LOS ANGELES COUNTY
COMMISSION ON HIV

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HIV PREVENTION PLANNING WORKGROUP
Virtual Meeting

Agenda and meeting packet will be available prior to the meeting at
http://hiv.lacounty.gov/Planning-Priorities-and-Allocations-Committee

Wednesday, August 23, 2023

4:00PM-5:30PM (PST)

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LOS ANGELES COUNTY
COMMISSION ON HIV

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PREVENTION PLANNING WORKGROUP
Virtual Meeting Agenda
Wednesday, August 23, 2023 @ 4:00 – 5:30pm

To Join by Computer:
https://lacountyboardofsupervisors.webex.com/lacountyboardofsupervisors/j.php?MTID=m4776519d20604cc649542ebc1d485162

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AGENDA

1. **Welcome and Introductions (4:00-4:10 pm)**

2. **COH Executive Director/Staff Report (4:10-4:20pm)**
   a. COH Bylaws Review Taskforce | UPDATES

3. **Co-Chairs' Report (4:20-4:30 pm)**
   a. Planning, Priorities and Allocations Committee August 15 Meeting

4. **Continue Review of Prevention Planning Standards (4:30-5:15)**

5. **Next Steps and Agenda Development for Next Meeting (5:15-5:20 pm)**

6. **Public Comment + Announcements (5:20-5:30 pm)**

7. **Adjournment (5:30 pm)**

VIRTUAL MEETING—PREVENTION PLANNING WORKGROUP (PPW)
Wednesday, July 26, 2023 | 4:00-5:30PM
MEETING SUMMARY

Attendees:

Miguel Martinez (Co-Chair)	Kevin Donnelly	Katja Nelson
Arlene Frames	Rob Lester	Benjamin White
Beverly Burgess	Vicki Ashley	Christiana Watkins
Joseph Green	Robert Aguayo	Genevieve Clavreul
Commission on HIV (COH) Staff: Cheryl Barrit, Jose Rangel-Garibay, Lizette Martinez		
Division of HIV and STD Programs (DHSP) Staff: Paulina Zamudio		

1. **Welcome and Introductions**
   Miguel Martinez, Co-Chair, welcomed attendees and led introductions.

2. **Executive Director/Staff Report**
   C. Barrit provided an overview of the creation and purpose of the Commission on HIV (COH) Bylaws Review Taskforce that was created to review and update COH bylaws. The taskforce has begun their review and proposed revisions to the bylaws and will be sharing with the various committees, caucus' and workgroups for input/feedback. Commission staff will share recommendations for feedback once revisions are completed.
   - C. Barrit also reminded the group of the next Commission on HIV meeting on August 10th at 9am at St. Anne's Conference Center.

3. **Co-Chairs' Report**
   a. **Planning, Priorities, and Allocations (PP&A) Committee June 20 Meeting**
   - M. Martinez asked K. Donnelly, PP&A co-chair to provide a brief recap of the June 20 PP&A Committee meeting.
   - K. Donnelly provided a recap of the May meeting highlighting a discussion on opportunities to maximize Ryan White Program (RWP) funds with the advent of Medi-Cal expansion beginning in January 2024. Proposed recommendations focused on ensuring continuity of care as people transition from the RWP to Medi-Cal. June PP&A meeting included HRSA recommendations on the Integrated HIV Plan, a discussion around the final unmet needs report focusing on individuals in care but not virally suppressed and identifying opportunities to expand testing and prevention efforts in SPA 6. He also noted the planning of focus groups to engage Community Advisory Boards to gather feedback on

current HIV prevention and care services to identify opportunities for improvement.

- The July PP&A meeting was cancelled, and the next PP&A meeting will be Tuesday, August 15 at 1:00-3:00pm at the Vermont Corridor.
- M. Martinez noted all status neutral recommendations will be presented to the PP&A Committee once the workgroup has had a chance to hear updates on harm reduction activities from the Substance Use Prevention and Control (SAPC) program and formulate any recommendations related to harm reduction.
- Commission staff, L. Martinez reported that the Standards and Best Practices (SBP) Committee did an initial review of the proposed LA County Status Neutral Framework and suggested: 1) to list the social determinants of health directly within the graphic (instead of a footnote) and, 2) add "Regular Engagement in" to the Quality Care section.
- After some discussion it was voted to not incorporate SBP's suggestions. The workgroup noted the graphic should be kept simple and noted "Quality Care" was a standard for provider to follow and not describing consumer behaviors. Instead, the workgroup recommended adding language within the Prevention Standards to describe the framework.

4. Begin Review of Prevention Standards

- M. Martinez kicked off the discussion of the Prevention Standards with a brief overview and noting the standards have not been updated since 2018. He noted overall changes of integrating STIs into the standards to address the syndemic of HIV and STIs and incorporating the status neutral framework thinking specifically on how it impacts prevention efforts.
- Additional recommendations to include new innovations include, PrEP, PEP, DoxyPEP, undetectable equals untransmittable (U=U), status neutral planning, and alignment with the current Integrated HIV Plan.
- M. Martinez asked for clarification of the scope of the Prevention Standards review. C. Barrit reminded the group that the SBP Committee is looking to the workgroup to provide their expertise around prevention and that the workgroup is free to suggest major restructuring, omission or needed additions, as appropriate.
- P. Zamudio requested prevention utilization data and an opportunity to have a joint meeting with the SBP Committee. C. Barrit noted that the COH does not have prevention data and would look to DHSP and recommended including prevention standards beyond what is currently available to all potential strategies.

- L. Martinez reminded the workgroup that there is opportunity for continued input once recommendations are sent to the SBP Committee through the public comment period.
- It was recommended to add Social Determinants of Health and Navigation subsections to the Core Prevention Components section.
- It was noted that many workgroup members did not have a chance to review the Prevention Standards prior to the meeting and had challenges focusing on specific recommendations. As such, the workgroup decided to commit to doing a thorough review of the prevention standards to provide tangible feedback and submit recommendations to staff before the next PPW meeting.
- The workgroup decided to meet in August to avoid delaying progress on revisions to the Prevention Standards. Members selected specific sections to review/revise and submit to Commission staff by August 14th. Staff will combine recommendations ahead of the August meeting and the group will review at their next meeting. Staff confirmed that a Word version of the document would be sent to members before the meeting adjourned.

5. **Next Steps and Agenda Development for Next Meeting**
    - Workgroup members will review the Prevention Standards and submit recommendations/revisions to Commission staff by Monday, August 14th.
    - The Prevention Planning Workgroup will meet in August to continue review and revisions to the Prevention Standards.
    - The next virtual PPW meeting will be Wednesday, August 23rd at 4:00-5:30pm.

6. **Public Comment + Announcements –** J. Green announced that the COH Executive Committee was meeting the following day July, 27th at 1pm at the Vermont Corridor and invited people to attend.

7. **Adjournment –** The meeting was adjourned by M. Martinez.

LOS ANGELES COUNTY
COMMISSION ON HIV

POLICY/PROCEDURE #08.1102	Subordinate Commission Working Units	Page 1 of 12

F I N A L Revised
Approved 8/11/16

SUBJECT: **The role(s), structures and governing rules of the Commission's various types of subordinate committees and working groups.**

PURPOSE: **To describe the purpose, status, structure, rules, work and timeframes of various subordinate working groups that facilitate advancement, review and completion/fulfillment of Commission responsibilities, tasks, work and projects.**

BACKGROUND:

- Federal Ryan White legislation is the largest source of non-entitlement funding for HIV care and treatment in the country. Part A funding is directed to the most impacted urban jurisdictions across the country. The Ryan White Treatment and Modernization Act of 2009 requires all Part A jurisdictions established before 2008 to create local HIV planning councils. The Health Resources and Services Administration (HRSA) in the US Department of Health and Human Services (DHHS) administers the Ryan White Program nationally.

- The Los Angeles County Commission on HIV serves as LA County's Ryan White and Centers for Disease Control (CDC) prevention HIV planning council. The County has chartered the Commission in County Code, Ordinance 3.29. Both roles as the Ryan White HIV planning council and a County-chartered commission carry specific responsibilities and expectations. The Commission's annual work plan is driven and governed by all of these sources (Ryan White legislation, HRSA and CDC guidance, and County directive/need), yielding an annual schedule of review, discussion, decision-making and work product.

- In order to fulfill its responsibilities and accomplish the work assigned to it, the Commission adopted a strategy in 2003 that relies almost entirely on its committees to perform initial analysis of, generate recommendations to and implement actions for the full Commission. Since then, the Commission's committees have had an indispensable impact on the Commission's capacity to fulfill its varied responsibilities and advance significant initiatives benefiting people with HIV/AIDS/STDs in LA County.

- While the Commission generates, modifies and/or finalizes work and/or decisions, it rarely prepares the work directly as a full body. Rather, it relies on the standing committees and other working groups to forward recommended decisions or work for consideration by the full body. As a result, the Commission counts on the committees and related work units to complete more focused analysis. The committees, in turn, may rely on different types of working units to which they assign/delegate the work. This policy details the various working units the Commission and its committees can access to advance and expedite its decisions and work as needed.

POLICY:

1) **Policy/Procedure Description**: These policies and descriptions define and detail the organization, structure and governing rules/procedures of various working units the Los Angeles County Commission on HIV can engage to generate, develop and complete tasks and work necessary to fulfill its mission and purpose.

2) **Committee-Driven Process**: The Commission is an HIV community planning body that regularly generates planning and implementation decisions and work product consistent with federal Ryan White legislative and Los Angeles County Charter requirements and guidance. Generally, the Commission's work flow and process is "committee-driven," meaning that recommended decisions, actions and work are typically proposed by the Commission's standing committees or other working units to the full Commission for review, consideration, and final decision-making. While the Com-mission generates, modifies and/or finalizes work and/or decisions, it rarely performs the work directly as a full body.

3) **Standing Committees**: The Commission's primary working units are the five standing committees—the Executive, Public Policy (PP), Operations, Planning, Priorities and Allocations, (PP&A) and Standards and Best Practices (SBP). Each of the standing committees has specific responsibilities detailed in the Commission's By-Laws, which they, in turn, implement through ongoing analysis, study, discussion, debate, decision-making, work product, action and/or implementation.

4) **Annual Work Planning**: The Executive Director in consultation with the Co-Chairs and Committee Co-Chairs will develop an Annual Work Plan at the beginning of the program year (March – February). The annual work plan will be aligned with the Comprehensive HIV Plan's Goals and Objectives Section.

5) **Role of the Working Units**: The Commission, its Co-Chairs, the Executive Committee and the Commission's standing committees are entitled to establish caucuses, subcommittees, ad-hoc committees, task forces and various types of working groups to more thoroughly address responsibilities, decisions, work, tasks and projects in accordance with their and the Commission's work plan.

6) **Openness and Transparency Requirements**: Like the Commission, the standing committees are covered by the Ralph M. Brown Act, comply with HRSA guidance and other "sunshine" law requirements regarding meeting transparency and related agendas, notices and preparations; meeting conduct, voting procedures and decision-making; public participation; and meeting record-keeping.

7) **Caucus(es)**: The Commission establishes caucuses, as needed, to provide a forum for Commission members of designated "special populations" to discuss their Commission-related experiences and to strengthen that population's voice in Commission deliberations. Caucuses are not, by definition, Brown Act-covered bodies, and are not required to comply with open meeting, public participation and other, related "sunshine" requirements. With Commission consent, caucuses determine their membership, meeting conduct and timelines, work plans, and activities.

8) **Ad-Hoc Committee(s)**: The Commission, its Co-Chairs and/or the Executive Committee can create ad-hoc committees to address longer-term Commission special projects or initiatives that require more than one standing committee's input, involvement and/or representation. Once the project has been completed, the ad-hoc committee automatically sunsets. The Commission Co-Chairs are responsible for assigning Commission members to the ad-hoc committees, and during their tenure, ad-hoc committees maintain the same stature and reporting expectations as other standing committees. Ad-hoc committees are required to comply with all of the same Brown Act and other transparency requirements as the Commission and its standing committees.

9) **Subcommittee(s)**: Standing Committees and/or their co-chairs may establish subcommittees to address and carry out work, tasks and activities to address one of the committee's primary responsibilities. Consequently, subcommittees are not necessarily time-limited, but the committee can extend, suspend, amend and or conclude the subcommittee's work at any time. The committee may delegate certain authorities to the subcommittee, and the subcommittee's work plan is incorporated into the committee work plan. The committee's co-chairs assign committee, and possibly other Commission, members to the subcommittee. Sub-committees are required to comply with all of the same Brown Act and other transparency requirements as their respective committees.

10) **Task Forces(s)**: Task Forces can be created by the Commission, its Co-Chairs and/or the Executive Committee, and are intended to address a significant Commission priority that may entail multiple levels of work or activity and are envisioned as longer-term in nature. Task forces are similar to ad-hoc committees, except that their membership is expected to include at least as many non-Commission members as Commission members. Task force decisions, work, activities and plans must be reported to and approved by the Executive Committee. While, technically, task forces do not have to comply with Brown Act and other

transparency requirements, it is encouraged that they do so in the spirit of the law. Various community task forces are **<u>not</u>** formal Commission working units, unless recognized as such by the Commission; however, they are invited to report and recommend actions to the Commission.

11) **Work Group(s)**: Work groups are primarily created by the committees for work on a single, short-term project that the committee cannot as thoroughly address during its regular meetings. By definition, work groups—which can come in many different forms—are only operational for short, time-limited periods. Commission and non-Commission members may participate in a work group, but no more Commission members than the originating committee's quorum. Work groups are not covered by the Brown Act and other transparency laws, and the final decisions/recommendations/work serve as a record of the work group's deliberations and must be forwarded to the originating committee for review, consideration and modification/approval.

12) **Organizational Purpose, Structure and Responsibilities**: The following procedures comprehensively describe the various types of subordinate Commission working units; their role(s) and purpose(s); the conditions under which they can be established; and what rules, governance, processes and expectations guide their activities. Each working unit description approximates the following organization:
    - Establishing authority
    - Definition, standing and reporting responsibilities
    - Role and purpose
    - Necessary conditions/provisions
    - Legal requirements
    - Organization, membership and leadership
    - Scope of responsibility and timeframe
    - Staff support, and
    - Other distinctions.

PROCEDURE(S):

1. **Work Plan Implementation**: The Commission develops an annual work plan for the federal Ryan White program year (March – February) detailing the tasks and work projects it expects to complete in the year and that serves as the Commission's primary work outline Each of the Commission's standing committees and caucuses prepares an individual work plan, and the compilation of those work plans is modified/ approved by the Commission.
    a. Commission decisions and work products are guided by federal Ryan White legislation, Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention (CDC) and County Ordinance requirements and guidance.
    b. The work plan is a "living document" that may change as unanticipated pressing, urgent and/or time-sensitive issues need to be addressed during the course of the year.

c. Various types of subordinate working units are created at the Commission to carry out and fulfill work and decision-making responsibilities in accordance with that workplan. The organization, structures, rules, work activities and timelines for each type of working group are defined in the following procedures.

d. The group's work objectives and timeframe for completing them will dictate which type of working unit is necessary to carry out those responsibilities.

2. **Standing Committee(s)**: The Commission's standing committees and their respective responsibilities are authorized by and defined in the Commission's By-Laws (*see Pol/Proc #06.1000: Commission By-Laws*). The standing committees:
   - are continuing work units;
   - meet monthly or more frequently;
   - concurrently juggle multiple tasks and activities within their respective purviews; and
   - are the Commission's primary means of discharging its duties and responsibilities.

a. All of the Commission's major function(s) and responsibilities are assigned to at least one of the standing committees. While the standing committees primarily generate recommendations and propose work products for the Commission's modification/ approval, they are authorized to make some limited final decisions—such as document revisions in the Operations and Standards and Best Practices (SBP) Committees, policy position modifications in the Public Policy (PP) Committee, and final appeals at the Planning, Priorities and Allocations (PP&A) Committee.

b. Standing committees forward reports, completed work and Committee-approved decisions/recommendations to the Executive Committee and the Commission, as appropriate, understanding agenda items at those meetings.

c. As the Commission's fundamental working units and in the spirit of transparent and open decision-making, the standing committees are subject to Ralph M. Brown Act, HRSA and other applicable sunshine law requirements .As such, the standing committees must adhere to the relevant rules governing:
   - meetings open to the public;
   - public participation and comment periods;
   - development, notification and posting of agendas;
   - quorums and voting procedures; and
   - meeting record-keeping, audio-recording, and minutes.

   1) The Commission's standing committees perform their work, conduct their business, and discuss and deliberate in open, public settings and meetings (except for rare closed Committee sessions that are consistent with Brown Act provisions).
   2) Members of the public are encouraged to attend and participate in standing committee meetings.

