LOS ANGELES COUNTY
COMMISSION ON HIV

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STANDARDS AND BEST PRACTICES COMMITTEE MEETING

TUESDAY, MAY 6, 2025
10:00 AM -- 12:00 PM (PST)

510 S. Vermont Avenue, 14th Floor, LA 90020
Validated Parking @ 523 Shatto Place, LA 90020

All attendees must check-in with security personnel on the 9th floor lobby and wait for Commission staff members to escort to the 14th floor.

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

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https://lacountyboardofsupervisors.webex.com/weblink/register/r9541e1372fcad78b088c40f5d67d1498

Notice of Teleconferencing Sites

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

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

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

Accommodations

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

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

together.

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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 6, 2025 | 10:00AM – 12:00PM

510 S. Vermont Ave
Vermont Corridor 14th Floor Conference Room
Los Angeles, CA 90020
Validated Parking: 523 Shatto Place, Los Angeles, CA 90020

For those attending in person, as a building security protocol, attendees entering the first-floor lobby must notify security personnel that they are attending the Commission on HIV meeting. Additionally, all attendees must check-in with security personnel on the 9th Floor lobby and wait for a Commission staff members to escort them to the 14th floor.

MEMBERS OF THE PUBLIC WHO WISH TO JOIN VIRTUALLY, REGISTER HERE:
https://lacountyboardofsupervisors.webex.com/weblink/register/r9541e1372fcad78b088c40f5d67d1498
To Join by Telephone: 1-213-306-3065
Password: STANDARDS Access Code: 2534 624 6866

Standards and Best Practices Committee (SBP) Members:			
Erika Davies *Co-Chair*	Arlene Frames *Co-Chair (LOA)*	Dahlia Ale-Ferlito	Mikhaela Cielo, MD
Sandra Cuevas	Caitlin Dolan (Committee-only)	Kerry Ferguson (Alternate)	Lauren Gersh, LCSW *(Committee-only)*
David Hardy, MD *(Alternate)*	Mark Mintline, DDS *(Committee-only)*	Andre Molette	Byron Patel, RN
Sabel Samone-Loreca *(Alternate to Arlene Frames)*	Martin Sattah, MD	Kevin Stalter	Russell Ybarra
QUORUM: 9			

AGENDA POSTED: April 29, 2025.

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

PUBLIC COMMENT: Public Comment is an opportunity for members of the public to comment on an agenda item, or any item of interest to the public, before or during the Commission's consideration of the item, that is within the subject matter jurisdiction of the Commission. To submit Public Comment, you

may join the virtual meeting via your smart device and post your Public Comment in the Chat box -or- email your Public Comment to hivcomm@lachiv.org -or- submit your Public Comment electronically here. All Public Comments will be made part of the official record.

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

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

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

I. ADMINISTRATIVE MATTERS

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

II. PUBLIC COMMENT

10:10 AM – 10:15 AM

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

III. COMMITTEE NEW BUSINESS ITEMS

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

IV. REPORTS

7. Executive Director/Staff Report — 10:15 AM – 10:25 AM
   a. Operational and Commission—Updates
8. Co-Chair Report — 10:25 AM – 10:35 AM
   a. 2025 Committee Meeting Calendar—Updates
   b. Service Standards Revision Tracker—Updates
9. Division on HIV and STD Programs (DHSP) Report — 10:35 AM—10:40 AM

V. DISCUSSION ITEMS

10. Transitional Case Management Service Standards Review — 10:40 AM—11:40 AM
11. Patient Support Services (PSS) Service Standards Review — 11:40 AM—11:45 AM

VI. NEXT STEPS 11:45 AM – 11:55 AM

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

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

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

VIII. ADJOURNMENT 12:00 PM

15. Adjournment for the meeting of May 6, 2025.

PROPOSED MOTIONS	
MOTION #1	Approve the Agenda Order as presented or revised.
MOTION #2	Approve the Standards and Best Practices Committee minutes, as presented or revised.

LOS ANGELES COUNTY
COMMISSION ON HIV

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

Approved by COH 6/8/23

CODE OF CONDUCT

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

All participants and stakeholders should adhere to the following:

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

HYBRID MEETING GUIDELINES, ETTIQUETTE & REMINDERS

(Updated 7.15.24)

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

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

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

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

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

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

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

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

DRAFT

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COMMISSION ON HIV

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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 1, 2025

COMMITTEE MEMBERS P = Present | A = Absent					
Erika Davies, *Co-Chair*	P	Arlene Frames	P	Martin Sattah, MD	P
Kevin Stalter, *Co-Chair*	A	Lauren Gersh, LCSW	P	Russell Ybarra	P
Dahlia Ale-Ferlito	P	David Hardy, MD	P		
Mikhaela Cielo, MD	P	Mark Mintline, DDS	A		
Sandra Cuevas	P	Andre Molette	P	Danielle Campbell, MPH, *COH Co-chair*	
Kerry Ferguson	P	Byron Patel, RN	P	Joseph Green, *COH Co-Chair Pro-Tem*	P
COMMISSION STAFF AND CONSULTANTS					
Cheryl Barrit, Jose Rangel-Garibay, Lizette Martinez					
DHSP STAFF					
-					
COMMUNITY MEMBERS					
John Mones, Katja Nelson, Marta Melendez					

**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
Joseph Green, COH Co-Chair, called the meeting to order at 10:15am and led introductions.

I. ADMINISTRATIVE MATTERS

1. APPROVAL OF AGENDA

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

2. APPROVAL OF MEETING MINUTES

MOTION #2: Approve the 02/04/25 and the 03/11/25 SBP Committee meeting minutes, as presented ***(Approved by consensus).***

II. PUBLIC COMMENT

3. OPPORTUNITY FOR PUBLIC TO ADDRESS COMMISSION ON ITEMS OF INTEREST WITHIN COMMISSION JURISDICTION

: There were no public comments.

III. COMMITTEE NEW BUSINESS ITEMS

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

IV. REPORTS

5. EXECUTIVE DIRECTOR/STAFF REPORT

- **Operational and Programmatic Updates**
  Cherly Barrit, COH Executive Director, reported that the "Ryan White Care Act Legislation" training will be on April 2, 2025, from 12pm-1pm via WebEx. Committee members noted that the links on the training calendar included in the meeting packet do not work; Commission staff will revise the links and send an updated reminder to all Commissioners by the end of the day.
- C. Barrit noted that the next COH meeting will be on April 10, 2025, at the St. Anne's Conference center. The meeting will focus on funding uncertainties and reallocations for a worst-case scenario. Staff from the Division on HIV and STD Programs (DHSP) will present an overview of the core and support service utilization reports to set the context for the reallocations exercise. C. Barrit noted that Valerie Coachman-Moore will facilitate the deliberations. C. Barrit noted that the COH meeting packet will includes a report summarizing the listening sessions for the Comprehensive Effectiveness Review and Restructuring Project held in late March. She added that additional virtual listening sessions will be available in April to allow commissioners who missed the previous session have an opportunity to participate and share their feedback. Lastly, C. Barrit mentioned that following the main meeting, the Consumer Caucus will hold a listening session for consumers of Ryan White Program (RWP) Dental Services with the goal of identifying what is working, what is not working, and what can be improved regarding dental services. RWP dental service providers are also invited to attend and participate.

6. CO-CHAIR REPORT

- **Review 2025 Committee Meeting Calendar**
  J. Green led the committee through a review of the 2025 meeting calendar and the service standards revision tracker to determine if all meetings listed on the calendar are needed. Jose Rangel-Garibay, COH staff, reminded attendees that the next SBP committee meeting will be on May 5, 2025, and will take place on the 14th floor of the Vermont Corridor building. Attendees will need to check-in in with security personnel on the 9th floor and wait for COH staff to escort them to the 14th floor. The June 3, 2025, SBP committee meeting will be on the 9th floor. COH staff is working on reserving conference rooms for the remainder of the year and will send an updated meeting calendar once the rooms have been confirmed.
- **Service Standards Revision Tracker—Updates**
  The committee discussed the need to review and update several service standards, including mental health, patient support services, and legal services. C. Barrit shared that the committee prioritize service standard reviews based on the following criteria:
    - DHSP Request for Proposal (RFP) cycle
    - Community concern or environmental change
    - Last review of standard is greater than 3 years
    - The Universal Service Standards and Client Bill of Rights is reviewed every 2 years

  She also reminded the committee to also consider reviewing standards for services that are not currently funded should funding become available. J. Rangel-Garibay provided an overview of the service standards revision tracker document and noted that the following service standards have not been reviewed in the past 3 years:
    - Legal Services, Mental Health, Psychosocial Support, Language Interpretation Services, Substance Use and Residential Treatment, Benefits Specialty Services, and Home-based Case Management.

