together.

WE CAN END HIV IN OUR COMMUNITIES ONCE & FOR ALL

STANDARDS AND BEST PRACTICES COMMITTEE MEETING

Monday, May 18, 2026

10:00 am - 12:00 pm (PST)

510 S. Vermont Ave. Terrace Level Conference Rooms (9th Floor), Los Angeles, CA 90020
Validated parking: 523 Shatto Place, Los Angeles, CA 90020

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

The commission on HIV will be begin using zoom as part of its ongoing exploration of virtual and hybrid meeting platforms. This transition is intended to improve accessibility, participation, and the overall meeting experience for attendees. No registration is required to join the meeting.

TO JOIN VIRTUALLY, PLEASE USE THE LINK BELOW

https://bos-lacounty-gov.zoom.us/j/87082174233?pwd=e1ny8Av3DsXkJnZIVimb8ojDjBMTcg.1

PUBLIC COMMENTS

Public Comment is an opportunity for members of the public to address the Commission on an agenda item or other matter within the Commission's subject matter jurisdiction. Comments may be provided in person or submitted electronically to hivcomm@lachiv.org. Please include your name, the related agenda item, and whether you would like your comment stated during the meeting.

ACCOMMODATIONS

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

Visit us online: **http://hiv.lacounty.gov**

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510 S. Vermont Avenue, 14th Floor, Los Angeles, CA 90020
MAIN: 213.738.2816 | EMAIL: hivcomm@lachiv.org | WEB: https://hiv.lacounty.gov

AGENDA FOR THE REGULAR MEETING OF THE STANDARDS AND BEST PRACTICES COMMITTEE

MONDAY, MAY 18, 2026 | 10:00 AM—12:00 PM
510 S. Vermont Ave.
Terrace Level Conference Room (9th Floor), Los Angeles, CA 90020
Validated Parking: 523 Shatto Place, Los Angeles, CA 90020

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

TO JOIN THE MEETING VIRTUALLY, PLEASE USE THE LINK BELOW—NO REGISTRATION IS REQUIRED:
https://bos-lacounty-gov.zoom.us/j/87082174233?pwd=e1ny8Av3DsXkJnZIVimb8ojDjBMTcg.1

COMMITTEE CO-CHAIRS: Caitlin Dolan and Montana Volby

AGENDA POSTED: May 13, 2026

VIRTUAL AND HYBRID MEETING PLATFORM: The Commission on HIV will begin using Zoom as part of its ongoing exploration of virtual and hybrid meeting platforms. This transition is intended to improve accessibility, participation, and the overall meeting experience for attendees. **No registration is required to join the meeting.**

PUBLIC COMMENT: Public Comment is an opportunity for members of the public to comment on an agenda item, or any item of interest to the public, before or during the Commission's consideration of the item, that is within the subject matter jurisdiction of the Commission. Public Comment is limited to two minutes each and will be made part of the official record. Public Comment may be provided in person during the meeting in accordance with the meeting procedures or may be submitted electronically at hivcomm@lachiv.org.

ACCOMMODATIONS: Interpretation services for the hearing impaired and translation services for languages other than English are available free of charge with at least 72 hours' notice before the meeting date. To arrange for these services, please contact the Commission office at hivcomm@lachiv.org or leave a voicemail at 213.738.2816.

Los servicios de interpretación para personas con impedimento auditivo y traducción para personas que no hablan inglés están disponibles sin costo. Para pedir estos servicios, póngase en contacto con la Oficina de la Comisión al (213) 738-2816 (teléfono), o por correo electrónico a HIVComm@lachiv.org, por lo menos 72 horas antes de la junta.

SUPPORTING DOCUMENTATION: Supporting documents are available on the Commission's website https://hiv.lacounty.gov/meetings.

1. ADMINISTRATIVE MATTERS

- **A.** Call to Order and Roll Call — 10:00 AM—10:05 AM
- **B.** Code of Conduct and Meetings Guidelines — 10:05 AM—10:07 AM
- **C.** Approval of the Agenda — **MOTION #1** — 10:07 AM—10:09 AM
- **D.** Approval of Prior Meeting Minutes — **MOTION #2** — 10:09 AM—10:10 AM

2. PUBLIC COMMENT 10:10 AM—10:15 AM

Opportunity for members of the public to address the Commission on agenda items or other matters within the subject matter jurisdiction of the Commission. For those who wish to provide public comment may do so in person or by emailing hivcomm@lachiv.org.

3. COMMITTEE NEW BUSINESS ITEMS 10:15 AM—10:20 AM

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

4. REPORTS

- **A.** Commission on HIV (COH) Staff Report — 10:20 AM—10:25 AM
  - i. Operational and Commission Updates
- **B.** Co-Chair Report — 10:25 AM—10:45 AM
  - i. 2026 SBP Workplan and Meeting Calendar Review

  MOTION #3—Approve the Standards and Best Practices Committee 2026 Workplan as presented or revised.
- **C.** Division of HIV and STD Programs (DHSP) — 10:45 AM—10:55 AM

5. DISCUSSION 10:55 AM—11:50 AM

- **A.** Assessment of the Efficiency of the Administrative Mechanism Overview
- **B.** Universal Service Standards and Client Bill of Rights and Responsibilities Overview

6. NEXT STEPS 11:50 AM—11:55 AM

- A. Task/Assignment Recap
- B. Agenda Development for the Next Meeting

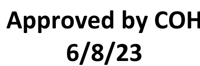
7. ANNOUNCEMENTS 11:55 AM—12:00 PM

Opportunity for members of the public and Commission members to announce community events, workshops, trainings, and other related activities. Announcements will follow the same protocols as Public Comment.

8. ADJOURNMENT **12:00PM**

PROPOSED MOTION(S)/ACTIONS(S)	
MOTION #1	Approve the agenda order, as presented or revised.
MOTION #2	Approved the prior Committee meeting minutes, as presented or revised.
MOTION #3	Approve the Standards and Best Practices Committee 2026 workplan, as presented or revised.

STANDARDS AND BEST PRACTICES COMMITTEE MEMBERSHIP		
Gerardo	Almazan	Committee-Only Member
Oscar	Arellano	Committee-Only Member
Robert	Bolan, MD	Community-Based & AIDS Service Orgs (CBO/ASO)
Mikhaela	Cielo, MD	Ryan White Part D / CYF Providers
Anthony	Corona	Committee-Only Member
Johnny	Cross	Committee-Only Member
Caitlin	Dolan	Committee-Only Member
Arlene	Frames	Committee-Only Member
Lauren	Gersh	Committee-Only Member
Joseph	Green	Committee-Only Member
LeiLani	Johnson	Committee-Only Member
Roberto	Lara	Committee-Only Member
Eric	Mattern	Substance Use Providers
Byron	Patel, RN, ACRN	Health Care Providers (FQHCs)
Emmanuel	Sanchez-Ramos, DrPH, MPH	Affected & Disproportionately Impacted Communities
Draya	Santiago	Committee-Only Member
Harold	Sarmiento	Committee-Only Member
Montana	Volby	Unaffiliated Representative - SPA 1
QUORUM: 10		



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

CODE OF CONDUCT

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

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

All participants and stakeholders should adhere to the following:

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

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

Hybrid Meeting Guidelines

(Updated 4.27.26)

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

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

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

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

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

☐ Attendees joining online should **remain muted** unless called upon.

☐ Commissioners and Committee-only members invoking **SB 707 for "Just Cause"** must communicate their intentions to staff no later than one hour before the meeting. Members requesting to join pursuant to SB 707 must have their audio and video on for the entire duration of the meeting and disclose whether there is a person over the age of 18 in the room in order to be counted toward quorum and have voting privileges.

☐ Members will be required to explicitly state their agency's **Ryan White Program Part A and CDC HIV Prevention conflicts of interest** on the record. A list of conflicts can be found in the meeting packet, courtesy of staff.

If you experience challenges in logging into the virtual meeting, please contact Commission staff at hivcomm@lachiv.org for assistance. Please note that staff may have limited availability during meetings and responses may be delayed. We appreciate your patience and will follow up as soon as we're able.

Meeting FAQ

Quick guide for joining Commission hybrid meetings

We are moving from WebEx to Zoom.
Same meeting, same community space ... just a new virtual room.

1. Join with the link

Click the Zoom link in the agenda or meeting notice. No registration is needed unless the notice says otherwise.

2. Start on mute

Please keep your mic muted until it is your turn to speak. This keeps the audio clear for everyone.

3. Public comment

When public comment opens, use Raise Hand. Staff will call on speakers and help with unmuting.

4. Chat + helpful links

Chat may be used for meeting links, reminders, or support. Please keep comments respectful and meeting-related.

5. Captions + access

Look for CC or Show Captions. For interpretation or other access needs, contact staff as early as possible.

6. Quick fixes

No sound? Click Join Audio. Video issue? Click Start Video. Connection trouble? Leave and rejoin, or call in by phone if listed.

Mute/Unmute	Start Video	Raise Hand	Chat	Captions
Bottom left	Bottom left	Reactions or More	Toolbar	CC / Show Captions

Quick reminder: Zoom is just the room. Your voice and participation are still the most important part.

Questions? Email hivcomm@lachiv.org or check the meeting notice for call-in details.

DRAFT 2026 STANDARDS AND BEST PRACTICES COMMITTEE MASTER WORKPLAN *(SUBJECT TO CHANGE)*

PURPOSE

To define the scope, priorities, and core activities of the **Standards & Best Practices (SBP) Committee** during the Ryan White Program Year (March 1, 2026 – February 28, 2027), in alignment with the revised Commission Bylaws, Ryan White HIV/AIDS Program (RWHAP) Part A legislative and program expectations, CDC/HRSA integrated planning guidance, and the Commission's restructured governance model. The SBP Committee leads the Commission's work to strengthen the quality, consistency, and effectiveness of the HIV service delivery system by supporting clinical quality management, developing and maintaining service standards, identifying best practices, assessing service effectiveness, and advancing service system improvements in coordination with DHSP and other Commission working units.

CRITERIA

Activities included in this workplan are selected based on their ability to:

- Fulfill SBP responsibilities defined in the Commission Bylaws;
- Support compliance with RWHAP Part A, HRSA expectations, CDC/HRSA integrated planning guidance, Brown Act, and County requirements;
- Strengthen quality management and performance/outcomes accountability across the HIV service continuum;
- Promote consistent, evidence-informed standards and best practices in HIV prevention and care;
- Identify service gaps and recommend feasible system improvements and directives; and
- Align with Commission and staff capacity, recognizing a bi-monthly meeting schedule.

CORE COMMITTEE RESPONSIBILITIES

The SBP Committee is responsible for:

- Supporting DHSP's Clinical Quality Management Plan and reviewing aggregate quality, utilization, and outcomes data to assess service effectiveness;
- Identifying, reviewing, and recommending service standards, best practices, and outcome measures across the HIV care continuum;
- Evaluating service effectiveness, including outcomes, cost effectiveness, capacity, access, and service models;
- Identifying service gaps, system inefficiencies, and improvement opportunities, and recommending corrective actions to DHSP and the Commission;
- Recommending service delivery improvements and implementation directives, in coordination with the Planning, Priorities & Allocations Committee;
- Conducting the Assessment of the Administrative Mechanism and overseeing implementation of adopted recommendations;
- Promoting consistency and quality in HIV services countywide through system-level review (not individual provider oversight); and
- Carrying out additional responsibilities as assigned by the Commission or Board of Supervisors.

DRAFT 2026 STANDARDS AND BEST PRACTICES COMMITTEE MASTER WORKPLAN *(SUBJECT TO CHANGE)*

ACRONYMS	
• **COH:** Commission on HIV • **DHSP:** Division on HIV and STD Programs • **BOS:** Board of Supervisors • **HRSA:** Health Resources and Services Administration • **MCE:** Membership and Community Engagement Committee • **PP&A:** Planning, Priorities, and Allocations Committee • **SBP:** Standards and Best Practices Committee	• **EO:** Executive Office • **CEO LAIR:** Chief Executive Office Legislative Affairs and Intergovernmental Relations • **OA:** California Office of AIDS • **CHIPTS:** Center for HIV Identification, Prevention, and Treatment Services.

#	OBJECTIVE	TASKS/ACTIVITIES	TIMELINE	NOTES/COMMENTS
1	Establish committee leadership.	• Hold nominations for committee co-chairs. • Elect committee co-chairs.	April	**COMPLETED**
2	Develop 2026 committee workplan.	• Review and adopt annual workplan *(subject to change).* • Establish meeting calendar *(subject to change).*	May	
3	Monitor progress on committee workplan.	• Provide monthly updates/reports to Executive Committee and COH.	Ongoing	
4	Conduct committee orientation.	• Review role, scope, and responsibilities of committee.	April	**COMPLETED**
5	Assist with development of the BOS Annual Report	• Outline SBP Committee key accomplishments and challenges • Submit accomplishments and challenges to Executive Committee for incorporation into BOS Annual Report.	Jan-Feb 2027	
6	Conduct review/revisions of service standards, as needed.	• Conduct review/revisions of service standards, as needed. • Develop schedule based on service rankings, DHSP RFP schedule, consumer/provider concern, or in response to changes in the HIV care continuum. • Review service utilization reports. • Collaborate with DHSP, COH committees and caucuses, and RWHAP Part A providers.	Ongoing	Review Universal Service Standards and Client Bill of Rights and Responsibilities.
7	Conduct the Assessment of the Efficiency of the Administrative Mechanism.	• Review assessment tool, revise as needed. • Conduct assessment for PY 35 (Mar 1, 2025-Feb 28, 2026) • Collaborate with DHSP and RWHAP Part A providers. • Analyze and report findings.	May-Jul	Review and launch assessment tool in May/June; Analyze findings and submit report to EC in June; COH review in July.

