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STANDARDS AND BEST PRACTICES COMMITTEE MEETING

Tuesday, April 2, 2024
10:00Am-12:00pm (PST)

Vermont Corridor
510 S. Vermont Ave. Terrace Conference Room TK05

****Valet Parking: 523 Shatto Place, LA 90020****

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

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

Members of the Public May Join in Person or Virtually.
For Members of the Public Who Wish to Join Virtually, Register Here:
https://lacountyboardofsupervisors.webex.com/weblink/register/r4d47d1d60bb650f65d2165363865708a
To Join by Telephone: +1-213-306-3056 United States Toll (Los Angeles)
Password: STANDARDS **Access Code:** 2537 952 6920

Scan QR code to download an electronic copy of the meeting agenda and packet on your smart device. Please note that hard copies of materials will not be made available during meetings unless otherwise determined by staff in alignment with the County's green initiative to recycle and reduce waste. **If meeting packet is not yet available, check back 2-3 days prior to meeting; meeting packet subject to change. Agendas will be posted 72 hours prior to meeting per Brown Act.*

Notice of Teleconferencing Sites:

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510 S. Vermont Ave., 14th Floor, Los Angeles CA 90020
MAIN: 213.738.2816 EML: hivcomm@lachiv.org WEBSITE: https://hiv.lacounty.gov

AGENDA FOR THE REGULAR MEETING OF THE LOS ANGELES COUNTY COMMISSION ON HIV

STANDARDS AND BEST PRACTICES COMMITTEE

TUESDAY, April 2, 2024| 10:00 AM – 12:00 PM

510 S. Vermont Ave
Terrace Level Conference Room TK05
Los Angeles, CA 90020
Validated Parking: 523 Shatto Place, Los Angeles, CA 90020

For those attending in person, as a building security protocol, attendees entering the first-floor lobby must notify security personnel that they are attending the Commission on HIV meeting to access the Terrace Conference Room (9th floor) where our meetings are held.

MEMBERS OF THE PUBLIC WHO WISH TO JOIN VIRTUALLY, REGISTER HERE:
https://lacountyboardofsupervisors.webex.com/weblink/register/r4d47d1d60bb650f65d2165363865708a
To Join by Telephone: 1-213-306-3065
Password: STANDARDS Access Code: 2537 952 6920

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

AGENDA POSTED: March 28, 2024.

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

PUBLIC COMMENT: Public Comment is an opportunity for members of the public to comment on an agenda item, or any item of interest to the public, before or during the Commission's consideration of the

item, that is within the subject matter jurisdiction of the Commission. To submit Public Comment, you may join the virtual meeting via your smart device and post your Public Comment in the Chat box -or- email your Public Comment to hivcomm@lachiv.org -or- submit your Public Comment electronically here. All Public Comments will be made part of the official record.

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

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

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

I. ADMINISTRATIVE MATTERS

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

II. PUBLIC COMMENT — 10:10 AM – 10:15 AM

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

III. COMMITTEE NEW BUSINESS ITEMS

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

IV. REPORTS

7. Executive Director/Staff Report — 10:15 AM – 10:45 AM
   a. Operations and Programmatic Updates
   b. Service Standards Development Refresher

8. Co-Chair Report — 10:45 AM – 11:00 AM
   a. 2024 Workplan and Meeting Schedule—Updates

b. Service Standards Revision Tracker—Updates

9. Division on HIV and STD Programs (DHSP) Report 11:00 AM—11:20 AM

V. DISCUSSION ITEMS

10. Ambulatory Outpatient Medical (AOM) Service Standards Review 11:20 AM—11:45 AM

VI. NEXT STEPS 11:45 AM – 11:50 AM

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

VII. ANNOUNCEMENTS 11:50 AM – 12:00 PM

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

VIII. ADJOURNMENT 12:00 PM

15. Adjournment for the meeting of April 2, 2024.

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

HYBRID MEETING GUIDELINES, ETTIQUETTE & REMINDERS

(Updated 3.22.23)

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

- The conference room speakers are *extremely* sensitive and will pick up even the slightest of sounds, i.e., whispers. If you prefer that your private or side conversations, not be included in the meeting recording which, is accessible to the public, we respectfully request that you step outside of the room to engage in these conversations.
- Turn off your ringers/notifications on your smart devices so as not to disrupt the meeting.
- Your voice is important, and we want to ensure that it is captured accurately on the record. Please be respectful of one another and minimize crosstalk.

