LOS ANGELES COUNTY
COMMISSION ON HIV

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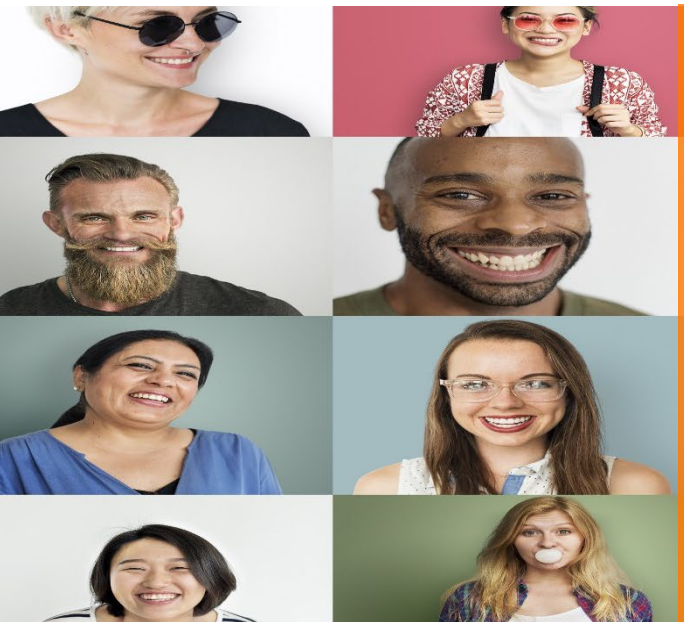

****VIRTUAL ONLY****

Consumer Caucus Virtual Meeting

THURSDAY, SEPTEMBER 11, 2025

12:00 PM - 1:30 PM

NOTE TIME CHANGE

TO JOIN, CLICK HERE:

https://lacountyboardofsupervisors.webex.com/lacountyboardofsupervisors/j.php?MTID=m70803531456e3238e743868eb53ca2c7

Meeting number: 2530 606 7110 Password: CONSUMER

📣 Join the Conversation

We'll be reviewing the draft Patient Support Services Standards, which outline how services like peer navigation, housing, benefits, and counseling support people living with HIV. Join us to ensure consumer needs and voices are included in shaping these services in LA County.

Meeting materials can be accessed at
https://hiv.lacounty.gov/meetings

Meaningful Involvement by People Living with HIV/AIDS #MIPA

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LOS ANGELES COUNTY COMMISSION ON HIV

VIRTUAL ONLY

CONSUMER CAUCUS (REVISED) MEETING AGENDA

THURSDAY, SEPTEMBER 11, 2025 @ 12:00PM-1:30PM

TO JOIN, CLICK HERE:

https://lacountyboardofsupervisors.webex.com/lacountyboardofsupervisors/j.php?MTID=m70803531456e3238e743868eb53ca2c7

Meeting number: 2530 606 7110 Password: CONSUMER

The Consumer Caucus is a subordinate body of the Los Angeles County Commission on HIV (COH) that amplifies the voices of people living with HIV (PWH) and those at-risk. It serves as a bridge between the community and the Commission, ensuring that the lived experiences and needs of PWH and those at-risk help shape HIV planning, funding, and service decisions. To learn more about the Consumer Caucus, click HERE.

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1. CO-CHAIR WELCOME & INTRODUCTIONS 12:00 PM – 12:05 PM
2. COH ED/STAFF REPORT 12:05 PM – 12:05 PM
3. CO-CHAIR REPORT 12:05 PM – 12:20 PM
   - Unaffiliated Consumer Stipend Program Updates
   - Caucus Standing Meeting Schedule & PURGE Decision-Making Tool
   - 2025 Workplan Review
   - USCHA Participant Feedback
4. DISCUSSION 12:20 PM – 1:20 PM

   Non-Medical Case Management: Patient Support Services Standards – REVIEW & FEEDBACK
   Review the draft Patient Support Services Standards, which guide how services like peer navigation, housing, benefits, substance use support, and counseling are delivered, to make sure they reflect consumer needs and lived experiences.
5. RECAP & NEXT STEPS 1:20 PM – 1:25 PM
6. PUBLIC COMMENT & ANNOUNCEMENTS 1:25 PM – 1:30 PM
7. ADJOURNMENT 1:30 PM

LOS ANGELES COUNTY
COMMISSION ON HIV

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

Approved by COH 6/8/23

CODE OF CONDUCT

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

All participants and stakeholders should adhere to the following:

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

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

HOUSE RULES

Consumer Caucus Meetings

1. **Active Listening**: Practice active listening during discussions. Allow each member to express their thoughts without interruption and try to understand their perspective before responding.

