LOS ANGELES COUNTY
COMMISSION ON HIV

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STANDARDS AND BEST PRACTICES COMMITTEE MEETING

Tuesday, May 7, 2024
10:00am-12:00pm (PST)

Vermont Corridor
510 S. Vermont Ave. Terrace Conference Room TK08
****Valet Parking: 523 Shatto Place, LA 90020****

Agenda and meeting materials will be posted on our website at http://hiv.lacounty.gov/Meetings

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

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For Members of the Public Who Wish to Join Virtually, Register Here:
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To Join by Telephone: +1-213-306-3056 United States Toll (Los Angeles)
Password: STANDARDS **Access Code:** 2533 885 6187

	Scan QR code to download an electronic copy of the meeting agenda and packet on your smart device. Please note that 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. **If meeting packet is not yet available, check back 2-3 days prior to meeting; meeting packet subject to change. Agendas will be posted 72 hours prior to meeting per Brown Act.*

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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, May 7, 2024| 10:00 AM – 12:00 PM

510 S. Vermont Ave
Terrace Level Conference Room TK08
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 to access the Terrace Conference Room (9th floor) where our meetings are held.

MEMBERS OF THE PUBLIC WHO WISH TO JOIN VIRTUALLY, REGISTER HERE:
https://lacountyboardofsupervisors.webex.com/weblink/register/rb879d8feb82767a9e8dc75cecd5865e4
To Join by Telephone: 1-213-306-3065
Password: STANDARDS Access Code: 2533 885 6187

Standards and Best Practices Committee (SBP) Members:			
Erika Davies *Co-Chair*	Kevin Stalter *Co-Chair*	Mikhaela Cielo, MD	Sandra Cuevas
Kerry Ferguson (Alternate)	Arlene Frames	Wendy Garland, MPH *(DHSP Representative)*	Lauren Gersh, LCSW *(Committee-only)*
David Hardy, MD *(Alternate)*	Mark Mintline, DDS *(Committee-only)*	Andre Molette	Byron Patel, RN
Martin Sattah, MD	Russell Ybarra		
QUORUM: 8			

AGENDA POSTED: May 1, 2024.

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. Executive Director/Staff Report — 10:15 AM – 10:25 AM
   a. Operational and Programmatic Updates

8. Co-Chair Report — 10:25 AM – 10:35 AM
   a. 2024 Workplan and Meeting Schedule—Updates
   b. Service Standards Revision Tracker—Updates

9. Division on HIV and STD Programs (DHSP) Report 10:35 AM—10:40 AM

V. DISCUSSION ITEMS

10. Ambulatory Outpatient Medical (AOM) Service Standards Review 10:40 AM—11:50 AM
    a. AOM Service Provider Listening Session

VI. NEXT STEPS 11:50 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 May 7, 2024.

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.

HYBRID MEETING GUIDELINES, ETTIQUETTE & REMINDERS

(Updated 3.22.23)

☐ This meeting is a **Brown-Act meeting** and is being recorded.

- The conference room speakers are *extremely* sensitive and will pick up even the slightest of sounds, i.e., whispers. If you prefer that your private or side conversations, not be included in the meeting recording which, is accessible to the public, we respectfully request that you step outside of the room to engage in these conversations.
- 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. *For members of the public attending virtually, you may also submit your public comment via the Chat box. Should you wish to speak on the record, please use the "Raised Hand" feature or indicate your request in the Chat Box and staff will call upon and unmute you at the appropriate time. Please note that all attendees are muted unless otherwise unmuted by staff.*

☐ 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, at all times, 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.

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*

Presence at meetings is recorded based on the attendance roll call. Only members of the Commission on HIV are accorded voting privileges and must verbally acknowledge their attendance in order to vote.
Approved meeting minutes are available on the Commission's website; meeting recordings are available upon request.

STANDARDS AND BEST PRACTICES (SBP) COMMITTEE MEETING MINUTES

April 2, 2024

COMMITTEE MEMBERS P = Present | A = Absent					
Erika Davies, *Co-Chair*	P	Arlene Frames	P	Andre Molette	A
Kevin Stalter, *Co-Chair*	P	Wendy Garland, MPH	P	Byron Patel, RN	P
Mikhaela Cielo, MD	P	Lauren Gersh, LCSW	P	Martin Sattah, MD	EA
Sandra Cuevas	P	David Hardy, MD	A	Juan Solis	A
Kerry Ferguson	P	Mark Mintline, DDS	EA	Russell Ybarra	P
COMMISSION STAFF AND CONSULTANTS					
Cheryl Barrit; Lizette Martinez					
DHSP STAFF					
Carolyn Duclayan-Vismanos					
COMMUNITY MEMBERS					
Arburtha Franklin, Rita Garcia					

**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.*
***LOA: Leave of absence*

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

CALL TO ORDER-INTRODUCTIONS-CONFLICT OF INTEREST STATEMENTS
The meeting was called to order at 10:06am.

I. ADMINISTRATIVE MATTERS

1. APPROVAL OF AGENDA

MOTION #1: Approve the agenda order, as presented ***(✓Passed by consensus)***.

2. APPROVAL OF MEETING MINUTES

MOTION #2: Approve the 3/05/24 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

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**: Kevin
There were no committee new business items.

IV. REPORTS

5. **EXECUTIVE DIRECTOR/STAFF REPORT**

- **Operational and Programmatic Updates**
Cheryl Barrit, Executive Director of the Commission, reported that project officers from the Health Resources and Services Administration (HRSA) are doing a site visit from May 21, 2024 thru May 23, 2024. HRSA launched a new technical assistance program for planning councils and informed the COH that Los Angeles County is among the initial 6 jurisdictions receiving the technical assistance program. COH staff are currently preparing all the documents requested from the project officers in preparation for the site visit. The Planning, Priorities, and Allocations (PP&A) Committee, the Executive Committee (EC), and the Operations Committee all have their meetings during the HRSA site visit timeframe; the project officers have indicated they will attend the EC meeting but have not expressed commitment to attend the other two. Once the site visit ends, a report will be shared with the COH. She noted that the EC submitted the following technical assistance requests: feedback on the proposed changes to the COH's bylaws; feedback on the updated priority setting and allocations process and planning framework; recommendations on integrating prevention into the priority setting and allocations process; feedback on the updated conflicts of interest management process; innovative ways for membership recruitment and retention; feedback on the proposed membership rotation and term limits described in the bylaws revisions. C. Barrit added that the technical assistance program is intended to be an ongoing project and asked that any additional technical assistance requests be sent to the COH staff to share with the HRSA staff.

  Russel Ybarra asked if the term limits provision in the proposed bylaws changes apply to consumers. C. Barrit shared that the provision would apply to all members of the Commission. She added that LA County Board of Supervisors (BOS) has over 300 commissions/boards and that historically, the BOS has waived term limits to avoid having too many vacancies in commission/board membership; these more than 300 commissions/boards serve as a major vehicle for the BOS to gain an understanding of community affairs. During the most recent HRSA site visit in 2023, HRSA indicated that Commissioners serving on the COH need to have term limits which prompted the Bylaws Review Task Force to propose a bylaw change that implements a term limit for Commissioners serving on the COH. The proposed change is to allow Commissioners to serve 2-3 years terms and then taking a 12-month break in between terms.

- C. Barrit reminded attendees that the next Commission meeting will be on Thursday April 11, 2024 at the Martin Luther King (MLK) Behavioral Health Center; this is the same location where the March COH meeting was held. The meeting will feature a round table discussion convening housing experts and resources. Among the panelists will be representatives from the Division on HIV and STD Programs (DHSP), the Housing Opportunities for Persons with AIDS (HOPWA), Comprehensive Housing Information & Referrals for People Living with HIV/AIDS (CHIRP) LA, the CEO's Homeless Initiative, the City of Los Angeles Section 8 program, the Los Angeles Housing Services Authority (LAHSA), and the County of Los Angeles Housing for Health Program. The representatives will provide a brief overview of their respective programs and then participated in a panel discussion facilitated by the COH co-chairs. The intent behind the presentations and panel discussion is for attendees to gain a better understanding of housing resources available in Los Angeles County and how to navigate them.

- **Service Standards Development Refresher**
  C. Barrit provided a refresher training on the service standards development process. The purpose of this training is for new committee members to become better acquainted with the roles and responsibilities of the Standards and Best Practices (SBP) Committee. C. Barrit noted that a more comprehensive training on the Service Standards Development and other topics related to the core functions of the COH are available on the COH website under the "Resources" section. Kevin Stalter added that the SBP Committee aims to write the standards in a way that they are understood and accessible to consumers. Refer to the meeting packet for a copy of the presentation materials.

6. CO-CHAIR REPORT

- **2024 Workplan Development and Meeting Schedule**
  Erika Davies provided an overview of the 2024 workplan. She noted that on 3/5/24 the SBP Committee approved the Prevention Services standards and elevated them to the Executive Committee for review and approval. Once approved, the document will move to the full COH body for approval at the April 11, 2024 meeting. C. Barrit noted that the Aging Caucus had requested the SBP Committee to develop Transitional Case Management standards for people 50+; however, at the March SBP Committee, the Committee decided to instead develop a global transitional case management standards document that includes sections for priority populations such as youth, the elderly, and the formally incarceration/justice involved.

  E. Davies welcomed two new members to the Committee, Sandra Cuevas, and Kerry Ferguson, and offered them the opportunity to introduce themselves and share some background information on their involvement in HIV-related community engagement and other activities.

- **Service Standard Revision Tracker**
  The Transitional Case Management Youth service standards development are pending. The Emergency Financial Assistance (EFA) and the Ambulatory Outpatient Medical (AOM) service standards will be reviewed in 2024. The Transportation Services and the Temporary and Permanent Housing Services standards both will have solicitations posted in 2024.

7. DIVISION ON HIV AND STD PROGRAMS (DHSP) REPORT

Wendy Garland reported that DHSP is working on developing a Request for Proposal (RFP) for AOM and Medical Case Management (MCC) as well as an RFP for Prevention Services. Additionally, is working on a report on testing services which is an overall survey of all the testing services and initiatives that DHSP currently supports; the report is expected to be completed by the end of April. She introduced Carolyn Duclayan-Vismanos who is part of the Clinical Quality Management team at DHSP. Carolyn shared she oversees the Customer Support Program and works with Maureen Bradley. W. Garland noted that Carolyn is also part of the DHSP team working on updating the MCC Program. She added that the MCC program was implemented 10 years ago was designed to respond to an HIV epidemic that looks very different from what we have now. The intent behind the updates to the MCC program is to ensure that it is a service that is as responsive as possible to the changing needs of consumers and the teams implementing the program. W. Garland added that the development of the RFP will include MCC, AOM, and other forms of case management and is happening in tandem with the updates to the MCC program. She noted that the RFP will include details about the MCC program but will be mostly contract requirements that describe the components an agency needs to have in place to provide MCC services. She also acknowledged that with Medical expansion and the increasing availability of additional options for clients to have their medical care paid for, less clients are leaning on Ryan White as a payor source; However, she emphasized that MCC continues to be an important anchor for clients and clinics in providing comprehensive wrap-around services that may not be covered by other payor sources. Sandra Cuevas asked how the CalAIM

initiative interact with the MCC program? W. Garland shared that MCC is more comprehensive.

V. DISCUSSION ITEMS

8. Ambulatory Outpatient Medical (AOM) Service Standards Review

E. Davies noted that the meeting packet includes a factsheet for the AOM services and an MCC/AOM service utilization report; both items were developed by DHSP. C. Barrit added that W. Garland presented the MCC/AOM service utilization report to the PP&A Committee in August 2023. W. Garland shared a couple key takeaways from the report and noted that a report with Year 33 data will be available soon. Refer to the meeting packet for a copy of the materials.

E. Davies provided a walkthrough of the current AOM service standards document and solicited initial feedback from Committee members. The Committee noted the following:

- Consistent wording when referring to AOM services throughout the document
- Reformat the document to conform with the structure of recently reviewed service standards
- Update the goals section to be consistent with the AOM factsheet
- Reduce the length of the introduction section to avoid repetitive content throughout the document
- Verify the websites/links in the document work and remove any that are no longer relevant or outdated
- Expand on service standards related to patient retention and reengagement strategies such as offering transportation services to clients
- Update the Department of Health and Human Services (DHHS) clinical guidelines mentioned in the document
- Expand the staffing model to include additional providers such as social workers
- Create an appendix that includes a list of the items to ask during a comprehensive examination
- Rename the "Assessment/Re-Assessment" section to "Interview/Medical Examination"
- Remove the components that refer to/related to MCC service standards to avoid confusion and redundancy
- Explain the fundamental differences between AOM and MCC.

C. Barrit asked W. Garland and C. DV for additional guidance on the distinguishing characteristics of the two programs. W. Garland recommended also engaging the DHSP Medical Advisory Committee and solicit their feedback on the standards once the Committee has completed a more in-depth review of the document.

C. Barrit noted that performance measures and related metrics should not be included in the service standards per HRSA guidance. These measures are developed by DHSP and included in contracts. The COH can offer feedback to DHSP regarding the performance measures, but the COH should not be involved in the contract development process; that is a sole responsibility of the grantee, DHSP.

VI. NEXT STEPS

9. TASK/ASSIGNMENTS RECAP:

- COH staff will revise the AOM service standards document.

11. AGENDA DEVELOPMENT FOR NEXT MEETING:

- Continue review of the AOM service standards.

VII. ANNOUNCEMENTS

12. OPPORTUNITY FOR PUBLIC AND COMMITTEE TO MAKE ANNOUNCEMENTS:

- There were no announcements.

VIII. ADJOURNMENT

13. ADJOURNMENT: The meeting adjourned at 11:55am.

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 4/12/24

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
ALVAREZ	**Miguel**	No Affiliation	No Ryan White or prevention contracts
ARRINGTON	**Jayda**	Unaffiliated consumer	No Ryan White or prevention contracts
BALLESTEROS	**Al**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV)
			STD Screening, Diagnosis, and Treatment
			Health Education/Risk Reduction (HERR)
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
BURTON	**Alasdair**	No Affiliation	No Ryan White or prevention contracts
CAMPBELL	**Danielle**	T.H.E. Clinic, Inc.	Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Transportation Services
CIELO	**Mikhaela**	LAC & USC MCA Clinic	Biomedical HIV Prevention
CONOLLY	**Lilieth**	No Affiliation	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
DAVIES	**Erika**	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DONNELLY	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
FERGUSON	**Kerry**	ViiV Healthcare	No Ryan White or prevention contracts
FINDLEY	**Felipe**	Watts Healthcare Corporation	Transportation Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Oral Health Care Services
			Biomedical HIV Prevention
			STD Screening, Diagnosis and Treatment
FRAMES	**Arlene**	Unaffiliated consumer	No Ryan White or prevention contracts
FULLER	**Luckie**	Invisible Men	No Ryan White or prevention contracts
GERSH (SBP Member)	**Lauren**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			Nutrition Support
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Residential Care Facility - Chronically Ill
			Data to Care Services
GONZALEZ	**Felipe**	Unaffiliated consumer	No Ryan White or Prevention Contracts
GORDON	**Bridget**	Unaffiliated consumer	No Ryan White or prevention contracts
GREEN	**Joseph**	Unaffiliated consumer	No Ryan White or prevention contracts
HALFMAN	**Karl**	California Department of Public Health, Office of AIDS	Part B Grantee
HARDY	**David**	LAC-USC Rand Schrader Clinic	No Ryan White or prevention contracts
HERRERA	**Ismael "Ish"**	Unaffiliated consumer	No Ryan White or prevention contracts
KOCHEMS	**Lee**	Unaffiliated consumer	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MARTINEZ (PP&A Member)	**Miguel**	Children's Hospital Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
			Promoting Healthcare Engagement Among Vulnerable Populations
MARTINEZ-REAL	**Leonardo**	Unaffiliated consumer	No Ryan White or prevention contracts
MAULTSBY	**Leon**	Charles R. Drew University	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
MENDOZA	**Vilma**	Unaffiliated consumer	No Ryan White or prevention contracts
MINTLINE (SBP Member)	**Mark**	Western University of Health Sciences (No Affiliation)	No Ryan White or prevention contracts
MOLETTE	**Andre**	Men's Health Foundation	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
			Data to Care Services
MURRAY	**Derek**	City of West Hollywood	No Ryan White or prevention contracts
NASH	**Paul**	University of Southern California	Biomedical HIV Prevention

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
NELSON	**Katja**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			Nutrition Support
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Residential Care Facility - Chronically Ill
			Data to Care Services
OSORIO	**Ronnie**	Center For Health Justice (CHJ)	Transitional Case Management - Jails
			Promoting Healthcare Engagement Among Vulnerable Populations
PATEL	**Byron**	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Transportation Services
PERÉZ	**Mario**	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee
RICHARDSON	**Dechelle**	AMAAD Institute	Community Engagement/EHE
ROBINSON	**Erica**	Health Matters Clinic	No Ryan White or prevention contracts
ROSALES	**Ricky**	City of Los Angeles AIDS Coordinator	No Ryan White or prevention contracts
RUSSEL	**Daryl**	Unaffiliated consumer	No Ryan White or prevention contracts
SATTAH	**Martin**	Rand Schrader Clinic LA County Department of Health Services	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
SAN AGUSTIN	**Harold**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV)
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
SPENCER	**LaShonda**	Oasis Clinic (Charles R. Drew University/Drew CARES)	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
STALTER	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
TALLEY	**Lambert**	Grace Center for Health & Healing (No Affiliation)	No Ryan White or prevention contracts
VALERO	**Justin**	No Affiliation	No Ryan White or prevention contracts
WEEDMAN	**Jonathan**	ViaCare Community Health	Biomedical HIV Prevention
YBARRA	**Russell**	Capitol Drugs	No Ryan White or prevention contracts

LOS ANGELES COUNTY
COMMISSION ON HIV

2024 TRAINING SCHEDULE

SUBJECT TO CHANGE

- "*" Asterisk denotes mandatory training for all commissioners.
- All trainings are open to the public.
- Click on the training topic to register.
- Certifications of Completion will be provided.
- All trainings are virtual.

Co-Chair Roles and Responsibilities	February 13, 2024 4:00-5:00PM
General Orientation and Commission on HIV Overview *	March 26, 2024 3:00-4:30PM
Priority Setting and Resource Allocation Process & Service Standards Development *	April 23, 2024 3:00-4:30PM
Ryan White Care Act Legislative Overview Membership Structure and Responsibilities *	July 17, 2024 3:00-4:30PM
Policy Priorities and Legislative Docket Development Process	October 2, 2024 3:00-4:30PM

LOS ANGELES COUNTY COMMISSION ON HIV

LOS ANGELES COUNTY COMMISSION ON HIV 2024
STANDARDS AND BEST PRACTICES WORKPLAN (Updates in RED)

Co-Chairs: Erika Davies, Kevin Stalter

Adopted on: 4/2/24

Purpose of Work Plan: To focus and prioritize key activities for SBP Committee for 2024.

#	TASK/ACTIVITY	DESCRIPTION	TARGET COMPLETION DATE	STATUS/NOTES/OTHER COMMITTEES INVOLVED
1	Review and refine 2024 workplan and meeting calendar.	COH staff to update 2024 workplan and meeting calendar monthly.	Ongoing, as needed	Workplan revised/updated on: 12/05/23, *02/29/24, 03/28/24, 4/30/24*
2	Update Universal service standards and Consumer Bill of Rights	Annual review of the standards. Revise/update document as needed.	COMPLETE	The COH approved the document on 01/08/24. The Committee decided to move the document to a bi-annual review or as needed/requested.
3	Update the Medical Care Coordination (MCC) service standards	Committee received a public comment requesting for a review and update of the MCC services standards.	COMPLETE	The COH approved the document on 01/08/24.
4	Update Prevention Service standards	Review and revise/update document as needed.	COMPLETE	Committee forwarded the document to the Prevention Planning Workgroup for review at their 07/26/23 meeting. The PPW co-chairs presented the proposed revisions to the Prevention standards on 11/7/23. The Committee approved the standards and elevated them to the Executive Committee and full COH for approval. The COH approved the Prevention Standards on 4/11/24.
5	Develop global Transitional Case Management Service standards.	This standard will include sections for priority populations such as youth, older adults (50+), and justice involved individuals. The section for older adults will focus on healthcare navigation	Late 2024	The Committee will review meeting calendar on 5/7/24 and determine when to schedule the review.

		between the Ryan White Care system, Medi-Cal, and Medi-Care.		
6	Update the Emergency Financial Assistance service standards	Committee received a request to consider reviewing the EFA service standards.	Late 2024	The Committee will review meeting calendar on 5/7/24 and determine when to schedule the review.
7	Update Ambulatory Outpatient Medical Services standards	Upcoming solicitation to release in Nov. 2024	August 2024	The Committee will continue their review on May 7. 2024. *COH staff will convene a listening session for AOM service providers.*
8	Update Transportation Services standards	Upcoming solicitation to release in Oct. 2024.	TBD	The Committee will review meeting calendar on 5/7/24 and determine when to schedule the review.
9	Update Temporary and Permanent Housing Services standards	Upcoming solicitation to release in Nov. 2024.	TBD	The Committee will review meeting calendar on 5/7/24 and determine when to schedule the review.

LOS ANGELES COUNTY
COMMISSION ON HIV

STANDARDS AND BEST PRACTICES COMMITTEE
2024 MEETING CALENDAR | (updated 04.18.24)

DATE	KEY AGENDA ITEMS/TOPICS (subject to change; for planning purposes)
~~**Feb. 6, 2024**~~	Meeting Cancelled due to significant weather event.
Mar. 5, 2024 10am to 12pm *Room TK08*	Review and Adopt 2024 Committee workplan and meeting calendar Deliberate and establish standards review schedule for 2024 Review and approve HIV/STI Prevention Services standards HIV/STI Prevention Services standards on Executive Committee agenda
Apr. 2, 2024 10am to 12pm *Room TK05*	Service standard development refresher Review AOM service standards HIV/STI Prevention Services standards on COH agenda
May 7, 2024 10am to 12pm *Room TK08*	Continue review of AOM service standards
Jun. 4, 2024 10am to 12pm *Pending*	*Tentative: Invite providers contracted to provide AOM for a subject matter expert panel and solicit their feedback/recommendations*
Jul. 2, 2024 10am to 12pm *Pending*	Independence Day Holiday 7/4/24
Aug. 6, 2024 10am to 12pm *Pending*	
Sep. 3, 2024 10am to 12pm *Pending*	Labor Day Holiday 9/2/24
Oct. 1, 2024 10am to 12pm *Pending*	
Nov. 5, 2024 10am to 12pm *Pending*	Commission on HIV Annual Conference 11/14/2024
Dec. 3, 2024 10am to 12pm *Pending*	Elect Co-chairs for 2024 Reflect on 2024 accomplishments Draft workplan and meeting calendar for 2025

LOS ANGELES COUNTY
COMMISSION ON HIV

Facilitation Questions for Ambulatory Outpatient Medical (AOM) Service Provider Listening Session

1. What is the scope of work for AOM now? Does AOM include social worker/case manager level staff? Should AOM include social worker/case manager staff?