Byron Patel, committee member, suggested to prioritize a review of Patient Support Services (PSS) before tackling other standards. Lauren Gersh and Caitlin Dolan, committee members, also expressed interest in developing standards for PSS. C. Barrit noted that staff will research which service category would fit PSS; J. Rangel-Garibay suggested adding an addendum to the Ambulatory Outpatient Medical (AOM) service standard instead of developing a standalone service standard. The committee decided to prioritize reviews for the following service standards for the remainder for 2025: Transitional Case Management, PSS, and mental health. COH staff will prepare the documents for review at the May 6, 2025, committee meeting.

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

There was no report.

V. DISCUSSION ITEMS

8. Transitional Case Management Service Standards Review

J. Rangel-Garibay provided a brief overview of the draft Transitional Case Management (TCM) service standards document noting that the committee will focus on developing TCM service standards for justice-involved individuals (formally labeled as "recently incarcerated"), youth, and older adults (50+) living with HIV/AIDS. The document includes an explanation for the purpose of service standards, an overview describing TCM and the population-specific service components, and a list of recommended training topics for TCM staff. He added that the following are common service components for TCM programs and recommend the committee consider exploring these when developing the TCM service standards for older adults (50+) living with HIV/AIDS. The proposed service components for TCM are: Comprehensive Assessment; Care Planning; Case Management; Medication Reconciliation; Resource Navigation; and Follow-up Care Coordination.

C. Barrit reminded the committee that with the expansion of Medi-Cal through CalAIM, DHSP does not handle TCM-Justice Involved services anymore; those services are now provided by the Department of Health Services (DHS) under their Office of Diversion and Reentry (ODR) which develops and implements programs to divert people with serious mental, and/or behavioral health needs away from the LA County Jail and into community-based care. She added that care coordination for justice-involved individuals is done by DHS with guidance provided by Medi-Cal and emphasized that this does not preclude the SBP committee from developing service standards for TCM Justice-Involved Individuals.

Kerry Ferguson, committee member, recommended adding "Medication reconciliation" as a subheading under "Care Planning" with an emphasis on ensuring both linkages to care and provision of a 30-day supply of medication at minimum. The consensus was to include "Medication reconciliation" when describing the "Care Planning" service component since medication continuity is critical for achieving/maintaining viral suppression. The committee also discussed the impact time of release has on care coordination activities. The committee discussed the "Resource Navigation" service component and identified the following as key post-release priorities for justice-involved individuals: housing, food, and stability/safety. Medical needs are not typically top of the list for most. Sandra Cuevas and Martin Sattah, committee members, recommended inviting subject matter experts that work in the jails to provide their insights to the committee at the May 6, 2025, meeting or a future meeting. COH staff will follow-up with S. Cuevas and M. Sattah to coordinate the invitation and add the item to the May 6, 2025, agenda.

C. Barrit reminded the committee of the differences between the populations the TCM standard will cover. TCM Youth encompasses the transition of youth living with HIV/AIDS out of the foster care system into systems of care for adults such as Medi-Cal, Ryan White, and other health insurance systems of care. TCM Justice-involved individuals primarily focuses on adults living with HIV/AIDS who have are recently incarcerated and transitioning back into the community. Both TCM populations require coordination of services and resource navigation

assistance to ensure the individual remains in care and achieves/maintains viral suppression as they navigate between environments.

J. Rangel-Garibay added that the TCM for older adults (50+) living with HIV/AIDS focuses on the transition between systems of health such as the Ryan White Program, Medi-Cal, and Medicare. C. Barrit recommend that the committee consider expanding the scope of the standard and consider exploring other use cases for a TCM for older adults (50+) living with HIV/AIDS such as transitions to/from skilled nursing facilities, hospitals, and community-living. J. Green requested that the TCM for older adults (50+) living with HIV/AIDS is sent to the Aging Caucus for review and feedback. C. Barrit noted that once the SBP committee has drafted that portion of the TCM service standards document, COH staff will share the document with the Aging Caucus. Currently, there is not enough content for the Aging Caucus to react to. Lastly, Erika Davies, committee co-chair, recommended adding transportation coordination and advanced directive discussion/development to the "Resource Navigation" section for older adults (50+) living with HIV/AIDS.

The committee discussed the "Recommend Training Topics for TCM Staff" section of the document and decided to explore specialized training recommendations for different populations. J. Green suggested the committee consider incorporating person-first language as a recommended training topic for TCM staff.

Arlene Frames, committee member, asked if the COH doing anything to push back on the cuts to federal funding. C. Barrit shared that the County and the Department of Public Health (DPH) have been writing letters to the federal government expression concerns about funding cuts for HIV and public health. She added that the Board of Supervisors (BOS) is working with County lobbyists in Washington D.C. to fight against funding cuts. She also encouraged individual advocacy such as contacting elected officials to voice concerns about funding cuts.

VI. NEXT STEPS

9. TASK/ASSIGNMENTS RECAP:

- COH staff will follow-up with committee members regarding reaching to speakers for
- COH staff will revise the draft Transitional Case Management service standards document for the committee to continue their review at their May 6, 2025, meeting.
- COH staff will prepare a draft of the Patient Support Services service standards for the committee to review at their May 6, 2025, meeting.

11. AGENDA DEVELOPMENT FOR NEXT MEETING:

- Continue review of the Transitional Case Management service standards.
- Initiate review of Patient Support Services service standards.

VII. ANNOUNCEMENTS

12. OPPORTUNITY FOR PUBLIC AND COMMITTEE TO MAKE ANNOUNCEMENTS:

- Russell Ybarra announced that the SPA 4 meeting will take place on April 8th, 2025, at the West Hollywood Swimming Pool building from 12pm-2pm.
- Sandra Cuevas announced that the calendar for provider/capacity building trainings led by the Pacific AIDS Education Training Center (PAETC) will be available soon.

VIII. ADJOURNMENT

13. ADJOURNMENT: The meeting adjourned at 11:54 am.

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 4/28/25

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
ALE-FERLITO	**Dahlia**	City of Los Angeles AIDS Coordinator	No Ryan White or prevention contracts
ALVAREZ	**Miguel**	No Affiliation	No Ryan White or prevention contracts
ARRINGTON	**Jayda**	Unaffiliated representative	No Ryan White or prevention contracts
BALLESTEROS	**Al**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & Linked Referral…(CSV)
			STD Screening, Diagnosis, and Treatment
			High Impact HIV Prevention
			Mental Health
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
			Data to Care 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)
			Biomedical HIV Prevention
			Transportation Services
CIELO	**Mikhaela**	Los Angeles General Hospital	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	Community Engagement/EHE

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
DAVIES	**Erika**	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DAVIS (PPC Member)	**OM**	Aviva Pharmacy	No Ryan White or prevention contracts
DOLAN (SBP Member)	**Caitlyn**	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
DONNELLY	**Kevin**	Unaffiliated representative	No Ryan White or prevention contracts
FERGUSON	**Kerry**	ViiV Healthcare	No Ryan White or prevention contracts
FINLEY	**Jet**	Unaffiliated representative	No Ryan White or prevention contracts
FRAMES	**Arlene**	Unaffiliated representative	No Ryan White or prevention contracts
FRANKLIN*	**Arburtha**	Translatin@ Coalition	Vulnerable Populations (Trans)
GARCIA	**Rita**	No Affiliation	No Ryan White or prevention contracts
GERSH (SBP Member)	**Lauren**	APLA Health & Wellness	High Impact HIV Prevention
			Benefits Specialty
			Nutrition Support
			Sexual Health Express Clinics (SHEx-C)
			Data to Care Services
			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
			Intensive Case Management
GONZALEZ	**Felipe**	Unaffiliated representative	No Ryan White or Prevention Contracts
GORDON	**Bridget**	Unaffiliated representative	No Ryan White or prevention contracts
GREEN	**Gerald**	Minority AIDS Project	Benefits Specialty
GREEN	**Joseph**	Unaffiliated representative	No Ryan White or prevention contracts
			Ambulatory Outpatient Medical (AOM)