2. **Stay On Topic:** Keep discussions focused on the agenda and relevant issues. Avoid veering off into unrelated topics to make the most of everyone's time and energy.

3. **One Person, One Voice**: Give everyone an opportunity to speak before allowing individuals to speak again. This ensures that multiple perspectives are considered and prevents domination of the conversation by a few individuals.

4. **ELMO Principle**: A acronym for "Enough, Let's Move On." When a topic has been thoroughly discussed, respectfully say "ELMO", signaling the need to transition to the next agenda item.

5. **"Vegas" Rule:** "What's discussed in the Caucus, stays in the Caucus." Respect the confidentiality of sensitive information shared within the Caucus unless there is explicit permission to share.

6. **Respect Diversity & Use Inclusive Language**: Embrace diversity of opinions, backgrounds, and experiences. Be open to different viewpoints and avoid making assumptions about others based on their beliefs. Be mindful of the language you use and strive to be inclusive and respectful. Avoid offensive or discriminatory language.

7. **Use Parking Lot:** Utilize the "parking lot" to capture ideas, questions, or discussions not directly related to the current agenda item to address later or offline with staff and/or leadership.

LOS ANGELES COUNTY
COMMISSION ON HIV

Consumer Caucus Meeting Recap

Date: Thursday, August 14, 2025 | Time: 1:30 PM – 3:00 PM (Virtual)
Co-Chairs: Vilma Mendoza, Alasdair Burton & Ish Herrera (LOA)

To learn more about the Consumer Caucus, ***CLICK HERE***

Thank you to everyone who joined us for the August 14th Consumer Caucus virtual meeting. Below is a brief recap of our discussion and key next steps:

Welcome & Reports

- Co-chairs and members introduced themselves, reaffirming the Caucus' role in ensuring meaningful involvement of people living with HIV (PWH) in planning and decision-making.
- Staff provided updates on Commission restructuring and budgetary constraints, noting that staffing and RWP and County funding shifts may impact Commission operations into 2026 and beyond.

Co-Chair Updates

- **Shared outcomes from the recent Subordinate Working Unit Leadership Meeting**, including coordination on bylaws review and Brown Act compliance
  - ✓ Key highlights included:
    1. Per Brown Act and County Counsel guidance, caucuses may no longer maintain standing meeting schedules. Instead, they will need to use the PURGE decision-making tool to determine when meetings are necessary. The Caucus will further deliberate on how to structure its future meeting schedule under this requirement.
    2. HRSA cautioned caucuses with naming conventions that reference federally targeted populations to consider reimagining their caucus structures. Specific guidance is expected at the next HRSA Project Officer call in September, after which staff will provide an update to the Caucus.

- **Provided a follow-up on the Navigating the Ryan White Program (RWP) & Medi-Cal Listening Session**, noting that a written summary is forthcoming. A follow-up survey will also be launched to capture additional feedback from frontline staff, consumers who were unable to attend, and community members less familiar with available services.

- **Previewed the Caucus' September–December 2025 meeting schedule**, which will include:
  - ✓ Review of the Patient Support Services Standards (currently out for public comment)
  - ✓ A staff-led training on how to use the Commission's website and electronic forms
  - ✓ A request for updated CQM data presentations from DHSP

- **Reviewed the 2025 Workplan**, ensuring its activities remain aligned with Commission priorities and broader federal guidance.

Discussion Items

- **Stipend Policy Review:**
  - ✓ The Caucus continued its June discussion on updates to the current stipend policy, including consideration of an "à la carte" model – which was approved for the current stipend policy but not for the updated stipend policy that will correspond to the $500 proposed increase. In addition, the Caucus is tasked with developing a clear justification for the proposed increase and establishing reasonable requirements to support it.
  - ✓ Members expressed concern about the availability of funds and long-term sustainability, given broader Commission budget cuts. To address this, the Caucus agreed to pause the discussion to allow COH staff and DHSP to hold necessary budget conversations, with a commitment to revisit the issue and close the loop at a future meeting.
  - ✓ Staff clarified that while the proposed increase of up to $500 per month has been adopted by the Consumer Caucus, Operations Committee, and Executive Committee, it still awaits final approval. The changes will be presented to the full Commission on October 9 as part of the proposed bylaw revisions, after which the ordinance will be submitted to the Board of Supervisors for review and final action. If approved by both the Commission and the Board, the $500 increase and updated stipend policy will take effect at the start of the new program year (March 1, 2026), contingent on funding availability.

