approve the Housing Case Management Standard of Care, as presented **(*Passed by Consensus*)**.
2. ***Medication Assistance/Access Standard of Care***: There was no discussion.
   MOTION 6: Approve the Medication Assistance and Access Standard of Care, as presented **(*Passed as part of the Consent Calendar*)**.
3. ***Pol. #05.8001: Grievance Process***: Public comment was opened until 8/31/2011.
4. ***Standards of Care Publication***: Work is on track for finalization by the end of summer.
5. ***Evaluation of Service Effectiveness (ESE)***: Work is ongoing.

C. Joint Public Policy (JPP) Committee:

1. ***AB 1300 (Blumenfield): Medical Marijuana***: Mr. Simon reported JPP voted to change its position from support to oppose as the language that defined a collective was removed. That language would have made it easier for local jurisdictions to enforce appropriate regulations. Removing it leaves language vague and subject to onerous regulation.
   MOTION 7: Oppose AB 1300: Medical Marijuana (Blumenfield), and forward recommended position to the CEO, Board of Supervisors and relevant departments **(*Passed as part of the Consent Calendar; 1 Abstention*)**.
2. ***SB 531 (Rubio): Search Warrants: HIV Testing***: JPP voted to change its position from support to removal from the docket. The bill maintained a court order for testing, but changed the time for it from 72 to 48 hours for consistency with Federal law. The bill has since died and JPP felt it both unnecessary to maintain it on the docket and possibly confusing as some had mistakenly thought it removed the requirement for a court order thereby criminalizing HIV.
   MOTION 8: Remove support for SB 531: Search Warrants: HIV Testing (Rubio), and remove from legislative docket **(*Passed as part of the Consent Calendar; 1 Abstention*)**.
3. ***State FY 2011-2012 Budget***: Mr. Simon noted no significant changes in the budget signed by Governor Brown. A summary of budget areas pertinent to HIV can be viewed at www.jerry.davila@lacity.org.
4. ***Ryan White Reauthorization 2013***: This work group to develop principles for the next reauthorization meets the fourth Wednesday, 11:00 am to 1:00 pm, prior to the JPP meeting. All are invited. Recent new participants to expand representation are Joe Acosta, former co-chair of the Inland Empire HIV Planning Council; Doris Wahl, Founder, Whittier Rio Hondo AIDS Project; and a representative form the Desert AIDS Project.

D. Operations Committee:

1. ***Membership Renewals***: Ms. O'Malley noted the packet reminder for those in seats with expiring terms to submit their renewal applications if they intend to continue serving on the Commission.

2. ***Community Membership Nomination***:
   MOTION 9: Nominate Aaron Fox as a PPC representative community member to the Joint Public Policy (JPP) Committee and forward to the Board of Supervisors for appointment **(*Passed as part of the Consent Calendar*)**.
3. ***Commission Membership Nominations***:
   MOTION 10: Nominate Carlos Vega-Matos and Kevin Lewis to the Part B representative seat and the District 2 Consumer representative, Alternate seat, respectively, and forward to the Board of Supervisors for appointment **(*Passed as part of the Consent Calendar*)**.
4. ***Pol. #09.4203: Membership Applications***:
   MOTION 11: Approve Policy/Procedure #09.4203 (Commission Membership Applications), as presented **(*Passed as part of the Consent Calendar*)**.
5. ***Pol. #09.1007: Community Member Appointments***: This was opened for public comment until 7/31/2011.
6. ***Commission New Member Orientation***: The next Orientation will follow the 8/11/2011 Commission, 2:00 to 4:00 pm.

18. TASK FORCE REPORTS:

A. Community Task Forces: There were no reports.

B. Comprehensive Care Planning Task Force (CCP TF): The last meeting was cancelled, but work continues slightly ahead of schedule. Ms. Watt noted it is clear from meetings, such as the PPC and the Integration Task Force, that collaborative planning is developing organically. The next meeting will be 7/26/2011, 9:30 to 11:30 am.

