LOS ANGELES COUNTY
COMMISSION ON HIV

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STANDARDS AND BEST PRACTICES (SBP) COMMITTEE MEETING MINUTES

September 6, 2018

MEMBERS PRESENT	MEMBERS ABSENT	PUBLIC	COMM STAFF/ CONSULTANTS
Joseph Cadden, MD, *Co-Chair*	David Lee, MD	Jason Brown	Cheryl Barrit, MPIA
Ace Robinson, MPH, *Co-Chair*	Jazielle Newsome	Tobias Brown, RN	Jane Nachazel
Erika Davies		Amy Croft	Doris Reed
Wendy Garland, MPH	**DHSP STAFF**	Noah Kaplan, LCSW	Julie Tolentino, MPH
Bradley Land	Lisa Klein	Andre Molette	
Kevin Stalter		Shirell Wooten	

CONTENTS OF COMMITTEE PACKET

1) **Agenda**: Standards and Best Practices (SBP) Committee Meeting Agenda, *9/6/2018*
2) **Minutes**: Standards and Best Practices (SBP) Committee Meeting Minutes, *8/2/2018*
3) **Press Release**: New CDC analysis shows steep and sustained increases in STDs in recent years, *8/28/2018*
4) **Public Comments**: Los Angeles County, Commission on HIV, Standards and Best Practices Committee, Medical Care Coordination (MCC) Services Standards, Reviewer/Public Comments, *9/4/2018*
5) **Comments**: Commission on HIV Question: Mental Health vs. Behavioral Health, *8/16/2018*
6) **L.A. Care Health Plan**: Behavioral Health Services, *2018*
7) **Standards**: Los Angeles County Commission on HIV, Medical Care Coordination Services Standards of Care, *Draft 9/6/2018*

CALL TO ORDER: Mr. Robinson called the meeting to order at 10:10 am.

I. ADMINISTRATIVE MATTERS

1. **APPROVAL OF AGENDA**:
MOTION #1: Approve the Agenda Order, as presented ***(Passed by Consensus)***.

2. **APPROVAL OF MEETING MINUTES**:
MOTION #2: Approve the 8/2/2018 Standards and Best Practices (SBP) Committee Meeting Minutes, as presented ***(Passed by Consensus)***.

II. PUBLIC COMMENT

3. **OPPORTUNITY FOR PUBLIC TO ADDRESS COMMISSION ON ITEMS OF INTEREST WITHIN COMMISSION JURISDICTION**: There were no comments.

III. COMMITTEE COMMENT

4. **NON-AGENDIZED OR FOLLOW-UP**: There were no comments.

IV. REPORTS

5. **EXECUTIVE DIRECTOR/STAFF REPORT**:
   a. **Vaccine Coverage Survey Project**:
      - Ms. Barrit noted Franklin D. Pratt, MD, MPHTM, FACEP, Medical Director, Vaccine Preventable Disease Control (VPDC) Program, Department of Public Health (DPH) has been regularly attending full Commission and SBP Committee meetings to provide updates on VPDC efforts, DPH alerts, and outbreaks. VPDC continues outreach to different stakeholders, including PLWH and MSM, to better target health education and programming to different communities.
      - Dr. Pratt introduced a VPDC vaccine portfolio at SBP with a menu of vaccines recommended for adults customized for some populations including PLWH and MSM. Historically, childhood immunization has been emphasized with tracking and verification, e.g., through schools, but urgency fades with age. The portfolio is meant to normalize ongoing care.
      - Part of the project is a series of surveys to inform best practices and clinical support for medical providers to promote vaccines to adults. Dr. Pratt and his team are currently working on a draft "Vaccine Coverage Survey" for a targeted group of providers. It still needs to go through the Institutional Review Board (IRB) process.
      - Meanwhile, Ms. Barrit and Ms. Tolentino reviewed the survey and met with the VPDC team to provide feedback on 9/5/2018. Core aspects of their review were: whether the survey makes sense to providers; how data will be used; will data be useful for Commission interests; and its usefulness for the public health infrastructure and communities at risk.
      - VPDC has revised the questions. Ms. Barrit suggested forwarding the revision to the Co-Chairs; and Commissioners Martin Sattah, MD, who works with the community; and Lee Kochems, MA, who has an anthropologist background.
      - ➲ Ms. Barrit has asked Dr. Pratt to keep SBP updated on the survey and present on results to the Commission.
      - ➲ Mr. Stalter suggested Commission Co-Chairs thank Dr. Pratt for his Commission outreach when they introduce him.