- **Dental Services Listening Session Follow-Up:** Staff presented highlights from April's session on dental services, with the Caucus agreeing to launch a follow-up survey to collect additional feedback. Members emphasized the need to hear from both consumers and providers to address service gaps. The April listening session summary can be found HERE.

Key Themes & Concerns

- **Funding:** Ongoing reductions to HIV-related budgets—including potential impacts on Part F (dental services and education)—were flagged as critical issues. UCLA remains the largest funded provider of RWP dental services, raising concerns of capacity strain.
- **Engagement**: Participants raised concerns about maintaining consistent consumer engagement despite financial and staffing challenges. There needs to be an ongoing check-in on how consumers are doing by simply asking the question, "How are you doing"? "What are your needs and concerns right now?"
- **Future Planning:** Members discussed the need for ongoing attention to HIV prevention strategies, mental health, and addressing consumers' lived experiences in future agendas.

Public Comment & Announcements

- Announcements highlighted upcoming opportunities to participate in standards review and listening sessions.

Next Steps

- Circulate stipend policy updates for continued feedback.
- Launch the follow-up dental services survey.
- Prepare for the September meeting, which will focus on the Patient Support Services Standards currently out for public comment.
- The next Caucus meeting will be virtual and will be held Thursday, September 11, 2025 – time TBD. **Reminder, the September Commission meeting is canceled.*

To learn more about the Consumer Caucus, CLICK HERE

LOS ANGELES COUNTY COMMISSION ON HIV

Subordinate Working Units Meeting Decision-Making Tool

(July 2025)

For Caucuses, Task Forces & Work Groups – refer to Policy #08.1102 for a description of the role(s), structures and governing rules of the Commission's various types of subordinate committees and working groups.

This tool is designed to help leadership for subordinate working units to decide when to hold a meeting and why, ensuring that meetings are intentional, legally compliant, and aligned with strategic Commission goals.

The PURGE Test

Use the acronym PURGE to determine whether a meeting should be scheduled. *All five criteria must be met.*

Decision Criteria	Guiding Questions	Proceed with Meeting?
Purpose	Is there a clear purpose or deliverable (e.g., planning an event, responding to a directive, presenting to full Commission)?	☐ Yes, if deliverable is identified
Urgency	Is there a time-sensitive issue that must be addressed before the next scheduled Commission meeting?	☐ Yes, if time-sensitive and cannot be addressed elsewhere
Readiness	Are the necessary materials, leadership, facilitators, or information available to conduct a productive meeting? Is there confirmed leadership capacity, including commitment from at least two Commissioners in good standing to lead the subgroup?	☐ Yes, if ready
Goal Alignment	Does the topic support the goals of the Commission, integrated plan, or specific motion/request? Can an existing committee fulfill the function or task?	☐ Yes, if aligned
Engagement	Will there be sufficient participation or community input to inform a meaningful discussion? Consider time, date, competing/conflicting events, meeting format (hybrid/in person/virtual)	☐ Yes, if members/stakeholders are confirmed

If one or more PURGE criteria are not met, consider using an alternative format—such as email, workgroup, or leadership/staff facilitation—instead of holding a full meeting.

CONSUMER CAUCUS 2025 DISCUSSION TOPICS

*Subject to updates

**Per Brown Act rules, caucuses may no longer maintain standing meeting schedules. Instead, they will need to use the PURGE decision-making tool to determine when meetings are necessary.*

