LOS ANGELES COUNTY
COMMISSION ON HIV

Visit us online: http://hiv.lacounty.gov
Get in touch: hivcomm@lachiv.org
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STANDARDS AND BEST PRACTICES COMMITTEE MEETING

TUESDAY OCTOBER 7, 2025
10:00 AM -- 12:00 PM (PST)

510 S. Vermont Avenue, 9th Floor, LA 90020
Validated Parking @ 523 Shatto Place, LA 90020

As a building security protocol, attendees entering form the 1st floor lobby must notify security personnel that they are attending the Commission on HIV meeting to access the Terrace Conference Room (9th Floor) where our meetings are held.

Agenda and meeting materials will be posted on our website
https://hiv.lacounty.gov/standards-and-best-practices-committee

Register Here to Join Virtually

https://lacountyboardofsupervisors.webex.com/weblink/register/r40b5dc6910f8ee0293edb3714bb27091

Notice of Teleconferencing Sites

Public Comments

You may provide public comment in person, or alternatively, you may provide written public comment by:

- Emailing hivcomm@lachiv.org
- Submitting electronically at https://www.surveymonkey.com/r/PUBLIC_COMMENTS

** Please indicate your name, the corresponding agenda item, and whether you would like to state your public comment during the meeting. All public comments will be made part of the official record.*

Accommodations

Requests for a translator, reasonable modification, or accommodation from individuals with disabilities, consistent with the Americans with Disabilities Act, are available free of charge with at least 72 hours' notice before the meeting date by contacting the Commission office at hivcomm@lachiv.org or 213.738.2816.

Scan QR code to download an electronic copy of the meeting packet. Hard copies of materials will not be available in alignment with the County's green initiative to recycle and reduce waste. If meeting packet is not yet available, check back prior to meeting; meeting packet subject to change. Agendas will be posted 72 hours prior to meeting per Brown Act.

together.

WE CAN END HIV IN OUR COMMUNITIES ONCE & FOR ALL

Apply to become a Commission member at: https://www.surveymonkey.com/r/COHMembershipApp
For application assistance, call (213) 738-2816 or email hivcomm@lachiv.org

LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave., 14th Floor, Los Angeles CA 90020
MAIN: 213.738.2816 EML: hivcomm@lachiv.org WEBSITE: https://hiv.lacounty.gov

AGENDA FOR THE REGULAR MEETING OF THE LOS ANGELES COUNTY COMMISSION ON HIV

STANDARDS AND BEST PRACTICES COMMITTEE

TUESDAY, OCTOBER 7, 2025 | 10:00AM – 12:00PM

510 S. Vermont Ave
Vermont Corridor 9th Floor TK02 Conference Room
Los Angeles, CA 90020
Validated Parking: 523 Shatto Place, Los Angeles, CA 90020

For those attending in person, as a building security protocol, attendees entering the first-floor lobby must notify security personnel that they are attending the Commission on HIV meeting.

MEMBERS OF THE PUBLIC WHO WISH TO JOIN VIRTUALLY, REGISTER HERE:
https://lacountyboardofsupervisors.webex.com/weblink/register/r40b5dc6910f8ee0293edb3714bb27091
To Join by Telephone: 1-213-306-3065
Password: STANDARDS Access Code: 2539 193 2807

Standards and Best Practices Committee (SBP) Members:			
Erika Davies *Co-Chair*	Arlene Frames *Co-Chair*	Dahlia Ale-Ferlito	Mikhaela Cielo, MD
Sandra Cuevas	Caitlin Dolan *(Committee-only)*	Kerry Ferguson *(Alternate)*	Lauren Gersh, LCSW *(Committee-only)*
Mark Mintline, DDS *(Committee-only)*	Byron Patel, RN	Sabel Samone-Loreca *(Alt. to Arlene Frames)*	Martin Sattah, MD
Russell Ybarra			
QUORUM: 7			

AGENDA POSTED: October 1, 2025.

SUPPORTING DOCUMENTATION: Supporting documentation can be obtained via the Commission on HIV Website at: http://hiv.lacounty.gov or in person. The Commission Offices are located at 510 S. Vermont Ave., 14th Floor Los Angeles, 90020. **Validated parking is available at 523 Shatto Place, Los Angeles 90020.** **Hard copies of materials will not be made available during meetings unless otherwise determined by staff in alignment with the County's green initiative to recycle and reduce waste.*

PUBLIC COMMENT: Public Comment is an opportunity for members of the public to comment on an agenda item, or any item of interest to the public, before or during the Commission's consideration of the item, that is within the subject matter jurisdiction of the Commission. To submit Public Comment, you may join the virtual meeting via your smart device and post your Public Comment in the Chat box -or-

email your Public Comment to hivcomm@lachiv.org -or- submit your Public Comment electronically here. All Public Comments will be made part of the official record.

ATTENTION: Any person who seeks support or endorsement from the Commission on any official action may be subject to the provisions of Los Angeles County Code, Chapter 2.160 relating to lobbyists. Violation of the lobbyist ordinance may result in a fine and other penalties. For information, call (213) 974-1093.

ACCOMMODATIONS: Interpretation services for the hearing impaired and translation services for languages other than English are available free of charge with at least 72 hours' notice before the meeting date. To arrange for these services, please contact the Commission Office at (213) 738-2816 or via email at HIVComm@lachiv.org.

Los servicios de interpretación para personas con impedimento auditivo y traducción para personas que no hablan Inglés están disponibles sin costo. Para pedir estos servicios, póngase en contacto con Oficina de la Comisión al (213) 738-2816 (teléfono), o por correo electrónico á HIVComm@lachiv.org, por lo menos setenta y dos horas antes de la junta.

I. ADMINISTRATIVE MATTERS

1.	Call to Order & Meeting Guidelines/Reminders		10:00 AM – 10:03 AM
2.	Introductions, Roll Call, & Conflict of Interest Statements		10:03 AM – 10:05 AM
3.	Approval of Agenda	**MOTION #1**	10:05 AM – 10:07 AM
4.	Approval of Meeting Minutes	**MOTION #2**	10:07 AM – 10:10 AM

II. PUBLIC COMMENT

10:10 AM – 10:15 AM

5. Opportunity for members of the public to address the Committee of items of interest that are within the jurisdiction of the Committee. For those who wish to provide public comment may do so in person, electronically by clicking here, or by emailing hivcomm@lachiv.org.

III. COMMITTEE NEW BUSINESS ITEMS

6. Opportunity for Committee members to recommend new business items for the full body or a committee level discussion on non-agendized Matters not posted on the agenda, to be discussed and (if requested) placed on the agenda for action at a future meeting, or matters requiring immediate action because of an emergency situation, or where the need to take action arose subsequent to the posting of the agenda.

IV. REPORTS

7. COH Staff Report — 10:15 AM – 10:25 AM
   a. Operational and Commission—Updates
8. Co-Chair Report — 10:25 AM – 10:35 AM
   a. 2025 Committee Meeting Calendar—Updates
   b. Service Standards Revision Tracker—Updates
9. Division on HIV and STD Programs (DHSP) Report — 10:35 AM—10:45 AM

V. DISCUSSION ITEMS

10. Patient Support Services (PSS) Service Standards Updates — 10:45 AM—11:15 AM

MOTION #3: Approve the Patient Support Services (PSS) service standards, as presented

or revised, and elevate to the Executive Committee.

11. Mental Health Service Standards Review 11:15 AM—11:45 PM

VI. NEXT STEPS 11:45 AM – 11:55 AM

12. Task/Assignments Recap
13. Agenda development for the next meeting

VII. ANNOUNCEMENTS 11:55 AM – 12:00 PM

14. Opportunity for members of the public and the committee to make announcements.

VIII. ADJOURNMENT 12:00 PM

15. Adjournment for the meeting of October 7, 2025.

PROPOSED MOTIONS	
MOTION #1	Approve the Agenda Order as presented or revised.
MOTION #2	Approve the Standards and Best Practices Committee minutes, as presented or revised.
MOTION #3	Approve the Patient Support Services (PSS) service standards, as presented or revised, and elevate to the Executive Committee.

LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave 14th Floor • Los Angeles, CA 90020 • TEL (213) 738-2816 • FAX (213) 637-6748
HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov

Approved by COH 6/8/23

CODE OF CONDUCT

APPROVED BY OPERATIONS COMMITTEE ON 05/25/23; COH 06/08/23
Approved (11/12/1998); Revised (2/10/2005; 9/6/2005); **Revised (4/11/19; 3/3/22, 3/23/23; 5/30/23)**

The Commission on HIV welcomes commissioners, guests, and the public into a space where people of all opinions and backgrounds are able to contribute. In this space, we challenge ourselves to be self-reflective and committed to an ongoing understanding of each other and the complex intersectionality of the lives we live. We create a safe environment where we celebrate differences while striving for consensus in the fights against our common enemies: HIV and STDs. We build trust in each other by having honest, respectful, and productive conversations. As a result, the Commission has adopted and is consistently committed to implementing the following guidelines for Commission, committee, and associated meetings.

All participants and stakeholders should adhere to the following:

1) **We approach all our interactions with compassion, respect, and transparency.**
2) **We respect others' time by starting and ending meetings on time, being punctual, and staying present.**
3) **We listen with intent, avoid interrupting others, and elevate each other's voices.**
4) **We encourage all to bring forth ideas for discussion, community planning, and consensus.**
5) **We focus on the issue, not the person raising the issue.**
6) **Be flexible, open-minded, and solution-focused.**
7) **We give and accept respectful and constructive feedback.**
8) **We keep all issues on the table (no "hidden agendas"), avoid monopolizing discussions and minimize side conversations.**
9) **We have no place in our deliberations for racist, sexist, homophobic, transphobic, and other discriminatory statements, and "-isms" including misogyny, ableism, and ageism.**
10) **We give ourselves permission to learn from our mistakes.**

In response to violation of the Code of Conduct which results in meeting disruption, Include provisions of SB 1100 which states in part, ". . . authorize the presiding member of the legislative body conducting a meeting or their designee to remove, or cause the removal of, an individual for disrupting the meeting . . . . Removal to be preceded by a warning to the individual by the presiding member of the legislative body or their designee that the individual's behavior is disrupting the meeting and that the individual's failure to cease their behavior may result in their removal." Complaints related to internal Commission matters such as alleged violation of the Code of Conduct or other disputes among members are addressed and resolved in adherence to Policy/Procedure #08.3302." (Commission Bylaws, Article VII, Section 4.)

LOS ANGELES COUNTY
COMMISSION ON HIV

HYBRID MEETING GUIDELINES, ETTIQUETTE & REMINDERS

(Updated 7.15.24)

☐ This meeting is a **Brown-Act meeting** and is being recorded.
- Turn off your ringers/notifications on your smart devices so as not to disrupt the meeting.
- Your voice is important and we want to ensure that it is captured accurately on the record. Please be respectful of one another and minimize crosstalk.

☐ The **meeting packet** can be found on the Commission's website at https://hiv.lacounty.gov/meetings/ or accessed via the QR code provided. Hard copies of materials will not be provided in compliance with the County's green initiative to recycle and reduce waste.

☐ Please comply with the **Commission's Code of Conduct** located in the meeting packet.

☐ **Public Comment** for members of the public can be submitted in person, electronically @ https://www.surveymonkey.com/r/public_comments or via email at hivcomm@lachiv.org. *Please indicate your name, the corresponding agenda item, and whether you would like to state your public comment during the meeting; if so, staff will call upon you appropriately. Public comments are limited to two minutes per agenda item. All public comments will be made part of the official record.*

☐ For individuals joining in person, to mitigate any potential streaming interference for those joining virtually, we respectfully ask that you **not simultaneously log into the virtual option of this meeting via WebEx.**

☐ Committee members invoking **AB 2449 for "Just Cause" or "Emergency Circumstances**" must communicate their intentions to staff and/or co-chairs no later than the start of the meeting. Members requesting to join pursuant to AB 2449 must have their audio and video on for the entire duration of the meeting and disclose whether there is a person over the age of 18 in the room in order to be counted toward quorum and have voting privileges. For members joining virtually due to "Emergency Circumstances", a vote will be conducted by the Committee/COH for approval.

☐ Members will be required to explicitly state their agency's **Ryan White Program Part A and/or CDC prevention conflicts of interest** on the record (versus referring to list in the packet). A list of conflicts can be found in the meeting packet and are recorded on the back of members' name plates, courtesy of staff.

If you experience challenges in logging into the virtual meeting, please refer to the WebEx tutorial HERE or contact Commission staff at hivcomm@lachiv.org.

LOS ANGELES COUNTY COMMISSION ON HIV

2025 MEMBERSHIP ROSTER| UPDATED 9.26.25

SEAT NO.	MEMBERSHIP SEAT	Commissioners Seated	Committee Assignment	COMMISSIONER	AFFILIATION (IF ANY)	TERM BEGIN	TERM ENDS	ALTERNATE
1	Medi-Cal representative			***Vacant***		July 1, 2023	June 30, 2025	
2	City of Pasadena representative	1	EXC|SBP	Erika Davies	City of Pasadena Department of Public Health	July 1, 2024	June 30, 2026	
3	City of Long Beach representative	1	PP&A	Ismael Salamanca	Long Beach Health & Human Services	July 1, 2023	June 30, 2025	
4	City of Los Angeles representative	1	SBP	Dahlia Ale-Ferlito	AIDS Coordinator's Office, City of Los Angeles	July 1, 2024	June 30, 2026	
5	City of West Hollywood representative	1	PP&A	Dee Saunders	City of West Hollywood	July 1, 2023	June 30, 2025	
6	Director, DHSP **Non Voting*	1	EXC	Mario Pérez, MPH	DHSP, LA County Department of Public Health	July 1, 2024	June 30, 2026	
7	Part B representative	1		Leroy Blea	California Department of Public Health, Office of AIDS	July 1, 2024	June 30, 2026	
8	Part C representative			***Vacant***		July 1, 2024	June 30, 2026	
9	Part D representative	1	SBP	Mikhaela Cielo, MD	LAC + USC MCA Clinic, LA County Department of Health Services	July 1, 2023	June 30, 2025	
10	Part F representative	1	SBP	Sandra Cuevas	Pacific AIDS Education and Training - Los Angeles Area	July 1, 2024	June 30, 2026	
11	Provider representative #1	1	OPS	Leon Maultsby, DBH, MHA ***(pending)***	In The Meantime Men's Group, Inc	July 1, 2023	June 30, 2025	
12	Provider representative #2			***Vacant***		July 1, 2024	June 30, 2026	
13	Provider representative #3	1	PP&A	Harold Glenn San Agustin, MD	JWCH Institute, Inc.	July 1, 2023	June 30, 2025	
14	Provider representative #4	1	PP&A	LaShonda Spencer, MD	Charles Drew University	July 1, 2024	June 30, 2026	
15	Provider representative #5	1	SBP	Byron Patel, RN	Los Angeles LGBT Center	July 1, 2023	June 30, 2025	
16	Provider representative #6			***Vacant***		July 1, 2024	June 30, 2026	
17	Provider representative #7	1		David Hardy ,MD	University of Southern California	July 1, 2023	June 30, 2025	
18	Provider representative #8	1	SBP	Martin Sattah, MD	Rand Shrader Clinic, LA County Department of Health Services	July 1, 2024	June 30, 2026	
19	Unaffiliated representative, SPA 1			***Vacant***		July 1, 2023	June 30, 2025	Kerry Ferguson (SBP)
20	Unaffiliated representative, SPA 2	1	SBP	Russell Ybarra	*Unaffiliated representative*	July 1, 2024	June 30, 2026	
21	Unaffiliated representative, SPA 3	1	OPS	Ish Herrera ***(LOA)***	*Unaffiliated representative*	July 1, 2023	June 30, 2025	Joaquin Gutierrez (OPS)
22	Unaffiliated representative, SPA 4	1	PP	Jeremy Mitchell (aka Jet Finley)	*Unaffiliated representative*	July 1, 2024	June 30, 2026	Lambert Talley (PP&A)
23	Unaffiliated representative, SPA 5			***Vacant***	*Unaffiliated representative*	July 1, 2023	June 30, 2025	
24	Unaffiliated representative, SPA 6	1	OPS	Jayda Arrington	*Unaffiliated representative*	July 1, 2024	June 30, 2026	
25	Unaffiliated representative, SPA 7	1	EXC|OPS	Vilma Mendoza	*Unaffiliated representative*	July 1, 2023	June 30, 2025	
26	Unaffiliated representative, SPA 8	1	EXC|PP&A	Kevin Donnelly	*Unaffiliated representative*	July 1, 2024	June 30, 2026	Carlos Vega-Matos (PP&A)
27	Unaffiliated representative, Supervisorial District 1	1	PP	Leonardo Martinez-Real	*Unaffiliated representative*	July 1, 2023	June 30, 2025	
28	Unaffiliated representative, Supervisorial District 2			***Vacant***	*Unaffiliated representative*	July 1, 2024	June 30, 2026	
29	Unaffiliated representative, Supervisorial District 3	1	SBP	Arlene Frames	*Unaffiliated representative*	July 1, 2023	June 30, 2025	Sabel Samone-Loreca (SBP)
30	Unaffiliated representative, Supervisorial District 4			***Vacant***		July 1, 2024	June 30, 2026	
31	Unaffiliated representative, Supervisorial District 5	1	PP&A	Felipe Gonzalez	*Unaffiliated representative*	July 1, 2023	June 30, 2025	
32	Unaffiliated representative, at-large #1			***Vacant***	*Unaffiliated representative*	July 1, 2024	June 30, 2026	Reverend Gerald Green (PP&A)
33	Unaffiliated representative, at-large #2	1	PPC	Terrance Jones	*Unaffiliated representative*	July 1, 2023	June 30, 2025	
34	Unaffiliated representative, at-large #3	1	EXC|PP&A	Daryl Russell, M.Ed	*Unaffiliated representative*	July 1, 2024	June 30, 2026	
35	Unaffiliated representative, at-large #4	1	EXC	Joseph Green	*Unaffiliated representative*	July 1, 2023	June 30, 2025	
36	Representative, Board Office 1	1	PP&A	Al Ballesteros, MBA	JWCH Institute, Inc.	July 1, 2024	June 30, 2026	
37	Representative, Board Office 2	1	EXC	Danielle Campbell, PhDC, MPH	T.H.E Clinic, Inc. (THE)	July 1, 2023	June 30, 2025	
38	Representative, Board Office 3	1	EXC|PP	Katja Nelson, MPP	APLA	July 1, 2024	June 30, 2026	
39	Representative, Board Office 4			***Vacant***		July 1, 2023	June 30, 2025	
40	Representative, Board Office 5	1		Jonathan Weedman	ViaCare Community Health	July 1, 2024	June 30, 2026	
41	Representative, HOPWA			***Vacant***		July 1, 2023	June 30, 2025	
42	Behavioral/social scientist	1	EXC|PP	Lee Kochems, MA	*Unaffiliated representative*	July 1, 2024	June 30, 2026	
43	Local health/hospital planning agency representative			***Vacant***		July 1, 2023	June 30, 2025	
44	HIV stakeholder representative #1	1	EXC|OPS	Alasdair Burton	No affiliation	July 1, 2024	June 30, 2026	
45	HIV stakeholder representative #2	1	PP	Paul Nash, CPsychol AFBPsS FHEA	University of Southern California	July 1, 2023	June 30, 2025	
46	HIV stakeholder representative #3			***Vacant***		July 1, 2024	June 30, 2026	
47	HIV stakeholder representative #4	1	PP	Arburtha Franklin	Translatin@ Coalition	July 1, 2023	June 30, 2025	
48	HIV stakeholder representative #5	1	PP	Mary Cummings	Bartz-Altadonna Community Health Center	July 1, 2024	June 30, 2026	
49	HIV stakeholder representative #6	1	EXC|OPS	Dechelle Richardson	No affiliation	July 1, 2023	June 30, 2025	
50	HIV stakeholder representative #7	1	PP&A	William D. King, MD, JD, AAHIVS	W. King Health Care Group	July 1, 2024	June 30, 2026	
51	HIV stakeholder representative #8	1	EXC|OPS	Miguel Alvarez	No affiliation	July 1, 2024	June 30, 2026	
	TOTAL:	**38**						

LEGEND: EXC=EXECUTIVE COMM | OPS=OPERATIONS COMM | PP&A=PLANNING, PRIORITIES & ALLOCATIONS COMM | PPC=PUBLIC POLICY COMM | SBP=STANDARDS & BEST PRACTICES COMM

LOA: Leave of Absence

Overall total: 44

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 9/2/25

In accordance with the Ryan White Program (RWP), conflict of interest is defined as any financial interest in, board membership, current or past employment, or contractual agreement with an organization, partnership, or any other entity, whether public or private, that receives funds from the Ryan White Part A program. These provisions also extend to direct ascendants and descendants, siblings, spouses, and domestic partners of Commission members and non-Commission Committee-only members. Based on the RWP legislation, HRSA guidance, and Commission policy, it is mandatory for Commission members to state all conflicts of interest regarding their RWP Part A/B and/or CDC HIV prevention-funded service contracts prior to discussions involving priority-setting, allocation, and other fiscal matters related to the local HIV continuum. Furthermore, Commission members must recuse themselves from voting on any specific RWP Part A service category(ies) for which their organization hold contracts. ***An asterisk next to member's name denotes affiliation with a County subcontracted agency listed on the addendum.***

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
ALE-FERLITO	**Dahlia**	City of Los Angeles AIDS Coordinator	No Ryan White or prevention contracts
ALVAREZ	**Miguel**	No Affiliation	No Ryan White or prevention contracts
ARRINGTON	**Jayda**	Unaffiliated representative	No Ryan White or prevention contracts
BALLESTEROS	**Al**	JWCH, INC.	Benefits Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Mental Health
			Oral Health
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			HTS - Syphilis, DX Link TX - CSV
			Biomedical HIV Prevention
			Data to Care Services
			Medical Transportation Services
BLEA	**Leroy**	California Department of Public Health, Office of AIDS	Part B Grantee
BURTON	**Alasdair**	No Affiliation	No Ryan White or prevention contracts
CAMPBELL	**Danielle**	T.H.E. Clinic, Inc.	Core HIV Medical Services - AOM; MCC & PSS
			Medical Transportation Services
CIELO	**Mikhaela**	Los Angeles General Hospital	No Ryan White or prevention contracts
CUEVAS	**Sandra**	Pacific AIDS Education and Training - Los Angeles	No Ryan White or prevention contracts
CUMMINGS	**Mary**	Bartz-Altadonna Community Health Center	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
DAVIES	**Erika**	City of Pasadena	No Ryan White or prevention contracts
DAVIS (PPC Member)	**OM**	Aviva Pharmacy	No Ryan White or prevention contracts
DOLAN (SBP Member)	**Caitlyn**	Men's Health Foundation	Core HIV Medical Services - AOM; MCC & PSS
			Biomedical HIV Prevention Services
			Vulnerable Poplulations (YMSM)
			Sexual Health Express Clinics (SHEx-C)
			Data to Care Services
			Medical Transportation Services
DONNELLY	**Kevin**	Unaffiliated representative	No Ryan White or prevention contracts
FERGUSON	**Kerry**	No Affiliation	No Ryan White or prevention contracts
FINLEY	**Jet**	Unaffiliated representative	No Ryan White or prevention contracts
FRAMES	**Arlene**	Unaffiliated representative	No Ryan White or prevention contracts
FRANKLIN*	**Arburtha**	Translatin@ Coalition	Vulnerable Populations (Trans)
GERSH (SBP Member)	**Lauren**	APLA Health & Wellness	Benefits Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Intensive Case Managemenet Services
			Nutrition Support (Food Bank/Pantry Service)
			Oral Health
			STD-Ex.C
			HERR
			Biomedical HIV Prevention Services
			Medical Transportation Services
			Data to Care Services
			Residential Facility For the Chronically Ill (RCFCI)
GONZALEZ	**Felipe**	Unaffiliated representative	No Ryan White or Prevention Contracts
GREEN	**Gerald**	Minority AIDS Project	Benefits Specialty
GREEN	**Joseph**	Unaffiliated representative	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
GUTIERREZ	**Joaquin**	Unaffiliated representative	No Ryan White or prevention contracts
HARDY	**David**	University of Southern California	No Ryan White or prevention contracts
HERRERA	**Ismael "Ish"**	Unaffiliated representative	No Ryan White or prevention contracts
JONES	**Terrance**	Unaffiliated representative	No Ryan White or prevention contracts
KOCHEMS	**Lee**	Unaffiliated representative	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts
LESTER (PP&A Member)	**Rob**	Men's Health Foundation	Core HIV Medical Services - AOM; MCC & PSS
			Biomedical HIV Prevention Services
			Vulnerable Poplulations (YMSM)
			Sexual Health Express Clinics (SHEx-C)
			Data to Care Services
			Medical Transportation Services
MARTINEZ (PP&A Member)	**Miguel**	Children's Hospital Los Angeles	Core HIV Medical Services - AOM; MCC & PSS
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			Biomedical HIV Prevention Services
			Medical Transportation Services
MARTINEZ-REAL	**Leonardo**	Unaffiliated representative	No Ryan White or prevention contracts
MAULTSBY	**Leon**	In the Meantime Men's Group	Promoting Healthcare Engagement Among Vulnerable Populations
MENDOZA	**Vilma**	Unaffiliated representative	No Ryan White or prevention contracts
MINTLINE (SBP Member)	**Mark**	Western University of Health Sciences	No Ryan White or prevention contracts
NASH	**Paul**	University of Southern California	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
NELSON	**Katja**	APLA Health & Wellness	Benefits Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Intensive Case Managemenet Services
			Nutrition Support (Food Bank/Pantry Service)
			Oral Health
			STD-Ex.C
			HERR
			Biomedical HIV Prevention Services
			Medical Transportation Services
			Data to Care Services
			Residential Facility For the Chronically Ill (RCFCI)
PATEL	**Byron**	Los Angeles LGBT Center	Core HIV Medical Services - AOM; MCC & PSS
			Vulnerable Populations (YMSM)
			Vulnerable Populations (Trans)
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			HTS - Social and Sexual Networks
			Biomedical HIV Prevention Services
			Medical Transportation Services
PERÉZ	**Mario**	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee
RICHARDSON	**Dechelle**	No Affiliation	No Ryan White or prevention contracts
RUSSEL	**Daryl**	Unaffiliated representative	No Ryan White or prevention contracts
SALAMANCA	**Ismael**	City of Long Beach	Benefits Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Biomedical HIV Prevention Services
			HTS - Social and Sexual Networks
			Medical Transportation Services

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
SAMONE-LORECA	**Sabel**	Minority AIDS Project	Benefits Specialty
SATTAH	**Martin**	Rand Schrader Clinic LA County Department of Health Services	No Ryan White or prevention contracts
SAN AGUSTIN	**Harold**	JWCH, INC.	Benefits Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Mental Health
			Oral Health
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			HTS - Syphilis, DX Link TX - CSV
			Biomedical HIV Prevention Services
			Data to Care Services
			Medical Transportation Services
SAUNDERS	**Dee**	City of West Hollywood	No Ryan White or prevention contracts
SPENCER	**LaShonda**	Oasis Clinic (Charles R. Drew University/Drew CARES)	Core HIV Medical Services - PSS
			HTS - Storefront
			HTS - Social and Sexual Networks
TALLEY	**Lambert**	Grace Center for Health & Healing	No Ryan White or prevention contracts
VEGA-MATOS	**Carlos**	Men's Health Foundation	Core HIV Medical Services - AOM; MCC & PSS
			Biomedical HIV Prevention Services
			Vulnerable Poplulations (YMSM)
			Sexual Health Express Clinics (SHEx-C)
			Data to Care Services
			Medical Transportation Services
WEEDMAN	**Jonathan**	ViaCare Community Health	Biomedical HIV Prevention
			Core HIV Medical Services - AOM & MCC
YBARRA	**Russell**	Capitol Drugs	No Ryan White or prevention contracts

DRAFT

LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave. 14th Floor • Los Angeles, CA 90020 • TEL (213) 738-2816 • FAX (213) 637-4748
HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov • *VIRTUAL WEBEX MEETING*

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Approved meeting minutes are available on the Commission's website; meeting recordings are available upon request.