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

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

☐ **Public Comment** for members of the public can be submitted in person, electronically @ https://www.surveymonkey.com/r/public_comments or via email at hivcomm@lachiv.org. *For members of the public attending virtually, you may also submit your public comment via the Chat box. Should you wish to speak on the record, please use the "Raised Hand" feature or indicate your request in the Chat Box and staff will call upon and unmute you at the appropriate time. Please note that all attendees are muted unless otherwise unmuted by staff.*

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

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

Approved by COH
6/8/23

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

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.)

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 2/21/24

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
ALVAREZ	**Miguel**	No Affiliation	No Ryan White or prevention contracts
ARRINGTON	**Jayda**	Unaffiliated consumer	No Ryan White or prevention contracts
BALLESTEROS	**Al**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV)
			STD Screening, Diagnosis, and Treatment
			Health Education/Risk Reduction (HERR)
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
BURTON	**Alasdair**	No Affiliation	No Ryan White or prevention contracts
CAMPBELL *	**Danielle**	T.H.E. Clinic, Inc.	See attached subcontractor's list
CIELO	**Mikhaela**	LAC & USC MCA Clinic	Biomedical HIV Prevention
CUEVAS	**Sandra**	Pacific AIDS Education and Training - Los Angeles	No Ryan White or prevention contracts
CUMMINGS	**Mary**	Bartz-Altadonna Community Health Center	No Ryan White or prevention contracts
DAVIES	**Erika**	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DONNELLY	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
FINDLEY	**Felipe**	Watts Healthcare Corporation	Transportation Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Oral Health Care Services
			Biomedical HIV Prevention
			STD Screening, Diagnosis and Treatment
FRAMES	**Arlene**	Unaffiliated consumer	No Ryan White or prevention contracts
FULLER	**Luckie**	Invisible Men	No Ryan White or prevention contracts
GONZALEZ	**Felipe**	Unaffiliated consumer	No Ryan White or Prevention Contracts
GORDON	**Bridget**	Unaffiliated consumer	No Ryan White or prevention contracts
GREEN	**Joseph**	Unaffiliated consumer	No Ryan White or prevention contracts
HALFMAN	**Karl**	California Department of Public Health, Office of AIDS	Part B Grantee
HARDY	**David**	LAC-USC Rand Schrader Clinic	No Ryan White or prevention contracts
HERRERA	**Ismael "Ish"**	Unaffiliated consumer	No Ryan White or prevention contracts
KOCHEMS	**Lee**	Unaffiliated consumer	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts
MAGANA	**Jose**	The Wall Las Memorias, Inc.	HIV Testing Storefront
			HIV Testing Social & Sexual Networks
MARTINEZ (PP&A Member)	**Miguel**	Children's Hospital Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
			Promoting Healthcare Engagement Among Vulnerable Populations
MAULTSBY	**Leon**	Charles R. Drew University	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
MINTLINE (SBP Member)	**Mark**	Western University of Health Sciences (No Affiliation)	No Ryan White or prevention contracts
MURRAY	**Derek**	City of West Hollywood	No Ryan White or prevention contracts
NASH	**Paul**	University of Southern California	Biomedical HIV Prevention

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

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

DRAFT

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

STANDARDS AND BEST PRACTICES (SBP) COMMITTEE MEETING MINUTES

March 5, 2024

COMMITTEE MEMBERS P = Present | A = Absent					
Erika Davies, *Co-Chair*	EA	Lauren Gersh, LCSW	P	Martin Sattah, MD	A
Kevin Stalter, *Co-Chair*	EA	David Hardy, MD	EA	Juan Solis	A
Mikhaela Cielo, MD	P	Mark Mintline, DDS	P	Russell Ybarra	P
Arlene Frames	P	Andre Molette	P		
Wendy Garland, MPH	EA	Byron Patel, RN	P		
COMMISSION STAFF AND CONSULTANTS					
Cheryl Barrit; Jose Rangel-Garibay					
DHSP STAFF					
COMMUNITY MEMBERS					

**Some participants may not have been captured electronically. Attendance can be corrected by emailing the Commission.*
**Members of the public may confirm their attendance by contacting Commission staff at hivcomm@lachiv.org.*
**Meeting minutes may be corrected up to one year from the date of Commission approval.*
***LOA: Leave of absence*

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

CALL TO ORDER-INTRODUCTIONS-CONFLICT OF INTEREST STATEMENTS
The meeting was called to order at 10:09am.