MEETING LOGISTICS	TOPICS	NOTES/COMMENTS
~~January~~	~~CANCELED~~	
~~February~~	~~Consumer Resource Fair~~	
~~March (TCE)~~	~~Co-Chair Elections~~ ~~CQM 30-Minute Intro Presentation~~ ~~Housing Standards Review & Feedback~~	
~~April (St. Annes)~~	~~RWP Dental Services Listening Session~~	
~~May (St. Annes)~~	~~Dental Services Listening Session Follow Up & Next Steps~~	
~~June (Virtual)~~	~~Unaffiliated Consumer Member Stipend Program – Policy Update Discussion~~	
~~July (Vermont Corridor)~~	~~RWP & Med-Cal Transitions Listening Session~~	
~~August (Virtual)~~	~~Continued Stipend Policy Discussion~~ ~~Dental Services Listening Session F/U~~	
September (Virtual)	Patient Support Services Standard Review & Feedback	Reminder: September 19 Aging Event in Collab w/ Aging Caucus
October	COH Staff Technical Assistance in Navigating COH website and forms – TBD*	\Recommendation.to.move.this.item. to.the.Dec.Caucus.retreat.and. instead.close.the.loop.on.the. proposed.changes.to.the.stipend. policy.for.the.Oct.meeting¡
November	Annual Conference	*No meeting
December	Annual Consumer Retreat	Proposed agenda (ongoing) per prior discussions: - Review successes & assess strengths & areas of improvements - Develop 2026 workplan - DHSP CQM Presentation

Consumer Caucus Workplan 2025

(updated 8.11.25)

PURPOSE OF THIS DOCUMENT: To identify activities and priorities the Consumer Caucus will lead and advance throughout 2025.
CRITERIA: Select activities that 1) represent the core functions of the COH and Caucus, 2) advance the goals of the 2023 Comprehensive HIV Plan (CHP), and 3) align with COH staff and member capacities and time commitment.
CAUCUS RESPONSIBILITIES: 1) Facilitate dialogue among caucus members, 2) develop caucus voice at the Commission and in the community, 3) provide the caucus perspective on various Commission issues, and 4) cultivate leadership within the caucus membership and consumer community.

#	GOAL/ACTIVITY	ACTION STEPS/TASKS	TIMELINE/ DUE DATE	DESCRIPTION
1	~~**Consumer Resource Fair**~~	~~Plan a comprehensive resource fair for consumers of HIV prevention and services in Los Angeles County. This event will be a cross-collaborative effort involving all Caucuses to ensure it meets the diverse needs of our communities.~~	~~February 13, 2025~~	~~The theme for the event is "Love Begins with Me", a nod to self-care=self-love, aligning with Valentine's Day.~~ ~~Focus Areas:~~ ~~1.Holistic Wellness: Addressing physical, mental, spiritual, and financial health (e.g., nutrition, lifestyle, financial literacy, tech/computer literacy, estate planning).~~ ~~2.Empowerment & Advocacy: Providing skill-building opportunities to foster effective self-advocacy and empowerment.~~ ~~3.Community Engagement: Encouraging broader involvement beyond HIV status to support overall community connection.~~
2	**Consumer Feedback on Key Topics to Enhance HIV Services and Programs Vital for Quality of Life**	Gather feedback through listening sessions, public comments, and focus groups. Priority topics include: •~~Dental Services~~ •~~Commission Stipend Policy~~ •~~Ryan White Program & Medi-Cal/Medicaid Migration~~ •Transitional Case Management Service Standards Feedback •Patient Support Services Feedback	~~April 10, 2025~~ ~~June 12, 2025~~ ~~July 10, 2025~~ August 2025 September 2025	Align consumer reviews with the Standards & Best Practices (SBP) Committee service standards schedule, the Planning, Priorities & Allocations Committee (PP&A) needs assessments and other Commission activities.
3	**Leadership & Capacity Building**.	Coordinate consumer-specific trainings: • Ryan White Program 101 • Self/Community Advocacy • Digital Literacy (pending)	September 2025 October 2025	Continue to solicit training ideas from consumers. Refer to 2025 Commission training schedule for required HRSA Commissioner trainings. September 19, 2025 Cross-Collab event w/ Aging Caucus

Service Standard Development

LOS ANGELES COUNTY COMMISSION ON HIV

KEYWORDS AND ACRONYMS

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

WHAT ARE SERVICE STANDARDS?

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

WHAT ARE SERVICE CATEGORIES?

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

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

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

HRSA/HAB GUIDANCE FOR SERVICE STANDARDS

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

COH SERVICE STANDARDS

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

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

REMINDER

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

DEVELOPING SERVICE STANDARDS

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

SERVICE STANDARD DEVELOPMENT PROCESS

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

together.