STANDARDS AND BEST PRACTICES (SBP) COMMITTEE MEETING MINUTES

AUGUST 5, 2025

COMMITTEE MEMBERS P = Present | A = Absent EA = Excused Absence			
Erika Davies, *Co-Chair*	P	Lauren Gersh	P
Arlene Frames, *Co-Chair*	P	Mark Mintline	P
Dahlia Ale-Ferlito	P	Byron Patel	P
Mikhaela Cielo, MD	EA	Sabel Samone-Loreca	A
Sandra Cuevas	P	Martin Sattah	P
Caitlin Dolan	EA	Russell Ybarra	P
Kerry Ferguson	P		
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, Jose Rangel-Garibay, Lizette Martinez			
DHSP STAFF			
COMMUNITY MEMBERS			

*Some participants may not have been captured electronically. Attendance can be corrected by emailing the Commission.
*Members of the public may confirm their attendance by contacting Commission staff at hivcomm@lachiv.org.
*Meeting minutes may be corrected up to one year from the date of Commission approval.

Meeting agenda and materials can be found on the Commission's website at
https://hiv.lacounty.gov/standards-and-best-practices-committee/

**LOA: Leave of absence

CALL TO ORDER-INTRODUCTIONS-CONFLICT OF INTEREST STATEMENTS

Erika Davies, SBP committee co-chair, called the meeting to order at 10:07am and led introductions.

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 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 public comments.

III. COMMITTEE NEW BUSINESS ITEMS

4. **OPPORTUNITY FOR COMMISSIONERS TO RECOMMEND ITEMS FOR FUTURE AGENDAS, OR ITEMS REQUIRING IMMEDIATE ACTION DUE TO AN EMERGENCY, OR IF NEED FOR ACTION AROSE AFTER POSTING AGENDA**: There were no committee new business items.

IV. REPORTS

5. **EXECUTIVE DIRECTOR/STAFF REPORT**
   - **Operational and Programmatic Updates**
     Cherly Barrit, COH Executive Director, reported that the August and September full-body COH meetings are canceled. The next COH meeting will be on October 9th, 2025. She added that at the October COH meeting, the co-chairs will share public comments received for the COH restricting project and the proposed revisions to the COH bylaws. She noted that the Executive committee will review the feedback received on the proposed revisions to the COH bylaws at their August 28, 2025, meeting and determine which revisions will be voted on by the full body in October. She encouraged all members to participate in the deliberations and share their feedback to help shape the future of the COH. Lastly, she reminded the committee of her upcoming retirement on August 29, 2025, and noted that COH staff are still in negotiations with DHSP on the COH budget. COH staff are also in the process of redistributing projects and duties; She will share additional information as it becomes available. Committee members expressed their gratitude towards C. Barrit and congratulated her on her retirement.

6. **CO-CHAIR REPORT**
   - **Review 2025 Committee Meeting Calendar**
     E. Davies led the committee through a review of the 2025 meeting calendar and decided to cancel the September 2, 2025, meeting. The next SBP committee meeting will be on October 7, 2025. COH staff will send a meeting cancelation notice and post information on the October 7, 2025, on the COH website.
   - **Service Standards Revision Tracker—Updates**
     E. Davies reported that there is motion to approve the Transitional Case Management (TCM) service standards on the agenda for the August 29, 2025, Executive committee meeting. The SBP committee will vote to post the Patient Support Services (PSS) service standards for a public comment period and begin reviewing the Mental Health service standards.

6. **DIVISION ON HIV AND STD PROGRAMS (DHSP) REPORT**
   There was no report.

V. DISCUSSION ITEMS

7. **Transitional Case Management Service Standards Review**
   J. Rangel-Garibay, COH staff, provided an overview of the public comments received for the TCM service standards; a copy of the document can be found on page 19 the meeting packet. After reviewing the

public comments received, the committee decided the following:

- Add a description of In-Reach and change the heading to "Outreach and In-Reach"
- Rephrase "Resources and referrals" to "Benefits, resources, and referrals"
- Add "if possible" and "have TCM staff document that the agree agreed" to document client signature when writing utensils are not available.
- Add, "Participate in training as recommended by DHSP" and "Have provider agencies ensure that when staff are hired, they assist staff in attending some form of training"
- Remove "copies of diplomas on file" from the Staffing Requirements and Qualifications section.

MOTION #3: Approve the Transitional Case Management service standards, as presented or revised, and elevate to the Executive Committee. ***(✓Passed; Yes: D. Ale-Ferlito, S. Cuevas, K. Ferguson, A. Frames, L. Gersh, M. Mintline, B. Patel, M. Sattah, R. Ybarra, E. Davies).***

8. Non-Medical Case Management (NMCM) Service Standards Review

E. Davies reminded the committee of the changes to the PSS service standards and the decision to include PSS in the Non-Medical Case Management (NMCM) service standards instead of creating a standalone document based on guidance from DHSP. J. Rangel-Garibay provided an overview of the proposed changes to the NMCM service standards.

B. Patel, committee member, asked if PSS was a standalone program or if it is tied to Medical Case Management (MCC) or Ambulatory Outpatient Medical (AOM) clinic-based programs. Abel Alvarez, DHSP staff, noted that there are some agencies have standalone contracts for PSS while others have a combination of MCC and PSS, AOM and PSS, and MMC, AOM, and PSS. He added that the program was named PSS to assist clients that either did not meet the acuity threshold for MCC enrollment or do not want to be enrolled in an MCC or other clinic-based program but need additional support services. PSS fills the gap for provider agencies that may not have staff to offer support services to meet client needs. B. Patel noted that at their agency, they utilize PSS to hire a clinical support specialize that administers injectables such as Cabenuva; most clients receiving this service are undetectable and do not meet the acuity metrics to qualify for MCC.

A. Alvarez noted that DHPS is working with providers contracted to offer PSS to help them implement the program. After the first year of implementation, DHSP will evaluate the implementation efforts and develop recommendations, policies, and technical assistance based on their analysis. B. Patel suggested for the committee to wait for DHSP to complete their evaluation of the program implementation then proceed with additional revisions to the NMCM-PSS service standards. The committee decided to open the document for public comment and continue their review in October.

9. Mental Health (MH) Service Standards Review

The committee reviewed the MH service standards and proposed the following revisions:

- Mental Health Assessment Section:
    - Include option to complete the assessment through a virtual option.
    - Remove "Clients seen in crisis who are not currently in MCC program will be referred to one within three working days of stabilization" in both the narrative and table.

- Remove "expanded assessment" section in the table.
- Rephrase to "Reassessment conducted as needed or at a minimum of once every 12 months."
- Rephrase to "Assessments and reassessments completed by unlicensed providers will be cosigned by licensed clinical supervisors" throughout the document.
- Rephrase to "Co-signature of licensed provider on file in client chart."

- Treatment Provision Section:
  - Rephrase to "Treatment, as appropriate, will include counseling about."
  - Condense progress notes standards into single standard phrased, "Progress notes for all mental health treatment provided will document progress through treatment provisions."
- Informed Medication Consent section:
  - Research if there is a need for a separate informed medication consent for psychotropic medications.
- Case Conferences section:
  - Rephrase to, "Interdisciplinary case conferences will be held for each active client based on acuity and need."
- Staffing Requirements and Qualifications section:
  - Remove "HIV/AIDS" on second paragraph; there is no specified treatment for people living with HIV/AIDS compared to people not diagnosed with HIV/AIDS.
  - Remove requirement to complete 8 hours of CE/CME; retain requirement to participate in CE/CME on topics of HIV and mental health issues every two years.
  - Consult with mental health providers regarding the list of training topics.
  - Review current guidelines on APA and AMA regarding laws regarding ethical conduct; consider adding hyperlinks to the section instead of including the information. Review language on "Duty to Warn" description.

VI. NEXT STEPS

10. TASK/ASSIGNMENTS RECAP:

- COH staff will elevate the TCM service standards to the Executive committee for approval at their next meeting on August 29, 2025.
- COH staff will post the PSS service standards on the COH website for a public comment period.
- COH staff will send a reminder to committee members regarding the cancelation of the September 2, 2025, SBP committee meeting.
- COH staff will invite mental health providers to the October 7, 2025, SBP committee meeting to gather their feedback on the mental health service standards.

11. AGENDA DEVELOPMENT FOR NEXT MEETING:

- Continue review of the Patient Support Services (PSS) service standards.
- Continue review of Mental Health service standards.

VII. ANNOUNCEMENTS

12. OPPORTUNITY FOR PUBLIC AND COMMITTEE TO MAKE ANNOUNCEMENTS:

- No announcements.

VIII. ADJOURNMENT

13. ADJOURNMENT: The meeting adjourned at 11:57 am.

LOS ANGELES COUNTY
COMMISSION ON HIV

STANDARDS AND BEST PRACTICES COMMITTEE 2025 MEETING CALENDAR *(Last updated 10/01/25)*

DATE	KEY AGENDA ITEMS/TOPICS (subject to change; for planning purposes)
Jan. 7, 2025 1pm to 3pm TK02	• Hold co-chair nominations. • Review 2025 COH workplan and 2025 meeting calendar • Continue review of Temporary Housing service standards
Feb. 4, 2025 10am to 12pm TK02	• Elect co-chairs for 2025 term. • Establish standards review schedule for 2025. • Complete review of Temporary Housing service standards (RCFCI and TRCF) • Continue review of Permanent Housing service standards
Mar. 11, 2025 10am-12pm TK02	• Review public comments on "Housing Services" service standards • Initiate review of Transitional Case Management service standards
Apr. 1, 2025 10am-12pm 14th Floor	• Review Service Standards Development Tracker and determine review cycle • Continue review of Transitional Case Management service standards
May 6, 2025 10am-12pm 14th Floor	• Continue review of Transitional Case Management service standards • Preview Patient Support Services (PSS) service standards
Jun. 3, 2025 10am-12pm TK02	• Continue review of Transitional Case Management service standards • Review Patient Support Services (PSS) service standards
Jul. 1, 2025 10am-12pm TK02	• Continue review of Transitional Case Management (TCM) service standards • Review Patient Support Services (PSS) service standards
Aug. 5, 2025 10am-12pm TK02	• Finalize review of TCM service standards • Continue review of PSS service standards • Begin review of Mental Health (MH) service standards
Sep. 2, 2025	**Meeting Cancelled**
Oct. 7, 2025 10am-12pm TK02	• Review public comments received for PSS service standards • Continue review of MH service standards
Nov. 4, 2025 10am-12pm TK02	• Finalize review of MH service standards and post for public comment • Revisit Service Standard Review Tracker document • **REMINDER**: COH Annual Meeting will be on 11/13/25 at St. Annes
Dec. 2, 2025 10am-12pm TK02	**Consider rescheduling/cancelling due to World AIDS Day events.**

SERVICE STANDARDS REVISION DATE TRACKER FOR PLANNING PURPOSES

Last updated: 10/01/25

KEYWORDS AND ACRONYMS	
HRSA: Health Resources and Services Administration	**COH:** Commission on HIV
RWHAP: Ryan White HIV/AIDS Program	**DHSP:** Division on HIV and STD Programs
HAB PCN 16-02: HIV/AIDS Bureau Policy Clarification Notice 16-02 RWHAP: Eligible Individuals & Allowable Uses of Funds	**SBP Committee:** Standards and Best Practices Committee
	PLWH: People Living With HIV

*** SERVICES IN BLUE ARE CURRENTLY FUNDED ***

HRSA Service Category	COH Standard Title	DHSP Service	Description	Notes
N/A	AIDS Drug Assistance Program (ADAP) Enrollment	N/A	State program that provides medications that prolong quality of life and delay health deterioration to people living with HIV who cannot afford them.	ADAP contracts directly with agencies. Administered by the California Department of Public Health, Office of AIDS.
Child Care Services	Child Care Services	Child Care Services	Childcare services for the children of clients living with HIV, provided intermittently, only while the client attends in person, telehealth, or other appointments and/or RWHAP related meetings, groups, or training sessions.	**Last approved by COH: 7/8/2021**
Early Intervention Services	Early Intervention Program (EIS) Services	Testing Services	Targeted testing to identify HIV+ individuals.	**Last approved by COH: 5/2/2017**
Emergency Financial Assistance	Emergency Financial Assistance (EFA)	Emergency Rental Assistance	Pay assistance for rent, utilities, and food and transportation for PLWH experiencing emergency circumstances.	**Last approved by COH: 2/13/2025** **Updates from DHSP:** Clients must be facing eviction to qualify, the limit is $5,000 per year, per client, and applications are through Benefits Specialists.
Food Bank/Home Delivered Meals	Nutrition Support Services	Nutrition Support Services	Home-delivered meals and food bank/pantry services programs.	**Last approved by COH: 8/10/2023**
N/A	HIV/STI Prevention Services	Prevention Services	Services used alone or in combination to prevent the transmission of HIV and STIs.	**Last approved by COH: 4/11/2024** *Not a program- Standards apply to prevention services.*

*** SERVICES IN BLUE ARE CURRENTLY FUNDED ***

LOS ANGELES COUNTY COMMISSION ON HIV

HRSA Service Category	COH Standard Title	DHSP Service	Description	Notes
Home and Community-Based Health Services	Home-Based Case Management	Home-Based Case Management	Specialized home care for homebound clients.	**Last approved by COH: 9/9/2022**
Hospice	Hospice Services	Hospice Services	Helping terminally ill clients approach death with dignity and comfort.	**Last approved by COH: 5/2/2017**
Housing	Housing Services: Permanent Supportive	Housing For Health	Supportive housing rental subsidy program of LA County Department of Health Services.	**Last approved by COH: 4/10/2025**
Housing	Housing Services: Residential Care Facility for Chronically Ill (RCFCI) and Transitional Residential Care Facility (TRCF)	Housing Services RCFCI/TRCF	RCFCI: Home-like housing that provides 24-hour care. TRCF: Short-term housing that provides 24-hour assistance to clients with independent living skills.	**Last approved by COH: 4/10/2025**
Legal Services	Legal Services	Legal Services	Legal information, representation, advice, and services.	**Last approved by COH: 7/12/2018**
Linguistic Services	Language Interpretation Services	Language Services	Interpretation (oral and written) and translation assistance to assist communication between clients and their healthcare providers.	**Last approved by COH: 5/2/2017**
Medical Case Management	Medical Care Coordination (MCC)	Medical Care Coordination	HIV care coordination through a team of health providers to improve quality of life.	**Last approved by COH: 1/11/2024**
	Treatment Education Services	Treatment Education Services	Provide ongoing education and support to ensure compliance with a client's prescribed treatment regimen and help identify and overcome barriers to adherence.	**Last approved by COH: 5/2/2017**
Medical Nutrition Therapy	Medical Nutrition Therapy Services	Medical Nutrition Therapy	Nutrition assessment and screening, and appropriate inventions and treatments to maintain and optimize nutrition	**Last approved by COH: 5/2/2017**

*** SERVICES IN BLUE ARE CURRENTLY FUNDED ***

HRSA Service Category	COH Standard Title	DHSP Service	Description	Notes
			status and self-management skills to help treat HIV disease.	
Medical Transportation	Transportation Services	Medical Transportation	Ride services to medical and social services appointments.	**Last approved by COH: 2/13/2025**
Mental Health Services	Mental Health Services	Mental Health Services	Psychiatry, psychotherapy, and counseling services.	**Last approved by COH: 5/2/2017** *Committee will continue review on 10/7/25.*
Non-Medical Case Management	Benefits Specialty Services (BSS)	Benefits Specialty Services	Assistance navigating public and/or private benefits and programs.	**Last approved by COH: 9/8/2022**
	Patient Support Services (PSS)	Patient Support Services	Provide interventions that target behavioral, emotional, social, or environmental factors that negatively affect health outcomes with the aim of improving an individual's health functioning and overall well-being.	New service standard currently under development. *Committee will review public comments received and hold vote to approve on 10/7/25.*
	Transitional Case Management: Justice-Involved Individuals	Transitional Case Management- Jails	Support for post-release linkage and engagement in HIV care.	**Last approved by COH: 12/8/2022** *COH will review and hold vote to approval on 10/9/25*
	Transitional Case Management: Youth	Transitional Case Management- Youth	Coordinates services designed to promote access to and utilization of HIV care by identifying and linking youth living with HIV/AIDS to HIV medical and supportive services.	**Last approved by COH: 12/8/2022** *COH will review and hold vote to approval on 10/9/25*
	Transitional Case Management: Older Adults 50+	N/A	Coordinate transition between systems of care for older adults 50+ living with HIV/AIDS.	*COH will review and hold vote to approval on 10/9/25*
Oral Health Care	Oral Health Care Services	Oral Health Services	General and specialty dental care services.	**Last approved by COH: 4/13/2023**
Outpatient/Ambulatory Health Services	Ambulatory Outpatient Medical (AOM)	Ambulatory Outpatient Medical	HIV medical care accessed through a medical provider.	**Last approved by COH: 2/13/2025**
Outreach Services	Outreach Services	Linkage and Retention Program	Promote access to and engagement in appropriate services for people newly diagnosed or identified as	**Last approved by COH: 5/2/2017**

*** SERVICES IN BLUE ARE CURRENTLY FUNDED ***

HRSA Service Category	COH Standard Title	DHSP Service	Description	Notes
			living with HIV and those lost or returning to treatment.	
Permanency Planning	Permanency Planning	Permanency Planning	Provision of legal counsel and assistance regarding the preparation of custody options for legal dependents or minor children or PLWH including guardianship, joint custody, joint guardianship and adoption.	**Last approved by COH: 5/2/2017**
Psychosocial Support Services	Psychosocial Support Services	Psychosocial Support Services	Help PLWH cope with their diagnosis and any other psychosocial stressors they may be experiencing through counseling services and mental health support.	**Last approved by COH: 9/10/2020**
Referral for Health Care and Support Services	Referral Services	Referral	Developing referral directories and coordinating public awareness about referral directories and available referral services.	**Last approved by COH: 5/2/2017**
Substance Abuse Services (residential) Substance Abuse Outpatient Care	Substance Use Disorder and Residential Treatment Services	Substance Use Disorder Transitional Housing	Temporary residential housing that includes screening, assessment, diagnosis, and treatment of drug or alcohol use disorders.	**Last approved by COH: 1/13/2022**
N/A	Universal Standards and Client Bill of Rights and Responsibilities	N/A	Establishes the minimum standards of care necessary to achieve optimal health among PLWH, regardless of where services are received in the County. These standards apply to all services.	**Last approved by COH: 1/11/2024** *Not a program—SBP committee will review this document on a bi-annual basis or as necessary per community stakeholder, contracted agency, or COH request.*

Service Standard Development

LOS ANGELES COUNTY COMMISSION ON HIV

KEYWORDS AND ACRONYMS

BOS: Board of Supervisors
COH: Commission on HIV
SBP: Standards and Best Practices
DHSP: Division of HIV & STD Programs
RFP: Request for Proposal
HRSA: Health Resources and Services Administration
HAB: HIV/AIDS Bureau
RWHAP: Ryan White HIV/AIDS Program
PSRA: Priority Setting and Resource Allocations
PCN: Policy Clarification Notice

WHAT ARE SERVICE STANDARDS?

Service Standards establish the minimal level of service of care for consumers in Los Angeles County. Service standards outline the elements and expectations a RWHAP service provider must follow when implementing a specific Service Category **to ensure that all RWHAP service providers offer the same basic service components**.

WHAT ARE SERVICE CATEGORIES?

Service categories are the services funded by the RWHAP as part of a comprehensive service delivery system for people with HIV to improve retention in medical care and viral suppression.

Services fall under two categories: **Core Medical Services** and **Support Services**. **The COH develops service standards for 13 Core Medical Services, and 17 Support services.** As an integrated planning body for HIV prevention and care services, the COH also develops service standards for 11 Prevention Services.

A key resource the SBP Committee utilizes when developing services standards is the **HRSA/HAB PCN 16-02** which **defines and providers program guidance for each of the Core Medical and Support Services** and defines individuals who are eligible to receive these RWHAP services.

HRSA/HAB GUIDANCE FOR SERVICE STANDARDS

- Must be consistent with Health and Human Services guidelines on HIV care and treatment and the HRSA/HAB standards and performance measures and the National Monitoring Standards.
- Should NOT include HRSA/HAB performance measures or health outcomes.
- Should be developed at the local level.
- Are required for every funded service category.
- Should include input from providers, consumers, and subject matter experts.
- Be publicly accessible and consumer friendly.

COH SERVICE STANDARDS

Universal Service Standards	• General agency policies and procedures
	  ○ Intake and Eligibility
	  ○ Staff Requirements and Qualifications
	  ○ Cultural and Linguistic Competence
	  ○ Referrals and Case Closures
	• Client Bill of Rights and Responsibilities

Category-Specific Service Standards	• Include link to Universal Service Standards • Core Medical Services • Support Services
Service Standards General Structure	• Introduction • Service Overview • Service Components • Table of Standards & Documentation requirements

REMINDER

Service standards are meant to be flexible, not prescriptive, or too specific. Flexible service standards allow service providers to adjust service delivery to meet the needs of individual clients and reduce the need for frequent revisions/updates.

DEVELOPING SERVICE STANDARDS

Service standard development is a joint responsibility shared by DHSP and the COH. There is no required format or specific process defined by HRSA HAB. **The SBP Committee leads the service standard development process for the COH.**

SERVICE STANDARD DEVELOPMENT PROCESS

SBP REVIEW	• Develop review schedule based on service rankings, DHSP RFP schedule, a consumer/provider/service concern, or in response to changes in the HIV continuum of care. • Conduct review/revision of service standards which includes seeking input from consumers, subject matter experts, and service providers. • Post revised service standards document for public comment period on COH website.
COH REVIEW	• After SBP has agreed on all revisions, SBP holds a vote to approve. • Once approved, the document is elevated to Executive Committee and COH for approval. • COH reviews the revised/updates service standards and holds vote to approve. Once approved, the document is sent to DHSP.
DISSEMINATION	• Service standards are posted on **COH website** for public viewing and to encourage use by non-RWP providers. • DHSP uses service standards when developing RFPs, contracts, and for monitoring/quality assurance activities.
CYCLE REPEATS	• Service standards undergo revisions at least every 3 years or as needed. • DHSP provides summary information to COH on the extent to which service standards are being met to assist with identifying possible need for revisions to service standards.

together.