C. Commission/PPC Integration Task Force (CPI TF):

1. ***Testing and Linkage to Care/Treatment Plus (TLC+)***: Ms. Watt reported the Task Force has worked through a large document identifying activities related to testing, linkage to care and prevention including the impact of ECHPP and requirements of the new CDC FOA. Work has begun on similarly identifying care and treatment activities. The activities spreadsheet should be done in about two months. The spreadsheet will facilitate a Commission presentation including an assessment of existing service integration.

D. Health Care Reform Task Force (HCR TF):

1. ***Brief: Health Care Reform Implementation***: The brief was in the packet.
2. ***Brief: FY 2012 P-and-A Setting Guidance***: This brief will be distributed by email by 7/16/2011 so P&P can use it for FY 2012 Priority- and Allocation-Setting.
3. ***Low Income Health Programs (LIHPs)***:
   - Ms. Cross, Consultant, OAPP, presented an 1115 Waiver activities update including LIHPs and Medi-Cal migration.
   - The Master 1115 Waiver renewal for California by the Centers for Medicare and Medicaid Services (CMS) in November 2010 was designed as a bridge to full health care reform in 2014 by improving the safety net provider network, improving coordination of care for vulnerable populations, and expanding coverage for uninsured adults.
   - The two key impacts on PLWH are migration of Medi-Cal eligible people into managed care systems and the LIHPs.
   - Current Medi-Cal eligible Seniors and Persons with Disabilities (SPDs) are required to enroll in Medi-Cal managed care as of their birth month as of 6/1/2011.
   - There are several exceptions to mandatory enrollment. The most common for PLWH are those dually eligible for Medi-Cal and Medicare coverage and those with a Medi-Cal share-of-cost. People may also choose to enroll.
   - Medi-Cal has partnered with Health Care Options, which will help clients understand the process through materials and follow-up phone calls. Los Angeles County has a basic two-plan model through LA Care and Health Net, but also has some special needs plans, such as AIDS Healthcare Foundation (AHF), AltaMed and SCAN.
   - Submitting a Medi-Cal Exemption Request (MER) is one way to avert enrollment into Medi-Cal managed care. A client's physician completes a form that confirms a complicated, high-cost condition making managed care inappropriate. It can be extended. Medi-Cal law states HIV qualifies a client for MER, but a secondary Medi-Cal rule requires Medi-Cal nurses to establish if a client if a client is not medically stable enough for managed care. Advocates are working to ensure Medi-Cal follows the law. People should continue to file MERs.
   - The Continuity of Care Request is an alternate procedure in which a client's provider coordinates with a managed care company to contract for the care. This is a more complex process, so MER is likely to be more practical.
   - The Project Inform fact sheet in the packet is also on its website at www.projectinform.org. Health Care Options forms and marketing materials are at http://www.healthcareoptions.dhcs.ca.gov/HCOCSP/Home/default.aspx.
   - LIHPs are health initiatives designed to help counties identify their uninsured and get them into care prior to 2014.