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
GUTIERREZ	**Joaquin**	Connect To Protect LA/CHLA	HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Transportation Services
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 representative	No Ryan White or prevention contracts
JONES	**Terrance**	Unaffiliated representative	No Ryan White or prevention contracts
KOCHEMS	**Lee**	Unaffiliated representative	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts
LESTER (PP&A Member)	**Rob**	Men's Health Foundation	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
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 representative	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 representative	No Ryan White or prevention contracts
MINTLINE (SBP Member)	**Mark**	Western University of Health Sciences	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
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
			Oral Healthcare Services
NASH	**Paul**	University of Southern California	Biomedical HIV Prevention
			Community Engagement/EHE
			Oral Healthcare Services
NELSON	**Katja**	APLA Health & Wellness	High Impact HIV Prevention
			Benefits Specialty
			Nutrition Support
			Sexual Health Express Clinics (SHEx-C)
			Data to Care Services
			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
			Case Management

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
PATEL	**Byron**	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			High Impact HIV Prevention
			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
RAINES	**Aaron**	No Affiliation	No Ryan White or prevention contracts
RICHARDSON	**Dechelle**	No Affiliation	No Ryan White or prevention contracts
ROBINSON	**Erica**	Health Matters Clinic	No Ryan White or prevention contracts
RUSSEL	**Daryl**	Unaffiliated representative	No Ryan White or prevention contracts
SALAMANCA	**Ismael**	City of Long Beach	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			HIV Testing & Sexual Networks
SAMONE-LORECA	**Sabel**	Minority AIDS Project	Benefits Specialty
SATTAH	**Martin**	Rand Schrader Clinic LA County Department of Health Services	No Ryan White or prevention contracts

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
			High Impact HIV Prevention
			Mental Health
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
			Data to Care Services
SAUNDERS	**Dee**	City of West Hollywood	No Ryan White or prevention contracts
SPENCER	**LaShonda**	Oasis Clinic (Charles R. Drew University/Drew CARES)	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
STALTER	**Kevin**	Unaffiliated representative	No Ryan White or prevention contracts
TALLEY	**Lambert**	Grace Center for Health & Healing	No Ryan White or prevention contracts
VALERO	**Justin**	No Affiliation	No Ryan White or prevention contracts
VEGA-MATOS	**Carlos**	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
WEEDMAN	**Jonathan**	ViaCare Community Health	Biomedical HIV Prevention
YBARRA	**Russell**	Capitol Drugs	No Ryan White or prevention contracts

Los Angeles County Commission on HIV

REVISED 2025 TRAINING SCHEDULE

***SUBJECT TO CHANGE**

- All training topics listed below are mandatory for Commissioners and Alternates.
- All trainings are open to the public.
- Click on the training topic to register.
- Certificates of Completion will be provided.
- All trainings are virtual via Webex.
- For questions or assistance, contact: hivcomm@lachiv.org

Commission on HIV Overview	February 26, 2025 @ 12pm to 1:00pm
Ryan White Care Act Legislative Overview and Membership Structure and Responsibilities	~~March 26, 2025~~ @ 12pm to 1:00pm April 2, 2025
Priority Setting and Resource Allocations Process	April 23, 2025 @ 12pm to 1:00pm
Service Standards Development	May 21, 2025 @ 12pm to 1:00pm
Policy Priorities and Legislative Docket Development Process	June 25, 2025 @ 12pm to 1:00pm
Bylaws Review	July 23, 2025 @ 12pm to 1:00pm

LOS ANGELES COUNTY
COMMISSION ON HIV

STANDARDS AND BEST PRACTICES COMMITTEE 2025 MEETING CALENDAR *(Last updated 04/30/25)*

DATE	KEY AGENDA ITEMS/TOPICS (subject to change; for planning purposes)
Jan. 7, 2025 1pm to 3pm TK02	• Hold co-chair nominations. • Review 2025 COH workplan and 2025 meeting calendar • Continue review of Temporary Housing service standards
Feb. 4, 2025 10am to 12pm TK02	• Elect co-chairs for 2025 term. • Establish standards review schedule for 2025. • Complete review of Temporary Housing service standards (RCFCI and TRCF) • Continue review of Permanent Housing service standards
Mar. 11, 2025 10am-12pm TK02	• Review public comments on "Housing Services" service standards • Initiate review of Transitional Case Management service standards
Apr. 1, 2025 10am-12pm 14th Floor	• Review Service Standards Development Tracker and determine review cycle • Continue review of Transitional Case Management service standards
May 6, 2025 10am-12pm 14th Floor	• Continue review of Transitional Case Management service standards • Preview Patient Support Services (PSS) service standards
Jun. 3, 2025 10am-12pm TK02	
Jul. 1, 2025 10am to 12pm TK02	
Aug. 5, 2025 *TBD*	
Sep. 2, 2025 *TBD*	Consider rescheduling due to Labor Day holiday on 9/1/25.
Oct. 7, 2025 *TBD*	
Nov. 4, 2025 *TBD*	Commission on HIV Annual Conference 11/13/2025
Dec. 2, 2025 *TBD*	Consider rescheduling due to World AIDS Day events. Reflect on 2025 accomplishments. Co-Nominations for 2026.

LOS ANGELES COUNTY COMMISSION ON HIV

SERVICE STANDARDS REVISION DATE TRACKER FOR PLANNING PURPOSES

Last updated: 04/21/25

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

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

HRSA Service Category	COH Standard Title	DHSP Service	Description	Notes
N/A	AIDS Drug Assistance Program (ADAP) Enrollment	N/A	State program that provides medications that prolong quality of life and delay health deterioration to people living with HIV who cannot afford them.	ADAP contracts directly with agencies. Administered by the California Department of Public Health, Office of AIDS.
Child Care Services	Child Care Services	Child Care Services	Childcare services for the children of clients living with HIV, provided intermittently, only while the client attends in person, telehealth, or other appointments and/or RWHAP related meetings, groups, or training sessions.	**Last approved by COH: 7/8/2021**
Early Intervention Services	Early Intervention Program (EIS) Services	Testing Services	Targeted testing to identify HIV+ individuals.	**Last approved by COH: 5/2/217**
Emergency Financial Assistance	Emergency Financial Assistance (EFA)	Emergency Financial Assistance	Pay assistance for rent, utilities, and food and transportation for PLWH experiencing emergency circumstances.	**Last approved by COH: 2/13/2025**
Food Bank/Home Delivered Meals	Nutrition Support Services	Nutrition Support Services	Home-delivered meals and food bank/pantry services programs.	**Last approved by COH: 8/10/2023**
N/A	HIV/STI Prevention Services	Prevention Services	Services used alone or in combination to prevent the transmission of HIV and STIs.	**Last approved by COH: 4/11/2024** *Not a program- Standards apply to prevention services.*

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

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

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

HRSA Service Category	COH Standard Title	DHSP Service	Description	Notes
			status and self-management skills to help treat HIV disease.	
Medical Transportation	Transportation Services	Medical Transportation	Ride services to medical and social services appointments.	**Last approved by COH: 2/13/2025**
Mental Health Services	Mental Health Services	Mental Health Services	Psychiatry, psychotherapy, and counseling services.	**Last approved by COH: 5/2/2017** *Currently under review. SBP will begin review in June 2025.*
Non-Medical Case Management	Benefits Specialty Services (BSS)	Benefits Specialty Services	Assistance navigating public and/or private benefits and programs.	**Last approved by COH: 9/8/2022**
	Patient Support Services (PSS)	Patient Support Services	Provide interventions that target behavioral, emotional, social, or environmental factors that negatively affect health outcomes with the aim of improving an individual's health functioning and overall well-being.	*New service standard currently under development. SBP will begin review on 5/6/2025.*
	Transitional Case Management: Justice-Involved Individuals	Transitional Case Management- Jails	Support for post-release linkage and engagement in HIV care.	**Last approved by COH: 12/8/2022** *Currently under review. SBP will continue review on 5/6/2025.*
	Transitional Case Management: Youth	Transitional Case Management- Youth	Coordinates services designed to promote access to and utilization of HIV care by identifying and linking youth living with HIV/AIDS to HIV medical and supportive services.	**Last approved by COH: 12/8/2022** *Currently under review. SBP will continue review on 5/6/2025.*
	Transitional Case Management: Older Adults 50+	N/A	Coordinate transition between systems of care for older adults 50+ living with HIV/AIDS.	**Last approved by COH: 12/8/2022** *New service standard currently under development.*
Oral Health Care	Oral Health Care Services	Oral Health Services	General and specialty dental care services.	**Last approved by COH: 4/13/2023**
Outpatient/Ambulatory Health Services	Ambulatory Outpatient Medical (AOM)	Ambulatory Outpatient Medical	HIV medical care accessed through a medical provider.	**Last approved by COH: 2/13/2025**
Outreach Services	Outreach Services	Linkage and Retention Program	Promote access to and engagement in appropriate services for people newly diagnosed or identified as	**Last approved by COH: 5/2/2017**

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

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

Service Standard Development

LOS ANGELES COUNTY COMMISSION ON HIV

KEYWORDS AND ACRONYMS

BOS: Board of Supervisors
COH: Commission on HIV
SBP: Standards and Best Practices
DHSP: Division of HIV & STD Programs
RFP: Request for Proposal

HRSA: Health Resources and Services Administration
HAB: HIV/AIDS Bureau
RWHAP: Ryan White HIV/AIDS Program
PSRA: Priority Setting and Resource Allocations
PCN: Policy Clarification Notice

WHAT ARE SERVICE STANDARDS?