I. ADMINISTRATIVE MATTERS

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

2. APPROVAL OF MEETING MINUTES
MOTION #2: Approve the 12/05/23 SBP Committee meeting minutes, as presented ***(✓Passed by consensus).***

II. PUBLIC COMMENT

3. OPPORTUNITY FOR PUBLIC TO ADDRESS COMMISSION ON ITEMS OF INTEREST WITHIN COMMISSION JURISDICTION: There were no public comments.

III. COMMITTEE NEW BUSINESS ITEMS

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

IV. REPORTS

5. **EXECUTIVE DIRECTOR/STAFF REPORT**
   - **Operations and Programmatic Updates**
     Cheryl Barrit, Executive Director of the Commission, reported that Commission on HIV Annual Report for 2023 was submitted to the Executive Office of the Board of Supervisors on February 28. 2024. The document can be found on the Commission website under the "Our Work" tab. The report includes a summary for the different activities and work of the Commission such as standards or care revisions, Priority Setting and Resource Allocations process, and community engagement activities. She encouraged attendees to share the document with their colleagues and community members.
   - C. Barrit reminded attendees that the next Commission meeting will be on Thursday March 14, 2024 at the MLK Behavioral Health Center. The meeting will feature a data presentation led by Housing Opportunities for Persons With AIDS (HOPWA). The meeting will also include a panel discussion facilitated by the co-chairs of the Women's Caucus in commemoration of National Women and Girls HIV/AIDS awareness.
   - Jose Rangel-Garibay, Commission staff, noted that the meeting packet includes a copy of the Commissions 2024 Training calendar and encouraged Commissioners to register for the upcoming mandatory trainings. All trainings are virtual, and recordings are available on the Commission website.

6. **CO-CHAIR REPORT**
   - **"Commissioner Commitments"**
     C. Barrit referenced the Commission Duty Statement document in the packet and asked attendees how they envision to fulfill their role as Commissioners. She suggested improving attendance at Committee meetings and increasing participating in the Priority Setting and Resource Allocation (PSRA) process led by the Planning, Priorities, and Allocations (PP&A) Committee.
   - **Draft 2024 Workplan Development and Meeting Schedule**
     J. Rangel-Garibay provided an overview of the updates to the draft 2024 workplan. He noted that the Universal Standards and the Medical Care Coordination standards were approved by the Commission on January 8. 2024, and the Prevention Standards will be voted on for approval today. He added that the items 6 and 7 on the workplan are carry over items from 2023 and items 8-11 are recommendations for the Committee to consider for 2024. He also mentioned that the Committee should consider cancelling or scheduling the September meeting since the Labor Day holiday lands on the same week.
   - **Division on HIV and STD Programs (DHSP) Solicitation Priorities 2024**
     The committee reviewed the DHSP solicitation priorities document and deliberated on which service standard to review/update next. The Committee decided to prioritize reviews for the Ambulatory Outpatient Medical (AOM), Emergency Financial Assistance (EFA), and the Transitional Case Management (TCM) service standards in 2024. The TCM service standards will include sections that address the needs of specific sub-groups such as youth, and older adults. A copy of the document is included in the meeting packet.

7. **DIVISION ON HIV AND STD PROGRAMS (DHSP) REPORT**
   There was no DHSP report.

V. DISCUSSION ITEMS

8. **Prevention Service Standards Review**

J. Rangel-Garibay provided an overview of the edits to the document since the last time the Committee reviewed the document. A copy of the edits is included in the meeting packet. Joe Green requested that staff bring print copies of the Prevention Service standards to the Consumer Caucus meeting on March 14. He emphasized the importance of soliciting feedback and comments from consumers.