3) Agendas detailing topics to be addressed are developed for all meetings, and meeting agendas are posted 72 hours in advance.
4) A quorum must be present at any meeting in which votes are taken and only Board of Supervisor (BOS)-appointed Commission members are entitled to cast votes.
5) All meetings are electronically recorded and minutes summarizing meeting discussions and actions are subsequently produced and approved.

d. Standing committee voting privileges are only conferred on Board of Supervisors (BOS)-appointed Commission members who have been assigned to the Committee by the Commission's Co-Chairs, or designated OAPP representatives consistent with the By-Laws.
   1) There is no limit to the number of Commission members who can be assigned to a standing committee.
   2) The standing committee quorum equals one member more than 50% of the assigned membership.
   3) A quorum is required before votes can be taken at a meeting. While all of the Commission's working groups aim for consensus, votes may be necessary to arrive at a decision or for record-keeping purposes.
   4) A motion is successful when more than half of the voting members at the meeting support it.

e. Standing committees elect their committee co-chairs from among their designated membership.
   1) Although a standing committee meeting can proceed without a quorum (however no voting allowed), it cannot proceed without at least one of the Committee or Commission Co-Chairs to lead the meeting.
   2) The Commission's Ordinance and By-Laws dictate that all standing committee co-chairs also serve on the Commission's Executive Committee.

f. Standing committees determine their scope of responsibilities in accordance the standing committee's charge in the Commission By-Laws. The committee outlines how it intends to fulfill those responsibilities by detailing the projecting work tasks/activities and when they will be performed in its annual work plan.
   1) Work priorities are determined by the committee and its co-chairs, shifted accordingly throughout the year due to unforeseen circumstances.
   2) The Commission, its Co-Chairs and/or Executive Committee may also shift standing committee work priorities in consideration of overall Commission priorities and/or existing resources to support the entirety and scheduling of the anticipated Commission workload.

g. The Executive Director assigns each standing committee one lead and at least one support staff person from among the Commission Office staff.

3. **Caucus(es)**: Only the Commission is authorized to create Commission caucuses. When establishing a caucus, the Commission must balance the number of existing caucuses, their

workloads and schedules, and determine that staff resources exist to provide adequate support to the roster of caucuses and committees.

a. Only caucuses created by the Commission with BOS-appointed membership are formally recognized as formal working units of the Commission.
   1) Commission caucuses maintain the same stature as the Commission's standing committees, including monthly reporting responsibilities to the Commission.
   2) Consistent with the Commission's By-laws, caucuses do not maintain representative seats on the Executive Committee.

b. The caucus was developed as a vehicle to provide a safe and judgement-free setting where the Commission's caucus members can easily and freely discuss their reactions and experiences, share their insights, and exchange perceptions of issues addressed by the Commission among other Commission members who are more likely to share/ understand those perspectives. Second, the caucus was intended to develop a more organized voice to ensure that the caucus population's perspective is effectively heard when relevant issues are raised and discussed at the Commission. Thus, each caucus has four primary responsibilities:
   1) Facilitating a forum for a dialogue among the caucus members;
   2) Developing the caucus voice at the Commission and in the community;
   3) Providing the caucus perspective on various Commission issues; and
   4) Cultivating leadership in the caucus membership and population.

c. When forming a caucus, the Commission must adhere to the following criteria:
   1) the population proposed to be represented by the caucus must be one of the Commission's designated "special populations" ;
   2) the Commission must conclude that the population's voice can be strengthened by caucus representation; and
   3) caucus membership must include more than five Commission members and fewer members than the Commission quorum.

d. Since the caucus structurally does not comprise a quorum of the Commission or any of its standing committees, the Commission's caucuses are not governed by the Brown Act, HRSA, CDC or other rules and requirements that apply to the Commission's other committees. Consequently:
   1) the caucus is not required to adhere to quorum requirements;
   2) posted agendas are not required for the Caucuses; and
   3) caucus meetings are not open to Commission membership or the public, unless the caucus chooses to do so;
   4) caucus meetings are not audio recorded and meeting minutes are not produced, however the caucus may use meeting summaries to ensure operational efficiency.

e. Decisions about the caucus organization, structure, membership, process and schedule are left to the caucus membership:

    1) all Commission members of the designated population are considered members of the established caucus, whether or not they choose to participate;
    2) the caucus determines its leadership and leadership responsibilities;
    3) the caucus determines how and when to involve the broader Commission and community in its meetings and activities;
    4) the caucus determines its internal organization and meeting/activity schedule.

f. The caucus determines what and how many issues it will address throughout the year by establishing its own scope of responsibility and identifying the work and type of activities in which it will engage. Among the activities it may use to advance its work are education and dialogue, mobilization and advocacy, written communications, presentations, member recruitment, improved representation, events, community involvement, and other options.
    1) Like the standing committees, caucuses are expected to develop annual workplans, which, in turn, are included in the Commission's annual workplan.
    2) The Executive Committee's and Commission's modifications to caucus workplans and final approval of the annual Commission workplan constitute acceptance of the caucus' self-defined scope and timeframe of responsibility.

g. The Executive Director is responsible for determining who among the Commission staff is the most suited to provide staff support to the caucus.

4. **Subcommittee(s)**: Standing committees create subcommittees, as needed, to carry out one or more of the standing committee's major areas of responsibility. The standing committee can "sunset" a subcommittee or continue, amend, suspend, extend and/or reclaim the work or responsibility or parts of it at will.

    a. The subcommittee's work priorities are established by its respective standing committee as the standing committee deems appropriate as it endeavors to fulfill its responsibilities and determines that it does not have the time to address the topic as specifically as needed in the context of its regular meetings.

    b. Subcommittees must forward their decisions, recommendations and work products to their respective standing committees for consideration, review, modification and/or approval, unless the standing committee has instructed otherwise.
        1) Subcommittee reports are regularly agendized for their respective standing committee meetings.
        2) The standing committee may delegate a portion of the committee's decision-making authority to the subcommittee or instruct the subcommittee to report its decisions/actions directly to the full Commission.

    c. During its tenure, the subcommittee is considered a formal working unit of the Commission, and, as such, must comply with the same Brown Act, HRSA and other, related legal operational rules and requirements as standing committees (*see Procedure #2.c*).

d. The standing committee co-chairs are entitled to assign members of their committee to any subcommittees the committee establishes, and to determine if they will accept other Commission members who volunteer for the designated subcommittee(s).
    1) Standing committee rules governing membership, voting privileges and meeting conduct also apply to subcommittees (*see Procedure #2.d*)
    2) Only Commission or standing committee members with voting privileges are entitled to membership on subcommittees—although the public are invited to attend and participate in subcommittee meetings.
    3) Like the standing committees, subcommittees elect their own co-chairs. At least one of the standing committee co-chairs should attend and lead the first subcommittee meeting in order for the subcommittee to choose its own leadership.

e. While the standing committee determines the subcommittee's scope and limits of responsibility, the subcommittee may elaborate on that topic, extend, revise or modify it, and design the appropriate work strategies to address it, with the standing committee's or its co-chairs' consent.
    1) The subcommittee's annual work plan is incorporated into the standing committee's annual work plan.
    2) That responsibility may be time-limited or assumed to be a long-term or permanent delegation of the standing committee's authority.

f. The respective standing committee staff support also staffs its subcommittees.
    1) With the Executive Director, the standing committee must balance the number of its subcommittees, its work-load and schedule to determine if staff resources are adequate to provide the necessary support to a subcommittee.

5. **Ad-Hoc Committee(s)**: The Commission, its Co-Chairs or the Executive Committee are entitled to create ad-hoc committees, as needed and appropriate.

a. For the duration of an ad-hoc committee's work, the ad-hoc committee maintains the stature of Standing Committees, including regular inclusion on the agenda and reports to the Executive Committee and the Commission.
    1) Consistent with the Commission By-Laws, ad-hoc committees do not maintain representative seats on the Executive Committee.

b. Ad-hoc committees are "special project"-focused in nature, meaning they are assigned one significant project, versus limited-activity or short-term projects that can be addressed by other working units or as part of a standing committee's or subcommittee's more expansive agenda.

c. Ad-hoc committees are created for special projects that extend beyond a single standing committee's authority or purview and require membership from multiple committees.
    1) The Commission Co-Chairs determine who will serve on an ad-hoc committee by assigning members and/or accepting volunteers.

d. The ad-hoc committee determines rules, activities and schedules regarding its organization, membership and leadership.
   1) Ad-hoc committees must comply with all of the same legal requirements and guidance governing meeting preparations and their conduct as standing committees and subcommittees.

e. Given its defined purpose to address a single, significant Commission special project, an ad-hoc committee is established for a distinct time period and automatically sunsets at the conclusion or completion of the project.

f. Executive Committee staff support provides staff support to ad-hoc committees, unless the Executive Director designates other staff support.

6. **Task Force(s)**: Task Forces can be created by the Commission, its Co-Chairs or the Executive Committee. Task forces are intended to address a topic that is broader and more expansive in nature, encompassing multiple activities and a continuing, longer-term time frame.

a. Unlike ad-hoc committees or subcommittees with similar purposes, task forces are created to include Commission members and non-Commission members alike, generally at equal proportions, or with Commission members forming a minority of the task force membership.

b. Task forces report to the Executive Committee, to which they forward their recommendations and work. Since membership is not confined to solely Commission members, any recommendation or action from a Task Force must be approved by the Executive Committee before advancing it to the full Commission.

   1) The Commission's task forces are expected to provide periodic reports to the full body.

c. Technically—only unless the Task Force membership comprises a majority of Commission members from one of its working units—it does not have to comply with public noticing and other Brown Act rules; practicality, though, suggests compliance with those rules, even if not specifically mandated.

d. The task force membership is empowered to determine its own leadership, structure, and schedule.

e. The task force assumes its scope of responsibility and develops its work plan(s) in consultation with the Executive Committee and the Executive Director.
   1) The task force work plan, scheduling and timeline is incorporated into the Executive Committee's annual work plan.

f. Executive Committee staff support provides staff support to ad-hoc committees, unless the Executive Director designates other staff support.

g. It is important to note that the HIV community has created a number of population- and service-centered task forces that are **<u>not</u>** Commission working units, unless formally recognized by the Commission.
    1) Community task forces are welcome, though, to report their recommendations or work to the Commission under the standing "Task Force" agenda item, as needed and appropriate.

7. **Work Groups**: The committees are primarily responsible for establishing work groups, the most informal of the Commission's subordinate working units. Work groups are created to complete a specific short-term, single-focused task, resulting in a final work product that concludes the work group's activities.

a. Most frequently, work groups are established to work in more specific detail on a task that the committee does not have time to address in its regular meetings, or to finish a task that requires direct involvement and input from the work group members (e.g., such as developing plans, reviewing and generating documents and/or conducting studies, among other possible activities).
    1) All work group actions must be approved by the committee of origin, as work groups are only performing work on the committee's behalf and request.

b. Due to their short-term timeframe, specific work assignment and limited membership, work groups are not governed by the Brown Act or other sunshine law requirements.

c. Work groups cannot include more members than the originating standing committee's quorum, otherwise additional meeting preparation, membership, timeline and management requirements will be invoked.
    1) Work group meetings are not intended to be open to the public, or subject to transparency and public participation requirements.
    2) Work group meetings are, instead, intended to be working meetings that produce decisions, documents and/or other products that will be presented for open, public discussion, debate and/or consideration at the originating standing or other committee.
    3) Agendas and meeting minutes are not needed for work groups. Summaries may be provided, if needed, to capture information discussed at prior meetings or to ensure continuity and progress of meeting discussions.
    4) Generally, the final documentation and/or work product from the work group serves as a record of the work group meeting proceedings.

d. Work groups can come in many forms: as a committee work group, an expert review panel, a focus group or in other formats.

e. Non-Commission members can be included in the work group with the consent of the standing committee or the Executive Director, as needed.
    1) Due to the mix of Commission and non-Commission members on work groups, votes and voting procedures are not used at work group meetings.

    2) Due to its short-term nature, work groups do not require formal leadership.

f. The work group's scope of responsibility is defined by the originating committee, are short-term limited, and range from one to a dozen meetings in total.
    1) More frequently work groups meet only once or twice and finish their assigned projects within a month (for example, by the committee's next meeting).

g. Work groups are staffed by one of the committee's support staff and the work is not intended to exceed six months, at the maximum.

NOTED AND APPROVED: Cheryl A Barrit

EFFECTIVE DATE: December 9, 2010; 8/11/16

Original Approval: 12/9/10

Revision(s):7/25/16

S:\Administration\Policy & Procedure Manual\08.0000 Commssn Policies\08.1000 Gen Commssn Practices\08.1100 Structure\08.1102 Commssn Subordinate Work Groups\2016 Update\Pol-#08.1102-Subordinate Commssn Work Units-120910-FinalRevAppr81116.doc

LOS ANGELES COUNTY
COMMISSION ON HIV

Standards & Best Practices Committee Standards of Care Definition[1]

- **Service standards:**
  - Are written for service providers to follow.
  - Establish the minimal level of service or care that a Ryan White funded agency or provider may offer.
  - Are essential in defining and ensuring consistent quality care is offered to all clients.
  - Serve as a benchmark by which services are monitored and contracts are developed.
  - Define the main components/activities of a service category.
  - Do not include guidance on clinical or agency operations.

Core Medical Services	Description
Ambulatory Outpatient Medical (AOM) Services	HIV medical care access through a medical provider.
Home-based Case Management	Specialized home care for homebound clients.
Medical Care Coordination (MCC)	HIV care coordination through a team of health providers to improve quality of life.
Medical Specialty Services	Medical care referrals for complex and specialized cases.
Mental Health Services	Psychiatry, psychotherapy, and specialized cases.
Oral Health Services (General & Specialty)	General and specialty dental care services.
Supportive Services	**Description**
Benefits Specialty Services	Assistance navigating public and/or private benefits and programs (health, disability, etc.).
Language Translation Services	Translation services for non-English speakers and deaf and/or hard of hearing individuals.
Legal Services	Legal information, advice, and services.
Nutrition Support Services	Home-delivered meals, food banks, and pantry services.
Residential Care Facility for the Chronically Ill (RCFCI)	Home-like housing that provides 24-hour care.
Substance Use Disorder Transitional Housing (SUDTH)	Housing services for clients in recovery form drug or alcohol use disorders.
Transitional Case Management	Support for incarcerated individuals transitioning from County jails back to the community.
Transitional Residential Care Facility (TRCF)	Short-term housing that provides 24-hour assistance to clients with independent living skills.
Transportation Services	Ride services to medical and social services appointments.

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[1] Retrieved from https://targethiv.org/library/service-standards-guidance-ryan-white-hivaids-program-granteesplanning-bodies. December 2015.

SERVICE STANDARDS FOR TRANSITIONAL CASE MANAGEMENT: JUSTICE-INVOLVED INDIVIDUALS

LOS ANGELES COUNTY
COMMISSION ON HIV

Approved by the Commission on HIV on 12/8/22.

SERVICE STANDARDS: TRANSITIONAL CASE MANAGEMENT- JUSTICE-INVOLVED INDIVIDUALS

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

INTRODUCTION

Service standards for the Ryan White HIV/AIDS Part A Program outline the elements and expectations a service provider should follow when implementing a specific service category. The standards are written for providers for guidance on what services may be offered when developing their Ryan White Part A programs. The standards set the minimum level of care Ryan White funded agencies offer to clients, however, providers are encouraged to exceed these standards. The Los Angeles County Commission on HIV (COH) developed Transitional Case Management Services for justice-involved individuals standards to establish the minimum services necessary to coordinate care for individuals who are living with HIV and are transitioning back to the community and those that continue to experience recidivism. The development of the standards includes guidance from service providers, people living with HIV, the Los Angeles County Department of Public Health, Division of HIV and STD Programs (DHSP), members of the Los Angeles County Commission on HIV, Standards & Best Practices Committee, caucuses, and the public-at-large.