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

WHAT ARE SERVICE CATEGORIES?

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

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

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

HRSA/HAB GUIDANCE FOR SERVICE STANDARDS

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

COH SERVICE STANDARDS

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

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

REMINDER

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

DEVELOPING SERVICE STANDARDS

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

SERVICE STANDARD DEVELOPMENT PROCESS

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

together.

WE CAN END HIV IN OUR COMMUNITY ONCE AND FOR ALL

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

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TRANSITIONAL CASE MANAGEMENT SERVICES

(Draft as of 04/30/25)

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

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

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

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

Service Standards: Ryan White HIV/AIDS Programs

Contents

PURPOSE

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

DESCRIPTION

Transitional Case Management (TCM) is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services for special populations living with HIV/AIDS to mitigate and eliminate barriers to HIV care services. This service standard covers the following special populations: Justice-involved individuals, Transitional Youth, and Older Adults 50+. TCM services include:

- Intake and assessment of available resources and needs
- Periodic reassessments of status and needs
- Development and implementation of Individual Release Plans (*for justice-involved only)*
- Appropriate linked referrals to housing, community case management, medical/physical healthcare, mental health, dental health, and substance use disorder treatment
- Coordination of services that facilitate retention in care, achieve viral suppression, and maintain overall health and wellness
- Access to HIV and STI information, education, partner services, and behavioral and biomedical interventions such as Pre-Exposure Prophylaxis (PrEP) and Doxycycline Post-Exposure Prophylaxis (Doxy PEP) to prevent acquisition and transmission of HIV/STIs to prevent acquisition and transmission of HIV/STIs), and risk reduction
- Active, ongoing monitoring and follow-up
- Ongoing assessment of the client's needs and personal support systems

SCOPE OF TCM AS NON-MEDICAL CASE MANAGEMENT SERVICE PER HRSA PCN#16-02

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

- Initial Assessment of service needs

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

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

GENERAL ELIGIBILITY REQUIREMENTS FOR RYAN WHITE SERVICES

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

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

TRANSITIONAL CASE MANAGEMENT FOR JUSTICE-INVOLVED INDIVIDUALS LIVING WITH HIV/AIDS

The goal of TCM for Justice-Involved individuals living with HIV/AIDS is to improve HIV health outcomes among justice-involved people living with HIV/AIDS by supporting post-release linkage and engagement in HIV care. The objectives of TCM for Justice-Involved individuals living with HIV/AIDS include:

- Identify and address barriers to care
- Assist with health and social service system navigation
- Provide health education and risk reduction counseling
- Refer and link to culturally competent HIV medical providers
- Support reentry through community or jail-based resources

SERVICE STANDARDS

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

OUTREACH
Programs providing Transitional Case Management (TCM) for justice-involved individuals services will conduct outreach to educate potential clients, HIV and STI services providers and other supportive service organizations about the availability and benefits of transitional management services for justice-involved

persons living with HIV/AIDS within the Los Angeles County Jail system. Promotion and outreach will include the provision of information sessions to incarcerated people living with HIV/AIDS that facilitate enrollment into incarcerated TCM programs. Programs will collaborate with HIV primary health care and support services providers, as well as HIV and STI testing sites.

OUTREACH	
STANDARD	**DOCUMENTATION**
Transitional Case Management programs will conduct outreach to potential clients and providers.	Outreach plan on file at provider agency
Transitional Case Management programs will provide information sessions to incarcerated people living with HIV/AIDS.	Record of information sessions at provider agency. Copies of flyers and materials used. Record of referrals provided to clients.
Transitional Case Management programs establish appointments (whenever possible) prior to release date.	Record of appointment date.

COMPREHENSIVE ASSESSMENT

Comprehensive assessment/reassessment is completed in a cooperative, interactive, face-to-face interview process. Assessment/reassessment identifies and evaluates a client's medical, physical, psychosocial, environmental and financial strengths, needs and resources.

Comprehensive assessment is conducted to determine the:

- Client's needs for treatment and support services
- Client's current capacity to meet those needs
- Ability of the client's social support network to help meet client need(s)
- Extent to which other agencies are involved in client's care
- Areas in which the client requires assistance in securing services
- Client's medical home post-release and linkage to Medical Care Coordination (MCC) program prior to release to ensure continuity of care

COMPREHENSIVE ASSESSMENT	
STANDARD	**DOCUMENTATION**
Completed and enter comprehensive assessments into DHSP's data management system within 15 days of the initiation of services. Perform reassessments at least once per year or when a client's needs change or they have re-entered a case management program.	Comprehensive assessment or reassessment on file in client chart to include: • Date • Signature and title of staff person Client strengths, needs and available resources in: • Medical/physical healthcare • Medications and Adherence issues • Mental Health • Substance use and substance use treatment

	• Nutrition/Food • Housing and living situation • Family and dependent care issues • Access to gender-affirming care • Transportation • Language/Literacy skills • Religious/Spiritual support • Social support system • Relationship history • Domestic violence/Intimate Partner Violence (IPV) • History of physical or emotional trauma • Financial resources • Employment and Education • Legal issues/incarceration history • Environmental factors • HIV/STI prevention issues • Resources and referrals

INDIVIDUAL RELEASE PLAN (IRP)

An Individual Release Plan (IRP) determines the case management goals for a client and is developed in conjunction with the client and case manager within two weeks of the conclusion of the comprehensive assessment or reassessment. An IRP is a tool that enables the case manager to assist the client in systematically addressing barriers to HIV medical care by developing a concrete strategy to improve access and engagement in medical and other support services. All goals shall be determined by utilizing information gathered during assessment and subsequent reassessments.

INDIVIDUAL RELEASE PLAN	
STANDARD	**DOCUMENTATION**
Individual Release Plans (IRPs) will be developed in conjunction with the client within two weeks of completing the assessment or reassessment. IRPs will be updated on an ongoing basis.	IRP on file in client chart to include: • Name of client and case manager • Date and signature of case manager and client • Date and description of client goals and desired outcomes • Action steps to be taken by client, case manager and others • Customized services offered to client to facilitate success in meeting goals, such as referrals to peer navigators and other social or health services • Goal timeframes • Disposition of each goal as it is met, changed, or determined to be unattainable

IMPLEMENTATION, MONITORING, AND FOLLOW-UP OF IRP

Implementation, monitoring, and follow-up involved ongoing contract and interventions with (or on behalf of) the client to ensure that IRP goals are addressed, and that the client is linked to and appropriately accesses and maintains primary health care and community-based supportive services identified on the IRP. These activities ensure that referrals are completed, and services are obtained in a timely, coordinated fashion.