2. What is going well with AOM?

3. What barriers currently exist in providing AOM services? If no barriers existed, what service(s) would you offer clients?

4. Do you have any additional comments?

LOS ANGELES COUNTY COMMISSION ON HIV

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AMBULATORY OUTPATIENT MEDICAL (AOM) SERVICE STANDARDS

Draft for review by the Standards and Best Practices Committee on 5/7/24. ***Updated 5.01.24***

IMPORTANT: Service standards must 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:

- Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18)
- HIV/AIDS Bureau, Division of Metropolitan HIV/AIDS Programs National Monitoring Standards for Ryan White Part A Grantees: Program – Part A

INTRODUCTION

Service standards for the Ryan White HIV/AIDS Part A Program (RWHAP) outline the elements and expectations a service provider should follow when implementing a specific service category. The purpose of the standards is to ensure that all RWHAP service providers offer the same fundamental components of the given service category. Additionally, the standards set the minimum level of care Ryan White-funded service providers may offer clients, however, service providers are encouraged to exceed these standards.

The Los Angeles County Commission on HIV (COH) developed the Ambulatory Outpatient Medical (AOM) service standards to establish the minimum service necessary to provide HIV specialty medical care to people living with HIV. The developed of the standards included review of current clinical guidelines, as well as feedback from service providers, people living with HIV, members of the COH's Standards and Best Practices (SBP) Committee, COH caucuses, and the public-at-large. All service standards approved by the COH align with the Universal Service Standards and Client Bill of Rights and Responsibilities (Universal Standards) approved by the COH on January 11, 2024. AOM providers must also follow the Universal Standards in addition to the standards described in this document.

AMBULATORY OUTPATIENT MEDICAL (AOM) OVERVIEW

AOM Services are evidence-based preventive, diagnostic and therapeutic medical services provided through outpatient medical visits by California-licensed health care professionals. Clinics shall offer a full-range of health services to HIV-positive RWP eligible clients with the objective of helping them cope with their HIV diagnosis, adhere to treatment, prevent HIV transmission, and identify and address co-morbidities.

Ambulatory Outpatient Medical (AOM) services include, but are not limited to:

- Medical evaluation and clinical care including sexual history taking
- AIDS Drug Assistance Program (ADAP) enrollment services

- Laboratory testing including disease monitoring, STD testing, and other clinically indicated tests
- Linkage and referrals to medical subspecialty care, oral health, medical care coordination, mental health care, and other service providers
- Secondary HIV prevention in the ambulatory outpatient setting
- Retention of clients in medical care.

The goals of MO services include:

- Connect patients to high-quality care and medication even if they do not have health insurance
- Help patients achieve low/undetectable viral load to improve their health and prevent HIV transmission (Undetectable=Untransmittable)
- Prevent and treat opportunistic infections
- Provide education and support with risk reduction strategies

SERVICE COMPONENTS

HIV/AIDS AOM services form the foundation for the Los Angeles County HIV/AIDS continuum of care. AOM services are responsible for assuring that the full spectrum of primary and HIV specialty medical care needs for patients are met either by the program directly or by referral to other health care agencies. Services will be provided to individuals living with HIV who are residents of Los Angeles County and meet Ryan White eligibility requirements.

AOM services will be patient-centered, respecting the inherent dignity of the patient. Programs must ensure that patients are given the opportunity to ask questions and receive accurate answers regarding services provided by AOM service providers and other professionals to whom they are referred. Such patient-practitioner discussions are relationship building and serve to develop trust and confidence. Patients must be seen as active partners in decisions about their personal health care regimen.

AOM services must be provided consistent with the following treatment guidelines:

- Clinical Practice Guidance for Persson with Immunodeficiency Virus: 2020
- American Academy of HIV Medicine HIV Treatment Guidelines
- Guidelines for the Use of Antiretrovirals Agents in Adults and Adolescents with HIV

The core of the AOM services standard is medical evaluation and clinical care that includes:

- Initial assessment and reassessment
- Follow-up treatment visits
- Additional assessments
- Laboratory assessment and diagnostic screening (including drug resistance testing)
- Medication service
- Antiretroviral (ART) therapy
- Treatment adherence counseling

- Health maintenance
- Clinical trials
- Primary HIV nursing care
- Medical specialty services
- Nutrition screening and referral
- Referrals to other Ryan White Program services and other publicly funded healthcare and social services programs

MEDICAL EVALUATION AND CLINICAL CARE

AOM programs must confirm the presence of HIV infection and provide tests to diagnose the extent of immunologic deficiency in the immune system. Additionally, programs must provide diagnostic and therapeutic measures for preventing and treating the deterioration of the immune system and related conditions that conform to the most recent clinical protocols. At minimum, these services include regular medical evaluations; appropriate treatment of HIV infection; and prophylactic and treatment interventions for complications of HIV infection, including opportunistic infections, opportunistic malignancies and other AIDS defining conditions.

The following core services must be provided onsite or through referral to another facility offering the required service(s). Qualified health care professionals for these services include physicians, NPs and/or PAs except where indicated RNs may provide primary HIV nursing care services and linkage to medical care coordination services.

	STANDARD	DOCUMENTATION
	AOM medical visits/evaluation and treatment are scheduled for at least a minimum of every six months, at least 3 months apart if long-term stability and adherence are demonstrated.	Medical record review to confirm.
	AOM core services will be provided by physicians, NPs, and/or PAs. RNs will provide primary HIV nursing care services and linkage to medical care coordination (MCC), if appropriate	Policies and procedures manual and medical chart review to confirm.

INITIAL ASSESSMENT AND REASSESSMENT

Every effort should be made to accommodate timely medical appointments for patients newly diagnosed with HIV or newly re-engaging in HIV medical care. Clinics may receive requests for appointments from patients directly, from HIV test counselors, or from “linkage” staff such as patient navigators, whose role is to refer and actively engage patients back in medical care. If possible, patients should see their medical provider (or the MCC team) on their first visit to the clinic to help improve their success in truly engaging in their medical care.

The initial assessment of HIV-infected individuals must be comprehensive in its scope, including physical, sociocultural, and emotional assessments and may require two to three outpatient visits to complete. Unless indicated more frequently by a patient's changing health condition, a comprehensive reassessment should be completed on an annual basis. The AOM practitioners (physician, NP, PA, or RN) responsible for completing the initial assessment and reassessments will use assessment tools based on established HIV practice guidelines. While taking steps to ensure a patient's confidentiality, the results of these assessments will be shared with medical care coordination staff to help identify and intervene on patient needs. An initial assessment and annual reassessment for HIV-infected patient should include a general medical history; a comprehensive HIV-related history, including a psychosocial history; sexual health history, mental health, and substance abuse histories; and a comprehensive physical examination. When obtaining the patient's history, the practitioner should use vocabulary that the patient can understand, regardless of education level. AOM providers must follow and use the most current clinical guidelines and assessment tools for general medical and comprehensive HIV medical histories.

	STANDARD	DOCUMENTATION
	Comprehensive baseline assessment will be completed by physician, NP, PA, or RN and updated, as necessary.	Medical record review to confirm.

FOLLOW-UP TREATMENT VISITS

Patients should have follow-up visits scheduled following established clinical guidelines. If the patient is clinically unstable or poorly adherent, a more frequent follow-up should be considered. Visits should be scheduled more frequently at entry to care, when starting or changing ARV regimens, or for management of acute problems. Due to the complex nature of HIV treatment, ongoing AOM visits must be flexible in duration and scope, requiring that programs develop practitioner clinic schedules allowing for this complexity. Follow-up should be conducted as recommended by the specialist or clinical judgment.

	STANDARD	DOCUMENTATION
	Patients should have follow-up visits scheduled following established clinical guidelines.	Patient medical chart to confirm frequency.

OTHER ASSESSMENTS – OLDER ADULTS WITH HIV

According to the Health Resources and Service Administration (HRSA), the RWHAP client population is aging. Of the more than half a million clients served by RWHAP, 46.1 percent are aged 50 years and older and this continues to grow. While Ryan White clients in Los Angeles County show higher engagement and retention in care, and viral suppression rates, within the 50+ population there exists disparities by racial/ethnic, socioeconomic, geographic, and age groups stratification.

AOM providers must at minimum assess patients 50 years and older for mental health, neurocognitive disorders/cognitive function, functional status, frailty/falls and gait, social support and levels of interactions, vision, dental, and hearing. Additional recommended assessments and screenings for older adults living with HIV can be found on page 6 of the Aging Task Force Recommendations.

Other specialized assessments leading to more specific services may be indicated for patients receiving AOM services. AOM programs must designate a member of the treatment team (physician, RN, NP, or PA) to make these assessments in the clinic setting.

	STANDARD	DOCUMENTATION
	Other assessments based on patient needs will be performed.	Assessments and updates noted documented in patient's medical record.

LABORATORY ASSESSMENT AND DIAGNOSTIC SCREENING (INCLUDING DRUG RESISTANCE SCREENING)

AOM programs must have access to all laboratory services required to comply fully with established practice guidelines for HIV prevention and risk reduction and for the clinical management of HIV disease. Programs must assure timely, quality lab results, readily available for review in medical encounters.

DRUG RESISTANCE TESTING

When appropriate, AOM practitioners may order drug resistance testing to measure a patient's pattern of resistance of HIV to antiretroviral medications. Genotypic testing looks for viral mutations, and is expected for all naïve patients, and phenotypic testing measures the amount of drug needed to suppress replication of HIV. By using resistance testing, practitioners can determine if the virus is likely to be suppressed by each antiretroviral drug. This information is used to guide practitioners in prescribing the most effective drug combinations for treatment.

Counseling and education about drug resistance testing must be provided by the patient's medical practitioner, RN and/or other appropriate licensed health care provider (if designated by the practitioner). Patients must be fully educated about their medical needs and treatment options according to standards of medical care. Patients must be given an opportunity to ask questions about their immune system, antiretroviral therapies, and drug resistance testing. All patient education efforts will be documented in the patient record.

	STANDARD	DOCUMENTATION
	Baseline lab tests based on current clinical guidelines.	Record of tests and results on file in patient medical chart.
	Ongoing lab tests based on clinical guidelines and provider's clinical judgement.	Record of tests and results on file in patient medical chart.

	Appropriate health care provider will provide drug resistance testing as indicated.	Record of drug resistance testing on file in patient medical chart.
	Drug resistance testing providers must follow most recent, established resistance testing guidelines, including genotypic testing on all naïve patients.	Program review and monitoring to confirm.

MEDICATION SERVICES

Medications should be provided to interrupt or delay the progression of HIV-disease, prevent, and treat opportunistic infections, and promote optimal health. Patients should be referred to an approved AIDS Drug Assistance Program (ADAP) enrollment site and, as indicated, to medical care coordination programs for additional assistance with public benefit concerns. Patients eligible for ADAP will be referred to a participating pharmacy for prescriptions on the ADAP formulary. If the patient requires medications that are not listed on the ADAP formulary or that can be reimbursed through other local pharmacy assistance resources, the AOM program is responsible for making every effort possible to link them to medications and exercise due diligence for that effort consistent with their ethical responsibilities.

STANDARD		DOCUMENTATION
	Patients requiring medications will be referred to ADAP enrollment site. As indicated, patients will also be referred to medical care coordination programs for public benefits concerns.	ADAP referral documented in patient medical chart.
	AOM programs must exercise every effort and due diligence consistent with their ethical responsibilities to ensure that patients can get necessary medications not on the ADAP and local formularies.	Documentation in patient's medical chart.

ANTIRETROVIRAL THERAPY (ART)

Antiretroviral therapy will be prescribed in accordance with the established guidelines based upon the DHHS Guidelines for the Use of Antiretroviral Agents in HIV-infected Adults and Adolescents Decisions to begin ARV treatment must be collaborative between patient and MO practitioner.

STANDARD		DOCUMENTATION
	ART will be prescribed in accordance with DHHS Guidelines for the Use of Antiretroviral Agents in HIV-infected Adults and Adolescents.	Program monitoring to confirm.

	Patients will be part of treatment decision-making process.	Documentation of communication in patient medical chart.

MEDICATION ADHERENCE ASSESSMENT

Medication adherence assessment should be performed for patients if needed. An individual service plan (ISP) for treatment adherence may be developed for patients challenged by maintaining treatment adherence. ISPs will be developed in collaboration with the patient and, when possible, the patient's primary medical provider to address identified needs. ISPs will be revised at a minimum of every six months.

STANDARD		DOCUMENTATION
	Medical providers or treatment adherence counselors will provide direct treatment adherence counseling or refreshers to all patients.	Notes in medical file indicating that counseling was provided, by whom and relevant outcomes.
	Medical providers or treatment adherence counselors will develop treatment adherence assessments of patients where need is indicated.	Assessment on file in patient chart signed and dated by medical staff or treatment adherence counselor responsible, indicating, at a minimum, any follow-up intended.
	Medical providers will refer patients with more acute treatment adherence needs to specialized treatment adherence or treatment education programs.	Referral(s) noted in assessment and/or patient chart, as applicable.
	Medical providers or treatment adherence counselors will develop ISPs in collaboration with their patients and medical providers (when possible), as needed, based on specific needs identified in the assessment.	ISP on file in patient chart signed and dated by medical staff or treatment adherence counselor responsible and patient to include (at minimum): • Projected goals • Suggested interventions • Proposed timelines/outcomes • Patient tasks • Provider tasks
	ISPs will be revised on an ongoing basis, but no less than every six months.	Revised ISPs signed and dated by treatment adherence counselors and patient on file in patient chart.

ONE-ON-ONE PATIENT EDUCATION

Medical providers and MCC staff will provide one-on-one patient education to make information about HIV disease and its treatments available, as necessary.

STANDARD	DOCUMENTATION

	Medical provider or treatment adherence counselors may provide one-on-on patient support contacts to support patients as they seek and receive services. Support can include: • Accompanying patients to medical visits and clinical trials visits and/or providing transportation support • Helping patients understand HIV disease and treatment options • Helping patients with adherence issues • Providing emotional support	Progress notes on file in patient chart to include (at minimum): • Date, time spent, type of contact • What occurred during the contact • Signature and title of the person providing the contact • Referrals provided, and interventions made (as appropriate) • Results of referrals, interventions and progress made toward goals in the individual service plan (as appropriate)

STANDARD HEALTH MAINTENANCE

AOM practitioners will discuss general preventive health care and health maintenance with all patients routinely, and at a minimum, annually. AOM programs will strive to provide preventive health services consistent with the most current recommendations of the U.S. Preventive Health Services Task Force . AOM practitioners will work in conjunction with medical care coordination programs and medical nutrition therapy and other Ryan White programs to ensure that a patient's standard health maintenance needs are being met.

	STANDARD	DOCUMENTATION
	Practitioners will discuss health maintenance with patients annually (at minimum), including: • Cancer screening (cervical, breast, rectal — per American Cancer Society guidelines) • How to perform breast and testicular self-examinations • Vaccines • Pap screening • Hepatitis screening, vaccination • TB screening • Family planning • Counseling on safer sex and STI screening • Counseling on food and water safety • Counseling on nutrition, exercise, and diet	Annual health maintenance discussions will be documented in patient medical chart.

	• Harm reduction for alcohol and drug use • Smoking cessation • Mental health and wellness	

COMPLEMENTARY, ALTERNATIVE AND EXPERIMENTAL THERAPIES

AOM practitioners must be aware if their patients are accessing complementary, alternative, and experimental therapies. Providers are encouraged to discuss at regular intervals complementary and alternative therapies with patients, discussing frankly and accurately both their potential benefits and potential harm. Practitioners may consult the NIH National Center for Complementary and Alternative Medicine (http://nccam.nih.gov) for more information.

	STANDARD	DOCUMENTATION
	Practitioners must know if their patients are using complementary and alternative therapies and are encouraged to discuss these therapies with their patients regularly.	Record of therapy use and/or discussion on file in patient medical record.

PRIMARY HIV NURSING CARE

AOM programs will provide primary HIV nursing care performed by an RN and/or appropriate licensed health care provider. Services will be coordinated with medical care coordination programs to ensure the seamless, non-duplicative, and most appropriate delivery of service.

	STANDARD	DOCUMENTATION
	RNs and/or other appropriate licensed health care providers in AOM programs will provide primary HIV nursing care to include (at minimum): • Nursing assessment, evaluation, and follow-up • Triage • Consultation/communication with primary practitioner • Patient counseling • Patient/family education • Services requiring specialized nursing skill • Preventive nursing procedures • Service coordination in conjunction with medical care coordination	Documentation of primary HIV nursing care service provision on file in patient medical chart.

MEDICAL SPECIALTY SERVICES HIV/AIDS

AOM service programs are required to provide access to specialty and subspecialty care to fully comply with the DHHS Guidelines.

Such medical specialties for HIV-related specialty or subspecialty care include (but are not limited to):

- Cardiology
- Dermatology
- Ear, nose, and throat (ENT) specialty
- Gastroenterology
- Gerontology
- Gynecology
- Infusion therapy
- Neurology
- Ophthalmology
- Oncology
- Oral health
- Pulmonary medicine
- Podiatry
- Proctology
- General surgery
- Urology
- Nephrology
- Orthopedics
- Obstetrics
- Transgender care

MEDICAL SPECIALTY REFERRAL

Referrals to medical specialists are made as complications occur that are beyond the scope of practice of primary HIV medical and nursing care. Such complications require referral to specialty and subspecialty physicians for consultation, diagnosis, and therapeutic services. In some cases, the AOM practitioner may need only to consult verbally with a medical specialist for clarification and confirmation on an approach to HIV clinical management. In other cases, the physician may need to refer a patient to a medical specialist for diagnostic and therapeutic services. Medical specialty services are considered consultative; patients will be referred back to the original AOM clinic for ongoing primary HIV medical care.

AOM programs must develop written policies and procedures that facilitate referral to medical specialists. All referrals must be tracked and monitored. The results of the referrals must be documented in the patient's medical record.

	STANDARD	DOCUMENTATION
	AOM programs must develop policies and procedures for referral to all medical specialists.	Referral policies and procedures on file at provider agency.
	All referrals will be tracked and monitored.	Record of linked referrals and results on file in patient medical record.
	In referrals for medical specialists, medical outpatient specialty practitioners are responsible for: • Assessing a patient's need for specialty care • Providing pertinent background clinical information to medical specialist • Making a referral appointment	Record of referral activities on file in patient medical record.

	• Communicating all referral appointment information • Tracking and monitoring referrals and results • Assuring the patient returns to the AOM program of origin	

COORDINATION OF SPECIALTY CARE

It is imperative that AOM programs and medical specialists coordinate their care to ensure integration of specialty treatment with primary HIV medical care. As noted above, AOM programs must provide pertinent background clinical information in their referrals to medical specialists. In turn, specialists within the County-contracted system must provide to AOM programs a written report of their findings within two weeks of seeing a referred patient. Medical specialists within the County-contracted system must telephone AOM programs within one business day in the event that urgent matters arise, to follow up on unusual findings or to plan a required hospitalization.

STANDARD		DOCUMENTATION
	Specialists within the County-contracted system must provide written reports within two weeks of seeing a referred patient.	Specialty report on file at provider agency
	Specialists within the County-contracted system must telephone MO programs within one business day: • When urgent matters arise • To follow up on unusual findings • To plan required hospitalization	Documentation of communication in patient file at provider agency.

NUTRITION SCREENING AND REFERRAL

Nutrition is a component of the Public Health Service standards of care in order to guard against malnutrition and wasting. The physician, NP, PA, RN, or RD should screen all patients for nutrition concerns and provide a written prescription for all at-risk patients for medical nutrition therapy within six months of an individual becoming an active patient in the AOM program.

MO programs may provide medical nutrition therapy onsite or may refer patients in need of these services to specialized providers offsite.

All programs providing nutrition therapy (including MO services sites) must adhere to the Commission on HIV's Nutrition Therapy Standard of Care (2005).

STANDARD	DOCUMENTATION

	AOM service providers should screen all patients for nutrition-related concerns for all at-risk patients.	Record of screening for nutrition related problems noted in patient's medical chart.
	AOM service providers will provide a written prescription for all at-risk patients for medical nutrition therapy within six months of an individual becoming an active patient.	Record of screening for nutrition related problems noted in patient's medical chart.
	When indicated, patients will also be referred to nutrition therapy for: • Physical changes/weight concerns • Oral/GI symptoms • Metabolic complications and other medical conditions • Barriers to nutrition • Behavioral concerns or unusual eating behaviors • Changes in diagnosis	Record of linked referral on file in patient medical chart.
	Referral to medical nutrition therapy must include: • Written prescription, diagnosis, and desired nutrition outcome • Signed copy of patient's consent to release medical information • Results from nutrition-related lab assessments	Record of linked referral on file in patient medical chart.

MEDICAL CARE COORDINATION (MCC) SERVICES

In order to best address the complex needs of their patients, AOM providers are expected to partner with medical care coordination teams located at their clinics. For additional details, please see the Medical Care Coordination Standard of Care, Los Angeles Commission on HIV, 2024.

HIV PREVENTION IN AMBULATORY/OUTPATIENT MEDICAL SETTINGS

HIV prevention is a critical component to ongoing care for people living with HIV. Prevention services provided in AOM clinics include HIV counseling, testing and referral; partner counseling; prevention and medical care; and referral for intensive services. For additional details see the HIV Prevention Service Standards Los Angeles, Commission on HIV, 2024.

Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds

Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18)
Replaces Policy #10-02

Scope of Coverage: Health Resources and Services Administration (HRSA) Ryan White HIV/AIDS Program (RWHAP) Parts A, B, C, and D, and Part F where funding supports direct care and treatment services.

Purpose of PCN

This policy clarification notice (PCN) replaces the HRSA HIV/AIDS Bureau (HAB) PCN 10-02: Eligible Individuals & Allowable Uses of Funds. This PCN defines and provides program guidance for each of the Core Medical and Support Services named in statute and defines individuals who are eligible to receive these HRSA RWHAP services.

Background

The Office of Management and Budget (OMB) has consolidated, in 2 CFR Part 200, the uniform grants administrative requirements, cost principles, and audit requirements for all organization types (state and local governments, non-profit and educational institutions, and hospitals) receiving federal awards. These requirements, known as the "Uniform Guidance," are applicable to recipients and subrecipients of federal funds. The OMB Uniform Guidance has been codified by the Department of Health and Human Services (HHS) in 45 CFR Part 75—Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards. HRSA RWHAP grant and cooperative agreement recipients and subrecipients should be thoroughly familiar with 45 CFR Part 75. Recipients are required to monitor the activities of its subrecipient to ensure the subaward is used for authorized purposes in compliance with applicable statute, regulations, policies, program requirements and the terms and conditions of the award (see 45 CFR §§ 75.351-352).

45 CFR Part 75, Subpart E—Cost Principles must be used in determining allowable costs that may be charged to a HRSA RWHAP award. Costs must be necessary and reasonable to carry out approved project activities, allocable to the funded project, and allowable under the Cost Principles, or otherwise authorized by the RWHAP statute. The treatment of costs must be consistent with recipient or subrecipient policies and procedures that apply uniformly to both federally-financed and other non-federally funded activities.