SERVICE DESCRIPTION

Transitional Case Management: Justice-Involved Individuals[1] (TCM) is a client-centered activity that coordinates care for justice-involved individuals who are living with HIV and are transitioning back to the community and experiencing recidivism. TCM services include:

- Intake and assessment of available resources and needs

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[1] The title of the service was updated to "Transitional Case Management: Justice-Involved Individuals to reflect community and provider feedback and to align with the terminology guidance described in the "Addressing the HIV Care Needs of People with HIV in State Prison and Local Jails" Technical Expert Panel Executive Summary

- Periodic reassessment of status and needs
- Development and implementation of Individual Release Plans
- Appropriate referrals to housing, community case management, medical, mental health, and substance use treatment, dental health
- Services to facilitate retention in care, viral suppression, and overall health and wellness
- Access to HIV and STI information, education, partner services, and behavioral and biomedical interventions (such as pre-exposure prophylaxis (PrEP)) to prevent acquisition and transmission of HIV/STIs)

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 including Grief and Loss
- 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

The following are resources to assist agencies the health and social needs of this community:
https://wdacs.lacounty.gov/justice-involved-support-services/
https://careacttarget.org/sites/default/files/JailsLinkageIHIPPocketCard.pdf
https://www.cdc.gov/correctionalhealth/rec-guide.html
http://www.enhancelink.org/

SERVICE STANDARDS

All contractors must meet the Universal Standards of Care approved by the COH in addition to the following Incarcerated/Post-Release Transitional Case Management Services standards. The Universal Standards of Care can be accessed at: https://hiv.lacounty.gov/service-standards

SERVICE COMPONENT	STANDARD	DOCUMENTATION
Outreach	Transitional case management programs will conduct outreach to educate potential clients and HIV and STI services providers and other supportive service organizations about the availability and benefits of TCM services for justice-involved persons living with HIV.	Outreach plan on file at provider agency.
	Transitional case management programs will provide information sessions to incarcerated people living with HIV that facilitate enrollment into TCM services.	Record of information sessions at the 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.
Client Intake	Initiate a client record	Client record to include: • Client name and contact information including: address, phone, and email • Written documentation of HIV/AIDS diagnosis • Proof of LAC Residency or documentation that client will be released to LAC residency • Verification of client's financial eligibility for services • Date of intake • Emergency and/or

		next of kin contact name, home address, and telephone number • Signed and dated Release of Information, Limits of Confidentiality, Consent, Client Rights and Responsibilities, and Grievance Procedures forms
Comprehensive Assessment	Comprehensive assessment and reassessment are completed in a cooperative process between the TCM staff and the client and entered 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 is conducted to determine the: • Client's needs for treatment and support services including housing and food needs • Client's current capacity to meet those needs • Client's Medical Home post-release and linkage to Medical Case Management (MCC) team prior to release to ensure continuity of care • Ability of the client's social support network to help meet client need	Comprehensive assessment or reassessment on file in client chart to include: • Date of assessment/reassessment • Signature and title of staff person conducting assessment/reassessment • Client strengths, needs and available resources in the following areas: ○ Medical/physical healthcare ○ Medications and Adherence issues ○ Mental health ○ Substance use and substance use treatment ○ HCV/HIV dual diagnosis ○ Nutrition/food ○ Housing and living situation ○ Family and dependent care issues ○ Access to hormone replacement therapy, gender reassignment procedures, name change/gender change clinics and other transition-related

	• Extent to which other agencies are involved in client's care	services. ○ 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 ○ HIV and STI prevention issues
Individual Release Plan (IRP)	IRPs will be developed in conjunction with the client within two weeks of completing the assessment or reassessment The IRP should address, at minimum, the following: • Document discharge viral load • Document discharge medications ordered • Reasons for incarceration and prevention of recidivism • Transportation • Housing/shelter • Food • Primary health care • Mental health • Substance use treatment • Community-based case management IRPs will be updated on an	IRP on file in client chart to includes: • 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

	ongoing basis.	determined to be unattainable
Monitoring and Follow-up	Implementation, monitoring, and follow-up involve ongoing contact 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 access and maintains primary health care and community-based supportive services identified on the IRP. 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 • Identify available familial or partner resources • Help clients resolve barriers • Follow up on IRP goals • Maintain/attempt contact at a minimum of once every	Signed, dated progress notes on file that detail (at minimum): • 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 current status/results of same • Barriers to referrals and interventions/actions taken • Time spent with, or on behalf of, client • Case manager's signature and title

	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 incarcerated transitional case management at six month’s post-release. Transitioning may include sharing assessment documents and other documents that were collected with the receiving provider agency	
Staffing Requirements and Qualifications	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 and gender-fluid 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	Resume, training certificates, interview assessment notes, reference checks, and annual performance reviews on file.

	• Ability to respond appropriately in crisis situations • Effective organizational skills • Prioritize caseload • Patience • Multitasking skills Refer to list of recommend training topics for Transitional Case Management Staff	
	Case managers will hold a bachelor’s degree in an area of human services; high school diploma (or GED equivalent) and at least one year’s experience working as an HIV case manager or at least two years’ experience working within a related health services field. Prior experience providing services to justice-involved individuals 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 certifications/training as defined in the contract. Case management supervisors will complete DHSP’s required supervisor’s certification/training as defined in the contract.	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 degree-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.

LOS ANGELES COUNTY COMMISSION ON HIV PREVENTION SERVICES STANDARDS

Approved the Commission on HIV 06/14/18

TABLE OF CONTENTS

BACKGROUND

PURPOSE: HIV Prevention Service Standards outline the essential elements of service delivery a provider agency must adhere to when implementing HIV prevention services. The purpose of the service standards is to ensure consistent high-quality service delivery throughout Los Angeles County. Service standards establish the minimal level of service delivery. Providers are encouraged to exceed this minimal level if able to, given their capacity and scope.

A multitude of factors at the structural-, environmental-, interpersonal-, and individual-level impact the risk of HIV infection. Therefore, a multitude of strategies (e.g. housing, employment, social marketing, counseling, condom distribution, etc.) may also serve to prevent the acquisition of HIV. Because it is not feasible to create standards for every potential prevention service, the HIV Prevention Service Standards described in this document focus on ensuring that every individual at risk of acquiring or transmitting HIV infection is successfully connected to and retained in the prevention service(s) that are appropriate for them at any given point in time.

Additionally, because there are many different types of organizations that may provide prevention services, it should be understood that not every category of prevention standards described herein will be applicable to all agencies. For example, an agency that provides HIV/STD testing only, will not necessarily be expected to provide adherence services for clients who are accessing PrEP.

A NEW ERA OF HIV PREVENTION: The overall approach to HIV prevention has shifted drastically in recent years, due largely to major improvements in HIV medication, or antiretroviral therapy (ART). According to the Centers for Disease Control and Prevention, "people who take ART daily as prescribed and achieve and maintain an undetectable viral load have effectively no risk of sexually transmitting the virus to an HIV-negative partner. When ART results in viral suppression, defined as less than 200 copies/ml or undetectable levels, it prevents sexual HIV transmission."[1]

Treatment advancements have also ushered in a new era of HIV prophylaxis for HIV-negative individuals, specifically HIV pre-exposure prophylaxis (PrEP), and HIV post-exposure prophylaxis (PEP). PrEP is a daily pill taken by individuals who are HIV-negative before they are potentially exposed to HIV. PrEP, when taken consistently, is a highly effective prevention intervention. PEP is a 28-day course of an antiretroviral regimen taken within 72 hours of a high-risk HIV exposure to prevent HIV seroconversion.

Given these scientific breakthroughs, the central tenets of today's HIV prevention efforts focus on biomedical prevention interventions, including the viral suppression of HIV-positive individuals and widespread access to PrEP, particularly for populations that are

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[1] https://www.cdc.gov/hiv/library/dcl/dcl/092717.html

disproportionately impacted by HIV disease (i.e., Black and Latinx gay/bisexual/same-gender loving men, and transgender women of color).

DEFINITION OF HIV PREVENTION SERVICES: HIV Prevention Services are those services used alone or in combination to prevent the transmission of HIV. *Biomedical* HIV prevention refers to HIV prevention methods that use antiretroviral treatment (ART) to decrease the risk of HIV transmission by reducing the viral load of people living with HIV (PLWH) and/or by reducing the susceptibility of HIV infection among HIV-negative individuals (via PrEP and PEP).

GOALS OF HIV PREVENTION EFFORTS IN LOS ANGELES COUNTY: Aligned with the Los Angeles County Comprehensive HIV Plan (2017-2021)[2] and the National HIV/AIDS Strategy (NHAS)[3], the overarching goals of HIV prevention efforts in Los Angeles County are to:

1. Reduce new HIV infections, and
2. Reduce HIV-related disparities and health inequities.

Furthermore, these service standards support the Los Angeles County HIV/AIDS Strategy for 2020 and Beyond goals:

1. Reduce annual HIV infections to 500 by 2020
2. Increase the proportion of persons living with HIV who are diagnosed to at least 90% by 2022
3. Increase the proportion of diagnosed people living with HIV who are virally suppressed to 90% by 2022

METHOD/HIGH IMPACT PREVENTION: In order to achieve our goals, we must implement a *High-Impact Prevention*[4] approach that utilizes combinations of scientifically proven, cost-effective, and scalable interventions targeted to the populations most disproportionately impacted by HIV in Los Angeles County, as indicated by those populations with the highest HIV incidence rates and the lowest rates of viral suppression. The Los Angeles County Comprehensive HIV Plan (2017-2021), based on the most recent surveillance data, identifies the following populations that experience the highest HIV incidence rates in Los Angeles County:

- Men who have Sex with Men (MSM)
- Black/African American MSM, Transwomen, and Cisgender Women
- Transwomen
- Young Men (18-29) who have Sex with Men (YMSM)
- Persons living in the Metro, South, and South Bay Service Planning Areas (SPAs)

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[2] Los Angeles County Commission on HIV and the Los Angeles County Department of Public Health Division of HIV and STD Programs. Los Angeles County Comprehensive HIV Plan (2017-2021), September 2016.

[3] The National HIV/AIDS Strategy for the United States: Updated to 2020. https://www.aids.gov/federal-resources/national-hiv-aids-strategy/nhas-update.pdf

[4] High-Impact HIV Prevention: CDC's Approach to Reducing HIV Infections in the United States. https://www.cdc.gov/hiv/policies/hip/hip.html

Among people living with HIV, the following populations have the lowest rates of viral suppression in Los Angeles County:

- Persons who inject drugs (PWID)
- Youth (18-29 years)
- Cisgender women
- Transgender persons
- Blacks/African Americans
- American Indians/Alaska Natives

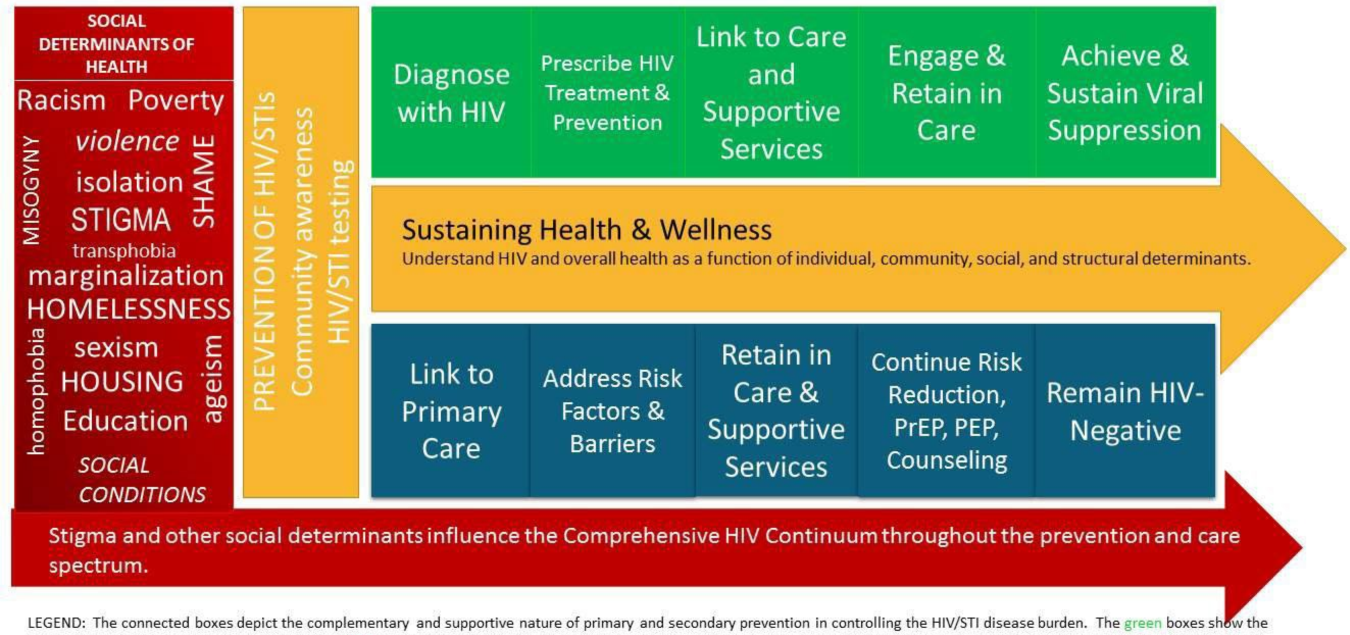
In addition, there are many other populations and sub-populations highly impacted by HIV, including, but not limited to:

- Latino MSM
- Asian/Pacific Islander MSM
- Latina Cisgender women
- People between the ages of 13-17
- People over the age of 50
- Incarcerated populations
- Stimulant users
- Commercial Sex Workers
- Sex and needle-sharing partners of individuals who are HIV-positive

FOUNDATION FOR DEVELOPMENT OF STANDARDS: The Los Angeles County Commission on HIV's *Comprehensive HIV Continuum Framework,* depicted in Figure 1, below, was used to guide the development of the HIV Prevention Service Standards. The *Comprehensive HIV Continuum* is an aspirational framework that builds upon the social ecological model to underscore the importance of addressing HIV care and prevention across several dimensions. The connected boxes depict the complementary and supportive nature of primary and secondary prevention in controlling the HIV/STD disease burden. The green boxes depict the HIV Care Continuum (focused on people living with HIV), while the blue boxes depict the HIV Prevention Continuum (focused on HIV-negative individuals).

Figure 1: The Los Angeles County Commission on HIV *Comprehensive HIV Continuum Framework*

Los Angeles County Commission on HIV
Comprehensive HIV Continuum Framework (Final Approved 12.8.16)



LEGEND: The connected boxes depict the complementary and supportive nature of primary and secondary prevention in controlling the HIV/STI disease burden. The green boxes show the HIV/AIDS treatment cascade (PLWHA) while the blue boxes depict the prevention continuum (HIV-negative). Both continua are equally important in decreasing new HIV/STI infections and sustaining health and wellness for PLWHA and those at risk for acquiring HIV/AIDS. The yellow arrow acknowledges that sustaining health and wellness is the ultimate goal for all people receiving HIV-related services, regardless of their status. The goal extends beyond achieving viral load suppression or maintaining a negative serostatus.

Standards Development Process: The development of the HIV Prevention Service Standards included the input and feedback of service providers, consumers, members of the Standards and Best Practices Committee (SBP), and the Los Angeles County Department of Public Health, Division of HIV and STD Programs. In addition, four Expert Review Panels (ERPs) composed of subject matter experts were convened to provide extensive critique on proposed standards. Moreover, two community meetings were convened to further vet the proposed standards. All comments were thoroughly reviewed by the SBP Committee resulting in recommended revisions.

In order to guide the development of the HIV Prevention Service Standards, SBP Committee members, ERPs, and community stakeholders considered the following questions:

1. Are the standards up-to-date and consistent with national standards of high-quality HIV and STD[5] prevention services?
2. Are the standards reasonable and achievable for providers?
3. Will the services meet consumer needs?
4. Are proposed standards client-centered?
5. What are the important outcomes we expect for people receiving these services? How can we measure whether or not the service is working for them?

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[5] For the purposes of this document, we chose to use the term STD (Sexually Transmitted Disease), rather than STI (Sexually Transmitted Infection). Factors that we weighted in making this decision included: perceived stigma; literal meaning of *disease* versus *infection*; and alignment with county, state, and national departmental names.

See Dr. H. Hunter Handsfield's article, "Sexually Transmitted Diseases, Infections, and Disorders: What's in a Name?" (http://www.ncsddc.org/blog/sexually-transmitted-diseases-infections-and-disorders-what's-name).

UNIVERSAL HIV PREVENTION SERVICE STANDARDS: In order to achieve the goals of reducing new HIV infections and HIV-related disparities, HIV prevention services in Los Angeles County must include the following universal standards:

Whole Person Care: Preventing HIV is typically one priority among many in the lives of people accessing our services. Therefore, HIV prevention services are most effective when they are delivered with the *whole person* in mind. Whenever possible, programs and services should attend to clients' overall physical health, mental health, and spiritual health, as guided by each individual client.

Address the social determinants of health: Social determinants of health are the economic and social conditions that influence the health of individuals and communities.[6] Social determinants shape the contexts that either increases or decreases an individual's risk of exposure to HIV. Because HIV disparities are inextricably linked to social determinants, interventions or services that focus on social determinants (e.g. racism, homophobia, transphobia, housing, education, employment, healthcare, etc.) are necessary to reduce these disparities. The implementation of such structural interventions typically requires a great deal of time and effort on behalf of multiple stakeholders, given that social determinants are deeply entrenched and institutionalized in our society. For this reason, many HIV prevention agencies may not have the capacity to implement structural or social level interventions. However, HIV prevention services should minimally reflect an understanding of the role of social determinants in their design (e.g. consider a client's competing priorities related to housing and employment). HIV prevention agencies, no matter how small, should strive to complement traditional HIV prevention services), with services that help to address social determinants (e.g. resume writing workshops).