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For additional information about the COH, please visit our website at: http://hiv.lacounty.gov

Subscribe to the COH email list: https://tinyurl.com/y83ynuzt

LOS ANGELES COUNTY COMMISSION ON HIV

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MENTAL HEALTH SERVICES

(Draft as of 10/02/25)

IMPORTANT: The service standards for Justice-involved individuals, Mental Health Services adhere to requirements and restrictions from the federal agency, Health Resources and Services Administration (HRSA). The key documents used in developing standards are as follows:

Human Resource Services Administration (HRSA) HIV/AIDS Bureau (HAB) Policy Clarification Notice (PCN) # 16-02 (Revised 10/22/18): Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds

HRSA HAB Policy Clarification Notice (PCN) # 18-02: The use of Ryan White HIV/AIDS Program Funds for Core Medical Services and Support Services for People Living with HIV Who Are Incarcerated and Justice Involved

HRSA HAB, Division of Metropolitan HIV/AIDS Programs: National Monitoring Standards for Ryan White Part A Grantees: Program – Part A

Service Standards: Ryan White HIV/AIDS Programs

Table of Contents

Introduction

Service standards outline the elements and expectations a Ryan White HIV/AIDS Program (RWHAP) provider follows when implementing a specific service category. The purposed of service standards is to ensure that all RWHAP providers offer the same fundamental components of the given service category across a service area. Service standards establish the minimal level of service or care that a RWHAP-funded agency or provider may offer in Los Angeles County.

Service Description

Mental health treatment for PLWH attempts to improve and sustain a client's quality of life. Counseling and psychotherapy have been shown to be helpful in alleviating or decreasing psychological symptoms that can accompany a diagnosis of HIV. Psychiatric treatment for PLWH attempts to stabilize mental health conditions while improving and sustaining quality of life. Evidence based psychiatric treatment approaches and psychotherapeutic medications have proven effective in alleviating or decreasing psychological symptoms and illnesses that may accompany a diagnosis of HIV. Often, PLWH have psychological illnesses that pre-date their infection, but have been exacerbated by the stress of living with a chronic illness.

Mental health services include:

- Mental health assessment
- Treatment planning
- Treatment provision
    - Individual counseling/psychotherapy
    - Family counseling/psychotherapy
    - Group counseling/psychotherapy
    - Psychiatric medication assessment, prescription and monitoring
    - Drop-in psychotherapy groups
    - Crisis intervention

General Eligibility Requirements for Ryan White Services

- Be diagnosed with HIV or AIDS with verifiable documentation.
- Be a resident of Los Angeles County
- Have an income at or below 500% of Federal Poverty Level.
- Provide documentation to verify eligibility, including HIV diagnosis, income level, and residency.

Given the barriers with attaining documentation, contractors are expected to follow the Los Angeles County, Department of Public Health, Division of HIV and STD Programs (DHSP) guidance for using self-attestation forms for documentation eligibility for Ryan White services.

Mental Health Service Components

HIV/AIDS mental health services are short-term or sustained therapeutic interventions provided by mental health professionals who specialize in HIV (see Appendix B for a description of mental health professionals) for clients experiencing acute and/or ongoing psychological distress. This document describes the following service components for Mental Health Services: Mental health Assessment, Treatment Plans, Treatment Provision, Documentation, Informed Medication Consent, Crisis Intervention,

MENTAL HEALTH ASSESSMENT

Mental health assessment is completed during a collaborative interview in which the client's biopsychosocial history and current presentation are evaluated to determine diagnosis and treatment plan. Reassessments are indicated when there is significant change in the client's status, or when the client re-enters treatment. To reduce client assessment burden, mental health providers should utilize existing assessments such as those performed by Medical Care Coordination (MCC) teams, as a tool to inform treatment plan development. Persons receiving crisis intervention or drop-in psychotherapy groups require a brief assessment of the presenting issues that supports the mental health treatment modality chosen.

MENTAL HEALTH SERVICES: MENTAL HEALTH ASSESSMENT	
STANDARD	DOCUMENTATION
Mental health assessments will be completed by mental health provider within two visits, but in no longer than 30 days.	Completed assessment, in client file to include: • Detailed mental health presenting problem • Psychiatric or mental health treatment history • Mental status exam • Complete DSM five axis diagnosis
Reassessment conducted as needed or at a minimum of once every 12 months.	Progress notes or new assessment demonstrating reassessment in client file.
Assessments and reassessments completed by unlicensed providers will be cosigned by licensed clinical supervisors.	Co-signature of licensed provider on file in client chart.

TREATMENT PLANS

Treatment plans are developed in collaboration with the client and outline the course of treatment and are required for clients receiving all mental health services, excluding drop-in psychotherapy groups and crisis intervention services. A treatment plan begins with a statement of problems to be addressed in treatment and follows with goals, objectives, timeframes, interventions to meet these goals, and referrals. Mental health assessment and treatment plans should be developed concurrently; however, treatment plans must be finalized within two weeks of the completion of the mental health assessment. Treatment plans must be developed by the same mental health provider that conducts the mental health assessment. Treatment plans will be reviewed and revised at a minimum of every 12 months.

MENTAL HEALTH SERVICES: TREATMENT PLANS	
STANDARD	DOCUMENTATION
Mental health assessments and treatment plans are developed concurrently and collaboratively with the client. Treatment plans must be finalized within two weeks of the completion of the mental health assessment and developed by the same mental health provider that conducts the mental health assessment.	Completed, signed treatment plan on file in client chart to include: • Statement of problem(s), symptom(s) or behavior(s) to be addressed in treatment • Goals and objectives • Interventions and modalities proposed • Frequency and expected duration of services • Referrals (e.g. day treatment programs, substance use treatment, etc.)

Review and revised treatment plan not less than once every twelve months.	Documentation of treatment plan revision in client chart.
Assessments and reassessments completed by unlicensed providers will be cosigned by licensed clinical supervisor.	Co-signature of licensed provider on file in client record.

TREATMENT PROVISION

Treatment provision consists of ongoing contact and clinical interventions with (or on behalf) of the client necessary to achieve treatment plan goals. All modalities and interventions in mental health treatment will be guided by the needs expressed in the treatment plan. Practitioners shall be knowledgeable about outcome research and utilize clinically proven treatment for their client's presenting problems. Treatment provision should be documented through progress notes and include the date and signature of the mental health provider. Progress notes completed by unlicensed providers will be cosigned by licensed clinical supervisor. See **Appendix C** for Descriptions of Treatment Modalities.

MENTAL HEALTH SERVICES: TREATMENT PROVISION	
STANDARD	DOCUMENTATION
Interventions and modalities will be determined by treatment plan.	Treatment plan signed and dated by mental health provider and client in client file.
Mental health providers will use outcome research and published standards of care, as appropriate and available, to guide their treatment.	Progress note signed and dated by mental health provider detailing interventions in client file.
Treatment, as appropriate, will include counseling about: • Prevention and transmission risk behaviors, including root causes and underlying issues related to increased HIV transmission behaviors • Substance use • Treatment adherence • Development of social support systems • Community resources • Maximizing social and adaptive functioning • The role of spirituality and religion in a client's life • Disability, death, and dying • Exploration of future goals	Progress note, signed and dated by mental health provider detailing counseling sessions in client file.
Progress notes for all mental health treatment provided will document progress through treatment provision.	Signed, dated progress note in client chart to include: • Date, type of contact, time spent • Interventions/referrals provided • Progress toward Treatment Plan goals • Newly identified issues • Client response
Progress notes completed by unlicensed providers will be cosigned by licensed clinical supervisor.	Co-signature of licensed provider on file in client record.

INFORMED MEDICATION CONSENT

Informed Medication consent is required of every patient receiving psychotropic medications.

MENTAL HEALTH SERVICES: INFORMED MEDICATION CONSENT	
STANDARD	DOCUMENTATION
An informed Medication Consent will be completed for all patients receiving psychotropic medications.	Completed, signed, and dated Informed Medication Consent on file in client chart indicating the patient has been told about and understands: • Medication benefits • Risks • Common side effects • Side effect management • Timetable for expected benefit
A new Informed Medication Consent will be completed whenever a new medication is prescribed.	New Informed Medication Consent on file in client chart.
Informed Medication Consents completed by unlicensed providers will be cosigned by medical doctor board-eligible in psychiatry.	Co-signature of licensed provider on file in client record.

CRISIS INTERVENTION

Crisis intervention is an unplanned service provided to an individual, couple or family experiencing biopsychosocial distress. These services focus on reversing and stabilizing crisis-related deterioration of functioning. Crisis intervention can be provided face-to-face or by telephone. It is imperative that client safety is assessed and addressed under these crisis situations. Crisis intervention services may occur as often as necessary to ensure client safety and maintenance of baseline functioning.

MENTAL HEALTH SERVICES: CRISIS INTERVENTION	
STANDARD	MEASURE
Crisis intervention services will be offered to clients experiencing psychological distress.	Progress notes to detail reasons for crisis intervention services.
Client safety will be continuously assessed and addressed when providing crisis intervention services.	Progress notes to detail safety assessment.
Progress notes will document crisis intervention services.	Signed, dated progress notes in client chart to include: • Date, time of day, and time spent with or on behalf of the client • Summary of crisis event • Interventions and referrals provided • Results of interventions and referrals • Follow-up plan

Progress notes completed by unlicensed providers will be cosigned by licensed clinical supervisor	Co-signature of licensed provider on file in client record.

TRIAGE/REFERRAL/COORDINATION

In certain cases, clients will require a higher level of mental health intervention than a given agency is able to provide. Mental health providers are responsible for referring these clients to additional mental health services including neuropsychological testing, day treatment programs and in-patient hospitalization. Referrals to other services including case management, treatment advocacy, peer support, medical treatment and dental treatment will also be made as indicated. Regular contact with client's primary care clinic and other providers will ensure integration of services and better client care.

MENTAL HEALTH SERVICES: TRIAGE/REFERRAL/COORDINATION	
STANDARD	DOCUMENTATION
As needed, providers will refer clients to full range of mental health services including: • Neuropsychological testing • Day treatment programs • In-patient hospitalization	Signed, dated progress notes to document referrals in client chart.
As needed, providers will refer to other services including case management, treatment advocacy, peer support, medical treatment, and dental treatment.	Signed, dated progress notes to document referrals in client chart.
Providers will attempt to make contact with a client's primary care clinic at minimum once a year, or as clinically indicated, to coordinate and integrate care. Contact with other providers will occur as clinically indicated.	Documentation of contact with primary medical clinics and providers to be placed in progress notes.

CASE CONFERENCES

Programs will conduct monthly interdisciplinary discussions of selected patients to assist in problem-solving related to a patient's progress toward mental health treatment plan goals and to ensure that professional guidance and high-quality mental health treatment services are being provided. All members of the treatment team available, including case managers, treatment advocates, medical personnel, etc., are encouraged to attend. Documentation of case conferences shall be maintained within each client record in a case conference log.

MENTAL HEALTH SERVICES: CASE CONFERENCES	
STANDARD	DOCUMENTATION
Interdisciplinary case conferences will be held for each active client based on acuity and need.	Case conference documentation, signed by the supervisor, on file in client chart to include: • Date, name of participants, and name of client • Issues and concerns • Follow-up plan

	• Clinical guidance provided • Verification that guidance has been implemented

CLIENT RETENTION AND CASE CLOSURE

Provider agencies will strive to retain clients in mental health treatment. A broken appointment policy and procedure to ensure continuity of service and retention of clients is required. Follow-up can include telephone calls, written correspondence and/or direct contact, and efforts to maintain a client's participation in care.

Case closure is a systematic process for discharging clients from mental health services. The process includes the completion of a Case Closure Summary (CCS) to be maintained in the client record. Case closure will be initiated if the patient does not receive mental health services or is unable to be contacted within a one-year period.

MENTAL HEALTH SERVICES: CLIENT RETENTION AND CASE CLOSURE	
STANDARD	DOCUMENTATION
Programs will develop a broken appointment policy to ensure continuity of service and retention of clients.	Written policy on file at provider agency.
Programs will provide regular follow-up procedures to encourage and help maintain a client in mental health treatment.	Documentation of attempts to contact in progress notes. Follow-up may include: • Telephone calls • Written correspondence • Electronic Medical Record • Direct contact
Programs will develop case closure criteria and procedures.	Case closure criteria and procedures on file at provider agency. Cases may be closed when the patient: • Successfully attains psychiatric treatment goals • Relocates out of the service area • Becomes eligible for benefits or other third-party payer (e.g. Medi-Cal, private medical insurance, etc.) • Has had no direct program contact in a one-year period • Is ineligible for the service • No longer needs the service • Discontinues the service • Is incarcerated long term • Utilizes the service improperly or has not complied with the client services agreement • Had died

Regular follow-up will be provided to clients who have dropped out of treatment without notice.	Documentation of attempts to contact in progress notes.
A Case Closure Summary will be completed for each client who has terminated treatment.	Signed, and dated Case Closure Summary on file in client chart to include: • Course of treatment • Discharge diagnosis • Referrals made • Reason for termination
Case Closure Summaries completed by unlicensed providers will be cosigned by licensed clinical supervisor.	Co-signature of licensed provider on file in client chart.

STAFFING REQUIREMENTS AND QUALIFICATIONS

Providers of mental health services will be master's or doctoral level graduate students in counseling, marriage and family therapy, nursing (with specialized mental health training), psychiatry, psychology, or social work.

Psychiatric treatment services are provided by medical doctors' board-eligible in psychiatry. A psychiatrist may work in collaboration with a psychiatric resident, or RN/NP. While state law governs prescription of medication, it is recommended that physicians licensed as such by the state of California shall prescribe all prescriptions for psychotropic medications. If an NP is utilized to provide medications, they must do so according to standardized protocol and under the supervision of a psychiatrist.

All staff hired by provider agencies will possess the ability to provide developmentally and culturally appropriate care to clients living with and affected by HIV. All clinical staff will have previous experience or training utilizing appropriate treatment modalities in practice.

All hired staff will participate in orientation and training before beginning treatment provision. Licensed providers are encouraged to seek consultation to address clinical, psychosocial, developmental, and programmatic issues, as needed. If providers are unlicensed, they must be clinically supervised in accordance with the requirements of the licensing board of their respective professions. Graduate-level interns must be supervised according to the requirement of their respective programs and to the degree that ensures appropriate practice.

Practitioners should have training and experience with HIV/AIDS related issues and concerns. Providers will participate in continuing education or Continuing Medical Education (CME) on the topics of HIV and mental health issues every two years.

Practitioners providing mental health services to people living with HIV should possess knowledge about the following:

- HIV disease and current medical treatments
- Medication interactions (for psychiatrists)
- Psychosocial issues related to HIV/AIDS
- Cultural issues related to communities affected by HIV/AIDS
- Mental disorders related to HIV and other medical conditions
- Mental disorders that can be induced by prescription drug use

- Adherence to medication regimens
- Diagnosis and assessment of HIV-related mental health issues
- HIV/AIDS legal and ethical issues
- Sexuality, gender, and sexual orientation issues
- Substance use theory, treatment, and practice

Finally, practitioners and staff must be aware of and able to practice under the legal and ethical obligations as set forth by California state law and their respective professional organizations.

Psychiatrists shall comply with existing laws regarding confidentiality, informed consent and client's rights, and shall conform to the standards and guidelines of the American medical Association and the American Psychiatric Association regarding ethical conduct, including:

- **Duty to treat:** Practitioners have an ethical obligation not to refuse treatment because of fear or lack of knowledge about HIV
- **Confidentiality:** Maintenance of confidentiality is a primary legal and ethical responsibility of the psychiatric practitioner.
- **Duty to warn:** Serious threats of violence against a reasonability identifiable victim must be reported. However, at present, in California, a person living with HIV engaging in behaviors that may put others at risk for HIV infection is not a circumstance that warrants breaking of confidentiality. Physicians, however, may notify identified partners who may have been infected, while other mental health providers are not permitted to do so.

Mental health services providers are advised to seek legal advice when they are unsure about issues and the level/ethical ramifications of their actions.

MENTAL HEALTH SERVICES: STAFFING REQUIREMENTS AND QUALIFICATIONS	
STANDARD	MEASURE
Provider will ensure that all staff providing psychiatric treatment services will be licensed, supervised by a medical doctor board-eligible in psychiatry, accruing house toward licensure or a registered graduate student enrolled in counseling, social work, psychology or marriage and family therapy program.	Documentation of licensure/professional/student status on file.
It is recommended that physicians licensed as such by the state of California shall prescribe psychotropic medications.	Documentation of licensure on file.
New staff will completed orientation/training prior to providing services.	Documentation of training file.
Mental health staff are training and knowledgeable regarding HIV/AIDS and the affected community.	Training documentation on file maintained in each personnel record which includes: • Date, time, and location of the function • Function type • Name of the agency and staff members attending the function • Name of the sponsor or provider

	• Training outline, meeting agenda and/or minutes
Programs will provide and/or allow access to ongoing staff training and development of staff including medical, psychiatric and mental health HIV-related issues.	Training documentation on file maintained in each personnel record which includes: • Date, time, and location of the function • Function type • Name of the agency and staff members attending the function • Name of sponsor or provider • Training outline, meeting agenda, and/or minutes
Licensed staff are encouraged to seek consultation as needed.	Documentation of consultation on file.
Treatment providers will practice according to California state law and the ethical codes of their respective professional organizations.	Chart review will ensure legally and ethically appropriate practice.
Psychiatric treatment providers will possess skill, experience and licensing qualifications appropriate to provision of psychiatric treatment services.	Resume and current license on file.
Unlicensed professional psychiatric and mental health professionals will receive supervision in accordance with sate licensing requirements. The Division on HIV and STD Programs (DHSP) will be notified immediately in writing if a clinical supervisor is not available.	Documentation of supervision on file.
Mental health service staff will complete documentation required by program.	Administrative supervisor will review documentation periodically.

ADMINSTRATIVE SUPERVISION

Programs will conduct client record reviews to assess that all required mental health documentation is completed properly in a timely manner and secured within the client records.

MENTAL HEALTH SERVICES: ADMINISTRATIVE SUPERVISION	
STANDARD	MEASURE
Programs shall conduct record reviews to ensure appropriate documentation.	Client record review, signed and dated by reviewed on file to include: • Checklist of required documentation • Written documentation identifying steps to be taken to rectify missing or incomplete documentation • Date of resolution for omissions

UTILIZING INTERNS, ASSOCIATES, AND TRAINEES

A significant portion of mental health services are provided by interns, associates and trained (IATs). While this process expands capacity by developing a well-trained workforce and provides increased access through cost effective services, extra care must be taken to ensure that high quality, ethical counseling and psychotherapy services are maintained. See **Appendix D** for additional information on Utilizing Interns, Associates, and Trainees (IATs).

MENTAL HEALTH SERVICES: UTILIZING INTERNS, ASSOCIATES, AND TRAINEES	
STANDARD	MEASURE
Programs using IATs will provide an orientation and training program of no less than 24 hours to be completed before IATs begin providing services.	Documentation of training/orientation on file at provider agency.
IATs will be assigned cases appropriate to experience and scope of practice and that can likely be resolved over the course of the IAT's internship.	Record of case assignment on file at provider agency.
Programs will provide IATs with clinical supervision in accordance with all applicable rules and standards.	Record of clinical supervision on file at provider agency.
IATs will inform clients of their status as an intern and the name of the supervisor covering the case.	Internship notification form, signed by the client and the therapist on file in client chart.
Termination/transition/transfer will be addressed at the beginning of assessment, treatment inception and six weeks prior to termination.	Signed, dated progress notes confirming termination/transition/transfer on file in client chart.
At termination the IAT and client will discuss accomplishments, challenges, and treatment recommendations.	Signed, dated progress notes detailing this discussion on file in client chart.
Clients requiring services beyond the IAT's internship will be referred immediately to another clinician.	Singed, dated, Client Transfer Form (CTF) in client chart.
All clients place don a waiting list will be offered the following options: • Telephone contact • Transition group • Crisis counseling	Signed, dated CTF that details the transfer plan on file in client chart.

Appendix A: Health Resources and Services Administration (HRSA) Guidance

Description:
Mental Health Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized withing the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

Program Guidance:
Mental Health Services are allowed only for PLWH who are eligible to receive HRSA RWHAP services.

Appendix B: Mental Health Service Providers

Providers of mental health services include licensed practitioners and unlicensed practitioners who practice under the supervision of a licensed mental health professional and as mandated by their respective licensing bodies. HIV/AIDS mental health psychiatric treatment services are provided by medical doctors (MDs) board-eligible in psychiatry. A psychiatrist may collaborate with a psychiatric resident or registered nurse/nurse practitioner (RN/NP) under the supervision of a medical doctor board-eligible in psychiatry. All prescriptions shall be prescribed solely by physician licensed by the state of California.

Licensed Practitioners:

- **Licensed Clinical Social Workers (LCSW):** LCSWs possess a mater's degree in social work (MSW). LCSWs are required to accrue 3,200 hours of supervised professional experience to qualify for licensing. The Board o Behavioral Science Examiners regulates the provision of mental health services by LCSWs.
- **Licensed Marriage and Family Therapists (LMFT):** LMFTs possess a master's degree in counseling. LMFTs are required to accrue 3,000 hours of supervised counseling or psychotherapy experience to qualify for licensing. The Board of Behavioral Science Examiners regulates the provision of mental health services by LMFTs.
- **Nurse Specialists and Practitioners:** Registered nurses (RNs) who hold a master's degree as a nurse practitioner (NP) in mental health or a psychiatric nurse specialist (PNS) are permitted to diagnose and treat mental disorders. NPs may prescribe medications in accordance with standardized procedures or protocols, developed and approved by the supervising psychiatrist, NP and facility administrator. Additionally, the NP must furnish and order medications under a psychiatrist's supervision.

  To qualify for prescribing medications, NPs must complete:
  - At least six months of psychiatrist-supervised experience in the ordering of medications or devices
  - A course in pharmacology covering the medications to be furnished or ordered

  RNs who hold a bachelor's degree are permitted to provide psychoeducational services but are not allowed to diagnose or treat mental disorders independently. Nurses and NPs are regulated by the California State Board of Nursing.

- **Psychiatrists:** Psychiatrists are physicians (medical doctors or MDs) who have completed an internship and psychiatric residency (most are three years in length). They are licensed by the state medical board, which regulates their provision of services, to practice independently. They are certified or eligible for certification by the American Board of Psychiatry. They have ultimate clinical authority but function collaboratively with multidisciplinary teams, which may include psychiatric residents or NPs. They initiate all orders for medications.

  They provide HIV/AIDS mental health treatment services as follows:
  - Examination and evaluation of individual patients
  - Diagnosis of psychiatric disorders

  - Medication treatment planning and management
  - Medical psychotherapy
  - Supervision of allied health professionals through a defined protocol
  - Participation and leadership in interdisciplinary case conferences including signing off on diagnoses and treatment plans
- **Psychologists:** Psychologists possess a doctoral degree in psychology or education (PhD, PsyD, EdD). Psychologists are required to accrue 3,000 hours of supervised professional experience to qualify for licensing. The Board of Psychology regulates the provision of mental health services by psychologists.

Unlicensed Practitioners:

- **Marriage family therapist (MFT) interns; psychological assistants, post-doctoral fellows and trainees; and social work associates:** Interns, assistants, fellows, and associates are accumulating supervised experience as part of their preparation for licensing or certification. They have completed graduate work in counseling, psychology or social work. These providers required direct supervision by a licensed mental health practitioner as mandated by their respective licensing bodies.

Marriage family therapist (MFT) trainees and social work interns: Trainees and interns are in the process of obtaining their master's degrees and completing the necessary practicum or field work in a site approved by their academic institutions. Trainees and interns require direct supervision by a licensed mental health practitioner at the approved site as mandated by their respective licensing bodies.

Appendix C: Description of Treatment Modalities

Ongoing psychiatric sessions: Mental health treatment should include counseling regarding knowledge of modes of transmission, prevention, risk and harm reduction strategies (as well as root causes and underlying issues related to increased HIV transmission behaviors). Substance use, treatment adherence, development of social support systems and community resources as indicated by the client's circumstance are important areas to be explored. Focus should also be placed on maximizing social and adaptive functioning. The role of and –when present in a client's life—spirituality and religion should be understood and utilized as a strength when present. If clients being to deteriorate physically, emotional distress can be relieved by helping them prepare for disability, even death. For the client whose health has improved, exploration of future goals including returning to school or work is indicated. When a signed release has been completed, sources of support and care can be recommended to significant others and family members.

The provision of specific types of psychotherapy (behavioral, cognitive, post-modern, psychodynamic) is guided by the individual client's need and based on published practice guidelines and research. For those clients on psychotropic medications, side effects of these agents should be assessed at each visit, along with the provision of education regarding such medications, within the scope of the provider's practice. As indicated, these clients will be referred to the prescribing physician for further information.