8	Review and monitor clinical quality management activities.	• Review report(s) on clinical quality management activities led by DHSP. • Review service category evaluation report(s). • Identify strategies for addressing findings. • Collaborate with DHSP; review service category evaluation report(s).	Ongoing	
9	Develop and monitor program directives.	• Develop and define directives for implementation of services and service models. • Ensure priorities and implementation efforts are consistent with needs, the HIV care continuum, and service delivery. • Develop strategies to address unmet need. • Collaborate with PP&A Committee.	Ongoing	
10	Compile best practices as related to HIV care and prevention.	• Identify, collect, and disseminate best practices for reducing HIV transmission, improving health outcomes, and optimizing quality of life and self-sufficiency for all PLWH.	Ongoing	

DRAFT 2026 STANDARDS AND BEST PRACTICES COMMITTEE MEETING CALENDAR *(SUBJECT TO CHANGE)*

MONTH	KEY ACTIVITIES
April 20, 2026 **10am-12pm**	• Nominate and elect committee co-chairs • Conduct committee orientation training • Review and adopt 2026 committee workplan
May 18, 2026 **10am-12pm**	• Review and launch Assessment of the Efficiency of the Administrative Mechanism (AEAM) assessment tool • Develop service standard development schedule
June 15, 2026 **10am-12pm**	• Discuss AEAM findings • Review service standards
August 17, 2026 **10am-12pm**	• Review program directives • Review service standards
November 2026 ****CANCELED****	Limited Executive Committee activity in recognition of the holiday period
December 2026 ****CANCELED****	Limited Executive Committee activity in recognition of the holiday period
October 19, 2026 **10am-12pm**	• Review service standards • Review clinical quality management report(s)
February 8, 2027 **10am-12pm**	• Draft 2027-28 committee workplan and meeting calendar • Draft service standard development schedule

Assessment of the Efficiency of the Administrative Mechanism (AEAM)

Ryan White Program Year 33 & 34
(March 1, 2023-February 29, 2024 and
March 1, 2024- February 28, 2025)

FINAL | Approved by the Commission on HIV on July 10, 2025

Assessment of the Administrative Mechanism Ryan White Program Year 33 & 34
(March 1, 2023-February 29, 2024 and March 1, 2024-February 28, 2025)

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I. Introduction and Purpose of Report

As a Ryan White Part A planning council, the Los Angeles County Commission on HIV ("the Commission") is required by Health Resources and Services Administration (HRSA) to conduct an "Assessment of the Efficiency of the Administrative Mechanism" (AEAM) annually. The AEAM is meant to evaluate the speed and efficiency with which Ryan White Program funding is allocated and disbursed for HIV services in Los Angeles County. The Operations Committee of the Commission led the development, implementation, and analysis of the AEAM for Ryan White Program Years 33 (March 1, 2023-February 29, 2024) and 34 (March 1, 2024-February 28, 2025). The purpose of this report is to present the findings of this assessment.

II. Assessment Methodology

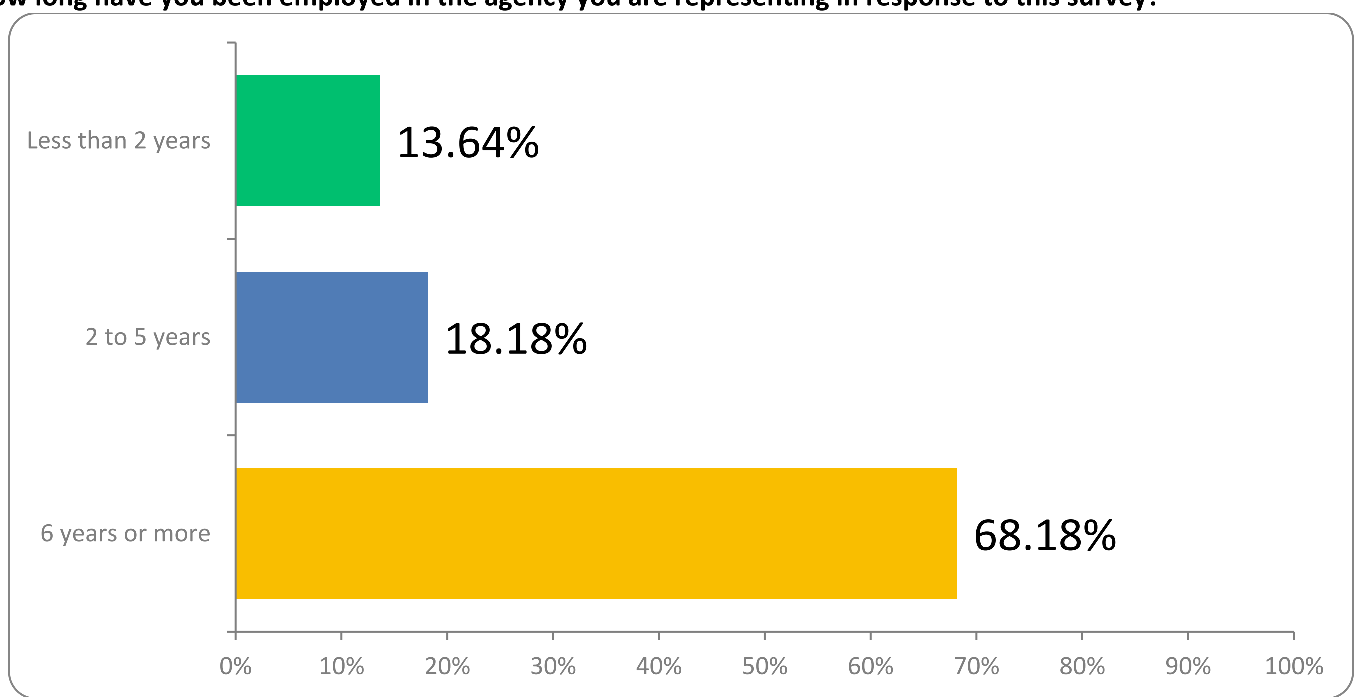
The AEAM covers 1) feedback from contracted agencies on the efficiency of Los Angeles County's administrative mechanisms (such as contracts, procurement, solicitations) to rapidly disburse funds to support HIV services in the community; and 2) survey and key informant interviews with key recipient staff to integrate their insights regarding the County's solicitations, contracting, and invoicing processes.

Online Survey for Contracted Providers:
Twenty-eight County-contracted HIV care providers were invited to participate in the AEAM survey between January 22 to February 28, 2025. Twenty agencies completed the survey. Agencies were asked to provide one response per agency. A raffle for a $100 gift card was used to incentivize provider responses.

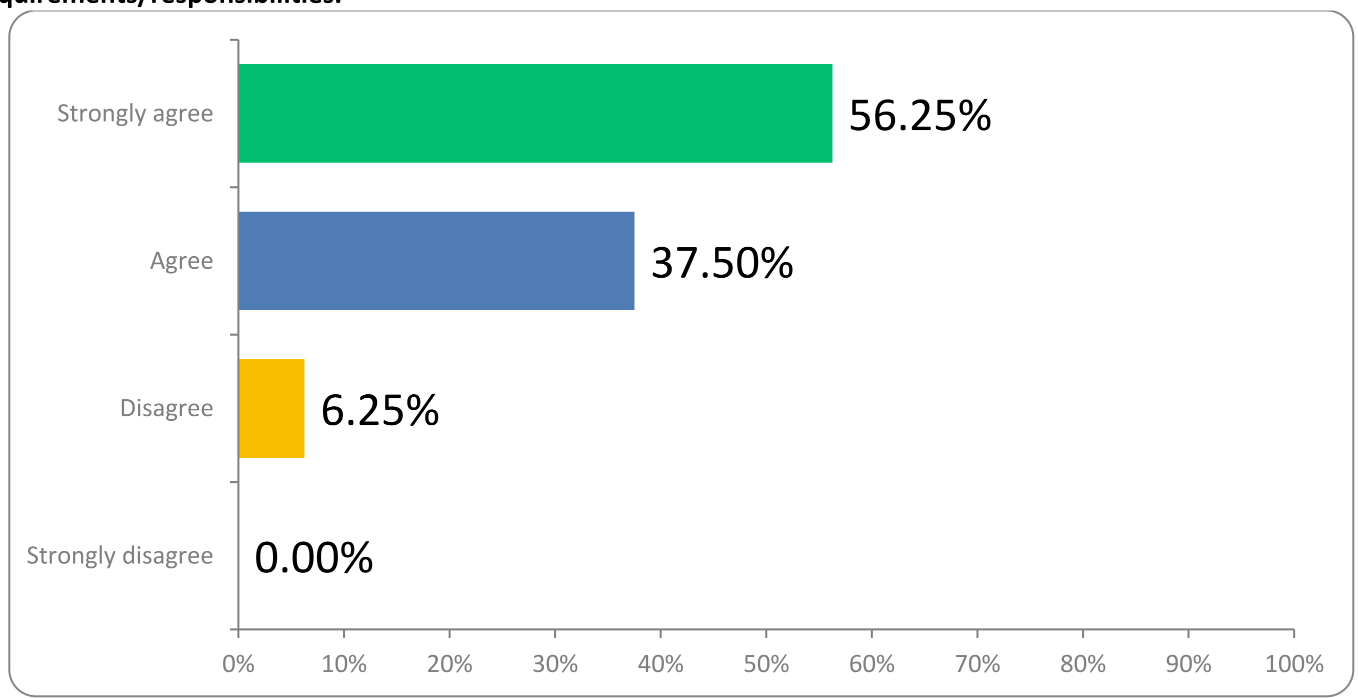
Limitations: Readers should not make broad interpretations with the results of the AEAM but rather, use the information as a record of perceptions and responses from those individuals and agencies who completed the survey.

III. Contracted Providers Responses

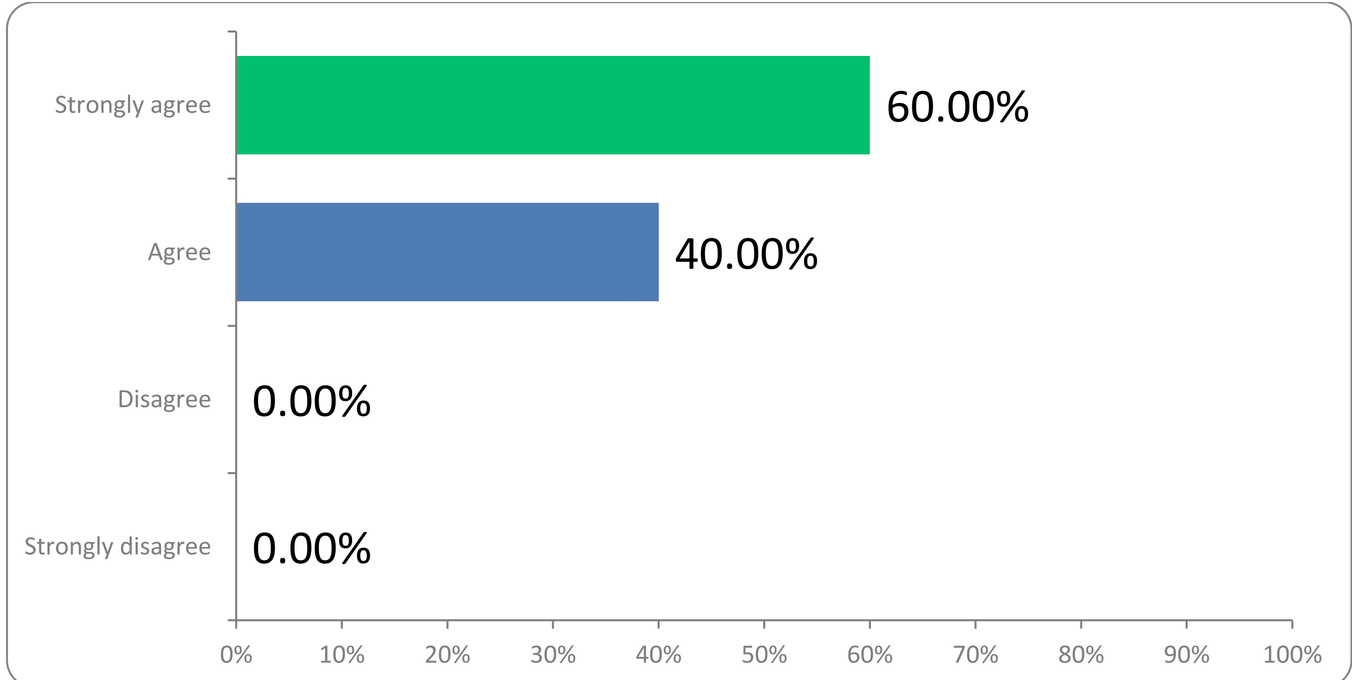
1. How long have you been employed in the agency you are representing in response to this survey?



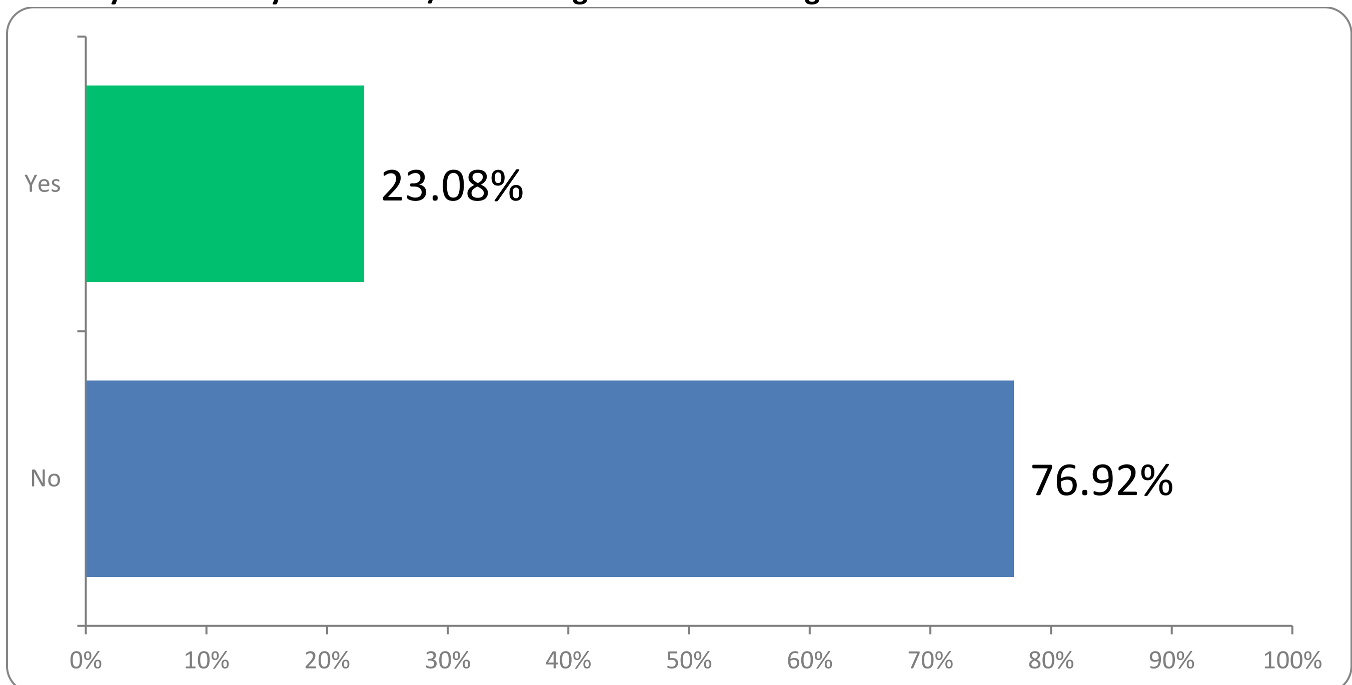
2. Please state the degree to which you agree with the following statement: The DHSP RFP provided clear instructions, outlined all policies and procedures of the procurement process, and expectations of work requirements/responsibilities.