Strength-Based: A strength-based approach to service design and provision seeks to understand and develop clients' strengths and capabilities that can lead to improved health and quality of life. Services that focus solely on individuals' deficits, needs, problems, or pathologies tend to focus only on what a client needs to "fix" about themselves, thus emphasizing negative behaviors rather than emphasizing resiliency and protective factors. Furthermore, when we emphasize what a client is lacking, a dependency is created on the provider and a process of disempowerment occurs. A strength-based approach focuses on individuals' strengths, resources and the ability to recover from adversity; allowing a client to focus on opportunities and solutions rather than problems and hopelessness. A strength-based approach results in different questions being asked (see Assessment section below) and facilitates an openness and exploration on behalf of the provider-client relationship.

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[6] World Health Organization, Commission on Social Determinants of Health. Geneva: WHO; 2008. Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health

Sex-Positive: When services are delivered from a “sex-positive” framework or attitude, they are free from judgment about clients’ sexual behaviors, including the behavior itself (as long as it is consensual); the number and type of sexual partners; and the frequency of sexual behaviors (Center for Positive Sexuality). A sex-positive attitude also serves to destigmatize sex, and may also serve to reduce other forms of stigma experienced by clients related to being gay, being transgender, living with, or being at risk for HIV, etc. Being sex-positive does not mean that you ignore behaviors or circumstances that may increase someone’s risk of acquiring HIV or STDs. On the contrary, when clients know that they will not be shamed or judged for the behaviors they engage in, they then will be more likely to disclose important facts and likely will be receptive to information from providers that helps them reduce their risk and/or build upon protective factors.

Cultural humility: All HIV prevention organizations should strive to deliver culturally responsive services. Culturally responsive services are those that are respectful of, and relevant to, the beliefs, practices, culture and linguistic needs of diverse consumer/client populations and communities.[7] Cultural responsiveness describes the capacity to respond to the issues of diverse communities. It thus requires knowledge and capacity at different levels of intervention: structural, community, organizational, and individual. Culturally responsive services acknowledge that power imbalances exist between groups of people and cultures based on historical and institutional oppression and privilege; that we are not simply “different” from one another. Culturally responsive agencies also create a physical environment that is welcoming, warm, and that communicates a sense of safety for clients.

Cultural humility is a lifelong process of self-reflection and self-critique whereby the individual not only learns about another’s culture, but one starts with an examination of her/his own beliefs and cultural identities (Tervalon & Murray-Garcia, 1998). This critical consciousness is more than just self-awareness but requires one to step back to understand one’s own assumptions, biases and values (Kumagai & Lypson, 2009). Individuals must look at one’s own background and social environment and how it has shaped experience. Cultural humility cannot be collapsed into a class or education offering; rather it’s viewed as an ongoing process. Tervalon and Murray-Garcia (1998) state that cultural humility is “best defined not as a discrete end point but as a commitment and active engagement in a lifelong process that individuals enter into on an ongoing basis with patients, communities, colleagues, and with themselves” (p. 118). This process recognizes the dynamic nature of culture since cultural influences change over time and vary depending on location. Throughout the day, many of us move between several cultures, often without thinking about it. For example, our home/ family culture often differs from our workplace culture, school culture, social group culture, or religious organization culture. The overall purpose of the process is to be aware of our own values and beliefs that come from a combination of cultures in order to increase understanding of others. One cannot

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[7] Adapted from: Curry-Stevens, A., Reyes, M.-E. & Coalition of Communities of Color (2014). *Protocol for culturally responsive organizations.* Portland, OR: Center to Advance Racial Equity, Portland State University.

understand the makeup and context of others' lives without being aware and reflective of his/her own background and situation.

To practice cultural humility is to maintain a willingness to suspend what you know, or what you think you know, about a person based on generalizations about their culture. Whereas cultural *competency* implies that one can function with a thorough knowledge of the mores and beliefs of another culture, cultural *humility* acknowledges that it is impossible to be adequately knowledgeable about cultures other than one's own. What you learn about your clients' culture stems from being open to what they themselves have determined is their personal expression of their culture. [8] Tenets of cultural humility include:

1) Lifelong learning & critical self-reflection
2) Recognizing and challenging power imbalances for respectful partnerships, and
3) Institutional accountability

Data driven and outcome-based: Data-driven and outcome-based program planning ensures that programs and services address specific needs in the community and lead to specific outcomes in mind, and including an evaluation component which enables you to capture data (Ryan et al, 2014). More specifically, data-driven and outcome-based programs and services:

- are designed based on quality data and with specific HIV-related outcomes in mind
- are responsive and relevant to the communities we serve
- are developed in response to specific drivers or causes of HIV-related problems in our communities
- are aligned with local and national HIV prevention goals
- require the collection and utilization of process and outcome data in order to continuously improve
- show meaningful results that demonstrate the value of our services
- contribute to the body of knowledge in the HIV field

Elicit community feedback: Responsive services are services that are designed and/or delivered with continuous feedback from the populations served. Feedback should help to ensure that the services are culturally appropriate, effective in preventing HIV, respectful of clients, strength-based, sex-positive and destigmatizing, and easily accessed. Feedback methods may include client satisfaction surveys, focus groups, secret shoppers, and other means to continuously assess quality of services.

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[8] Cultural humility: Essential foundation for clinical researchers, Katherine A. Yeager, PhD, RN and Susan Bauer-Wu, PhD, RN, FAAN

CORE PREVENTION COMPONENTS

Summary of Core Prevention Service Components: The HIV Prevention Service Standards detailed in this document seek to ensure the provision of a core set of integrated HIV prevention services aimed at preventing the acquisition and transmission of HIV and STDs. The Core Prevention Service Components are: Assessment, HIV/STD Testing and Retesting, Linkage to HIV Medical Care and Biomedical Prevention Services, Referral and Linkage to Non-Biomedical Prevention Services, and Retention and Adherence to HIV Medical Care and Prevention Services. These categories, in addition to their corresponding data indicators, documentation needs, and population-based outcomes, are outlined in Table 1.

Table 1: Summary of Core Prevention Service Components

Core Prevention Service Components	Data Indicators	Documentation Needs	Population- Based Outcomes
1. Assessment	• Number of clients/patients who complete assessments • Number of participants screened for: connection to a medical home; primary care engagement; insurance coverage; HIV status; STDs; immunizations; pregnancy; mental health; substance abuse; experiences of trauma and violence; housing and employment status; and sexual and needle- sharing behaviors that may increase their risk of HIV acquisition or transmission	• Completed assessments indicating specific areas or topics assessed and type of assessments used	• Decrease the number of new HIV infections • Decrease the number of STDs • Increase the number of persons with known HIV status • Increase the number of persons treated for STDs • Increase the number of newly diagnosed clients that have their first HIV medical visit within 72 hours of their diagnosis. • All service provides should strive towards linking newly- diagnosed PLWHA to anti-retroviral therapy within 72 hours of diagnosis.
2. HIV/STD Testing and Retesting	• Number of persons tested/screened for HIV and STDs • Number of persons tested/screened for HIV and STDs who have never tested/screened before • Number of persons who test positive for an STD who are treated or referred to treatment • Percentage of high-risk[9] negative clients having documentation of HIV/STD testing every 3 months • Type and number of • outreach and recruitment methods	• Documentation of HIV/STD testing in client files and data management system Documentation of type and frequency of outreach and recruitment methods • Documentation of clients treated for STDs or referred to treatment	

Core Prevention Service Components	Data Indicators	• Documentation Needs	• Population- Based Outcomes
3. Linkage to HIV Medical Care and Biomedical Prevention Services	**<u>HIV-positive individuals</u>:** • Number of HIV- positive clients linked to HIV medical care within 72 hours of receiving a HIV- positive test result. • Number of HIV- positive clients lost to care who re-engage in HIV medical care within 30 days of interaction with provider **HIV-negative individuals:** • Number of high-risk HIV-negative clients receiving education on PrEP • Number of high-risk[10] HIV-negative clients who are interested in PrEP • Number of high-risk HIV-negative clients interested in PrEP that are linked to a PrEP Navigator. • Number of high-risk HIV-negative clients who received a PrEP prescription • Number of high-risk HIV-negative clients receiving education on PEP • Number of high-risk HIV-negative clients who received PEP within 72 hours of exposure • Number of high-risk HIV-negative clients who accessed PEP and transitioned to PrEP	• Documentation of linkage to HIV medical care • Documentation of re-engagement in HIV medical care • Documentation of PrEP and PEP education • Documentation of client interest in learning more about PrEP (i.e. responded affirmatively to the question, “Would you like to learn more about PrEP or PEP?”) • Documentation of linkage to a PrEP services (may be internal or external linkage) • If available, documentation of PrEP or PEP prescription (may be client self-report) • Documentation of former PEP clients who currently access PrEP • Documentation of PrEP and PEP clients who are referred to medication adherence services	• Increase the number of out-of-care previously diagnosed clients that are re-engaged in HIV medical care within 30 days of their identification. • Increase the number of HIV positive clients that have at least 2 medical visits per year at least 3 months apart. Increase the number of HIV-positive persons that are virally suppressed (<200 copies/ml) • Increase the number of HIV negative clients that are given accurate PrEP and PEP information • Increase the number of high-risk HIV negative individuals accessing HIV PrEP and HIV PEP, as needed

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[9] “High risk” is defined as someone who has an HIV positive sex partner; a history of bacterial STD diagnosed in the past 12 months; a history of multiple sex partners of unknown HIV status; or other risk factors that increase HIV risk, including transactional sex (such as sex for money, drugs, housing); or someone who reports sharing injection equipment such as those used to inject drugs or hormones.

Core Prevention Service Components	Data Indicators	Documentation Needs	Population- Based Outcomes

4. **Referral and Linkage to Non- Biomedical Prevention Services**	• Number of high-risk HIV-negative and HIV- positive clients that are referred to needed non-biomedical prevention services, as indicated via the assessment process. This may include referrals to:
	  • behavioral interventions
	  • risk-reduction education
	  • syringe exchange
	  • housing services
	  • mental health services
	  • substance abuse services
	  • food pantries
	  • employment services
	  • health insurance navigation
	• Number of high-risk HIV-negative clients who have not accessed primary care in over one year linked to primary care medical visit within 90 days of assessment.[11]
	• Number of external and internal[12] condoms distributed free of charge
		• Documentation of referrals in client files and data management system
		• Documentation of linkage to primary care (may be client self-report)
		• Documentation of condom availability or distribution
			Same as above

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[11] Assuming that primary care is available to the client, which may not always be the case (i.e. for undocumented individuals, individuals who speak a language other than English, transgender individuals, etc., affordable and accessible primary care may not always be available).

[12] "External" and "internal" condoms are also known as "male" and "female" condoms, respectively, but are not referred to as such in this document since their use is not necessarily aligned with one's gender identity.

Core Prevention Service Components	Data Indicators	Documentation Needs	Population- Based Outcomes (from CHP)
5. Retention and Adherence to HIV Medical Care, ART, and Other Prevention Services	• Number of HIV- positive clients who receive HIV medical care at least 2 times per year, at least 3 months apart • Number of HIV- positive clients who adhere to their HIV medications • Number of HIV- positive clients who remained engaged in prevention service as needed • Number of PrEP and PEP clients referred to medication adherence interventions or support services. • Number of PrEP and PEP clients who access medication adherence interventions or support services. • Number of HIV- negative clients who remained engaged in prevention service as needed • Number of PrEP clients who adhere to PrEP medication per adherence plan determined with PrEP provider • Number of PEP clients who adhere to PEP for 28-day course	• Documentation of provision of service(s) • Documentation of client engagement in service(s) • Documentation of adherence to ART, PrEP or PEP medication (optimal adherence for PrEP is 90% and 95% for ART of prescribed doses) • Documentation of PrEP and PEP clients who access medication adherence services	Same as above

ASSESSMENT

Client assessments are often the first in-depth interaction a client has with a provider agency, and thus can foster a lasting positive relationship built on trust and respect, if conducted correctly. Conversely, an assessment that a client perceives to be judgmental or disrespectful in any way can impede the client's willingness or ability to secure necessary prevention services.

Standards for Assessment:

Assessments should be conducted by <u>trained personnel</u>.
The training should include basic client-centered counseling techniques (e.g. how to communicate in a non-judgmental manner, the use of appropriate body language, etc.), and should also include elements that are specific/relevant to the type of assessment(s) conducted. For example, providers should be trained in how to utilize specific mental health and/or substance abuse screening tools (e.g. Patient Health Questionnaire (PHQ-2)), if the assessment utilizes such tools.

The assessment process should include the following activities and or elements (not necessarily in this order):

1. Explain the purpose of the assessment and obtain verbal consent to continue
2. Conduct the assessment in private, with no other clients, and preferably no other staff members able to hear the conversation
3. Gather relevant information to determine the client's needs, risks, and strengths, when appropriate
4. Inform the client of the services available (internally and externally) and what the client can expect if they were to enroll
5. Establish the client's eligibility for services, including HIV status, if relevant, and other criteria
6. Inform the client of any documentation requirements for the assessment (e.g. income verification for insurance purposes)
7. Collect required county, state, federal client data for reporting purposes
8. Collect basic client information to facilitate client identification and client follow-up
9. Begin to establish a trusting client relationship.

Assessments should be a cooperative and interactive endeavor between the staff and the client, and should be conducted in a <u>strength-based manner</u>.

The assessment should highlight clients' skills, competencies and resilience in addition to their challenges and needs. Included below are some examples of strength-based questions[13] that may be asked during an assessment, or over the course of multiple assessments, as appropriate:

1. What is working well (either in general, or with respect to a certain subject, e.g. adherence, overall health, etc.)?
2. Can you think of things you have done in the past that have helped with ___?
3. What small thing could you do that would make _____better?
4. Tell me about what a good day looks like for you? What makes it a good day?
5. On a scale of 1 to 10 how would you say ____is? What might make that score a little better?
6. What are you most proud of in your life?
7. What inspires you?
8. What do you like doing? What makes this enjoyable?
9. What do you find comes easily to you?
10. What do you want to achieve in your life?
11. When things are going well in your life – tell me what is happening?
12. What are the things in your life that help you keep strong?
13. What do you value about yourself?
14. What would other people who know you say you are good at doing?
15. You are resilient. What do you think helps you bounce back?
16. What is one thing you could do to have better health, and feeling of wellbeing?
17. How have you faced/overcome the challenges you have had?
18. How have people around you helped you overcome challenges?
19. What are three things that have helped you overcome obstacles?
20. If you had the opportunity, what would you like to teach others?
21. Without being modest, what do you value about yourself, what are your greatest strengths?
22. How could/do your strengths help you to be a part of your community?
23. Who is in your life?
24. Who is important in your life?
25. How would you describe the strengths, skills, and resources you have in your life?
26. What could you ask others to do, that would help create a better situation for you?
27. What are the positive factors in your life at present?
28. What are three (or five or ten) things that are going well in your life right now?
29. What gives you energy?
30. What is the most rewarding part of your life?
31. Tell me about a time when you responded to a challenge in a way that made you feel really on top of things?
32. How have you been able to develop your skills?
33. How have you been able to meet your needs?
34. What kind of supports have you used that have been helpful to you? How did the supports improve things for you?
35. Tell me about any creative, different solutions you have tried. How did this work out?

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[13] Adapted from “50 First Strength-Based Questions” (http://www.changedlivesnewjourneys.com/50-first-strength-based-questions).

Clients should be the primary source of information during an assessment.
However, if appropriate and with client consent, assessments may include additional information from case manager(s), medical or psychosocial providers, caregivers, family members, and other sources of information.

Assessments should be conducted in a client-centered manner that accommodates clients who are unable or otherwise hesitant to attend the appointment at the provider agency.

Diverse methods of interaction (e.g., text-based, via social apps, in-person) should be supported, given that confidentiality policies are adhered to.

Assessments that are conducted should align with the client's reason(s) for accessing services and point of entry. For example, a client who is interested in accessing HIV/STD testing, PEP, or PrEP should not have to endure a lengthy assessment before accessing these services. Clients should be able to access services as expeditiously as possible. However, in some situations, or at a different point in time, a longer assessment may be appropriate.

Whenever possible, collect demographic information in a manner that is affirming of various identities and of intersecting identities.