HRSA HAB has developed program policies that incorporate both HHS regulations

and program specific requirements set forth in the RWHAP statute. Recipients, planning bodies, and others are advised that independent auditors, auditors from the HHS' Office of the Inspector General, and auditors from the U.S. Government Accountability Office may assess and publicly report the extent to which an HRSA RWHAP award is being administered in a manner consistent with statute, regulation and program policies, such as these, and compliant with legislative and programmatic policies. Recipients can expect fiscal and programmatic oversight through HRSA monitoring and review of budgets, work plans, and subrecipient agreements. HRSA HAB is able to provide technical assistance to recipients and planning bodies, where assistance with compliance is needed.

Recipients are reminded that it is their responsibility to be fully cognizant of limitations on uses of funds as outlined in statute, 45 CFR Part 75, the HHS Grants Policy Statement, and applicable HRSA HAB PCNs. In the case of services being supported in violation of statute, regulation or programmatic policy, the use of RWHAP funds for such costs must be ceased immediately and recipients may be required to return already-spent funds to the Federal Government. Recipients who unknowingly continue such support are also liable for such expenditures.

Further Guidance on Eligible Individuals and Allowable Uses of Ryan White HIV/AIDS Program Funds

The RWHAP statute, codified at title XXVI of the Public Health Service Act, stipulates that "funds received...will not be utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made under...an insurance policy, or under any Federal or State health benefits program" and other specified payment sources.[1] At the individual client-level, this means recipients must assure that funded subrecipients make reasonable efforts to secure non-RWHAP funds whenever possible for services to eligible clients. In support of this intent, it is an appropriate use of HRSA RWHAP funds to provide case management (medical or non-medical) or other services that, as a central function, ensure that eligibility for other funding sources is vigorously and consistently pursued (e.g., Medicaid, Children's Health Insurance Program (CHIP), Medicare, or State-funded HIV programs, and/or private sector funding, including private insurance).

In every instance, HRSA HAB expects that services supported with HRSA RWHAP funds will (1) fall within the legislatively-defined range of services, (2) as appropriate, within Part A, have been identified as a local priority by the HIV Health Services Planning Council/Body, and (3) in the case of allocation decisions made by a Part B State/Territory or by a local or regional consortium, meet documented needs and contribute to the establishment of a continuum of care.

HRSA RWHAP funds are intended to support only the HIV-related needs of

[1] *See* sections 2605(a)(6), 2617(b)(7)(F), 2664(f)(1), and 2671(i) of the Public Health Service Act.

eligible individuals. Recipients and subrecipients must be able to make an explicit connection between any service supported with HRSA RWHAP funds and the intended client's HIV care and treatment, or care-giving relationship to a person living with HIV (PLWH).

Eligible Individuals:

The principal intent of the RWHAP statute is to provide services to PLWH, including those whose illness has progressed to the point of clinically defined AIDS. When setting and implementing priorities for the allocation of funds, recipients, Part A Planning Councils, community planning bodies, and Part B funded consortia may optionally define eligibility for certain services more precisely, but they may NOT broaden the definition of who is eligible for services. HRSA HAB expects all HRSA RWHAP recipients to establish and monitor procedures to ensure that all funded providers verify and document client eligibility.

Affected individuals (people not identified with HIV) may be eligible for HRSA RWHAP services in limited situations, but these services for affected individuals must always benefit PLWH. Funds awarded under the HRSA RWHAP may be used for services to individuals affected by HIV only in the circumstances described below:

a. The primary purpose of the service is to enable the affected individual to participate in the care of a PLWH. Examples include caregiver training for in-home medical or support service; psychosocial support services, such as caregiver support groups; and/or respite care services that assist affected individuals with the stresses of providing daily care for a PLWH.

b. The service directly enables a PLWH to receive needed medical or support services by removing an identified barrier to care. Examples include payment of a HRSA RWHAP client's portion of a family health insurance policy premium to ensure continuity of insurance coverage that client, or childcare for the client's children while they receive HIV-related medical care or support services.

c. The service promotes family stability for coping with the unique challenges posed by HIV. Examples include psychosocial support services, including mental health services funded by RWHAP Part D only, that focus on equipping affected family members, and caregivers to manage the stress and loss associated with HIV.

d. Services to affected individuals that meet these criteria may not continue subsequent to the death of the family member who was living with HIV.

Unallowable Costs:
HRSA RWHAP funds may not be used to make cash payments to intended clients of HRSA RWHAP-funded services. This prohibition includes cash incentives and

cash intended as payment for HRSA RWHAP core medical and support services. Where direct provision of the service is not possible or effective, store gift cards,[2] vouchers, coupons, or tickets that can be exchanged for a specific service or commodity (e.g., food or transportation) must be used.

HRSA RWHAP recipients are advised to administer voucher and store gift card programs in a manner which assures that vouchers and store gift cards cannot be exchanged for cash or used for anything other than the allowable goods or services, and that systems are in place to account for disbursed vouchers and store gift cards.[3]

Other unallowable costs include:

- Clothing
- Employment and Employment-Readiness Services, except in limited, specified instances (e.g., Non-Medical Case Management Services or Rehabilitation Services)
- Funeral and Burial Expenses
- Property Taxes
- Pre-Exposure Prophylaxis (PrEP)
- non-occupational Post-Exposure Prophylaxis (nPEP)
- Materials, designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual
- International travel
- The purchase or improvement of land
- The purchase, construction, or permanent improvement of any building or other facility

Allowable Costs:
The following service categories are allowable uses of HRSA RWHAP funds. The HRSA RWHAP recipient, along with respective planning bodies, will make the final decision regarding the specific services to be funded under their grant or cooperative agreement. As with all other allowable costs, HRSA RWHAP recipients are responsible for applicable accounting and reporting on the use of HRSA RWHAP funds.

Service Category Descriptions and Program Guidance

The following provides both a description of covered service categories and program guidance for HRSA RWHAP Part recipient implementation. These service category descriptions apply to the entire HRSA RWHAP. However, for some services, the

[2] Store gift cards that can be redeemed at one merchant or an affiliated group of merchants for specific goods or services that further the goals and objectives of the HRSA RWHAP are allowable as incentives for eligible program participants.
[3] General-use prepaid cards are considered “cash equivalent” and are therefore unallowable. Such cards generally bear the logo of a payment network, such as Visa, MasterCard, or American Express, and are accepted by any merchant that accepts those credit or debit cards as payment. Gift cards that are cobranded with the logo of a payment network and the logo of a merchant or affiliated group of merchants are general-use prepaid cards, not store gift cards, and therefore are unallowable.

HRSA RWHAP Parts (i.e., A, B, C, and D) must determine what is feasible and justifiable with limited resources. There is no expectation that a HRSA RWHAP Part recipient would provide all services, but recipients and planning bodies are expected to coordinate service delivery across Parts to ensure that the entire jurisdiction/service area has access to services based on needs assessment.

The following core medical and support service categories are important to assist in the diagnosis of HIV infection, linkage to and entry into care for PLWH, retention in care, and the provision of HIV care and treatment. HRSA RWHAP recipients are encouraged to consider all methods or means by which they can provide services, including use of technology (e.g., telehealth). To be an allowable cost under the HRSA RWHAP, all services must:

- Relate to HIV diagnosis, care and support,
- Adhere to established HIV clinical practice standards consistent with U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV[4] and other related or pertinent clinical guidelines, and
- Comply with state and local regulations, and provided by licensed or authorized providers, as applicable.

Recipients are required to work toward the development and adoption of service standards for all HRSA RWHAP-funded services to ensure consistent quality care is provided to all HRSA RWHAP-eligible clients. Service standards establish the minimal level of service or care that a HRSA RWHAP funded agency or provider may offer within a state, territory or jurisdiction. Service standards related to HRSA RWHAP Core Medical Services must be consistent with U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV, as well as other pertinent clinical and professional standards. Service standards related to HRSA RWHAP Support Services may be developed using evidence-based or evidence-informed best practices, the most recent HRSA RWHAP Parts A and B National Monitoring Standards, and guidelines developed by the state and local government.

HRSA RWHAP recipients should also be familiar with implementation guidance HRSA HAB provides in program manuals, monitoring standards, and other recipient resources.

HRSA RWHAP clients must meet income and other eligibility criteria as established by HRSA RWHAP Part A, B, C, or D recipients.

RWHAP Core Medical Services

AIDS Drug Assistance Program Treatments

[4] https://aidsinfo.nih.gov/guidelines

AIDS Pharmaceutical Assistance

Early Intervention Services (EIS)

Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals

Home and Community-Based Health Services

Home Health Care

Hospice

Medical Case Management, including Treatment Adherence Services

Medical Nutrition Therapy

Mental Health Services

Oral Health Care

Outpatient/Ambulatory Health Services

Substance Abuse Outpatient Care

RWHAP Support Services

Child Care Services

Emergency Financial Assistance

Food Bank/Home Delivered Meals

Health Education/Risk Reduction

Housing

Legal Services

Linguistic Services

Medical Transportation

Non-Medical Case Management Services

Other Professional Services

Outreach Services

Permanency Planning

Psychosocial Support Services

Referral for Health Care and Support Services

Rehabilitation Services

Respite Care

Substance Abuse Services (residential)

Effective Date
This PCN is effective for HRSA RWHAP Parts A, B, C, D, and F awards issued on or after October 1, 2016. This includes competing continuations, new awards, and non- competing continuations.

Summary of Changes
August 18, 2016 –Updated *Housing Service* category by removing the prohibition on HRSA RWHAP Part C recipients to use HRSA RWHAP funds for this service.

December 12, 2016 – 1) Updated *Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals* service category by including standalone dental insurance as an allowable cost; 2) Updated *Substance Abuse Services (residential)* service category by removing the prohibition on HRSA RWHAP Parts C and D recipients to use HRSA RWHAP funds for this service; 3) Updated *Medical Transportation* service category by providing clarification on provider transportation; 4) Updated *AIDS Drug Assistance Program Treatments* service category by adding additional program guidance; and 5) Reorganized the service categories alphabetically and provided hyperlinks in the Appendix.

October, 22, 2018 – updated to provide additional clarifications in the following service categories:

Core Medical Services: *AIDS Drug Assistance Program Treatments; AIDS Pharmaceutical Assistance; Health Insurance Premium and Cost Sharing Assistance for Low-income People Living with HIV; and Outpatient/Ambulatory Health Services*
Support Services: *Emergency Financial Assistance; Housing; Non-Medical Case Management; Outreach; and Rehabilitation Services*.

Appendix

RWHAP Legislation: Core Medical Services

AIDS Drug Assistance Program Treatments

Description:
The AIDS Drug Assistance Program (ADAP) is a state-administered program authorized under RWHAP Part B to provide U.S. Food and Drug Administration (FDA)-approved medications to low-income clients living with HIV who have no coverage or limited health care coverage. HRSA RWHAP ADAP formularies must include at least one FDA-approved medicine in each drug class of core antiretroviral medicines from the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV.[5] HRSA RWHAP ADAPs can also provide access to medications by using program funds to purchase health care coverage and through medication cost sharing for eligible clients. HRSA RWHAP ADAPs must assess and compare the aggregate cost of paying for the health care coverage versus paying for the full cost of medications to ensure that purchasing health care coverage is cost effective in the aggregate. HRSA RWHAP ADAPs may use a limited amount of program funds for activities that enhance access to, adherence to, and monitoring of antiretroviral therapy with prior approval.

Program Guidance:
HRSA RWHAP Parts A, C and D recipients may contribute RWHAP funds to the RWHAP Part B ADAP for the purchase of medication and/or health care coverage and medication cost sharing for ADAP-eligible clients.

See PCN 07-03: The Use of Ryan White HIV/AIDS Program, Part B AIDS Drug Assistance Program (ADAP) Funds for Access, Adherence, and Monitoring Services

See PCN 18-01: Clarifications Regarding the use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost Sharing Assistance

See also AIDS Pharmaceutical Assistance and Emergency Financial Assistance

AIDS Pharmaceutical Assistance

Description:
AIDS Pharmaceutical Assistance may be provided through one of two programs, based on HRSA RWHAP Part funding.

1. A Local Pharmaceutical Assistance Program (LPAP) is operated by a HRSA RWHAP Part A or B (non-ADAP) recipient or subrecipient as a supplemental means of providing ongoing medication assistance when an HRSA RWHAP ADAP

[5] https://aidsinfo.nih.gov/guidelines

has a restricted formulary, waiting list and/or restricted financial eligibility criteria.

HRSA RWHAP Parts A or B recipients using the LPAP to provide AIDS Pharmaceutical Assistance must establish the following:

- Uniform benefits for all enrolled clients throughout the service area
- A recordkeeping system for distributed medications
- An LPAP advisory board
- A drug formulary that is
    - Approved by the local advisory committee/board, and
    - Consists of HIV-related medications not otherwise available to the clients due to the elements mentioned above
- A drug distribution system
- A client enrollment and eligibility determination process that includes screening for HRSA RWHAP ADAP and LPAP eligibility with rescreening at minimum of every six months
- Coordination with the state's HRSA RWHAP Part B ADAP
    - A statement of need should specify restrictions of the state HRSA RWHAP ADAP and the need for the LPAP
- Implementation in accordance with requirements of the HRSA 340B Drug Pricing Program (including the Prime Vendor Program)

2. A Community Pharmaceutical Assistance Program (CPAP) is provided by a HRSA RWHAP Part C or D recipient for the provision of ongoing medication assistance to eligible clients <u>in the absence of any other resources</u>.

HRSA RWHAP Parts C or D recipients using CPAP to provide AIDS Pharmaceutical Assistance must establish the following:

- A financial eligibility criteria and determination process for this specific service category
- A drug formulary consisting of HIV-related medications not otherwise available to the clients
- Implementation in accordance with the requirements of the HRSA 340B Drug Pricing Program (including the Prime Vendor Program)

Program Guidance:
For LPAPs: HRSA RWHAP Part A or Part B (non-ADAP) funds may be used to support an LPAP. HRSA RWHAP ADAP funds may not be used for LPAP support. LPAP funds are not to be used for emergency or short-term financial assistance. The Emergency Financial Assistance service category may assist with short-term assistance for medications.

For CPAPs: HRSA RWHAP Part C or D funds may be used to support a CPAP to routinely refill medications. HRSA RWHAP Part C or D recipients should use the Outpatient/Ambulatory Health Services or Emergency Financial Assistance service

categories for non-routine, short-term medication assistance.

See also AIDS Drug Assistance Program Treatments, Emergency Financial Assistance, and Outpatient/Ambulatory Health Services

Early Intervention Services (EIS)

Description:
The RWHAP legislation defines EIS for Parts A, B, and C. See § 2651(e) of the Public Health Service Act.

Program Guidance:
The elements of EIS often overlap with other service category descriptions; however, EIS is the combination of such services rather than a stand-alone service. HRSA RWHAP Part recipients should be aware of programmatic expectations that stipulate the allocation of funds into specific service categories.

- HRSA RWHAP Parts A and B EIS services must include the following four components:
    - Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be living with HIV
        - Recipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts
        - HIV testing paid for by EIS cannot supplant testing efforts paid for by other sources
    - Referral services to improve HIV care and treatment services at key points of entry
    - Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Care
    - Outreach Services and Health Education/Risk Reduction related to HIV diagnosis

- HRSA RWHAP Part C EIS services must include the following four components:
    - Counseling individuals with respect to HIV
    - High risk targeted HIV testing (confirmation and diagnosis of the extent of immune deficiency)
        - Recipients must coordinate these testing services under HRSA RWHAP Part C EIS with other HIV prevention and testing programs to avoid duplication of efforts
        - The HIV testing services supported by HRSA RWHAP Part C EIS funds cannot supplant testing efforts covered by other sources
    - Referral and linkage to care of PLWH to Outpatient/Ambulatory Health

Services, Medical Case Management, Substance Abuse Care, and other services as part of a comprehensive care system including a system for tracking and monitoring referrals
- Other clinical and diagnostic services related to HIV diagnosis

Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals

Description:

Health Insurance Premium and Cost Sharing Assistance provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. For purposes of this service category, health insurance also includes standalone dental insurance. The service provision consists of the following:

- Paying health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health Services, and pharmacy benefits that provide a full range of HIV medications for eligible clients; and/or
- Paying standalone dental insurance premiums to provide comprehensive oral health care services for eligible clients; and/or
- Paying cost sharing on behalf of the client.

To use HRSA RWHAP funds for health insurance premium assistance (not standalone dental insurance assistance), an HRSA RWHAP Part recipient must implement a methodology that incorporates the following requirements:

- Clients obtain health care coverage that at a minimum, includes at least one U.S. Food and Drug Administration (FDA) approved medicine in each drug class of core antiretroviral medicines outlined in the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV, as well as appropriate HIV outpatient/ambulatory health services; and
- The cost of paying for the health care coverage (including all other sources of premium and cost sharing assistance) is cost-effective in the aggregate versus paying for the full cost for medications and other appropriate HIV outpatient/ambulatory health services (HRSA RWHAP Part A, HRSA RWHAP Part B, HRSA RWHAP Part C, and HRSA RWHAP Part D).

To use HRSA RWHAP funds for standalone dental insurance premium assistance, an HRSA RWHAP Part recipient must implement a methodology that incorporates the following requirement:

- HRSA RWHAP Part recipients must assess and compare the aggregate cost of paying for the standalone dental insurance option versus paying for the full cost of HIV oral health care services to ensure that purchasing standalone dental insurance is cost effective in the aggregate, and allocate funding to Health Insurance Premium and Cost Sharing Assistance only

when determined to be cost effective.

Program Guidance:
Traditionally, HRSA RWHAP Parts A and B recipients have supported paying for health insurance premiums and cost sharing assistance. If a HRSA RWHAP Part C or Part D recipient has the resources to provide this service, an equitable enrollment policy must be in place and it must be cost-effective.

HRSA RWHAP Parts A, B, C, and D recipients may consider providing their health insurance premiums and cost sharing resource allocation to their state HRSA RWHAP ADAP, particularly where the ADAP has the infrastructure to verify health care coverage status and process payments for public or private health care coverage premiums and medication cost sharing.

See PCN 14-01: Clarifications Regarding the Ryan White HIV/AIDS Program and Reconciliation of Premium Tax Credits under the Affordable Care Act

See PCN 18-01: Clarifications Regarding the use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost Sharing Assistance

Home and Community-Based Health Services
Description:
Home and Community-Based Health Services are provided to an eligible client in an integrated setting appropriate to that client's needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider. Services include:

- Appropriate mental health, developmental, and rehabilitation services
- Day treatment or other partial hospitalization services
- Durable medical equipment
- Home health aide services and personal care services in the home

Program Guidance:
Inpatient hospitals, nursing homes, and other long-term care facilities are not considered an integrated setting for the purposes of providing home and community-based health services.

Home Health Care
Description:
Home Health Care is the provision of services in the home that are appropriate to an eligible client's needs and are performed by licensed professionals. Activities provided under Home Health Care must relate to the client's HIV disease and may include:

- Administration of prescribed therapeutics (e.g. intravenous and aerosolized treatment, and parenteral feeding)
- Preventive and specialty care
- Wound care

- Routine diagnostics testing administered in the home
- Other medical therapies

Program Guidance:
The provision of Home Health Care is limited to clients that are homebound. Home settings do not include nursing facilities or inpatient mental health/substance abuse treatment facilities.

Hospice Services
Description:
Hospice Services are end-of-life care services provided to clients in the terminal stage of an HIV-related illness. Allowable services are:

- Mental health counseling
- Nursing care
- Palliative therapeutics
- Physician services
- Room and board

Program Guidance:
Hospice Services may be provided in a home or other residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice services. This service category does not extend to skilled nursing facilities or nursing homes.

To meet the need for Hospice Services, a physician must certify that a patient is terminally ill and has a defined life expectancy as established by the recipient. Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under respective state Medicaid programs.

Medical Case Management, including Treatment Adherence Services
Description:
Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum.

Activities provided under this service category may be provided by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication).

Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- 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 members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Client-specific advocacy and/or review of utilization of services

In addition to providing the medically oriented activities above, Medical Case Management may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

Program Guidance:
Activities provided under the Medical Case Management service category have as their objective improving health care outcomes whereas those provided under the Non-Medical Case Management service category have as their objective providing guidance and assistance in improving access to needed services.

Visits to ensure readiness for, and adherence to, complex HIV treatments shall be considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment Adherence services provided during a Medical Case Management visit should be reported in the Medical Case Management service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.

Medical Nutrition Therapy
Description:
Medical Nutrition Therapy includes:
- Nutrition assessment and screening
- Dietary/nutritional evaluation
- Food and/or nutritional supplements per medical provider's recommendation
- Nutrition education and/or counseling

These activities can be provided in individual and/or group settings and outside of HIV Outpatient/Ambulatory Health Services.

Program Guidance:
All activities performed under this service category must be pursuant to a medical provider's referral and based on a nutritional plan developed by the registered dietitian or other licensed nutrition professional. Activities not provided by a

registered/licensed dietician should be considered Psychosocial Support Services under the HRSA RWHAP.

See also Food-Bank/Home Delivered Meals

Mental Health Services
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 within the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

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

See also Psychosocial Support Services

Oral Health Care
Description:
Oral Health Care activities include outpatient diagnosis, prevention, and therapy provided by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

Program Guidance:
None at this time.

Outpatient/Ambulatory Health Services
Description:
Outpatient/Ambulatory Health Services provide diagnostic and therapeutic-related activities directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings may include: clinics, medical offices, mobile vans, using telehealth technology, and urgent care facilities for HIV-related visits.

Allowable activities include:
- Medical history taking
- Physical examination
- Diagnostic testing (including HIV confirmatory and viral load testing), as well as laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment
- Prescription and management of medication therapy

- Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis, including audiology and ophthalmology

Program Guidance:
Treatment adherence activities provided during an Outpatient/Ambulatory Health Service visit are considered Outpatient/Ambulatory Health Services, whereas treatment adherence activities provided during a Medical Case Management visit are considered Medical Case Management services.

Non-HIV related visits to urgent care facilities are not allowable costs within the Outpatient/Ambulatory Health Services Category.

Emergency room visits are not allowable costs within the Outpatient/Ambulatory Health Services Category.

See PCN 13-04: Clarifications Regarding Clients Eligible for Private Insurance and Coverage of Services by Ryan White HIV/AIDS Program

See also Early Intervention Services

Substance Abuse Outpatient Care
Description:
Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Activities under Substance Abuse Outpatient Care service category include:

- Screening
- Assessment
- Diagnosis, and/or
- Treatment of substance use disorder, including:
    - Pretreatment/recovery readiness programs
    - Harm reduction
    - Behavioral health counseling associated with substance use disorder
    - Outpatient drug-free treatment and counseling
    - Medication assisted therapy
    - Neuro-psychiatric pharmaceuticals
    - Relapse prevention

Program Guidance:
Acupuncture therapy may be allowable under this service category only when, as part of a substance use disorder treatment program funded under the HRSA RWHAP, it is included in a documented plan.