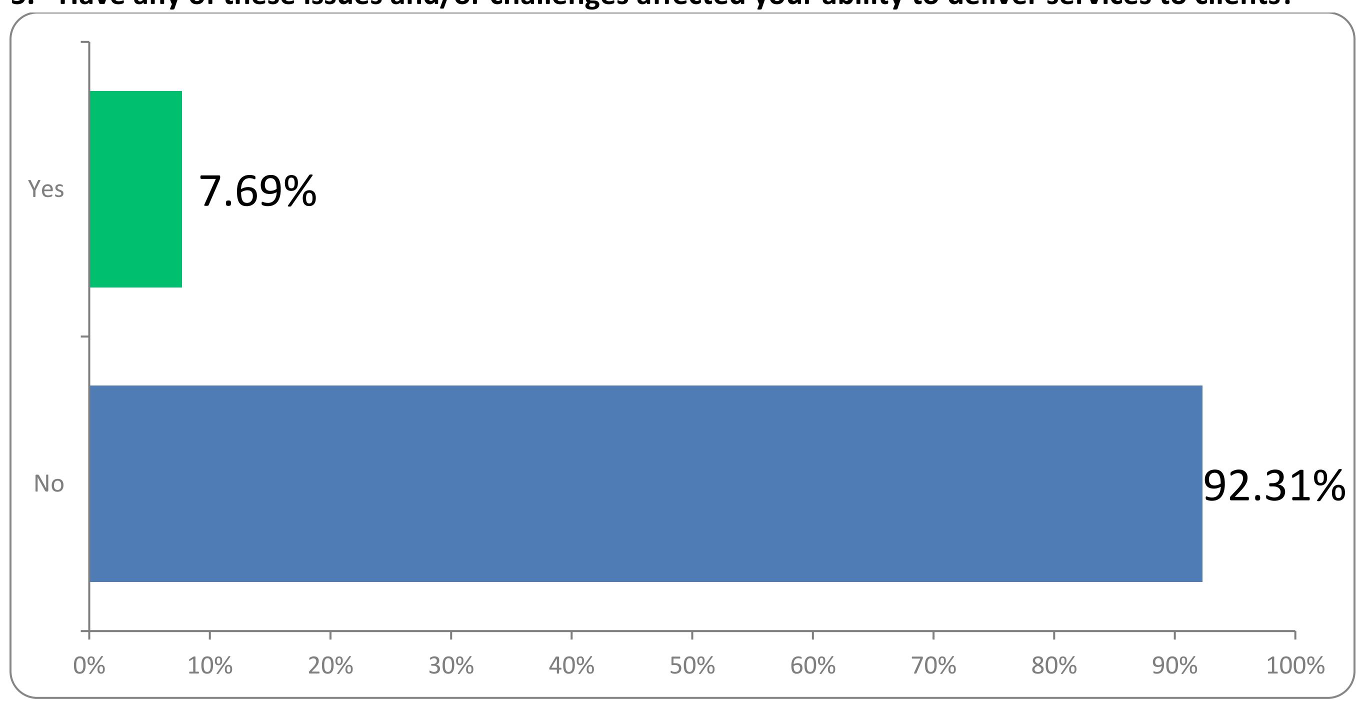
3. **Please state the degree to which you agree with the following statement: The DHSP competitive RFP procurement process is fair and all potential service providers are given a fair and equitable opportunity to apply.**



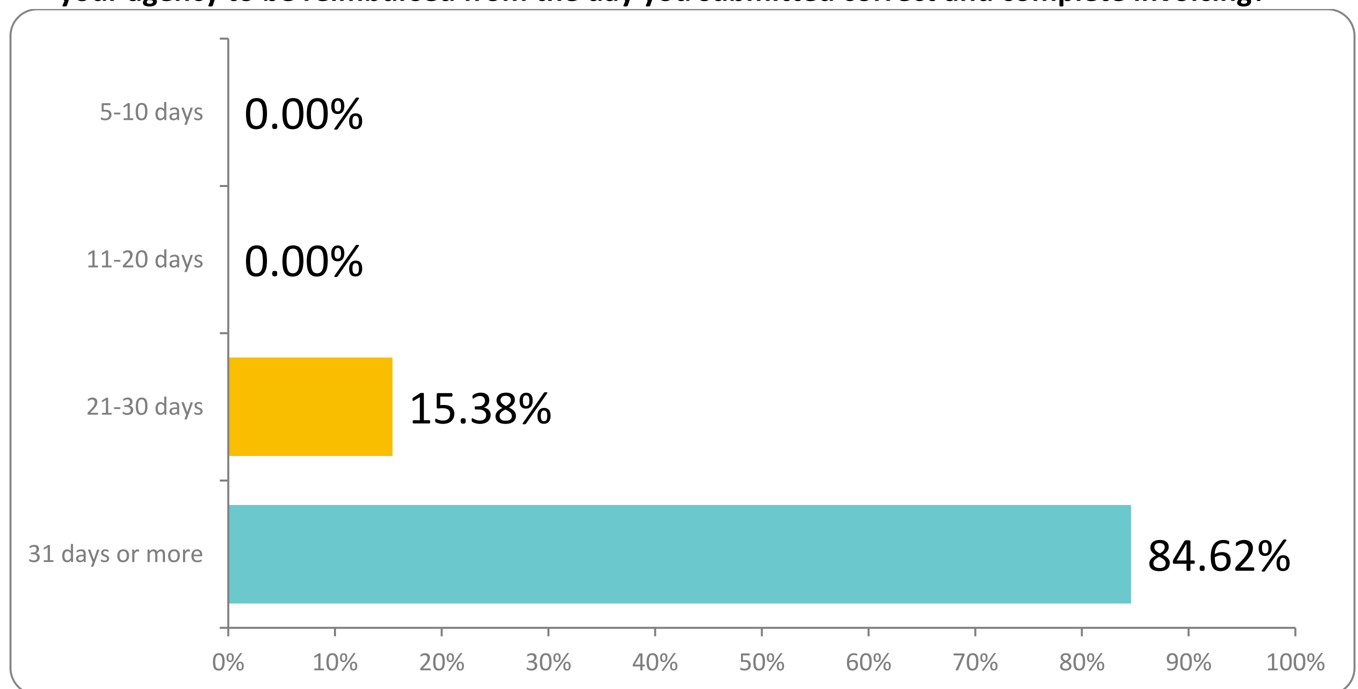
4. **Did you have any issues and/or challenges with executing the contract?**



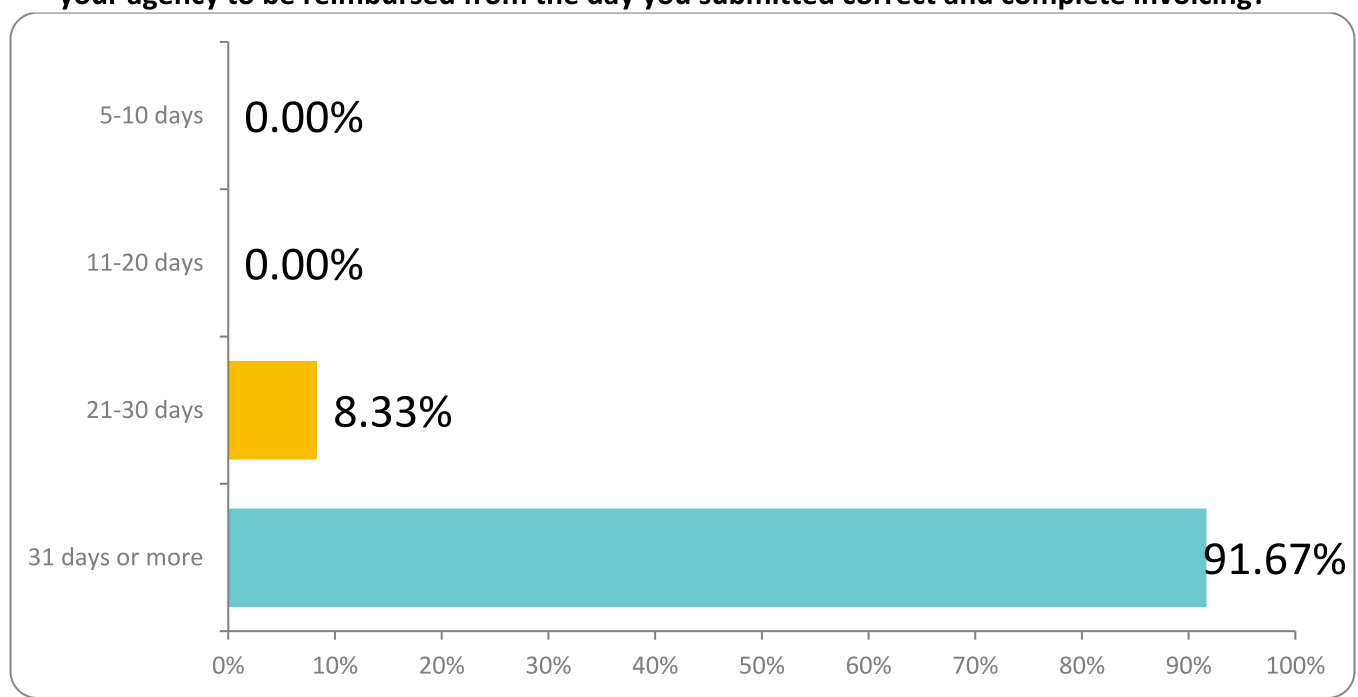
5. Have any of these issues and/or challenges affected your ability to deliver services to clients?



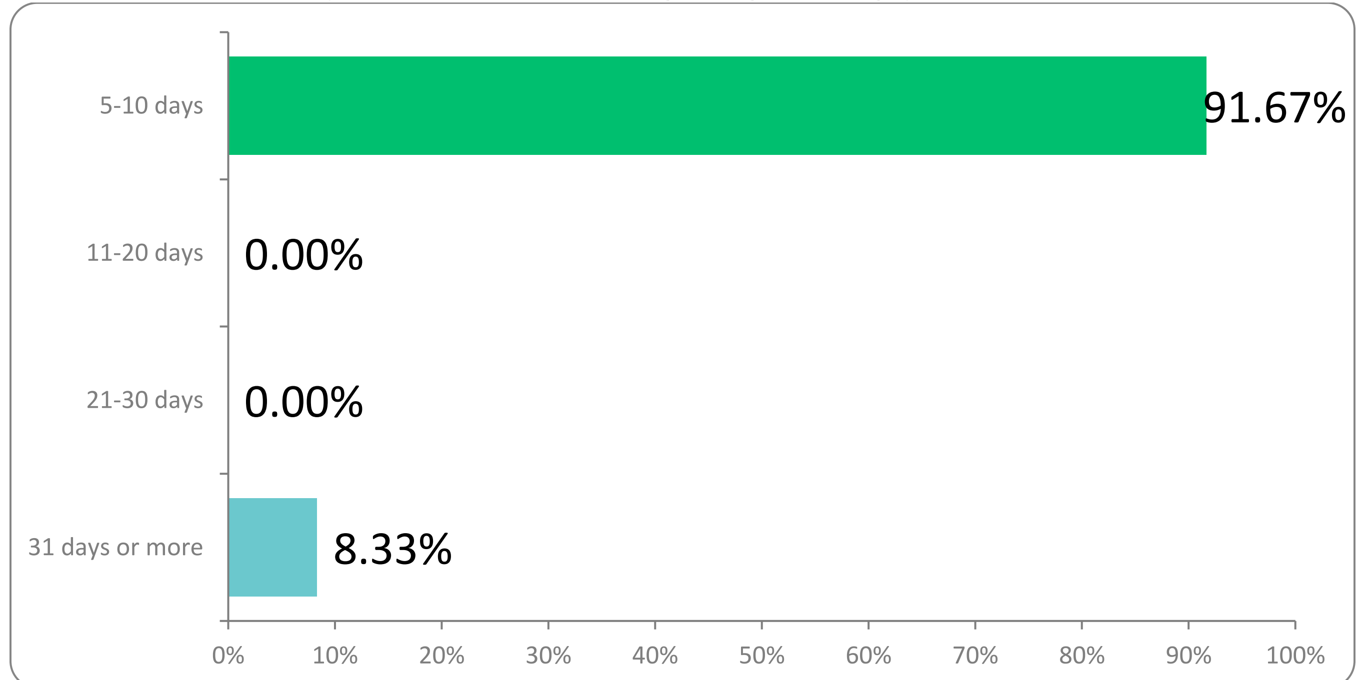
6. During PY 33 (March 1, 2023 - February 29, 2024), how many days, on average, did it take for your agency to be reimbursed from the day you submitted correct and complete invoicing?



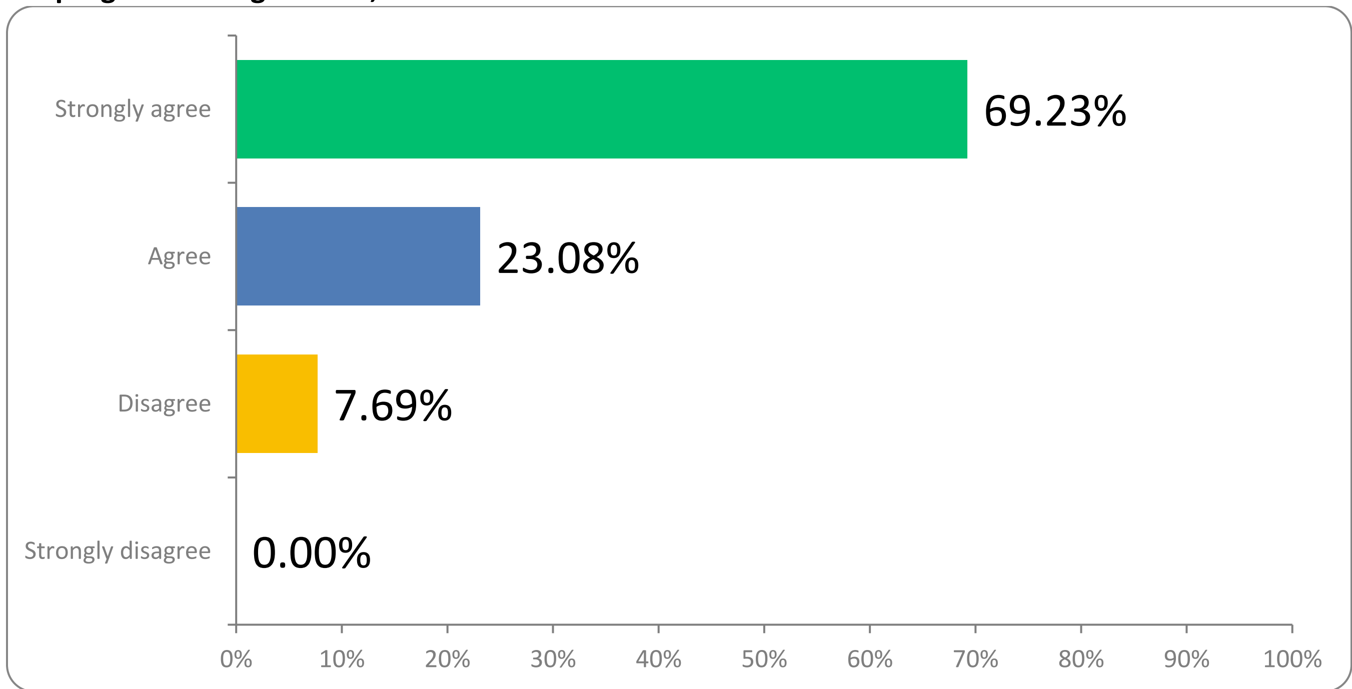
7. During PY 34 (March 1, 2024 – February 28, 2025), how many days, on average, did it take for your agency to be reimbursed from the day you submitted correct and complete invoicing?