For example, allow clients to identify their race or ethnicity using whatever categories best fit for them. When asking questions related to gender identify, consider using the two-step question that captures a transgender person's current gender identity as well as their assigned sex at birth: 1. What is your current gender identity? 2. What sex were you assigned at birth (on your original birth certificate)? Also, ask all clients what pronoun(s) to use to address them (he, she, they) (Center of Excellence for Transgender Health).

If appropriate, assess for barriers to accessing services and remaining engaged in services.

If barriers are identified, assist the client in identifying potential solutions.

Specific topics or areas should be assessed only if the provider can offer support, resources, referrals, and/or services in response.

For example, if questions are asked pertaining to a client's history of trauma, the provider should be prepared to handle a client's potential range of emotions. Given that providers/agencies have resources, referrals, and/or services at hand, consider including the following topics in client assessments:

- Connection to spirituality
- Intimate partner violence
- Trauma
- Sex-trafficking

The assessment process should utilize a health promotion approach.
This includes using information collected during the assessment/ screening to identify appropriate messages that promote health-seeking behavior and minimize risk-behaviors or circumstances. The intention is to offer information and suggest services and interventions that are tailored to the specific person (and their partners, if relevant) and to highlight current health promoting behaviors and overall strengths of the client. Health promotion includes provision of information or resources related to:

- overall health (may include overall physical health, nutrition, oral health, spiritual health, and emotional health)
- behavioral interventions (e.g., brief or intensive risk reduction strategies that encourage safer sex and use of sterile drug-injection equipment, substance use treatment)
- biomedical interventions (e.g., PrEP, STD services, special reproductive and pregnancy services)
- clarifying concepts and misinformation about HIV transmission, acquisition, or prevention methods
- specialized counseling and support to members of HIV-serodiscordant relationships
- a variety of condoms (e.g. external, internal[14], non-latex, etc.) and lubrication options
- new, sterile syringes through syringe services programs, pharmacists, physicians, or other legal methods to persons who lack consistent access to sterile drug-injection equipment

The assessment process should include assessing for medical and social factors that impact HIV acquisition and transmission.
Individuals at high risk for HIV acquisition or transmission can experience significant personal, social, and structural challenges, such as poverty, mental illness, substance use, unstable housing, and lack of regular medical care. Assessments should include questions pertaining to these medical and social factors that influence HIV acquisition or transmission.

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[14] "External" and "internal" condoms are also known as "male" and "female" condoms, respectively, but are not referred to as such in this document since their use is not necessarily aligned with one's gender identity.

HIV/STD TESTING AND RETESTING

HIV and STD testing often serve as the first point of entry in the HIV Care and Prevention Continua and for many, the key opportunity to facilitate linkage to a comprehensive array of services. Individuals at high risk for HIV should be tested every 3-6 months, regularly assessed for risks and needs, and linked or re-linked to other HIV prevention services, depending on their needs.

Agencies should implement a streamlined model of HIV testing that includes delivering key information, conducting the HIV test, completing brief risk screening, providing test results, providing referrals and/or ensuring linkages to services tailored to the client's status and specific needs.

Standards that apply to HIV/STD testing include[15]:

- HIV/STD testing must be voluntary and free from coercion. Patients/clients must not be tested without their knowledge/written consent.
- Opt-out HIV screening (notifying the patient/client that an HIV test will be performed, unless the patient/client declines) is recommended in all settings.
- Use of antigen and antibody (Ag/Ab) combination tests is encouraged unless persons are unlikely to receive their HIV test results. However, providers should be alert to the possibility of acute HIV infection and perform an (Ag/Ab) immunoassay or HIV RNA in conjunction with an antibody test. Persons suspected of recently acquired HIV infection should be referred immediately to an HIV clinical-care provider.
- Preliminary positive screening tests for HIV infection must be followed by additional testing to definitively establish the diagnosis.
- Agencies should adhere to local and state public health policies and laws to ensure they deliver high-quality HIV testing services that are culturally competent and linguistically appropriate.
- HIV testing should be simple, accessible, and straightforward. Minimize client barriers and focus on delivering HIV test results and on supporting clients to access follow-up HIV care, treatment, and prevention services as indicated.
- To reach populations at high risk for HIV infection, sites should employ strategic targeting and recruitment efforts, establish program goals and monitor service delivery to ensure targeted testing is achieving program goals.
- To provide the most accurate results to clients, sites should use HIV testing technologies that are the most sensitive, cost-effective, and feasible for use at their agency. Establishing relationships with facilities offering laboratory-based HIV testing is important for referring clients who may have acute HIV infection.

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[15] Adapted from *Implementing HIV Testing in Nonclinical Settings: A Guide for HIV Testing Providers*. https://www.cdc.gov/hiv/pdf/testing/cdc_hiv_implementing_hiv_testing_in_nonclinical_settings.pdf

- Sites should consider offering HIV testing services for couples or partnered relationships to (a) attract high-risk clients who are not otherwise testing and (b) identify HIV-discordant couples and previously undiagnosed HIV-positive clients.
- Diagnostic HIV testing and opt-out HIV screening should be a part of routine care in all health-care settings while also preserving the client's option to decline HIV testing and ensuring a provider-client relationship conducive to optimal clinical and preventive care.
- Inform clients at high-risk for HIV/STDs about 1) methods to reduce the risk of HIV/STD acquisition; 2) STDs that can facilitate HIV acquisition; 3) the benefits of screening for STDs (that are often asymptomatic) and STD treatment
- Assess these risk factors for HIV/STD transmission:
    - Sexual, alcohol, and drug-use triggers (boredom, depression, incarceration, sexual violence, sex work, abuse) and behaviors that may lead to HIV/STD transmission
    - Recent sex and/or needle-sharing partners who were treated for HIV/STDs, and/or other behaviors they may have that contribute to possible HIV acquisition
    - Past and recent HIV/STD diagnosis, screening, and symptoms
    - Survival sex work
    - Sense of self-worth
- Lack of basic health information and/or information pertaining to HIV/STD risk
- Offer external and internal condoms, and lubrication options
- Personnel from every HIV and STD testing site should be knowledgeable about the HIV and STD burden in their health district. Report cases of HIV/STDs according to jurisdiction requirements and inform clients diagnosed with HIV and/or STDs that case reporting may prompt the health department to offer voluntary, confidential partner services

STD Testing services must follow these guidelines, adapted from the CDC:[16]

1. All adults and adolescents ages 13 and older should be tested at least once for HIV.
2. Annual chlamydia screening of all sexually active cisgender women younger than 25 years, as well as older cisgender women with risk factors such as a sex partner who has a sexually transmitted infection
3. Annual gonorrhea screening for all sexually active cisgender women younger than 25 years, as well as older cisgender women with risk factors such as a sex partner who has a sexually transmitted infection.
4. Syphilis, HIV, hepatitis B, chlamydia and gonorrhea screening for all pregnant women, starting early in pregnancy, with repeat testing as needed, to protect the health of mothers and their infants.
5. Screening at least once a year for syphilis, chlamydia, gonorrhea, and hepatitis C for all sexually active gay, bisexual, and other men who have sex with men (MSM), as

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[16] Access this link for more information: http://publichealth.lacounty.gov/dhsp/Providers/LAC_ONLY_STDScreeningRecs-5-2017.pdf

well as sexual active transgender women who have sex with men. MSM or transgender women who have sex with men, who have unprotected sex should be screened more frequently for STDs (e.g., at 3-to-6 month intervals).

6. Sexually active gay and bisexual men and sexually active transgender women who have sex with men may benefit from more frequent HIV testing (i.e., every 3 to 6 months).
7. Anyone who has unprotected sex or shares injection drug equipment should get tested for HIV at least once a year.

In populations for whom no recommendations exist, screening should be based on risk factors, local epidemiology and prevalence of specific STDs in the service area. The Los Angeles County Department of Public Health, Division of HIV and STD Programs' (DHSP) mapping project[17] depicts STD and HIV burden by health district throughout Los Angeles County. This project ranks geographical areas (health districts) in order of highest to lowest HIV and STD burden by analyzing several important driving factors including number of infections, number of people infected, the population size, geographic size, and results from hot spot analyses.

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[17] http://publichealth.lacounty.gov/dhsp/Mapping.htm

LINKAGE TO HIV MEDICAL CARE AND BIOMEDICAL PREVENTION SERVICES

Once HIV status is determined and the needs of clients are identified via the assessment and/or screening process, they should be connected to appropriate services to address those needs <u>in the most expeditious manner possible</u>.

For both recently diagnosed and previously diagnosed HIV-positive clients, linkage to/re-engagement in HIV medical care is a critical component of the HIV Care Continuum. Likewise, for high-risk HIV-negative individuals who have recently been tested for HIV and STDs, linkage to biomedical interventions (i.e. PrEP and PEP) is a priority.

Linkage to Care Definition: Linkage to care is the first time a newly-diagnosed person living with HIV (PLWH) attends an appointment with an HIV medical service provider following their HIV diagnosis.

Linkage to Care Standard (Service Expectation): Newly-diagnosed PLWH receives ART within 72 hours of diagnosis.

*It is recognized that service providers that provide the full array of HIV prevention and treatment services must be supported and trained to build their capacity in order to reach this standard.

Standards for linking newly-diagnosed persons to HIV medical care and re-engaging previously diagnosed HIV-positive persons who have fallen out of care to HIV medical care include:

- Develop written protocols to ensure linkage to HIV care within 72 hours after diagnosis or re-engagement in care within 30 days after identification (for those out of care)
- Inform persons about the benefits of starting HIV care and antiretroviral treatment (ART) early (even when feeling well)
- Assess possible facilitators and barriers to linkage and retention and provide or make referrals for other medical and social services that may improve linkage and retention
- Help persons enroll in health insurance or medical assistance programs that provide HIV care or cover costs of care
- Collaborate with other health care providers, case managers, navigation assistants, nonclinical community-based organizations, and health department personnel to provide services that promote prompt linkage to and retention in care, disclosure and partner services
- Track outcomes of linkage and retention services and provide follow-up assistance to persons who have not started HIV medical care within 72 hours after diagnosis or within 30 days for those out of care

  - Train staff to comply with laws, policies, and procedures to protect patient confidentiality when exchanging personal, health, or financial information used for linkage and reengagement services
  - Provide staff training and tools to increase competence in serving patients with differing health literacy levels
  - Train clinical providers about the most recent U.S. Department of Health and Human Services guidelines that advise offering ART to all persons (regardless of CD4 cell count) for health benefits and preventing HIV transmission.
  - Help schedule the first HIV medical visit, seeking same-day or priority appointments when possible, especially for newly diagnosed persons
  - Provide transportation assistance to the first visit, when possible
  - Verify attendance at first visit by contacting the patient or the HIV health care provider
  - If the first visit was not completed, provide additional linkage assistance until visit is completed or no longer required
  - If providing HIV medical care, offer convenient scheduling whenever possible (e.g., same-day or priority appointments, extended hours)

Identify and utilize specific strategies designed to overcome barriers to successful linkage. Such strategies may include:

  - Co-locating HIV testing and HIV medical care services
  - Multiple case management sessions
  - Motivational counseling
  - Reminders for follow-up visits
  - Help enrolling in health insurance or medical assistance programs
  - Assist clients in securing documentation necessary to access medical services
  - Transportation services to the health care facility
  - Providing or linking to other medical or social services (e.g., substance abuse treatment, mental/behavioral health services, child care)
  - Maintaining relationship between patient and a consistent care team

Standards for linking HIV-negative persons to biomedical prevention interventions include:

  - If agencies do not provide PrEP services, they must develop written protocols/MOUs with agencies/clinics that do provide PrEP, outlining the referral and linkage process
  - Inform clients about the benefits of biomedical interventions to prevent the acquisition of HIV
  - Ask all high-risk HIV-negative clients if they are interested in learning more about PrEP or PEP
  - Connect all high-risk HIV-negative clients to a PrEP Navigator (in-house or external) within 24 hours (or 2 business days)
  - Provide immediate, active, and, if necessary, repeated, linkage services to clients with an expressed interest in PrEP, and the immediate need for PEP
- Counsel and refer individuals exposed to HIV within a 72 hour time range for evaluation to a PEP program or Emergency Department as appropriate.

- Provide follow-up assistance to clients who are not able to link to a PrEP Navigator
- If an agency provides PrEP, assess the client's readiness to engage in PrEP services and barriers and facilitators to starting services
- Help schedule appointments to see a PrEP Navigator or PrEP provider (in-house or external)
- Offer convenient scheduling whenever possible (e.g., same-day or priority appointments, extended hours)
- Maintain a client-friendly environment that welcomes and respects new clients
- Provide reminder (and accompaniment, if possible) for first appointment, using the client's preferred contact method(s)
- Offer support to encourage attendance (e.g., directions, transportation resources, such as Metro tokens or ride shares)
- Identify and utilize specific strategies designed to overcome barriers to successful linkage. Such strategies may include:
    - Co-locating HIV testing and biomedical interventions
    - Client accompaniment to access services
    - Multiple case management sessions
    - Motivational counseling
    - Providing trauma-informed care
    - Providing crisis intervention counseling
    - PrEP navigation
- Offer guidance and assistance on how to obtain financial assistance for PrEP through private- or public-sector sources
- Assist with health insurance and other benefits, including linkage to health insurance navigators, case management and client navigation, and intervention-specific programs (e.g. PrEP medication and co-pay assistance programs)

REFERRALS AND LINKAGES TO NON-BIOMEDICAL PREVENTION SERVICES

Although numerous HIV prevention related services exist throughout Los Angeles County, clients in need of services may not be willing or able to access them. For example, an undocumented transgender woman may want to access regular primary care, but may not feel comfortable doing so if she fears transphobia or legal implications. For this reason, while the ultimate goal is *linkage* to a needed service, oftentimes *referrals* are all an agency can be held accountable for.

Standards related to referring clients to non-biomedical services focus on *active referrals* rather than *passive referrals*. The latter defined as telling a client about a service and or giving them a phone number and leaving it up to them to initiate contact. Conversely, active referrals address barriers to accessing services by helping the client make contact with a service provider or agency. This may include scheduling the appointment with the client and/or accompanying them to their first appointment.

Based on information obtained via the assessment process, clients may be in need of any number of prevention services; specialty services that address medical needs (e.g. primary care); and/or social needs (e.g. needs related to housing, employment etc.). Whenever possible, agencies should strive to provide specialty services onsite. If this is not feasible, providers need to ensure that clients are referred to external specialty services. How these services are prioritized depends upon the need of each particular client.

The standards for actively referring clients to non-biomedical prevention services include:

- Developing written protocols/MOUs with other HIV/STD prevention and primary care providers and social service agencies to ensure linkage to appropriate prevention services
- Assisting clients with enrolling in health insurance by referring them to a benefits counselor
- Actively referring clients who are not accessing regular care to a medical home or primary care provider
- Assessing possible facilitators and barriers to accessing services
- Tracking outcomes of referral services (i.e. track linkages) and providing follow-up assistance to clients who have not been linked to prevention services
- Helping schedule the first prevention-related service appointment
- Linking all newly diagnosed individuals with HIV, syphilis or gonorrhea to the LAC DHSP Partner Counseling and Referral Services.
- Actively referring to mental/behavioral health services, substance use services, behavioral interventions and other psychosocial and ancillary services (e.g. housing, employment, nutritional and social support)
- Providing transportation assistance to the first visit, when possible
- Offering convenient scheduling whenever possible (e.g., same-day or priority appointments, extended hours)

- Maintaining a client-friendly environment that welcomes and respects new clients
- Providing reminders for first appointment, using the client's preferred contact method
- Offering support to encourage attendance (e.g., directions, transportation resources, such as Metro tokens or ride shares)
- Identifying and utilizing specific strategies designed to overcome barriers to successful linkage. Such strategies may include:
    - Co-locating HIV testing and prevention services
    - Multiple case management sessions
    - Motivational counseling
    - Trauma-informed care
    - Crisis intervention counseling
    - Navigation assistance
- Maintaining a relationship with a consistent prevention team
- Offering assistance with health insurance and other benefits, including active referrals to health insurance navigators
- Make available online directories of providers, agencies, telemedicine agencies, and professional advice hotlines that offer specialty services. Ensure that these resources are gay- and trans-affirming and otherwise culturally appropriate.
- Develop and participate in provider networks that offer specialty services for persons with HIV, especially persons who are uninsured or underinsured or who live in underserved areas
- Develop written protocols, memoranda of understanding, contracts, or other agreements that define financial arrangements, staff and agency responsibilities for providing linkages, making referrals, and the tracking of referral completion and satisfaction
- Establish policies and procedures to safeguard the confidentiality of personal and health information exchanged during the linkage/referral process
- Train staff and any specialty service providers in the following topics:
- Staff roles and responsibilities within the agency
- Issues such as sex trafficking, substance use, etc. that can provide a better understanding of their clients' needs
- Identifying specialty service providers who serve the community
- Tailoring of services to personal characteristics (e.g., language, location, and insurance status)
- Inter- and intra-agency referral procedures
- Maintaining confidentiality of collected personal information
- Advocating for persons who need specialty services
- Minor consent for HIV/STD testing (consent from youth aged 13 and older)
- Engage case managers, navigation assistants, or other staff to provide service coordination for persons living with or at risk for HIV who have complex needs
- Routinely provide print or audiovisual materials that describe specialty services provided onsite or through referrals
- Monitor the quality of referrals for specialty services to inform quality improvement

strategies (e.g., proportion of referred persons who obtained specialty services), client satisfaction, and barriers and facilitators

- Routinely assess agency staff regarding knowledge and comfort to offer the prevention services the agency is providing
- Include services related to economic empowerment and job-readiness
- Empower immigrant communities to access available services

RETENTION AND ADHERENCE TO HIV MEDICAL CARE, ART, AND HIV PREVENTION SERVICES

Retention to HIV medical care is described as at least 2 medical care visits per year, at least 3 months apart. Adherence to ART is described as the extent to which a person takes ART according to the medication instructions. An adherence to ART of 95% is required as an appropriate level to achieve maximal viral suppression and lower the rate of opportunistic infections (Patterson DL et al). Sustained high adherence is essential to suppress viral load in HIV positive individuals and, in turn, improve health outcomes and prevent HIV transmission. Adherence to ART is also critical to maximize the benefit of PrEP and PEP among HIV-negative individuals. Additionally, a key component of the Comprehensive HIV Continuum is retention and adherence to prevention services to facilitate ongoing access to the full array of services, including behavioral interventions, psycho-social services, etc.

