LOS ANGELES COUNTY
COMMISSION ON HIV

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

April 17, 2018

PP&A MEMBERS PRESENT	PP&A MEMBERS PRESENT *(cont.)*	PUBLIC	COMM STAFF/CONSULTANTS
Al Ballesteros, MBA, *Co-Chair*	Yolanda Sumpter	Scott Blackburn	Cheryl Barrit, MPIA
Jason Brown, *Co-Chair*	Russell Ybarra	Bridget Gordon	Carolyn Echols-Watson, MPA
Frankie Darling-Palacios		Katja Nelson	Jane Nachazel
Grissel Granados, MSW			Doris Reed
Abad Lopez	**PP&A MEMBERS ABSENT**		Julie Tolentino, MPH
Miguel Martinez, MPH, MSW	Susan Forrest		
Anthony Mills, MD	William King, MD		
Pamela Ogata, MPH	Derek Murray		**DHSP/DPH STAFF**
Deborah Owens Collins, PA-C, MSHCA, MSPAS, AAHIVS	Raphael Peña		Michael Green, PhD, MHSA
	Rebecca Ronquillo		Glenda Pinney, MPH, JD
LaShonda Spencer, MD			

CONTENTS OF COMMITTEE PACKET

1) **Agenda**: Planning, Priorities & Allocations (PP&A) Committee Meeting Agenda, *4/17/2018*
2) **Minutes**: Planning, Priorities & Allocations (PP&A) Committee Meeting Minutes, *3/20/2018*
3) **PowerPoint**: Los Angeles County's Substance Use Disorder System of Care, *Revised 2015*
4) **Pamphlet**: Los Angeles County Substance Use Treatment Services
5) **Directives**: Los Angeles County Commission on HIV (COH) FY 2017-2022 Program Directives, Proposed Updates for 2018 in Red, *4/17/2018*
6) **Table**: Los Angeles County Commission on HIV, Planning, Priorities and Allocations Committee, Rent Burden in Los Angeles County, *Revised*
7) **Table**: Chlamydia Cases and Rates (per 100,000) by Gender, Age Group, Race/Ethnicity, Los Angeles County, *Revised 2015*
8) **Table**: Gonorrhea Cases and Rates (per 100,000) by Gender, Age Group, Race/Ethnicity, Los Angeles County, *Revised 2015*
9) **Table**: Syphilis Cases and Rates (per 100,000) by Gender, Age Group, Race/Ethnicity, Los Angeles County, *Revised 2015*
10) **Table**: 2015 STD & Co-Infection Data for Los Angeles County, *2015*
11) **Table**: Los Angeles County Commission on HIV, Planning, Priorities and Allocations Committee, STI/HIV Risk Data, *2015/2016*
12) **Graphic**: Los Angeles County, Cities, Communities and Health Districts, *May 2003*
13) **Table**: 2012-2016 MAI Overview
14) **Graphic**: Prevention and Care Services Across the HIV Care Continuum Linked to LACHAS Goals for 2022, *4/17/2018*

CALL TO ORDER: Mr. Brown called the meeting to order at 1:05 pm.

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 3/20/2018 Planning, Priorities and Allocations (PP&A) 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**:
   - Mr. Blackburn, Program Administrator, Home Health Program, AIDS Project Los Angeles, reported proposed Medi-Cal AIDS Waiver Home Health Program rate increases were approved in the most recent state budget. Increases included administrative and case management fees paid directly to providers as well as fees to subcontractors for services like homemakers, Certified Nurse Assistants, and in-home psychotherapy.
   - A slight implementation delay occurred while the state determined rate caps and when to initiative new rates. There was then a process as the market reset subcontractor rates, but that is now mostly done resulting in a significant increase.
   - Increases are important since subcontractor rates were becoming noncompetitive, especially in light of state minimum wage increases, which ran the risk of losing subcontractors. On the other hand, DHSP has not yet augmented contracts to respond to the rate increase. Consequently, he and other program managers he has spoken with have had to reduce goals and objectives for the most recent contract extensions resulting in fewer clients served.
   - He suggested Minority AIDS Initiative (MAI) funds help augment these contracts, if feasible. Home-Based Case Management (H-B CM) clients are PLWH and generally over 50. All H-B CM providers offer services countywide and are in place.
   - ➲ Ms. Ogata will review and report back on funding for H-B CM services.