8. Please check the response time from DHSP regarding invoicing questions.

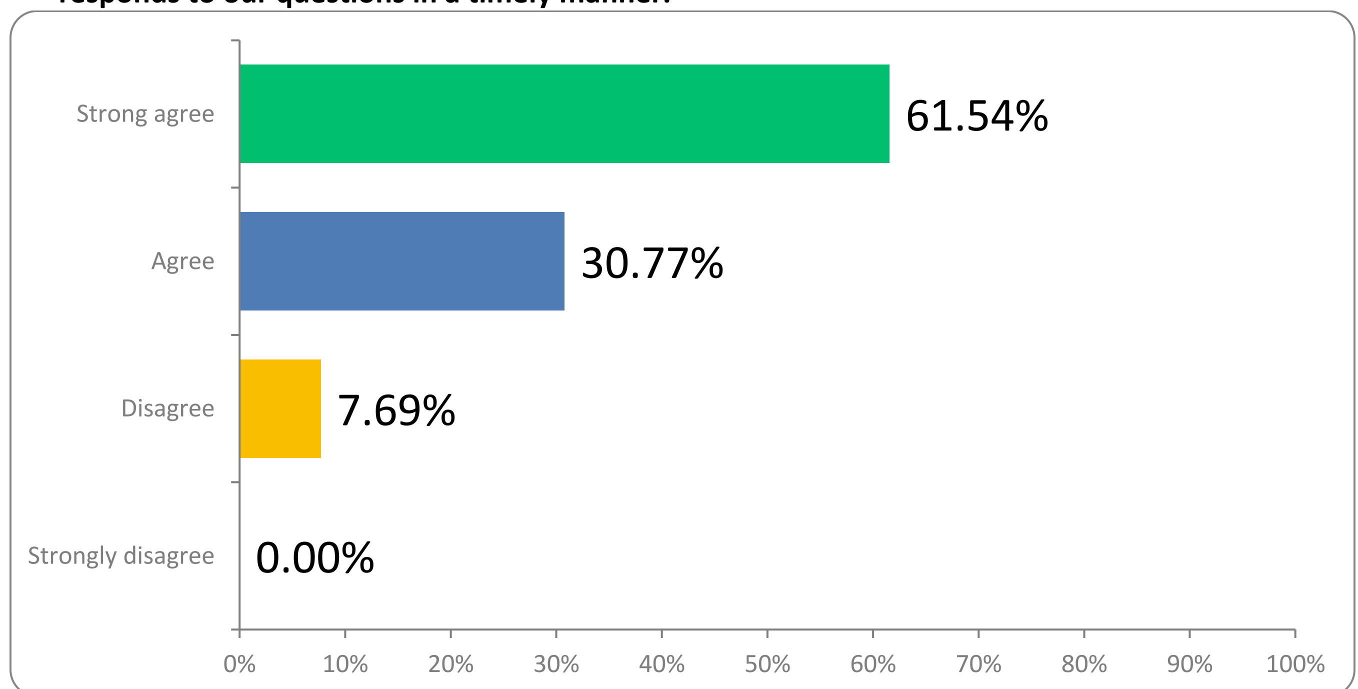


9. **Please state the degree to which you agree with the following statement: Our Contract Monitor provides clear and consistent responses to our questions and request for information, programmatic guidance, and technical assistance?**

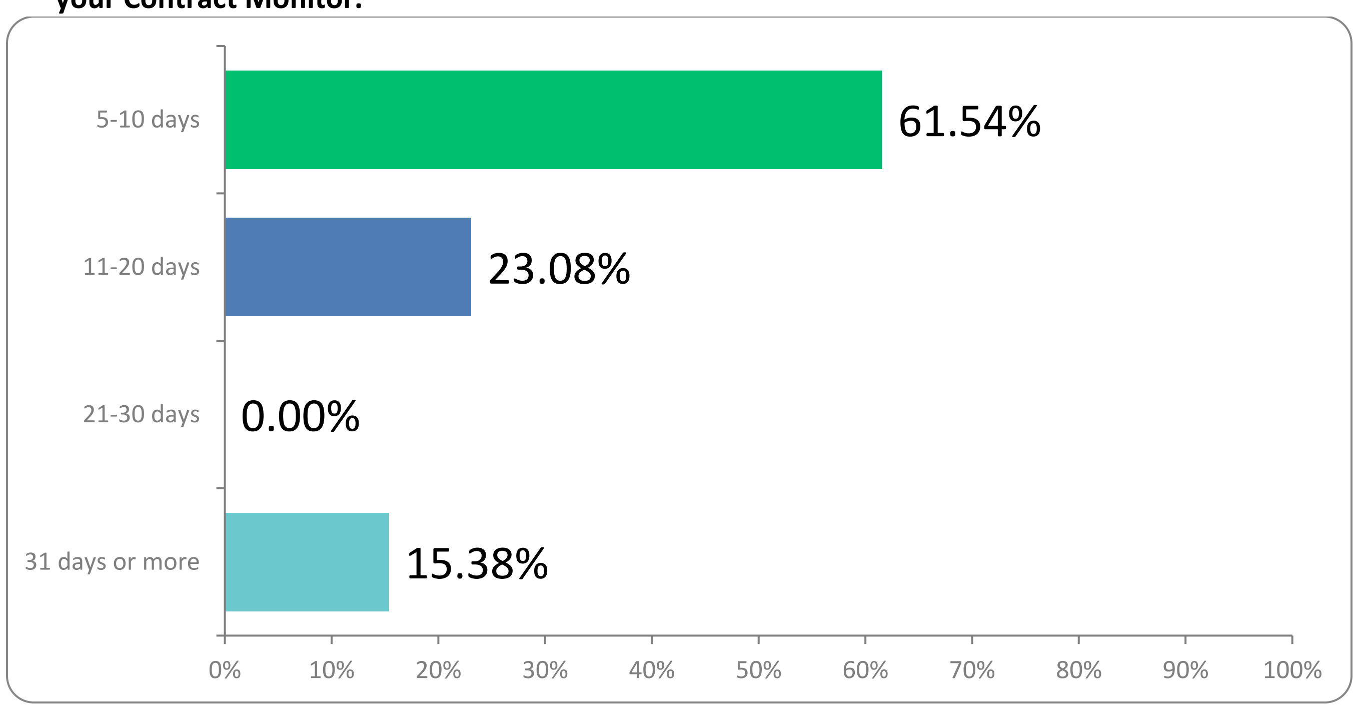


Other: Guidance is heavily dependent on the program manager.

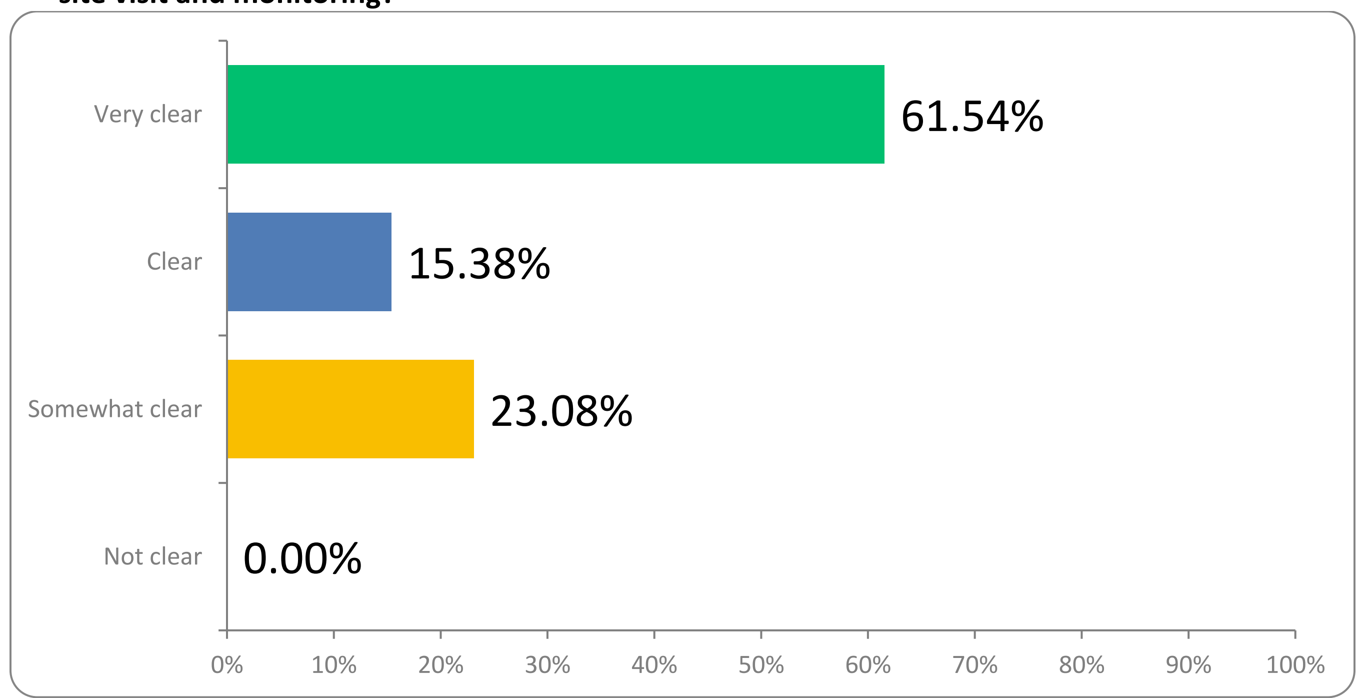
10. **Please state the degree to which you agree with the following statement: Our Contract Monitor responds to our questions in a timely manner.**



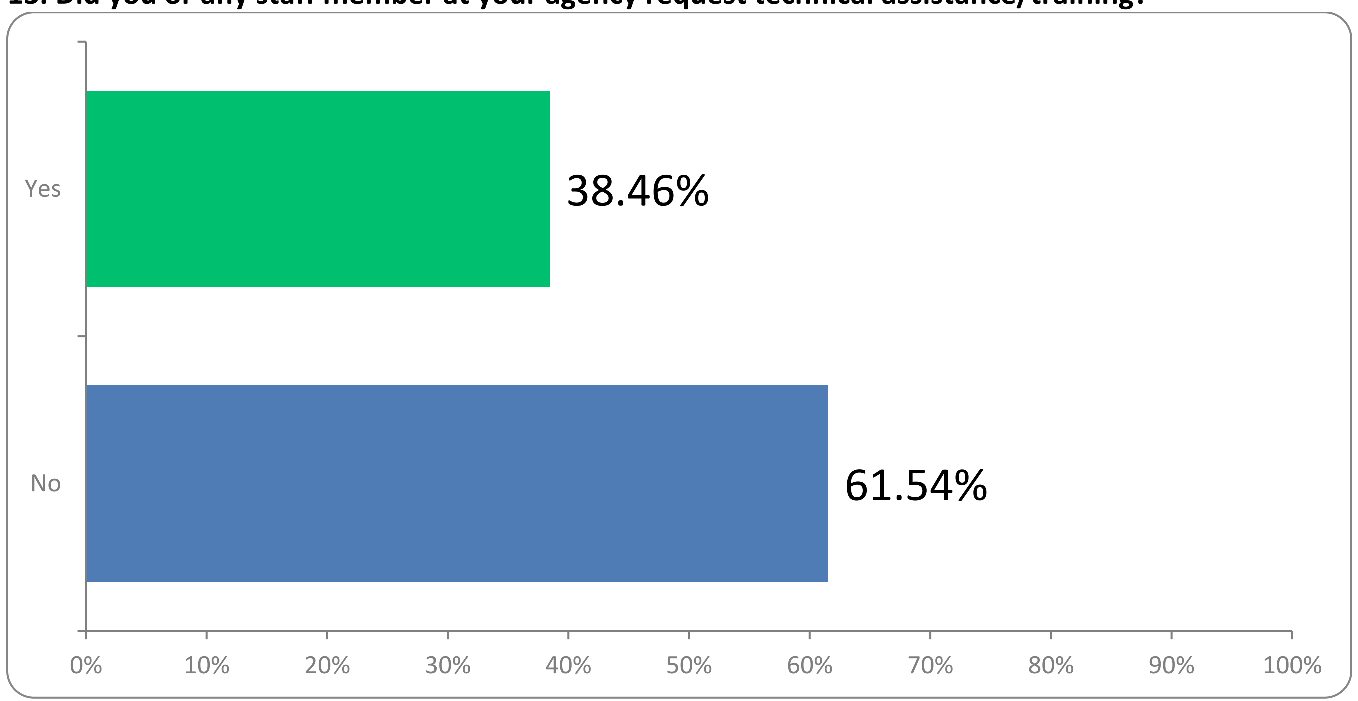
11. Please select the average response time for reprogramming/budget modifications request from your Contract Monitor.



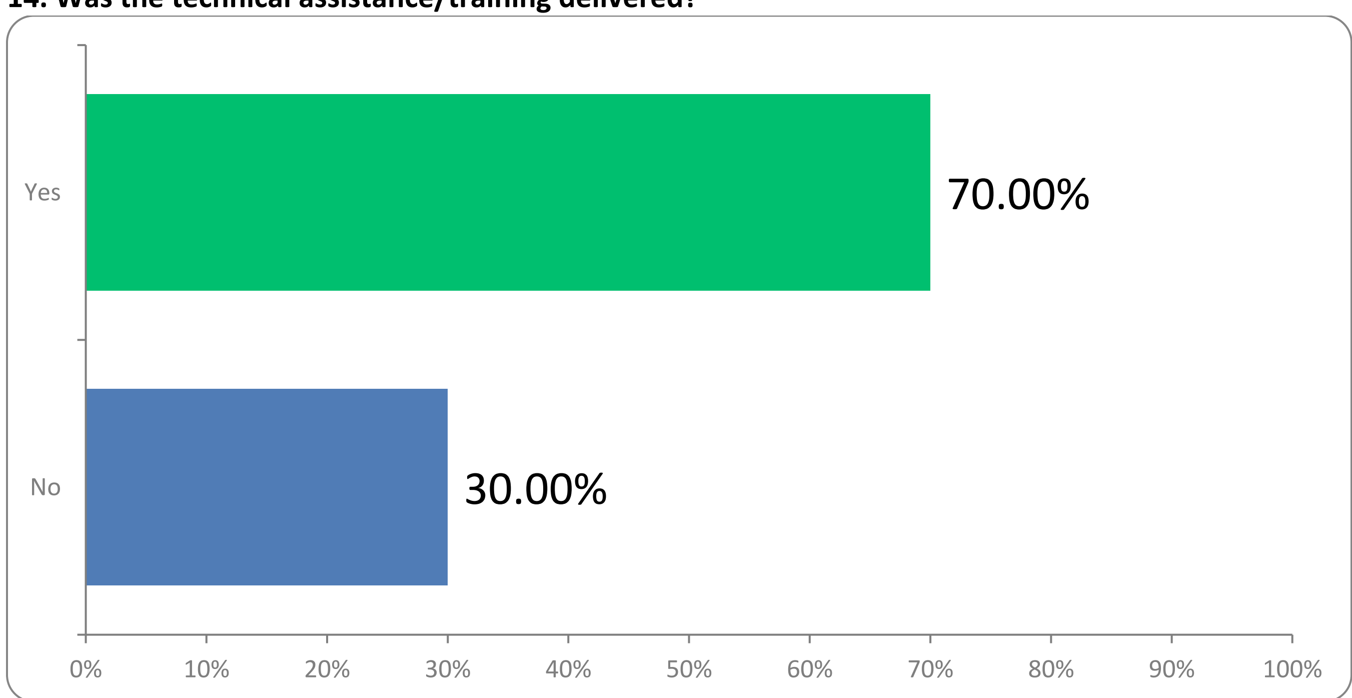
12. In terms of the process for program monitoring, are you clear on the expectations prior to the site visit and monitoring?