Individual counseling/psychotherapy: Individual counseling or psychotherapy may be either short- or long-term in duration, depending on the needs outlined in the treatment plan. Short-term or brief therapy lasts up to 12 sessions and can be most useful when client goals are specific and circumscribed. Longer-

term therapy providers a means to explore more complex issues that may interfered with a client's quality of life. Even in the case of longer-term therapy, specific, short-term, mutually defined goals are recommended to focus treatment and measure progress.

Family counseling/psychotherapy: A family may be defined as either the family of origin or a chosen family (Bor, Miller & Goldman, 1993). The impact of HIV on the family system can be enormous. The overall goal of family counseling/psychotherapy is to help families improve their functioning, given the complications of living with HIV. Interventions with the family system can be especially effective in helping children and caregivers with behavioral problems and symptoms.

Couples counseling/psychotherapy: This modality is most appropriate where the presenting problem is dissatisfaction or conflict within a relationship that impacts a person living with HIV. In cases of domestic violence, couples counseling should not begin until the provider determines the appropriateness of this modality based upon the progress both parties have made in individual or group treatment and the fact that current violence is no longer a risk. If these criteria are not met, members of such couples should be referred for individual or group treatment.

Group psychotherapy treatment: Group treatment can provide opportunities for increased social support vital to those isolated by HIV.

While groups may be led by a single leader, significant benefits arise when utilizing two co-facilitators:

- Fewer group cancellations due to facilitator absence
- Increased change that important individual and group issues will be explored
- Members can witness different skills and styles of the therapists
- Increased opportunity to work through transference relationships

Group treatment can be provided in a variety of formats:

- **Closed psychotherapy groups** typically require a process for joining and terminating. Closed groups usually have a set number of group members (between six and ten). This format providers an opportunity to build group cohesion and for members to take part in active interpersonal learning. These groups can be time limited or ongoing, issue specific or more general in content.
- **Open psychotherapy groups** do not require ongoing participation form clients. The group membership shifts from session to sessions, often requiring group leaders to be more structured and active in their approach. These groups can be especially useful to clients requiring immediate support, but unsure about making a commitment to ongoing treatment.

Drop-in groups can also be offered as a mental health service, as long as at least one of the leaders of the group is a mental health provider as defined in this standard.

- **Drop-in groups** do not have an ongoing membership. Instead of a psychotherapeutic focus, these groups focus on such functions as providing topic-specific education, social support and emotional encouragement. As such, they do not require inclusion in a client's treatment plan, nor is a full mental health assessment required to access this service.

Psychiatric evaluations, medication monitoring and follow-up: Psychiatrists shall use clinical presentation, evidence-based practice guidelines and specific treatment goals to guide the evaluation, prescription and monitoring of appropriate medication.

For medication monitoring and follow-up, visit frequency should be at a minimum:

- Once every two weeks in the acute phase
- Once every month in the sub-acute phase
- Once every three months in the maintenance phase

For those patients on psychotropic medication, side effects of these agents shall be assessed at each visit, along with the provision of education regarding their medications. In addition, these patients should regularly be counseled about the importance of adherence to psychotropic medications.

The American Psychiatric Association (2001) suggests the following general pharmacologic treatment guidelines, especially for those patients with symptomatic HIV disease:

- Use lower starting doses and titrate more slowly
- Provide the least complicated dosing schedules possible
- Concentrate on drug side effect profiles to avoid unnecessary adverse effects
- Be aware of drug metabolism/clearance pathways to minimize drug-drug interactions and possible organ damage

In general, refills shall not be written beyond three months of the last psychiatric visit. However, exception can be made in special circumstances or when the stability of the client warrants less frequent monitoring. Such exceptions shall be documented in client progress notes.

Psychiatrists must coordinate the provision of psychiatric care with primary care medical clinics and other related providers. Regular contact with a patient's primary care clinic and related providers will ensure integration of services and maintain care continuity.

Appendix D: Utilizing Interns, Associates, and Trainees (IATs)

Programs utilizing IATs will give thoughtful attention to:

- **Training:** Programs utilizing IATs will provide an orientation and training program of no less than 24 hours of instruction focusing on the specifics of providing HIV mental health services. This orientation/training will be completed before IATs begin providing services.
- **Case assignment:** IATs will only be assigned cases that are appropriate to their experience and scope of practice. Additionally, IAT should not be assigned cases that require an intervention that is longer term than the IAT's internship. Such cases should be referred to staff clinicians or referred out.
- **Supervision:** Programs will provide IATs with clinical supervision in accordance with all applicable rules and standards. Supervisors, or other appropriate mental health staff will always be available to IAT that they are providing direct services to clients.

IATs will explicitly inform their clients of their intern status at the beginning of treatment. A document that acknowledges IAT status and details the case supervisor's name will be signed by the client and IAT and placed in the client record. The issue of termination/transition/transfer (due to a therapist's IAT status) will be addressed at the beginning of the assessment, at treatment inception and revisited six weeks prior to IAT termination.

IATs will consult with the clinical supervisor prior to the termination/transition intervention with a client. As part of the termination process, the IAT and client will discuss the client's treatment accomplishments,

challenges, preference for future treatment and treatment recommendation. As is true throughout the treatment process, the clinical supervisor will provide oversight for the termination/transition process and cosign the IAT documentation.

While every effort should be made to ensure that IATs will not provider services for clients whose Treatment Plans extend past the internship term, it is recognized that in some cases, clients require unanticipated additional and/or ongoing treatment to meet the stated goals of their treatment plans. In such cases, special care must be given to the transfer of these clients.

Programs will endeavor to transfer IAT clients immediately to another clinician or outside program.

If a client must be placed on a waiting list for transfer to another clinician or IAT, programs will provide the following options for ongoing monitoring and crisis care:

- **Telephone contact:** Existing mental health staff or IAT will attempt contact at least twice a month to every client on the transfer waiting list to monitor current mental status and asses for emergent crises.
- **Transition group:** All clients on a transfer waiting list will be offered the opportunity to attend a transition group or another existing support group to monitor current mental status and assess for emergent crises.
- **Crisis counseling:** Utilizing both monitoring mechanisms noted above, all clients on a transfer waiting list will be informed of the availability of crisis counseling designated for them on an as needed basis.

Program will complete a Client Transfer Form (CTF) detailing the transfer plan for each IAT transfer.

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DRAFT NON-MEDICAL CASE MANAGEMENT: PATIENT SUPPORT SERVICES (PSS)

Table of Contents

IMPORTANT: The service standards for Non-Medical Case Management Services adhere to requirements and restrictions from the federal agency, Health Resources and Services Administration (HRSA). The key documents used in developing standards are as follows:

Human Resource Services Administration (HRSA) HIV/AIDS Bureau (HAB) Policy Clarification Notice (PCN) # 16-02 (Revised 10/22/18): Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds

HRSA HAB Policy Clarification Notice (PCN) # 16-02: The use of Ryan White HIV/AIDS Program Funds for Core Medical Services and Support Services for People Living with HIV Who Are Incarcerated and Justice Involved

HRSA HAB, Division of Metropolitan HIV/AIDS Programs: National Monitoring Standards for Ryan White Part A Grantees: Program – Part A

Service Standards: Ryan White HIV/AIDS Programs

Introduction

Service standards outline the elements and expectations a Ryan White service provider follows when implementing a specific service category. The purpose of the service standards is to ensure that all Ryan White service providers offer the same fundamental components of the given service category across a service area. Service standards establish the minimal level of service or care that a Ryan White funded agency or provider may offer in Los Angeles County. The development of the service standards includes guidance from service providers, consumers, and members of the Los Angeles County Commission (COH) on HIV, Standards and Best Practices (SBP) Committee.

General Eligibility Requirements for Ryan White Services

- Be diagnosed with HIV or AIDS with verifiable documentation.
- Be a resident of Los Angeles County
- Have an income at or below 500% of Federal Poverty Level.
- Provide documentation to verify eligibility, including HIV diagnosis, income level, and residency.

Given the barriers with attaining documentation, contractors are expected to follow the Los Angeles County, Department of Public Health, Division of HIV and STD Programs (DHSP) guidance for using self-attestation forms for documentation eligibility for Ryan White services.

Non-Medical Case Management Service Description

Non-Medical Case Management (NMCM) consists of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and other needed services. NMCM may also include assisting clients to obtain access to other public and private programs for which they may be eligible.

NMCM services include all types of case management models such as intensive case management, strengths-based case management, and referral case management. ~~An agency may offer a specific type of case management model depending on its capacity and/or the contract from the Division on HIV and STD Programs (DHSP). Depending on the type of case management offered, NMCM may also involve assisting the client's support network, key family members, and other individuals that play a direct role in the client's health and well-being.~~

Service components include:

- Initial assessment of service needs
- Development of a comprehensive, Individual Service Plan (ISP)

- Timely and coordinated access to needed core medical and support services to ensure continuity of care
- Client specific advocacy and service utilization review
- ~~Continuous~~ Ongoing client monitoring to assess progress on ISP and adjust as needed
- ~~Revisiting the Individual Service Plan and adjusting as necessary~~
- ~~Ongoing assessment of client needs and, if appropriate based on the case management offered, other key individuals in the client's support network~~

~~In the past, the DHSP has contracted Transitional Case Management for Youth and Justice-Involved populations under NMCM services.~~

In the past, DHSP has contracted Transitional Case Management services for Youth and Justice-Involved populations under NMCM services. In 2025, DHSP contracted Patient Support Services (PSS) under NMCM to support agencies in providing support services that address the unique needs of its clinic in support of clients' complex medical issues and social challenges. Clients do not need to be enrolled in MCC, AOM, of other clinic-based programs to receive PSS, however they must be Ryan White Program eligible. See the **General Eligibility Requirements for Ryan White Services** for more information.

Patient Support Services (PSS) are conducted by a multi-disciplinary team comprised of specialists who conduct client-centered interventions that target behavioral, emotional, social, or environmental factors that negatively affect health outcomes for Ryan White Program eligible clients with the aim of improving an individual's overall well-being and achieve or maintain viral suppression. PSS will deliver interventions directly to RWP eligible clients, link and actively enroll them with support services, and provide care coordination, when needed. Agencies contracted to provide PSS services must determine the type and number of support specialists from the list in **Appendix B** to makeup up PSS teams.

~~NMCM coordinates services for people living with HIV to improve health outcomes and facilitate client self-sufficiency. Case managers at provider agencies are responsible for educating clients on available HIV non-medical support services as well as serving as liaisons in improving access to services. Case managers are responsible for understanding HIV care systems and wrap-around services, advocating for clients, and accessing and monitoring client progress on an ongoing basis. Case managers identify client service needs in all non-medical areas and facilitate client access to appropriate resources such as health care, financial assistance, HIV education, mental health, substance use prevention, harm reduction and treatment, and other supportive services. Non-Medical Case Management services should be client-focused, increase client~~

~~empowerment, self-advocacy and medical self-management, as well as enhance their overall health status.~~

Non-Medical Case Management Service Standards

All contractors must meet the Universal Service Standards approved by the COH in addition to the following NMCM service standards. The Universal Service Standards can be accessed at: https://hiv.lacounty.gov/service-standards

Client Assessment and Reassessment

NMCM providers must complete an initial assessment within 30 days of intake through a collaborative, interactive, process between the case manager and client with the client as the primary source of information. With client consent, assessments may also include additional information from other sources such as service providers, caregivers, and family members to support client well-being and progress. Case management staff must comply with established agency confidentiality policies when soliciting information from external sources. ~~If a client's income, housing status, or insurance status has changed since assessment or the most recent reassessment, agencies must ensure that the data on the Client Information Form is updated accordingly.~~ Case managers will identify medical and non-medical service providers and make appointments as early as possible during the initial intake process for clients that are not ~~connected to primary medical care~~ linked to an MCC or AOM program~~. It is the responsibility of case management staff at the provider agency to~~ Case managers will conduct reassessments with the client as needed and based on contract guidelines from the DHSP.

The client assessment identifies and evaluates the medical, non-medical, physical, environmental, and financial strengths, needs, and resources. The assessments determines:

- Client needs for ~~treatment~~ core medical and support services
- Client capacity to meet those needs
- Ability of the client social support network to help meet client needs
- Extent to which other agencies are involved in client care
- Areas in which the client requires assistance in securing services

Assessment and reassessment topics may include~~, at minimum:~~

- Client strengths and resources
- Medical Care
- Mental health counseling/therapy
- Substance use, harm reduction, and treatment
- Nutrition/food
- Housing or housing related expenses
- Family and dependent care
- Transportation
- Linguistic services

- Social support system
- Community or family violence
- Financial resources
- Employment and education
- Legal needs
- Knowledge and beliefs about HIV
- Agencies that service client and household

~~Services provided to the client and actions taken on behalf of the client must be documented in progress notes and in the Individual Services Plan, which is developed based on the information gathered in the assessment and reassessments.~~

CLIENT ASSESSMENT AND REASSESSMENT	
STANDARD	**DOCUMENTATION**
Assessments will be completed within 30 days of initiation of services and at minimum should assess whether the client is in care. Accommodations may be made for clients who are unable to attend an appointment within the 30-day timeframe due to health reasons.	Completed assessment in client chart signed and dated by case manager.
Staff will conduct reassessments with the client as needed and in accordance with DHSP contract guidelines.	Completed reassessment in client chart signed and dated by case manager.

Individual Service Plan

An Individual Service Plan (ISP) is a tool that enables the case manager to assist the client in addressing barriers to medical care by developing an action plan to improve access and engagement in medical and ~~other~~ support services. ISPs are developed in conjunction with the client and case manager within two weeks of the conclusion of the comprehensive assessment or reassessment. ISPs include short-term and long-term client goals determined by utilizing information gathered during assessment and subsequent reassessments. ~~It is the responsibility of case managers to review and revise~~ Case managers will review, and revise ISPs as needed. ~~and based on client need.~~

The ISP should include: ~~a description of client specific service needs, referrals to be made, clear timeframes, and a plan to follow-up. ISPs will, at minimum, include the following:~~

- ~~Client and case manager names~~
- ~~Client and case manager signatures and date on the initial ISP and on subsequent, revised ISPs~~
- Description of client goals and desired outcomes

- Timeline for client goals and a plan to monitor client progress
- Action steps to be taken by client and/or case manager to accomplish goals
- Status of each goal as client progresses

As part of the ISP, case managers must ensure the coordination of the various services the client is receiving. Coordination of services requires identifying other staff or service provides with whom the client may be working. As appropriate and with client consent, case management staff act as liaisons among clients, caregivers, and other service providers to obtain and share information that supports optimal care and service provision. If a program is unable to provide a specific service, it must be able to make immediate and effective referrals. Case management staff is responsible for facilitating the scheduling of appointments, transportation, and the transfer of related information.

INDIVIDUAL SERVICE PLAN (ISP)	
STANDARD	**DOCUMENTATION**
ISPs will be developed collaboratively between the client and case manager within two weeks of completing the assessment or reassessment ~~and, at minimum,~~ should include: • Description of client goals and desired outcomes • Timeline for client goals and a plan to monitor client progress • Action steps to be taken by client and/or case manager to accomplish goals • Status of each goal as client progresses • ~~Timeline for when goals are expected to be met~~ • ~~Action steps to be taken and individuals responsible for the activity~~ • ~~Anticipated time for each action step and goal~~ • ~~Status of each goal as it is met, changed or determined to be unattainable~~	Completed ISP in client chart, dated and signed by client and case manager.
Staff will ~~update~~ revise the ISP yearly or as needed based on client progress or DHSP contract requirements.	~~Updated~~ Revised ISP in client chart, dated and signed by client and case manager.

~~Client Monitoring~~ ISP Implementation, Monitoring, and Follow-up

Case managers will implement, monitor, and follow-up on a client's ISP to ensure clients are accessing needed services and resolve any barriers clients may have in achieving their ISP goals. Case managers will maintain ongoing contact with client as appropriate, or based on DHSP contract requirements, to evaluate whether services provided are consistent with a client's ISP and to determine if a client requires a reassessment and/or revisions to their ISP.

~~Implementation, monitoring, and follow-up involve ongoing contact and interventions with, or on behalf of, the client to achieve the goals on the ISP. Case managers management staff are responsible for evaluating whether services provided to the client are consistent with the ISP, and whether there are any changes in the client's status that require a reassessment or updating revising the ISP. Client monitoring ensures that referrals are completed and needed services are obtained.~~

~~CLIENT MONITORING~~ ISP IMPLEMENTATION, MONITORING, AND FOLLOW-UP	
STANDARD	**DOCUMENTATION**
Case managers will implement, monitor, and follow-up on a client's ISP to ensure clients are accessing needed services and resolve any barriers clients may have in achieving their ISP goals. Implementation, monitoring, and follow-up activities include: ~~ensure clients are accessing needed services and will identify and resolve any barriers clients may have in following through with the ISP. Responsibilities include, at minimum:~~ • Monitor changes in the client's condition • Update/revise the ISP based on progress • Provide interventions and follow-up to confirm completion of referrals • Ensure coordination of care among client, caregiver(s), and service providers • Advocate on behalf of clients with other service providers • Empower clients to use independent living strategies	Signed, dated progress notes on file that detail~~, at minimum:~~ • Changes in the client's condition or circumstances • Progress made toward ISP goals • Barriers to ISP goals and actions taken to resolve them • Status of linked referrals and interventions ~~and status/results of same~~ • Barriers to referrals and interventions and actions taken to resolve them • Time spent with client • Case manager's signature and title

• Help clients resolve barriers to completing referrals, accessing or adhering to services • Follow-up on ISP goals • Maintain client contact as appropriate or based on DHSP contract requirements • Follow-up missed appointments by the end of the next business day	

Staff Requirements and Qualifications

~~Case management staff will have the knowledge, skills, and ability to fulfill their role including striving to maintain and improve professional knowledge related to their responsibilities, basing all services on assessment, evaluation, or diagnosis of clients, and providing clients with a clear description of services, timelines, and possible outcomes at the initiation of services. Staff are responsible for educating clients on the importance of adhering and staying engaged in care.~~

Case managers will have the knowledge, skills, and ability to fulfill their role while providing clients with a clear description of services, timelines, and possible outcomes at the initiation of services. Staff are responsible for educating clients on the importance of adhering and starting engaged in care.

Refer to Appendix B for additional staff requirements and qualifications for agencies with Patient Support Services contracts.

Case managers should have experience in or participate in trainings on:

- HIV/AIDS and related issues
- Effective interviewing and assessment skills
- Appropriately interacting and collaborating with others
- Effective written and verbal communication skills
- Working independently
- Effective problem-solving skills
- Responding appropriately in crisis situations

STAFF REQUIREMENTS AND QUALIFICATIONS	
STANDARD	**DOCUMENTATION**

Case managers will possess ~~with~~ experience in clinical and/or case management in an area of social services. Bachelor's degree in social work, counseling, psychology or a related field preferred and/or experienced consumers preferred. Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a multicultural environment.	Staff resumes on file.
Case management supervisors will possess ~~with~~ experience in clinical and/or case management in area of mental health, social work, counseling, nursing with specialized mental health training, or psychology. Master's degree in social work, Counseling, Psychology, or related field from an accredited social work program. On a case-by-case basis and with consultation and approval from DHSP, agencies may consider candidates with bachelor's degree in social work, counseling, psychology, or related field and 2 years of related work experience. Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a multicultural environment.	Staff resumes on file.

Appendix A: HRSA Guidance for Non-Medical Case Management

Description:
Non-Medical Case Management Services (NMCM) provide guidance and assistance in accessing

medical, social, community, legal, financial, and other needed services. NMCM services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicare, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans. This service category includes several methods of communication including face-to-face, phone contact, and any other forms of communication deemed appropriate by the RWHAP Part recipient. Key activities include:

- Initial Assessment of service needs
- Development of a comprehensive, individualized care plan
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family member's needs and personal support systems

Program Guidance:
Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services whereas Medical Case Management services have as their objective improving health care outcomes.

Appendix B: Patient Support Services (PSS) Support Specialist Descriptions

Agencies contracted to provide PSS services must determine the type and number of support specialists form the list below to make up PSS teams that address the unique needs of its clinic in support of clients' complex medical issues and social challenges.

Retention Outreach Specialist (ROS)

- Ensures that PLWH remain engaged in their care and have access to necessary resources and support.
- Integrates with other HIV clinic team members to effectively identify, locate, and re-engage clients who have lapsed in their HIV care.
- Provides a targeted assessment of barriers of care, outreach, linkage, and re-engagement services, focusing on clients who are considered "out of care," facilitating their return to consistent and effective HIV treatment and support services.
- Conducts field outreach operations to efficiently locate and assist clients who have disengaged from HIV care.
- Acts as the liaison between HIV counseling and testing sites and the medical clinic to ensure that new clients are enrolled in medical care seamlessly and in a timely fashion.
- Provides crisis interventions, offering immediate support in challenging situations.

- Provides services to clients not yet enrolled in PSS, MCC Services, or clinic-based programs and can outreach clients who have not yet enrolled into any services with provider agency.
- Collaborates with the HIV clinic team members, documents client interactions, and contributes to program evaluation.
- Demonstrates cultural and linguistic competency to effectively communicate with and support a diverse range of clients.
- Participates in case conferences as needed.

Must meet the following minimum qualifications:

- Must have a High School Diploma or successful completion of GED.
- Ability and interest in doing field-based work when necessary to locate or assist clients.
- Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a multicultural environment.

PSS Social Worker (SW)

- Determines client resources and needs regarding mental health services, substance use counseling and treatment, as well as housing and transportation issues to make appropriate referrals and linkages.
- Holds counselling and psychotherapy sessions for individuals, couples, and families.
- Provides support services utilizing housing-first, harm reduction, and trauma-informed care principles.
- Utilizes a sex positive framework including provision of patient education about U=U.
- Collaborates with the HIV clinic team, documents interactions, and contributes to program evaluation.
- Maintains knowledge of local, State, and federal services available.
- Addresses clients' socioeconomic needs, and as part of the PSS team, assists with client monitoring, referrals, and linkages to services, as well as following up with clients and tracking outcomes.
- Acts as the liaison between HIV counseling and testing sites and the medical clinic to ensure that new clients are enrolled in medical care seamlessly and in a timely fashion.
- Performs home visits and other field outreach on a case by-case basis.
- Provides urgent services to clients not yet enrolled in PSS.
- Participates in case conferences as needed.

- Conducts a comprehensive assessment of the SDH using a cooperative and interactive interview process. The assessment must be initiated within five working days of client contact and be appropriate for age, gender, cultural, and linguistic factors.
    - The assessment will provide information about each client's social, emotional, behavioral, mental, spiritual, and environmental status, family and support systems, client's coping strategies, strengths and weaknesses, and adjustment to illness.
    - SW will document the following details of the assessment in each client's chart:
        - Date of assessment;
        - Title of staff persons completing the assessment; and
        - Completed assessment form.
- Develops a PSS Intervention Plan SW will, in consultation with each client, develop a comprehensive multi-disciplinary intervention plan (IP). PSS IPs should include information obtained from the SDH assessment. The behavioral, psychological, developmental, and physiological strengths and limitations of the client must be considered by the SW when developing the IP. IPs must be completed within five days and must include, but not be limited to the following elements:
- Identified Problems/Needs: One or more brief statements describing the primary concern(s) and purpose for the client's enrollment into PSS as identified in the SDH assessment.
- Services and Interventions: A brief description of PSS interventions the client is receiving, or will receive, to address primary concern(s), describe desired outcomes and identify all respective PSS Specialist(s) assisting the client.
- Disposition: A brief statement indicating the disposition of the client's concerns as they are met, changed, or determined to be unattainable.
- IPs will be signed and dated by the client and respective SW assisting the client.
- IPs must be revised and updated, at a minimum, every six months.

Meets the following minimum qualifications:

- Master's degree in social work, Counseling, Psychology, or related field from an accredited social work program. On a case-by-case basis and with consultation and approval from DHSP, agencies may consider candidates with bachelor's degree in social work, counseling, psychology, or related field and 2 years of related work experience.
- Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a

multicultural environment.

Benefits Specialist

- Conducts client-centered activities and assessments that facilitate access to public benefits and programs. Focuses on assisting each client's entry into and movement through care service systems.
- Stays up to date on new and modified benefits, entitlements, and incentive programs available for PLWH.
- Ensures clients are receiving all benefits and entitlements for which they are eligible.
- Educates clients about available benefits and provides assistance with the benefits application process.
- Helps prepare for and facilitates relevant benefit appeals.
- Collaborates with the HIV clinic team, documents interactions, and contributes to program evaluation.
- Develops and maintains expert knowledge of local, State, and federal services and resources including specialized programs available to PLWH.
- Participates in case conferences as needed.

Meets the following minimum qualifications:

- High school diploma (or GED equivalent).
- Has at least one year of paid or volunteer experience making eligibility determinations and assisting clients in accessing public benefits or public assistance programs.
- Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a multicultural environment.

Housing Specialist

- Develops and maintains expert knowledge of, and contacts at, local housing programs and resources including specialized programs available to PLWH.
- Conducts housing assessments and creates individualized housing plans.
- Assists clients with applications to housing support services such as emergency financial assistance, referral and linkage to legal services (for issues such as tenant's rights and evictions), and navigation to housing opportunities for persons with AIDS programs.
- Conducts home or field visits as needed.
- Develops a housing procurement, financial, and self-sufficiency case management plan with clients as part of client housing plans.
- Offers crisis intervention and facilitates urgent referrals to housing services.