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

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NON-MEDICAL CASE MANAGEMENT

(Last approved by COH on 12/12/19; Draft as of 06/17/25)

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

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

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

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

Service Standards: Ryan White HIV/AIDS Programs

Contents

Introduction

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

General Eligibility Requirements for Ryan White Services

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

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

Non-Medical Case Management Service Description

Case management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet client's health and social services needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes.[1]

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

Non-Medical Case Management services include all types of case management models such as intensive case management, strengths-based case management, and referral case management; see Appendix A for additional information on case management models. An agency may offer a specific type

[1] Introduction to the Case Management Body of Knowledge. Commission for Case Manager Certification (CCMC). https://www.cmbodyofknowledge.com/content/introduction-case-management-body-knowledge

of case management model depending on its capacity and/or the contract from the Division on HIV and STD Programs (DHSP). Depending on the type of case management offered, NMCM may also involve assisting the client's support network, key family members, and other individuals that play a direct role in the client's health and well-being.

Service components include:

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

In the past, the DHSP has contracted Transitional Case Management for Youth and Justice-Involved populations under NMCM services. Additionally, in 2025, DHSP contracted Patient Support Services (PSS) in conjunction with Ambulatory Outpatient Medical (AOM) and Medical Case Management (MCC) services. See Appendix C for additional information on PSS.

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

Non-Medical Case Management Service Standards

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

Client Assessment and Reassessment

Non-Medical Case Management providers must complete an initial assessment within 30 days of intake through a collaborative, interactive, face-to-face process between the case manager and client with the client as the primary source of information. With client consent, assessments may also include additional information from other sources such as service providers, caregivers, and family members to support client well-being and process. Case management staff must comply with established agency confidentiality policies when soliciting information from external sources. It is the responsibility of case management staff at the provider agency to conduct reassessments with the client as needed and based on contract guidelines from the DHSP. If a client's income, housing status, or insurance status has changed since assessment or the most recent reassessment, agencies must ensure that the data on the Client Information Form is updated accordingly.

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

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

Assessment and reassessment topics may include, at minimum:

- Client strengths and resources
- Medical Care
- Mental health counseling/therapy
- Substance use, harm reduction, and treatment
- Nutrition/food
- Housing or housing related expenses
- Family and dependent care
- Transportation
- Linguistic services
- Social support system
- Community or family violence
- Financial resources
- Employment and education
- Legal needs
- Knowledge and beliefs about HIV
- Agencies that service client and household

Case managers will identify medical and non-medical service providers and make appointments as early as possible during the initial intake process for clients that are not connected to primary medical care. Services provided to the client and actions take on behalf of the client must be documented in progress notes and in the Individual Services Plan, which is developed based on the information gathered in the assessment and reassessments.

CLIENT ASSESSMENT AND REASSESSMENT

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

Individual Support Plan (ISP)

An Individual Service Plan (ISP) is a tool that enables the case manager to assist the client in systematically addressing barriers to HIV medical care by developing an action plan to improve access and engagement in medical and other support services. ISPs include short-term and long-term client goals determined by utilizing information gathered during assessment and subsequent reassessments. The ISP should include specific service needs, referrals to be made, clear timeframes, and a plan to follow-up.

ISPs are developed in conjunction with the client and case manager within two weeks of the conclusion of the comprehensive assessment or reassessment. It is the responsibility of case managers to review and revise ISPs as needed and based on client need. As part of the ISP, case managers must ensure the coordination of the various services the client is receiving. Coordination of services requires identifying other staff or service provides with whom the client may be working. As appropriate and with client consent, case management staff act as liaisons among clients, caregivers, and other service providers to obtain and share information that supports optimal care and service provision. If a program is unable to provide a specific service, it must be able to make immediate and effective referrals. Case management staff is responsible for facilitating the scheduling of appointments, transportation, and the transfer of related information.

ISPs will, at minimum, include the following:

- Client and case manager names
- Client and case manager signatures and date on the initial ISP and on subsequent, revised ISPs
- Description of client goals and desired outcomes
- Timeline for when goals are expected to be met
- Action steps to be taken by client and/or case manager to accomplish goals
- Status of each goal as client progresses

INDIVIDUAL SERVICE PLAN (ISP)	
STANDARD	**DOCUMENTATION**
ISPs will be developed collaboratively between the client and case manager within two weeks of completing the assessment or reassessment and, at minimum, should include: • Description of client goals and desired outcomes • Action steps to be taken and individuals responsible for the activity • Anticipated time for each action step and goal • Status of each goal as it is met, changed or determined to be unattainable ISPs should be completed as soon as possible given case management services should be based on the ISP.	Completed ISP in client chart, dated and signed by client and case manager.
Staff will update the ISP every six months, or as needed based on client progress or DHSP contract requirements, with client outcomes or ISP revisions based on changes in access to care and services.	Updated ISP in client chart, dated and signed by client and case manager.