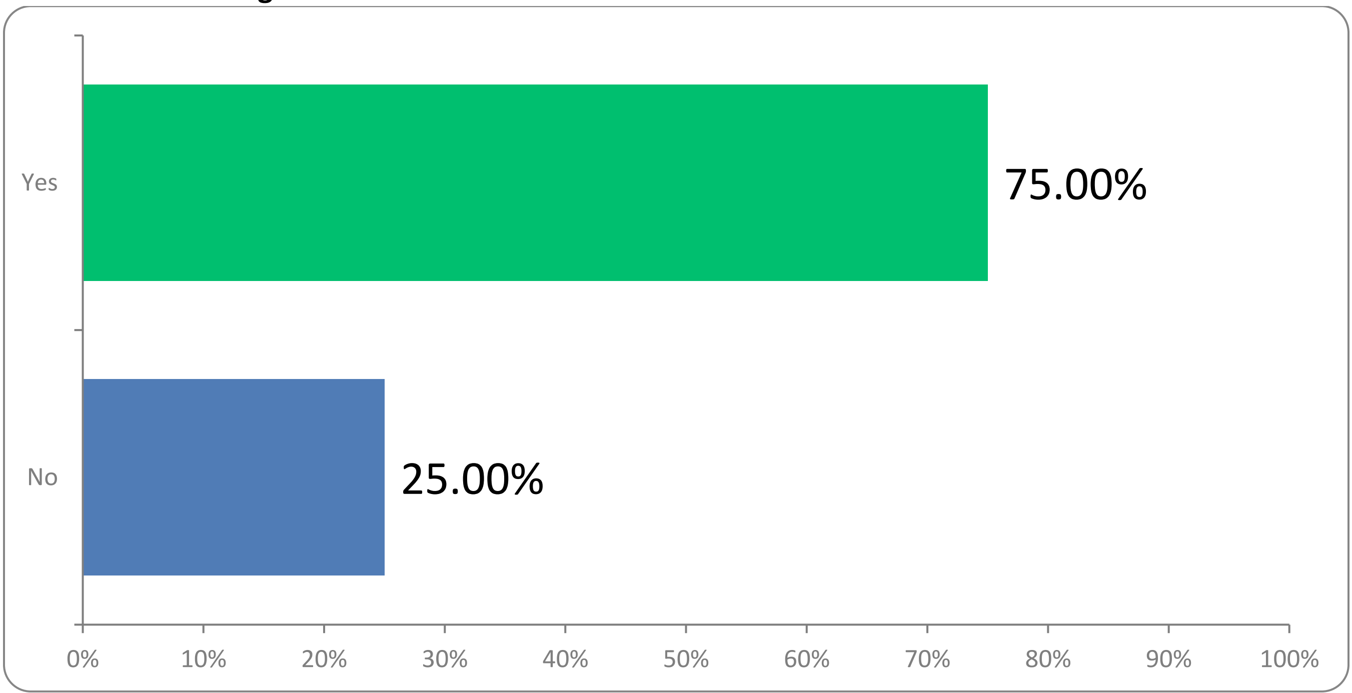
13. Did you or any staff member at your agency request technical assistance/training?



14. Was the technical assistance/training delivered?



15. Did the technical assistance/training meet your needs in helping you (or your agency) effectively address challenges?



Summary of Responses to Open-Ended Questions: *(some providers skipped the question)*

17. List the most recent Request for Proposals (RFPs) from DHSP that your agency applied for? Please specific RFP number, service category and submission date.

1. RFP NO. 2024 – 014: Comprehensive HIV and STD Prevention Services in Los Angeles County Date Submitted: 1/24/2025; Service Categories: Non-Clinic-Based Prevention Services, High Impact Prevention Programs (HIPP)
   RFP NO. 2024 – 010: Transportation Services for Eligible Ryan White Program Clients in Los Angeles County. Submitted: 10/28/2024
2. Core HIV Medical Services RFP 2024-00, Submitted 10/15/24 Comprehensive HIV and STD Prevention Services RFP 2024-014, Category 1 and Category 3, Submitted 1/27/25
3. Core HIV Medical Services for Persons Living with HIV RFP# 2024-008; applied for categories 1 (Ambulatory Outpatient Medical Services), 2 (Medical Care Coordination Services), and 3 (Patient Support Services); submitted 10/15/2024
4. Core HIV Medical Services (RFP #2024-008), Transportation Services RFA #2024-010, Comprehensive HIV AND STD Prevention Services in LA County RFP NO. 2024-014
5. Comprehensive HIV and STD Prevention Services (RFP 2024-014)
6. MCC/PSS: RFP 2024-008 due 10/15/24 HIV Testing/HIPP: RFP 2024-014 due 1/27/25
7. RFP NO. 2024-008
8. Our most recent contract is an amendment/continuation of an existing contract. The FAIN identifier is H8900016. We obtained the original contract through taking over an existing contract with a collaborative partner who was unable to provide services.

9. Core HIV Medical Services for Persons Living with HIV, RFP# 2024-008; applied for categories 1 (Ambulatory Outpatient Medical Services), 2 (Medical Care Coordination Services), and 3 (Patient Support Services); submitted 10/15/2024 Transportation Services for Eligible Ryan White Program Clients in Los Angeles County, RFA# 2024-010; submitted 10/29/2024
10. 10/15/2024 - RFP #2024-008 - Core HIV Medical Services for Persons Living with HIV 10/28/2024 - RFA #2024-010 - Transportation Services for Eligible RWP Clients in LAC
11. COMPREHENSIVE HIV AND STD PREVENTION SERVICES IN LOS ANGELES COUNTY RFP NO. 2024-014
12. None
13. 2024-008 AOM, MCC, PSS, 10/15/24 2024-014, Category 1 and 3, 1/27/25
14. Transportation Services for Eligible RW Program Clients in LA County #2024-010, 10/25/2025
15. RFP NO. 2024-008. CORE HIV MEDICAL SERVICES FOR PERSONS LIVING WITH HIV, SUBMITTED ON OCTOBER 11, 2024

18. When was your contract fully executed for PY 33 (March 1, 2023 - February 29, 2024)? *(some providers skipped the question)*

1. 03/01/2023
2. 12/28/2023
3. 04/05/2024
4. 03/01/2023
5. 03/26/2023
6. 07/19/2019
7. 07/11/2023
8. 01/16/2024
9. 05/10/2023
10. 03/08/2023
11. 04/24/2024

19. When was your contract fully executed for PY 34 (March 1, 2024 – February 28, 2025)? *(some providers skipped the question)*

1. 01/01/2024
2. 07/15/2024
3. 07/18/2024
4. 03/01/2024
5. 08/12/2024
6. 06/05/2024
7. 08/06/2024
8. 01/17/2024
9. 08/08/2024
10. 07/17/2024

20. Describe issues and/or challenges with executing the contracts, including factors within your respective agency. *(some providers skipped the question)*

1. NA
2. Different requirements needed based on the Program Manager
3. N/A
4. We are waiting for the contract. Budgets have been submitted and we are waiting on approvals.
5. The budgeting process.
6. N/A
7. There is typically a long wait time until our agency receives contracts from DHSP after budget/contract negotiations are submitted. Once a contract is received, it takes about 2-4 weeks for our agency to route for signatures, as there is a multi-layer review process internally.
8. getting the budget approved was the biggest hurdle.
9. Barriers within our agency.
10. The internal process within the city is lengthy and time consuming, as are DHSP processes.
11. NA

21. Please describe how these challenges were handled. (any issues and/or challenges with executing the contract) *(some providers skipped the question)*

1. NA
2. Different requirements needed based on the Program Manager
3. N/A
4. We are waiting for the contract. Budgets have been submitted and we are waiting on approvals.
5. The budgeting process.
6. N/A
7. There is typically a long wait time until our agency receives contracts from DHSP after budget/contract negotiations are submitted. Once a contract is received, it takes about 2-4 weeks for our agency to route for signatures, as there is a multi-layer review process internally.
8. getting the budget approved was the biggest hurdle.
9. Barriers within our agency.
10. The internal process within the city is lengthy and time consuming, as are DHSP processes.
11. NA

22. Please describe how these challenges were handled. (issues and/or challenges affected your ability to deliver services to clients?) *(some providers skipped the question)*

1. NA
2. N/A
3. We are not going to stop services because of a missing contract.
4. Hard work and communication with county program staff.
5. N/A
6. Increased communication frequency.

7. N/A

23. Please describe any factors contributing to the delay in reimbursements, including factors within your respective agency. *(some providers skipped the question)*

1. Delay in reimbursement was due to delay in contract execution.
2. We don't know why there is a delay.
3. Slow processing time
4. Our budget modification approval took more than 3 months.
5. No factors within our agency that contribute to the delay in reimbursements. Once invoices are submitted, it typically takes 30 or more days to receive reimbursements.
6. n/a
7. Agency internal issues related to delays in submission of invoicing
8. Staffing shortages and recruiting delays.
9. NONE

24. Please share any other comments you have below: *(some providers skipped the question)*

1. It is not consistent program to program. There are also discrepancies between fiscal monitoring by the county and what is allowed in the budgets.
2. For most aspects of our contract, we receive timely responses. However, the budget modification process generally takes 31 or more days, and we have to reach out repeatedly to receive a response. Regarding monitoring and site visits, we have four separate monitoring visits that could be done at once but are conducted by separate DHSP departments that do not communicate with each other. This is ultimately inefficient and more time consuming.
3. Often the monitoring report does not match the comments made during the monitoring close out.
4. DHSP program advisors are consistently responding in a timely manner.
5. DHSP DETAILED AUDIT TOOL SHOULD BE PROVIDED TO AGENCIES EVERY YEAR.
6. We developed an online portal to increase efficiency in client services. The process for DHSP to approve this portal took a significant amount of time, which interfered with our ability to serve clients in a timely manner.
7. Both HTS and Biomedical RedCap had system issues throughout 2024. HTS Prevention RedCap reporting and access for staff are still an issue. In addition, due to changes in setting up reporting functions in RedCap, our site was unable to run internal reports to enter correct data into the monthly narrative report.
8. NA

IV. Recipient Surveys Responses and Key Informant Interviews

Summary of Responses from DHSP (Recipient):

The local Recipient of Ryan White Part A funding in Los Angeles County is the Division of HIV and STD Programs (DHSP), Department of Public Health. As part of the AEAM, two senior managers in charge of managing the RFP and contracting processes from DHSP participated in the key informant interviews. In addition, the Commission developed a survey specifically for DHSP, to harness a comprehensive review and understanding of the recipient's processes regarding solicitations, contracts execution, and payments to subrecipients. The Recipient's responses are summarized below:

#	Question	Recipient Response
PART 1: REQUEST FOR PROPOSALS/SOLICITATIONS:		
1	**How many Requests for Proposals (RFPs) were released for the PY 33 Ryan White Program (March 1, 2023 to February 29, 2024)?**	2
2	**If RFPs were released in PY 33 (March 1, 2023 to February 29, 2024), select the service categories.**	Home-based Case Management Work Order Solicitation (Case management- Home Based Services via Supportive and/or Housing Services Master Agreement (SHSMA)) Childcare Services for Ryan White Program Eligible Clients in LAC (RFA)
3	**How many proposals were received for each of the service category selected in Question #2.**	Case management- Home Based – 7 proposals received. Childcare Services – 1 proposal received, but did not pass Minimum Mandatory Requirements (MMR) Review.
4	**Of the proposals received in PY 33 (March 1, 2023 to February 29, 2024), how many were new service providers?**	4 Please note that ALL 4 new service providers mentioned above in question 4 were NOT funded/awarded contracts. *These 3 providers indicated prior contracts with DHS, and regional centers, but were new to DPH/DHSP.*

5	**Of these proposals, how many service providers were awarded contracts for Ryan White program funds?**	4
6	**How many Requests for Proposals (RFPs) were released for the PY 34 (March 1, 2024 to February 28, 2025) Ryan White Program?**	4
7	**If RFPs were released in PY 34 (March 1, 2024 to February 28, 2025), select the service categories.**	Ambulatory Outpatient Medical (AOM) Medical Specialty Services Transportation Other (please specify) Patient Support Services (PSS)
8	**How many proposals were received for each of the service category selected in Question #7.**	Core HIV Medical Services comprised of AOM, MCC, and PSS. A total of 20 proposals were submitted for the Core HIV Medical Services RFP, with 18 submissions in each respective category. Ambulatory Outpatient Medical (AOM) – 18 proposals received. Medical Specialty Services (Same as Medical Care Coordination) MCC – 18 proposals received. Patient Support Services (PSS) – 18 proposals received. Transportation services – 21 applications received.

9	**Of the proposals received in PY 34 (March 1, 2024 to February 28, 2025), how many were new service providers?**	2 There were 2 new service providers to DHSP. <u>Transportation Services:</u> There were 2 new service providers who applied for Transportation services, but did not pass MMR Review.
10	**Of these proposals, how many service providers were awarded contracts for Ryan White program funds?**	39 service providers were awarded. Core HIV Medical Services – 20 (all proposals) were awarded contracts. Transportation Services – 19 out of the 21 applications received were awarded contracts.
PART II: EXECUTING CONTRACTS WITH SERVICE PROVIDERS:		
11	**How many contracts were fully executed in PY33 (March 1, 2023 to February 29, 2024)?**	A total of 64 *(renewal amendments to extend the term of the contracts with the same contract period:* *Benefits specialty services (BSS)* *Medical specialty services (MSS)* *Residential* *Medical care coordination (MCC)* *Substance use disorder transitional housing (SUDTH)* *Transitional case management (TCM)*

		Legal *Transportation*
12	**How many contracts were fully executed in PY34 (March 1, 2024 to February 28, 2025)?**	Total of 75 (renewal amendments to extend the term of contracts with same contract period (Mental health, AOM, MCC, Oral, Legal, Data mgmt., BSS, Residential SUDTH, and MSS)
13	**In general, what is the average timeframe for executing service agreements?**	46-60 days (this depends greatly upon the point determined to be the start of the process)
PART III PAYMENT: Service Provider Reporting and Invoicing Process		
14	**During PY 33 (March 1, 2023 to February 29, 2024), what was the average amount of time in days between receipt of a complete monthly report and invoice from a service provider and the issuance of a payment?**	15-30 days
15	**During PY 34 (March 1, 2024 to February 28, 2025), what has been the average amount of time in days between receipt of a complete monthly report and invoice from a service provider and the issuance of a payment?****	15-30 days It varies from agency to agency. Some agencies submit their invoices and monthly reports on time, aligning with their contract amount and approved budget. Some don’t even submit their invoices in a timely manner and require extensive follow-up by finance staff and the Program Manager. However, DHSP agencies have 30 days to bill, and DHSP finance has 30 days to process once it receives the

		invoice and monthly report. It would be safe to assume that about 15 – 30 days.