III. COMMITTEE COMMENT

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

IV. REPORTS

5. **EXECUTIVE DIRECTOR'S REPORT**:
   a. **Los Angeles County HIV/AIDS Strategy (LACHAS)**:
      - Ms. Barrit thanked everyone who attended the San Fernando Valley 4/12/2018 LACHAS meeting. Many provider representatives and patients expressed appreciation for the opportunity to attend a meeting in their local area.
      - Commissioners from the community were acknowledged and their contact information was in the packet.
      - Comparatively few evaluations were returned. It does appear more education on and practice using the Health District (HD) model would help. Commission and DHSP staff will consider how to revise documents to improve HD education.
      - The 5/10/2018 Commission meeting will return to St. Anne's Conference Center while the 6/14/2018 meeting will again move out to the HDs by targeting the San Gabriel Valley, in particular the El Monte area.
      - Board of Supervisors (BOS) Health Deputies and City of Los Angeles Council members are interested and supportive.

6. **CO-CHAIRS' REPORT**: There was no report.

7. **DIVISION OF HIV AND STD PROGRAMS (DHSP), DPH UPDATE**: There was no additional report outside agendized items.

V. PRESENTATION

8. **SUBSTANCE ABUSE PREVENTION AND CONTROL (SAPC), DPH**:
   a. **Drug Medi-Cal Program**:
      - Ms. Barrit noted this presentation was requested by PP&A due to the expansion of Medi-Cal to cover substance abuse treatment that previously would have been covered by the Ryan White Program (RWP).