- Collaborates with the HIV clinic team, documents interactions, and contributes to program evaluation.
- Attends meetings and trainings to improve skills and knowledge of best practices in permanent supportive housing and related issues.
    - Participates in case conferences as needed.

Meets the following minimum qualifications:

- Bachelor's degree or a minimum of two years' experience in social services, case management, or other related work.
- Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a multicultural environment.

Substance Use Disorder (SUD) Specialist

- Conducts SUD assessments and devises personalized SUD plan with clients as part of the client's individualized care plan.
- Provides one-on-one counseling to prevent and/or support clients through recurrence by assisting and recognizing causal factors of substance use and developing coping behaviors.
- Connects clients to harm reduction resources, medications for addiction treatment, cognitive behavioral therapy, and other SUD treatment services available to reduce substance use, or to prevent or cope with recurrence.
- Collaborates with other HIV clinic team members to align substance use treatment goals with overall care, documents interactions, and contributes to program evaluation.
- Conducts individual and group counseling sessions using evidence-based interventions to address personalized goals and develop needed skill sets to minimize relapse and maintain sobriety.
- Oversees or leads day-to-day operations of contingency management programs or other evidence-based interventions.
- Provides education on harm reduction strategies and additional key resources to clients.
- Participates in case conferences as needed.

Meets the following minimum qualifications:

- Certified as a Substance Use Counselor.
- Has at least one year of experience in an SUD program with experience providing counseling to individuals, families, and groups.

- Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a multicultural environment.

Clinical Nursing Support Specialist

- Provides enhanced clinical nursing support, performed by a registered nurse to facilitate:
  - Administration and supervision of client injectable medications and vaccinations;
  - Tracking of clients receiving long-acting injectable, multi-dose injectable treatments, or multi-dose vaccine series; monitors clients for side effects; makes appointments for subsequent nursing visits to ensure timely receipt of injections; and
  - Coordinates care activities among care providers for patients receiving long-acting injectable medications, vaccinations, and other injectable medications to ensure appropriate delivery of HIV healthcare services.
- Participates in case conferences as needed.
- Collaborates with the HIV clinic team, conducts health assessments as needed, documents interactions, and contributes to program evaluation.

Meets the following minimum qualifications:

- Must be a Registered Nurse.
- Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a multicultural environment.

Peer Navigator

- Provides client-centered group or individual psycho-social support services to assist PLWH by providing a safe space where lived experiences and challenges can be discussed without judgement. Topics to be discussed include but are not limited to:
  - Living with HIV;
  - Healthy lifestyles (including substance use) and relationships;
  - Adherence to treatment;
  - Access and barriers to care;
  - Prevention (PrEP, PEP, DoxyPEP, treatment as prevention);
  - Disclosing status; and
  - Stigma.
- Supports individuals who may be newly diagnosed, newly identified as living with HIV, or who may require additional support to engage in and maintain HIV medical care and

support services to ensure that clients are linked to care and continuously supported to remain in care.

- Conducts individual and group interventions to address personalized goals and develop needed skill sets for healthy living, ensure medication adherence and support a positive outlook for individuals living with HIV.
- Collaborates with other HIV clinic team members to align treatment goals with overall care, documents interactions, and contributes to program evaluation.
- Oversees incentives, contingency management programs, and/or other evidence-based interventions.
- Provides education on HIV clinic services available and additional key resources to clients.
- Participates in case conferences as needed.

Meets the following minimum qualifications:

- Is reflective of the population and community being served.
- Has lived experience.
- Must NOT be a current client of Contractor's clinic.
- Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a multicultural environment.

Hello Commission,

Here is our feedback along with a few questions regarding the PSS standards of care.

1. **Are the PSS service standards reasonable and achievable for providers?**

- Yes, the standards seem reasonable. However, I wonder if agencies are fully staffed to meet most of these requirements.
- How might budget cuts impact the ability to achieve these standards and overall program goals?

2. **Do the PSS service standards meet consumer needs?**

- Yes, consumer needs appear to be addressed. That said:
    - Are the standards culturally inclusive, particularly for non-English speakers?
    - Were consumer voices or lived experiences incorporated into the development of these standards?
    - Are there resources or considerations for undocumented patients?

3. **Additional comments:**

- Will providers receive training to ensure proper implementation of the standards?
- How will program goals be set, and how will compliance with these standards be measured or evaluated?

Best regards,

Marta Melendez | HIV Services Manager
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COMMUNITY HEALTH CENTER
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Ryan White Program Utilization Summary: Core Services
RW Year 34: March 1, 2024 - February 28, 2025

Sona Oksuzyan, Supervising Epidemiologist
Amanda Wahnich, Supervising Epidemiologist
Monitoring and Evaluation Unit
Division of HIV and STD Programs

September 16, 2025

Agenda

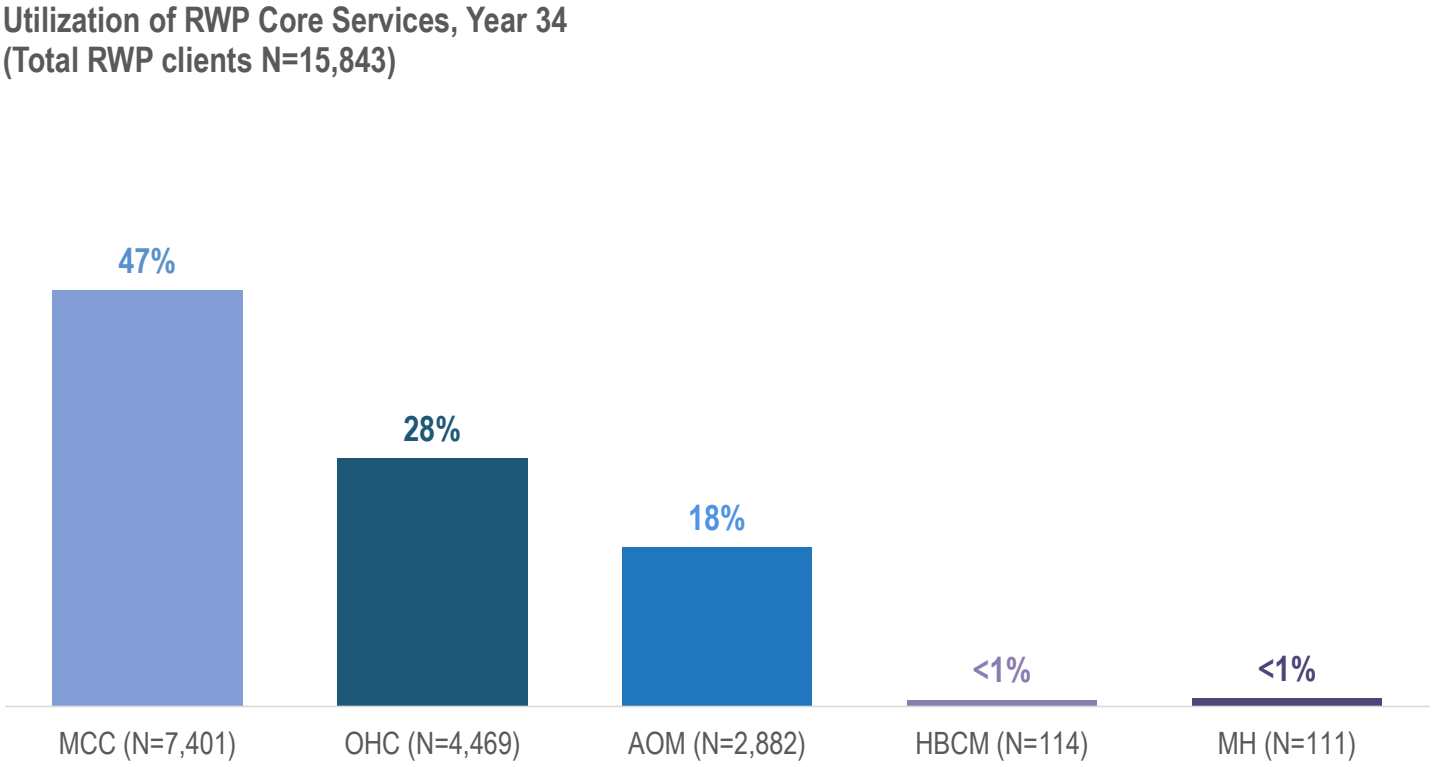
- Core Services Overview
- Core Services Deep Dive Framework
- Core Services Expenditures
- Key Takeaways

County of Los Angeles Public Health

Overview of Core Services

Medical Care Coordination (MCC) 18 contracted sites	Addresses **patients' medical and non-medical needs through coordinated case management** to support continuous engagement in care and adherence to ART
Oral Health Care (OHC) 12 contracted sites	Provides **routine comprehensive oral health care**, including prevention, treatment, counseling, and education
Ambulatory Outpatient Medical (AOM) 18 contracted sites	Provides **comprehensive outpatient care** including primary medical care, HIV medication management, laboratory testing, counseling, nutrition education, case management, support groups, and access to specialized HIV treatment options
Mental Health (MH) 7 contracted sites	Provides **mental health assessment, treatment planning and provision**
Home-Based Case Management (HBCM) 5 contracted sites	Provides c**lient-centered case management and social work activities**, focusing on care for **PLWH who are functionally impaired and require intensive home and/or community-based care**

Medical Care Coordination (MCC) was the most highly used core service in Year 34.



RWP Year 34: Core Service Category Deep Dive Framework & Discussion

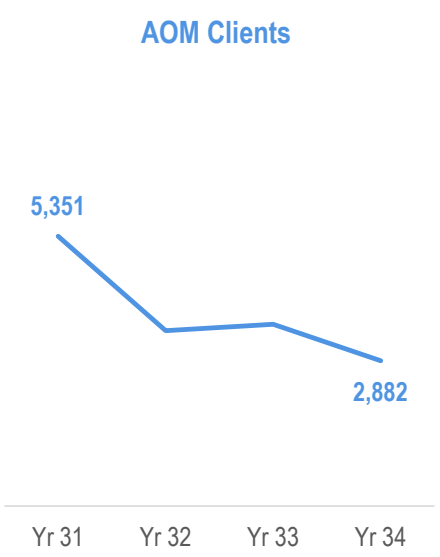
Overall Service Utilization and Expenditure Summary	• Client Served • Service Units (Total and Per Client) • Expenditures (Total and Per Client)
Client Demographics	• Gender • Race • Age
Priority Population Engagement	• Latinx MSM • Black/AA MSM • Age ≥ 50 years • Age 13-29 clients • Women of color • Transgender Clients • PWID • Unhoused < 12 months
Health Determinants	• Primary language • Income • Primary insurance • Housing status • Incarceration history
HIV Care Continuum Outcomes	• Engaged in Care • Retained in Care • Suppressed Viral Load

Ambulatory Outpatient Medical (AOM)

- 20% reduction in service utilization in Year 34 compared to Year 33
- 31% reduction in expenditures in Year 34 compared to Year 33

County of Los Angeles Public Health

- A total of **2,882 unique clients** received AOM services, which represent almost a fifth (18%) of RWP clients.
- There was an **overall decline in AOM utilization over the last couple of years** largely due to DHS agencies departure from RWP and partially due to Medi-Cal expansion.



AOM Service Utilization & Expenditures Summary, Year 34

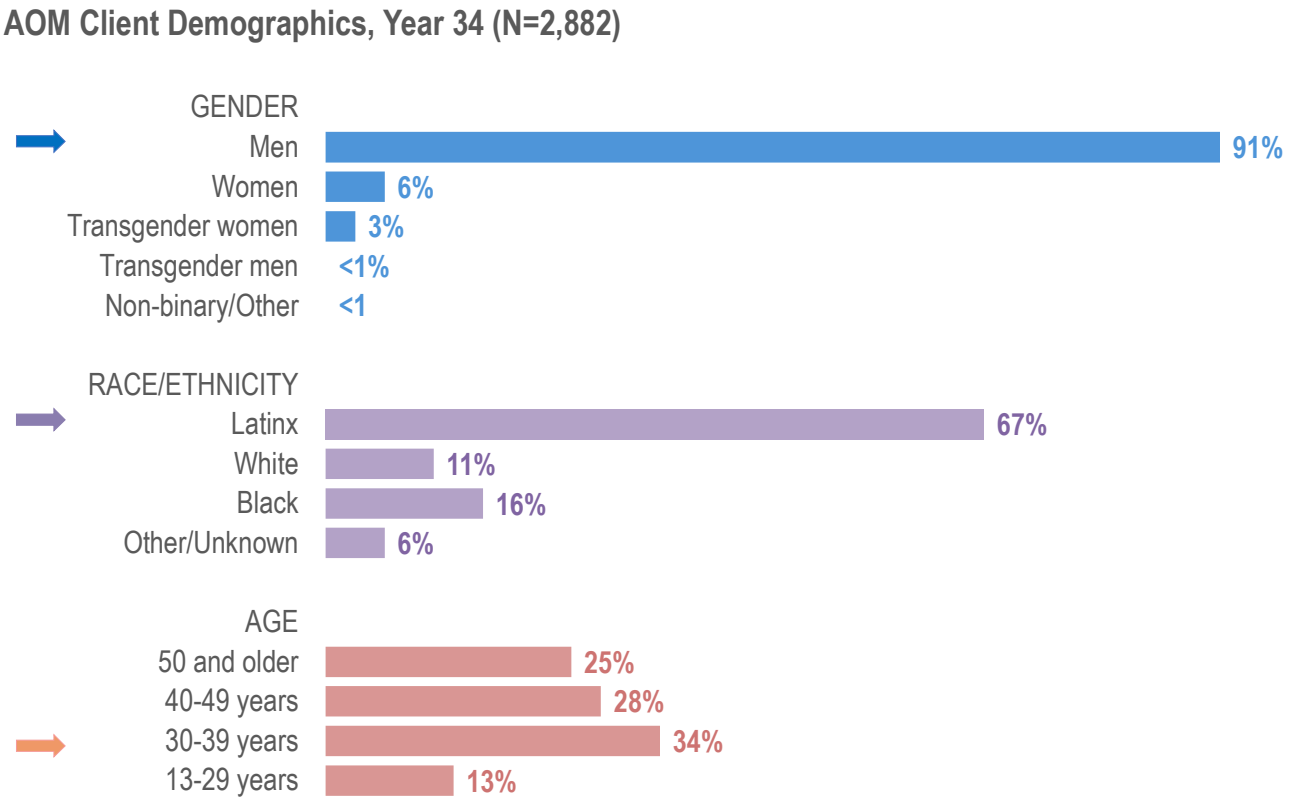
Service Category	Unique Clients Served	Service Unit(s)	Total Service Units	Units Per Client	Expenditures	Expenditures per client
AOM	**2,882**	Visits/ Procedures	**n/a**	**n/a**	***$5,183,652***	***$1,799***
Fee for Service	**2,882**	**Visits**	**7,480**	**3**	***$3,417,295***	***$1,186***
Supplemental AOM Procedures	2,639	Procedures	53,157	20	*$1,257,972*	*$477*
Medical Subspecialty*					*$508,385*	

Funding Source:

- *RWP Part A - $4,949,495*
- *HIV NCC - $234,157*

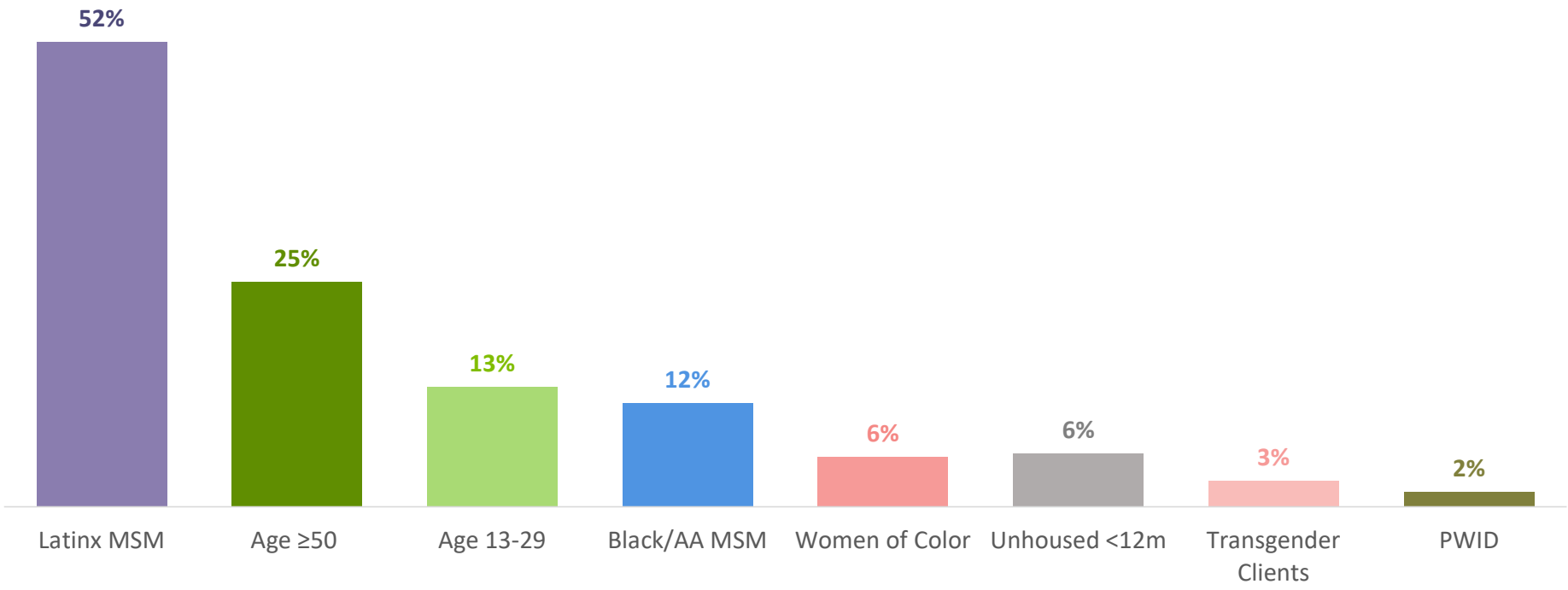
*No data in CaseWatch

AOM clients were predominantly cisgender men, Latinx and people aged 30-39 years old.



AOM services are reaching clients in LAC priority populations*

- **Latinx MSM** clients represented the **largest percentage of AOM clients**
- Clients **age ≥ 50** represented a **quarter of AOM clients**



*Priority population groups are not mutually exclusive, they overlap.

Most AOM clients predominantly spoke English, lived at/below FPL, permanently housed, and no insurance or incarceration history.

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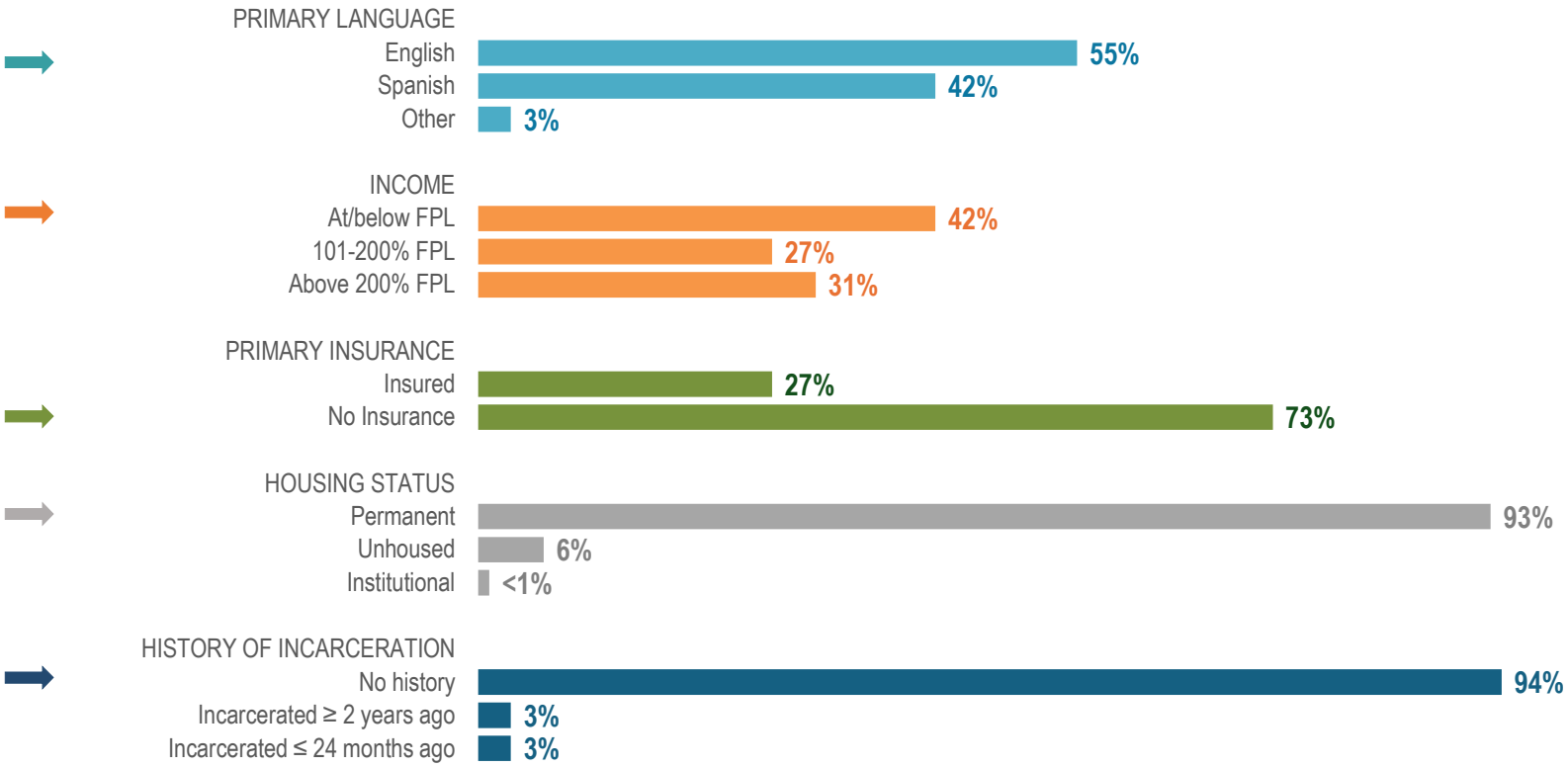
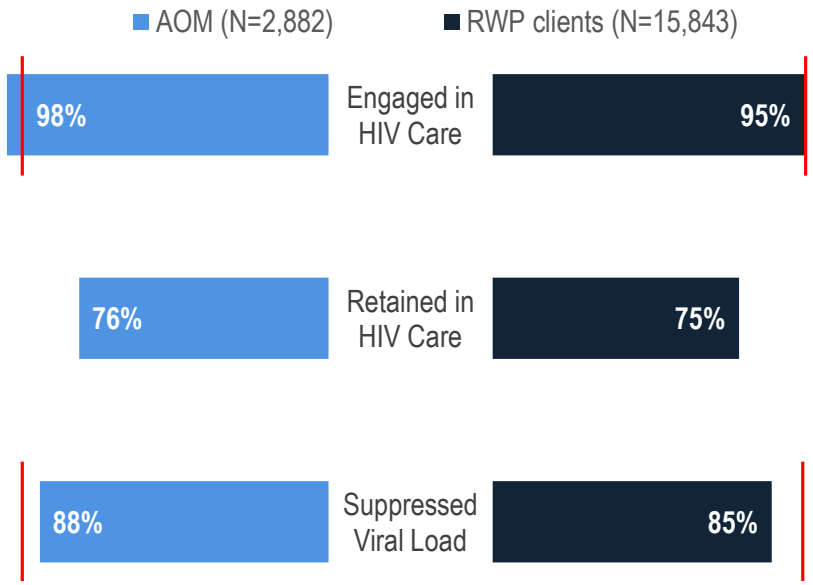
AOM Client Health Determinants, Year 34 (N=2,882)



Overall, AOM Clients had better HIV care outcomes attainment compared to RWP clients

- Engagement[a], retention in care[b], and viral load suppression[c] percentages were higher for AOM clients compared to RWP clients overall, Year 34.
- AOM clients did not meet the EHE target of 95% for viral suppression. However, they met the local target of 95% for engagement in care in Year 34.



Data source: HIV Casewatch as of 5/1/2025

[a]**Engagement in Care** defined as 1 ≥ viral load, CD4 or genotype test reported in the 12-month period based on HIV laboratory data as of 5/5/2025
[b]**Retention in care** defined as 2 ≥ viral load, CD4 or genotype test reported >30 days apart in the 12-month period based on HIV laboratory data as of 5/5/2025
[c]**Viral suppression** defined as most recent viral load test <200 copies/mL in the 12-month period based on HIV laboratory data as of 5/5/2025

Medical Care Coordination (MCC)

Highest utilized RWP service

- 7% increase in service utilization in Year 34 compared to Year 33
- 9% increase in expenditures in Year 34 compared to Year 33

County of Los Angeles Public Health

- A total of **7,401 unique clients** received MCC services, which represent 47% of RWP clients.
- **MCC service utilization** in starting to **have an uptick in Year 34** compared to the previous 2 years.