6. **CO-CHAIR REPORT**:
   - Mr. Robinson was prompted by Mr. Land's discussion of issues for PLWH over 40 to explore best practices for that population. He had an opportunity to shadow Kaiser Permanente co-morbidity program staff, e.g., reflecting the need for increased rectal screenings to catch precancerous lesions. That is also related to the vaccination discussion regarding HPV.
   - To get ahead of trends, it is important to be responsive to the fact that the majority of PLWH in the United States are now over 45. The United States Conference on AIDS is acknowledging this trend and hosting a preconference on HIV and aging.
   - Kaiser Permanente has also updated their PrEP guidelines to include those who weigh equal to or greater than 77 pounds. Normalizing public health messaging of PrEP and Undetectable Equals Untransmittable (U=U) is key to meeting goals.

V. DISCUSSION ITEMS

7. **MEDICAL CARE COORDINATION (MCC) STANDARDS**:
   - Ms. Tolentino emailed all MCC teams to request Standards feedback. Ms. Garland asked people to consider what makes sense to include in Standards versus operationalization activities within DHSP purview, e.g., minimum frequencies should make sense for assessment, acuity determination, and care plans. Some comments are mixed, but DHSP will track all comments and try to provide more clarity around items raised when guidelines are next updated.
   - Attendees discussed 8/2/2018 SBP meeting comments on whether both the Registered Nurse (RN) and Case Worker (CW) should be present for initial assessment. Ms. Garland said the MCC team concept is collaborative, but there can be issues operationalizing it. Dr. Cadden, Medical Director, Rand Schrader Clinic said this is one of two key roadblocks to a successful program. Tobias Brown added he was the only Medical Care Manger (MCM) at a clinic for a new team making it very hard.
   - Ms. Garland said the strong emphasis on collaboration is based on DHSP's experience with MCC's precursor, Medical Case Management. While not explicitly stated, assessments were to be done together by a case manager and nurse, but the program was siloed resulting in both overlap and contradictions between psychosocial and medical aspects. Monitoring showed zero communication between the aspects and no coordination or integration for the client.
   - Dr. Cadden pointed out everything stops when complete teams are unavailable. Social Work received the Rand Schrader Clinic MCC grant, but program design excludes the Medical Director and Nurse Manager so coordination is poor. Nursing is in its own silo at Rand Schrader Clinic and the Nurse Manager refuses to report to Social Work. He suggested a methodology under which they compare notes, but not necessarily at the same time. Several noted flexibility is required.