- Ms. Pinney presented a PowerPoint on the Substance Use Disorder (SUD) system of care administered by SAPC for LAC Medi-Cal, My Health LA, and some criminal justice, perinatal, Cal-Works, and General Relief (GR) populations.
- SAPC's mission is to reduce community and individual problems related to alcohol and drug abuse through evidence-based programs and policy advocacy. There were 55,985 SUD admissions in Fiscal Year (FY) 2015-2016.
- Most services are contracted out except for one County-run residential and outpatient facility in the Antelope Valley. There are over 150 contracted community-based SUD providers offering services at over 300 sites. Provider eligibility to contract with SAPC changed as of July 2017 when Drug Medi-Cal Waiver was instituted.
- At that time, SAPC implemented System Transformation to Advance Recovery and Treatment - LAC's SUD Organized Delivery System (START-ODS) to increase access to SUD, broaden available services, and organize the system of care.
- Recovery Bridge Housing (RBH) is not actually part of Drug Medi-Cal, but is part of the new, expanded benefit package. It provides a safe, abstinence-based, interim living environment for homeless or unstably housed SAPC outpatients who meet criteria of medical necessity. RBH replaces sober living which did not require participation in treatment. One of PP&A's concerns had been the 90-day length of stay, but it was increased to 180 days at the start of April 2018.
- At the same time, coverage loss due to a lapse in abstinence, a 60 day postpartum patient limit, and $45 per day per bed excluding room and board reflect barriers that point to a broader conversation on leveraging resources.
- Case Management (CM) ensures integrated, coordinated care across Medi-Cal Managed Care, LAC services, and community services/supports for LAC residents eligible or enrolled in Medi-Cal, My Health LA, or other LAC-funded programs. Providers can now bill up to seven hours per month of CM which can be used for a variety of purposes including help enrolling in Medi-Cal, food stamps, or completing the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) for the Los Angeles Homeless Services Authority (LAHSA).
- SAPC understands that nearly 25% of its patients are homeless and is developing a homeless provider network. Providers are being asked to complete the VI-SPDAT for their homeless clients, but just 19 providers have access to the system now. LAHSA has agreed to provide some 150 licenses and training for remaining providers to join the system.
- Patients can enter the SUD system via: a 15-20 minute phone Substance Abuse Service Helpline (SASH) screening and referral, including for STDs, at any time; a Client Engagement and Navigation Services (CENS) in-person assessment and referral at over 40 sites, including for some patients engaged through outreach; or, except for some populations such as GR, via the public, web-based appointment and bed availability dashboard, Service and Bed Availability Tool (SBAT).
- Resources on the SAPC website help locate services and offer information including a patient handbook and brochure.
- Regarding medical necessity as a barrier, Ms. Pinney said the full assessment has six dimensions, e.g., medical health, mental health, risk of relapse, live-in environment. An algorithm score based on questions identifies a level of care, but counselors can over-ride it. As of 12/4/2017, electronic health records (SAGE), screening and assessment tools are online. Both nurses and counselors answer SASH which is also the call center for Whole Person Care and Nurse Advice.
- Ms. Barrit asked about appropriateness of sites for RWP clients. Ms. Pinney replied SAPC distributed a self-survey to inform SBAT development, but some sites are more accurately reflected than others. A cultural competency work group was developing criteria for specific populations though she did not know whether LGBTQ were identified. All providers were notified prior to Drug Medi-Cal Waiver implementation that they needed to be Drug Medi-Cal certified to maintain LAC contracts. Less than five have yet to comply. The main barrier is staffing requirements.
- Drug Medi-Cal is a carve-out from Managed Care Medi-Cal so clients must be residents of LAC. Individuals enrolled with Medi-Cal in other counties who wish to receive services in LAC need to request transfer of their Medi-Cal to LAC. Providers may initiate services prior to transfer of Medi-Cal, but might not be paid for such services.
- The state limits Drug Medi-Cal residential treatment to twice per year, but LAC bases all decisions on medical necessity.
- ➲ Ms. Pinney will refer to SAPC a request for ongoing coordination on programming and funding alignment with DHSP.
- ➲ Ms. Pinney will provide the screening tool pertinent to identifying those at high risk for HIV and indicate any potential referral to PrEP. This tool is used nationally and was not developed by SAPC so would be difficult to revise.
- ➲ Ms. Pinney will follow-up with the Medical Director on how HIV physicians can follow their patients in rehab; consistency of pharmacy services; and provider requirements for addressing PLWH medical needs during rehab.
- ➲ Ms. Pinney will provide data on how many PLWH and people at risk of HIV are being served by SAPC broken down by Service Planning Area (SPA), Supervisorial District, and, if possible, by Health District (HD).
- ➲ Staff will invite Ms. Pinney back for a more customized presentation, e.g., with demographics of PLWH in the SAPC system and utilization rates to more fully inform Priority- and Allocation-Setting.