IMPLEMENTATION, MONITORING, AND FOLLOW-UP OF IRP	
STANDARD	**DOCUMENTATION**
Case managers will: • Provide referrals, advocacy, and interventions based on the intake, assessment, and IRP • Monitor changes in the client's condition • Update/revise the IRP • Provide interventions and linked referrals • Ensure coordination of care • Help clients submit applications and obtain health benefits and care • Conduct monitoring and follow-up to confirm completion of referrals and service utilization • Advocate on behalf of clients with other service providers • Empower clients to use independent living strategies • Help clients resolve barriers • Follow-up on IRP goals • Maintain/attempt contact at minimum of once every two weeks and at least one face-to-face contact monthly • Follow-up missed appointments by the end of the next business day • Collaborate with the client's community-based case manager for coordination and follow-up when appropriate • Transition clients out justice-involved TCM at six month's post-release.	Signed, dated progress notes on file that detail, at minimum, the following: • Description of client contacts and actions taken • Date and type of contact • Description of what occurred • Changes in the client's condition or circumstances • Progress made toward IRP goals • Barriers to IRPs and actions taken to resolve them • Linked referrals and interventions and status/results • Barriers to referrals and interventions • Time spent with, or on behalf of, client • Case manager's signature and title

STAFFING REQUIREMENTS AND QUALIFICATIONS

At minimum, all TCM staff will be able to provide linguistically and culturally appropriate care to people living with HIV/AIDS and complete documentation as required by their positions. Case management staff will complete an agency-based orientation and be trained and oriented regarding client confidentiality and HIPAA regulations before providing services. See "Personnel and Cultural Linguistic Competence" section on the Universal Service Standards.

STAFFING REQUIREMENTS AND QUALIFICATIONS	
STANDARD	**DOCUMENTATION**
Case managers will have: • Knowledge of HIV/STIs and related issues • Knowledge of and sensitivity to incarceration and correctional settings and populations • Knowledge of and sensitivity to lesbian, gay, bisexual, and transgender persons • Effective Motivational Interviewing and assessment skills • Ability to appropriately interact and collaborate with others • Effective written/verbal communication skills • Ability to work independently • Effective problem-solving skills • Ability to respond appropriately in crisis situations • Effective organizational skills • Prioritize caseload • Patience • Multitasking skills Refer to "Recommended Training Topics for Transitional Case Management Staff."	Resume, training certificates, interview assessment notes, reference checks, and annual performance reviews on file.
Case managers will meet one of the following educational requirement criteria: • A bachelor's degree in a Health or Human Services field and have completed a minimum of eight hours of course work on the basics of HIV/AIDS prior to providing services to clients • An associate degree plus one-year direct case management experience in health or human services • A high school diploma or GED and a minimum of three years of experience providing direct social services to patients/clients within a medical setting or in the field of HIV. Prior experience providing services to justice-involved individuals is preferred. Personal life experience is highly valued and should be considered when making hiring decisions.	Resumes on file at provider agency documenting experience. Copies of diplomas on file.

All staff will be given orientation prior to providing services.	Record of orientation in employee file at provider agency.
Case management staff will complete DHSP's required case management certifications/training within three months of being hired. Case management supervisors will complete DHSP's required supervisors certification/training within six months of being hired.	Documentation of certification completion maintained in employee file.
Case managers and other staff will participate in recertification as required by DHSP.	Documentation of training maintained in employee files to include: • Date, time, and location of function • Function type • Staff members attending • Sponsor or provider of function • Training outline, handouts, or materials • Meeting agenda and/or minutes
Case management staff will receive a minimum of four hours of client care-related supervision per month from a master's level mental health professional.	All client care-related supervision will be documented as follows, at minimum: • Date of client care-related supervision • Supervision format • Name and title of participants • Issues and concerns identified • Guidance provided and follow-up plan • Verification that guidance and plan have been implemented • Client care supervisor's name, title, and signature.
Clinical supervisor will provide general clinical guidance and follow-up plans for case management staff.	Documentation of client care related supervision for individual clients will be maintained in the client's individual file.

TRANSITIONAL CASE MANAGEMENT FOR YOUTH LIVING WITH HIV/AIDS

For the purposes of these standards, "youth" is defined as adolescents and young adults aged 13-29 years old living with HIV/AIDS, including homeless, runaways, and emancipating/emancipated youth at risk for HIV/STIs. Transitional Case Management (TCM) for youth is a client-centered activity that coordinates services designed to promote access to and utilization of HIV care by identifying and linking youth living with HIV/AIDS to HIV medical and supportive services. The objectives of TCM for youth living with HIV/AIDS include:

- Locating youth not engaged in HIV care
- Identifying and addressing client barriers to care (e.g. homelessness, substance use, and emotional distress)
- Reducing homelessness

- Reducing substance use
- Improving the health status of transitional youth
- Easing a youth's transition from living on the streets or in foster care to community care
- Increasing access to education
- Increasing self-efficacy and self-sufficiency
- Facilitating access and adherence to primary health care
- Ensuring access to appropriate services and to the continuum of care
- Increasing access to HIV information and education
- Developing resources and increasing coordination between providers

Providers of TCM for Youth living with HIV/AIDS services are expected to follow the "Best Practices for Youth-Friendly Clinical Services," developed by Advocates for Youth, a national organization that advocates for policies and champions programs that recognize young people's rights to honest sexual health information.

SERVICE STANDARDS

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

OUTREACH

Outreach activities are defined as targeted activities designed to bring youth living with HIV/AIDS into HIV medical treatment services. This includes effective and culturally relevant methods to located, engage, and motivate youth living with HIV/AIDS in HIV medical services.

OUTREACH	
STANDARD	**DOCUMENTATION**
Transitional case management programs will outreach to potential clients and providers.	Outreach plan on file at provider agency.

COMPREHENSIVE ASSESSMENT AND REASSESSMENT

Comprehensive assessment and reassessment is completed in a cooperative, interactive, face-to-face interview process. Youth-friendly assessment(s) should consider the length of the questionnaire. Providers are highly encouraged to use or adapt youth-friendly assessment tools such as the HEADSS assessment for adolescents (Home and Environment; Education and Employment; Activities; Drugs; Sexuality; Suicide; Depression).

Assessment/reassessment identifies and evaluates a client's medical, physical, psychosocial, environmental and financial strengths, needs, and resources.

Comprehensive assessment is conducted to determine the following:

- Client's needs for engaging in HIV medical care and treatment, and supportive services
- Client's current capacity to meet those needs

- Ability of the client's social support network to help client gain access to, engage in, and maintain adherence to HIV care and treatment
- Extent to which other agencies are involved in client's care
- Areas in which the client requires assistance in securing services
- Readiness for transition to adult/mainstream case management services. Youth may remain in TCM for youth services until age 29. Appropriateness of continued transitional case management services will be assessed annually, and clients shall be transitioned into non-youth specific HIV care as appropriate but not later than aged 30. Planing will be made for eventual transition to adult/non-youth specific case management at leas by the client's 30th birthday)
- Eligibility for the Los Angeles County Department of Mental Health (DMH) Transition Age Youth Services, Adult Services Full-Service Partnership Program, and other DMH and Los Angeles County-funded programs to ensure continuing support while the client is in receiving TCM for youth services or once the client has completed or aged out of TCM youth services.

COMPREHENSIVE ASSESSMENT AND REASSESSMENT	
STANDARD	**DOCUMENTATION**
Completed and enter comprehensive assessments into DHSP's data management system within 30 days of the initiation of services. Perform reassessments at least once per year or when a client's needs change or they have re-entered a case management program.	Comprehensive assessment or reassessment on file in client chart to include: • Date • Signature and title of staff person Client strengths, needs and available resources in: • Medical/physical healthcare • Medications and Adherence issues • Mental Health • Substance use and substance use treatment • Nutrition/Food • Housing and living situation • Family and dependent care issues • Access to gender-affirming care • DCFS and other agency involvement • Transportation • Language/Literacy skills • Religious/Spiritual support • Social support system • Relationship history • Domestic violence/Intimate Partner Violence (IPV) • History of physical or emotional trauma • Financial resources • Employment and Education • Legal issues/incarceration history • Risk behaviors

	• HIV/STI prevention issues • Harm reduction services and support • Environmental factors • Resources and referrals • Assessment of readiness for transition to adult services.

INDVIDUAL SERVICE PLAN (ISP)

An Individual Service Plan (ISP) determines the case management goals for a client and is developed in conjunction with the client and case manager within two weeks of the completion of the comprehensive assessment or reassessment. A service plan is a tool that enables the case manager to assist the client in systematically addressing barriers to HIV medical care by developing a concrete strategy to improve access and engagement to needed medical and other support services. All goals shall be determined by utilizing information gathered during assessment and subsequent reassessments.

INDIVIDUAL SERVICE PLAN	
STANDARD	**DOCUMENTATION**
ISPs will be developed in conjunction with the client within two weeks of completing the assessment or reassessment.	ISP on file in client chart to include: • Name of client and case manager • Date and signature of case manager and client • Date and description of client goals and desired outcomes • Action steps to be taken by client, case manager and others • Goal timeframes • Disposition of each goal as it is met, changed or determined to be unattainable

BRIEF INTERVENTIONS

Brief intervention sessions actively facilitate a client's entry into HIV medical care through the resolution of barriers to primary HIV-specific healthcare. The interventions focus on specific barriers identified through a client assessment and assist the client in successfully addressing those barriers to HIV care. Case managers must prepare clients for the transition into non-youth specific HIV medical services and a lifetime of managing HIV/AIDS. This includes empowering youth with information and skills necessary to increase their readiness to engage in non-youth specific HIV medical care.