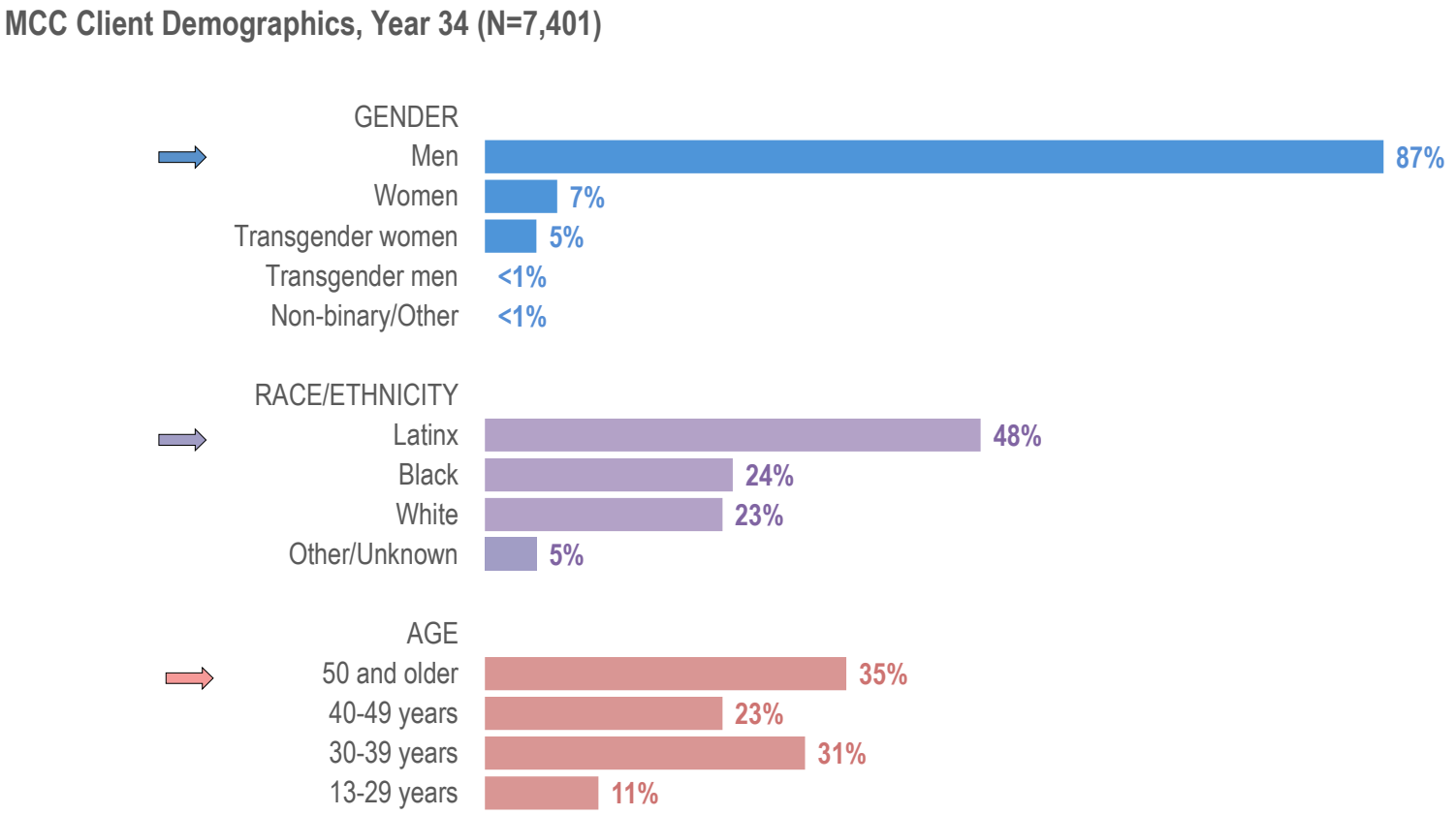
MCC Service Utilization & Expenditures Summary, Year 34

Service Category	Unique Clients Served	Service Unit(s)	Total Service Units	Units Per Client	Expenditures	Expenditures per client
MCC	7,401	Hours	102,451	14	*$11,684,158*	*$1,579*

Funding Source:

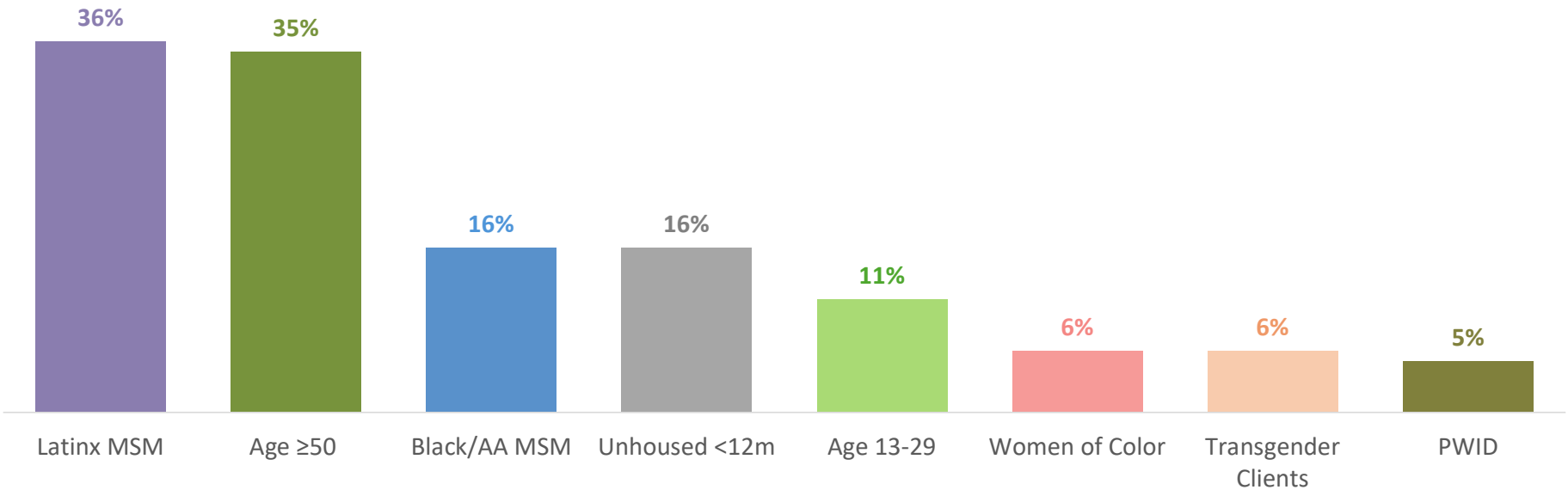
- *Part A - $11,684,158*

MCC clients were predominantly cisgender men, Latinx and people aged 50 and older.



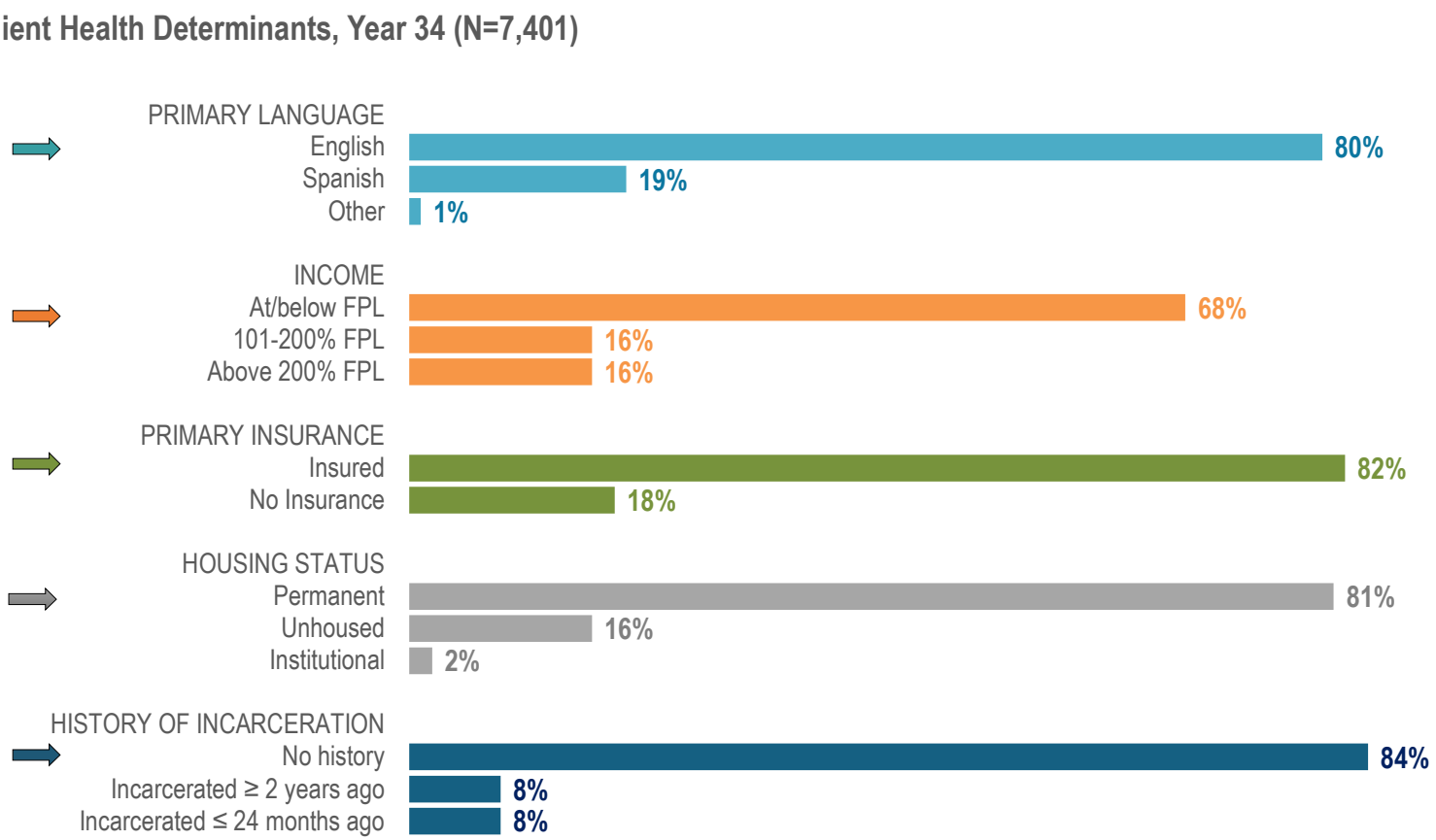
LAC Priority Populations Accessing the MCC Services*, Year 34

- **Latinx MSM** clients represented the largest percentage
- **Clients age ≥ 50** represented over a third of all MCC clients



*Priority population groups are not mutually exclusive, they overlap.

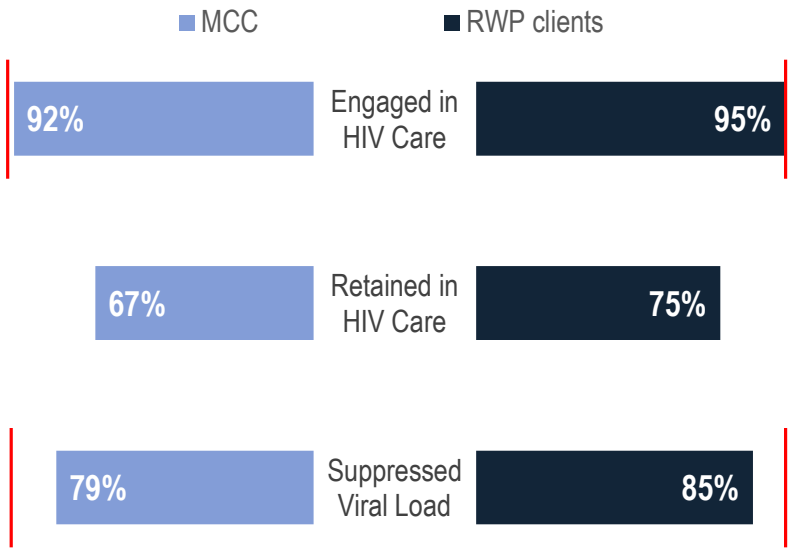
Most of MCC clients spoke English, lived at or below FPL, permanently housed, and no history of incarceration.



Overall, MCC clients had lower HIV care outcome attainment compared to RWP clients.

- Engagement[a], retention[b], and viral load suppression[c] percentages were lower for MCC clients compared to RWP clients overall, Year 34.

- MCC clients did not meet the EHE targets
  - MCC clients have more barriers than RWP overall



Data source: HIV Casewatch as of 5/1/2025

[a]**Engagement in Care** defined as 1 ≥ viral load, CD4 or genotype test reported in the 12-month period based on HIV laboratory data as of 5/5/2025
[b]**Retention in care** defined as 2 ≥ viral load, CD4 or genotype test reported >30 days apart in the 12-month period based on HIV laboratory data as of 5/5/2025
[c]**Viral suppression** defined as most recent viral load test <200 copies/mL in the 12-month period based on HIV laboratory data as of 5/5/2025

Oral Health Care (OHC)

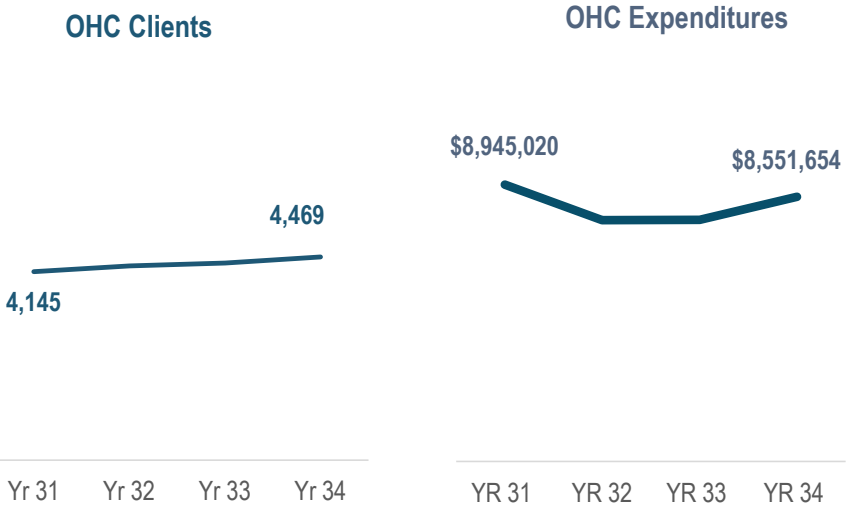
Second highest utilized RWP service

- 3% increase in service utilization in Year 34 compared to Year 33
- 10% increase in expenditures in Year 34 compared to Year 33

A total of **4,469 unique clients** received **Oral Health Care services** representing 28% of RWP clients.

- *General Oral Health* services were provided to **4,185** clients.
- *Specialty Oral Health* services were provided to **986** clients.

Oral Health Care utilization **increased** in the past 4 years.



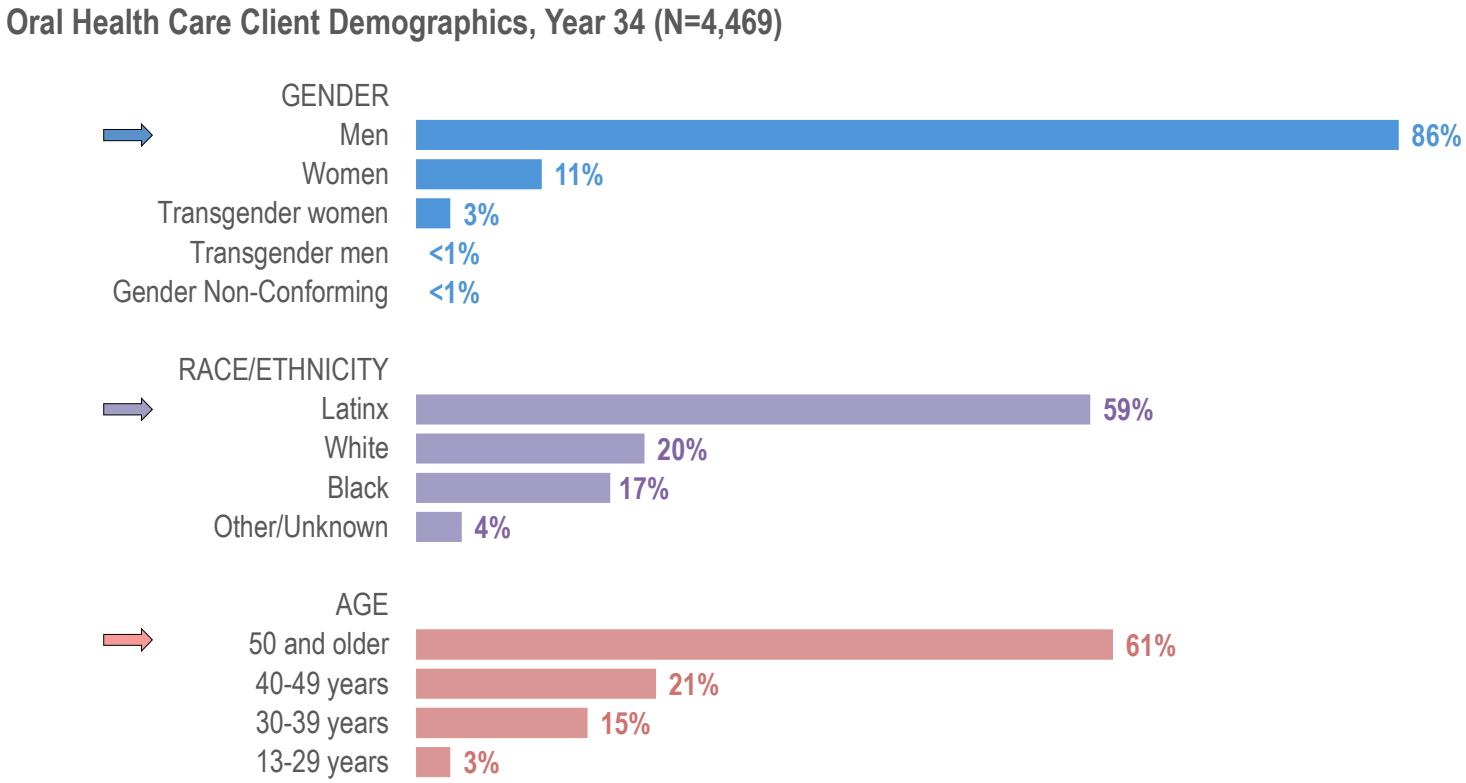
Oral Health Care Service Utilization & Expenditures Summary, Year 34

Service Category	Unique Clients Served	Service Unit(s)	Total Service Units	Units Per Client	Expenditures	Expenditures per client
Oral Health	**4,469**	**Procedures**	**49,240**	**11**	***$8,551,671***	***$1,914***
General	4,185	Procedures	44,064	11	$6,005,983	$1478 $136 per procedure
Specialty	986	Procedures	5,176	5	$2,545,671	$2,582 $492 per procedure

Funding Source:

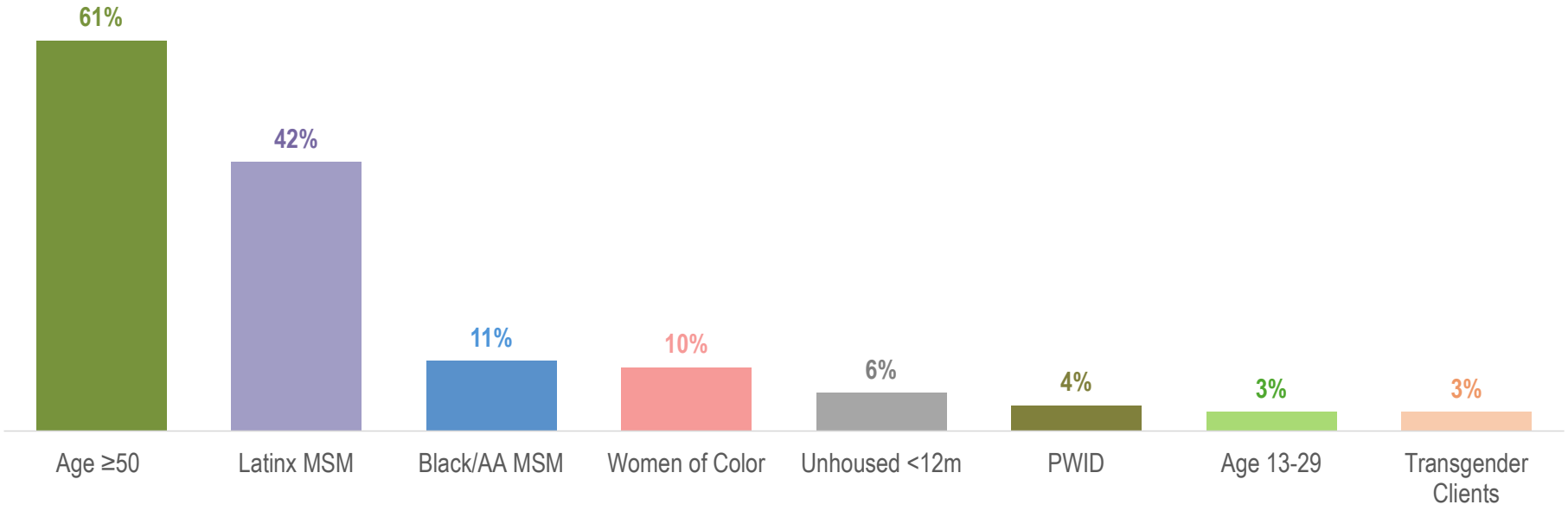
- *Part A - $8,551,654*

Oral Health Care clients were predominantly men, Latinx and people aged 50 and older.



LAC Priority Populations Accessing the OHC Services*, Year 34

- **Clients aged ≥ 50** represented the largest percentage of Oral Health Care clients
- **Latinx MSM clients** were the second largest population served by Oral Health Care
- Percentages for General and Specialty Oral Health Care look similar

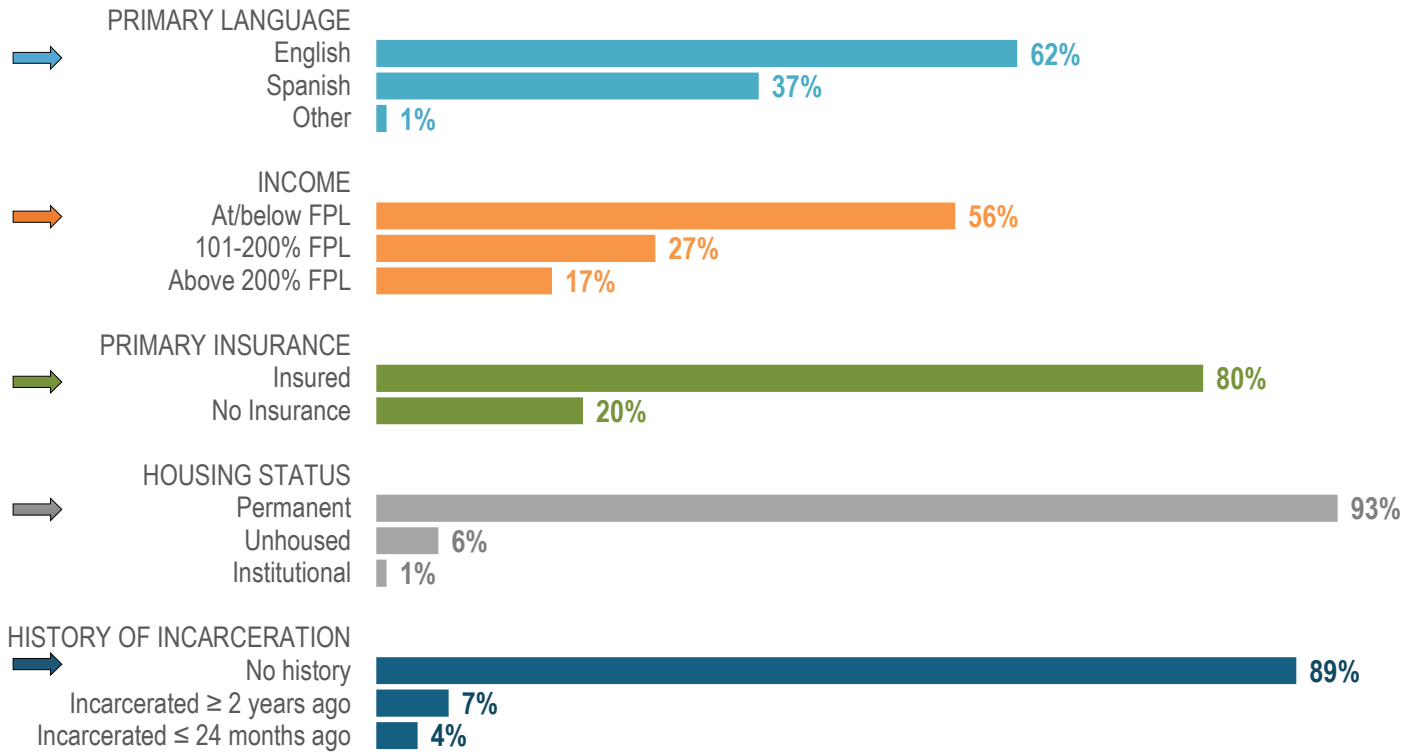


*Priority population groups are not mutually exclusive, they overlap.