VI. DISCUSSION

9. MASTER PROGRAM DIRECTIVE:

- Ms. Barrit noted the updated document in the packet and additional data requested by PP&A on STDs and poverty.
- STD data is reflected by tables on Chlamydia, gonorrhea, syphilis, as well as a combined table of those STDs and HIV, co-infection with two or more STDs, and co-infection with at least one STD and HIV.
- Poverty is reflected by rent burden in Los Angeles County (LAC) by HD based on a larger LAC document by city. Renters spending more than 30% of their income on rent are considered "rent burdened" while those spending more than 50% are considered "severely rent-burdened." With today's market, even 44.49% of those in the least impacted HD, Whittier, is rent burdened. The top three HDs are: Central, 70.46%; South, 69.82%; and Southeast, 69.39%. Four more are above 60%.
- Dr. Mills suggested breaking out rent burdened versus severely rent-burdened, but Mr. Martinez felt data without median income is misleading as those with higher incomes retain more purchasing options after rent. Ms. Barrit noted data can be broken down more, but the most rent burdened HDs still face high poverty, HIV and STD burdens, and fewer resources.
- For more data points, the LAC Health Survey, Office of Community Health Assessment, Department of Public Health (DPH), reports data for several indicators by Service Planning Area (SPA) and HD every three to five years.
- Mr. Ballesteros suggested Commissioners present on data for their HDs, at least those most impacted, at the Commission.
- Ms. Barrit noted this document was last approved by the Commission on 3/9/2017. Revisions in red include alignment with the Comprehensive HIV Plan (CHP) and LACHAS, e.g., a particular focus on Young MSM (YMSM), African American MSM, Latino MSM, transgender persons and, in particular regarding STDs, women of color. A new column has also been added to the start of tables for both the General and MAI Directives to state the three LACHAS goals. No determinations on which HDs to prioritize has yet been made, but placeholder language reflects priorities based on disease burden, gaps, and needs.
- Strategies already in the document that intersect with and relate to prevention were highlighted in yellow.
- The MAI Allocations Plan Update (2017-2022) was incorporated beginning on page 7, subject to change as needed to maximize Part A as noted above, with: Housing Services, 53%; Outreach, 26%; and, Non-Medical Case Management, 21%. CHP prevention activities addressing communities of color and other highly impacted populations were added on pages 11-12. Housing specific directives starting at the bottom of page 12 stress leveraging and coordinating services for best impact.
- Dr. Green provided a revised HIV Care Continuum graphic highlighting the LACHAS goals by 2022 of: 1. Reduce annual HIV infections to 500; 2. Increase percentage of PLWH who are diagnosed to at least 90%; 3. Increase percentage of diagnosed PLWH who are virally suppressed to at least 90%. The goals serve as lenses for HIV Care Continuum stages of diagnosed with HIV, linked to care, retention in care, and viral suppression with prevention and care services linked to pertinent goals.
- This tool can help inform directives to further refine services in light of the LACHAS goals, e.g., to support Goal 1, focus Transitional Case Management on high risk HIV- people who are leaving incarceration.
- Mr. Martinez said, while Directives open by identifying highly impacted and at risk populations, he was struck by how nebulous actual activities are. Data reflects the need to center on African American populations in order to be effective. He urged considering how to develop and apply an equity framework to the Directives in reviewing the document this month.
- Dr. Green pointed out that the new tool of HD maps can help focus resources to each HD's key issues. That is a much more granular approach than the usual allocation of funds to a service category or, at best, to address services at the SPA level. HD maps also identify locations of services and service deserts which can prompt identifying agencies as close as possible to a highlighted population as well as spurring solicitations and partnership efforts to bolster agencies in service deserts.
- Ms. Gordon was concerned that both the Hollywood-Wilshire and Southwest HDs have high disease burdens, but the former has many more services. She urged a focus on HDs with both high disease burden and service gaps and needs.
- Ms. Sumpter recommended a greater focus on program effectiveness. Ms. Ogata noted the revised HIV Care Continuum graphic reflects all current DHSP-funded programs, but does not address effectiveness or service gaps. Wendy Garland, MPH does report on program evaluations and outcomes at the Standards and Best Practices Committee. Ms. Ogata will be reporting at PP&A on service utilization data for the number of clients served and the number of service units delivered.
- Ms. Barrit said several Commissioners have raised effectiveness questions on reach, breadth, and scope of interventions to better inform decision-making, e.g., which testing sites are high performing and how to ensure others improve.
- Dr. Green noted historically PP&A has prioritized service categories by placing them all on the wall and each person voting according to their own preferences. He suggested using the three LACHAS goals as lenses with a separate vote for each.
- For most service categories, DHSP has struggled to define outcomes. It has used retention in care and viral suppression as proxies for many service categories because there was nothing better that could be measured reliably. It is difficult to look at a tapestry of services and objectively determine which ones had the biggest impact on viral suppression.
- To better address this issue, DHSP has further refined its reorganization by consolidating Planning, Development and Research (PDR) under Dr. Green. PDR sections are: Data Management and Infomatics, Grants Administration, Program Development, Research and Evaluation, and Strategic Planning. Jointly they streamline the collection, analysis, and

dissemination of data so PDR can look across the spectrum of data sets, identify the most useful data, make comparisons, and then share that information. DHSP is using this new structure to review each service category for its logical outcomes.