BRIEF INTERVENTIONS	
STANDARD	**DOCUMENTATION**
Case managers will: • Provide interventions and linked referrals • Risk Reduction Counseling: Provide risk reduction/harm reduction sessions for clients that are actively engaging in	Signed, dated progress notes on file that detail, at minimum: • Description of client contracts and actions taken • Date and type of contact

behaviors that put them at risk for transmitting HIV and acquiring other STIs. • Linkage to HIV Medical Care: To assist the client with access to and engagement in primary HIV-specific health care by linking them to an HIV medical clinic • Disclosure and Partner Notification: Addressing disclosure and partner notification for clients who have not disclosed their HIV status to partner(s) or family member(s). • Help clients resolve barriers	• Description of what occurred • Changes in the client's condition or circumstances • Progress made toward goals • Barriers to ISPs and actions taken to resolve them • Linked referrals and interventions and status/results • Barriers to referrals and interventions/actions taken • Time spent with, or on behalf of, client • Case manager's signature and title • Detailed transition plan to adult services with specific linkage to health, medical, and social services.

IMPLEMENTATION, MONITORING, AND FOLLOW-UP OF ISP

Implementation, Monitoring, and Follow-up of Isp involve ongoing contact and interventions with (or on behalf of) the client to ensure that ISP goals are addressed, and that the client is linked to and appropriately accesses and maintains primary healthcare and community-based supportive services identified on the ISP. These activities ensure that referrals are completed, and services are obtained in a timely, coordinated fashion.

IMPLEMENTATION, MONITORING, AND FOLLOW-UP OF ISP	
STANDARD	**DOCUMENTATION**
Case managers will: • Provide referrals, advocacy, and interventions based on the intake, assessment, and ISP • Monitor changes in the client's condition • Update/revise the ISP • Provide interventions and linked referrals • Ensure coordination of care • Help clients submit applications and obtain health benefits and care • Conduct monitoring and follow-up to confirm completion of referrals and service utilization • Advocate on behalf of clients with other service providers • Empower clients to use independent living strategies • Help clients resolve barriers • Follow-up on ISP goals	Signed, dated progress notes on file that detail, at minimum, the following: • Description of client contacts and actions taken • Date and type of contact • Description of what occurred • Changes in the client's condition or circumstances • Progress made toward ISP goals • Barriers to ISPs and actions taken to resolve them • Linked referrals and interventions and status/results • Barriers to referrals and interventions • Time spent with, or on behalf of, client • Case manager's signature and title • Detailed transition plan to adult services, with specific linkage to health, medical, and social services

• Maintain/attempt contact at minimum of once every two weeks and at least one face-to-face contact monthly • Follow-up missed appointments by the end of the next business day • Collaborate with the client's community-based case manager for coordination and follow-up when appropriate • Transition clients out of TCM when appropriate • Develop a transition plan to adult services such as Medical Care Coordination (MCC), job placement, permanent supportive housing, or other appropriate services at least 6 months prior to formal date of release from TCM for youth program • Upon transition case, communicate to client the availability of case manager for occasional support and role as a resource to maintain stability for client.	• Documentation of expedited linkage to MCC for eligible clients

STAFFING REQUIREMENTS AND QUALIFICATIONS

At minimum, all TCM staff will be able to provide linguistically and culturally appropriate care to clients and complete documentation as required by their positions. Case management staff will complete an agency-based orientation and be trained and oriented regarding client confidentiality and HIPAA regulations before providing services. See "Personnel and Cultural Linguistic Competence" section on the Universal Service Standards.

STAFFING REQUIREMENTS AND QUALIFICATIONS	
STANDARD	**DOCUMENTATION**
Case managers will have: • Knowledge of HIV/STIs and related issues • Knowledge of and sensitivity to run away, homeless or emancipating/emancipated youth • Effective Motivational Interviewing and assessment skills • Knowledge of adolescent development • Knowledge of, and sensitivity to, lesbian, gay, bisexual, and transgender persons • Ability to appropriately interact and collaborate with others • Effective written/verbal communication skills	Resume, training certificates, interview assessment notes, reference checks, and annual performance reviews on file.

• Ability to work independently • Effective problem-solving skills • Ability to respond appropriately in crisis situations • Effective organizational skills Refer to "Recommended Training Topics for TCM Youth Staff."	
Case managers will meet one of the following educational requirement criteria: • A bachelor's degree in a Health or Human Services field and have completed a minimum of eight hours of course work on the basics of HIV/AIDS prior to providing services to clients • An associate degree plus one-year direct case management experience in health or human services • A high school diploma or GED and a minimum of three years of experience providing direct social services to patients/clients within a medical setting or in the field of HIV. Prior experience providing services to run away, homeless, emancipated or emancipating youth is preferred. Personal life experience with relevant issues is highly valued and should be considered when making hiring decisions.	Resumes on file at provider agency documenting experience. Copies of diplomas on file.
All staff will be given orientation prior to providing services.	Record of orientation in employee file at provider agency.
Case management staff will complete DHSP's required case management certifications/training within three months of being hired. Case management supervisors will complete DHSP's required supervisors certification/training within six months of being hired.	Documentation of certification completion maintained in employee file.
Case managers and other staff will participate in recertification as required by DHSP.	Documentation of training maintained in employee files to include: • Date, time, and location of function • Function type • Staff members attending • Sponsor or provider of function • Training outline, handouts, or materials • Meeting agenda and/or minutes

Case management staff will receive a minimum of four hours of client care-related supervision per month from a master's level mental health professional.	All client care-related supervision will be documented as follows, at minimum: • Date of client care-related supervision • Supervision format • Name and title of participants • Issues and concerns identified • Guidance provided and follow-up plan • Verification that guidance and plan have been implemented • Client care supervisor's name, title, and signature.
Clinical supervisor will provide general clinical guidance and follow-up plans for case management staff.	Documentation of client care related supervision for individual clients will be maintained in the client's individual file.

TRANSITIONAL CASE MANAGEMENT FOR OLDER ADULTS 50+ LIVING WITH HIV/AIDS

PURPOSE

Coordinate transition between systems of care for older adults 50+ living with HIV/AIDS.

SERVICE COMPONENTS

Comprehensive Assessment: identifies and reevaluates a client's medical, physical, psychosocial, environmental and other health and social service needs. To ensure optimal transitional care plans for older adults living with HIV who may be eligible for other payor sources outside of or in tandem with Ryan White-funded services, comprehensive assessments and screenings should be performed when the client approaches their 50th birthday.

Assessments may include: (assessments conducted under other RW medical services such as AOM or MCC may be used as a base to avoid duplicative assessments and burden on the client and provider).

1. Comprehensive benefits analysis and financial security
2. Clients 55 years and older should be assessed for eligibility for Program of All-Inclusive Care for the Elderly (PACE)
3. Mental health
4. Hearing
5. Neurocognitive disorders/cognitive function
6. Functional status
7. Frailty/falls and gait
8. Social support and levels of interactions, including access to care giving support and related services.
9. Vision

10. Dental
11. Hearing
12. Osteoporosis/bone density
13. Cancers
14. Muscle loss and atrophy
15. Nutritional needs
16. Housing status
17. Immunizations
18. Polypharmacy/drug interactions
19. HIV-specific routine tests
20. Cardiovascular disease
21. Smoking-related complications
22. Renal disease
23. Coinfections
24. Hormone deficiency
25. Peripherical neuropathologies
26. Sexual health
27. Advance care planning
28. Occupational and physical therapy

**these assessments an screenings are derived from the Aging Task Force Recommendations.*

Care Planning

Once the comprehensive assessment is completed, a standing care plan should be developed in collaboration with the client that the patient may use to communicate their care needs to providers who may be operating under different healthcare systems. Care plans should at a minimum include the client's health goals, medication adherence and continuity, eligibility for services, and an HIV care provider contact to assist with communicating care needs during periods of transitions another health system (such as Medi-Cal, Medicare), or non-HIV specialist providers.