Client Monitoring

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

CLIENT MONITORING	
STANDARD	**DOCUMENTATION**
Case managers will ensure clients are accessing needed services and will identify and resolve any barriers clients may have in following through the ISP. Responsibilities include, at minimum: • Monitor changes in the client's condition • Update/revise the ISP based on progress • Provide interventions and follow-up to confirm completion of referrals	Signed, dated progress notes on file that detail, at minimum: • Changes in the client's condition or circumstances • Progress made toward ISP goals • Barriers to ISPs and actions taken to resolve them

• Ensure coordination of care among client, caregiver(s), and service providers • Advocate on behalf of clients with other service providers • Empower clients to use independent living strategies • Help clients resolve barriers to completing referrals, accessing or adhering to services • Follow-up on ISP goals • Maintain client contact at minimum one time per year, as needed, or based on DHSP contract requirements • Follow-up missed appointments by the end of the next business day	• Linked referrals and interventions and status/results of same • Barriers to referrals and interventions, actions taken • Time spent • Case manager's signature and title

Staff Requirements and Qualifications

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

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

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

STAFF REQUIREMENTS AND QUALIFICATIONS	
STANDARD	**DOCUMENTATION**
Case managers with experience in clinical and/or case management in an area of social services. Bachelor's degree in a related field preferred and/or experienced consumers preferred.	Staff resumes on file.

Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a multicultural environment.	
Case management supervisors with experience in clinical and/or case management in area of mental health, social work, counseling, nursing with specialized mental health training, psychology. Master's degree in a related field preferred and/or experienced consumer preferred. Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a multicultural environment.	Staff resumes on file.

Appendix A: HRSA Guidance for Non-Medical Case Management

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

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

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

Appendix B: Case Management Models

Referral (Brokerage) Case Management
This is the first formally articulated approach to case management. Focuses on assessing needs, referring to services, and coordinating and monitoring on-going treatment. The case manager coordinates services provided by a variety of agencies and professionals.

Strengths-based Case Management
Developed in response to concerns that services and systems focus mainly on limitations and impairments vs. strengths and capabilities, this model focuses on individual strengths, the helping relationship as essential, contact in the community, and a focus on growth, change and consumer choice. Case managers provide direct services.

Intensive Case Management
Developed to meet the needs of high service users, focuses on low staff to client ratios, outreach, services brought to the client, and practical assistance in a variety of areas. May include outreach and counseling services, including skill-building, family consultations and crisis intervention. Caseloads are not normally shared.

Retrieved from https://www.homelesshub.ca/resource/step-step-comprehensive-approach-case-management

Appendix C: Patient Support Services (PSS) Service Description

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

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

Retention Outreach Specialist (ROS)

- Ensures that PLWH remain engaged in their care and have access to necessary resources and support.
- Integrates with other HIV clinic team members to effectively identify, locate, and re-engage clients who have lapsed in their HIV care.

- Provides comprehensive assessment, outreach, linkage, and re-engagement services, focusing on clients who are considered "out of care," facilitating their return to consistent and effective HIV treatment and support services.
- Conducts field outreach operations to efficiently locate and assist clients who have disengaged from HIV care.
- Acts as the liaison between HIV counseling and testing sites and the medical clinic to ensure that new clients are enrolled in medical care seamlessly and in a timely fashion.
- Provides crisis interventions, offering immediate support in challenging situations.
- Provides services to clients not yet enrolled in PSS, MCC Services, or clinic-based programs and can outreach clients who have not yet enrolled into any services with Contractor.
- Collaborates with the HIV clinic team members, documents client interactions, and contributes to program evaluation.
- Demonstrates cultural and linguistic competency to effectively communicate with and support a diverse range of clients.
- Participates in case conferences as needed.