- Medicaid Coverage Expansion (MCE) is for those with income equal to or less than 133% of Federal Poverty Level (FPL) and Health Care Coverage Initiative (HCCI) is for those at 134%-200% FPL. Both are funded by 50% county and 50% matching Federal funds for 19- to 65-year-old legal residents not otherwise eligible for coverage.
- Twenty-four counties applied for LIHPs including Los Angeles via Healthy Way LA (HWLA). Pasadena also applied.
- LIHPs provide comprehensive coverage including outpatient, inpatient and medications and require demonstrated access. HWLA will begin with the MCE population and may expand to HCCI next year if feasible.
- Many served by RW are also LIHP populations, but HIV advocates were not allowed to join the 1115 Waiver stakeholder planning group. Counties did not expect to cover PLWH, so RW funding issues were not considered.
- HRSA, however, asserts LIHPs should cover PLWH as RW is funding of last resort. Advocacy is ongoing, including with HRSA, CMS and the Office of National AIDS Policy (ONAP). Counties did not budget for the PLWH population and most assert they would have to lower the LIHP income level to serve that population or go bankrupt.
- HWLA and OAPP meet weekly. The California HIV Alliance met with DHCS and OA resulting in a 7/12/2011 letter to DHCS to halt PLWH enrollment pending issue resolution. Two possible strategies are to carve PLWH out of the LIHP or ask California to pursue a separate, HIV-specific 1115 Waiver allowing uninsured PLWH to enroll in full Medi-Cal.
- Mr. Land expressed concern about gaps in care during enrollment processes for various programs. He added that materials have become so complicated he can barely understand his Medi-Cal Explanation of Benefits.
- Mr. Engeran-Cordova noted LIHPs are a key issue due to the significant RW-LIHP population overlap. He suggested RW might be considered as a PLWH LIHP since it is designated as "payer of last resort." Ms. Cross noted many barriers to that including the LIHP requirement for county expenditures and HRSA statutory rules, so it is unlikely.
- Mr. Johnson noted current LIHPs rely heavily on Federally Qualified Health Centers (FQHCs) and look-alikes, while the RW system does not. Ms. Cross said the idea of a second 1115 Waiver to move PLWH into full Medi-Cal would avert addressing that issue, but it is a complicated process and Sacramento said it lacks staff and resources to develop the application.
- Dr. Younai asked about Oral Health as part of specialty services especially as Denti-Cal still pays for extractions, but most providers require co-pays. Ms. Cross said the issue has not been raised in a meaningful way.
- Mr. Sotomayor asked about wait lists. Ms. Cross said they are included as a possibility since LIHP funds are limited. That is part of the discussion about PLWH coverage as their more expensive care could limit availability for others.
- Mr. Liso expressed concern that LIHP is expanding services now with 50% county and 50% matching Federal funds, but funding to maintain continuity of care after 2014 may not be assured and that patients may not be able to assume share-of-cost. Ms. Cross replied in 2014 people will move into the Medicaid expansion or insurance. There is a proposal for Federal Medicaid expansion reimbursement higher than that for the LIHP for the first few years.

19. PUBLIC HEALTH/HEALTH CARE AGENCY REPORTS:

A. Department of Health Services (DHS):

- Mr. Johnson introduced Dr. Katz, Director, DHS. He was Director, Department of Public Health, San Francisco, for 13 years where he pioneered the first attempt at universal health care and implemented significant housing improvements.
- Dr. Katz said he began in the field in 1983 as a co-founder of the Boston AIDS Action Committee. His experience with the epidemic was a large part of why he chose San Francisco for his training and has continued to work as a clinician.
- He believes there are tremendous opportunities to improve the Los Angeles system of care for everyone. It is a large system with many great people, but with some problems, especially in being client-friendly, e.g., centers are not inviting, signage is poor, staff does not greet people warmly and there are long waits for established appointments. Changes are happening such as elimination of block appointments (all patients told to come at 9:00 am and then wait).
- What has been lost is a palpable sense of mission that taking care of people is a wonderful way of life.
- There are questions about how best to integrate care for PLWH into health care reform. The goal is to maximize Federal funds for best possible care for all regardless of pre-existing condition, income, immigration or insurance status. He has no set approaches, and noted that HIV advocates have excelled at active participation and overcoming beaurocratic hurdles.
- DHS will face a funding challenge if eligible PLWH are required to enroll in LIHPs and cannot receive ADAP, but the challenge will be met to ensure correct care including medications. Dr. Katz also noted that RW funding will need to continue meeting the needs of the undocumented and supportive services not offered under Medicaid.
- Mr. Johnson noted RW and LIHPs systems are very different, which makes it hard to integrate them where appropriate. Dr. Katz said the payer should be invisible to the consumer. Care should meet consumer needs. Paying for it is separate, e.g., LIHP 340B pricing excludes commercial pharmacies, but a pharmacy benefit management system is possible.