MOTION #3: Approve the Prevention Services standards, as presented or revised and elevate to the Executive Committee. ***(✓Passed; Yes=5: Molette, Patel, Cielo, Mintline, Green. Abstain= 2: Ybarra, Frames No= 0).***

VI. NEXT STEPS

9. TASK/ASSIGNMENTS RECAP:

- ➲ COH staff will edit the Prevention Service standards and elevate the document to the Executive Committee for review at their March 28, 2024 meeting. COH staff will also share the Prevention Standards with the Consumer Caucus and the Transgender Caucus and solicit their feedback.
- ➲ COH staff will update the Committee's workplan.
- ➲ COH staff will prepare the Ambulatory Outpatient Medical service standards for Committee review.

11. AGENDA DEVELOPMENT FOR NEXT MEETING:

- Adopt draft workplan and meeting calendar for 2024.
- Conduct a service standards development refresher training for new Committee members.
- Conduct initial overview of the Ambulatory Outpatient Medical service standards.

VII. ANNOUNCEMENTS

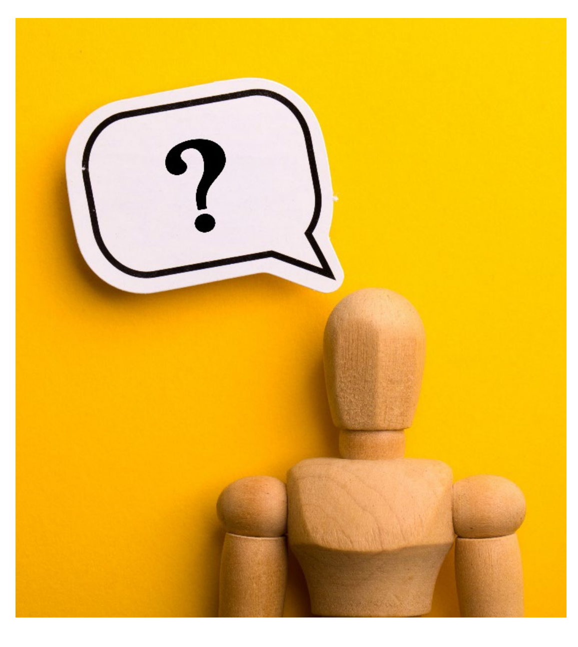
12. OPPORTUNITY FOR PUBLIC AND COMMITTEE TO MAKE ANNOUNCEMENTS:

- Russell Ybarra announced that Capital Drugs will host their annual health fair on March 23rd which will include over 70 vendors and will offer free vaccinations to attendees (MPOX, flu, and COVID).
- C. Barrit announced that registration for the National Ryan White Conference is now open; registration for the virtual component of the conference is free. She mentioned that Commission co-chair Danielle Campbell and co-chair Pro-Tem Joe Green will participate in-person.
- Joe Green announced that the LA LGBT Center Senior Services Department holds a variety of programming for older adults living with HIV. He encouraged attendees to register for their newsletter.

VIII. ADJOURNMENT

13. ADJOURNMENT: The meeting adjourned at 11:05am.

What are service standards?



- Outline the elements and expectations a Ryan White (RW) service provider follows when implementing a specific service category
- Ensure that all RW service providers offer the same **basic** service components
- Establish the **minimal** level of service of care for consumers throughout the jurisdiction

How are service standards used?

- Service standard development is a joint responsibility shared by DHSP and COH
- Service standards are used in:
  - DHSP Request for Proposals (RFPs)
  - Service provider contracts
  - Monitoring/quality assurance
- Service providers are encouraged to participate in COH deliberations and planning activities

How are service standards used? Cont.

- DHSP provides summary information to the COH on the extent to which the service standards are being met (based on monitoring)
- DHSP assists with identifying possible need for revisions to service standards including:
  - Service providers are following standards, but medical outcomes are not good
  - Service providers are finding it very difficult to meet some standards
  - Service standards are discouraging flexibility needed for service innovations or appropriate care for diverse populations

Developing Service Standards

- No required format or specific process defined by HRSA/HAB
- The Standards and Best Practices (SBP) Committee:
  - Leads the service standards development process for the Commission on HIV
  - Agrees on outline to be used for all service standards
  - Determines the schedule for review/update (at least every 3 years)

Developing Service Standards Cont.