Syringe access services are allowable, to the extent that they comport with current appropriations law and applicable HHS guidance, including HRSA- or HAB-specific

guidance.

See also Substance Abuse Services (residential)

RWHAP Legislation: Support Services

Child Care Services
Description:
The HRSA RWHAP supports intermittent Child Care Services for the children living in the household of PLWH who are HRSA RWHAP-eligible clients for the purpose of enabling those clients to attend medical visits, related appointments, and/or HRSA RWHAP-related meetings, groups, or training sessions.

Allowable use of funds include:

- A licensed or registered child care provider to deliver intermittent care
- Informal child care provided by a neighbor, family member, or other person (with the understanding that existing federal restrictions prohibit giving cash to clients or primary caregivers to pay for these services)

Program Guidance:
The use of funds under this service category should be limited and carefully monitored. Direct cash payments to clients are not permitted.

Such arrangements may also raise liability issues for the funding source which should be carefully weighed in the decision process.

Emergency Financial Assistance
Description:
Emergency Financial Assistance provides limited one-time or short-term payments to assist an HRSA RWHAP client with an urgent need for essential items or services necessary to improve health outcomes, including: utilities, housing, food (including groceries and food vouchers), transportation, medication not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance, or another HRSA RWHAP-allowable cost needed to improve health outcomes. Emergency Financial Assistance must occur as a direct payment to an agency or through a voucher program.

Program Guidance:
Emergency Financial Assistance funds used to pay for otherwise allowable HRSA RWHAP services must be accounted for under the Emergency Financial Assistance category. Direct cash payments to clients are not permitted.

Continuous provision of an allowable service to a client must not be funded through Emergency Financial Assistance.

Food Bank/Home Delivered Meals
Description:

Food Bank/Home Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following:

- Personal hygiene products
- Household cleaning supplies
- Water filtration/purification systems in communities where issues of water safety exist

Program Guidance:
Unallowable costs include household appliances, pet foods, and other non-essential products.

See Medical Nutrition Therapy. Nutritional services and nutritional supplements provided by a registered dietitian are considered a core medical service under the HRSA RWHAP.

Health Education/Risk Reduction
Description:
Health Education/Risk Reduction is the provision of education to clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status. Topics covered may include:

- Education on risk reduction strategies to reduce transmission such as pre-exposure prophylaxis (PrEP) for clients' partners and treatment as prevention
- Education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage)
- Health literacy
- Treatment adherence education

Program Guidance:
Health Education/Risk Reduction services cannot be delivered anonymously.

See also Early Intervention Services

Housing
Description:
Housing provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services).

Housing activities also include housing referral services, including assessment, search,

placement, and housing advocacy services on behalf of the eligible client, as well as fees associated with these activities.

Program Guidance:
HRSA RWHAP recipients and subrecipients that use funds to provide Housing must have mechanisms in place to assess and document the housing status and housing service needs of new clients, and at least annually for existing clients.

HRSA RWHAP recipients and subrecipients, along with local decision-making planning bodies, are strongly encouraged to institute duration limits to housing activities. HRSA HAB recommends recipients and subrecipients align duration limits with those definitions used by other housing programs, such as those administered by the Department of Housing and Urban Development, which currently uses 24 months for transitional housing.

Housing activities cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments or rental deposits,[6] although these may be allowable costs under the HUD Housing Opportunities for Persons with AIDS grant awards.

Housing, as described here, replaces PCN 11-01.

Legal Services
See Other Professional Services

Linguistic Services
Description:
Linguistic Services include interpretation and translation activities, both oral and written, to eligible clients. These activities must be provided by qualified linguistic services providers as a component of HIV service delivery between the healthcare provider and the client. These services are to be provided when such services are necessary to facilitate communication between the provider and client and/or support delivery of HRSA RWHAP-eligible services.

Program Guidance:
Linguistic Services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS).

Medical Transportation
Description:
Medical Transportation is the provision of nonemergency transportation that enables an eligible client to access or be retained in core medical and support services.

Program Guidance:
Medical transportation may be provided through:

[6] See sections 2604(i), 2612(f), 2651(b), and 2671(a) of the Public Health Service Act.

- Contracts with providers of transportation services
- Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or other support services, but should not in any case exceed the established rates for federal Programs (Federal Joint Travel Regulations provide further guidance on this subject)
- Purchase or lease of organizational vehicles for client transportation programs, provided the recipient receives prior approval for the purchase of a vehicle
- Organization and use of volunteer drivers (through programs with insurance and other liability issues specifically addressed)
- Voucher or token systems

Costs for transportation for medical providers to provide care should be categorized under the service category for the service being provided.

Unallowable costs include:

- Direct cash payments or cash reimbursements to clients
- Direct maintenance expenses (tires, repairs, etc.) of a privately-owned vehicle
- Any other costs associated with a privately-owned vehicle such as lease, loan payments, insurance, license, or registration fees.

Non-Medical Case Management Services

Description:

Non-Medical Case Management Services (NMCM) is the provision 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/or 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 Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans. NMCM Services includes all types of case management encounters (e.g., face-to-face, telehealth, phone contact, and any other forms of communication). Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Client-specific advocacy and/or review of utilization of services
- 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 members' needs and personal support systems

Program Guidance:
NMCM Services have as their objective providing coordination, guidance and assistance in improving access to and retention in needed medical and support services to mitigate and eliminate barriers to HIV care services, whereas Medical Case Management Services have as their objective improving health care outcomes.

Other Professional Services
Description:
Other Professional Services allow for the provision of professional and consultant services rendered by members of particular professions licensed and/or qualified to offer such services by local governing authorities. Such services may include:

- Legal services provided to and/or on behalf of the HRSA RWHAP-eligible PLWH and involving legal matters related to or arising from their HIV disease, including:
    - Assistance with public benefits such as Social Security Disability Insurance (SSDI)
    - Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the HRSA RWHAP
    - Preparation of:
        - Healthcare power of attorney
        - Durable powers of attorney
        - Living wills
- Permanency planning to help clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including:
    - Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney
    - Preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption
- Income tax preparation services to assist clients in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits.

Program Guidance:
Legal services exclude criminal defense and class-action suits unless related to access to services eligible for funding under the RWHAP.

See 45 CFR § 75.459

Outreach Services

Description:

The Outreach Services category has as its principal purpose identifying PLWH who either do not know their HIV status, or who know their status but are not currently in care. As such, Outreach Services provide the following activities: 1) identification of people who do not know their HIV status and/or 2) linkage or re-engagement of PLWH who know their status into HRSA RWHAP services, including provision of information about health care coverage options.

Because Outreach Services are often provided to people who do not know their HIV status, some activities within this service category will likely reach people who are HIV negative. When these activities identify someone living with HIV, eligible clients should be linked to HRSA RWHAP services.

Outreach Services must:

1) use data to target populations and places that have a high probability of reaching PLWH who
    a. have never been tested and are undiagnosed,
    b. have been tested, diagnosed as HIV positive, but have not received their test results, or
    c. have been tested, know their HIV positive status, but are not in medical care;
2) be conducted at times and in places where there is a high probability that PLWH will be identified; and
3) be delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort.

Outreach Services may be provided through community and public awareness activities (e.g., posters, flyers, billboards, social media, TV or radio announcements) that meet the requirements above and include explicit and clear links to and information about available HRSA RWHAP services. Ultimately, HIV-negative people may receive Outreach Services and should be referred to risk reduction activities. When these activities identify someone living with HIV, eligible clients should be linked to HRSA RWHAP services.

Program Guidance:

Outreach Services provided to an individual or in small group settings cannot be delivered anonymously, as some information is needed to facilitate any necessary follow-up and care.

Outreach Services must not include outreach activities that exclusively promote HIV prevention education. Recipients and subrecipients may use Outreach Services funds for HIV testing when HRSA RWHAP resources are available and where the testing would not supplant other existing funding.

Outreach Services, as described here, replaces PCN 12-01.

See also Early Intervention Services

Permanency Planning
See Other Professional Services

Psychosocial Support Services
Description:
Psychosocial Support Services provide group or individual support and counseling services to assist HRSA RWHAP-eligible PLWH to address behavioral and physical health concerns. Activities provided under the Psychosocial Support Services may include:

- Bereavement counseling
- Caregiver/respite support (HRSA RWHAP Part D)
- Child abuse and neglect counseling
- HIV support groups
- Nutrition counseling provided by a non-registered dietitian (*see* Medical Nutrition Therapy Services)
- Pastoral care/counseling services

Program Guidance:
Funds under this service category may not be used to provide nutritional supplements (*See* Food Bank/Home Delivered Meals).

HRSA RWHAP-funded pastoral counseling must be available to all eligible clients regardless of their religious denominational affiliation.

HRSA RWHAP Funds may not be used for social/recreational activities or to pay for a client's gym membership.

For HRSA RWHAP Part D recipients, outpatient mental health services provided to affected clients (people not identified with HIV) should be reported as Psychosocial Support Services; this is generally only a permissible expense under HRSA RWHAP Part D.

See also Respite Care Services

Rehabilitation Services
Description:
Rehabilitation Services provide HIV-related therapies intended to improve or maintain a client's quality of life and optimal capacity for self-care on an outpatient basis, and in accordance with an individualized plan of HIV care.

Program Guidance:

Allowable activities under this category include physical, occupational, speech, and

vocational therapy.

Rehabilitation services provided as part of inpatient hospital services, nursing homes, and other long-term care facilities are not allowable.

Referral for Health Care and Support Services
Description:
Referral for Health Care and Support Services directs a client to needed core medical or support services in person or through telephone, written, or other type of communication. Activities provided under this service category may include referrals to assist HRSA RWHAP-eligible clients to obtain access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other state or local health care and supportive services, or health insurance Marketplace plans).

Program Guidance:
Referrals for Health Care and Support Services provided by outpatient/ambulatory health care providers should be reported under the Outpatient/Ambulatory Health Services category.

Referrals for health care and support services provided by case managers (medical and non-medical) should be reported in the appropriate case management service category (i.e., Medical Case Management or Non-Medical Case Management).

See also Early Intervention Services

Respite Care
Description:

Respite Care is the provision of periodic respite care in community or home-based settings that includes non-medical assistance designed to provide care for an HRSA RWHAP-eligible client to relieve the primary caregiver responsible for their day-to-day care.

Program Guidance:
Recreational and social activities are allowable program activities as part of a Respite Care provided in a licensed or certified provider setting including drop-in centers within HIV Outpatient/Ambulatory Health Services or satellite facilities.

Funds may be used to support informal, home-based Respite Care, but liability issues should be included in the consideration of this expenditure. Direct cash payments to clients are not permitted.

Funds may not be used for off premise social/recreational activities or to pay for a client's gym membership.

See also Psychosocial Support Services

Substance Abuse Services (residential)
Description:
Substance Abuse Services (residential) activities are those provided for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder. Activities provided under the Substance Abuse Services (residential) service category include:

- Pretreatment/recovery readiness programs
- Harm reduction
- Behavioral health counseling associated with substance use disorder
- Medication assisted therapy
- Neuro-psychiatric pharmaceuticals
- Relapse prevention
- Detoxification, if offered in a separate licensed residential setting (including a separately-licensed detoxification facility within the walls of an inpatient medical or psychiatric hospital)

Program Guidance:
Substance Abuse Services (residential) is permitted only when the client has received a written referral from the clinical provider as part of a substance use disorder treatment program funded under the HRSA RWHAP.

Acupuncture therapy may be an allowable cost under this service category only when it is included in a documented plan as part of a substance use disorder treatment program funded under the HRSA RWHAP.

HRSA RWHAP funds may not be used for inpatient detoxification in a hospital setting, unless the detoxification facility has a separate license.

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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

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

LOS ANGELES COUNTY COMMISSION ON HIV

510 S. Vermont Ave. Floor 14, Los Angeles, CA 90020
(213) 738-2816 | hivcomm@lachiv.org

AMBULATORY OUTPATIENT MEDICAL (AOM) SERVICE STANDARDS

For review by the Standards and Best Practices Committee on 4/2/24. ***Updated 4.15.24***

IMPORTANT: Service standards must 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:

- Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18)
- HIV/AIDS Bureau, Division of Metropolitan HIV/AIDS Programs National Monitoring Standards for Ryan White Part A Grantees: Program – Part A

INTRODUCTION

Service standards for the Ryan White HIV/AIDS Part A Program (RWHAP) outline the elements and expectations a service provider should follow when implementing a specific service category. The purpose of the standards is to ensure that all RWHAP service providers offer the same fundamental components of the given service category. Additionally, the standards set the minimum level of care Ryan White-funded service providers may offer clients, however, service providers are encouraged to exceed these standards.

The Los Angeles County Commission on HIV (COH) developed the Ambulatory Outpatient Medical (AOM) service standards to establish the minimum service necessary to provide HIV specialty medical care to people living with HIV. The developed of the standards included review of current clinical guidelines, as well as feedback from service providers, people living with HIV, members of the COH's Standards and Best Practices (SBP) Committee, COH caucuses, and the public-at-large. All service standards approved by the COH align with the Universal Standards of Care and Client Bill of Rights and Responsibilities (Universal Standards) approved by the COH on January 11, 2024. AOM providers must also follow the Universal Standards of Care in addition to the standards described in this document.

~~SERVICE INTRODUCTION~~AMBULATORY OUTPATIENT MEDICAL (AOM) OVERVIEW

AOM Services are evidence-based preventive, diagnostic and therapeutic medical services provided through outpatient medical visits by California-licensed health care professionals. Clinics shall offer a full-range of health services to HIV-positive RWP eligible clients with the objective of helping them cope with their HIV diagnosis, adhere to treatment, prevent HIV transmission, and identify and address co-morbidities.

~~HIV/AIDS medical outpatient --referred to as "Ambulatory Outpatient Medical" herein—services are up-to-date educational, preventive, diagnostic and therapeutic medical services provided by licensed health~~

~~care professionals with requisite training in HIV/AIDS. Such services will include care for people living with HIV (PLWH) throughout the entire continuum of the disease.~~

Ambulatory Outpatient Medical (AOM) services include, but are not limited to:

- Medical evaluation and clinical care including sexual history taking
- AIDS Drug Assistance Program (ADAP) enrollment services;
- Laboratory testing including disease monitoring, STD testing, and other clinically indicated tests;
- Linkage and referrals to medical subspecialty care, oral health, medical care coordination, mental health care, and other service providers;
- Secondary HIV prevention in the ambulatory outpatient setting; and
- Retention of clients in medical care.~~Medical specialty services~~
- ~~Medical care coordination~~
- ~~Adherence counseling~~
- ~~Laboratory testing (including drug resistance and other specialized tests)~~
- ~~Nutrition therapy~~
- ~~HIV prevention in ambulatory/outpatient settings~~
- ~~Sexually transmitted infection (STI) prevention and testing~~

The goals of MO services include:

- Connect patients to high-quality care and medication even if they do not have health insurance
- Help patients achieve low/undetectable viral load to improve their health and prevent HIV transmission (Undetectable=Untransmittable)
- Prevent and treat opportunistic infections
- Provide education and support with risk reduction strategies~~Interrupting or delaying the progression of HIV disease and STIs~~
- ~~Preventing and treating opportunistic infections~~
- ~~Promoting optimal health~~
- ~~Interrupting further HIV and STI transmission by providing the background for appropriate behavioral change~~

~~The Los Angeles County Commission on HIV and Division of HIV and STD Programs (DHSP) have developed this standard of care to set minimum quality expectations for service provision and to guarantee patients consistent care, regardless of where they receive services in the County.~~

~~**MEDICAL SPECIALTY SERVICES**~~

~~All MO services will be provided in accordance with published standards of care, Commission on HIV guidelines and procedures, and in accordance with California Business and Professions Code, as well as local laws and regulations.~~

~~Services will be provided by health care professionals with requisite training in HIV/AIDS, including physicians, physician assistants (PAs) and/or nurse practitioners (NPs). Such practitioners will be licensed to practice by the state of California.~~

~~Facilities providing MO services must be:~~

- ~~Licensed as a medical clinic facility, approved through the Los Angeles County Department of Public Health, Health Division for Licensing and Certification, in cooperation with the California Department of Health Services (CDHS) Approved as an enrollment site by the CDHS and by the Los Angeles County Department of Public Health, DHSP~~
- ~~Compliant with the Health Insurance Portability and Accountability Act, 1996 (HIPAA) and with the requirements of Title 17 and Title 22 of the California Code of Regulations~~
- ~~Licensed and Medi-Cal certified by the Los Angeles County Department of Public Health, Health Division for Licensing and Certification in cooperation with CDHS and must comply with current federal and State standards for such programs (in order to be funded by DHSP)~~

~~Many of the MO care facilities funded by DHSP are also accredited by the Joint Committee on Accreditation of Healthcare Organizations (JCAHO) and/or are designated as federally qualified health care (FQHC) facilities by the federal Department of Health and Human Services (DHH). While JCAHO accreditation and FQHC status are not required, HIV/AIDS MO care programs are developed, implemented, and monitored with similar administrative and clinical capacities and competencies characteristic of clinics that are JCAHO accredited and/ or FQHCs (or FQHC Look-a-Likes). (See the California Primary Care Association www.cpca.org and National Association of Community Health Centers, Inc. www.nachc.com)~~

~~MEDICAL SPECIALTY SERVICES~~

~~MO programs must make referrals to medical specialty providers who meet two requirements:~~

1. ~~Licensed as a physician (Medical Doctor (MD) or Doctor of Osteopathy (DO)) by the Medical Board of California or by the California Board of Osteopathic Examiners.~~
2. ~~Completed the training and examination process required for certification by the respective national medical specialty professional board or meets requirements for board-eligibility.~~

~~ADHERENCE COUNSELING~~

~~Medication adherence counseling will be provided in accordance with the Commission on HIV guidelines and procedures, and local laws and regulations. Medication adherence counseling should be provided in the context of a medical or medical care coordination (MCC) visit by either a medical provider or a trained MCC team member. Adherence assessments should be performed on a regular basis and documented in medical progress notes and MCC documents.~~

~~NUTRITION SCREENING AND REFERRAL~~

~~All nutrition counseling services will be provided in accordance with published standards of care, Commission on HIV guidelines and procedures, and in accordance with California Business and Professions Code section 2585-2586.8, as well as local laws and regulations. Either MO or MCC providers are responsible for screening patients' nutritional needs, noting positive screens in the medical chart, and referring patients to medical nutrition therapy programs as needed.~~

~~Either the provider's own medical nutrition therapy program or a program to which they refer will operate under the direct supervision of a registered dietitian or nutritionist consistent with California~~

~~Business and Professions Code section 2585-2586.8. Registered dietitians providing medical nutrition therapy services will have advanced knowledge of nutrition issues for people living with HIV, maintain membership in the HIV/AIDS Dietetic Practice Group, and maintain professional education (CPE) units/hours, primarily in HIV nutrition and other related medical topics as administered by the Commission on Dietetic Registration.~~

~~SERVICE CONSIDERATIONS~~

~~General Considerations:~~ ~~MO services will be patient-centered, respecting the inherent dignity of the patient. Programs must ensure that patients are given the opportunity to ask questions and receive accurate answers regarding services provided by MO practitioners and other professionals to whom they are referred. Such patient-practitioner discussions are relationship-building and serve to develop trust and confidence. Patients must be seen as active partners in decisions about their personal health care regimen. Practitioners are directed to patient-oriented HIV/AIDS care and prevention websites such as Project Inform (www.projectinform.org) and The Body (www.thebody.com) for more information about discussing HIV/AIDS from a patient-centered approach.~~

~~Medical Evaluation and Clinical Care:~~ ~~MO programs must confirm the presence of HIV infection and provide tests to diagnose the extent of immunologic deficiency in the immune system. Additionally, programs must provide diagnostic and therapeutic measures for preventing and treating the deterioration of the immune system and related conditions that conform to the most recent clinical protocols. At minimum, these services include regular medical evaluations; appropriate treatment of HIV infection; and prophylactic and treatment interventions for complications of HIV infection, including opportunistic infections, opportunistic malignancies, other AIDS-defining conditions and other STIs.~~

~~Medication Adherence Counseling:~~ ~~All HIV treatment adherence counseling will be provided in accordance with the Commission on HIV guidelines and procedures, and local laws and regulations. Treatment adherence counseling should be provided in the context of a medical or medical care coordination visit by a medical provider. Adherence assessments will be performed on a regular basis and reported as medical progress notes. Referrals to the Medical Care Coordination (MCC) team for more thorough adherence counseling will be made by the provider when appropriate.~~

~~Medical Specialty Services:~~ ~~MO programs must make referrals to medical specialty providers who meet two requirements:~~

1. ~~Are licensed as a physician (Medical Doctor (MD) or Doctor of Osteopathy (DO)) by the Medical Board of California or by the California Board of Osteopathic Examiners; and~~
2. ~~Have completed the training and examination process required for certification by the respective national medical specialty professional board or meets requirements for board-eligibility.~~

~~Nutrition Screening and Referral:~~ ~~All nutrition counseling services will be provided in accordance with published standards of care, Commission on HIV guidelines and procedures, and in accordance with California Business and Professions Code section 2585- 2586.8, as well as local laws and regulations.~~

~~Medical Care Coordination Services:~~ ~~All MO programs must partner with medical care coordination services, either directly or through cooperative agreements. Medical care coordination services are~~

~~supervised and overseen by a team consisting of a registered nurse and a master's level patient care manager.~~

~~**HIV Prevention in Ambulatory/Outpatient Settings:** HIV prevention is a critical component to ongoing care for people living with HIV. Prevention services provided in MO clinics include HIV counseling, testing and referral; STI counseling, testing and referral; partner counseling; prevention and medical care; and referral for intensive services.~~

~~**Common Service Components:** Common service components include:~~

- ~~Patient intake~~
- ~~Referral~~
- ~~Patient education~~
- ~~Patient records~~
- ~~Patient retention~~
- ~~Case closure~~

SERVICE COMPONENTS

HIV/AIDS AOM~~MO~~ services form the foundation for the Los Angeles County HIV/AIDS continuum of care. ~~(County of Los Angeles HIV/AIDS Comprehensive Care Plan, 2002).~~ AOM~~MO~~ services are responsible for assuring that the full spectrum of primary and HIV specialty medical care needs for patients are met either by the program directly or by referral to other health care agencies. Services will be provided to individuals living with HIV who are residents of Los Angeles County and meet Ryan White eligibility requirements.