- Dr. Katz noted LIHP is a transition to 2014 when that population will move to Medi-Cal which includes medication. Medi-Cal will also cost counties less, since the LIHPs only provide a 50% match for county expenditures.
- Mr. Land asked about Dr. Katz's article regarding the shift from specialty to primary care for PLWH. Dr. Katz said he considers himself a primary care physician though certified in HIV care. He wrote to address changes in his practice.
- His key concern five or six years ago was a regimen that suppressed HIV. He did a lot of resistance testing and consulted specialists on regimens. Now most patients are fully suppressed if adherent. Instead, issues are those he studied in residency such as hypertension, elevated cholesterol and heart problems. Some specialists he has worked with are not as conversant in such issues. He was reflecting this shift in the need for HIV-experienced physicians who are generalists.
- Dr. Younai asked about the earlier suggestion for a second HIV-specific 1115 Waiver. Dr. Katz said it was a good idea, but LIHP only runs to 2014 so it would be very hard to move through the process that quickly. He noted it is best to consistently build health systems, so it would have been better overall to expand Medi-Cal with a county contribution.
- Mr. Engeran-Cordova asked about a LIHP carve-out of PLWH. Dr. Katz said it would be preferable, but CMS seems averse consistent with their approach to Medicaid albeit that is a full system. DHS must be prepared for a Plan B.
- Mr. Ballesteros expressed concern regarding gay, bisexual and transgender high HIV-risk populations. Primary care is one of the best means of prevention, but FQHCs and look-alikes have traditionally not served those populations. He suggested developing a better nexus for outreach. Ms. Watt added there is some incentive in the LGBT communities to become HIV+ or purchase an HIV+ test result in order to get health care as access to other healthcare is so poor.
- She added she has been a contractor with Substance Abuse Prevention and Control (SAPC) for 25 years and has found ongoing rampant homophobia. Dr. Katz noted SAPC is under his sister department, DPH, but he will engage where he can. He has already spoken to them about the lack of methadone maintenance, except for those with Medi-Cal. Ms. Mendia added there is also a need to foster sex-positive interventions as she has found social marketing sexaphobic.
- Ms. Jackson urged Dr. Katz to help providers strategize together better to meet challenges. He will consider options.
- Ms. O'Malley said that as a nurse she finds clients consistently face discrimination based on sexual orientation and diagnosis. The transition makes access to quality care harder. Dr. Katz agreed "poverty medicine" that places convenience before the consumer is a universal problem. He is working to learn and improve DHS.
- Ms. James urged more physician training for aging PLWH. Addicts trying to stay sober can relapse when physicians are unfamiliar with issues such as bone decay. Dr. Katz said there is some research, but aging itself is under-addressed. He advised aging clients to be alert to a possibly better regimen and to share tips, e.g., taking a medication with water.
- Mr. Vincent-Jones asked Dr. Katz how he envisioned the future of RW. Dr. Katz felt advocacy would keep RW alive, but at lower funding levels. Health care reform will reduce the RW patient population by half. Advocacy will be needed to maintain RW for the other half not covered in Health Care Reform.
- A major challenge will be Disproportionate Share Hospital (DSH) Federal program adjustments. DSH funds help urban public hospitals serve the poor, but will decline in 2014 as the Medicaid population increases. County hospitals must offer care that attracts Medi-Cal clients or only high risk, uninsured populations will remain without necessary funds.
- Mr. Land said the Commission has worked to address access, e.g., via Medical Care Coordination development. He suggested closer cooperation with DHS. Dr. Katz was especially interested in Consumer Caucus input on DHS services, and asked the Caucus to further dialogue with him about how to improve DHS access and service delivery.

20. HEALTH CARE/BRIDGE TO REFORM DISCUSSION: There was no additional discussion.

21. **COMMISSION COMMENT**: There were no comments.