Standards related to retention and adherence to HIV medical care and ART include:

- Develop protocols to update patient contact information at each visit (e.g., residence, phone number(s), payment method)
- Develop procedures to routinely assess factors that enable or hinder attending visits
- Establish procedures to identify patients at risk for lapses in care and services that support their continued care
- Establish methods to monitor timing and completion of each patient’s scheduled medical visits
- Schedule follow-up HIV medical care visits
- Provide reminders for all visits, using the person’s preferred method of contact
- Reinforce the benefits of regular HIV care for improving health and preventing HIV transmission to others during in-person encounters or outreach by phone, email, or other methods
- Periodically assess facilitators and barriers to retention and motivate the person to overcome the barriers
- Verify if the person attended follow-up visits, even when the patient was seen in another clinical setting
- Participate in multidisciplinary teams with health educators, service linkage facilitators, community health workers, case managers, nurses, pharmacists, and physicians to assess and support adherence to antiretroviral treatment
- Provide adherence support tailored to each person’s regimen and characteristics, according to provider role, authority, and setting
- Provide or refer to medication adherence interventions
- Offer advice on how to obtain sustained coverage or subsidies for ART through private- or public-sector sources

Standards related to retention and adherence to prevention services, including biomedical prevention services, include:

- Inform clients about the benefits of sustained adherence to PrEP and PEP. Optimal PrEP adherence is 90% of prescribed doses.

- Reinforce the benefits of prevention services
- Regularly assess facilitators and barriers to retention, and supporting clients to overcome identified barriers
- Regularly assess clients’ need for prevention services: *Have their needs changed? Do they no longer need services? Do they need different services?*
- Provide adherence support tailored to each client's needs and characteristics, and/or connect clients to medication adherence interventions
- Work with client to develop a plan for stopping PrEP, when appropriate (e.g. temporarily, long-term, or quitting use) and transitioning to other prevention options, including addressing relationship issues and health issues that increase HIV/STD risk
- Provide or make referrals for services to address factors that may impair adherence (e.g., comorbidity, financial, psychosocial, and structural issues)
- Offer advice on how to maintain financial assistance for PrEP through private- or public-sector sources
- Advise clients to take PrEP medications as prescribed; provide information about the regimen, and check for understanding in the following areas:
    - Details of the regimen, including dosing method and schedule, dietary restrictions, and what to do when drinking alcohol or when missing doses
    - Consequences of missing doses
    - Potential side effects
    - Potential interactions with other prescription, nonprescription, and recreational drugs, alcohol, and dietary supplements that may impair PrEP medication effectiveness or cause toxicity that could impair adherence
    - Advising the client that PrEP does not protect them from other STDs and pregnancy
- Routinely assess the client's questions, concerns, or challenges regarding PrEP use to identify potential problems
- Assess self-reported adherence at each visit using a nonjudgmental manner
- Assess and manage side effects at each visit
- Consider assessing PrEP prescription refills or pill counts, if feasible, when needed to supplement routine assessment of self-reported adherence
- Address misinformation, misconceptions, negative beliefs, or other concerns about PrEP regimen or adherence
- Acknowledge the challenges of maintaining high adherence over a time and offer long-term adherence support, especially when health coverage, insurance, or other life circumstances change
- Promote disclosure of challenges to adherence, and when disclosures occur, address them in a nonjudgmental manner
- Apply motivational interviewing techniques during routine adherence assessments. These include:
    - asking about the methods clients have successfully used or could use to increase adherence
    - asking about recent challenges to adherence and how they could be overcome

- Offer advice, tools, and training tailored to individual strengths, challenges, and circumstances to support adherence. Examples of advice include:
    - linking taking PrEP to daily events, such as meals or brushing teeth
    - using pill boxes, dose-reminder alarms, or diaries as reminders
    - carrying extra pills when away from home
    - actions to take if pill supply is depleted or nearly depleted
    - avoiding treatment interruptions when changing routines (e.g., travel, erratic housing, or legal detention)
- Encourage persons to seek adherence support from family members, partners, or friends, if appropriate
- Provide or refer to medication adherence interventions

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Paulina Zamudio	Los Angeles County Division of HIV and STD Programs

Key Resources Used to Help Inform the Development of the Prevention Service Standards

Centers for Disease Control and Prevention, Health Resources and Services Administration, National Institutes of Health, American Academy of HIV Medicine, Association of Nurses in AIDS Care, International Association of Providers of AIDS Care, National Minority AIDS Council, and Urban Coalition for HIV/AIDS Prevention Services. Recommendations for HIV Prevention with Adults and Adolescents with HIV in the United States, 2014: Summary for Health Departments and HIV Planning Groups. 2014. http://stacks.cdc.gov/view/cdc/26065.

Department of Public Health, Division of HIV and STD Programs, Request for Statement of Qualifications for Biomedical HIV Prevention Services. July 2015.

Expert Review Panels and Key Informant Interviews

Federal Response: HIV Prevention
https://www.hiv.gov/federal-response/federal-activities-agencies/hiv-prevention-activities

Funding Opportunity Announcement (FOA) PS18-1802: Integrated Human Immunodeficiency Virus (HIV) Surveillance and Prevention Programs for Health Departments
https://www.cdc.gov/hiv/funding/announcements/ps18-1802/index.html

Healthy People 2020 Evidence-Based Resources
https://www.healthypeople.gov/2020/tools-resources/Evidence-Based-Resources

Kumagai AK, Lypson ML. Beyond cultural competence: Critical consciousness, social justice, and multicultural education. Academic Medicine. 2009;84(6):782–787.

M. Tervalon, J. Murray-Garcia (1998). Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education, Journal of health care for the poor and underserved, Vol. 9, No. 2. (May 1998), pp. 117-125.

Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV. Department of Health and Human Services. Available at http://www.aidsinfo.nih.gov/ContentFiles/ AdultandAdolescentGL.pdf. Accessed April 24, 2018.

Paterson, D.L. *et al*. Adherence to protease inhibitor therapy and outcomes in patients with HIV infection. *Annals of Internal Medicine*. **133**, 21–30. PMID: 10877736 (2000).

Pre-exposure Prophylaxis for the Prevention of HIV Infection in the United States – 2017 Update: A Clinical Practice Guide. U.S. Public Health Service, Centers for Disease Control and Prevention

Promising Practices Database. Thinkhealthla.org

Recommendations for Inclusive Data Collection of Trans People in HIV Prevention, Care & Services. Center of Excellence for Transgender Health. http://transhealth.ucsf.edu/trans?page=lib-data-collection . Accessed May 20, 2018.

Ryan GW et al, Data-Driven Decision-Making Tools To Improve Public Resource Allocation For Care And Prevention Of HIV/AIDS. Health Affairs 2014 Volume 33 No. 3. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2013.1155

What is positive Sexuality? Center for Positive Sexuality. http://positivesexuality.org/education/presentations/what-is-positive-sexuality/

Los Angeles County Commission on HIV Prevention Planning Workgroup
Prevention Standards Comments Log (as of 8/21/23)

Source	Section - Subsection	Comment or Question
Dr. King	Background – Purpose	• Insert statement on Status Neutral
	Background – Goals of HIV Prevention Efforts in Los Angeles County	• Are listed goals current? • Is it just PWID or also stimulant use in LAC? Perhaps use SUD instead and collapse PWID and SUD.
	Background – Foundation for Development of Standards	• Are we incorporating language regarding status neutral framework here and changing the model?
	Background –Standards Development Process	• This will need to be changed to reflect the current method of updating: agreeing on the modification of status neutral; review by the PPW committee and???
	Universal Standards – Addressing the Social Determinants of Health	• Should we include treatment providers need to address SDH: (accessible hours), childcare; clean needle exchange.
	Universal Standards – Cultural Humility	• This is great. Need a sentence of two to tie into HIV/STD prevention. Does it result in reducing distrust? Do clients feel more welcome in such environments?
	Universal Standards – Data Driven and Outcome-based	• Not all agencies are able to collect, analyze and react to client data.
	Core Prevention Components – Summary of Core Prevention Service Components	• Considering our conversations in the last 2 PPA meetings, we need to incorporate a blurb on the impact of insurance as a barrier to care. Managed Medicaid is going to impact accessing care within the time frames mentioned below. Clients are not going to be able to be seen within 72 hours if they are in such networks and seeking new care.
	Core Prevention Components – Table 1 – HIV/STD Testing and Retesting	• For population-based outcomes “Increase the number of newly diagnosed clients that have their first HIV medical visit within 72 hours of their diagnosis”, Including telehealth visits to make 72 hrs possible? What about barriers to care such as insurances, which can delay this linkage to care?
	Core Prevention Components – Table 1 – Linkage to HIV Medical Care and Biomedical Prevention Services	• Add the following data indicators: ○ Number of high-risk HIV-negative clients who received an Injectable PrEP prescription ○ Number of high-risk HIV-negative clients who maintain appts for PrEP prescription Oral or Injectable • Include doxyPEP for HIV negative individuals
	Core Prevention Components – Table 1 – Referral and Linkage to Nonbiomedical Prevention Services	• Include documentation of harm reduction under documentation needs

	Assessment – Standards for Assessment	• This seems lengthy to occur during a provider visit. Does this happen during intake/case management. Is this reimbursable? ○ Again, this is long. Can we find a way to shorten this? Is there a EB study that looks at these questions and determines the most effective or empathetic ones, to shorten this list? • Do we recommend telehealth to do these assessments?
	Assessment - Clients should be the primary source of information during an assessment.	• Do we recommend telehealth to do these assessments?
	Assessment – Assessments that are conducted should align with the client's reason(s) for accessing services and point of entry	• Good point. Can we arrange a different order for these bullet points?
	Assessment – Whenever possible, collect demographic information in a manner that is affirming of various identities and of intersecting identities.	• When referring to asking clients about preferred pronouns: Great, also put in a discrete portion of the chart. Does the provider's Electronic Medical Record (EMR) have the ability to do this?
	HIV/STD Testing and Retesting - Standards that apply to HIV/STD testing	• Should we include a quick blurb about STD swabs oral, vaginal rectal? Include statement about HPV, a std associated with rectal cancer
	Linkage to HIV Medical Care and Biomedical Prevention Services - Linkage to Care Definition	• Is this a DPH standard because it also includes reengagement within 30 days?
	Linkage to HIV Medical Care and Biomedical Prevention Services	• Use of telehealth to facilitate access
	Referrals and Linkages to Non-biomedical Prevention Services	• List needs to be condensed to reduce redundancy and should include telehealth
	Retention and Adherence to HIV Medical Care, ART, and HIV Prevention Services	• Definition of retention should be cited as either the CDC definition or the HRSA definition of retention • How do you verify if a person attended follow-up visits, even when the patient was seen in another clinical setting • Distinguish between oral and long-acting injectable (LAI) PrEP

Miguel Martinez	Background - New Era of Prevention	• Add language for injectable treatment and injectable PrEP • Include short summary of status neutral planning
	Background - Definition of HIV Prevention Services	• Add STIs or create separation subsection dedicated to STIs
	Background – Goals of HIV Prevention Efforts in LAC	• Add STI to subsection title • Update to reflect current Integrated Plan ○ Add STI goals
	Background – Method/High Impact Prevention	• Does this become about targeting priority populations?
	Background – Standards Development Process	• Add process used to update standards once revisions are completed
	Whole document	• Decide to use STD or STI and ensure consistent use throughout document
	Universal Standards – Universal HIV Prevention Services Standards	• Add STI to title • Add status neutral framework to section
	Core Prevention Components – Table 1	• Outcomes should be updates based on goals highlighted in Universal Standards section • Include STI specific data indicators
	Assessment	• This section is critical
	HIV/STD Testing and Retesting	• Include multi-site testing (i.e. pharyngeal, anal and genital screening)
	Whole document	• How do we give credit to original contributors as well as to those who contribute to this iteration?
Paulina Zamudio	Universal Standards	• Introduced Trauma-informed Care subsection Trauma-informed care shifts the focus from “What’s wrong with you?” to “What happened to you?” A trauma-informed approach acknowledges that prevention providers need to have a complete picture of a patient’s life situation — past and present — in order to provide effective services with a healing orientation. Adopting trauma-informed practices can potentially improve patient engagement, and health outcomes, as well as provider and staff wellness. Trauma-informed care seeks to: • Realize the widespread impact of trauma and understand paths for recovery; • Recognize the signs and symptoms of trauma in patients, families, and staff; • Integrate knowledge about trauma into policies, procedures, and practices; and • Actively avoid re-traumatization. A comprehensive approach to trauma-informed services must be adopted at all organizational levels. Too frequently, providers attempt to implement trauma-informed care at the direct service level without the proper supports necessary for broad organizational culture change.

		This can lead to uneven, and often unsustainable, shifts in day-to-day operations. This narrow focus also fails to recognize how staff, such as front desk workers and security personnel, often have significant interactions with clients and can be critical to ensuring that clients feel safe.
	Core Prevention Components – Table 1 – HIV/STD Testing and Retesting	• Change title to "HIV Testing and STD Screening and Treatment" • Include following data indicators: ○ Number of persons who test positive for HIV who are linked to HIV Care ○ Number of persons who test negative for HIV or STD who are linked to PrEP • Add "HIV or STD" to "Documentation of clients treated for STDs or referred to treatment" • Remove "All service providers should strive towards linking newly diagnosed PLSHA to antiretroviral therapy within 72 hours of diagnosis" from Population-based Outcomes • Add "Increase the number of persons with negative HIV or STD test results to PrEP" to Population-based Outcomes
	Core Prevention Components – Table 1 – Linkage to HIV Medical Care and Biomedical Prevention Services	• Include a separate section for Prep/PEP and not have it together with HIV Testing • Change "Number of previously diagnosed HIV- positive clients lost to care who re-engage in HIV medical care within 30 days of interaction with provider" to "Number of previously diagnosed HIV- positive clients lost to care linked to care within 72 hours of session" in data indicators section • Remove the following data indicators: ○ Number of high-risk HIV negative clients who are interested in PrEP ○ Number of high-risk HIV negative clients who received a PrEP prescription
	Core Prevention Components – Table 1 – Referral and Linkage to Non- Biomedical Prevention Services	• Rephrase title to "Referral and Linkage to Behavioral Prevention Services" • Under documentation needs, remove "may be client self-report" from "Documentation of linkage to primary care (may be client self-report)" • Suggest removal of 90-day time frame for high-risk HIV negative clients who do not have a primary care provider to be linked to primary care medical visit within 90 days of assessment due to access barriers
	Core Prevention Components – Table 1 – Retention and Adherence to HIV Medical Care, ART, and Other Prevention Services	• For data indicator "Number of HIV- positive clients who adhere to their HIV medications", How is adherence to HIV medications measured? Undetectable viral load? • Remove data indictor "Number of PEP clients who adhere to PEP for 28-day course" or list different options
	Assessment	• Is there a definition for "lengthy assessment" Longer than 5 minutes, more than 15 questions? Some people think a 3-question assessment is too long.
	HIV/STD Testing and Retesting	• Separate HIV and STD; HIV testing and STD screening and treatment • Add STD testing every 3-6 months for high-risk individuals • It's important to note that additional testing to definitively establish HIV diagnosis maybe done outside of the prevention provider. Confirmatory testing is done by medical providers.