- The SBP Committee prioritizes reviews/updates to service standards based on:
    - Service category's allocation level
    - Local priority
    - DHSP's RFP schedule
    - A consumer, provider, or service concern
    - To respond to environmental or continuum of care changes (COVID-19, status neutral approach)

Service Standards Review Cycle

SBP Review

- SBP develops review schedule based on service rankings, DHSP RFP schedule, or in response to environmental or continuum of care changes
- SBP conducts review/revision of service standards which includes input from consumers, experts, and service providers
- SBP posts the revised/updated service standards for a public comment period

COH Review

- Commission on HIV reviews the revised/updated service standards and holds vote to approve. Once approved, the service standards are sent to DHSP

Dissemination

- Service standards are posted on the COH website for public viewing and to encourage use by Non-Ryan White providers
- DHSP uses service standards in RFP's, contracts, and for monitoring/quality assurance. DHSP provides feedback to COH on provider implementation
- Revisions to service standards occur at least every 3 years or as needed

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

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

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

Standards of Care Review
Guiding Questions

1. Are the standards up-to-date and consistent with national standards of high quality HIV and STD prevention services?
2. Are the standards reasonable and achievable for providers?
3. Will the services meet consumer needs? Are the proposed standards client-centered?
4. What are the important outcomes we expect for people receiving this service? How can we measure whether or not the service is working for them?
5. Is there anything missing from the standards related to HIV prevention and care?
6. Is there anything missing in regard to other topics such as reducing stigma, social determinants of health, immigration issues, support around insurance and housing, etc.?
7. Are the references still relevant?

Ryan White Program Service Categories

Core Medical Services	Supportive Services

• AIDS Drug Assistance Program (ADAP) Treatments
• Local AIDS Pharmaceutical Assistance Program (LPAP)
• Early Intervention Services (EIS)
• Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals
• Home and Community-Based Health Services (aka Home-based Case Management)
• Home Health Care
• Hospice Services
• Medical Case Management, including Treatment Adherence Services (aka Medical Care Coordination)
• Medical Nutrition Therapy
• Mental Health Services
• Oral Health Care
• Outpatient/Ambulatory Health Services
• Substance Abuse Outpatient Care
	• Childcare Services
	• Emergency Financial Assistance
	• Food Bank/Home Delivered Meals
	• Health Education/Risk Reduction
	• Housing
	• Linguistic Services
	• Medical Transportation
	• Non-Medical Case Management Services
	• Other Professional Services
	    • Legal Services
	    • Permanency Planning
	• Outreach Services
	• Permanency Planning
	• Psychosocial Support
	• Referral for Healthcare and Support Services
	• Rehabilitation
	• Respite Care
	• Substance Abuse (Residential)

Click here for more information on allowable use of funds.

LOS ANGELES COUNTY COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 9003.0 • TEL (213) 738-2816 • FAX (213) 637-4748
www.hivcommission-la .info

DUTY STATEMENT, COMMISSIONER (subject to change)

POLICY:

1) Candidates for membership on the Commission on HIV must complete a membership application and are evaluated/scored by the Commission's Operations Committee, consistent with Policy/ Procedure #09.4205 *(Commission Membership Evaluation and Nomination Process).* The Operations Committee recommends candidates for membership to the Commission, which, in turn nominates them to the Board of Supervisors by a majority vote. The Board of Supervisors is responsible for appointing members to the Commission.

DUTIES AND RESPONSIBILITIES: In order to be an effective, active member of the Commission on HIV, an individual must meet the following demands of Commission membership:

1. Representation/Accountability:

- Possess a thorough knowledge of HIV/AIDS/STI issues and affected communities, and the organization or constituency the member represents;
- Continually and consistently convey two-way information and communication between the organization/constituency the member represents and the Commission;
- Provide the perspective of the organization/constituency the member represents and the Commission to other, relevant organizations regardless of the member's personal viewpoint;
- Participate and cast votes in a manner that is best for the entire County, regardless of the personal opinions of the member personal or the interests/opinions of the organization/constituency the member represents.