AOM ~~MO~~ services will be patient-centered, respecting the inherent dignity of the patient. Programs must ensure that patients are given the opportunity to ask questions and receive accurate answers regarding services provided by ~~MO~~AOM ~~practitioners~~service providers and other professionals to whom they are referred. Such patient-practitioner discussions are relationship building and serve to develop trust and confidence. Patients must be seen as active partners in decisions about their personal health care regimen. ~~Practitioners are directed to patient-oriented HIV/AIDS care and prevention websites such as Project Inform (www.projectinform.org) and The Body (www.thebody.com) for more information about discussing HIV/AIDS from a patient-centered approach~~

~~HIV MO~~AOM services must be provided consistent with ~~United States Public Health Service~~the following treatment guidelines: ~~(www.aidsinfo.nih.gov/).~~

Clinical Practice Guidance for Persson with Immunodeficiency Virus: 2020

American Academy of HIV Medicine HIV Treatment Guidelines

Guidelines for the Use of Antiretrovirals Agents in Adults and Adolescents with HIV

~~Other established practice guidelines, standards, and protocols, may be used to provide state-of-the-art prevention and care services for all patients, including the most recent versions of sources such as:~~

- ~~Johns Hopkins AIDS Service (www.hopkins-aids.edu)~~
- ~~New York Department of Health AIDS Institute (www.hivguidelines.org)~~
- ~~HIV/AIDS Bureau (www.hab.hrsa.gov)~~
- ~~Center for Disease Control Division of HIV Prevention – Treatment (www.cdc.gov)~~

~~The scope of this MO services standard is broad and varied, encompassing many distinct services and several separate contracts.~~

The core of the AOM~~MO~~ services standard is medical evaluation and clinical care that includes:

- Initial assessment and reassessment
- Follow-up treatment visits
- Additional assessments
- Laboratory assessment and diagnostic screening (including drug resistance testing)
- Medication service
- Antiretroviral (ARV) therapy
- Treatment adherence counseling
- Health maintenance
- Clinical trials
- Primary HIV nursing care
- Medical specialty services
- Nutrition screening and referral
- Referrals to other Ryan White Program services and other publicly funded healthcare and social services programs

~~In addition to this core service, the MO standard includes incorporation of the following services:~~

- ~~Medical care coordination services~~
- ~~HIV prevention in ambulatory/outpatient settings, including:~~
- ~~HIV Counseling, Testing and Referral for Partners and Social Affiliates~~
- ~~Partner Counseling and Referral Services (PCRS), postexposure prophylaxis (PEP), and preexposure prophylaxis (PrEP)~~
- ~~Referral for Intensive Services~~

~~Finally, this standard addresses components common to all of the services previously discussed. Common service components include:~~

- ~~Patient intake~~
- ~~Referral~~
- ~~Patient education~~
- ~~Patient records~~
- ~~Patient retention~~
- ~~Case closure~~

	~~STANDARD~~	~~DOCUMENTATION~~
	~~AOM services will be patient-centered, respecting the dignity of the patient.~~	~~Supervision and program review to confirm.~~
	~~AOM services will be provided in accordance with PHS guidelines and other established standards and guidelines.~~	~~Program monitoring to confirm.~~

MEDICAL EVALUATION AND CLINICAL CARE

AOM~~MO~~ programs must confirm the presence of HIV infection and provide tests to diagnose the extent of immunologic deficiency in the immune system. Additionally, programs must provide diagnostic and therapeutic measures for preventing and treating the deterioration of the immune system and related conditions that conform to the most recent clinical protocols. At minimum, these services include regular medical evaluations; appropriate treatment of HIV infection; and prophylactic and treatment interventions for complications of HIV infection, including opportunistic infections, opportunistic malignancies and other AIDS defining conditions.

The following core services must be provided onsite or through referral to another facility offering the required service(s). Qualified health care professionals for these services include physicians, NPs and/or PAs except where indicated ~~(see Staff Requirements and Qualifications for details about qualifications).~~ RNs may provide primary HIV nursing care services and linkage to medical care coordination services.

~~HIV MO services must be provided consistent with United States Public Health Service treatment guidelines (www.aidsinfo.nih.gov/).~~

~~Other established practice guidelines, standards, and protocols, may be used to provide state-of-the-art prevention and care services for all patients, including the most recent versions of sources such as:~~

- ~~Johns Hopkins AIDS Service (www.hopkins-aids.edu)~~
- ~~New York Department of Health AIDS Institute (www.hivguidelines.org)~~
- ~~HIV/AIDS Bureau (www.hab.hrsa.gov)~~
- ~~Center for Disease Control Division of AIDS Prevention – Treatment (www.cdc.gov)~~
- ~~John G. Bartlett, MD, Abbreviated Guide to Medical Management of HIV Infection The Pocket Guide to Adult HIV/AIDS Treatment~~
- ~~Jean R. Anderson, MD (editor), A Guide to the Clinical Care of Women with HIV \~~
- ~~Guidelines for preventing opportunistic infections among HIV-infected persons (Morbidity and Mortality Weekly Report)~~
- ~~CDC Sexually Transmitted Disease Treatment Guidelines (Morbidity and Mortality Weekly Report) (www.cdc.gov/std)~~

	STANDARD	DOCUMENTATION
	AOM medical visits/evaluation and treatment are scheduled for at least a minimum of every ~~four~~ six months, at least 3 months apart ~~a~~	Medical ~~chart~~ record review to confirm.

	~~minimum of every six months~~ if long-term stability and adherence are demonstrated.	
	AOM core services will be provided by physicians, NPs, and/or PAs. RNs will provide primary HIV nursing care services and linkage to medical care coordination (MCC), if appropriate~~.~~	Policies and procedures manual and medical chart review to confirm.

INITIAL ASSESSMENT AND REASSESSMENT

Every effort should be made to accommodate timely medical appointments for patients newly diagnosed with HIV or newly re-engaging in HIV medical care. Clinics may receive requests for appointments from patients directly, from HIV test counselors, or from "linkage" staff such as patient navigators, whose role is to refer and actively engage patients back in medical care. If possible, patients should see their medical provider (or the MCC team) on their first visit to the clinic to help improve their success in truly engaging in their medical care.

The initial assessment of HIV-infected individuals must be comprehensive in its scope, including physical, sociocultural, and emotional assessments and may require two to three outpatient visits to complete. Unless indicated more frequently by a patient's changing health condition, a comprehensive reassessment should be completed on an annual basis. The AOM~~MO~~ practitioners (physician, NP, PA or RN) responsible for completing the initial assessment and reassessments will use assessment tools based on established HIV practice guidelines. While taking steps to ensure a patient's confidentiality, the results of these assessments will be shared with medical care coordination staff to help identify and intervene on patient needs. An initial assessment and annual reassessment for HIV-infected patient should include a general medical history; a comprehensive HIV-related history, including a psychosocial history; sexual health history, mental health, and substance abuse histories; and a comprehensive physical examination. When obtaining the patient's history, the practitioner should use vocabulary that the patient can understand, regardless of education level. AOM providers must follow and use the most current clinical guidelines and assessment tools for general medical and comprehensive HIV medical histories.

~~General medical histories should include (at minimum):~~

- ~~History of present illness~~
- ~~Past hospitalizations, past and current illnesses~~
- ~~Past immunizations~~
- ~~Travel history and place of birth~~
- ~~Sexual history~~
- ~~Occupational history and hobbies~~
- ~~Pets/animal exposures~~
- ~~Current treatment, prescription, and non-prescription medicines (including complementary and alternative therapies, illicit substances, and hormones)~~
- ~~Allergies~~
- ~~Full review of systems~~
- ~~Mental health~~

~~Comprehensive HIV-related histories should include (at minimum):~~

- ~~HIV treatment history and staging~~
  - ~~Most recent viral load and CD4 count~~
  - ~~Nadir CD4 and peak viral load~~
  - ~~Current and previous ARV regimens~~
  - ~~Previous adverse ARV drug reactions~~
  - ~~Previous adverse reactions to drugs used for opportunistic infection prophylaxis~~
- ~~History of HIV-related illness and opportunistic infections~~
- ~~History of sexually transmitted diseases (STDs)~~
- ~~History of tuberculosis (TB)~~
- ~~History of hepatitis and hepatitis vaccines~~
- ~~Psychiatric history~~
  - ~~Diagnosed psychiatric diseases~~
  - ~~Previous/current treatment for psychiatric diseases~~
  - ~~Disability related to psychiatric disease~~
  - ~~Homicidality and suicidality~~
- ~~Sociocultural assessment~~
- ~~Transfusion or blood product history, especially before 1985~~
- ~~Review of sources of past medical care (obtaining past medical records whenever possible)~~
- ~~HIV-specific review of systems~~
  - ~~Skin~~
  - ~~Eyes~~
  - ~~Ear, nose, and throat~~
  - ~~Stomatognathic~~
  - ~~Pulmonary~~
  - ~~Cardiovascular~~
  - ~~Gastrointestinal/hepatic~~
  - ~~Endocrine~~
  - ~~Genitourinary~~
  - ~~OB/GYN~~
  - ~~Dermatologic~~
  - ~~Musculoskeletal~~
  - ~~Neurologic~~
  - ~~Hematopoietic~~
  - ~~Metabolic~~
- ~~Sexual history~~
  - ~~Sexual activity~~
  - ~~Sexual practices~~
  - ~~Gender identity~~
  - ~~Past and current partners~~
  - ~~Risk behavior assessment~~
- ~~Substance use history~~
  - ~~Past and current use and types of drugs, including alcohol~~

- ~~Frequency of use and usual route of administration~~
- ~~Risk behavior assessment~~
- ~~History of treatment~~

- ~~Tobacco use history~~

~~Comprehensive physical exams should include (at minimum):~~

- ~~Temperature, vital signs, height, and weight~~
- ~~Pain assessment~~
- ~~Ophthalmologic examination~~
- ~~Ears, nose, and throat examination~~
- ~~Dermatological examination~~
- ~~Lymph node examination~~
- ~~Oral examination~~
- ~~Pulmonary examination~~
- ~~Cardiac examination~~
- ~~Abdominal examination~~
- ~~Genital examination~~
- ~~Rectal examination~~
- ~~Neurological examination~~

	STANDARD	DOCUMENTATION
	Comprehensive baseline assessment will be completed by physician, NP, PA, or RN and updated, as necessary.	Medical records ~~Comprehensive baseline assessment and updates/~~ ~~follow-up treatment (as necessary) in patient medical~~ ~~chart to include:~~ ~~• General medical histories (at minimum):~~ ~~• History of present illness~~ ~~• Past hospitalizations, illnesses~~ ~~• Past immunizations~~ ~~• Travel history, place of birth~~ ~~• Sexual history~~ ~~• Occupational history~~ ~~• Pets/animal exposures~~ ~~• Current treatment, medicines~~ ~~• Allergies~~ ~~• Full review of systems~~ ~~• Mental health~~ ~~• Comprehensive HIV-related histories (at minimum):~~ ~~• HIV treatment history and staging~~ ~~• History of HIV-related illness and infections~~ ~~• History of sexually transmitted diseases~~

		~~• History of TB~~ ~~• History of hepatitis and vaccines~~ ~~• Psychiatric history~~ ~~• Sociocultural assessment~~ ~~• Transfusion/blood product history~~ ~~• Past medical care review and obtaining medical records~~ ~~• HIV-specific review of systems~~ ~~• Sexual history~~ ~~• Substance use history~~ ~~• Tobacco use history~~ ~~• Comprehensive physical exams (at minimum):~~ ~~• Temperature, vital signs, height, and weight~~ ~~• Pain assessment~~ ~~• Ophthalmologic~~ ~~• Ears, nose, and throat~~ ~~• Dermatological~~ ~~• Lymph node~~ ~~• Oral~~ ~~• Pulmonary~~ ~~• Cardiac~~ ~~• Abdominal~~ ~~• Genital~~ ~~• Rectal~~ ~~• Neurological~~

FOLLOW-UP TREATMENT VISITS

- Patients should have follow-up visits scheduled ~~every three to four months, except at the practitioner's discretion when a patient has demonstrated long-term stability and adherence in his/her medical regime~~following established clinical guidelines. ~~The U.S. Public Health standard requires at least two visits a year.~~ If the patient is clinically unstable or poorly adherent, ~~monthly~~ a more frequent follow-up should be considered. Visits should be scheduled more frequently at entry to care, when starting or changing ARV regimens, or for management of acute problems. Due to the complex nature of HIV treatment, ongoing ~~HIV MO~~ AOM visits must be flexible in duration and scope, requiring that programs develop practitioner clinic schedules allowing for this complexity. Follow-up should be conducted as recommended by the specialist or clinical judgment.

~~At minimum, a medical visit for a returning patient will include a problem focused history, problem-focused examination, and straightforward medical decision-making~~

~~Follow-up visits should record and address:~~

- ~~Temperature, vital signs, height, and weight~~

- ~~Problems list status and updates including sexual history~~
- ~~Pain assessment~~
- ~~Adherence with the treatment plan~~
- ~~In addition to regularly scheduled viral load measurements (see Laboratory Assessment and Diagnostic Screening), viral load also should be measured according to prevailing medical standards and current guidelines.~~
- ~~Resistance testing should be performed (if feasible) for patients when viral failure to ARV has been demonstrated and/or when suboptimal suppression of viral load occurs (see more detailed discussion in Drug Resistance Testing)~~
- ~~Laboratory tests (as outlined in Laboratory Assessment and Diagnostic Screening)~~
- ~~Prophylaxis for opportunistic infections offered to each patient as indicated by immune status. Refer to current guidelines and prevailing standards for prophylaxis of opportunistic infections from DHHS Guidelines for Opportunistic Infections (www. aidsinfo.nih.gov/). Documentation of current therapies should be maintained on all patients receiving prophylaxis.~~
- ~~HIV-infected women should have a documented cervical Pap smear dated within the last year. Normal smears should be followed with a second smear in six months. If both results are negative, subsequent Pap smears should be performed annually. Smears showing severe inflammation or reactive changes should be reevaluated within three to six months.~~
- ~~Diagnosis of SIL or atypical squamous cells of undetermined significance should be followed with colposcopic examination of the lower genital tract. Inquire about last menstrual period and contraception, when appropriate.~~
- ~~Regular discussions of family planning and contraception should be conducted with female patients. For patients who are pregnant, the medical provider should discuss pregnancy and treatment options.~~
- ~~Anal and rectal exams should be performed at least annually. Baseline and periodic anal Pap smears for high-risk populations may be considered, with appropriate referral to specialists for high resolution anoscopy for those patients with abnormal results. (As this is an area of emerging data, any newly adopted national guidelines are recommended if/when they are disseminated.)~~
- ~~For patients who have no history of TB or positive PPD tests, a PPD test or Interferon Gamma Release Assay (IGRA) should be performed at least annually, with results recorded. Record attempts to follow up with patients who do not return for PPD reading. For all positive IGRA tests and PPD tests of at least five millimeters of induration, a chest X-ray should be obtained to rule out active pulmonary disease, and, if appropriate, prophylaxis should be given. If there is a history of a positive PPD or IGRA, any record of prophylactic treatment should be noted in the chart. Risk assessment for TB should be assessed annually with a symptom screen to detect acute disease.~~
- ~~Advance directives, durable powers of attorney, living wills and other planning documents, including POLST (physician's orders for life sustaining treatment) and DNR (do not resuscitate) status, should be addressed at the beginning of treatment and at any appropriate time in the course of the illness.~~

- ~~Patients with CD4 counts below 50 should be referred for ophthalmic examination by a trained retinal specialist for screening or as recommended by that specialist, according to prevailing medical standards and current guidelines.~~
- ~~Follow-up should be conducted as recommended by the specialist or clinical judgment.~~
- ~~Documentation of discussions of safer sex practices for both men and women. Patients in sero-discordant relationships should be educated about options for HIV pre-exposure prophylaxis (PrEP) or post-exposure prophylaxis (PEP) for their partners. Referrals for PrEP and PEP should be made for these partners.~~

~~Following standards of care for HIV prevention and treatment, MO practitioners must include the following in each patient encounter:~~

- ~~Providing brief HIV and STI prevention messages (asking patients about risk behaviors, and positively reinforcing patient's report of risk reduction behavior)~~
- ~~Asking patients about problems and concerns with medication adherence and making suggestions to support adherence (such as pill boxes, alarms)~~
- ~~Screening patients' nutritional needs and referring them for medical nutrition therapy services when and as needed~~
- ~~Asking patients about their social living conditions, ensuring that lack of housing, food or other social needs do not become a barrier to treatment adherence~~
- ~~Providing patient education on HIV disease, symptoms, medications, and treatment regimens to increase patient participation in treatment decision-making (see www. IHI.org for Institute for Healthcare Improvement guidelines on "Self-Management"); patient education on medications will include instructions, risks and benefits, compliance, side effects and drug interaction~~
- ~~Building and maintaining patient relationships, increasing the likelihood that patients may ask for needed emotional support, or talk with practitioners about substance abuse issues~~

	STANDARD	DOCUMENTATION
	Patients should have follow-up visits scheduled following established clinical guidelines. ~~Follow-up visits for patients receiving ARV therapy should be scheduled every three to four months, except at the practitioner's discretion when a patient has demonstrated long-term stability and adherence in his/her medical regime. Follow-up visits should be scheduled every three to six months for patients who are not receiving ARV therapy. U.S. Public Health Standards require at least two visits annually. Follow-up visits should be scheduled more frequently at entry to care, when starting or changing ARV regimens, or for management of acute problems.~~	Patient medical chart to confirm frequency.

	~~Follow-up visits should include (at minimum):~~ ~~• Temperature, vital signs, height, and weight~~ ~~• Problems list and updates including sexual history~~ ~~• Pain assessment~~ ~~• Treatment plan adherence~~ ~~• Viral load at regular intervals and prior to and after ARV treatment initiation~~ ~~• Resistance testing (if necessary) for ARV viral failure~~ ~~• Suboptimal viral load suppression~~ ~~• Laboratory tests~~ ~~• Opportunistic infection prophylaxis and documentation~~ ~~• Annual (at minimum) cervical Pap smears for women~~ ~~• Annual (at minimum) anal and rectal exams~~ ~~• Annual (at minimum) PPD test, chest X-ray and~~ ~~• prophylaxis as indicated~~ ~~• Advance directives and planning documents addressed at treatment initiation and as indicated~~ ~~• Referral for ophthalmic examination for patients with CD4 counts below 50~~ ~~• Family planning/contraception (for women) and safer sex discussions and documentation~~	~~Patient medical chart to confirm referrals and/or content of follow-up visits.~~
	~~Each patient encounter will include:~~ ~~• HIV and STI prevention messages~~ ~~• Treatment adherence counseling and support as needed~~ ~~• Nutrition screening, and referrals as needed~~ ~~• Social living conditions review~~ ~~• Patient education on HIV disease, symptoms, medications, and treatment regimens~~	~~Progress notes in patient chart to confirm.~~

OTHER ASSESSMENTS **– OLDER ADULTS WITH HIV**

According the Health Resources and Service Administration (HRSA), the RWHAP client population is aging. Of the more than half a million clients served by RWHAP, 46.1 percent are aged 50 years and older and this continues to grow. While Ryan White clients in Los Angeles County show higher engagement and retention in care, and viral suppression rates, within the 50+ population there exists disparities by racial/ethnic, socioeconomic, geographic, and age groups stratification.

AOM providers must a minimum assess patients 50 years and older for mental health, neurocognitive disorders/cognitive function, functional status, frailty/falls and gait, social support and levels of interactions, vision, dental, and hearing. Additional recommended assessments and screenings for older adults living with HIV can be found on page 6 of the Aging Task Force Recommendations.

Other sSpecialized assessments leading to more specific services may be indicated for patients receiving AOM~~MO~~ services. AOM~~MO~~ programs must designate a member of the treatment team (physician, RN, NP or PA) to make these assessments in the clinic setting. ~~The following specialized assessments must be made available as part of the MO services:~~

- ~~An ARV readiness assessment at first diagnosis of HIV infection for all patients starting combination therapies (see: www.hivguidelines.org AIDS Institute Clinical Guidelines, Best Practices, "Promoting Adherence to HIV Antiretroviral Therapies.").~~

~~The assessment should include:~~

- ~~A medication adherence assessment regularly as needed for those not fully adherent~~
- ~~Level of knowledge and understanding about the HIV disease process~~
- ~~Primary health care services and adherence to these services~~
- ~~Awareness of available treatment options, clinical trials, and resources~~
- ~~Literacy~~
- ~~Current or future adherence barriers~~
- ~~Support system~~

~~Patients with full adherence do not need adherence assessments every six months, but documentation in the medical chart should demonstrate continued adherence at least every six months.~~

~~For patients enrolled in MCC services, the medical care coordination staff may do this assessment and deliver the adherence interventions. The MCC assessment, which is performed at least every six months, will document adherence for patients in MCC.~~

- ~~An HIV and STI prevention and education assessment for patients and their partners who need focused attention and support to modify high risk behaviors (see tools and guides in Morbidity and Mortality Weekly Report, July 18, 2003/Vol.52/No. RR-12). The assessment should be performed at least every six months.~~
- ~~A nutrition screening for patients needing education and support for maintaining good nutrition, food and water safety, and food and nutritional interactions with treatment regimens (see the Commission on HIV's Nutrition Therapy Standard of Care, 2005). An assessment should be performed as baseline, and follow-up screenings performed and documented in the medical charts at least annually.~~

STANDARD		DOCUMENTATION
	Other assessments based on patient needs will be performed. ~~Assessments will be performed as indicated, including:~~ ~~• ARV readiness assessment at first diagnoses of HIV infection~~ ~~• Treatment adherence assessment regularly as needed for those patients who are not fully adherent. MCC assessment performed at least every six months~~ ~~• HIV and STI prevention and education assessment performed every six months~~ ~~• Nutrition assessment performed at baseline and nutrition screenings updated at least every six months~~	Assessments and updates noted documented in patient's medical ~~chart~~record.

LABORATORY ASSESSMENT AND DIAGNOSTIC SCREENING (INCLUDING DRUG RESISTANCE SCREENING)

AOM~~MO~~ programs must have access to all laboratory services required to comply fully with established practice guidelines for HIV prevention and risk reduction and for the clinical management of HIV disease. Programs must assure timely, quality lab results, readily available for review in medical encounters.

~~Baseline lab tests (preferably at fasting) for all HIV-positive persons should include:~~

- ~~Complete Blood Count (CBC)~~
- ~~Liver function tests~~
- ~~Blood Urea Nitrogen (BUN)~~
- ~~Creatinine~~
- ~~Protein~~
- ~~Albumin~~
- ~~Glucose~~
- ~~Triglycerides~~
- ~~Cholesterol~~
- ~~Syphilis serology, urine, Gonorrhea Chlamydia (GC)/Chlamydia and rectal/oral swabs for GC/Chlamydia~~
- ~~Toxoplasma gondii antibody screening~~
- ~~Urinalysis~~
- ~~CD4 count and HIV-RNA viral load~~
- ~~Chest X-ray~~
- ~~Purified Protein Derivative (PPD) or IGRA (QuantiFERON)~~
- ~~Cervical Pap smear (if not done in past year)~~
- ~~Hepatitis A screening for those not previously vaccinated~~
- ~~Hepatitis B and C serology*~~

~~* If the serology for hepatitis C is reactive, then tests to determine whether the patient has chronic hepatitis C infection should be done. If a quantitative hepatitis C viral load is indicated, and if the virus is present, the patient should be counseled and evaluated for hepatitis treatment and as appropriate, treatment should be initiated.~~

~~Follow-up and ongoing lab tests for patients should include, at a minimum:~~

- ~~Annual: CBC, liver function tests, BUN, cholesterol, triglycerides (preferably fasting)~~
- ~~Every six months: CD4, HIV-RNA, syphilis serology, urine GC/Chlamydia and rectal GC, oral GC/Chlamydia testing for sexually active patients based on risk behavior~~

~~In accordance with Public Health Standard guidelines, follow-up, and ongoing lab tests for patients on ARV should include:~~

- ~~CBC, liver function tests, BUN, creatinine, glucose, cholesterol, triglycerides (preferably fasting), CD4, HIV-RNA and syphilis serology. Urine GC/Chlamydia, rectal GC, and oral GC/Chlamydia testing should be offered for sexually active patients based on risk behavior.~~

DRUG RESISTANCE TESTING

When appropriate, AOM~~MO~~ practitioners may order drug resistance testing to measure a patient's pattern of resistance of HIV to antiretroviral medications. Genotypic testing looks for viral mutations, and is expected for all naïve patients, and phenotypic testing measures the amount of drug needed to suppress replication of HIV. By using resistance testing, practitioners can determine if the virus is likely to be suppressed by each antiretroviral drug. This information is used to guide practitioners in prescribing the most effective drug combinations for treatment.