Rob Lester	Core Prevention Components – Table 1 – Assessments	I think this is too much to try and screen for during an HIV testing visit. Our patients regularly report that the risk assessment questionnaire is too long and too invasive. For a patient whose only clinical care is an HIV test, it's not appropriate to ask them about things like "experiences of trauma and violence". And from the provider perspective, it's just not possible to elicit this information appropriately and provide meaningful care based on the information in the context of a 10-minute testing appointment.
	Core Prevention Components – Table 1 – HIV/STD Testing and Retesting	For Population-based outcome “Increase the number of newly diagnosed clients that have their first HIV medical visit within 72 hours of their diagnosis” • On one hand, getting someone linked quickly is important and increases the likelihood of retention in care, but if the provider is doing Rapid ART, then you usually draw labs at the time of the test and provide a script or starter pack of meds. If this visit is conducted by an sexual health provider, then we really still need to link the patient to proper HIV care. That visit should be at least a week or so later, otherwise the provider won't have access to the labs needed for a meaningful visit. So, it may be necessary to consider these as to different treatment paths.
	Core Prevention Components – Table 1 - Linkage to HIV Medical Care and Biomedical Prevention Services	• Clarify whether linkage to PrEP services is navigation or clinical services and define "linkage" • For HIV-negative individuals data indicator ○ Are each of these data points really necessary? Navigators work a limited number of hours per week. If they're doing paperwork, they're not seeing patients. • Rephrase “Increase the number of HIV negative clients that are given accurate PrEP and PEP information” ○ This implies that there's an issue with contractors providing inaccurate info. Perhaps "evidence based"?
	Core Prevention Components – Table 1 - Referral and Linkage to Non- Biomedical Prevention Services	• For data indictor “Number of high-risk HIV-negative and HIV- positive clients that are referred to needed non-biomedical prevention services, as indicated via the assessment process.” ○ How is the assessment process conceptualized? This seems to be modeled on MCC (which is an excellent program) but I'm not sure that level of intensity is appropriate for PrEP patients.
	Assessment	• There are a lot of underlying assumptions here about what the patient wants and needs. At a minimum, "patient centered care" should mean that the patient has agency to opt out of invasive questionnaires. This raises a larger issue: is the purpose of publicly-funded sexual health services to provide targeted services to high needs individuals (low-volume, high-intensity) or to maximize the number of people receiving sexual health services (high-volume, low-intensity)? • When I read this I wonder why would a patient sit through this when they can go online and get it mailed to them free by Mistr? • Start the assessment section with the following (move up in document) and strongly emphasized:

		○ "Assessments that are conducted should align with the client's reason(s) for accessing services and point of entry. For example, a client who is interested in accessing HIV/STD testing, PEP, or PrEP should not have to endure a lengthy assessment before accessing these services. Clients should be able to access services as expeditiously as possible. However, in some situations, or at a different point in time, a longer assessment may be appropriate." • Strong support for the following section "Specific topics or areas should be assessed only if the provider can offer support, resources, referrals, and/or services in response."
	HIV/STD Testing and Retesting	• Noted it's very difficult to get assessment of risk factors for HIV/STD transmission to mesh up with a streamlined model of HIV testing.
	Linkage to HIV Medical Care and Biomedical Prevention Services	• How does linkage to care definiton work with same-day Rapid ART? • Noted importance of maintain relationship between patient and a consistent care team
Beverly Burgess	Core Prevention Components – Table 1 - Linkage to HIV Medical Care and Biomedical Prevention Services	• Who is providing the PrEP and PEP educational materials? Are the materials designed by LA County, CBO, CDC, or pharmaceutical companies? Do they have to be approved by DHSP? • Remove "Documentation of client interest in learning more about PrEP (i.e. responded affirmatively to the question, "Would you like to learn more about PrEP or PEP?")" under documentation as is redundant • High-risk includes those who have sex without a condom or with partners not on PrEP.
Robert Aguayo	*Introduced new section focused on Health Navigation*	Health Navigation Services focus on educating clients on addressing risk taking behaviors identified during a risk assessment session and provide the clients with skills to strengthen, manage and minimize barriers to accessing HERR and care services such as HIV Testing, linkage to HIV medical care, STD screening, and/or treatment and access to Hepatitis C screening, PrEP/PEP and/or syringe exchange. Sessions will focus on Health Education/Risk Reduction Prevention, Behavior Change Skills Building and increasing knowledge of access to care services based on the client's risk assessment. Sessions can be provided on a one-to-one basis or group setting depending on the client's preference, need and/or environment. Sessions can be conducted on an ongoing basis, depending on need, and can be from 1 to 3 weekly or semi-monthly sessions. Referral and Linkages to HIV, STD and care services will be provided to clients to increase clients' knowledge and access of these available services. If possible, referrals should be to local facilities, clinics, and service providers in the area of the client. Local referrals are essential to addressing and minimizing transportation barriers to services. Health Navigators/Behavior Health Educators will canvas the target areas to identify and document all available service providers that can be used as referral sources for clients. Health Navigators/Behavior Health Educators will become familiar with the access, referral, and intake process in order to educate

		clients of this process when providing referral for services. This is also an essential step in addressing barriers to services due to clients' lack of knowledge of the intake process which discourages their access to services and care. If possible, a 30 day follow up session should be conducted to re-access clients' current situation and, if needed, additional services.

DRAFT

LOS ANGELES COUNTY
COMMISSION ON HIV

RYAN WHITE PROGRAM
UNIVERSAL STANDARDS

Approved by COH on 2/11/21

Draft as of 08/01/23 for

Executive Committee Review.

LOS ANGELES COUNTY
COMMISSION ON HIV

TABLE OF CONTENTS

IMPORTANT: Service standards must adhere to requirements and restrictions from the federal agency, Health Resources and Services Administration (HRSA). The key documents used in developing standards are as follows:

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

INTRODUCTION

Standards of Care outline the elements and expectations a Ryan White service provider follows when implementing a specific service category. Standards of Care are available for each service category to set the minimum level of care Ryan White funded agencies should offer to clients. The Standards are intended to help Ryan White Part A funded agencies meet the needs of their clients. Providers are encouraged to exceed these standards.

The Los Angeles County Commission on HIV developed the Universal Standards of Care to reflect current guidelines from federal and national agencies on HIV care and treatment, and to establish the minimum standards of care necessary to achieve optimal health among people living with HIV (PLWH), regardless of where services are received in the County. The development of the Standards includes guidance from service providers, consumers and members of the Los Angeles County Commission on HIV, Standards and Best Practices Committee.

UNIVERSAL STANDARDS OVERVIEW

The objectives of the Universal Standards are to ensure agencies:

- Provide services that are accessible and non-discriminatory to all PLWH in Los Angeles County
- Educate staff and clients on the importance of receiving care, treatment as prevention, and how maintaining an undetectable viral load results in no risk of HIV transmission
- Protect client rights and ensure quality of care
- Provide client-centered, age appropriate, culturally, and linguistically competent care
- Provide high quality services through experienced and trained staff
- Meet federal, state, and county requirements regarding safety, sanitation, access, and public health.
- Guarantee client confidentiality, protect client autonomy, and ensure a fair process of addressing grievances
- Prevent information technology security risks and protect patient information and records
- Inform clients of services, establish eligibility, and collect information through an intake process
- Effectively assess client needs and encourage informed and active participation
- Address client needs through coordination of care and referrals to needed services
- Ensure that the quality of service and materials given to patients during telehealth encounter is similar with in-person visits.

1. GENERAL AGENCY POLICIES

All agencies offering Ryan White services must have written policies that address client confidentiality, release of information, client grievance procedures, and eligibility. Agency policies and procedures facilitate service delivery as well as ensure safety and well-being of clients and staff. Agencies are encouraged to build their telehealth technology infrastructure and capacity to include videoconferencing to facilitate patient-provider connectivity and relationships.

1.0 GENERAL AGENCY POLICIES	
Standard	**Documentation**
1.1 Agency develops or utilizes an existing client confidentiality policy in accordance with state and federal laws to assure protection of client HIV status, behavioral risk factors, and/or use of services.	1.1 Written client confidentiality policy on file with specific information technology safeguards for confidentiality and patient information if using telehealth service modality.
1.2 Agency is responsible for informing the patient that they have the right to obtain copies of their medical and other health records maintained by the agency.	1.2 Written policy for informing the patient of their rights to receive a copy of their medical records. The policy should contain a description of the process for obtaining records, such as a verbal or written request and a reasonable timeframe for patients to receive the information.
1.3 Client determines what information of theirs can be released and with whom it can be shared. Services using telehealth modality are subject to consent by the patient.	1.3 Completed *Release of Information Form* on file including: • Name of agency/individual with whom information will be shared • Information to be shared • Duration of the release consent • Client signature For agencies and information covered by the Health Insurance Portability and Accountability Act (HIPAA), form must be HIPAA disclosure authorization compliant. The form must also be compliant with the CA Medi-Cal telehealth policy.[1]
1.4 Agency develops or utilizes an existing grievance procedure to ensure clients have recourse if they feel they are being treated in an unfair manner or feel they are not receiving quality services.	1.4 Written grievance procedure on file that includes, at minimum: • Client process to file a grievance • Information on the Los Angeles County Department of Public Health, Division of HIV & STD Programs (DHSP) Customer Support Program[2] 1-800-260-8787. DHSP Customer Support Program information is posted in a visible location on site or provided to the patient at the beginning of a telehealth encounter.

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[1] California Department of Health Care Services Telehealth Provider Manual can be accessed here https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/mednetele.pdf

[2] More information on the Customer Support Program can be found here: DHSP_CSP_CustomerSupportForm_Website-ENG-Final_12.2022.pdf (lacounty.gov)

1.5 Agency provides eligibility requirements for services available upon request. Eligibility requirements must follow guidance from Division of HIV & STD Programs (DHSP) and HRSA under Policy Clarification Notice #16- 02[3]	1.5 Written eligibility requirements on file.
1.6 All client files are stored in a secure and confidential location, and electronic client files are protected from unauthorized use. Protection of client files and information must cover use of electronic medical records, phones, text messages, email, and telehealth modalities.	1.6 Client files must be locked and/or password protected with access provided only to appropriate personnel. Agencies must establish written procedures and IT policies for message encryption and restrictions on staff access to protect client information.
1.7 Agency maintains progress notes of all communication between provider and client.	1.7 Legible progress notes maintained in individual client files that include, at minimum: • Date of communication or service • Service(s) provided Recommended referrals linking clients to needed services (See Section 6: Referrals and Case Closure)
1.8 Agency develops or utilizes an existing crisis management policy.	1.8 Written crisis management policy on file that includes, at minimum: • Mental health crises • Dangerous behavior by clients or staff
1.9 Agency develops a policy on utilization of Universal Precaution Procedures[4,5]. Staff members are trained in universal precautions.	1.10 Written policy or procedure on file. Documentation of staff training in personnel file.
1.10 Agency ensures compliance with Americans with Disabilities Act[6] (ADA) criteria for programmatic accessibility (e.g. building and design accessibility, parking, etc.). For agencies with multiple sites, all sites must comply with the ADA requirements.	1.10 ADA criteria on file at all sites.
1.11 Agency complies with all applicable state and federal workplace and safety laws and regulations, including fire safety.	1.11 Signed confirmation of compliance with applicable regulations on file.

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[3] PCN 16-02 RWHAP Services Eligible Individuals and Allowables Uses of Funds (hrsa.gov)

[4] Bloodborne Infectious Diseases | NIOSH | CDC

[5] Bloodborne Pathogens - Worker protections against occupational exposure to infectious diseases | Occupational Safety and Health Administration (osha.gov)

[6] Laws, Regulations & Standards | ADA.gov

2. CLIENT RIGHTS AND RESPONSIBILITIES

A key component of HIV/AIDS service delivery is the historic and continued involvement of people living with HIV in the design and evaluation of services. The quality of care and quality of life for people living with HIV/AIDS is maximized when people living with HIV are active participants in their own health care decisions with their providers. This can be facilitated by ensuring that clients are aware of and understand the importance of their input in the development of HIV programming.

2.0 CLIENT RIGHTS AND RESPONSIBILITIES	
Standard	**Documentation**
2.1 Agency ensures services are available to any individual who meets the eligibility requirements for the specific service category.	2.1 Written eligibility requirements on file. Client utilization data made available to funder.
2.2 Agency includes input from people living with HIV/AIDS in the design and evaluation of services to ensure care is client centered.	2.2 Written documentation of how input was received to inform service planning and evaluation in regular reports. Lists may include: • Consumer Advisory Board meetings • Participation of people living with HIV in HIV program committees or other planning bodies • Needs assessments • Anonymous patient satisfaction surveys. Discreet drop off boxes should be available in various sites throughout the agency and/or anonymous electronic follow-up surveys emailed to patients after their appointment. • Focus groups
2.3 Agency ensures that clients receive information technology support and training on how to use telehealth services.	2.3 Written checklists and/or "how to" guides are provided to patients prior to their telehealth appointment. Materials may be emailed to patient and/or posted on the agency website. The document should contain at least the following information: • Instructions on how to use telehealth tools (i.e., phone, laptop, tablets, etc.) in plain language and available in the patient's preferred language. • Telephone number for technical support or trouble shooting available before, during and after the telehealth appointment.

2.4 Agency ensures that clients retain the right to accept or decline a telehealth visit. The ultimate decision on the mode of service delivery, whether in-person or telehealth, must be determined by the client first before an appointment is made.	2.4 Written procedures and telehealth acceptance or denial form completed by patients prior to the appointment.
2.5 Agency provides each client a copy of the *Patient & Client Bill of Rights & Responsibilities (Appendix B)* document that informs them of the following: • Confidentiality policy • Expectations and responsibilities of the client when seeking services • Client right to file a grievance • Client right to receive no-cost interpreter services • Client right to access their file (if psychotherapy notes cannot be released per clinician guidance, agency should provide a summary to client within 30 days) • Reasons for which a client may be removed from services and the process that occurs during involuntary removal	2.5 *Patient and Client Bill of Rights* document is signed by client and kept on file.

3. STAFF REQUIREMENTS AND QUALIFICATIONS

Staff must be well qualified and, if necessary, hold all required licenses, registration, and/or degrees in accordance with applicable State and federal regulations as well as requirements of the Los Angeles County Department of Public Health, Division of HIV & STD Programs. At minimum, all staff will be able to provide timely, linguistically, and culturally competent care to people living with HIV. Staff will complete orientation through their respective hiring agency, including a review of established programmatic guidelines, and supplemental trainings as required by the Los Angeles County Department of Public Health, Division of HIV and STD Programs. The AIDS Education Training Center (AETC)[7] offers a variety of training for the HIV workforce.

3.0 STAFF REQUIREMENTS AND QUALIFICATIONS	
Standard	**Documentation**
3.1 Staff members meet the minimum qualifications for their job position and have the knowledge, skills, and ability to effectively fulfill their role and the communities served. Employment is an essential part of leading an independent, self-directed life for all people, including those living with HIV/AIDS. Agencies should develop policies that strive to hire PLWH in all facets of service delivery, whenever appropriate.	3.1 Hiring policy and staff resumes on file.

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[7] Welcome | AIDS Education and Training Centers National Coordinating Resource Center (AETC NCRC) (aidsetc.org)

3.2 If a position requires licensed staff, staff must be licensed to provide services.	3.2 Copy of current license on file.
3.3 Staff will participate in trainings appropriate to their job description and program a. Required education on how a client achieving and maintaining an undetectable viral load for a minimum of six months will not sexually transmit HIV. Continuing to take HIV medications as directed is imperative to stay undetectable. b. Staff should have experience in or participate in trainings on: • LGBTQ+/Transgender community and HIV Navigation Services (HNS)[8] provided by Centers for Disease Control and Prevention (CDC). • Trauma informed care • Providing care for older adults • Mental Health First Aid	3.3 Documentation of completed trainings on file
3.4 New staff will participate in trainings to increase capacity for fulfilling the responsibilities of their position. a. Required completion of an agency-level orientation within 6 weeks of hire b. Training within 3 months of being hired appropriate to the job description. c. Additional trainings appropriate to the job description and Ryan White service category.	3.4 Documentation of completed trainings on file
3.5 Staff are required to coordinate across Ryan White funded and non-funded programs to ensure clients' needs are met.	3.5 Documentation of staff efforts of coordinating across systems for the client on file (e.g. housing case management services, etc.).