Must meet the following minimum qualifications:

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

PSS Social Worker (SW)

- Determines client resources and needs regarding mental health services, substance use counseling and treatment, as well as housing and transportation issues to make appropriate referrals and linkages.
- Holds counselling and psychotherapy sessions for individuals, couples, and families.
- Provides support services utilizing housing-first, harm reduction, and trauma-informed care principles.
- Utilizes a sex positive framework including provision of patient education about U=U.
- Collaborates with the HIV clinic team, documents interactions, and contributes to program evaluation.
- Maintains knowledge of local, State, and federal services available.

- Addresses clients' socioeconomic needs, and as part of the PSS team, assists with client monitoring, referrals, and linkages to services, as well as following up with clients and tracking outcomes.
- Acts as the liaison between HIV counseling and testing sites and the medical clinic to ensure that new clients are enrolled in medical care seamlessly and in a timely fashion.
- Performs home visits and other field outreach on a case by-case basis.
- Provides urgent services to clients not yet enrolled in PSS.
- Participates in case conferences as needed.
- Conducts a comprehensive assessment of the SDH using a cooperative and interactive face-to-face interview process. The assessment must be initiated within five working days of client contact and be appropriate for age, gender, cultural, and linguistic factors.
    - The assessment will provide information about each client's social, emotional, behavioral, mental, spiritual, and environmental status, family and support systems, client's coping strategies, strengths and weaknesses, and adjustment to illness.
    - SW will document the following details of the assessment in each client's chart:
        - Date of assessment;
        - Title of staff persons completing the assessment; and
        - Completed assessment form.
- Develops a PSS Intervention Plan SW will, in consultation with each client, develop a comprehensive multi-disciplinary intervention plan (IP). PSS IPs should include information obtained from the SDH assessment. The behavioral, psychological, developmental, and physiological strengths and limitations of the client must be considered by the SW when developing the IP. IPs must be completed within five days and must include, but not be limited to the following elements:
- Identified Problems/Needs: One or more brief statements describing the primary concern(s) and purpose for the client's enrollment into PSS as identified in the SDH assessment.
- Services and Interventions: A brief description of PSS interventions the client is receiving, or will receive, to address primary concern(s), describe desired outcomes and identify all respective PSS Specialist(s) assisting the client.
- Disposition: A brief statement indicating the disposition of the client’s concerns as they are met, changed, or determined to be unattainable.
- IPs will be signed and dated by the client and respective SW assisting the client.
- IPs must be revised and updated, at a minimum, every six months.

Meets the following minimum qualifications:

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

Benefits Specialist

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

Meets the following minimum qualifications:

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

Housing Specialist

- Develops and maintains expert knowledge of, and contacts at, local housing programs and resources including specialized programs available to PLWH.
- Conducts housing assessments and creates individualized housing plans.

- Assists clients with applications to housing support services such as emergency finance assistance, referral and linkage to legal services (for issues such as tenant's rights and evictions), and navigation to housing opportunities for persons with AIDS programs.
- Conducts home or field visits as needed.
- Develops a housing procurement, financial, and self-sufficiency case management plan with clients as part of client housing plans.
- Offers crisis intervention and facilitates urgent referrals to housing services.
- Collaborates with the HIV clinic team, documents interactions, and contributes to program evaluation.
- Attends meetings and trainings to improve skills and knowledge of best practices in permanent supportive housing and related issues.
    - Participates in case conferences as needed.

Meets the following minimum qualifications:

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

Substance Use Disorder (SUD) Specialist

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

Meets the following minimum qualifications:

- Certified as a Substance Use Counselor.
- Has at least one year of experience in an SUD program with experience providing counseling to individuals, families, and groups.
- Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a multicultural environment.

Clinical Nursing Support Specialist

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

Peer Navigator

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

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

Meets the following minimum qualifications:

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

We're Listening

share your concerns with us.

HIV + STD Services Customer Support Line

(800) 260-8787

Why should I call?

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

Will I be denied services for reporting a problem?

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

Can I call anonymously?

Yes.

Can I contact you through other ways?

Yes.

By Email:
dhspsupport@ph.lacounty.gov

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

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

Estamos Escuchando

Comparta sus inquietudes con nosotros.

Servicios de VIH + ETS
Línea de Atención al Cliente

(800) 260-8787

¿Por qué debería llamar?

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

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

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

¿Puedo llamar de forma anónima?

Si.

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

Si.

Por correo electronico:
dhspsupport@ph.lacounty.gov

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

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