~~Drug resistance testing services will be based upon most recent established guidelines and standards of care including the PHS Guidelines and the Infectious Disease Society of America Guidelines, as well as the DHHS Panel on Antiretroviral Guidelines for Adults and Adolescents' Recommendations for HIV Viral Load Testing and the CDHS's Recommended General Clinical Guidelines. Practitioners are directed to HIV Resistance Web at www. HIVRESITANCEWEB.com for Ask the Experts; and www.thebody.com for the Forum on Drug Resistance and Staying Undetectable for more information.~~

Counseling and education about drug resistance testing must be provided by the patient's medical practitioner, RN and/or other appropriate licensed health care provider (if designated by the practitioner). Patients must be fully educated about their medical needs and treatment options according to standards of medical care. Patients must be given an opportunity to ask questions about their immune system, antiretroviral therapies, and drug resistance testing. All patient education efforts will be documented in the patient record.

STANDARD		DOCUMENTATION
	Baseline lab tests based on current clinical guidelines. ~~should include:~~ ~~• CBC~~ ~~• Liver function tests~~ ~~• BUN~~ ~~• Creatinine~~	Record of tests and results on file in patient medical chart.

	~~• Protein~~ • ~~Albumin~~ ~~• Glucose~~ ~~• Triglycerides~~ ~~• Cholesterol~~ ~~• Syphilis serology, urine GC/Chlamydia, rectal GC, oral GC/Chlamydia (based on risk)~~ ~~• Toxoplasma gondii antibody screening~~ ~~• Urinalysis~~ ~~• CD4 count and HIV-RNA viral load~~ ~~• Chest X-ray~~ ~~• PPD~~ ~~• Cervical Pap smear (if not done in past year)~~ ~~• Hepatitis A screening for those not previously vaccinated~~ ~~• Hepatitis B and C serology~~	
	Ongoing lab tests based on clinical guidelines and provider's clinical judgement. ~~for patients should include, at a minimum: • Annual: CBC, liver function tests, BUN, cholesterol, triglycerides (preferably fasting) • Every six months: CD4, HIV-RNA, syphilis serology and urine and rectal GC/Chlamydia and oral GC for sexually experienced patients at increased risk~~	Record of tests and results on file in patient medical chart.
	Appropriate health care provider will provide drug resistance testing as indicated.	Record of drug resistance testing on file in patient medical chart.
	Drug resistance testing providers must follow most recent, established resistance testing guidelines, including genotypic testing on all naïve patients.	Program review and monitoring to confirm.

MEDICATION SERVICES

Medications should be provided to interrupt or delay the progression of HIV-disease, prevent, and treat opportunistic infections, and promote optimal health. Patients should be referred to an approved AIDS Drug Assistance Program (ADAP) enrollment site and, as indicated, to medical care coordination programs for additional assistance with public benefit concerns. Patients eligible for ADAP will be referred to a participating pharmacy for prescriptions on the ADAP formulary. If the patient requires medications that are not listed on the ADAP formulary or that can be reimbursed through other local pharmacy assistance resources, the AOM~~MO~~ program is responsible for making every effort possible to link them to medications and exercise due diligence for that effort consistent with their ethical responsibilities. ~~For a more detailed discussion of ADAP services, please see the ADAP Enrollment Standard of Care, Los Angeles County Commission on HIV, 2008. For more information about Medical Care Coordination services, please see the Medical Care Coordination Standard of Care, Los Angeles County Commission on HIV, 2008.~~

STANDARD		DOCUMENTATION
	Patients requiring medications will be referred to ADAP enrollment site. As indicated, patients will also be referred to medical care coordination programs for public benefits concerns.	ADAP referral documented in patient medical chart.
	aom~~MO~~ programs must exercise every effort and due diligence consistent with their ethical responsibilities to ensure that patients can get necessary medications not on the ADAP and local formularies.	Documentation in patient's medical chart.

ANTIRETROVIRAL ~~(ARV)~~ THERAPY (ART)

Antiretroviral therapy will be prescribed in accordance with the established guidelines based upon the DHH~~S~~S Guidelines for the Use of Antiretroviral Agents in HIV-infected Adults and Adolescents ~~(www.aidsinfo.nih.gov/).~~ Decisions to begin ARV treatment must be collaborative between patient and MO practitioner. ~~All patients will be given a readiness assessment (e.g., http://www.hivguidelines.org/public_html/center/best-practices/treatment_adherence/pdf/treat_adherence_full.pdf, New York AIDS Institute Clinical Guidelines, Best Practices, Promoting Adherence to HIV Antiretroviral Therapies, pp. 9-10) prior to prescribing ARV. Patients should be informed about the changes in lifestyle, body image and side effects that may accompany ARV treatment. Patients will be given the time necessary to make an informed decision about initiating treatment. This collaborative decision-making process must be documented in the patient medical record.~~

~~Decisions to begin ARV therapy should be based on an assessment of three major factors:~~

- ~~The patient's clinical and immunologic status~~
- ~~The patient's willingness and ability to adhere to the therapy prescribed~~
- ~~The risk of long-term toxicity Consistent with U.S. Public Health Standard guidelines, ARV treatment is recommended for all HIV-infected patients who feel ready, willing, and able to commit to therapy.~~

STANDARD		DOCUMENTATION
	~~ARV therapy~~ART will be prescribed in accordance with DHHS Guidelines for the Use of Antiretroviral Agents in HIV-infected Adults and Adolescents.	Program monitoring to confirm.
	Patients will be part of treatment decision-making process.	Documentation of communication in patient medical chart.

MEDICATION ADHERENCE ASSESSMENT

Medication adherence assessment should be performed for patients if ~~need~~needed. ~~is indicated.~~ An individual service plan (ISP) for treatment adherence may be developed for patients challenged by maintaining treatment adherence.

~~ISPs are tailored to each patient's specific needs identified in the assessment and will include (at minimum):~~

- ~~Short- and long-term projected goals~~
- ~~Suggested interventions~~
- ~~Proposed timelines and outcomes~~
- ~~Patient tasks~~
- ~~Provider tasks~~

ISPs will be developed in collaboration with the patient and, when possible, the patient's primary medical provider to address identified needs. ISPs will be revised at a minimum of every six months.

	STANDARD	DOCUMENTATION
	Medical providers or treatment adherence counselors will provide direct treatment adherence counseling or refreshers to all patients.	Notes in medical file indicating that counseling was provided, by whom and relevant outcomes.
	Medical providers or treatment adherence counselors will develop treatment adherence assessments of patients where need is indicated.	Assessment on file in patient chart signed and dated by medical staff or treatment adherence counselor responsible, indicating, at a minimum, any follow-up intended.
	Medical providers will refer patients with more acute treatment adherence needs to specialized treatment adherence or treatment education programs.	Referral(s) noted in assessment and/or patient chart, as applicable.
	Medical providers or treatment adherence counselors will develop ISPs in collaboration with their patients and medical providers (when possible), as needed, based on specific needs identified in the assessment.	ISP on file in patient chart signed and dated by medical staff or treatment adherence counselor responsible and patient to include (at minimum): • Projected goals • Suggested interventions • Proposed timelines/outcomes • Patient tasks • Provider tasks
	ISPs will be revised on an ongoing basis, but no less than every six months.	Revised ISPs signed and dated by treatment adherence counselors and patient on file in patient chart.

ONE-ON-ONE PATIENT EDUCATION

Medical providers and MCC staff will provide one-on-one patient education to make information about HIV disease and its treatments available, as necessary.

	STANDARD	DOCUMENTATION
	Medical provider or treatment adherence counselors may provide one-on-on patient support contacts to support patients as they seek and receive services. Support can include: • Accompanying patients to medical visits and clinical trials visits and/or providing transportation support • Helping patients understand HIV disease and treatment options • Helping patients with adherence issues • Providing emotional support	Progress notes on file in patient chart to include (at minimum): • Date, time spent, type of contact • What occurred during the contact • Signature and title of the person providing the contact • Referrals provided, and interventions made (as appropriate) • Results of referrals, interventions and progress made toward goals in the individual service plan (as appropriate)

~~**ONE-ON-ONE PATIENT SUPPORT**~~

~~Accompanying patients to medical visits and clinical trials visits when appropriate to assure patients are receiving services:~~

- ~~Helping patients understand HIV disease and treatment options~~
- ~~Helping patients with adherence issues~~
- ~~Providing emotional support~~

	~~STANDARD~~	~~DOCUMENTATION~~
	~~Medical provider or treatment adherence counselors may provide one-on-on patient support contacts to support patients as they seek and receive services. Support can include:~~ ~~• Accompanying patients to medical visits and clinical trials visits~~ ~~• Helping patients understand HIV disease and treatment options~~ ~~• Helping patients with adherence issues~~ ~~• Providing emotional support~~	~~Progress notes on file in patient chart to include (at minimum):~~ ~~• Date, time spent, type of contact~~ ~~• What occurred during the contact~~ ~~• Signature and title of the person providing the contact~~ ~~• Referrals provided, and interventions made (as appropriate)~~ ~~• Results of referrals, interventions and progress made toward goals in the individual service plan (as appropriate)~~

STANDARD HEALTH MAINTENANCE

AOM~~MO~~ practitioners will discuss general preventive health care and health maintenance with all ~~HIV-infected~~ patients routinely, and at a minimum, annually. AOM~~MO~~ programs will strive to provide preventive health services consistent with the most current recommendations of the U.S. Preventive Health Services Task Force ~~(see http://www.ahrq.gov/clinic/prevnew.htm for current guidelines).~~ ~~MO~~ AOM practitioners will work in conjunction with medical care coordination programs and medical nutrition therapy and other Ryan White programs to ensure that a patient's standard health maintenance needs are being met.

~~Standard health maintenance should include the following services and discussions (at minimum):~~

- ~~Cancer screening (cervical, breast, rectal — per American Cancer Society guidelines)~~
- ~~Influenza vaccine~~
- ~~Tetanus/diphtheria update~~
- ~~Pneumovax~~
- ~~Meningococcal vaccine for high-risk men who have sex with men (MSM) and those who request it~~
- ~~Pap screening~~
- ~~Hepatitis screening, vaccination~~
- ~~TB screening~~
- ~~Family planning~~
- ~~Counseling on safer sex and STD screening~~
- ~~Counseling on food and water safety~~
- ~~Counseling on nutrition, exercise, and diet~~
- ~~Harm reduction for alcohol and drug use~~
- ~~Smoking cessation~~

~~In addition, patients should be taught how to perform breast and testicular self-examinations.~~

	STANDARD	DOCUMENTATION
	Practitioners will discuss health maintenance with patients annually (at minimum), including: • ~~Cancer screening (per American Cancer Society guidelines)~~ ~~• Influenza vaccine~~ ~~• Tetanus/diphtheria update~~ ~~• Pneumovax~~ ~~• Meningococcal vaccine for high-risk MSM and those who request it~~ ~~• Pap screening~~ ~~• Hepatitis screening, vaccination~~ ~~• TB screening~~ ~~• Family planning~~ ~~• Counseling on safer sex and STD screening~~ ~~• Counseling on food and water safety~~ ~~• Counseling on nutrition, Exercise, and diet~~ ~~• Harm reduction for alcohol and drug use~~ • ~~• Smoking cessation~~ Cancer screening (cervical, breast, rectal — per American Cancer Society guidelines) • **How to perform breast and testicular self-examinations** • Vaccines • Pap screening	Annual health maintenance discussions will be documented in patient medical chart.

	• Hepatitis screening, vaccination • TB screening • Family planning • Counseling on safer sex and STI screening • Counseling on food and water safety • Counseling on nutrition, exercise, and diet • Harm reduction for alcohol and drug use • Smoking cessation • Mental health and wellness	

COMPLEMENTARY, ALTERNATIVE AND EXPERIMENTAL THERAPIES

AOM~~MO~~ practitioners must be aware if their patients are accessing complementary, alternative, and experimental therapies. Providers are encouraged to discuss at regular intervals complementary and alternative therapies with patients, discussing frankly and accurately both their potential benefits and potential harm. Practitioners may consult the NIH National Center for Complementary and Alternative Medicine (http://nccam.nih.gov) for more information. ~~Patients can be referred to the New Mexico AIDS InfoNet (http:// AIDSinfonet.org) for "patient-friendly" information on complementary and alternative therapies.~~

STANDARD		DOCUMENTATION
	Practitioners must know if their patients are using complementary and alternative therapies and are encouraged to discuss these therapies with their patients regularly.	Record of therapy use and/or discussion on file in patient medical record.

~~**CLINICAL TRIALS**~~

~~MO programs should develop relationships with centers that provide AIDS clinical research. MO practitioners must also discuss patient participation in clinical trial research projects. Patients and practitioners are directed to the AIDS Clinical Trials Information Service which provides current information on federally and privately sponsored clinical trials (http:// aidsinfo.nih.gov/clinical_trials/), as well as the AIDS Clinical Trials Group (www.actis.org), AIDS Clinical Trials Info Hotline (800-874-2572) and the HIV/AIDS Treatment Info Service (www.hivatis.org) for more information.~~

~~STANDARD~~		~~DOCUMENTATION~~
	~~MO programs must develop relationships with centers that provide AIDS clinical research.~~	~~Documentation of linkages on file at provider agency.~~
	~~MO practitioners must provide information about participation in clinical trials to patients.~~	~~Documentation of discussion on file in patient medical chart.~~

PRIMARY HIV NURSING CARE

AOM~~MO~~ programs will provide primary HIV nursing care performed by an RN and/or appropriate licensed health care provider. Services will be coordinated with medical care coordination programs to ensure the seamless, non-duplicative, and most appropriate delivery of service. ~~Primary nursing services will include (but not be limited to):~~

- ~~Nursing assessment, evaluation, and follow-up~~
- ~~Triage as appropriate~~
- ~~Consultation and ongoing communication with primary practitioner~~
- ~~Patient counseling~~
- ~~Patient and family education~~
- ~~Provision of any service which requires substantial specialized nursing skill~~
- ~~Initiation of appropriate preventive nursing procedures~~
- ~~Coordination of other services to assist in the medical management of patient in conjunction with medical care coordination~~

	STANDARD	DOCUMENTATION
	RNs and/or other appropriate licensed health care providers in AOM~~MO~~ programs will provide primary HIV nursing care to include (at minimum): • Nursing assessment, evaluation, and follow-up • Triage • Consultation/communication with primary practitioner • Patient counseling • Patient/family education • Services requiring specialized nursing skill • Preventive nursing procedures • Service coordination in conjunction with medical care coordination	Documentation of primary HIV nursing care service provision on file in patient medical chart.

MEDICAL SPECIALTY SERVICES HIV/AIDS

AOM~~MO~~ service programs are required to provide access to specialty and subspecialty care to fully comply with the DHHS Guidelines.~~Public Health Service (PHS) Guidelines (www.aidsinfo.nih.gov/).~~

Such medical specialties for HIV-related specialty or subspecialty care include (but are not limited to):

- Cardiology
- Dermatology
- Ear, nose, and throat (ENT) specialty
- Gastroenterology
- Gerontology
- Gynecology
- Infusion therapy

- Neurology
- Ophthalmology
- Oncology
- Oral health
- Pulmonary medicine
- Podiatry
- Proctology
- General surgery
- Urology
- Nephrology
- Orthopedics
- Obstetrics
- Transgender care

MEDICAL SPECIALTY REFERRAL

Referrals to medical specialists are made as complications occur that are beyond the scope of practice of primary HIV medical and nursing care. Such complications require referral to specialty and subspecialty physicians for consultation, diagnosis, and therapeutic services. In some cases, the AOM~~MO~~ practitioner may need only to consult verbally with a medical specialist for clarification and confirmation on an approach to HIV clinical management. In other cases, the physician may need to refer a patient to a medical specialist for diagnostic and therapeutic services. Medical specialty services are considered consultative; patients will be referred back to the original AOM~~MO~~ clinic for ongoing primary HIV medical care.

AOM~~MO~~ programs must develop written policies and procedures that facilitate referral to medical specialists. All referrals must be tracked and monitored. The results of the referrals must be documented in the patient's medical record.

~~When referring to medical specialists, medical outpatient practitioners are responsible for:~~

- ~~Assessing a patient's need for specialty care~~
- ~~Providing pertinent background clinical information to medical specialist, including (but not limited to):~~
  - ~~Copy of relevant primary care notes~~
  - ~~Current medications~~
  - ~~Copies of labs or imaging procedures~~
  - ~~Copies of relevant previous consultation reports~~
- ~~Making a referral appointment with the medical specialist~~
- ~~Communicating all referral appointment information~~
- ~~Tracking and monitoring referrals and results~~
- ~~Assuring the patient returns to the MO program of origin for continued HIV/AIDS primary health care services~~

STANDARD	DOCUMENTATION

	AOM~~MO~~ programs must develop policies and procedures for referral to all medical specialists.	Referral policies and procedures on file at provider agency.
	All referrals will be tracked and monitored.	Record of linked referrals and results on file in patient medical record.
	In referrals for medical specialists, medical outpatientspecialty practitioners are responsible for: • Assessing a patient's need for specialty care • Providing pertinent background clinical information to medical specialist • Making a referral appointment • Communicating all referral appointment information • Tracking and monitoring referrals and results • Assuring the patient returns to the AOM~~MO~~ program of origin	Record of referral activities on file in patient medical record.

COORDINATION OF SPECIALTY CARE

It is imperative that AOM~~MO~~ programs and medical specialists coordinate their care to ensure integration of specialty treatment with primary HIV medical care. As noted above, AOM~~MO~~ programs must provide pertinent background clinical information in their referrals to medical specialists. In turn, specialists within the County-contracted system must provide to AOM~~MO~~ programs a written report of their findings within two weeks of seeing a referred patient. Medical specialists within the County-contracted system must telephone AOM~~MO~~ programs within one business day in the event that urgent matters arise, to follow up on unusual findings or to plan a required hospitalization.

STANDARD		DOCUMENTATION
	Specialists within the County-contracted system must provide written reports within two weeks of seeing a referred patient.	Specialty report on file at provider agency
	Specialists within the County-contracted system must telephone MO programs within one business day: • When urgent matters arise • To follow up on unusual findings • To plan required hospitalization	Documentation of communication in patient file at provider agency.

~~**LETTERS OF AGREEMENT (LOAS)**~~

~~To demonstrate collaboration and formal relationship with providers, programs must have written LOAs or contracts with all medical specialists used by MO practitioner for referral. The LOAs must describe the procedure for written and verbal communications between the referring MO practitioner and the consulting medical specialists. Follow-up between specialty providers and MO providers is of critical importance.~~

~~LOAs should outline (at minimum):~~

- ~~Description of services provided by each party~~
- ~~Fees if any~~
- ~~Restrictions on services~~
- ~~Expectations and safeguards regarding client confidentiality~~
- ~~Procedures related to sharing client information~~
- ~~Timeframe for consult results, plan and/or follow-up~~
- ~~Follow-up requirements~~
- ~~Contact person for services issues and referral tracking~~
- ~~Policies and procedures for tracking missed appointments~~
- ~~Specific time frame for agreement~~
- ~~Reporting requirements, documents, and timeframes~~
- ~~Participation in networks, case conferences or other meetings~~
- ~~Participation in monitoring and quality management activities~~

	~~STANDARD~~	~~DOCUMENTATION~~
	~~MO programs will have written LOAs or contracts with all medical specialists utilized.~~	~~LOAs or contracts on file at provider agency that include (at minimum):~~ ~~• Description of services~~ ~~• Fees~~ ~~• Restrictions on services~~ ~~• Confidentiality expectations and safeguards~~ ~~• Procedures for sharing client information~~ ~~• Timeframes~~ ~~• Follow-up requirements~~ ~~• Contact person~~ ~~• Policies and procedures~~ ~~• Reporting requirements~~ ~~• Participation in networks, case conferences or other meetings~~ ~~• Quality management activities~~

NUTRITION SCREENING AND REFERRAL

Nutrition is a component of the Public Health Service standards of care in order to guard against malnutrition and wasting. The physician, NP, PA, RN or RD should screen all patients for nutrition concerns and provide a written prescription for all at-risk patients for medical nutrition therapy within six months of an individual becoming an active patient in the AOM~~MO~~ program.

~~In addition, patients should be referred to a registered dietitian for the following conditions:~~

- ~~Physical changes and weight concerns~~
- ~~Oral/Gastro-Intestinal (GI) symptoms~~
    - ~~Metabolic complications and other medical conditions (diabetes, hyperlipidemia, hypertension, pregnancy, etc.)~~
- ~~Barriers to nutrition, including living environment and functional status~~

- ~~Behavioral concerns or unusual eating behaviors~~

~~Changes in diagnosis requiring nutrition intervention~~

~~A referral to medical nutrition therapy must include:~~

- ~~A written order/referral with the diagnosis and desired nutrition outcome~~
- ~~Signed copy of patient's consent to release medical information, if an external referral results from nutrition-related lab assessments~~

MO programs may provide medical nutrition therapy onsite or may refer patients in need of these services to specialized providers offsite.

All programs providing nutrition therapy (including MO services sites) must adhere to the Commission on HIV's Nutrition Therapy Standard of Care (2005).

	STANDARD	DOCUMENTATION
	~~MO~~ AOM practitioners should screen all patients for nutrition-related concerns for all at-risk patients.	Record of screening for nutrition related problems noted in patient's medical chart.
	AOM ~~MO~~ practitioners will provide a written prescription for all at-risk patients for medical nutrition therapy within six months of an individual becoming an active patient.	Record of screening for nutrition related problems noted in patient's medical chart.
	When indicated, patients will also be referred to nutrition therapy for: • Physical changes/weight concerns • Oral/GI symptoms • Metabolic complications and other medical conditions • Barriers to nutrition • Behavioral concerns or unusual eating behaviors • Changes in diagnosis	Record of linked referral on file in patient medical chart.
	Referral to medical nutrition therapy must include: • Written prescription, diagnosis, and desired nutrition outcome • Signed copy of patient's consent to release medical information • Results from nutrition-related lab assessments	Record of linked referral on file in patient medical chart.