Resource Navigation

Resource navigation seeks to assist clients with understanding and accessing information about resources available to them and their caregivers. At a minimum, case managers should:

1. Work with the client and show them what benefits they may be eligible for using Benefitscheckup.org.
2. Connect them to a Benefits Specialty Services (BSS) to access and enroll in public and/or private health and disability programs.
3. Educate and assist client in navigating enrollment and application processes.

Follow-up Support: Ongoing contact and intervention with (or on behalf of) the client to ensure that care plan goals and resource needs are addressed, and that the client is linked to and appropriately accesses and maintains primary health care and community-based supportive services identifies on the care plan.

TCM Older Adults Service Components	
STANDARD	**DOCUMENTATION**
Comprehensive Assessment and Screening	Recommended assessment and screenings are completed around the client's 50th birthday.
Care Planning	Results of the assessments/screenings are used to develop a care plan that at minimum contains the client's health goals, medication adherence and continuity, eligibility for services, and an HIV care provider contact to assist with communicating care needs during periods of transitions another health system (such as Medi-Cal, Medicare), or non-HIV specialist providers.
Resource Navigation	Documentation of joint effort with client to identify programs they may be eligible for via Benefitscheckup.org, BSS, and assistance with enrollment/application process.
Follow-up Support	Documentation of contact with and offers of support for clients regarding the status of their care plan and enrollment in other services at 3-month intervals up to a year.

RECOMMENDED TRAINING TOPICS FOR TRANSITIONAL CASE MANAGEMENT STAFF

Transitional Case Management staff should complete ongoing training related to the provision of TCM services. Staff development and enhancement activities should include, but not be limited to:

- HIV/AIDS Medical and Treatment Updates
- Risk Behavior and Harm Reduction Interventions
- Addiction and Substance Use Treatment
- HIV Disclosure and Partner Services
- Trauma-informed Care
- Person First Language
- Mental health and HIV/AIDS
- Legal Issues, including Jails/Corrections Services
- Alternatives to Incarceration Training
- Integrated HIV/STI prevention and care services including Hepatitis C screening and treatment
- Sexual identification, gender issues, and provision of trans-friendly services
- Stigma and discrimination and HIV/AIDS
- Health equity and social justice

- Motivational interviewing
- Knowledge of available housing, food, and other basic need support services

RECOMMENDED TRAINING TOPICS FOR TCM FOR YOUTH STAFF:

- Integrated HIV/STI prevention and care services
- The role of substances in HIV and STI prevention and progression
- Substance use harm reduction models and strategies
- Sexual identification, gender issues, and provision of trans-friendly services
- Cultural competence
- Correctional issues
- Youth development issues
- Risk reduction and partner notification
- Current medical treatment and updates
- Mental health issues for people living with HIV
- Confidentiality and disclosure
- Behavior change strategies
- Stigma and discrimination
- Community resources including public/private benefits
- Grief and loss

LOS ANGELES COUNTY COMMISSION ON HIV

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PATIENT SUPPORT SERVICES

(Draft as of 04/30/25)

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

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

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

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

Service Standards: Ryan White HIV/AIDS Programs

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DESCRIPTION

The County of Los Angeles (County), Department of Public Health (DPH), Division of HIV and STD Programs (DHSP) oversees the provision of Core HIV Medical Services to eligible clients.

- Core HIV Medical Services provide evidence-based preventive, diagnostic, and therapeutic medical services to RWP eligible HIV-positive clients.
- Core HIV Medical Services are expected to interrupt or delay the progression of HIV disease; promote timely access to care; prevent and treat opportunistic infections; promote optimal health and quality of life; and reduce further HIV transmission by providing clients the education and support for appropriate risk reduction strategies for persons living with HIV (PLWH).
- Core HIV Medical Services use federal Department HHS, HRSA, RWP Part A funds.
- Contractor will provide Core HIV Medical Services as a last resort for clients who are ineligible to receive HIV medical care services reimbursed by another third-party payer source. To determine whether clients are eligible for third-party payer sources or other available payment assistance programs, Contractor must conduct benefits screening as of the initial step in delivering Core HIV Medical Services, including assisting clients in benefits enrollment and billing third-party payer sources for client services, where possible. Third-party payer sources include available public payer sources including, but not limited to Medicare, Medi-Cal, and the Veteran's Administration as well as private insurance plans, including those provided by employers or purchased by an individual. Whether public or private, third-party payer sources must be utilized prior to Contractor accessing RWP funds to support any or all a client's AOM Services.
- Core HIV Medical Services are comprised of the following three categories:
    - Category 1: Ambulatory Outpatient Medical (AOM) Services
    - Category 2: Medical Care Coordination (MCC) Services
    - Category 3: Patient Support Services (PSS)

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

SCOPE OF TCM AS NON-MEDICAL CASE MANAGEMENT SERVICE PER HRSA PCN#16-02

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

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

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

GENERAL ELIGIBILITY REQUIREMENTS FOR RYAN WHITE SERVICES

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

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

PSS STAFFING REQUIREMENTS

Contractor must determine the type and number of support specialists from the list below to make up PSS teams to address the unique needs of its clinic in support of clients' complex medical issues and social challenges:

- **Retention Outreach Specialist (ROS)**
    - Ensures that PLWH remain engaged in their care and have access to necessary resources and support.
    - Demonstrates compassion and commitment to making a significant impact in the lives of those affected by HIV.
    - Integrates with other HIV clinic team members to effectively identify, locate, and re-engage clients who have lapsed in their HIV care.
    - Provides comprehensive assessment, outreach, linkage, and re-engagement services, focusing on clients who are considered "out of care," facilitating their return to consistent and effective HIV treatment and support services.
    - Conducts field outreach operations to efficiently locate and assist clients who have disengaged from HIV care.
    - Acts as the liaison between HIV counseling and testing sites and the medical clinic to ensure that new clients are enrolled in medical care seamlessly and in a timely fashion.
    - Provides crisis interventions, offering immediate support in challenging situations.
    - Provides services to clients not yet enrolled in PSS, MCC Services, or clinic-based programs and can outreach clients who have not yet enrolled into any services with Contractor.

- Collaborates with the HIV clinic team members, documents client interactions, and contributes to program evaluation.
- Demonstrates cultural and linguistic competency to effectively communicate with and support a diverse range of clients.
- Participates in case conferences as needed.
- Must meet the following minimum qualifications:
  - Must have a High School Diploma or successful completion of GED.
- Ability and interest in doing field-based work when necessary to locate or assist clients.
- Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a multicultural environment.
- Valid Class C California Driver's License, proof of vehicle insurance, and reliable transportation for travel to a variety of sites throughout LAC.
- Desirable Qualifications:
  - Knowledge of HIV disease, behaviors that transmit HIV, and those disease conditions that are co- morbid with HIV;
  - Ability to interact in a nonjudgmental and empathetic manner with PLWH and AIDS as well as their partners;
  - Must have good interpersonal skills;
  - Comfortable with field outreach; and
  - Ability to advocate for clients.

- **PSS Social Worker (SW)**
  - Determines client resources and needs regarding mental health services, substance use counseling and treatment, as well as housing and transportation issues to make appropriate referrals and linkages.
  - Holds counselling and psychotherapy sessions for individuals, couples, and families.
  - Provides support services utilizing housing-first, harm reduction, and trauma-informed care principles.
  - Utilizes a sex positive framework including provision of patient education about U=U.
  - Collaborates with the HIV clinic team, documents interactions, and contributes to program evaluation.
  - Maintains knowledge of local, State, and federal services available.
  - Addresses clients' socioeconomic needs, and as part of the PSS team, assists with client monitoring, referrals, and linkages to services, as well as following up with clients and tracking outcomes.
  - Acts as the liaison between HIV counseling and testing sites and the medical clinic to ensure that new clients are enrolled in medical care seamlessly and in a timely fashion.
  - Performs home visits and other field outreach on a case by-case basis.
  - Provides urgent services to clients not yet enrolled in PSS.
  - Participates in case conferences as needed.
  - Conducts a comprehensive assessment of the SDH using a cooperative and interactive face-to-face interview process. The assessment must be initiated within five working days of client contact and be appropriate for age, gender, cultural, and linguistic factors.