KEY INFORMANT INTERVIEW RESPONSES

OVERVIEW OF THE SOLICITATIONS/REQUEST FOR PROPOSALS PROCESS AT DPH/DHSP

Based on key informant interviews with 2 DHSP senior staff and review of Request for Proposals (RFP) documents publicly available on the DPH Contracts and Grants Division, below is a summary of the key elements and process related to the solicitations and contracting procedures at the DHSP/DPH.

SOLICITATIONS PROCESS:

- The solicitations process is designed to ensure County programs do not enter into contractual agreements without a full, unbiased review and that community-based organizations (CBOs) receiving contracts meet requirements and are fully accountable to the County and federal grant requirements.
- DHSP staff begins planning and developing RFPs at least 12 months in advance to ensure continuity of care and to avoid service interruptions. There is extensive review from County Counsel to ensure that RFPs and contract documents meet the County's legal review and requirements.
- Proposal evaluation is in phases: first, to ensure they meet mandatory minimum requirements; second, and review panel convened by Contracts and Grants (C&G), DPH; third, final funding recommendations; fourth, departmental reviews; fifth, contracts go to the Board for approval. Once approved, contract negotiations occur with the CBOs, then a Board Letter is submitted for contract approval. Once approved, the CBOs sign the contracts and then they can be executed.
- DPH C&G is charged with overseeing the contracting process and solicitations for DPH overall but, for DHSP, C&G manages solicitation while DHSP manages programmatic content, contract negotiations, and contract monitoring.
- C&G's role includes responding to questions on a solicitation and releases an addendum that may clarify or change some solicitation language and answer specific questions. C&G, in collaboration with DHSP, will host a proposer's conference.
- Proposers must meet the County's minimum mandatory requirements (MMRs) as well as appear to be able to sustain services for 90 days without County funds to demonstrate financial stability. Proposers passing those tests go on to further evaluation.
- RFP reviewers are typically subject matter experts and resource partners within the County. DHSP is responsible for identifying unbiased, non-conflicted evaluators for review panels. Identifying external reviewers outside of the County is challenging due to several factors. For instance, serving on review panels requires significant time for no pay and evaluators must sign a statement of no conflict of interest so local providers are often ineligible. In addition, external reviewers may not be fully aware of the complexity of the needs and service landscape of Los Angeles County.
- Application reviewers/evaluators receive an orientation prior to receiving the proposals. The

orientation entails a review of how to use a common evaluation tool, their roles and responsibilities, the purpose and aim of the RFP. The evaluators conduct their individual reviews followed by a group discussion of their ratings and feedback. An average score for each proposal is derived from the discussions.

- Contractors are selected and funding recommendations are developed based on evaluation scores as well as funding requirements, geographic distribution of services and targeted populations defined in the solicitation, and availability of funding. Funding amount requested typically exceed available resources. Proposers may request a debriefing after the recommendations to review their proposals. They may appeal decisions.

OVERVIEW OF THE CONTRACTS EXECUTION PROCESS AT DPH/DHSP

- Once an agency has been identified as a successful bidder, they receive a letter from C&G notifying them of their selection and that a meeting with DHSP to initiate contract negotiations would be forthcoming within 2-3 days.
- DHSP provides instructions on how and where to submit budgets and scopes of work and other documents required to complete the contract. A dedicated email address is used to facilitate the submission of required contractual documents. Contractors are given at least a month to complete and submit all required documents. DHSP strives to accommodate requests for extensions from agencies which impacts the timeline for executing the contract.
- Once all contractual documents are received, DHSP reviews the documents for completeness and alignment of budgets with the scope of work and the goals and objectives of the RFP. The review process entails 3 levels of review involving the program manager, supervisor, and the Chief of Contracted Community Services (CCS). Follow-up meetings are then scheduled with the agency to secure additional documents, as needed, and discuss budget requests to ensure accuracy and optimal use of grant funds to meet service delivery requirements and standards. Agencies are given about a week to respond to questions and submit additional information as directed by DHSP.
- Once all documents are received by DHSP, their finance team will conduct additional review. The thorough programmatic and fiscal review seeks to ensure that budgets and scopes of work contain appropriate funding, staffing and service delivery mechanisms.
- The final stage of the contracting process involves securing authorized signatures from the agency and DHSP. The length of time varies depending on the agency's approval process, as some agencies may need to secure approval from their Board of Directors and City Councils. Academic institutions tend to have a longer internal approval procedures and chain of command. On average, most contracts are signed and executed within a month. Depending on if the agency requested extensions or was delayed in submitting required documentations, the process may take up to 4 months. In the case of academic institutions, the process has taken up to 1 year in the past.

Efforts by DHP to Encourage Providers to Apply for Ryan White Part A Funds

- The DPH C&G Division disseminates announcements for RFPs on behalf of the entire Department. C&G maintains a listserv of agencies registered to receive notices on funding

opportunities for DPH. In addition, funding notices are also released via the County's Internal Services Department (ISD) which maintains a database of agencies that have registered to declare their interest in doing business with the County. RFPs are posted on the DHSP website with a corresponding link to the C&G website for the full details about the RFP. Combined, these distribution listings reach a broad array of agencies and organizations of varying sizes and service areas of focus or expertise.

Key Factors that Contribute to Delays in Executing Agreements

- As described in the contract execution process earlier, delays in the process typically involve time needed by agencies to submit accurate documents and information required by the County and DHSP and the processes internal to the agencies related to securing authorized signatures for the contracts.
- The recipient noted that some agencies are able to return a signed within the same day which helps with expediting the execution of the contract.

Contract Terminations

- DHSP key informants indicated that no contracts were terminated during PY 33 and 34. One agency, a language service provider, elected to end their contract with the County due low utilization from service providers and clients.

Monthly Report Review and Invoice Payment Process

- The monthly invoicing instructions and forms are available on the DHSP website. Monthly invoices are due no later than 30 days after the end of each month. Invoices must be accompanied by all required program (narrative) reports and data in order for DHSP to process payment. DHSP staff will reach out to contractors if required forms are missing, inaccurate, or incomplete. Once DHSP receives an accurate invoice along with the monthly narrative program report, DHSP's timeframe is to pay the agency within 30 days.

Factors that may Contribute to Delays in Payments to Service Providers

- DHSP key informants noted that the common factor that affects timely payments is failure to submit accurate invoices and narrative reports on time. Agencies are instructed to correct invoices if DHSP finds discrepancies between the approved budget and allowed expenses, which affects the 30-day turnaround time for payment. Budget modification requests pending DHSP approval may also affect the timely submission of invoices to DHSP. With regard to budget modification requests, DHSP strives to approve the request within a month, however, it may take up to 3 months depending on the review and questions from DHSP.

Technical Assistance or Training Provided to Service Providers Aimed at Improving Knowledge and Skills Related to Invoicing and Monthly Reporting Requirements

- DHSP covers these areas during the successful bidders conference. DHSP provides ongoing technical assistance to agencies on an individual basis and as a collective. Additional trainings are provided when new staff are onboarded to ensure that scopes of work, approved budget and contractual requirements are understood and followed by the agency. DHSP routinely receives and responds to questions and request for guidance on how to develop a budget,

budget modification and invoicing.
- Other types of training and technical assistance provided by DHSP include how to use CaseWatch, or other systems for data collection and HIV educational and skills building.

Improvements or Successes Related to Administrative Mechanisms:
- DHSP's effort to contract with a third-party administrator (TPA) has been a significant improvement in their ability to expedite contracts for smaller grants under the Ending the HIV Epidemic initiative. The TPA model may be used for some Ryan White categories, perhaps those with smaller contractual amounts, but not for larger service categories with more complex service and contractual requirements. TPAs would be fiscally challenged to float the cost of paying RW contractors for larger service categories. DHSP is seeking to identify another qualified TPA to enhance their administrative capacity to expedite contracts.
- The County's emergency declaration to address homelessness has been useful for utilizing the sole source contracting mechanism to expedite service agreements specifically tied to the homelessness crisis.
- DHSP developed a more streamlined internal process to review contracts and invoices, decreasing the amount and frequency of back-and-forth communication between DHSP and agencies. Additionally, DHSP has established a more efficient internal communication and coordination process with the finance unit to understand programmatic requirements and minimize separate and often repetitive layers of review between finance and programmatic staff.
- The DPH C&G unit provides enhanced infrastructure and capacity support for DHSP to release and manage several RFPs in a single year.

V. Key Themes

PROVIDER PERSPECTIVES

The County's Request for Proposals (RFP) Process is Clear
Providers indicated high marks regarding DHSP's RFP process, ranging from over 93% to 100% of providers agreeing or strongly agreeing with the clarity, fairness, and competitiveness of the RFP process.

Contract Execution Timeframe is Influenced by Agency Procedures
Almost 77% of responses indicated that they did not have issues and or challenges with executing contracts. Some agencies noted that delays were due to their agency's internal approval processes adding to the overall timeframe for contract execution. Furthermore, agencies noted that the budgeting process and rounds of reviews and approvals also contribute to the delay in executing

contracts.

Average Timeframe for Payment is 31+ Days
During PY 33, respondents almost 85% indicated that on average, it took 31 or more days for their agency to be reimbursed from the day they submitted a correct and complete invoice. For PY 34, the response was almost 92%. Delays in reimbursements could be impacted by staffing shortages and submission of incorrect or incomplete invoices which must be submitted with a program narrative report.

Prompt Responses to Invoicing Questions
With regard to response time from DHSP on invoicing questions, almost 92% of respondents indicated receiving a response with 5 to 10 days. Additionally, 23% and 69% percent "agreed" or "strongly agreed" that their contract monitor provides clear and consistent responses to questions and request for information, programmatic guidance, and technical assistance.

Mixed Reactions around Communication of Expectations Prior to Site Visits and Program Monitoring
While some of the responses noted that program managers conveyed expectations clearly prior to site visits, there were also comments that alluded to the need for clearer communication of expectations for program monitoring prior to the site visit and better explanation for changes in expectations from year to year. In terms of the process for program monitoring, responses were varied: 23% somewhat clear, 15% clear, and 61% very clear.

Contractors Receive Regular Feedback on Performance and Technical Assistance (TA) on Barriers and Challenges
In general, the majority of the comments, appear to show that DHSP regularly provides feedback on contractor performance and that the feedback is helpful in improving program policies, procedures, and assisting the agencies meet their contractual goals. 75% of the respondents indicated that the TA and training they received met their needs and helped their agencies address challenges.

RECIPIENT PERSPECTIVES

The Recipient conduct broad provider outreach and information dissemination efforts to promote RFPs.

- DHSP and DPH uses a broad distribution list to disseminate RFPs and funding announcements, reaching a wide variety of agencies of diverse size, organizational capacity, and service area expertise.

The Recipient continues to enact procedures aimed at improving their review and approval process.

- DHSP continues to make positive improvements in managing solicitations, executing contracts, and processing payments to agencies through improved internal processes, communications with agencies, and ongoing general and customized training for agency staff.

The Recipient leverages the County's administrative infrastructure.

- DHSP has a well-established process, infrastructure and partnership with DPH C&G and County Counsel that help to facilitate the solicitations process.

The Recipient engages providers by seeking their input in shaping RFPs.

- DHSP seeks provider input regarding service needs and ideas for improving programs to help develop RFPs.

VI. Recommendations:

This AEAM highlighted key suggestions for improvement based on provider and recipient survey responses and interviews:

- Continue to improve payment turnaround cycles within 30 days.
- Expedite or shorten the length of time it takes to execute a contract or approve a budget modification.
- Ensure uniformity in the information communicated by program and fiscal managers to contracted agencies, particularly for site visits and audits.
- Strengthen TA and training for programmatic and fiscal staff within DHSP and for contracted providers to ensure consistency of information, particularly for agencies that face staffing challenges (i.e., recruitment, retention, turnover).

The general comments collected from this AEAM reflect the recurring themes from previous assessments such as consistency of information received from DHSP, setting clear expectations for audits/site visits; and invoice payment turnaround time.

DHSP continues to explore additional mechanisms to more quickly fund HIV services in Los Angeles County. For example, DHSP's experience with using a third-party administrator, Heluna Health, to issue HIV prevention RFPs, serves as a model for expediting some of the Ryan White service contracts. Despite the bureaucratic challenges associated with a large municipal government the size of Los Angeles County, DHSP continues to improve various administrative mechanisms to ensure that life-saving services reach people living with HIV in a timely and efficient manner.

Los Angeles County Commission on HIV (COH)
Assessment of the Efficiency of the Administrative Mechanism Annual
COH Member Survey
Final Revised 01.13.25

Purpose: The Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87) mandates the Los Angeles County Commission on HIV (COH) to conduct an annual Assessment of the Efficiency of the Administrative Mechanism (AEAM). This assessment is a review of how quickly and well the Ryan White HIV/AIDS Program Part A recipient, the Division of HIV and STD Programs (DHSP), Los Angeles County Department of Public Health, carries out the process to contract with and pay providers in a timely manner for delivering HIV-related services to meet the needs of people living with HIV (PLWH) throughout our Eligible Metropolitan Area (EMA).

The Los Angeles County Commission on HIV, as the federally mandated local planning council, is responsible for conducting the AEAM. The completion of the annual AEAM is a federal requirement under the Ryan White HIV/AIDS Program and your cooperation is greatly appreciated.

Please be open and honest in your responses. Your responses are confidential and will be kept private. All responses will be summarized and individual responses will not be reported to DHSP or the Commission.

Instructions: Please complete all sections and provide responses based on Ryan White Program Year 33 (PY33) and PY 34. PY 33 begins March 1, 2023 and ends February 29, 2024. PY 34 begins March 1, 2024 and ends February 28, 2025. The survey will take 15-20 minutes to complete. If you have any questions, please contact Cheryl Barrit, Executive Director, Los Angeles County Commission on HIV, at 213-618-6164 or cbarrit@lachiv.org.

Please complete your survey by February 14, 2025. Completed surveys will be entered into a raffle to receive a $100 Visa Gift Card. Thank you!

The contact information requested below is for gift card raffle purposes only. It will allow Commission staff to contact you in case you win the raffle.