Most Oral Health Care clients were English-speakers, lived at or below FPL, were insured, permanently housed, and no history of incarceration.

County of Los Angeles Public Health

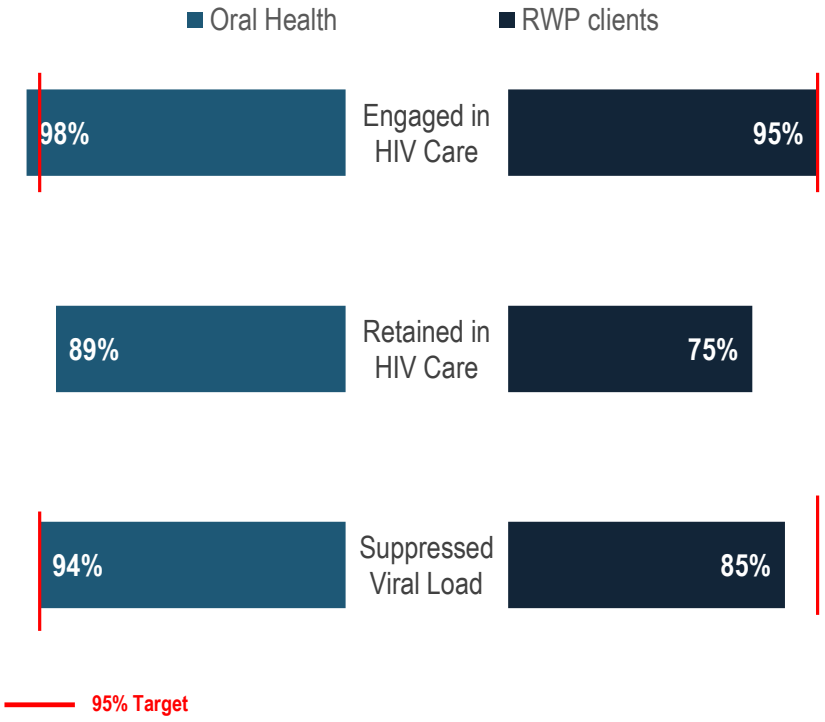
Oral Health Care Health Determinants, Year 34 (N=4,469)



HIV Care Continuum in Oral Health Care clients, Year 34, N=4,469

- Engagement[a], retention in care[b], and viral load suppression[c] percentages were higher for Oral Health Care clients compared to RWP clients overall, Year 34.

- Oral Health Care clients did not meet the EHE target of 95% for viral suppression. However, they met the local target of 95% for engagement in care.



Data source: HIV Casewatch as of 5/1/2025

[a]**Engagement in Care** defined as 1 ≥ viral load, CD4 or genotype test reported in the 12-month period based on HIV laboratory data as of 5/5/2025
[b]**Retention in care** defined as 2 ≥ viral load, CD4 or genotype test reported >30 days apart in the 12-month period based on HIV laboratory data as of 5/5/2025
[c]**Viral suppression** defined as most recent viral load test <200 copies/mL in the 12-month period based on HIV laboratory data as of 5/5/2025

Home-Based Case Management (HBCM)

- 5% reduction in service utilization in Year 34 compared to Year 33
- 13% reduction in expenditures in Year 34 compared to Year 33

A total of **114 unique clients** received **HBCM services**, representing **<1% of RWP clients**.

- Attendant Care – 10 clients
- Case Management – 113 clients
- Equipment – 1 client
- Homemaker services – 67 clients
- Nutrition services – 26 clients
- Psychotherapy – 35 clients

HBCM utilization decreased in the past 4 years.

HBCM Service Utilization & Expenditures Summary, Year 34

- Homemaker subservice had the highest service utilization overall and per client.
- Case management had the highest expenditure overall and per client.

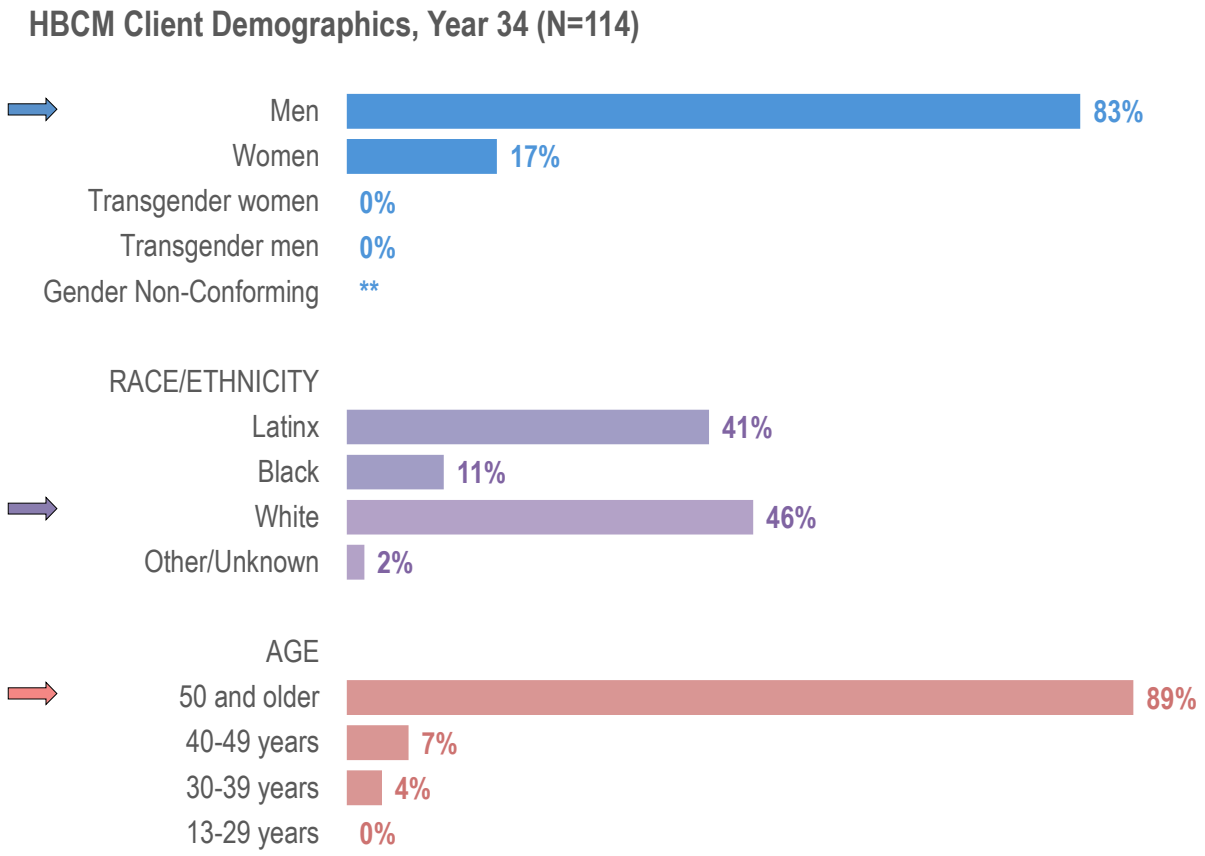
Service Category	Unique Clients Served	Service Unit(s)	Total Service Units	Units Per Client	Expenditures	Expenditures per client
HBCM	**114**	**Various**	**32,640**	**286**	***$2,503,193***	***$21,958***
Case Management	113	*Hours*	5,209	46	*$1,373,093*	*$12,151*
Homemaker	67	*Hours*	20,348	304	*$660,477*	*$9,858*
Attendant Care	10	*Hours*	2,037	204	*$96,202*	*$9,620*
Psychotherapy CM	35	*Hours*	851	24	*$102,163*	*$2,919*
Durable Medical Equipment	1	*Medical Equipment*	2	2	*$296*	*$296*
Nutrition	26	*Nutritional Supplements*	4,193	161	*$6,077*	*$234*

Funding Source:

- *Part A - $1,670,226*
- *HIV NCC - $832,967*

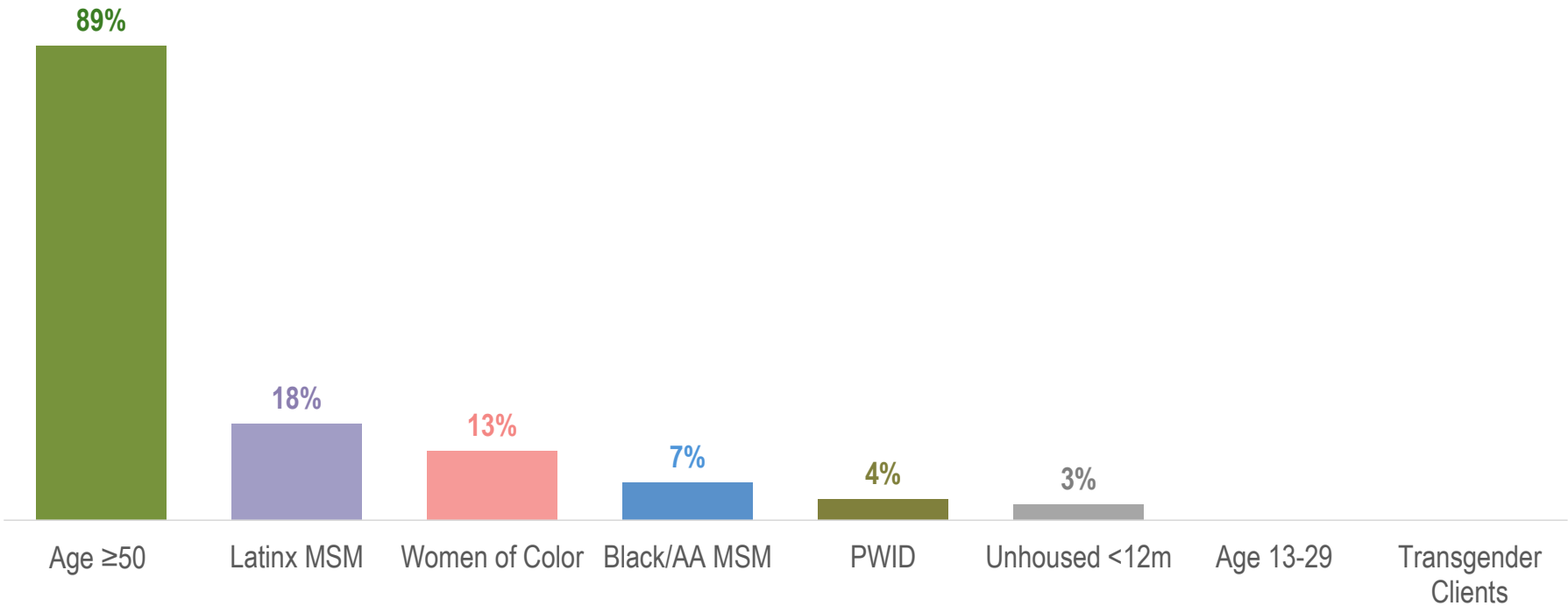
* No information in CaseWatch; we distributed Administrative costs to all HBCM clients

HBCM clients were predominantly men, White and people aged 50 and older.



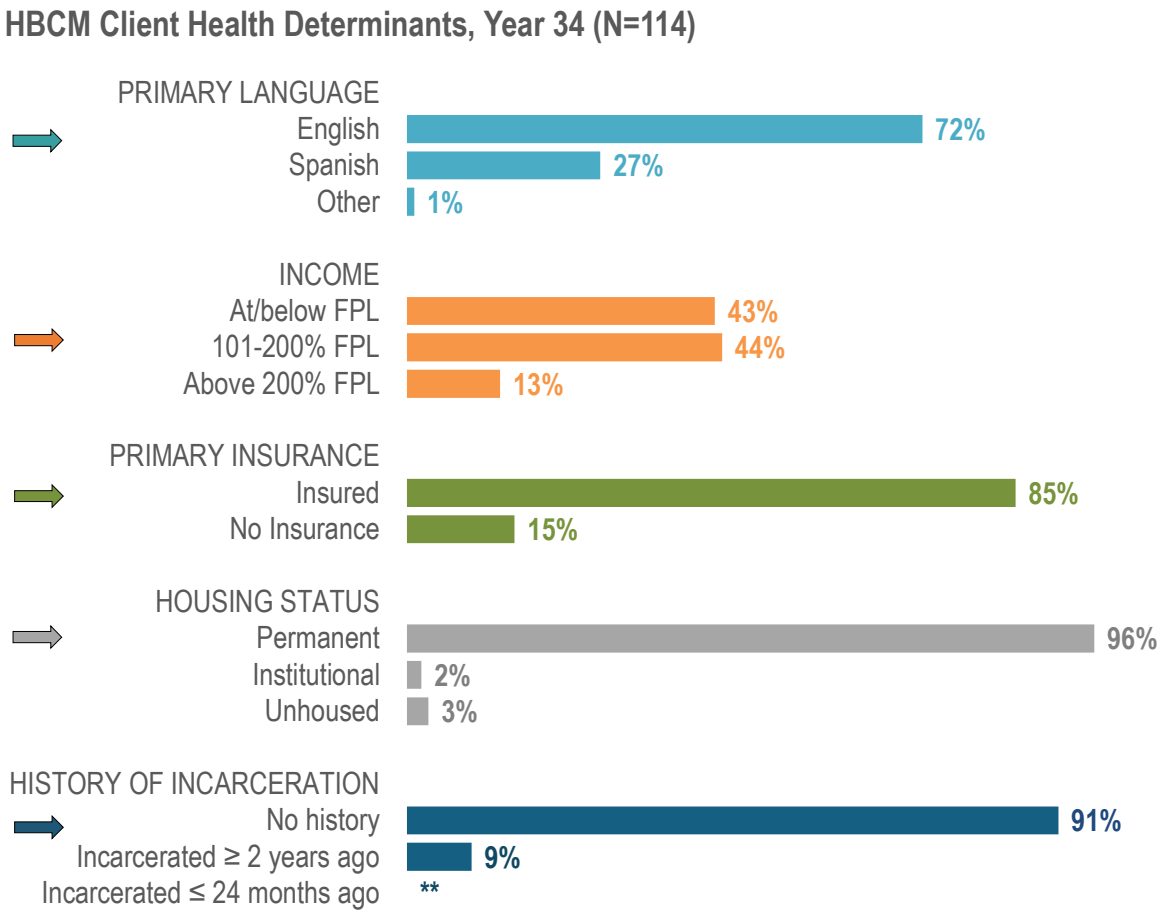
LAC Priority Populations Accessing HBCM Services*, Year 34

- **Clients age ≥ 50** represented the majority of HBCM clients
- **Latinx MSM clients** were the next highest served by HBCM



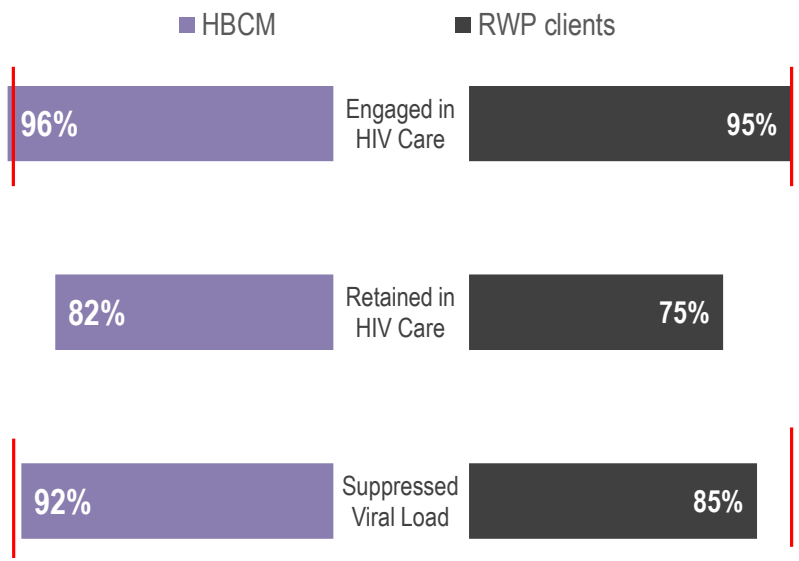
*Priority population groups are not mutually exclusive, they overlap.

Most HBCM clients were English-speakers, lived above FPL, insured, had permanent housing, and no history of incarceration.



HIV Care Continuum in HBCM clients, Year 34 (N=114)

- Engagement[a] and retention in care[b], as well as viral load suppression[c] percentages were higher for HBCM clients compared to RWP clients overall, Year 34.
- HBCM clients met the EHE targets for engagement in care.



Data source: HIV Casewatch as of 5/1/2025

[a]**Engagement in Care** defined as 1 ≥ viral load, CD4 or genotype test reported in the 12-month period based on HIV laboratory data as of 5/5/2025
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[c]**Viral suppression** defined as most recent viral load test <200 copies/mL in the 12-month period based on HIV laboratory data as of 5/5/2025

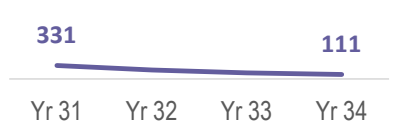
Mental Health (MH) Services

- 5% reduction in service utilization in Year 34 compared to Year 33
- 13% reduction in expenditures in Year 34 compared to Year 33

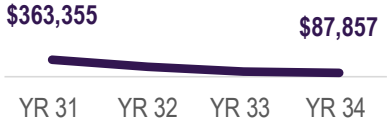
A total of **111 unique clients** received **Mental Health services**, representing **<1% of RWP clients.**

MH utilization decreased in the past 4 years, likely due to a lack of providers within RWP.

MH Clients



MH



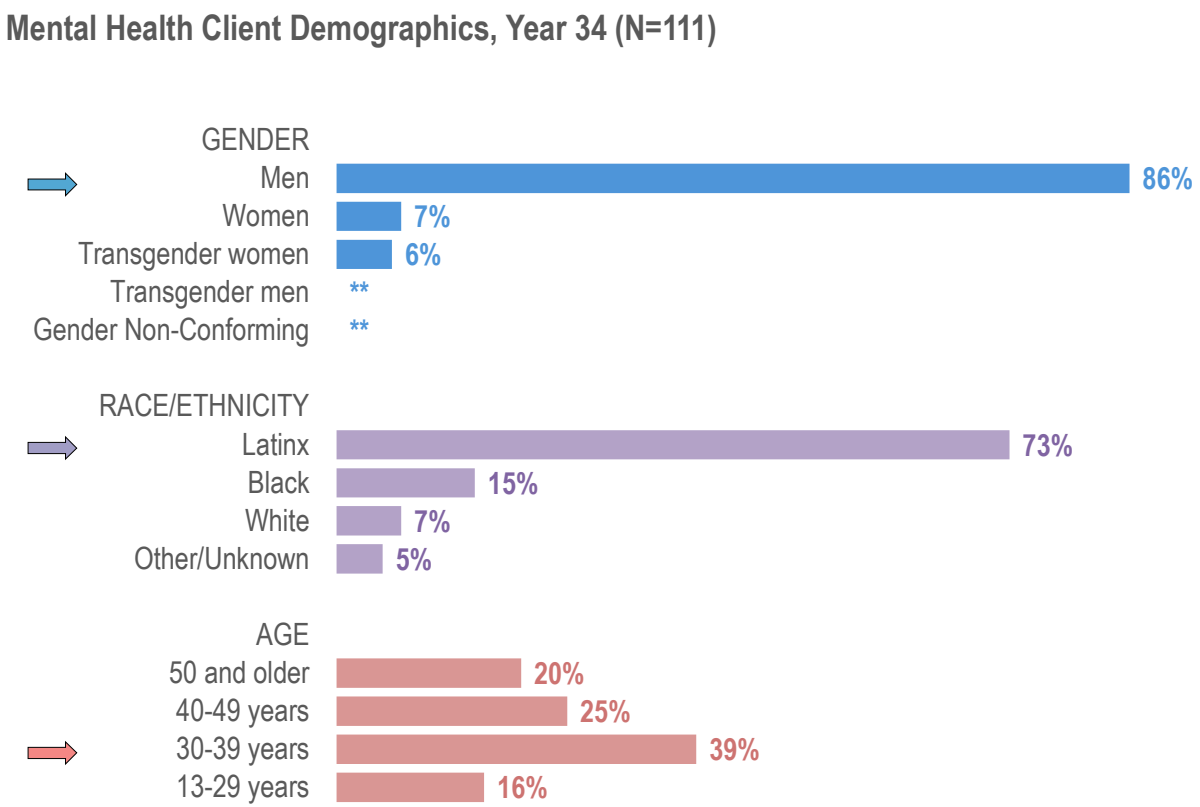
Mental Health Service Utilization & Expenditures Summary, Year 34

Service Category	Unique Clients Served	Service Unit(s)	Total Service Units	Units Per Client	Expenditures	Expenditures per client
Mental Health	**111**	**Sessions**	**547**	**5**	***$87,857***	***$792***

Funding Source:

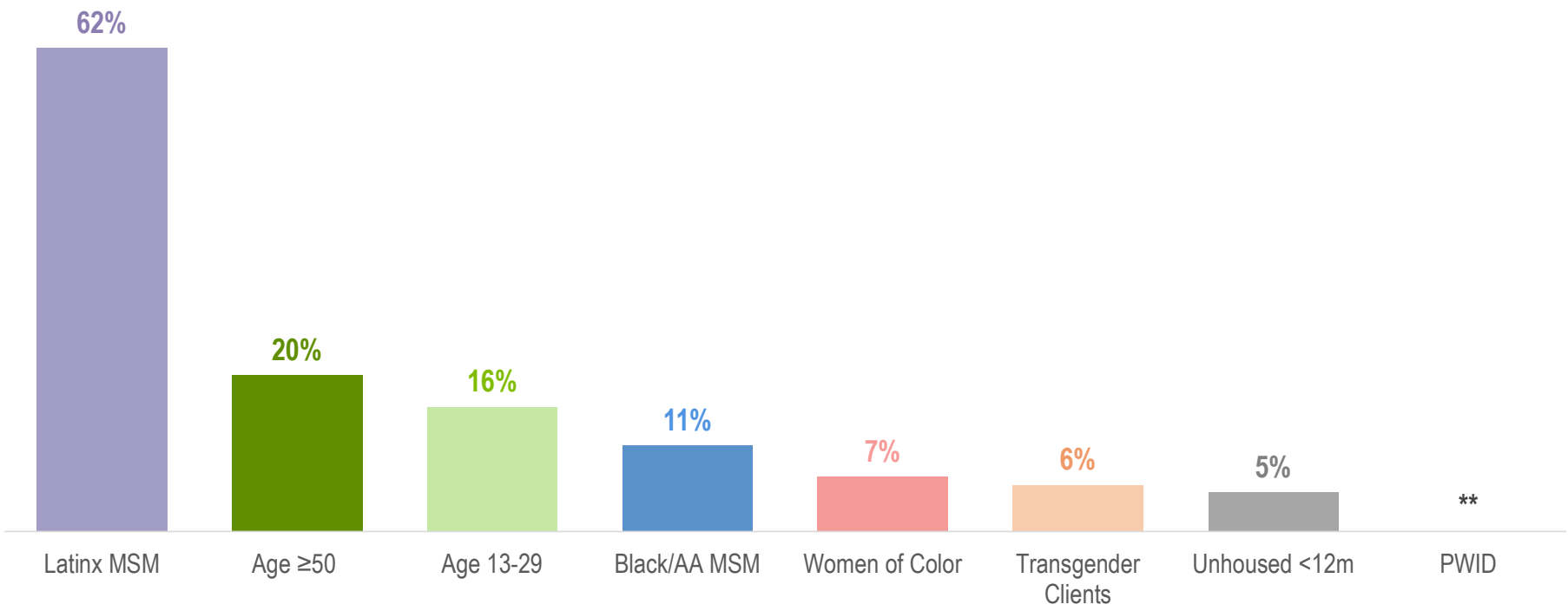
- *Part A - $87,857*

Mental Health Client were predominantly men, Latinx and aged 30-39 years.