        - The assessment will provide information about each client's social, emotional, behavioral, mental, spiritual, and environmental status, family and support systems, client's coping strategies, strengths and weaknesses, and adjustment to illness.
        - SW will document the following details of the assessment in each client's chart:
            - Date of assessment;
            - Title of staff persons completing the assessment; and
            - Completed assessment form.
    - Develops a PSS Intervention Plan SW will, in consultation with each client, develop a comprehensive multi-disciplinary intervention plan (IP). PSS IPs should include information obtained from the SDH assessment. The behavioral, psychological, developmental, and physiological strengths and limitations of the client must be considered by the SW when developing the IP. IPs must be completed within five days and must include, but not be limited to the following elements:
        - Identified Problems/Needs: One or more brief statements describing the primary concern(s) and purpose for the client's enrollment into PSS as identified in the SDH assessment.
        - Services and Interventions: A brief description of PSS interventions the client is receiving, or will receive, to address primary concern(s), describe desired outcomes and identify all respective PSS Specialist(s) assisting the client.
        - Disposition: A brief statement indicating the disposition of the client's concerns as they are met, changed, or determined to be unattainable.
        - IPs will be signed and dated by the client and respective SW assisting the client.
        - IPs must be revised and updated, at a minimum, every six months.
    - Meets the following minimum qualifications:
        - Master's degree in social work, Counseling, Psychology, or related field from an accredited social work program.
        - Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a multicultural environment.
        - Valid Class C California Driver's License, proof of vehicle insurance, and reliable transportation for travel to a variety of sites throughout LAC.
    - Desirable Qualifications:
        - Have a minimum of two years of relevant work experience with clients in public health, community services or medical settings.
        - Knowledge of HIV disease, behaviors that transmit HIV, and those disease conditions that are co- morbid with HIV;
        - Ability to interact in a nonjudgmental and empathetic manner with PLWH and AIDS as well as their partners; and
        - Ability to hold counselling and psychotherapy sessions for individuals, couples, and families.
- **Benefits Specialist (BS)**

- Conducts client-centered activities and assessments that facilitate access to public benefits and programs. Focuses on assisting each client's entry into and movement through care service systems.
- Stays up to date on new and modified benefits, entitlements, and incentive programs available for PLWH.
- Ensures clients are receiving all benefits and entitlements for which they are eligible.
- Educates clients about available benefits and provides assistance with the benefits application process.
- Helps prepare for and facilitates relevant benefit appeals.
- Collaborates with the HIV clinic team, documents interactions, and contributes to program evaluation.
- Develops and maintains expert knowledge of local, State, and federal services and resources including specialized programs available to PLWH.
- Participates in case conferences as needed. 9. Meets the following minimum qualifications:
    - High school diploma (or GED equivalent).
    - Has at least one year of paid or volunteer experience making eligibility determinations and assisting clients in accessing public benefits or public assistance programs.
    - Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a multicultural environment.
    - Valid Class C California Driver's License, proof of vehicle insurance, and reliable transportation for travel to a variety of sites throughout LAC.
- Desirable Qualifications:
    - Knowledge of HIV disease, behaviors that transmit HIV, and those disease conditions that are co- morbid with HIV;
    - Ability to interact in a nonjudgmental and empathetic manner with PLWH and AIDS as well as their partners;
    - Must have good interpersonal skills;
    - Comfortable with field outreach; and
    - Ability to advocate for clients.

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

- Collaborates with the HIV clinic team, documents interactions, and contributes to program evaluation.
- Attends meetings and trainings to improve skills and knowledge of best practices in permanent supportive housing and related issues.
- Participates in case conferences as needed.
- Meets the following minimum qualifications:
  - Bachelor's degree or a minimum of two years' experience in social services, case management, or other related work.
  - Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a multicultural environment.
  - Valid Class C California Driver's License, proof of vehicle insurance, and reliable transportation for travel to a variety of sites throughout LAC.
- Desirable Qualifications:
  - Knowledge of HIV disease, behaviors that transmit HIV, and those disease conditions that are co- morbid with HIV;
  - Ability to interact in a nonjudgmental and empathetic manner with PLWH and AIDS as well as their partners;
  - Must have good interpersonal skills;
  - Comfortable with field outreach; and
  - Ability to advocate for clients; and
  - Willingness and ability to learn how to navigate the complex housing support systems in LAC.

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

        - Has at least one year of experience in an SUD program with experience providing counseling to individuals, families, and groups.
        - Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a multicultural environment.
        - Valid Class C California Driver's License, proof of vehicle insurance, and reliable transportation for travel to a variety of sites throughout LAC.
    - Desirable Qualifications:
        - Knowledge of HIV disease, behaviors that transmit HIV, and those disease conditions that are co- morbid with HIV;
        - Ability to interact in a nonjudgmental and empathetic manner with PLWH and AIDS as well as their partners;
        - Must have good interpersonal skills;
        - Comfortable with field outreach; and
        - Ability to advocate for clients.
- **Clinical Nursing Support Specialist:**
    - Provides enhanced clinical nursing support, performed by a registered nurse to facilitate:
        - Administration and supervision of client injectable medications and vaccinations;
        - Tracking of clients receiving long-acting injectable, multi-dose injectable treatments, or multi-dose vaccine series; monitors clients for side effects; makes appointments for subsequent nursing visits to ensure timely receipt of injections; and
        - Coordinates care activities among care providers for patients receiving long-acting injectable medications, vaccinations, and other injectable medications to ensure appropriate delivery of HIV healthcare services.
    - Participates in case conferences as needed.
    - Collaborates with the HIV clinic team, conducts health assessments as needed, documents interactions, and contributes to program evaluation.
    - Meets the following minimum qualifications:
        - Must possess a current license to practice as a registered nurse (RN) issued by the State of California Board of Registered Nursing.
        - Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a multicultural environment.
        - Valid Class C California Driver's License, proof of vehicle insurance, and reliable transportation for travel to a variety of sites throughout LAC.
    - Desirable Qualifications:
        - Knowledge of HIV disease, behaviors that transmit HIV, and those disease conditions that are co-morbid with HIV;
        - Ability to interact in a nonjudgmental and empathetic manner with PLWH and AIDS as well as their partners;
        - Have good interpersonal skills;

        - Comfortable with field outreach; and
        - Ability to advocate for clients.

- **Peer Navigator (PN):**
    - Provides client-centered group or individual psycho-social support services to assist PLWH by providing a safe space where lived experiences and challenges can be discussed without judgement. Topics to be discussed include but are not limited to:
        - Living with HIV;
        - Healthy lifestyles (including substance use) and relationships;
        - Adherence to treatment;
        - Access and barriers to care;
        - Prevention (PrEP, PEP, DoxyPEP, treatment as prevention);
        - Disclosing status; and
        - Stigma.
    - Supports individuals who may be newly diagnosed, newly identified as living with HIV, or who may require additional support to engage in and maintain HIV medical care and support services to ensure that clients are linked to care and continuously supported to remain in care.
    - Conducts individual and group interventions to address personalized goals and develop needed skill sets for healthy living, ensure medication adherence and support a positive outlook for individuals living with HIV.
    - Collaborates with other HIV clinic team members to align treatment goals with overall care, documents interactions, and contributes to program evaluation.
    - Oversees incentives, contingency management programs, and/or other evidence-based interventions.
    - Provides education on HIV clinic services available and additional key resources to clients.
    - Participates in case conferences as needed.
    - Meets the following minimum qualifications:
        - Is reflective of the population and community being served.
        - Has lived experience.
        - Must NOT be a current client of Contractor's clinic.
        - Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a multicultural environment.
        - Valid Class C California Driver's License, proof of vehicle insurance, and reliable transportation for travel to a variety of sites throughout LAC.
    - Desirable Qualifications:
        - Knowledge of HIV disease, behaviors that transmit HIV, and those disease conditions that are co- morbid with HIV;
        - Ability to interact in a nonjudgmental and empathetic manner with PLWH and AIDS as well as their partners;
        - Must have good interpersonal skills;
        - Comfortable with field outreach, and
        - Ability to advocate for clients.

Estamos Escuchando

Comparta sus inquietudes con nosotros.

Servicios de VIH + ETS
Línea de Atención al Cliente

(800) 260-8787

¿Por qué debería llamar?

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

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

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

¿Puedo llamar de forma anónima?

Si.

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

Si.

Por correo electronico:
dhspsupport@ph.lacounty.gov

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

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

We're Listening

share your concerns with us.

HIV + STD Services Customer Support Line

(800) 260-8787

Why should I call?

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

Will I be denied services for reporting a problem?

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

Can I call anonymously?

Yes.

Can I contact you through other ways?

Yes.

By Email:
dhspsupport@ph.lacounty.gov

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

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