- DHSP's in-depth analysis of agency needs and capacity along with available funding informed design of a Medical Care Coordination (MCC) program that evidence has demonstrated works well in keeping people linked to care and getting them virally suppressed. DHSP has not yet had time to do that analysis of other service categories, but is engaged in the work.
- ➲ Add to page 2, Program Directive, bullet 1: "..., and populations most disproportionately affected."
- ➲ Staff will incorporate recommendations and present the revised iteration at the 5/15/2018 PP&A meeting for review. The goal is full Commission approval in July or August in time for the RWP Part A application submission.
- ➲ Staff will distribute electronic iterations of the revised HIV Care Continuum graphic and HD map. The documents will also be included in the 5/15/2018 meeting packet.

10. **2018 PREVENTION PLAN**: There was no additional discussion.

11. **MINORITY AIDS INITIATIVE (MAI) PLAN**:
    - Dr. Green reviewed the 2012-2016 MAI Overview table of each year's award; carryover, if any; MAI total; expenditures; and supported service categories. All funds were expended in 2012 and 2013 so there was no carryover in 2013 or 2014.
    - RWP Part A funds cannot be carried over to the next year without penalty including loss of eligibility for the next year's Part A supplemental award. MAI funds, however, can be carried over without penalty so DHSP can protect unexpended funds from a service category for use in the next year by shifting them into MAI.
    - Congress allocates specific funds for MAI each year. The Health Resources and Services Administration (HRSA) allocates funds based on an internal formula much like the Part A formula award. DHSP does not request specific funds.
    - Final MAI expenditures for 2017 will not be available until May or June 2018 to ensure that Part A funds are maximized and determine what carryover, if any, will be needed. Dr. Green noted that, unlike many other jurisdictions, most LAC Part A funds are also expended for people of color so MAI can be used to ensure funds are not lost due to underspending.
    - 2017 was unique because significant resources were allocated to housing with the expectation that DHSP would have a streamlined Department of Health Services (DHS) process for the Memorandum of Understanding (MOU) with Housing For Health (HFH). In fact, DHSP did not receive the fully executed MOU until December 2017 or January 2018 so resources were not spent on housing services as anticipated. DHS is now waiting to hear from their contractors that they are ready to accept referrals which should occur in the next few weeks. The 2017 grant term ended 2/28/2018.
    - 2018 MAI housing allocations should be expended with implementation of HFH services. Expenditures may still need to be shifted from MAI to maximize Part A if other service categories are underspent, e.g., mental health due to migration to Medi-Cal or substance abuse due to migration to Drug Medi-Cal. If so, then there would still be some MAI carryover.

VII. NEXT STEPS

12. **TASK/ASSIGNMENTS RECAP**: There were no additional items.

13. **AGENDA DEVELOPMENT FOR NEXT MEETING**: There were no additional items.

VIII. ANNOUNCEMENTS

14. **OPPORTUNITY FOR PUBLIC AND COMMITTEE TO MAKE ANNOUNCEMENTS**:
    - Frankie Darling-Palacios announced the Trans Wellness Center ribbon cutting on 4/24/2018, 10:00 am, followed by tours at their space shared with APAIT and others at 3055 Wilshire Boulevard, 3rd Floor. A 6:00 to 9:00 pm community celebration will be at LA Celebrations Banquet Hall, 2969 Wilshire Boulevard. Valet parking is $7. Staff will email the links to RSVP.
    - APAIT was also hosting an open house that day until 5:00 pm at the 3055 Wilshire Boulevard, 3rd Floor site.

IX. ADJOURNMENT

15. **ADJOURNMENT**: The meeting adjourned at 3:50 pm.