Q1. First and Last Name

Q2. Email and phone number

Commissioners only:

1. How long have you served as a Commissioner and/or Alternate on the Los Angeles County Commission on HIV?
   - Less than 1 year
   - 1-3 years
   - 4-6 years
   - 7 years or more

2. Which committee were you a member of during the Ryan White Program Year 33 priority setting and resource allocation process? Program Year 33 is defined as March 1, 2023 – February 29, 2024.
   - Operations
   - Planning, Priorities and Allocations
   - Public Policy
   - Standards and Best Practices
   - N/A-I was not a member
   - Comments

3. Which committee were you a member of during the Ryan White Program Year 34 (March 1, 2024 – February 28, 2025) priority setting and resource allocation process? Program year 34 is defined as March 1, 2024 - February 28, 2025.
   - Operations
   - Planning, Priorities and Allocations
   - Public Policy
   - Standards and Best Practices
   - N/A-I was not a member
   - Comments

4. During the Ryan White Program 33 and 34 planning cycle, do you recall any of the following DHSP reports being provided as a part of the priority setting and resource allocation process?
   - Ryan White Program expenditure reports
   - Service utilization data
   - Needs assessment data
   - Program and Expenditures updates
   - Prevention data (such as HIV/STD Testing Services; National HIV Behavioral Surveillance Project; LAC Apps-Based Survey; Contacted Biomedical Services; Contracted HIV Education and Risk Reduction (HERR) Services); Contracted Vulnerable Populations Services)
   - HIV and STD Surveillance data
   - Comments

5. Please state the degree to which you agree with the following statement: *There is opportunity for consumer participation and input in the planning, priority setting and resource allocation process.*
   - Strongly agree
   - Agree
   - Disagree
   - Strongly disagree
   - Comments

6. Please state the degree to which you agree with the following statement: *During the PY 33 and PY 34 planning cycles, I was notified of planning, priority setting and resource allocation activities and meetings.*

- Strongly agree
- Agree
- Disagree
- Strongly disagree
- Comments

7. Please state the degree to which you agree with the following statement: *In terms of structure and process, the Commission on HIV is effective as a planning body.*

- Strongly agree
- Agree
- Disagree
- Strongly disagree

8. Please state the degree to which you understand the following:

- Structure of the Commission on HIV (Completely understand; Somewhat understand; Mostly don't understand; Don't understand at all; N/A; Comments)
- Role of the Commission on HIV (Completely understand; Somewhat understand; Mostly don't understand; Don't understand at all; N/A; Comments)
- Process(es) of the Commission on HIV (Completely understand; Somewhat understand; Mostly don't understand; Don't understand at all; N/A; Comments)

9. Please state the degree to which you agree with the following statements: *The Commission on HIV has prepared me to make decisions related to:*

- Service standards (Strongly agree; Agree; Neither Agree nor Disagree; Disagree; Strongly Disagree; N/A; Comments
- Allocation/Reallocation Process (Strongly agree; Agree; Neither Agree nor Disagree; Disagree; Strongly Disagree; N/A; Comments
- Service Category Prioritization (Strongly agree; Agree; Neither Agree nor Disagree; Disagree; Strongly Disagree; N/A; Comments

10. Please indicate the degree to which you believe the priorities and allocations established by the Commission on HIV in the Ryan White Program Years 33 and 34 were followed by DHSP.

- A great deal
- A lot
- A moderate amount
- A little
- Not at all
- Comments

Assessment of the Efficiency of the Administrative Mechanism (AEAM)
Ryan White Program Year (PY) 33 and 34
Provider Survey
Final Revised 01.13.25

Please complete the survey below.

Purpose: The Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87) mandates the Los Angeles County Commission on HIV (COH) to conduct an annual Assessment of the Efficiency of the Administrative Mechanism (AEAM). This assessment is a review of how quickly and well the Ryan White HIV/AIDS Program Part A recipient, the Division of HIV and STD Programs (DHSP), Los Angeles County, Department of Public Health, carries out the process to contract with and pay providers in a timely manner for delivering HIV-related services to meet the needs of people living with HIV (PLWH) throughout our Eligible Metropolitan Area (EMA).

The Los Angeles County Commission on HIV, as the federally mandated local planning council, is responsible for conducting the AEAM. The completion of the annual AEAM is a federal requirement under the Ryan White HIV/AIDS Program and your cooperation is greatly appreciated.

Your responses will be kept private and confidential. All responses will be summarized in aggregate; no individual responses will be reported to DHSP or the Commission. Therefore, please be open and honest in your responses.

Instructions: Please complete all sections and provide responses based on Program Year 33 (PY33) (March 1, 2023 - February 28, 2024) and PY 34 (March 1, 2024 – February 29, 2025). It should take 15-20 minutes to complete. If you have any questions, please contact Cheryl Barrit, Executive Director, Commission on HIV, at 213-618-6164 or cbarrit@lachiv.org.

Kindly complete the survey by February 14, 2025. Completed surveys will be entered in a raffle to receive a $100 Visa Gift Card. One response per agency only. Thank you!

The contact information requested below is for gift card raffle purposes only. It will allow Commission staff to contact you in case you win the raffle.

Q1. First and Last Name

Q2. Name of Provider Agency

Q3. Title/Position

Q4. Email and phone number

Q5. How long have you been employed in the agency you are representing in response to this survey?
- Less than 2 years
- 2 to 5 years
- 6 years or more

Request for Proposals (RFP) Process and Selection of Service Providers

Q1. List the most recent Request for Proposals (RFPs) from DHSP that your agency applied for? Please specific RFP number, service category and submission date.

Q2. Please state the degree to which you agree with the following statement: *The DHSP RFP provided clear instructions, outlined all policies and procedures of the procurement process, and expectations of work requirements/responsibilities.*
- Strongly agree
- Agree
- Disagree
- Strongly disagree

Q3. Please state the degree to which you agree with the following statement: The DHSP competitive RFP procurement process is fair and all potential service providers are given a fair and equitable opportunity to apply.
- Strongly agree
- Agree
- Disagree
- Strongly disagree

Service Agreement(s) Process

Q1. When was your contract fully executed for PY 33? (March 1, 2023 - February 29, 2024)

Q2. When was your contract fully executed for PY 34 (March 1, 2024 – February 28, 2025)

Q3. For your most recent contract with DHSP, how long did it take to complete the contract negotiation?

Q3. Did you have any issues and/or challenges with executing the contract? ___YES ___NO

Q4. Describe issues and/or challenges with executing the contracts, including factors within your respective agencies.

Q5. Have any of these issues and/or challenges affected your ability to deliver services to clients?
___YES ___NO
Q6. Please describe how these challenges were handled.

Service Provider Invoicing and Payment

Q1. During PY 33 (March 1, 2023 - February 28, 2024), how many days, on average, did it take for your agency to be reimbursed from the day you submitted correct and complete invoicing?

a. 5-10 days
b. 11-20 days
c. 21-30 days
d. 31 days or more

Q2. During PY 34 (March 1, 2024 – February 29, 2025), how many days, on average, did it take for your agency to be reimbursed from the day you submitted correct and complete invoicing?

a. 5-10 days
b. 11-20 days
c. 21-30 days
d. 31 days or more

Q3. Please describe any factors contributing to the delay in reimbursements, including factors within your own respective agencies. Include steps taken to address delays in reimbursements.

Communications with DHSP

Q1. Please check the average response time from DHSP regarding invoicing questions.

1. 5-10 days
2. 11-20 days
3. 21-30 days
4. 31 days or more

Q2. Please state the degree to which you agree with the following statement. *Our Contract Monitor provides clear and consistent responses to our questions and request for information, programmatic guidance, and technical assistance?*

a. Strongly agree
b. Agree
c. Disagree
d. Strongly disagree

Q3. Please state the degree to which you agree with the following statement. *Our Contract Monitor responds to our questions in a timely manner?*

a. Strongly agree
b. Agree

c. Disagree
d. Strongly disagree

Q4. Please select the average response time for reprogramming/budget modifications request from your Contract Monitor.

1. 5-10 days
2. 11-20 days
3. 21-30 days
4. 31 days or more

Q5. In terms of the process for program monitoring, are you clear on the expectations prior to the site visit and monitoring?

1. Very clear
2. Clear
3. Somewhat clear
4. Not clear

Q6. Did you or any staff member at your agency request technical assistance/training?

a. Yes
b. No
c. Unsure – or comment box

Q7. Was the technical assistance/training delivered?

a. Yes
b. No
c. Unsure – or comment box

Q8. Did the technical assistance/training meet your needs in helping you (or your agency) effectively address challenges?

a. Yes
b. No
c. Unsure – or comment box

Q9. Additional Comments:

Assessment of the Efficiency of the Administrative Mechanism (AEAM)
Recipient Survey (Division of HIV and STD Programs)
Ryan White Program Year (PY) 33 and PY 34
PY 33 = March 1, 2023 to February 29, 2024
PY 34 = March 1, 2024 to February 28, 2025
Final Revised 2.7.25

Background and Purpose:

The Ryan White HIV/AIDS Treatment Extension Act requires each Ryan White HIV/AIDS Program (RWHAP) Part A program's planning council or body (PC/B) to "assess the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need within the eligible area and at the discretion of the planning council, assess the effectiveness, either directly or through contractual arrangements, of the services offered in meeting the identified needs."[Section 2602(b)(4)(E)]. This AEAM survey is aimed at securing information from the recipient regarding solicitations, contracts execution, and payments to subrecipients.

REQUEST FOR PROPOSALS/SOLICITATIONS:

1. How many Requests for Proposals (RFPs) were released for the PY 33 Ryan White Program? {0-10}
2. If RFPs were released in PY 33, list the service categories and the number of proposals received per service category. {List service categories from DHSP Fact sheets online}
3. Of the proposals received in PY 33, how many were new service providers? {1-10}
4. Of these proposals, how many service providers were awarded contracts for Ryan White program funds? {0-10; OTHER}
5. How many Requests for Proposals (RFPs) were released for the PY 34 Ryan White Program? {0-10}
6. If RFPs were released in PY 34, list the service categories and the number of proposals received per service category. {List service categories from DHSP Fact sheets online}
7. Of the proposals received in PY 34, how many were new service providers? {0-10; OTHER}
8. Of these proposals, how many service providers were awarded contracts for Ryan White program funds? {0-10; OTHER}

EXECUTING CONTRACTS WITH SERVICE PROVIDERS:

1. How many contracts were fully executed in PY33? {0-10; OTHER}
2. How many contracts were fully executed in PY34? {0-10; OTHER}
3. In general what is the average timeframe for executing service agreements? {14 days; 15-30 days; 31-45 days; 46-60 days; 61+ days; Other}

PAYMENT: Service Provider Reporting and Invoicing Process

1. During PY 33, what was the average amount of time in days between receipt of a complete monthly report and invoice from a service provider and the issuance of a payment? {14 days; 15-30 days; 31-45 days; 46-60 days; 61+ days; Other}
2. During PY 34, what has been the average amount of time in days between receipt of a complete monthly report and invoice from a service provider and the issuance of a payment? {14 days; 15-30 days; 31-45 days; 46-60 days; 61+ days; Other}

Interview:
RFPs/ Solicitations

1. Please describe the process used to review proposals for PY 33 and PY 34.OK
2. During PY 33 and PY 34, what work was undertaken by the Recipient to encourage new providers to apply for Ryan White Part A funds; such as outreach to potential new service providers.

Contract Execution:

1. Describe key factors that contribute to delays in executing agreements with service providers?
2. Were there any contracts that were terminated and what was the reason for contract termination? {Yes/No}
3. How were services handled for terminated contracts?

Payment

1. Please describe the monthly report review and invoice payment process.

3. List/describe any factors contributing to the delay in payments to service providers.
4. List any technical assistance or training provided to service providers aimed at improving

knowledge and skills related to invoicing and monthly reporting requirements.

Successes and Improvements

1. List/describe improvements made and/or successes regarding:
   A. RFPs
   B. Contracting
   C. Payments
   D. Technical assistance
   E. Training
   F. Capacity building assistance efforts

Assessment of the Efficiency of the Administrative Mechanism Document Review
(To be conducted by staff by reviewing meeting minutes and other relevant documentation)
Ryan White Program Year (PY) 33 and PY 34

USE OF FUNDS: Priorities, Resource Allocations, Directives and Reprogramming

1. Describe the COH's PSRA process as defined in policies and procedures.

   Policy -09 5203 – Priority Setting and Resource Allocations (PSRA) Framework outlines the **Priority Setting and Resource Allocation (PSRA)** process for Ryan White Part A funding, specifying how services are prioritized and resources allocated. It follows the guidelines set by Ryan White and County legislation. Key components of the policy include:
   1. **Leadership & Involvement**: The PSRA process is led by the Commission's Planning, Priorities, and Allocations (PP&A) Committee, with input from the Division of HIV and STD Programs (DHSP), consumer feedback from the Comprehensive HIV Plan, and provider input through surveys and forums. The process is multi-year, involving ongoing stakeholder input and aligning with the HRSA Ryan White HIV/AIDS Program (RWP) cycle.
   2. **Data-Driven Decisions**: Priorities and allocations are based on data, not personal experiences, using needs assessments, cost, and service utilization data. Conflicts of interest must be disclosed and followed as per the Conflict-of-Interest Policy.
   3. **Annual Review**: Allocations are reviewed annually to ensure they align with community needs and funding requirements. Data from various sources inform changes to priorities or allocations.
   4. **Specific Populations and Areas**: The needs of specific populations and geographic areas are considered in decision-making and may influence recommendations on how to address these needs.
   5. **Voting and Training**: A final vote on priorities and allocations is presented to the full planning council after being reviewed by the PP&A Committee. Commissioners must complete annual PSRA training to be eligible to vote.
   6. **Paradigms and Values**: The PP&A Committee uses established paradigms and operating values from the previous year to guide decision-making.
   7. **Service Access and Quality**: The Status Neutral HIV and STI Delivery System framework is employed to ensure that services focus on high-quality care, engaging and retaining individuals in services regardless of whether they are for HIV treatment or prevention.
   8. **Equity and Parity**: Decisions should ensure equal access to care for all eligible HIV/AIDS populations, regardless of geographic location.
   9. **HIV Care Continuum Focus**: The main goal is improving performance on the HIV Care Continuum, especially regarding linkage to care and retention. The Planning Council prioritizes getting people into care, with a focus on key services like primary care and medications.

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10. **Comprehensive HIV Plan (CHP)**: The current goals, objectives, and priorities from the Comprehensive HIV Plan are considered in the decision-making process to ensure alignment with long-term goals.

The procedures are outlined as followed:

1. **Priority Setting**: The process considers the services needed for a comprehensive continuum of care, considering both available funding and unmet service demands.
2. **Service Categories Presentation**: The Commission staff presents a list of HRSA fundable service categories (core and support), along with their definitions.
3. **Prevention Categories**: The Commission staff also presents a list of HIV prevention categories from the latest approved Prevention Service Standards.
4. **Service Data Compilation**: The Division of HIV and STD Programs (DHSP) compiles various reports, including service utilization, client data, expenditure reports, and prevention data, highlighting challenges and opportunities for service improvements.
5. **Consultation with Caucuses**: Before the priority setting process begins, the PP&A Committee consults with all Caucuses to:
    - Gather consumer opinions on service priorities and resource allocation.
    - Review the Ryan White Program Service Utilization Reports and prevention data from DHSP.
    - Review recent financial reports on HIV prevention and care.
    - Examine key goals and objectives from the Comprehensive HIV Plan and Ending the HIV Epidemic Plan.
6. **Focus Groups and Surveys**: The PP&A Committee organizes focus groups or surveys with providers to gather input for the PSRA process.
7. **Service Prioritization:** The PP&A Committee ranks service categories based on need, using data from the Comprehensive HIV Plan, needs assessments, HIV epidemiology reports, fiscal reports, and service utilization data. This ranking is done once, irrespective of funding scenarios.
8. **Resource Allocation:** After prioritizing service categories, the PP&A Committee determines resource allocations. These can be allocated by specific amounts or percentages, and adjustments can be made based on funding scenarios. Stakeholders suggesting funding changes should also provide recommendations on how these adjustments will affect the continuum of care.
9. **Approval of Allocations:** The PP&A Committee presents and seeks approval for service priorities and allocations at the August or September Commission meeting, prior to the RWP Part A application deadline.
10. **Reallocation of Funds**: If reallocations are needed, adequate data must be presented and documented in meeting minutes. Reallocation proposals must be approved by the Commission, with a written justification for the changes. DHSP is authorized to adjust allocations by up to 10% without needing further Commission approval.
11. **Appeals Process (30 Days After Approval)**: The PP&A Committee will consider appeals related to new information or procedural issues in the PSRA process within 30 days of the allocations being approved.
12. **Development of Directives:** The PP&A Committee uses input from the PSRA process to create directives, which are guidance and recommendations on how to best meet service needs. These directives are approved by the PP&A Committee and forwarded to DHSP for consideration and potential implementation.
13. **Ongoing Review and Data Collection**: Throughout the year, the PP&A Committee

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continues to study service categories, populations, and planning issues, compiling necessary data for future processes.