2. Commitment/Participation:

a) Commitment to fill a full two-year Commission term.

b) A pledge to:

- respect the views of other members and stakeholders, regardless of race, ethnicity, sexual orientation, HIV status or other factors;
- comply with "Robert's Rules of Order, Newly Revised", the Ralph M. Brown Act, the Commission's Code of Conduct and applicable HIPAA rules and requirements;
- consider the views of others with an open mind;
- actively and regularly participate in the ongoing decision-making processes; and
- support and promote decisions resolved and made by the Commission when representing the Commission.

c) A commitment to devote a minimum of ten hours per month to Commission/committee attendance, preparation and other work as required by your Commission membership.

d) Each year of the two-year term, the Commissioner is expected to attend* and participate in, at a minimum, these activities:

- Two all-day Commission orientation meetings *(firstyear only)* and assorted orientations and trainings of shorter length throughout the year;
- One to two half-day County commission orientations *(alternate years);*
- One half- to full-day Commission meeting monthly;
- One two- to three-hour committee meeting once a month;
- All relevant priority- and allocation-setting meetings;
- One all-day Commission Annual Meeting in the Fall;
- Assorted voluntary workgroups, task forces and special meetings as required due to committee assignment and for other Commission business.

***Stipulation:** Failure to attend the required meetings may result in a Commissioner's removal from the body.*

3. Knowledge/Skills:

a) A commitment to constantly develop, build, enhance and expand knowledge about the following topics:

- general information about HIV/STIs and its impact on the local community;
- a comprehensive HIV/STI continuum of care/prevention services, low-income support services, and health and human service delivery;
- the Commission's annual HIV service priorities, allocations and plans;
- the Ryan White Program, County health service and Medicaid information and other information related to funding and service support.

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

Co-Chairs: Erika Davies, Kevin Stalter				
Adopted on: TBD				
Purpose of Work Plan: To focus and prioritize key activities for SBP Committee for 2024.				
#	**TASK/ACTIVITY**	**DESCRIPTION**	**TARGET COMPLETION DATE**	**STATUS/NOTES/OTHER COMMITTEES INVOLVED**
1	Review and refine 2024 workplan.	COH staff to update 2024 workplan monthly.	Ongoing, as needed	Workplan revised/updated on: 12/05/23, *02/29/24*, *03/28/24*
2	Provide feedback on implementation of the Comprehensive HIV Plan (CHP).	Collaborate with the PP&A Committee to support the implementation of the CHP.	Ongoing, as needed	
3	Update Universal service standards and Consumer Bill of Rights	Annual review of the standards. Revise/update document as needed.	COMPLETE	The COH approved the document on 01/08/24. The Committee decided to move the document to a bi-annual review or as needed/requested.
4	Update the Medical Care Coordination (MCC) service standards	Committee received a public comment requesting for a review and update of the MCC services standards.	COMPLETE	The COH approved the document on 01/08/24.
5	Update Prevention Service standards	Review and revise/update document as needed.	May. 2024	Committee forwarded the document to the Prevention Planning Workgroup for review at their 07/26/23 meeting. The PPW co-chairs presented the proposed revisions to the Prevention standards on 11/7/23. The Committee approved the standards and elevated them to the Executive Committee and full COH for approval.
6	Update the Transitional Case Management: Youth service standards	Schedule and conduct review of the standard.	TBD	The Committee will review meeting calendar on 3/5/24 and determine when to schedule the review.

7	Develop Transitional Case Management: 50+ service standards	Develop a TCM service standard that focused on healthcare navigation between the Ryan White Care System, Medi-Cal, and Medi-Care for people living with HIV 50+.	TBD	The Committee will review meeting calendar on 3/5/24 and determine when to schedule the review.
8	Update the Emergency Financial Assistance service standards	Committee received a request to consider reviewing the EFA service standards.	Late 2024	The Committee will review meeting calendar on 3/5/24 and determine when to schedule the review.
9	Update Ambulatory Outpatient Medical Services standards	Upcoming solicitation to release in Nov. 2024	Late 2024	The Committee will begin their review on April 2, 2024.
10	Update Transportation Services standards	Upcoming solicitation to release in Oct. 2024.	TBD	The Committee will review meeting calendar on 3/5/24 and determine when to schedule the review.
11	Update Temporary and Permanent Housing Services standards	Upcoming solicitation to release in Nov. 2024.	TBD	The Committee will review meeting calendar on 3/5/24 and determine when to schedule the review.