22. **ANNOUNCEMENTS**: Mr. Wise introduced "Making It Count: California's Names-Based HIV Reporting System," a report by AIDS Project Los Angeles and the UCLA Center for HIV Identification, Prevention and Treatment Services (CHIPTS) funded through the California HIV/AIDS Research Program (CHRP). The report finds most PLWH in care or tested in California are in the case registry system and offers suggestions for continued improvements.

23. **ADJOURNMENT**: Mr. Johnson adjourned the meeting at 2:00 pm.

A. In Memory of Suzi Rodriguez and Jean Harris:

- Mr. Ballesteros said Ms. Rodriguez was the first Co-Chair of the Los Angeles HIV Health Services Planning Council, a substance abuse treatment and health care advocate and AIDS activist. A Latina from East Los Angeles, she fought for equal funding across the County and for national services as a CAEAR Coalition member. She co-founded the Los

Angeles County HIV Drug and Alcohol Task Force and worked with people from all backgrounds. A celebration of her life was planned for 7/19/2011, 6:00 pm, at Tamayo's Restaurant in East Los Angeles.

- Mr. Engeran-Cordova said Ms. Harris was a passionate advocate in the LGBT community in Long Beach and statewide. Dr. Katz added that Ms. Harris helped with needle exchange in San Francisco under Mayor Frank Jordan.

B. Roll Call (**Present)**: Aviña, Bailey, Ballesteros, Engeran-Cordova, Giugni, Goddard, Green, James, Johnson, Kochems, Land, Liso, Long, Lopez, Mendia, O'Brien, O'Malley, Orozco/Kelly, Peterson, Rivera, Sotomayor, Washington-Hendricks, Watt, Younai

MOTION AND VOTING SUMMARY		
MOTION 1: Approve the Agenda Order.	***Passed by Consensus***	**MOTION PASSED**
MOTION 2: Approve minutes from the 6/9/2011 Commission on HIV meeting with Item 16, Bullet 2, Line 2 corrected from "U.S. citizen for five or more years" to "U.S. citizen or legal resident for five or more years."	***Passed by Consensus***	**MOTION PASSED**
MOTION 3: Approve the Consent Calendar with Motions 4 and 5 pulled.	***Passed by Consensus*** ***Abstention:*** Long, Motions 7 and 8	**MOTION PASSED** **Abstention**: 1, Motions 7 and 8
MOTION 4: Approve revisions to Policy/Procedure #08.1306 [Adherence to the Principles of the Health Insurance Portability and Accountability Act (HIPAA)], as presented.	***Passed by Consensus***	**MOTION PASSED**
MOTION 5: Approve the Housing Case Management Standard of Care, as presented.	***Passed by Consensus***	**MOTION PASSED**
MOTION 6: Approve the Medication Assistance and Access Standard of Care, as presented.	***Passed as part of the Consent Calendar***	**MOTION PASSED**
MOTION 7: Oppose AB 1300: Medical Marijuana (Blumenfield), and forward recommended position to the CEO, Board of Supervisors and relevant departments.	***Passed as part of the Consent Calendar*** ***Abstention:*** Long	**MOTION PASSED** **Abstention**: 1
MOTION 8: Remove support for SB 531: Search Warrants: HIV Testing (Rubio), and remove from legislative docket.	***Passed as part of the Consent Calendar*** ***Abstention:*** Long	**MOTION PASSED** **Abstention**: 1
MOTION 9: Nominate Aaron Fox as a PPC representative community member to the Joint Public Policy (JPP) Committee and forward to the Board of Supervisors for appointment.	***Passed as part of the Consent Calendar***	**MOTION PASSED**
MOTION 10: Nominate Carlos Vega-Matos and Kevin Lewis to the Part B representative seat and the District 2 Consumer representative, Alternate seat, respectively, and forward to the Board of Supervisors for appointment.	***Passed as part of the Consent Calendar***	**MOTION PASSED**
MOTION 11: Approve Policy/Procedure #09.4203 (Commission Membership Applications), as presented.	***Passed as part of the Consent Calendar***	**MOTION PASSED**