2. Did the COH follow its PSRA process, policies and procedures?

   Yes, the COH followed it's PSRA process, policies and procedures. Led by the PP&A Committee, the COH followed the policies and procedures set forth in the PSRA Framework in setting priorities and allocating resources, reviewing and revising allocations, and addressing stakeholder concerns, with an emphasis on continuous data collection, stakeholder engagement, and alignment with broader HIV-related goals.

3. List data, fiscal, and programmatic reports received from the Recipient to help inform the PSRA process:

Type of Data /Information Received from Recipient	Date Received by the COH	Date presented to the COH or PP&A
HIV/STD Surveillance Data HIV among the AIAN population in LAC	11/10/22, 11/13/23 8/10/23	11/10/22, 11/13/23 – COH 8/10/23 – COH
EHE Progress Updates	11/10/22, 11/13/23, 6/13/24, 11/9/24	11/10/22, 11/13/23, 6/13/24, 11/9/24 – COH
Utilization Reports	8/15/23 (AOM & MCC) 9/19/23 (Mental Health, SUD Residential) 10/17/23 (Housing, EFA, Nutrition Support) 12/14/23 – Oral Health 1/23/24 – HBCM, Benefits Specialty, TCM 5/9/24 – Linkage and Re-Engagement Program	8/15/23 – PP&A 9/19/23 – PP&A 10/17/23 – PP&A 12/14/23 – PP&A 1/23/24 – PP&A 5/9/24 - COH
Expenditure Reports	5/16/23 8/15/23 2/20/24 7/16/24 8/27/24 2/18/25 – Part A & MAI	5/16/23 – PP&A 8/15/23 – PP&A 2/20/24 – PP&A 7/16/24 – PP&A 8/27/24 – PP&A 2/18/25 – PP&A
Unmet Needs Reports	4/13/23 (Late Diagnoses) 5/11/23 (Out of Care) 6/8/23 (In Care, Not Virally Suppressed)	4/13/23 – COH 5/11/23 – COH 6/8/23 - COH

Other Reports

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HIV Care Cascade (Department of Health Services)	9/14/23	9/14/23 - COH
Harm Reduction • City of Long Beach • City of Pasadena • City of Los Angeles • City of West Hollywood	 • 9/14/23 • 9/14/23 • 9/14/23 • 9/14/23	 • 9/14/23 – COH • 9/14/23 – COH • 9/14/23 – COH • 9/14/23 – COH
Part C Overview	10/12/23	10/12/23 - COH
Part F Overview	5/9/24	5/9/24 - COH
Housing Opportunities for People Living with AIDS (HOPWA) 3- Part Series Addressing Critical Issues Facing People Living with HIV and Housing	2/8/24 – Part 1 Program Overview 3/14/24 – Part 2 Data 4/22/24 – Part 3 Housing Providers Panel Discussion and Overview	2/8/24 – COH 3/14/24 – COH 4/22/24 - COH
Healthcare in Action - Street Medicine Model	7/11/24	7/11/24 - COH

4. List PP&A and COH meeting dates and approval dates for PY 33 allocations, reallocations, and directives.

PP&A Meeting Dates	COH Meeting Dates
• 3/21/23 • 4/18/23 • 5/16/23 - PP&A reallocation approval • 6/20/23 • 7/18/23 – canceled • 8/15/23 • 9/19/23 • 10/17/23 • 11/21/23 – canceled • 12/14/23 • 1/23/24 • 2/20/24	• 3/9/23 • 4/13/23 • 5/11/23 • 6/8/23 - COH reallocation approval • 7/13/23 - canceled • 8/10/23 • 9/14/23 • 10/12/23 • 11/9/23 • 1/11/24 • 2/8/24
PY 33 Allocations approved by PP&A on 11/16/21, COH 1/13/22 PY33 Reallocation approval dates – PP&A reallocation approval 8/27/24, COH reallocation approval 9/26/24 (approval at Executive Committee due to lack of quorum at 9/12/24 COH meeting) PY32-24 Directive approval dates – PP&A 5/7/22, COH 6/9/22	

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5. List PP&A and COH meeting dates and approval dates for PY 34 allocations, reallocations, and directives.

PP&A Meeting Dates	COH Meeting Dates
• 3/19/24 • 4/16/24 • 5/21/24 - canceled • 6/18/24 • 7/16/24 • 8/27/24 • 9/17/24 • 10/15/24 • 11/19/24 • 12/17/24 – canceled • 1/21/25 • 2/18/25	• 3/14/24 • 4/11/24 • 5/9/24 • 6/13/24 • 7/11/24 • 8/8/24 • 9/12/24 • 10/10/24 - canceled • 11/14/24 • 12/12/24 – canceled • 1/9/25 – canceled • 2/13/25
PY 34 Allocations approved by PP&A 11/16/21, COH 1/13/22 PY34 Reallocation Approval Dates – pending PY32-24 Directive approval dates – PP&A 5/7/22, COH 6/9/22	

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UNIVERSAL STANDARDS OF CARE AND CLIENT BILL OF RIGHTS AND RESPONSIBILITIES

Los Angeles County Commission on HIV

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Approved by the Commission on HIV on January 11, 2024.

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

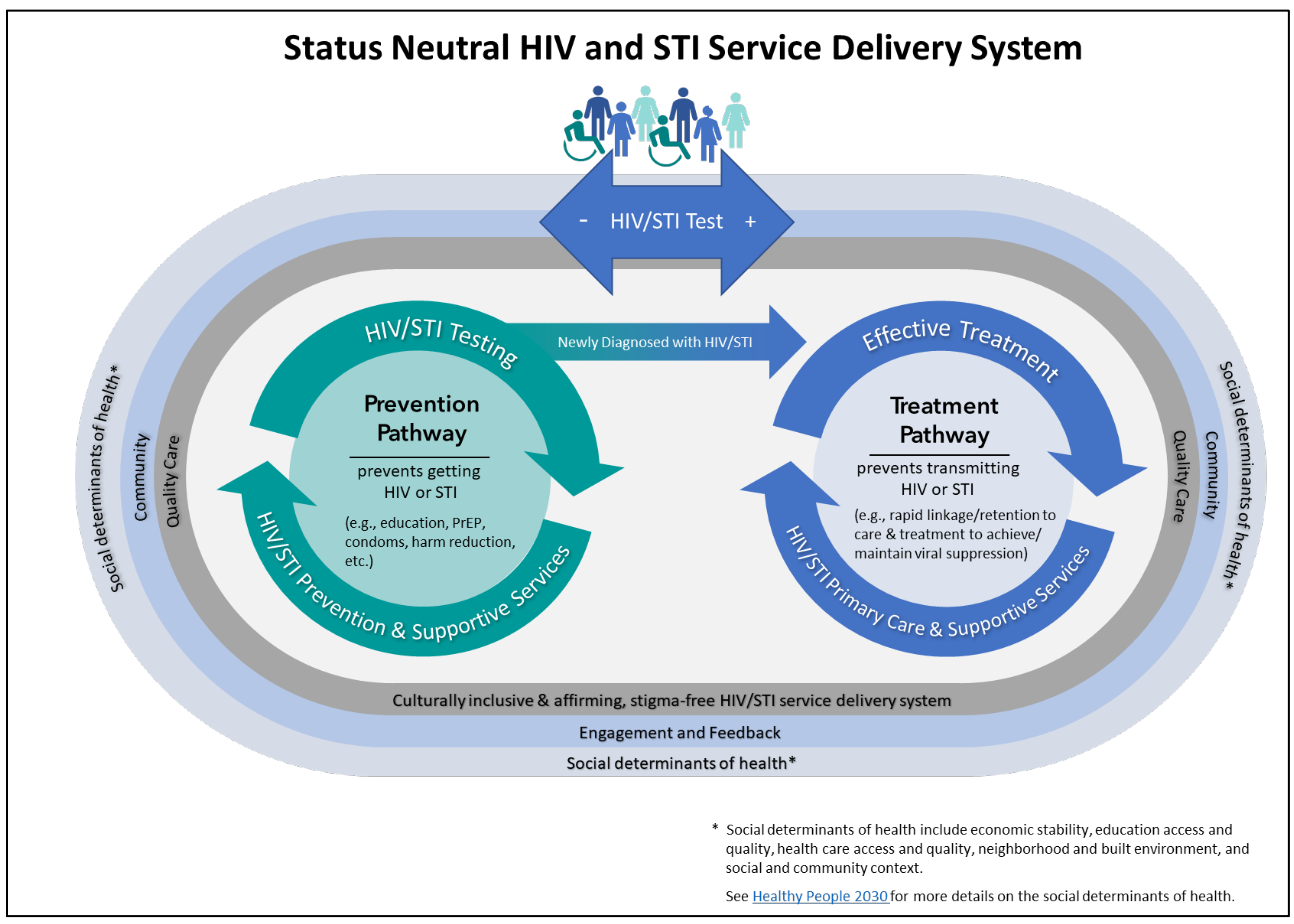
Introduction

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 (COH) 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 Los Angeles County (LAC). The development of the standards includes guidance from service providers, consumers, members of the COH and the Standards and Best Practices (SBP) Committee.

Additionally, providers are encouraged to adopt the "Status Neutral HIV and STI Service Delivery System Framework," that addresses both HIV care and prevention and is responsive to the unique needs of their clients (see **Figure 1**). The framework functions to provide comprehensive support and care to address the social determinants of health that create HIV and STI disparities. A status-neutral approach means that all people are treated in the same way and are linked to preventive care, medical care, and supportive services, regardless of HIV or STI status. When done effectively, rapidly linking newly diagnosed people to HIV treatment and those who test negative to ongoing prevention services will decrease new HIV infections, support positive people to thrive with and beyond HIV, and works to reduce health disparities.

Figure 1 - Status Neutral HIV and STI Service Delivery System Framework
(Adapted from the Centers for Disease Control and Prevention Status Neutral HIV Prevention and Care Framework)



Further information on the "Status Neutral HIV and STI Service Delivery System Framework," and standards related to prevention can be found at https://hiv.lacounty.gov/service-standards.

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 LAC.
- Educate staff and clients on the importance of receiving care, treatment as prevention, and how maintaining an undetectable viral load will result in little to 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 and guidelines 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.

Section 1.0—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.	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.	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.	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.	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.
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 #16-023	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.	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.	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.	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.	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	ADA criteria on file at all sites.

	sites must comply with the ADA requirements.	
1.11	Agency complies with all applicable state and federal workplace and safety laws and regulations, including fire safety.	Signed confirmation of compliance with applicable regulations on file.

Section 2.0—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.	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.	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.	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.	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	*Patient and Client Bill of Rights* document is signed by client and kept on file.

Section 3.0—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.	Hiring policy and staff resumes on file.
3.2	If a position requires licensed staff, staff must be licensed to provide services.	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	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	Documentation of completed trainings on file

	the job description and Ryan White service category.	
3.5	Staff are required to coordinate across Ryan White funded and non-funded programs to ensure clients' needs are met.	Documentation of staff efforts of coordinating across systems for the client on file (e.g. housing case management services, etc.).

Section 4.0—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 Services9 (CLAS) in Health and Health Care. As noted in the CLAS Standards10, 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, 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.	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.	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).	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.	*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 b. Ensure quality of language skills of self-reported bilingual staff who use their non-English language skills during client encounters	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.).	Materials and signage in a visible location and/or on file for reference.

Section 5.0—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

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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.	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.	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

Section 6.0—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.

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	Identified resources for referrals at provider agency (e.g. lists on file, access to websites). • 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).	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. 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.	Attempts to contact client and mode of communication documented in file. • 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.	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.
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.	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 and 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.

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)
   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—Division on HIV/STD Programs Customer Support Program

The Division of HIV and STD Programs' (DHSP) Customer Support Program aims to assist consumers of HIV and STD services who have experienced difficulty accessing services from DHSP-funded

providers throughout Los Angeles County. If you or someone you know is a consumer of HIV and STD services who have experienced difficulty accessing services from DHSP-funded providers throughout Los Angeles County, the Customer Support Program can assist with accessing HIV or STD services and addressing concerns about the quality of services received.

Please contact the Customer Support Program via email dhspsupport@ph.lacounty.gov , online http://publichealth.lacounty.gov/dhsp/QuestionServices.htm or by telephone at (800) 260-8787. By contacting the Customer Support Program, you will **not** be denied services. Your name and personal information can be kept confidential.

APPENDIX D—Get Protected LA and I'M+ LA Resources

The Division of HIV and STD Programs' (DHSP) Get Protected LA and I'M+ LA online resources offer information on the free or low-cost HIV care (including medical and/or support services) that are available through the Ryan White Program for eligible people living with HIV in Los Angeles County regardless of citizenship or lack of insurance. Visit the website at: https://getprotectedla.com/impositivela/

APPENDIX E—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

ENDNOTES

[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)

[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

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

[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)

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

[12] HIV Treatment Guidelines | NIH

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

[14] HIV Care Program

[15] LA County Department of Public Health

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

Approved by the Commission on HIV on January 11, 2024.

Estamos Escuchando

Comparta sus inquietudes con nosotros.

Servicios de VIH + ETS
Línea de Atención al Cliente

(800) 260-8787

¿Por qué debería llamar?

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

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

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

¿Puedo llamar de forma anónima?

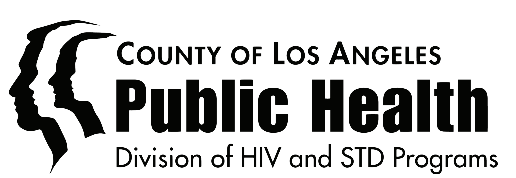
Si.

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

Si.

Por correo electronico:
dhspsupport@ph.lacounty.gov

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



We're Listening

share your concerns with us.

HIV + STD Services Customer Support Line

(800) 260-8787

Why should I call?

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

Will I be denied services for reporting a problem?

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

Can I call anonymously?

Yes.

Can I contact you through other ways?

Yes.

By Email:
dhspsupport@ph.lacounty.gov

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