MEDICAL CARE COORDINATION (MCC) SERVICES

In order to best address the complex needs of their patients, ~~MO~~ AOM providers are expected to partner with medical care coordination teams located at their clinics. ~~MCC services are supervised and overseen by a team consisting of a registered nurse and a master's level patient care manager.~~

~~MCC services shall include:~~

- ~~Outreach~~
- ~~Intake~~
- ~~Comprehensive assessment/reassessment~~
- ~~Patient acuity assessment~~
- ~~Comprehensive treatment plan~~
- ~~Implementation and evaluation of comprehensive treatment plan~~
- ~~Referral and coordination of care~~
- ~~Case conferences~~
- ~~Benefits specialty services~~
- ~~HIV prevention, education, and counseling~~
- ~~Patient retention services~~

For additional details, please see the Medical Care Coordination Standard of Care, Los Angeles Commission on HIV, 2024~~08~~.

~~STANDARD~~		~~DOCUMENTATION~~
	~~MO programs will provide medical care coordination services either directly or through cooperative agreement. Services are supervised by an RN and a master's level patient care manager and include:~~ ~~• Outreach~~ ~~• Intake~~ ~~• Comprehensive assessment/reassessment~~ ~~• Patient acuity assessment~~ ~~• Comprehensive treatment plan~~ ~~• Implementation and evaluation of comprehensive treatment plan~~ ~~• Referral and coordination of care~~ ~~• Case conferences~~ ~~• Benefits specialty services~~ ~~• HIV prevention, education, and counseling~~ ~~• Patient retention services~~	~~Documentation of medical care coordination services and/or referral on file in patient medical chart.~~

HIV PREVENTION IN AMBULATORY/OUTPATIENT MEDICAL SETTINGS

HIV prevention is a critical component to ongoing care for people living with HIV. Prevention services provided in ~~MO~~ AOM clinics include HIV counseling, testing and referral; partner counseling; prevention and medical care; and referral for intensive services. For additional details see the Commission on HIV's Prevention Services Standards, 2025. (add hyperlink)

~~PREVENTION AND MEDICAL CARE~~

~~Consistent with the CDC's and the local Prevention Planning Committee (PPC)'s prevention standards, health care practitioners providing MO services are required to incorporate HIV prevention into the routine medical care of all HIV-infected patients. MO practitioners will:~~

- ~~Screen patients for risk behaviors~~
- ~~Communicate prevention messages to patients~~
- ~~Discuss sexual practices and drug use with patients~~
- ~~Positively reinforce changes to safer behavior~~
- ~~Refer patients for substance abuse treatment~~
- ~~Facilitate partner notification, counseling, and testing; provide education and referrals for partners to PrEP and PEP~~
- ~~Identify and treat other sexually transmitted diseases (see "Incorporating HIV Prevention into the Medical Care of Persons Living with HIV," Morbidity and Mortality Weekly Report, July 18, 2003/Vol.52/No. RR-12)~~

~~HIV COUNSELING, TESTING AND REFERRAL FOR PARTNERS AND SOCIAL AFFILIATES~~

~~MO programs must offer HIV counseling, testing, referral and partner counseling to all patients, partners and social affiliates through linkages and referral to HIV/AIDS testing sites (see: http://www.lapublichealth.org/aids/hivtestsites/Sites0503.pdf). Programs providing MO services must accept referrals of HIV-positive individuals from HIV/AIDS testing sites for medical evaluation and clinical care. MO programs are required to use the HIV Information Resources System (HIRS) that integrates HIV testing and counseling with treatment services.~~

~~PARTNER COUNSELING AND REFERRAL SERVICES (PCRS)~~

~~MO programs must offer partner counseling and referral services (PCRS), including partner notification services. At the initial visit, MO practitioners should discuss whether a patient's sex and needle-sharing partners have been informed of their exposure to HIV. During each routine follow-up visit, patients should be asked if there are new sex and/or needlesharing partners who have not been informed of their exposure to HIV. MO practitioners should develop competencies in helping patients notify their partners. State law allows medical providers to disclose potential HIV exposure to HIV-infected persons' partners (see California Health and Safety Code). In these circumstances, the medical provider should disclose the test result and information about HIV transmission with the patient first, attempt to obtain the patient's voluntary consent for notification of his or her contacts, and notify the patient of his or her intent to notify the contacts. Patients who need more intensive risk reduction interventions with partners must be referred to Los Angeles County's Prevention Case Management Program.~~

~~REFERRAL FOR INTENSIVE SERVICES~~

In some cases, the MO practitioner will need to refer a patient to more intensive prevention support services in conjunction with the medical care coordination team. Programs must develop written referral policies, procedures, and protocols to guide the MO practitioner in making successful prevention referrals. This referral process must incorporate the considerations described in "Engaging the Patient in the Referral Process" and "Referral Guides and Information" (pages 13-14), "Incorporating HIV Prevention into the Medical Care of Persons Living with HIV," Morbidity and Mortality Weekly Report, July 18, 2003/ Vol.52/No. RR-12).

	STANDARD	**DOCUMENTATION**
	MO specialty practitioners must: • Screen for risk behaviors • Communicate prevention messages • Discuss sexual practices and drug use • Reinforce safer behavior • Refer for substance abuse treatment • Facilitate partner notification, counseling, and testing • Identify and treat sexually transmitted diseases	Record of screening for nutrition related problems noted in patient's medical chart.
	MO programs must offer HIV counseling, testing, referral to all partners and social affiliates.	Record of services on file in patient medical record.
	Programs will provide PCRS services to all partners.	Record of PCRS services on file in patient medical record.
	As indicated, patients will be referred for intensive prevention services in conjunction with their medical care coordination program.	Record of linked referral on file in patient medical record.
	Programs must accept referrals from testing sites for medical evaluation and clinical care and are required to utilize HIRS.	Program review and monitoring to confirm.
	Programs must develop written prevention referral policies, procedures and protocols.	Prevention referral policies and procedures on file at provider agency.

PATIENT INTAKE

Intake is required for all patients who request or are referred to HIV/AIDS MO services. The intake determines eligibility and includes demographic data, emergency contact information, next of kin and eligibility documentation. The intake process also acquaints the patient with the range of services offered and determines the patient's interest in such services. Patient intake will be completed in the first contact with the potential patient.

As part of the intake process, the client file will include the following information (at minimum):

- Written documentation of HIV status
- Proof of Los Angeles County residency
- Verification of financial eligibility for services

- Date of intake
- Client name, home address, mailing address and telephone number
- Emergency and/or next of kin contact name, home address and telephone number

Required Forms: Programs must develop the following forms in accordance with state and local guidelines.

Completed forms are required for each patient:

- Release of Information (must be updated annually). New forms must be added for those individuals not listed on the existing Release of Information (specification should be made about what type of information can be released).
- Limits of Confidentiality (Confidentiality Policy)
- Consent to Receive Services
- Patient Rights and Responsibilities
- Patient Grievance Procedures

STANDARD		DOCUMENTATION
	Intake process is begun during first contact with patient.	Intake tool, completed and in client file, to include (at minimum): • Documentation of HIV status • Proof of LA County residency • Verification of financial eligibility • Date of intake • Client name, home address, mailing address and telephone number • Emergency and/or next of kin contract name, home address and telephone number
	Confidentiality policy and Release of Information is discussed and completed.	Release of Information signed and dated by patient on file and updated annually.
	Consent for Services completed	Signed and dated Consent in patient file.
	Patient is informed of Rights and Responsibility and Grievance Procedures.	Signed and dated forms in patient file.

REFERRAL

All patients in the clinic should be screened for their need for Medical Care Coordination (MCC) services at least twice a year. Referrals to other health care and social service professionals are made as the patient's health status indicates and/or when the needs of the patient cannot be met by the MO program's established range of services. Medical care coordination team members can assist with referrals for patients enrolled in MCC.

MO programs must develop written policies and procedures that facilitate referral to all health and social service providers in the HIV/AIDS continuum of care. All referrals must be tracked and monitored. The results of the referrals must be documented in the patient's medical record.

~~As indicated, patients will be referred to the following services (at minimum, based on need):~~

- ~~ADAP~~
- ~~Medical care coordination~~
- ~~Medical specialties~~
- ~~Psychiatric and mental health services~~
- ~~STI testing and counseling~~
- ~~Substance abuse services~~
- ~~Partner counseling and referral~~
- ~~Medical nutrition therapy~~
- ~~Oral health assessment and screening~~

~~An annual referral to oral health care is required (see the Commission on HIV's Oral Health Care Standard of Care, 2005)~~

	~~STANDARD~~	~~DOCUMENTATION~~
	~~MO programs must develop policies and procedures for referral to all health and social service providers in the HIV/AIDS continuum of care.~~	~~Referral policies and procedures on file at provider agency.~~
	~~All referrals will be tracked and monitored.~~	~~Record of linked referrals and results on file in patient medical record.~~
	~~As indicated, patients will be referred to (at minimum):~~ ~~• ADAP~~ ~~• Medical care coordination~~ ~~• Medical specialties~~ ~~• Psychiatric/mental health services~~ ~~• Substance abuse services~~ ~~• Partner counseling and referral~~ ~~• Medical nutrition therapy~~ ~~• Oral health assessment and screening~~ ~~Annual referral to oral health care is required.~~	~~Record of linked referrals and results on file in patient medical record.~~

~~PATIENT EDUCATION~~

~~Patient education is the responsibility of all MO practitioners. Patient education is ongoing, and time must be allowed for education during each patient visit. Patients should be fully educated about their medical needs and treatment options within the standards of medical care. MO practitioners will document the patient education encounter and content in the medical record.~~

~~Specifically, treatment adherence assessment should be provided at baseline and counseling should be addressed in every MO visit. If the patient is fully adherent, then counseling should be provided as necessary per the discretion of the practitioner.~~

~~To assure consistency, MO programs must develop written educational protocols in accordance with PHS standards that address (at minimum):~~

- ~~Disease management~~
- ~~HIV prevention~~
- ~~Health maintenance~~
- ~~Other treatment issues~~

	~~STANDARD~~	~~DOCUMENTATION~~
	~~Patient education about medical needs and treatment options should occur at every visit. Notations in chart; initial assessment and progress notations.~~	~~Record of education encounters on file in patient medical record.~~
	~~Treatment adherence assessment should be provided in baseline.~~	~~Notations in chart; initial assessment and progress notations.~~
	~~Patient education about medical needs and treatment options should occur at every visit.~~	~~Record of education encounters on file in patient medical record.~~
	~~Treatment adherence counseling should be provided in every visit unless the patient is fully adherent.~~	~~Treatment adherence assessment should be provided in baseline.~~ ~~Notations in chart; initial assessment and progress notations.~~
	~~MO programs must develop written educational protocols in accordance with PHS standards.~~	~~Education protocols on file at provider agency that address (at minimum):~~ ~~• Disease management~~ ~~• HIV prevention~~ ~~• Health maintenance~~ ~~• Other treatment issues~~

~~PATIENT RECORDS~~

~~Patient records will be organized clearly and consistently by all MO providers. Records should be easily legible and follow a uniform format with a logical flow of information. Patient records will be kept in detail consistent with good medical and professional practice in accordance with the California Code of Regulations. Data should be entered in a timely fashion and be appropriately dated.~~

~~Records will include admission records, patient interviews, progress notes and a record of services provided by various clinical staff.~~

~~All clinical and health services records will be co-located in a "unit record" and include (at minimum):~~

- ~~Documentation of HIV disease or AIDS diagnosis~~
- ~~Complete medical, sexual, and social history~~
- ~~Completed physical examination and assessment signed by a licensed health care professional~~
- ~~Differential diagnosis~~
- ~~Current and appropriate treatment plan~~

- ~~Current problem list~~
- ~~Progress notes documenting patient status, condition and response to interventions, procedures, and medications~~
- ~~Documentation of all contacts with patient, including date, time, services, provided, referrals given and signature and title of person providing services~~

~~Patient unit records will also include the following documentation (at minimum):~~

- ~~Specialty-specific assessment, diagnosis, and treatment plan~~
- ~~Documentation of special tests ordered~~
- ~~Documentation of clinical assessments or diagnoses~~
- ~~Documentation of health education and risk reduction activities~~
- ~~Documentation of referrals and consults~~
- ~~Documentation of patient education (risk reduction, treatment regimens, adherence, nutrition, health maintenance, etc.)~~
- ~~Necessary patient and family contact information and identifiers~~
- ~~Signed Consent to receive treatment and prevention services~~
- ~~Signed Release of Information for each referral made~~
- ~~Legible provider signatures~~
- ~~Easily accessible quantitative viral measures, drug allergies and drug resistances~~
- ~~Evidence of screening for patients at risk for TB, hepatitis, or STDs~~
- ~~Evidence of referral for health care maintenance and immunizations~~
- ~~Evidence of service provider coordination activities~~
- ~~Evidence of assessment for mental health and substance abuse services~~
- ~~Evidence for the need of, referral to, or provision of, medical care coordination (e.g., MCC screen, assessment, and progress notes)~~

~~In addition, patient medical records shall include a notation of health maintenance activities appropriate for the care of people living with HIV including (but not limited to):~~

- ~~Influenza vaccine~~
- ~~Tetanus/diphtheria update~~
- ~~Pneumovax~~
- ~~Meningococcal vaccine for high-risk men who have sex with men (MSM) and those who request it~~
- ~~Pap screening~~
- ~~Hepatitis screening, vaccination~~
- ~~TB screening~~
- ~~Family planning~~
- ~~Counseling on safer sex and STD screening~~
- ~~Counseling on food and water safety~~
- ~~Counseling on nutrition~~
- ~~Harm reduction for alcohol and drug use~~
- ~~Smoking cessation~~

	~~STANDARD~~	~~DOCUMENTATION~~
	~~Patient records will be kept in accordance with the California Code of Regulations.~~	~~Program review and monitoring to confirm.~~
	~~Patient unit records will include:~~ ~~• Documentation of HIV disease or AIDS diagnosis~~ ~~• Medical, sexual, and social history~~ ~~• Physical exam and assessment signed by licensed professional~~ ~~• Differential diagnosis~~ ~~• Current treatment plan~~ ~~• Current problem list~~ ~~• Progress notes~~ ~~• Documentation of all contacts with patient, including date, time, services, provided, referrals given and signature and title of person providing services~~ ~~Additional documentation including:~~ ~~• Specialty-specific assessment, diagnosis and treatment plan~~ ~~• Special tests~~ ~~• Clinical assessments or diagnoses~~ ~~• Health education and risk reduction activities~~ ~~• Referrals and consults~~ ~~• Patient education~~ ~~• Patient and family contact information and identifiers~~ ~~• Signed Consent for treatment and prevention services~~ ~~• Signed releases of information~~ ~~• Provider signatures~~ ~~• Viral measures, drug allergies and drug resistances~~ ~~• TB, hepatitis or STD screening~~ ~~• Coordination activities~~ ~~• Mental health and substance abuse service assessments~~ ~~• Referral to or provision of medical care coordination~~ ~~• Health care maintenance to include:~~ ~~• Influenza vaccine~~ ~~• Tetanus/diphtheria update~~ ~~• Pneumovax~~	~~Program review of patient unit records to confirm.~~

	• Meningococcal vaccine for high-risk MSM and those who request it • Pap screening • Hepatitis screening, vaccination • TB screening • Family planning • Counseling on safer sex and STD screening • Counseling on food and water safety • Counseling on nutrition • Harm reduction for alcohol and drug use	

PATIENT RETENTION IN CARE

Programs will strive to retain patients in MO services. To ensure continuity of service and retention of patients, programs will be required to establish a broken appointment policy. Follow-up can include telephone calls, written correspondence and/or direct contact, and strives to maintain a patient's participation in care. Such efforts shall be documented in the progress notes within the patient record. If a pattern of broken or failed appointments persists, patients must be referred to specialized adherence services and/or medical care coordination for support.

Medical Care Coordination staff should be involved in the identification and follow-up of patients who have fallen out of regular medical care.

STANDARD		DOCUMENTATION
	Programs will develop a broken appointment policy to ensure continuity of service and retention of patients.	Written policy on file at provider agency.
	Programs shall provide regular follow-up procedures to encourage and help maintain a patient in MO services.	Documentation of attempts to contact in signed, dated progress notes. Follow-up may include: • Telephone calls • Written correspondence • Direct contact
	If broken or failed appointments persist, patients must be referred to specialized adherence services and/or medical care coordination.	Documentation of referral in patient record.

CASE CLOSURE

Case closure is a systematic process for disenrolling patients from medical outpatientspecialty services. The process includes formally notifying patients of pending case closure and completing a case closure summary to be kept on file in the patient record. All attempts to contact the patient and notifications about case closure will be documented in the patient file, along with the reason for case closure.
Cases may be closed when the patient:

- Relocates out of the service area
- Has had no direct program contact in the past six months

- ~~Is ineligible for the service~~
- ~~No longer needs the service~~
- ~~Discontinues the service~~
- ~~Changes his or her primary care provider~~
- ~~Is incarcerated long term~~
- ~~Uses the service improperly or has not complied with the client services agreement~~
- ~~Has died~~

	~~STANDARD~~	~~DOCUMENTATION~~
	~~MO 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:~~ ~~• Relocates out of the service area~~ ~~• Has had no direct program contact in the past six months~~ ~~• Is ineligible for the service~~ ~~• No longer needs the service~~ ~~• Discontinues the service~~ ~~• Changes his or her primary care provider~~ ~~• Is incarcerated long term~~ ~~• Uses the service improperly or has not complied with the client services agreement~~ ~~• Has died~~
	~~Programs will attempt to notify patients about case closure.~~	~~Patient chart will include attempts at notification and reason for case closure.~~

~~STAFFING REQUIREMENTS AND QUALIFICATIONS~~

~~At minimum, all MO services staff will be able to provide linguistically and culturally ageappropriate care to people living with HIV and complete documentation as required by their positions. Staff will complete an agency-based orientation before providing services. All new staff must receive HIV/AIDS education within the first three months of employment. Staff will also be trained and oriented regarding patient confidentiality and HIPAA regulations. In addition, staff will be provided with ongoing, consistent supervision that addresses clinical, administrative, psychosocial, developmental, and programmatic issues on a monthly basis.~~

~~Programs will develop personnel policies and procedures that require and support the continuing education of all HIV/AIDS health care professionals. Programs are expected to budget costs for HIV/AIDS continuing education specifically in HIV prevention and disease management, to purchase practice guidelines in formats easily accessible and usable for practitioners, and to provide practitioners routine access to computerized educational and prevention/care treatment problem solving (e.g., The Body at www.thebodypro.com; HIV InSite at www.hivinsite.ucsf.edu; Johns Hopkins AIDS Service at www.hopkins-aids.edu; or, Medline Plus – AIDS at www.nlm.nih.gov/medlineplus/aids.html).~~

~~Programs will develop consultation protocols to assist MO health care professionals seeking expert advice and consultation whenever needed. Seeking expert advice and using the many local or regional university-based consultation services is evidence of competent prevention and disease management.~~

~~All MO providers are expected to practice in accordance with applicable state and federal regulations, statutes, and laws. MO practitioners must comply with codes of ethics and with any special HIV/AIDS policies from their respective national professional associations.~~

~~HIV MO services will be provided by a multidisciplinary team consisting of a primary care provider at the level of a state of California licensed physician, NP, and/or PA and an RN. The expanded team will include a medical care coordination staff, registered dietitian, health educator, treatment educator/advocate, and other ancillary support service providers for formal coordination of these services.~~

	~~STANDARD~~	~~DOCUMENTATION~~
	~~MO staff will be able to provide linguistically, and culturally age-appropriate care and complete documentation as required by their positions.~~	~~Resumes and record of training in employee file to verify.~~
	~~Staff will receive an agency orientation, HIV training within three months of employment and oriented and trained in confidentiality and HIPAA compliance.~~	~~Record of orientation and training in employee file.~~
	~~Staff will receive consistent supervision in clinical, administrative, psychosocial, developmental, and programmatic issues on a monthly basis.~~	~~Supervision record on file at provider agency.~~
	~~Programs will budget costs for HIV/AIDS continuing education.~~	~~Budget review to confirm.~~
	~~Programs will develop consultation protocols.~~	~~Consultation protocols on file at provider agency.~~
	~~MO providers are expected to practice in accordance with state and federal regulations, statutes, and laws, as well as codes of ethics and with any special HIV/ AIDS policies from their respective national professional associations.~~	~~Program review and monitoring to confirm.~~

~~HEALTH CARE PROFESSIONALS~~

~~The following categories of health care professionals are approved to provide medical services in MO care programs:~~

- ~~Physician (MD or DO) who is an HIV/AIDS specialist~~
- ~~NP who is an HIV/AIDS specialist~~
- ~~PA who is an HIV/AIDS specialist~~

RNs and licensed vocational nurses (LVNs) may provide primary HIV nursing care services and medical care coordination.

STAFF QUALIFICATIONS

Agencies requesting funding to provide MO services must employ, contract, or refer to professionals with the following qualifications:

- **Physician HIV Specialist:** A physician (MD or DO) providing MO services must hold a valid license to practice medicine in the state of California (Medical Board of California or California Board of Osteopathic Examiners) and must either be credentialed as an HIV/AIDS Specialist by the American Academy of HIV Medicine, or must meet the following criteria:
  - In the immediately preceding 24 months, has provided continuous and direct medical care consistent with current Public Health Service Guidelines with peer review and supervision to a minimum of 20 patients who are infected with HIV, **and**
  - Has completed any one of the following:
    - In the immediately preceding 12 months has obtained board certification or recertification in the field of infectious diseases
    - In the immediately preceding 12 months has successfully completed a minimum of 30 hours of "Category 1 Continuing Medical Education" in the prevention, diagnosis, and treatment of HIV-infected patients
  - In the immediately preceding 12 months has successfully completed a minimum of 15 hours of "Category 1 Continuing Medical Education" in the prevention, diagnosis, and treatment of HIV-infected patients and successfully completed the "HIV Medicine Competency Maintenance Examination" administered by the American Academy of HIV Medicine (www.aahivm.org)
  - Has a credible plan to complete HIV/AIDS specialist criteria within one year
  - Is in a fellowship or other training program under the supervision of a physician who meets these criteria

- **NP HIV/AIDS Specialist:** An NP providing MO services must have the following qualifications:
  - Licensure as an RN
  - An NP certificate or master's degree from a school accredited by the California Board of Registered Nursing
  - A credential as an HIV/AIDS specialist by the American Academy of HIV Medicine (www.aahivm.org) or have a credible plan to complete HIV/AIDS specialist criteria within one year.

To prescribe medicine, the NP must complete a pharmacology course and work six months under a physician's supervision and hold a DEA license.