4. CULTURAL AND LINGUISTIC COMPETENCE

Ryan White funded agencies must provide services that are culturally and linguistically competent based on the National Standards for Culturally and Linguistically Appropriate Services[9] (CLAS) in Health and Health Care. As noted in the CLAS Standards[10], ensuring culturally and linguistically appropriate services advances health equity, improves quality, and helps eliminate health care disparities by establishing a blueprint for health and health care organizations. For the purpose of these standards, culture is defined as the integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial,

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[8] HIV Navigation Services | Treat | Effective Interventions | HIV/AIDS | CDC

[9] Culturally and Linguistically Appropriate Services - Think Cultural Health (hhs.gov)

[10] CLAS Standards - Think Cultural Health (hhs.gov)

ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics. The standards below are adapted directly from the National CLAS Standards.

Agencies should also strive towards acknowledging implicit bias, how it plays a role in service delivery, and how it can be addressed and countered. Agencies must provide services that align with strategies to reduce implicit bias by the Institute for Healthcare Improvement. For the purpose of the standards, implicit bias refers to the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner. These biases, which encompass both favorable and unfavorable assessments, are activated involuntarily and without an individual's awareness or intentional control. Residing deep in the subconscious, these biases are different from known biases that individuals may choose to conceal for the purposes of social and/or political correctness.

Cultural competence and acknowledging implicit bias rely on behaviors, attitudes, and policies that come together in a system, agency, or among individuals that reduces stigma and enables effective delivery of services. Linguistic competence is the ability to communicate effectively with clients, including those whose preferred language is not the same as the provider's, those who have low literacy skills, and/or those with disabilities. Cultural and linguistic competence is a goal toward which all service providers must aspire, but one that may never be completely achieved given the diversity of languages and cultures throughout our communities, and understanding that culture is dynamic in nature, and individuals may identify with multiple cultures over the course of their lifetime. However, agencies should ensure staff are involved in a continual process of learning, personal growth, and training that increases cultural and linguistic competence, addresses implicit bias, decreases stigma, and enhances the ability to provide appropriate services to all individuals living with HIV/AIDS.

Federal and State language access laws require health care facilities that receive federal or state funding to provide competent interpretation services to limited English proficiency patients at no cost, to ensure equal and meaningful access to health care services. Interpretation refers to verbal communication where speech is translated from a speaker to a receiver in a language that the receiver can understand. Translation refers to the conversion of written material from one language to another.

4.0 CULTURAL AND LINGUISTIC COMPETENCE	
Standard	**Documentation**
4.1 Recruit, promote, and support a culturally and linguistically diverse workforce that are responsive to the population served.	4.1 Documentation of how staff demographics reflect the demographics of clients served on file (e.g. race, gender identity, age, sexual orientation, lived experience etc.)
4.2 Agency develops or utilizes existing culturally and linguistically appropriate policies and practices. Agency educates and trains workforce on culturally and linguistically appropriate practices on an ongoing basis.	4.2 Written policy and practices on file Documentation of completed trainings on file.
4.3 Provide resources onsite to facilitate communication for individuals who experience impairment due to a challenging medical condition or status (e.g. augmentative and alternative communication resources or auxiliary aids and services)	4.3 Resources on file a. Checklist of resources onsite that are available for client use. b. Type of accommodations provided documented in client file.

4.4 Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.	4.4 *Signed Patient & Client Bill of Rights and Responsibilities* document on file that includes notice of right to obtain no-cost interpreter services.
4.5 Ensure the competence of individuals providing language assistance a. Use of untrained individuals and/or minors as interpreters should be avoided Ensure quality of language skills of self-reported bilingual staff who use their non-English language skills during client encounters	4.5 Staff resumes and language certifications, if available, on file.
4.6 Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area in clinic points of entry (e.g. registration desks, front desks, reception, waiting rooms, etc.) and areas where work with client is performed (e.g. clinic rooms, meeting rooms, etc.)	4.6 Materials and signage in a visible location and/or on file for reference.

5. INTAKE AND ELIGIBILITY

All clients who request or are referred to HIV services will participate in an intake process conducted by appropriately trained staff. The intake worker will review client rights and responsibilities, explain available services, the confidentiality and grievance policy, assess immediate service needs, and secure permission to release information

5.0 INTAKE AND ELIGIBILITY	
Standard	**Documentation**
5.1 Intake process begins within 5 days of initial contact and is completed within 30 days of initial contact with client.	5.1 Completed intake on file that includes, at minimum: • Client's legal name, name if different than legal name, and pronouns • Address, phone, and email (if available). A signed affidavit declaring homelessness should be kept on file for clients without an address. • Preferred method of communication (e.g., phone, email, or mail) • Emergency contact information • Preferred language of communication • Enrollment in other HIV/AIDS services. • Primary reason and need for seeking services at agency If client chooses not to complete the intake within 30 days of initial contact, document attempts to contact client and mode of communication in client file.
5.2 Agency determines client eligibility	5.2 Documentation includes: • Los Angeles County resident • Income equal to or below the required Federal Poverty Level (FPL) as determined by Division of HIV & STD Programs • Verification of HIV diagnosis

6. REFERRALS AND CASE CLOSURE

A client case may be closed through a systematic process that includes case closure justification and a transition plan to other services or other provider agencies, if applicable. Agencies should maintain a list of resources available for the client for referral purposes. If the client does not agree with the reason for case closure, they should follow the grievance policy at the provider agency and/or be referred to the Department of Public Health, Division of HIV and STD Programs Customer Support Program[11].

6.0 REFERRALS AND CASE CLOSURE	
Standard	**Documentation**
6.1. Agency will maintain a comprehensive list of providers for full spectrum HIV-related and other service referrals a. Staff will provide referrals to link clients to services based on assessments and reassessments	6.1 Identified resources for referrals at provider agency (e.g. lists on file, access to websites) a. Written documentation of recommended referrals in client file
6.2 If needed, staff will engage additional providers for specific support services (e.g. behavioral health, substance use, housing)	6.2 Agency establishes partnerships with agencies for referrals as needed. Memoranda of Understanding (MOU) on file.
6.3 For clients with missed appointments or pending case closure, staff will attempt to contact client. a. Cases may be closed if the client: • Relocates out of the service area • Is no longer eligible for the service • Discontinues the service • No longer needs the service • Puts the agency, service provider, or other clients at risk • Uses the service improperly or has not complied with the services agreement • Is deceased • Has had no direct agency contact, after repeated attempts, for a period of 12 months.	6.3 Attempts to contact client and mode of communication documented in file. a. Justification for case closure documented in client file
6.4 Agency has a transition procedure in place that is implemented for clients leaving services to ensure a smooth transition.	6.4 Completed transition summary in file, signed by client and supervisor (if possible). Summary should include reason for case closure; and a plan for transition to other services, if applicable, with confirmation of communication between referring and referral agencies, or between client and agency.

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[11] DHSP_CSP_CustomerSupportForm_Website-ENG-Final_12.2022.pdf (lacounty.gov)

6.5 Agency develops or utilizes existing due process policy for involuntary removal of clients from services; policy includes a series of verbal and written warnings before final notice and case closure.	6.5 Due process policy on file as part of transition, and case closure policy described in the *Patient & Client Bill of Rights and Responsibilities* document. (Refer to Appendix B).

APPENDIX A: RYAN WHITE PART A SERVICE CATEGORIES

The Ryan White HIV/AIDS Program Part A provides assistance to communities that are most severely impacted by the HIV epidemic. Part A funds must be used to provide core medical and support services for people living with HIV.

Core Medical Services	Description
Ambulatory Outpatient Medical (AOM) Services	HIV medical care access through a medical provider.
Home-based Case Management	Specialized home care for homebound clients.
Medical Care Coordination (MCC)	HIV care coordination through a team of health providers to improve quality of life.
Medical Specialty Services	Medical care referrals for complex and specialized cases.
Mental Health Services	Psychiatry, psychotherapy, and specialized cases.
Oral Health Services (General & Specialty)	General and specialty dental care services.
Supportive Services	**Description**
Benefits Specialty Services	Assistance navigating public and/or private benefits and programs (health, disability, etc.).
Language Translation Services	Translation services for non-English speakers and deaf and/or hard of hearing individuals.
Legal Services	Legal information, advice, and services.
Nutrition Support Services	Home-delivered meals, food banks, and pantry services.
Residential Care Facility for the Chronically Ill (RCFCI)	Home-like housing that provides 24-hour care.
Substance Use Disorder Transitional Housing (SUDTH)	Housing services for clients in recovery form drug or alcohol use disorders.
Transitional Case Management	Support for incarcerated individuals transitioning from County jails back to the community.
Transitional Residential Care Facility (TRCF)	Short-term housing that provides 24-hour assistance to clients with independent living skills.
Transportation Services	Ride services to medical and social services appointments.

APPENDIX B: PATIENT & CLIENT BILL OF RIGHTS AND RESPONSIBILITIES

It is the provider's responsibility to provide clients a copy of the Patient & Client Bill of Rights and Responsibilities in all service settings, including telehealth. The purpose of this Patient and Client Bill of Rights is to help enable clients to act on their own behalf and in partnership with their providers to obtain the best possible HIV/AIDS care and treatment. This Bill of Rights and Responsibilities comes from the hearts of people living with HIV/AIDS in the diverse communities of Los Angeles County. As someone newly entering or currently accessing care, treatment, or support services for HIV/AIDS, you have the right to:

A. Respectful Treatment and Preventative Services

1. Receive considerate, respectful, professional, confidential, and timely care and preventative services (such as screenings and vaccinations) in a safe client-centered, trauma-informed environment without bias.
2. Receive equal and unbiased care according to your age and needs in accordance with federal and State laws.
3. Receive information about the qualifications of your providers, particularly about their experience managing and treating HIV/AIDS or related services.
4. Be informed of the names and work phone numbers of the physicians, nurses, and other staff members responsible for your care.
5. Receive safe accommodations for protection of personal property while receiving care services.
6. Receive services that are culturally and linguistically appropriate, including having a full explanation of all services and treatment options provided clearly in your own language and dialect.
7. Review your medical records and receive copies of them upon your request (reasonable agency policies including reasonable fee for photocopying may apply).

B. Competent, High-Quality Care

1. Have your care provided by competent, qualified professionals who follow HIV treatment standards as set forth by the U.S. Department of Health and Human Services[12] (HHS), the Centers for Disease Control and Prevention[13] (CDC), the California Department of Health Services[14], and the County of Los Angeles Department of Public Health[15].
2. Have access to these professionals at convenient times and locations.
3. Receive appropriate referrals to other medical, mental health or care services.
4. Have their phone calls and/or emails answered with 1-5 business days based on the urgency of the matter.

C. Participate in the Decision-making Treatment Process

1. Receive complete and up-to-date information in words you understand about your diagnosis, treatment options, medications (including common side effects and complications) and prognosis that can reasonably be expected.
2. Participate actively with your provider(s) in discussions about choices and options available for your treatment.
3. Make the final decision about which treatment option is best for you after you have been given all relevant information about these choices and the clear recommendation of your provider.
4. Have access to patient-specific education resources and reliable information and training about patient self-management.

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[12] HIV Treatment Guidelines | NIH

[13] Guidelines and Recommendations | Clinicians | HIV | CDC

[14] HIV Care Program

[15] LA County Department of Public Health

5. Refuse any and all treatments recommended and be told of the effect that not taking the treatment may have on your health, be told of any other potential consequences of your refusal, and be assured that you have the right to change your mind later.
6. Be informed about and afforded the opportunity to participate in any appropriate clinical research studies for which you are eligible.
7. Refuse to participate in research without prejudice or penalty of any sort.
8. Refuse any offered services or end participation in any program without bias or impact on your care.
9. Be informed of the procedures at the agency for resolving misunderstandings, making complaints, or filing grievances.
10. Receive a response to a complaint or grievance within 30-45 days of filing it.
11. Be informed of independent ombudsman or advocacy services outside the agency to help you resolve problems or grievances (see number at bottom of this form), including how to access a federal complaint center within the Center for Medicare and Medicaid Services[16] (CMS).

D. Confidentiality and Privacy

1. Receive a copy of your agency's Notice of Privacy Policies and Procedures. (Your agency will ask you to acknowledge receipt of this document.)
2. Keep your HIV status confidential. Have information explained to you about confidentiality policies and under what conditions, if any, information about HIV care services may be released.
3. Request restricted access to specific sections of your medical records.
4. Authorize or withdraw requests for your medical record from anyone else besides your health care providers and for billing purposes.
5. Question information in your medical chart and make a written request to change specific documented information. (Your physician has the right to accept or refuse your request with an explanation.)

E. Billing Information and Assistance

1. Receive complete information and explanation in advance of all charges that may be incurred for receiving care, treatment, and services as well as payment policies of your provider.
2. Receive information on any programs to help you pay and assistance in accessing such assistance and any other benefits for which you may be eligible.

F. Patient/Client Responsibilities

In order to help your provider give you the care to which you are entitled, you also have the responsibility to:

1. Participate in the development and implementation of your individual treatment or service plan to the extent that you are able.
2. Provide your providers, to the best of your knowledge, accurate and complete information about your current and past health and illness, medications and other treatment and services you are receiving, since all of these may affect your care. Communicate promptly any changes or new developments.
3. Communicate to your provider whenever you do not understand information you are provided.
4. Follow the treatment plan you have agreed to and understand the consequences of failing to adhere to the recommended course of treatment or of using alternative treatments.
5. Understand that cases may be closed if the client:
    i. Relocates out of the service area
    ii. Is no longer eligible for the service(s)
    iii. Discontinues the service(s)
    iv. No longer needs the service(s)

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[16] Home - Division of Appeals Policy (lmi.org)

        v. Puts the agency, service provider, or other clients at risk
        vi. Uses the service(s) improperly or has not complied with the services agreement
        vii. Is deceased
        viii. Has had no direct agency contact, after repeated attempts, for a period of 12 months

6. Keep your appointments and commitments at this agency or inform the agency promptly if you cannot do so.
7. Keep your provider or main contact informed about how to reach you confidentially by phone, mail, or other means.
8. Follow the agency's rules and regulations concerning patient/client care and conduct.
9. Be considerate of your providers and fellow clients/patients and treat them with the respect you yourself expect.
10. Refrain from the use of profanity or abusive or hostile language; threats, violence, or intimidations; carrying weapons of any sort; theft or vandalism; sexual harassment and misconduct.
11. If you are a person living with a Substance Use Disorder, please be open and honest with your provider about your substance use so that any issues can be properly addressed.

For More Help or Information

Your first step in getting more information involving any complaints or grievances is to speak with your provider or a designated client services representative or patient or treatment advocate at the agency. If this does not resolve the problem in a reasonable time span, or if serious concerns or issues arise and you would like to speak with someone outside the agency, you may call the number below for confidential, independent information and assistance.

Division of HIV and STD Programs | Customer Support Program
(800) 260-8787 | 8:00 am – 5:00 Monday – Friday

APPENDIX C: TELEHEALTH RESOURCES

- **Federal and National Resources:**
    - HRSA's Ryan White HIV/AIDS Program Expanding HIV Care Through Telehealth CARE Action Newsletter October 2019: https://hab.hrsa.gov/sites/default/files/hab/Publications/careactionnewsletter/telehealth.pdf
- **Telehealth Discretion During Coronavirus:**
    - AAFP Comprehensive Telehealth Toolkit: https://www.aafp.org/dam/AAFP/documents/practice_management/telehealth/2020-AAFP-Telehealth-Toolkit.pdf
    - ACP Telehealth Guidance & Resources: https://www.acponline.org/practice-resources/business-resources/telehealth
    - ACP Telemedicine Checklist: https://www.acponline.org/system/files/documents/practice-resources/health-information-technology/telehealth/video_visit_telemedicine_checklist_web.pdf
    - AMA Telehealth Quick Guide: https://www.ama-assn.org/practice-management/digital/ama-telehealth-quick-guide
    - CMS Flexibilities for Physicians: https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf - "Under the CARES Act, CMS is waiving the requirements of section 1834(m)(1) of the ACT and 42 CFR § 410.78(a)(3) for use of interactive telecommunications systems to furnish telehealth services, to the extent they require use of video technology, for certain services. This waiver allows the use of audio-only equipment to furnish services described by the codes for audio-only telephone evaluation and management services, and behavioral health counseling and educational services."
    - CMS Flexibilities for RHCs and FQHCs: https://www.cms.gov/files/document/covid-rural-health-clinics.pdf - "Medicare telehealth services generally require an interactive audio and video telecommunications system that permits real-time communication between the practitioner and the patient. (During the PHE, some telehealth services can be furnished using audio-only technology.)"
    - CMS Fact Sheet on Virtual Services: https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet
    - Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency
    - Using Telehealth to Expand Access to Essential Health Services during the COVID-19 Pandemic