- Dr. Cadden also felt it was a key mistake to allow entry level individuals to deal with complex patients but, as it is, he said the position should be promotable to Licensed Clinical Social Worker (LCSW) so staff does not promote out of the team.
- Ms. Garland offered her perspective as someone who helped develop MCC and some historical context but, ultimately, Standards are the creation of SBP. Mr. Land hears site visit feedback that DHSP program managers are somewhat inflexible and refer questions back to the Standards. That is appropriate, but SBP may need to adjust Standards to accommodate MCC team variances when the collaborative ideal is not feasible. More flexibility may also improve patient follow-up.
- He also expressed concern over physician exclusion from MCC team interaction. They should be able to follow-up.
- Dr. Cadden would like a DHSP program manager for an MCC team to be able to ask the social work director and perhaps the medical and nursing directors about key roadblocks and work with them to develop options.
- Mr. Stalter had multiple staffing concerns: high vacancies; pay sufficient to retain cohesive teams; and degree requirements versus the best person for the position. For example, an agency recently hired a transgender woman to run their MCC team for transgender persons and the population responded in numbers because people prefer to talk to someone like them.
- Ms. Garland noted MCC launched in agencies contracted for Ambulatory Outpatient Medical (AOM). The upcoming MCC Requests For Proposals (RFP) process offers an opportunity to address issues via DHSP and contracted agency negotiations. A core challenge is that the agencies all have different clinic flows and ways of operating so it is hard to craft one approach.
- Dr. Cadden recommended crafting a two-phase Standards: 1. List an ideal complement of staff performing specified functions to achieve identified outcomes. 2. Some provider sites may be unable to meet those particulars but, with appropriate supervision and demonstrable educational experience, may be granted permission to fill in behind prescribed positions to obtain the necessary outcomes. His clinic has never had three full MCC teams for more than a week.
- Mr. Kaplan agreed turnover was high. Los Angeles County (LAC) has increased RN and Master of Social Work (MSW) salaries to community standards, but in exit interviews staff express not feeling free to perform per their education and experience. Everything is very prescribed, e.g., each patient communication must be tracked. Medical providers, including physicians, do not want to deal with MCC due to its complexity, e.g., even knowing whether or not someone is enrolled is complex.
- Mr. Robinson, on the other hand, has built two MCC teams that have remained intact for over a year. Organizations vary.
- Attendees extensively discussed Mr. Kaplan's recommendation to update language from "retention" to "engaged." A community sense is growing that the latter better embodies the ultimate goal of engaging patients in all aspects of their own care in order to better self-manage. "Retention," on the other hand, reflects a sense of confinement.
- On a related matter, retention specialists are now proscribed from working with clients unless they are lost to follow-up or staff cannot contact them. The MCC nurse, social worker, and case worker positions lack field capability so are proscribed from helping a currently enrolled client at risk of being lost to care with, e.g., going to the food bank or the Department of Public Social Services (DPSS). Clients can fall through this gap between definitions for the various positions.
- Mr. Kaplan added another issue is re-assessment requirements. Rigid set windows are based on acuity rather than allowing teams to re-assess based on need. A full 2.5 hour re-assessment is required if the window is missed by as little as one day. That both takes time from services and patients may drop MCC to avoid it which then locks staff out of Casewatch.
- Ms. Garland urged being judicious in separating issues with operationalizing Standards from the Standards themselves. An appendix can be added with additional resources for the various areas including strength-based assessment questions. Mr. Kaplan agreed and supports tracking outcomes, but suggested Standards should ensure they not interfere with services.
- Perhaps more pertinent to guidelines, he also suggested replacing the rather intrusive re-assessment questions on sexual behavior with questions about sexual health, pleasure, or what sex means to them for a more client-centered approach. Mr. Stalter said this topic was also raised in the Commission report on three men of color who did agency secret shopping for HIV tests. He had asked them if the sexual behavior questions were consistent across agencies, were delivered in a nonjudgmental way, and appeared to have a purpose besides invading their private lives. The questions failed on all counts.
- He would like to see questions. His agency developed written questions to ensure only needed information was requested. Questions should be nonjudgmental and as few as possible to avoid shaming clients so they are more likely to be honest. Tobias Brown preferred to tailor questions to clients, but Mr. Kaplan felt less experienced staff need more guidance.
- Finally, Mr. Kaplan noted clients are screened twice a year for MCC. The process for enrolling clients between those two times is lengthy and challenging. He urged trusting MCC teams to enroll clients due to changes, e.g., becoming homeless.
- Ms. Garland said the screener was developed to meet the Standards' goal of ensuring everyone in the clinic had some level of MCC while targeting those with the greatest needs. A full assessment for everyone was not feasible so a population health approach screens for clients with sentinel issues that indicate a need for more services, i.e., clients not virally suppressed, with a recent STD, and with no recent medical appointment. It should not be a barrier to increasing services.