The NP works under the supervision of an HIV/AIDS specialist physician. Physician supervision must include regular chart review, as well as oversight of scheduled direct patient care. Programs will develop, implement, and maintain standardized procedures for all medical functions to be performed by the NP

~~using the Guidelines for Developing Standardized Procedures produced by the California Board of Registered Nursing and the Medical Board of California. The NP must work within the scope of practice defined by Section 2834 Nurse Practitioner, California Code of Regulations 1435, 1470, and 1480 (www.rn.ca.gov/policies/pdf/ npr-b-23.pdf).~~

- ~~**PA HIV/AIDS Specialist:** A PA providing MO services must have graduated from a medical training program approved by the California Physician Assistant Committee and must have passed the Physician Assistant National Certifying Examination (PANCE) offered by the National Commission on Certification of Physician Assistants (NCCPA). PAs must be licensed by the Physician Assistant Committee, Department of Consumer Affairs' Medical Board of California, and must be credentialed as an HIV/AIDS specialist by the American Academy of HIV Medicine (www.aahivm.org) or have a credible plan to complete HIV/AIDS specialist criteria within one year. The PA works under the direct supervision of an HIV/AIDS specialist physician. Physician supervision must include regular chart review, as well as oversight of scheduled direct patient care. (For regulations specifying physician accountabilities, supervision requirements and a description of a PA's scope of practice, see: www.physicianassistant.ca.gov.) The state-required Delegation of Services Agreement between the supervising physician and PA must specify HIV/AIDS medical services delegated to the PA and must be available for review (www.physicianassistant.ca.gov/delegation.pdf). PAs authorized by supervising physicians to issue written "drug orders" for medication and medical devices must do so in compliance with the amended (January 1, 2000) Physician Assistant Practice Act (BPC, Section 3502.1).~~
- ~~**Medical Specialists:** MO programs are responsible for recruiting medical specialists who have demonstrated experience in HIV/AIDS specialty/subspecialty care. Ideally, medical specialists will already be providing care for people living with HIV in their current practices and have the requisite training and certification in his or her respective medical specialty or subspecialty. Medical specialists must maintain their licenses by fulfilling the continuing education requirements established by their respective professional state and national boards. Additionally, medical specialists must be board-certified or board-eligible in their specialty. MO programs are encouraged to pass along educational opportunities and materials to their contracted specialists to improve their HIV knowledge and expertise. All medical specialists are expected to practice in accordance with applicable state and federal regulations, statutes, and laws. Medical specialists must comply with codes of ethics and with any special HIV/AIDS policies from their respective national professional associations.~~
- ~~**RN:** An RN providing MO services must hold a license in good standing from the California State Board of Registered Nurses, be a graduate from an accredited nursing program with a Bachelor of Science in Nursing (BSN) or two-year nursing associate's degree. Prior to employment, a BSN must have experience providing direct care to HIV-infected individuals, and an RN with an associate degree must have practiced one year in an HIV/AIDS clinic setting providing direct care to HIV-positive patients (see: Association of Nurses in AIDS Care www.anacnet.org). The RN must practice within the scope of practice defined in the California Business & Professional Code, Section 2725 RN Scope of Practice (www.rn.ca.gov).~~

~~STANDARD~~	~~DOCUMENTATION~~

	~~Physicians (MD or DO) providing MO services hold state of California license (Medical Board of California or California Board of Osteopathic Examiners) and be credentialed as an HIV/AIDS specialist, have a credible plan to complete HIV/AIDS specialist criteria within one year or meet strict experience criteria.~~	~~Resumes and verification of specialist or experience criteria on file at provider agency.~~
	~~NP HIV/AIDS specialists practitioners providing MO services must hold:~~ ~~• Licensure as an RN~~ ~~• NP certificate or master's degree from an accredited school~~ ~~• Credential as an HIV/AIDS specialist or credible plan to complete credential in one year~~	~~Resumes and verification of specialist and experience criteria on file at provider agency~~
	~~NPs prescribing medications must hold a DEA license.~~	~~Practitioner furnishing certificates on file at provider agency.~~
	~~NPs must be supervised by an HIV/AIDS specialist physician, including chart review and oversight of scheduled direct patient care. Programs will develop standardized procedures for medical functions performed by the NP.~~	~~Record of physician supervision on file at provider agency. NP standardized procedures on file at provider agency.~~
	~~NPs must work within the scope of practice defined by Section 2834 Nurse Practitioner, California Code of Regulations 1435, 1470, and 1480.~~	~~Program review and monitoring to confirm.~~
	~~PAs providing MO services must have:~~ ~~• Graduated from an approved medical training program~~ ~~• Passed the Physician Assistant National Certifying Examination (PANCE)~~ ~~• A license from the Physician Assistant Committee~~ ~~• A credential as an HIV/AIDS specialist, or have a credible plan to complete credential in one year~~	~~Resumes and verification of specialist and experience criteria on file at provider agency~~
	~~PAs must be supervised by an HIV/AIDS specialist physician, including chart review and oversight of scheduled direct patient care.~~	~~Record of physician supervision on file at provider agency.~~
	~~PAs issuing drug orders must do so in compliance with the amended (January 1, 2000) Physician Assistant Practice Act (BPC, Section 3502.1).~~	~~Program review and monitoring to confirm.~~

	~~It is preferred that medical specialists will have demonstrated experience in HIV specialty care, including providing care to people living with HIV in current practice.~~	~~Documentation of experience on file at provider agency.~~
	~~Medical specialists must maintain licenses and requirements established by their respective professional state and national boards and will be board-certified or board-eligible in their specialty.~~	~~Specialists licenses and board status documentation on file at provider agency.~~
	~~Medical specialists are expected to practice in accordance with state and federal regulations, statutes, and laws, as well as codes of ethics and with any special HIV/AIDS policies from their respective national professional associations.~~	~~Program review and monitoring to confirm.~~
	~~RNs providing MO services must:~~ ~~• Hold a license in good standing from the California State Board of Registered Nurses~~ ~~• Be a graduate from an accredited nursing program with a BSN or two-year nursing associate degree~~ ~~• Have experience providing direct HIV care (BSNs)~~ ~~• Have practiced one year in an HIV/AIDS clinic setting providing direct care to HIV-positive patients (associate degrees)~~ ~~• Practice within the scope defined in the California Business & Professional Code, Section 2725~~	~~Resumes on file at provider agency to verify experience. Program review and monitoring to confirm.~~

~~EDUCATION AND LICENSING~~

~~Staff employed to provide MO services must maintain licenses by fulfilling the financial and continuing education requirements established by their respective professional state and national boards. MO practitioners must complete one accredited continuing educational course addressing HIV/AIDS treatment adherence (for free local CEU sites see the AIDS Education and Training Center at www.aids-ed.org), one accredited course addressing HIV/AIDS clinical care management (for free local CEU sites see the AIDS Education and Training Center at www.aids-ed.org), and one accredited course in HIV/AIDS prevention, education and risk reduction (for free local CEU sites see the National Network of STD/HIV Prevention Training Centers at http://depts.washington.edu/nnptc) designed specifically for practitioners in MO settings. These requirements must be met annually for continued employment in the MO care program.~~

~~In selecting other continuing education courses to fulfill licensing requirements, MO practitioners are encouraged to select a majority of courses related to their respective scopes of practice and courses related to services within the HIV/AIDS continuum's primary health care core.~~

	STANDARD	DOCUMENTATION
	MO staff must maintain licenses by completing continuing education requirements of their respective professional boards.	Record of continuing education in employee files at provider agency.
	MO practitioners must complete annually: • One accredited HIV/AIDS treatment adherence course • One accredited HIV/AIDS clinical care management course • One accredited HIV/AIDS prevention, education, and risk reduction course	Record of continuing education in employee files at provider agency.

CERTIFICATIONS

MO practitioners requiring certification as an HIV/AIDS specialist must maintain this certification every two years as required by the regulations set by the American Academy of HIV Medicine.

Certification requirements include:

- Maintain current, valid MD, DO, PA or NP state license
- Provide direct, continuous care for at least 20 HIV patients over the past two years
- Complete at least 30 hours of HIV-related CME Category 1 credits over the past two years
- Successfully complete the HIV Medicine Credentialing Examination at time of application

The MO practitioners will comply with all additional certifications for health care staff required by the agency of employment and by their respective professional state boards. RNs are encouraged to pursue registered designation as an "AIDS Certified Registered Nurse" offered by the Association of Nurses in AIDS Care and the HIV/AIDS Nursing Certification Board (see: www.anacnet.org).

	STANDARD	DOCUMENTATION
	MO HIV/AIDS specialists must maintain certification every two years.	Record of certification in employee file at provider agency.
	Other MO practitioners will comply with necessary certifications required by professional boards, etc.	Record of certification in employee file at provider agency.

STAFFING RATIOS SERVICES

Physicians should maintain a doctor-to-patient ratio of not more than 1:1,500 if they do not supervise any NP or PA staff. Due to the amount of time the physician must devote to supervision, for clinics with NPs and PAs, the doctor-to-patient ratio declines for every additional supervision responsibility: it should not exceed 1:1,200 when a physician supervises one NP or PA staff person, 1:900 when supervising two NP and/or PA staff people, 1:600 when supervising three NP and/or PA staff people, and 1:300 when supervising four NP or PA staff people.

For each NP or PA, the ratio of medical professional-to-patients does not exceed 1:1,500.

	STANDARD	DOCUMENTATION
	Doctor-to-patient staffing ratios for physicians should be: • 1:1,500 with no supervisees • 1:1,200 with one NP/PA supervisee • 1:900 with two NP/PA supervisees • 1:600 with three NP/PA supervisees • 1:300 with four NP/PA supervisees	Program review and monitoring to confirm.
	NP- or PA-to-patient ratio should not exceed 1:1,500.	Program review and monitoring to confirm.

ADDITIONAL OUTPATIENT STAFF—MEDICAL CARE COORDINATION

MEDICAL CARE MANAGERS

Medical care managers will be RNs in good standing and licensed by the California Board of Registered Nursing. An RN providing care coordination services must be a graduate of an accredited nursing program with a Bachelor of Science in Nursing (BSN) or two-year nursing associate's degree. The RN must practice within the scope of practice defined in the California Business & Professional Code, Section 2725 RN Scope of Practice (www.rn.ca. gov).

Medical care managers will practice in accordance with applicable state and federal regulations. Care managers will uphold the Code of Ethics for Nurses with Interpretive Statements (2001: ANA Board of Directors and Congress of Nursing Practice and Economics). Additionally, medical care managers will comply with special codes of ethics or HIV/AIDS policies from their national professional associations (see www.nursingworld. org for ANA Position Statements and www.anacnet.org for Policy Position Statements and Resolutions.)

PATIENT CARE MANAGERS

Patient care managers providing medical care coordination services will hold a Master of Social Work (MSW) degree or related master's degree (e.g., psychology, human services, counseling) from an accredited program. Patient care managers workers will practice in accordance with applicable state and federal regulations, uphold the Social Work Code of Ethics (http://www.naswdc.org/pubs/code/default.asp) and comply with the staff development and education requirements noted below.

CASE WORKERS

Case workers will hold one of the following (at minimum):

- A bachelor's degree in an area of human services
- A high school diploma (or GED equivalent) and at least one year's experience providing direct patient care in a related health services field

Case workers with medical specialty will be an LVN or certified medical assistant with at least one year's experience working in HIV care or have an LVN license and at least three years' experience providing direct patient care within a related health services field.

	~~STANDARD~~	~~DOCUMENTATION~~
	~~RNs providing medical care coordination services must:~~ ~~• Hold a license in good standing from the California State Board of Registered Nursing~~ ~~• Be a graduate from an accredited nursing program with a BSN or two-year nursing associate's degree~~ ~~• Practice within the scope defined in the California Business & Professional Code, Section 2725~~	~~Resumes on file at provider agency to verify experience. Program review and monitoring to confirm.~~
	~~Patient care managers providing medical care coordination services will:~~ ~~• Hold an MSW degree or related degree (psychology, human services, counseling)~~ ~~• Practice in accordance with applicable state and federal regulations, uphold the Social Work Code of Ethics (http://www.naswdc.org/pubs/code/default.asp)~~ ~~• Comply with the staff development and education requirements noted below~~	~~Resumes on file at provider agency to verify experience. Program review and monitoring to confirm.~~
	~~Case workers will hold a bachelor's degree in an area of human services; a high school diploma or GED; and at least one year's experience providing direct patient care in a related health services field.~~	~~Resumes on file at provider agency to verify experience. Program review and monitoring to confirm.~~
	~~Medical specialty case workers will be an LVN or certified medical assistant with at least one year's HIV experience or have an LVN license and at least three years' experience within a related health services field.~~	~~Resumes on file at provider agency to verify experience. Program review and monitoring to confirm.~~

~~MEDICAL NUTRITION THERAPY (OPTIONAL)~~

~~REGISTERED DIETITIAN~~

~~In addition to registration requirements, registered dietitians working in agencies or clinics that provide medical nutrition therapy will have the following:~~

- ~~Broad knowledge of principles and practices of nutrition and dietetics~~
- ~~Advanced knowledge in the nutrition assessment, counseling, evaluation, and care plans of people living with HIV~~

- ~~Advanced knowledge of current scientific information regarding nutrition assessment and therapy and the ability to distill and communicate this information to clients and other service providers~~

~~Registered dietitians will practice according to the code of ethics of the American Dietetic Association (found online at http://www.eatright.org/Public/index_8915.cfm).~~

~~Among the principles included in this code of ethics, a registered dietitian will:~~

- ~~Practice dietetics based on scientific principles and current information~~
- ~~Present substantiated information and interpret controversial information without personal bias; recognizing that legitimate differences of opinion exist~~
- ~~Provide sufficient information to enable clients and others to make their own informed decisions~~
- ~~Protect confidential information and make full disclosure about any limitations on his/ her ability to guarantee full confidentiality~~
- ~~Provide professional services with objectivity and with respect for the unique needs and values of individuals~~

~~Registered dietitians will participate in Dietitians in AIDS Care, maintain membership in SERVICES the HIV/AIDS Dietetic Practice Group of the American Dietitian Association and complete current professional education (CPE) units/hours, primarily in HIV nutrition and other related medical topics as administered by the Commission on Dietetic Registration.~~

	~~STANDARD~~	~~DOCUMENTATION~~
	~~At minimum, all medical nutrition therapy staff will be able to provide appropriate care to people living with HIV, complete documentation as required by their positions and maintain appropriate licensure if applicable.~~	~~Staff resumes and qualifications on file at provider agencies.~~
	~~Registered dietitians will have the following (at minimum):~~ ~~• Broad knowledge of principles and practices of nutrition and dietetics~~ ~~• Advanced knowledge in the nutrition assessment, counseling, evaluation, and care plans of people living with HIV~~ ~~• Advanced knowledge of current scientific information regarding nutrition assessment and therapy~~	~~Staff resumes, qualifications and records of training on file at provider agencies.~~
	~~Registered dietitians will practice according to their code of ethics.~~	~~Performance review to confirm.~~
	~~Registered dietitians will maintain membership in the HIV/AIDS Dietetic Practice Group.~~	~~Record of membership in employee file.~~

	~~Registered dietitians will maintain current professional education (CPE) units/hours, primarily in HIV nutrition and other related medical topics as administered by the Commission on Dietetic Registration.~~	~~Training record in employee file.~~

~~MEDICAL OUTPATIENT-SPECIFIC PROGRAM REQUIREMENTS~~

~~TB SCREENING~~

~~All MO care program staff, other program employees, volunteers, and consultants who have routine, direct contact with clients living with HIV must be screened annually for tuberculosis. Programs are directed to the TB Control Program at 2615 S. Grand Avenue in Los Angeles 90007 (Phone 213-744-6151) for more information~~

~~STANDARD~~		~~DOCUMENTATION~~
	~~All MO staff, volunteers and consultants with routine, direct patient contact must be screened for TB.~~	~~Record of TB screening for staff, volunteers, and consultants on file at provider agency~~

~~OCCUPATIONAL POSTEXPOSURE PROPHYLAXIS (PEP)~~

~~MO programs must develop policies and procedures to address the risks for occupational HIV and hepatitis exposure. Programs should aggressively promote and monitor risk reduction behaviors and actively support MO primary care professionals in PEP. Reports for occupationally acquired HIV should be made to Division of Healthcare Quality Promotion at 800-893-0485. Programs and practitioners are directed to the National Clinician's PEP Hotline at 800-448-4911 or www.ucsf.edu/hivcntr; and the Hepatitis Hotline: 888-443-7232 or www.cdc.gov/hepatitis for more information.~~

~~STANDARD~~		~~DOCUMENTATION~~
	~~MO programs must develop policies and procedures concerning HIV and hepatitis exposure.~~	~~Exposure policies and procedures on file at provider agency.~~
	~~Reports of occupational HIV exposure must be made to Division of Healthcare Quality Promotion.~~	~~Record of reports on file at provider agency.~~

~~STATE-MANDATED HIV REPORTING~~

~~Consistent with the State Health and Safety Code (Section 2643.5), all MO practitioners are mandated to report laboratory test results that indicate HIV, a component of HIV, or antibodies to or antigens of HIV. Within seven calendar days of receipt of a confirmed HIV test and partial non-name code from a laboratory, MO practitioners must complete an HIV/ AIDS Case Report Form using the non-name code (as specified in Section 2641.75) and report the HIV case to the County HIV Epidemiology Program, unless previously reported by the practitioner.~~

~~STANDARD~~	~~DOCUMENTATION~~

	~~MO practitioners will report positive HIV test results to LA County Epidemiology Program.~~	~~Copies of HIV/AIDS Case Report form using non-name code on file at provider agency.~~

~~PATIENT/STAFF/COLLEAGUE COMMUNICATION~~

~~Agencies must develop written policies and procedures to address communication between MO staff, patients, and other professionals to include a protocol for colleagues, social service professionals, patients, partners, family members or other supportive persons to contact staff for emergencies, holidays, and weekends.~~

	~~STANDARD~~	**~~DOCUMENTATION~~**
	~~MO programs must develop policies and procedures to address communication between staff, patients, family members and other professionals, including emergency contact provisions.~~	~~Communication policies and procedures on file at provider agency.~~

~~TRANSLATION/LANGUAGE INTERPRETERS~~

~~Federal and state language access laws (Title VI of the Civil Rights Act of 1964 and California's 1973 Dymally-Alatorre Bilingual Services Act) require health care facilities that receive federal or state funding to provide competent interpretation services to limited English proficiency (LEP) patients at no cost, to ensure equal and meaningful access to health care services. MO programs must develop procedures for the provision of such services, including the hiring of staff able to provide services in the native language of LEP patients.~~

	~~STANDARD~~	**~~DOCUMENTATION~~**
	~~MO programs must develop policies and procedures to address the provision of competent interpretation services to LEP patients at no cost.~~	~~Interpretation policies and procedures on file at provider agency.~~

~~POLICY AND PROCEDURE MANUAL~~

- ~~All MO programs will develop and maintain a written policy and procedure manual which will include mandatory policies, procedures, protocols, and standards of care related to the following (at minimum): Coordination of care with other providers, including specialty care, case management, mental health, treatment education, inpatient care, etc.~~
- ~~Patient hospitalization arrangements~~
- ~~Home health care for patients whose health status warrants, including mechanisms for coordination of care between primary caregivers, inpatient providers, and home care providers~~
- ~~Referral processes to support services as needed~~

	~~STANDARD~~	**~~DOCUMENTATION~~**
	~~MO programs must develop policies and procedures manual to address mandatory policies, procedures, protocols, and standards~~	~~Policies and procedures manual on file at provider agency that addresses (at minimum):~~

		• Coordination of care • Patient hospitalization • Home health care • Referrals to support services

DEFINITIONS AND DESCRIPTIONS

Clinical trials are research studies focus on HIV pathology, treatment and management of complications and co-infections.

Counseling is a discussion with a patient/patient and/or family member about diagnostic results and impressions; prognosis; risks and benefits of treatment; instructions for treatment management and follow-up; treatment adherence; risk factor reduction and general education.

Dietitians must be registered dietitians and are experts in food and nutrition, promoting good health through proper eating. They supervise the preparation and service of food, develop modified diets, and educate individuals and groups on good nutrition habits and self-management skills.

Drug resistance testing measures the pattern of resistance of HIV to antiretroviral medications. Genotypic testing looks for viral mutations and phenotypic testing measures the amount of drug needed to suppress replication of HIV.

HIV counseling and testing services provide testing for the presence of antibodies to HIV, counseling before and after taking the test, referrals to other services as needed by the patient and the provision of appropriate interventions based on the HIV/AIDS risks assessed.

Immune deficiency caused by HIV is a spectrum of disease ranging from asymptomatic HIV disease to AIDS as defined by the Federal Centers for Disease Control and Prevention (CDC).

Licensed, primary health care professional is defined as a physician, physician assistant and/or nurse practitioner providing primary HIV medical care. Such person will be licensed to practice by the state of California.

Linked referrals assist patients in accessing services including making an appointment for the indicated service.

Medical care coordination integrates the efforts of medical and social service providers by developing and implementing a therapeutic plan.

Medical nutrition therapy is provision of specific nutrition counseling and interventions to help treat HIV disease, including screening, referral, assessment, intervention, and communication. Medical nutrition therapy involves both assessment and appropriate treatments to maintain and optimize nutrition status.

Medical specialty services provide consultation, diagnosis, and therapeutic services for medical complications beyond the scope of practice of primary medical and nursing care for people living with HIV.

Medication adherence counseling is one-on-one counseling to maintain or improve the patient's adherence to the HIV prescribed regimen and case plan and can be provided by professional medical staff or medical care coordination team member.

MO services are up-to-date educational, preventive, diagnostic and therapeutic medical services provided by licensed health care professionals with requisite training in HIV/AIDS.

MO visits are defined as face-to-face encounters between licensed primary health care professionals (physician, registered nurse (RN), nurse practitioner (NP), or (PA)) and patients involving evaluation, diagnosis, and treatment.

~~Procedures (e.g., drawing blood, collecting specimens, performing laboratory tests, taking X-rays, filling, or dispensing prescriptions) without a face-to-face patient/practitioner encounter do not constitute a separate MO visit.~~

~~**New patient** is defined as an individual who is receiving MO services for the first time through a specific program or facility. A patient is only considered new once in any facility.~~

~~**Nutrition screening and referral** is a medical provider's initial assessment of a patient's nutritional needs, and subsequent action (referral for medical nutrition therapy) as needed.~~

~~**Patient education contact** is defined as a one-on-one encounter between the patient and treatment advocate involving educational activities that are consistent with the patient's individual service plan (ISP).~~

~~**Patient support encounter** involves activities consistent with the ISP, but which are supportive, not primarily educational, in nature.~~

~~**Sexually active** at increased risk individuals have been engaged in sexual activity without protection within the last 12 months; are sexually active with multiple sexual partners; are using drugs (particularly IDU/meth), and/or have had STDs within the last 12 months (Centers for Disease Control and Prevention definition).~~

~~**Treatment adherence** is defined as a patient's ability and level of success in following an HIV prescribed regimen.~~

~~**Treatment education** is the service designed to address patients' adherence to their treatment regimen and to educate them about their medications and treatment plan. Treatment education should be provided as part of the MO visit, and can be provided as a separate, supplementary service (see Treatment Education Standard of Care, Los Angeles County Commission on HIV, 2008).~~

REFERENCES --PENDING--