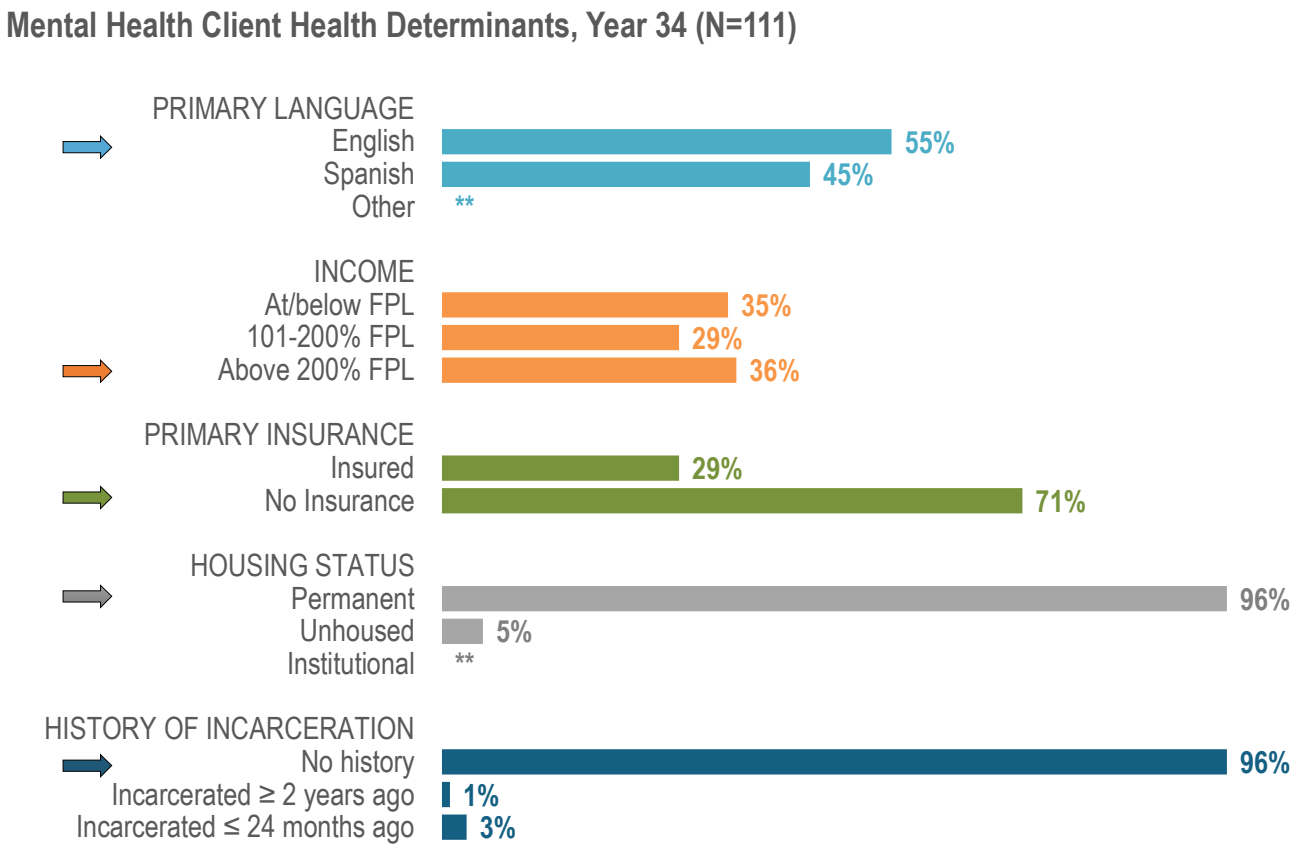
LAC Priority Populations Accessing Mental Health Services*, Year 34

- **Latinx MSM clients** represented the majority of Mental Health clients
- **Clients age ≥ 50** were the next highest priority population served by Mental Health



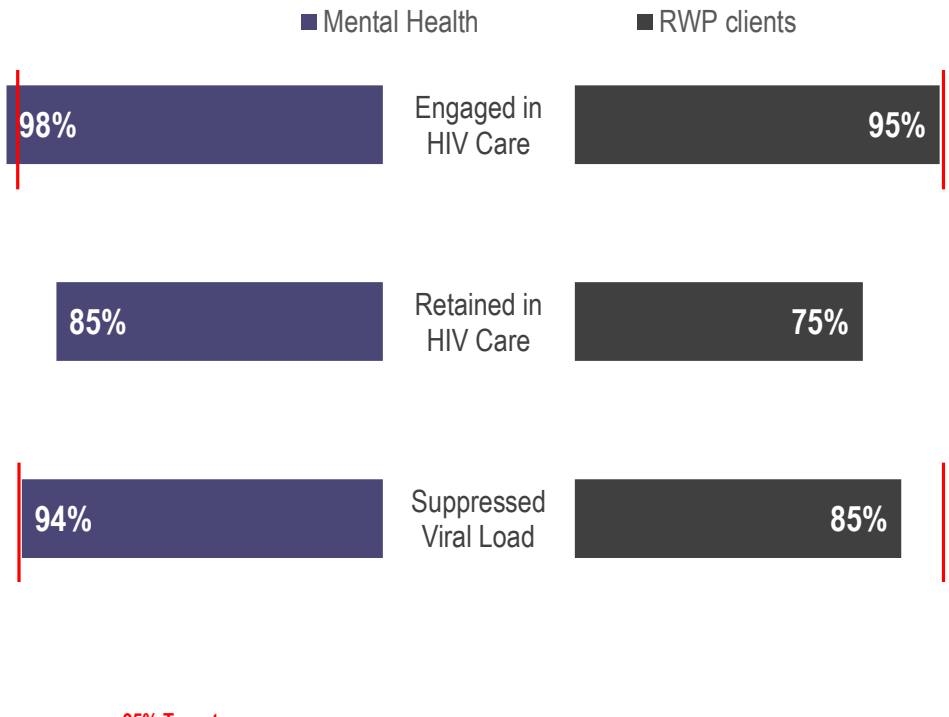
*Priority population groups are not mutually exclusive, they overlap.

MH clients were predominantly English speakers, had varied FPL, uninsured, permanently housed, and had no history of incarceration.



HIV Care Continuum in Mental Health clients, Year 34 (N=111)

- Engagement[a], retention in care[b], and viral load suppression[c] percentages were higher for Mental Health clients compared to RWP clients overall, Year 34.
- Mental Health clients did not meet the EHE target of 95% for viral suppression. However, they met the local target of 95% for engagement in care.



Data source: HIV Casewatch as of 5/1/2025

[a]**Engagement in Care** defined as 1 ≥ viral load, CD4 or genotype test reported in the 12-month period based on HIV laboratory data as of 5/5/2025
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[c]**Viral suppression** defined as most recent viral load test <200 copies/mL in the 12-month period based on HIV laboratory data as of 5/5/2025

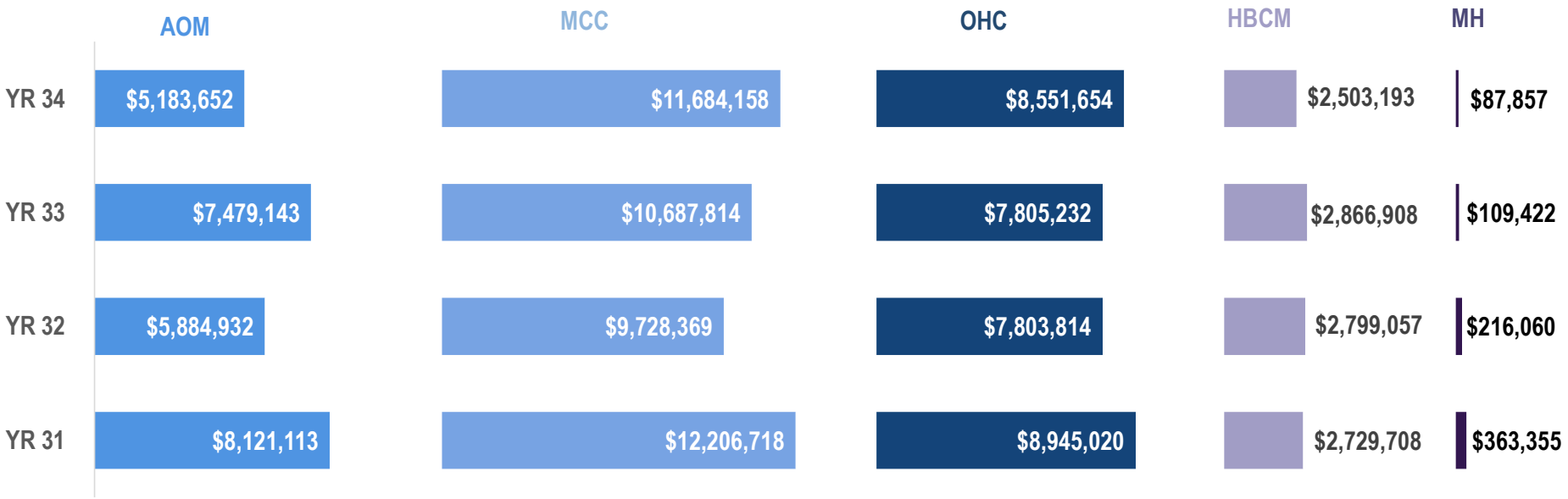
Core RWP Services Expenditures

AOM	*$5,183,652*
MCC	*$11,684,158*
Oral Health	*$8,551,654*
HBCM	*$2,503,193*
Mental Health	*$87,857*

County of Los Angeles Public Health

Expenditures for Years 31-34 by Core Service Category

AOM, **HBCM** and **Mental Health** services expenditures generally decreased since Year 31 with the lowest in Year 34. Expenditures for **Oral Health Care** services gradually increased over four years. **MCC** expenditures varied, increased compared to Years 32-33.



Expenditures per Client for Core RWP Services, Year 34

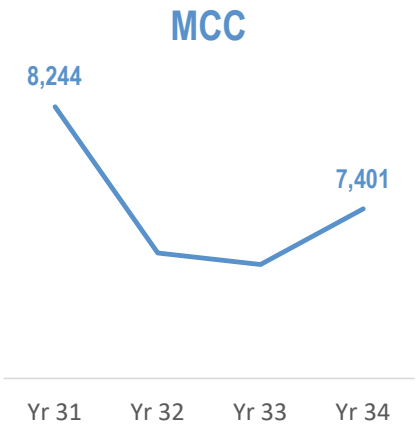
- **The highest expenditures per client** were spent **for HBCM**.
- **The lowest expenditures per client** were spent for **MH**, followed by **AOM** services.

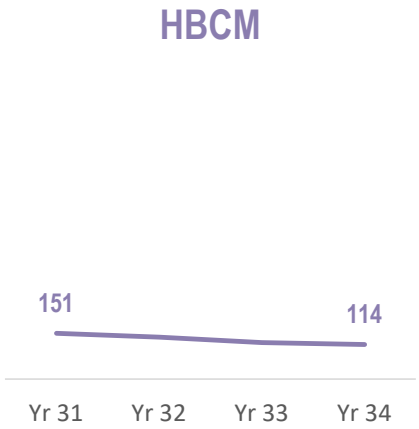
Service Category	Number of clients	% of RWP clients	Expenditures	% of total expenditures	Expenditures per client
MCC	7,401	47%	*$11,684,158*	*19%*	*$1,579*
Oral Health	4,469	28%	*$8,551,654*	*14%*	*$1,914*
AOM	2,882	18%	*$5,183,652*	*8%*	*$1,187*
HBCM	114	< 1%	*$2,503,193*	*4%*	***$21,958***
Mental Health	111	< 1%	*$87,857*	*<1%*	*$792*

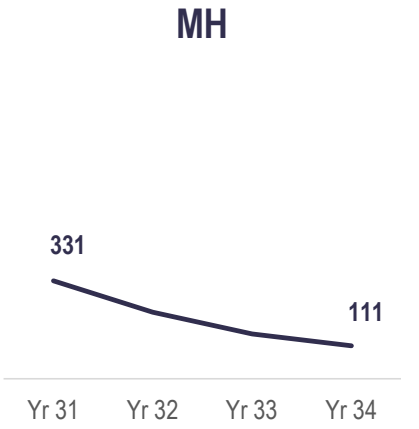
Key Takeaways

- Core Services Utilization
- Client Demographics
- HCC Outcomes
- Expenditures

Core Service Utilization, Years 31-34







Core Service Category	Year 34 Service Utilization Impact	Reasons for Year 34 Impact
AOM	Decreased utilization	DHS departure, Medi-Cal expansion
MCC	Increased utilization	Most consistently utilized service.
OH	Increased Utilization	Recovery from COVID-19 pandemic drop in Year 30
HBCM	Decreased Utilization	Medi-Cal expansion
MH	Decreased Utilization	Lack of MH providers within RWP, Medi-Cal expansion

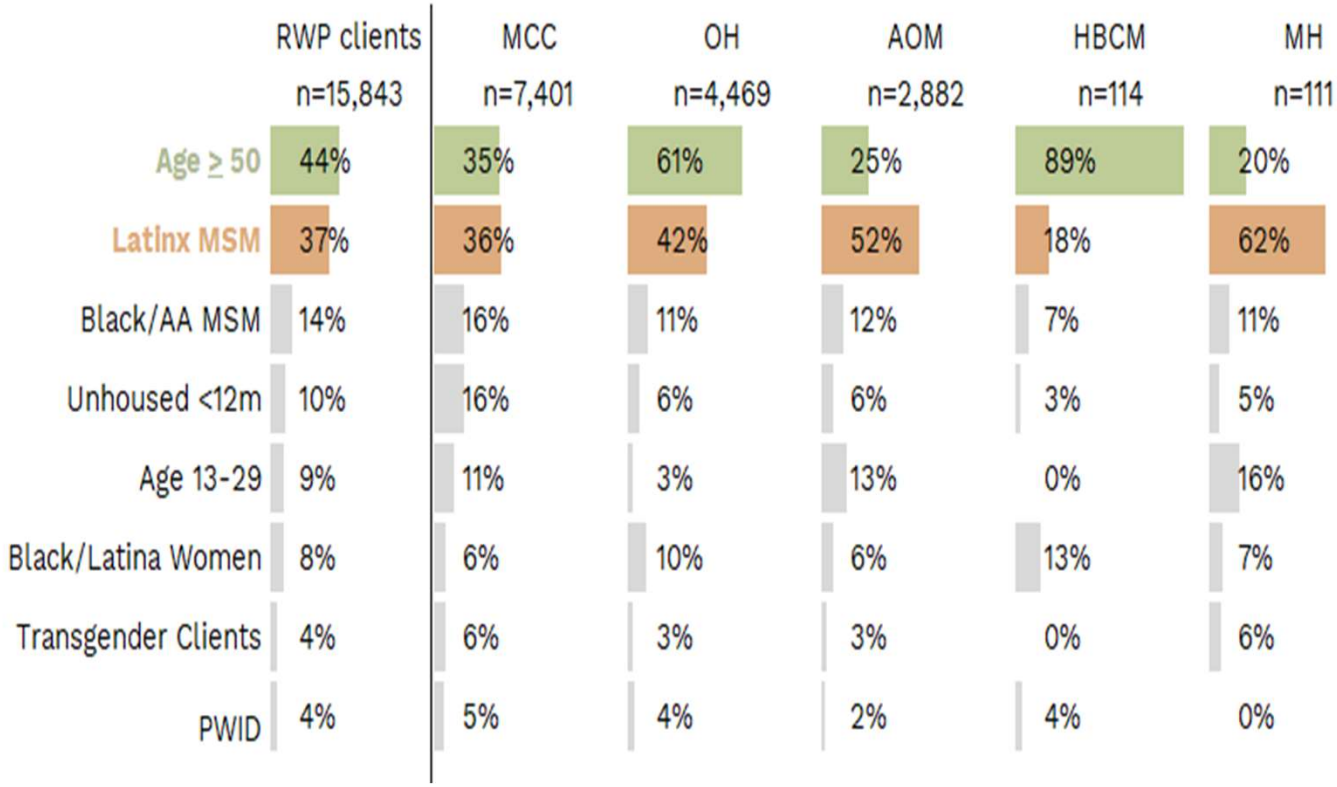
Key Takeaways: Client Demographics

- Primarily **men** across all services.
- Proportionate representation of **Latinx** individuals;
  - except AOM and HBCM with relatively high percentage of white individuals.
- Age distribution varies by service category. However, for all Core services, except AOM, the highest percentage of client were **aged 50 and older**.

	RWP clients n=15,843	MCC n=7,401	OH n=4,469	AOM n=2,882	HBCM n=114	MH n=111
GENDER						
Men	86%	87%	86%	91%	83%	87%
Women	10%	7%	11%	6%	17%	7%
Transgender Women	4%	5%	3%	3%	0%	5%
Trangender Men	0%	<1%	<1%	<1%	0%	<1%
Non-binary/Other	0%	<1%	<1%	<1%	**	<1%
RACE/ETHNICITY						
Latinx	53%	48%	59%	25%	41%	48%
Black	23%	24%	17%	28%	11%	24%
White	21%	23%	20%	34%	46%	23%
Other/Unknown	5%	5%	4%	13%	2%	5%
AGE						
50 and older	44%	35%	61%	25%	90%	35%
40-49 years	22%	23%	21%	28%	7%	23%
30-39 years	25%	31%	15%	34%	4%	31%
13-29 years	9%	11%	3%	13%	0%	11%

Key Takeaways: Priority Population

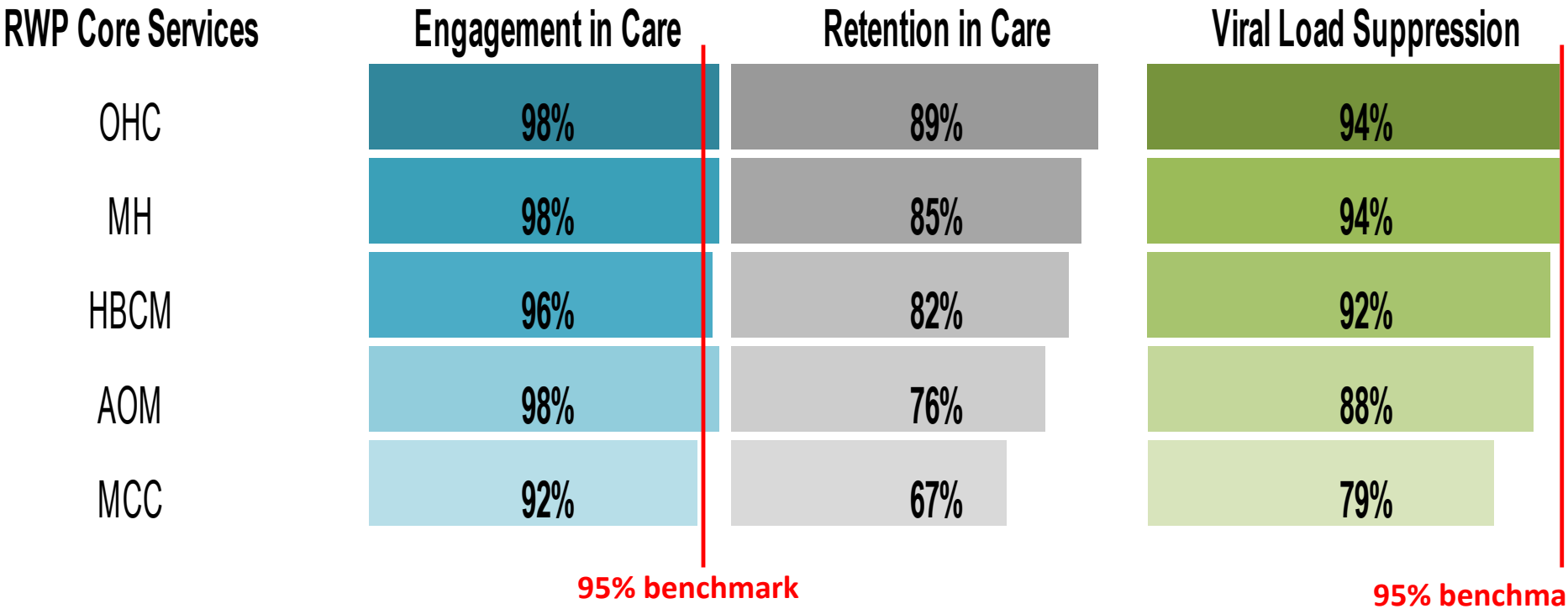
- The top RWP Core services utilized by priority populations were **MCC**, **Oral Health**, and **AOM**.
- Core services utilization among LAC priority population was consistent relative to their size (larger population – higher utilization):
  - **Latinx MSM** and **people aged ≥ 50 and older** were the **highest utilizers** of RWP Core services
    - RWP client **aged 50 and older** were the highest utilizers of Oral Health and HBCM services
    - **Latinx MSM** were the highest utilizers of AOM, MCC and MH services
  - **Lowest utilization** of RWP Core services was among **transgender people, PWID, unhoused** or **youth aged 13-29,** the smallest priority populations.



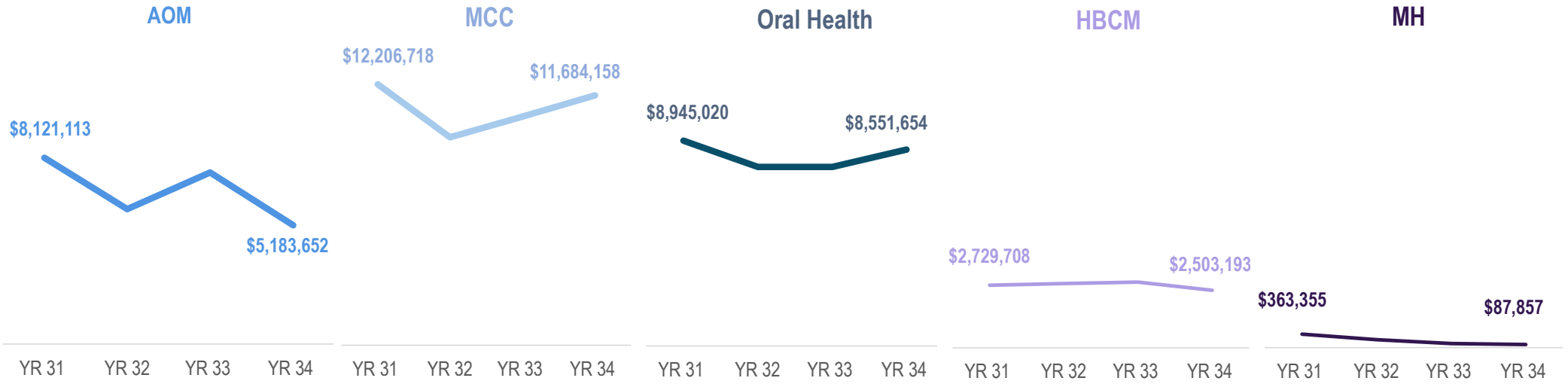
*Priority population groups are not mutually exclusive, clients may overlap

HIV Care Continuum Outcomes, Yr 34

Best outcomes were observed among RWP clients using OHC, HBCM, and MH services.



Key Takeaways - Expenditures



Core Service Category	Expenditures per Service	Expenditures per Clients	Reasons for Year 34 Changes
AOM	Decreased expenditures	Second lowest expenditures per client	Decrease in the number of clients served due to DHS departure and Medi-Cal expansion
MCC	Increased expenditures		Increase in number of clients; most consistently utilized service. Staffing.
OHC	Increased expenditures	Second highest expenditures per client	Recovery from COVID-19 pandemic drop in Year 30
HBCM	Decreased expenditures	Highest expenditures per clients	Decreased number of clients but not a significant decrease in expenditures in Year 34. Staffing.
MH	Decreased expenditures	Lowest expenditures per client	Decreased number of clients due to lack of MH providers within RWP. Medi-Cal expansion.

Next Steps

- Present to COH on the second of two major service clusters
  - Support Services (EFA, Housing, NMCM, Nutrition Support, LRP, Substance Use Residential)
- Examine detailed utilization of RWP services within each LAC priority populations
- Examine RWP by priority population over time

Questions/Discussion

Thank you!

- Acknowledgements
  - Monitoring and Evaluation – Siri Chirumamilla
  - Surveillance – Kathleen Poortinga, Priya Patel
  - PDR – Victor Scott, Michael Green
  - CCS – Paulina Zamudio and the RWP program managers
  - RWP agencies and providers
  - RWP clients

Estamos Escuchando

Comparta sus inquietudes con nosotros.

Servicios de VIH + ETS
Línea de Atención al Cliente

(800) 260-8787

¿Por qué debería llamar?

La Línea de Atención al Cliente puede ayudarlo a acceder a los servicios de VIH o ETS y abordar las inquietudes sobre la calidad de los servicios que ha recibido.

¿Se me negarán los servicios por informar de un problema?

No. No se le negarán los servicios. Su nombre e información personal pueden mantenerse confidenciales.

¿Puedo llamar de forma anónima?

Si.

¿Puedo ponerme en contacto con usted a través de otras formas?

Si.

Por correo electronico:
dhspsupport@ph.lacounty.gov

En el sitio web:
http://publichealth.lacounty.gov/dhsp/QuestionServices.htm

County of Los Angeles
Public Health
Division of HIV and STD Programs

We're Listening

share your concerns with us.

HIV + STD Services Customer Support Line

(800) 260-8787

Why should I call?

The Customer Support Line can assist you with accessing HIV or STD services and addressing concerns about the quality of services you have received.

Will I be denied services for reporting a problem?

No. You will not be denied services. Your name and personal information can be kept confidential.

Can I call anonymously?

Yes.

Can I contact you through other ways?

Yes.

By Email:
dhspsupport@ph.lacounty.gov

On the web:
http://publichealth.lacounty.gov/dhsp/QuestionServices.htm

County of Los Angeles Public Health
Division of HIV and STD Programs