- Mr. Stalter pointed out risk behaviors have changed. He recently saw a different physician who was very nonjudgmental, but asked what percentage of time he used a condom. He replied he has sorted for the last eight years instead and takes into account if partners are in treatment and on PrEP. "Safe sex" today is different from 10 years ago.
- Ms. Garland noted revised questions were drafted a year or two ago. They ask if the person has had any sexual partners in the last six months and then what percentage of time the person used condoms on a scale of 1-100. However, some determinations of what risk is have changed in that time, e.g., whether partners are virally suppressed and/or use PrEP.
- Mr. Kaplan urged expanding guidelines to allow a nurse or social worker to make referrals through the override process.
- In many areas, he felt proposed Standards waver between standards and operationalization, e.g., on page 9, the Integrated Care Plan (ICP) section is overly detailed. Multiple such sections could be summarized in a paragraph rather than drawn out.
- Throughout the Standards, he also noted expectations for MCC teams to do community engagement and education, but that has no service code. Ms. Garland has discussed that with Ms. Keresoma, but Ms. Garland saw that as a DHSP role using different skills. DHSP was bringing MCC teams together with HIV testing and mental health providers.
- Mr. Robinson felt staff who have already built community trust will be more effective in MCC outreach roles. Ms. Garland suggested a separate indicator for agencies to identify - yes or no - whether they have an outreach plan.
- Ms. Barrit reminded the body that Standards are intended to be the floor, minimum service expectations, not the ceiling. Agencies with the capability to exceed Standards are encouraged, but not required, to do so. MCC Standards, like all Standards, should be client driven, client centered, and client first so barriers need to be addressed.
- A consistent theme across Standards pertains to the difficulty in evaluating individuals per that person's agency rather than the Ryan White care system as a whole. The goal is to break down silos and inter-agency competition for patients created inadvertently by the way contracts are developed and evaluated. Access should ideally be seamless across the system.
- Casewatch issues depress agency interest in using features such as referral forms. Agencies spend most of their time in eHR systems. Ms. Garland noted those can be mapped into Casewatch, but DHSP was deferring that while it looks into other systems. Casewatch has multiple functions beyond enrolling clients, e.g., billing and data submittal to Health Resources and Services Administration (HRSA). Meanwhile, LAC Information Technology (IT) is also working on centralizing all LAC systems.
- Mr. Robinson stressed ensuring staff is reflective of populations served. In particular, nearly half of MCC clients are African American, but leadership and staff do not reflect that. Transgender persons are also under-represented.

➲ Ms. Garland will follow-up with Terina Keresoma on whether retention specialists can serve enrolled clients.

➲ Ms. Barrit, Ms. Tolentino, Ms. Garland, and Ms. Keresoma will separate out comments more appropriate for DHSP to address, i.e., guidelines, clarification of guidance interpretation, or contracting administration. They will also identify comments pertaining to Standards within the purview of SBP and the Commission with a report to SBP at its next meeting. Suggested language will be provided on: staffing waiver; consistency of terms; best practices summit; leadership/staff reflectiveness, especially African Americans and other under-represented populations; and case load (discussed previously).

➲ Dr. Cadden will forward to Ms. Garland information on Keck's electronic patient and billing system.

➲ Investigate how Housing Works in the City of New York coordinated IT for their providers.

➲ In coordination with Assessment of the Administrative Mechanism (AAM) work, explore how to address Casewatch issues.

➲ Add question on whether or not agency has a policy(ies) regarding separating clients and missed appointments.

➲ Mr. Kaplan will forward to Ms. Barrit for distribution a recent *New York Times* article that reflects better health outcomes for African Americans with diabetes and an African American provider versus those without an African American provider.

VI. NEXT STEPS

8. **TASK/ASSIGNMENTS RECAP**: There was no additional discussion.

9. **AGENDA DEVELOPMENT FOR NEXT MEETING**:

➲ Reschedule next meeting to 10/9/2018, 10:00 a, to 12:00 noon, due to conflict with infectious Disease Week.

VII. ANNOUNCEMENTS

10. **OPPORTUNITY FOR PUBLIC AND COMMITTEE TO MAKE ANNOUNCEMENTS**: There were no announcements.

VIII. ADJOURNMENT

11. **ADJOURNMENT**: The meeting adjourned at 12:15 pm.