STANDARDS AND BEST PRACTICES COMMITTEE
2024 MEETING CALENDAR | (updated 03.28.24)

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

Service Standards Revision Date Tracker as of 02/15 /24 FOR PLANNING PURPOSES

COH Standard Title	DHSP Service	Description	Date of Last Revision	Notes
AIDS Drug Assistance Program (ADAP) Enrollment	AIDS Drug Assistance Program (ADAP) Enrollment	State program that provides medications that prolong quality of life and delay health deterioration to people living with HIV who cannot afford them.	n/a	ADAP contracts directly with agencies. Administered by the California Department of Public Health, Office of AIDS (CDPH/OA).
Benefits Specialty Services	Benefits Specialty Services (BSS)	Assistance navigating public and/or private benefits and programs (health, disability, etc.)	Last approved by COH on Sep. 8, 2022.	Upcoming solicitation—release Nov. 2024.
Emergency Financial Assistance	Emergency Financial Assistance (EFA)	Pay for rent, utilities (including cell phone and Wi-Fi), and food and transportation.	Last approved by COH on Jun. 11, 2020.	Committee will review in 2024.
HIV/STI Prevention Services	Prevention Services	Services used alone or in combination to prevent the transmission of HIV and STIs.	*Review in-progress*	Not a program—standards apply to prevention services. Upcoming solicitation—release Aug./Sep. 2024
Home-Based Case Management	Home-Based Case Management	Specialized home care for homebound clients.	Last approved by COH on Sep. 9, 2022.	Active solicitation
Language Interpretation Services	Language Services	Translation and interpretation services for non-English speakers and	Last approved by COH in 2017.	

COH Standard Title	DHSP Service	Description	Date of Last Revision	Notes
		deaf and.org hard of hearing individuals.		
Legal Services	Legal Services	Legal information, representation, advice, and services.	Last approved by COH on Jul. 12, 2018.	
Medical Care Coordination	Medical Care Coordination (MCC)	HIV care coordination through a team of health providers to improve quality of life.	Last approved by COH on Jan. 11, 2024.	Upcoming solicitation—release Nov. 2024
Medical Outpatient Services	Ambulatory Outpatient medical (AOM) Services	HIV medical care accessed through a medical provider.	Last approved by COH on Jan. 13, 2006.	Committee will review in 2024. Upcoming solicitation—release Nov. 2024
Medical Specialty	Medical Specialty Services	Medical care referrals for complex and specialized cases.		
Mental Health Services	Mental health Services	Psychiatry, psychotherapy, and counseling services.	Last approved by COH in 2017.	
Nutrition Support	Nutrition Support Services	Home-delivered meals, food banks, and pantry services.	Last approved by COH on Aug. 10, 2023.	Upcoming solicitation—release Oct. 2024
Oral Health Care	Oral Health Services (General and Specialty)	General and specialty dental care services.	Last approved by COH on Apr. 13, 2023.	

COH Standard Title	DHSP Service	Description	Date of Last Revision	Notes
Psychosocial Support	Psychosocial Support/Peer Support Services	Help people living with HIV cope with their diagnosis and any other psychosocial stressors they may be experiencing through counseling services and mental health support.	Last approved by COH on Sep. 10, 2020.	Upcoming solicitation—Release TBD
Substance Use Residential and Treatment Services	Substance Use Disorder Transitional Housing (SUDTH)	Housing services for clients in recovery from drug or alcohol use disorders.	Last approved by COH on Jan. 13, 2022.	
Temporary Housing Services	Residential Care Facility for the Chronically Ill (RCFCI)	Home-like housing that providers 24-hour care.	Last approved by COH on Feb. 8, 2018.	Upcoming solicitation—release Nov. 2024
Temporary Housing Services	Transitional Residential Care Facility (TRCF)	Short-term housing that providers 24-hour assistance to clients with independent living skills.	Last approved by COH on Feb. 8, 2018	Upcoming solicitation—release Nov. 2024
Transitional Case Management Services, Youth	Transitional Case Management—Youth	Client-centered, comprehensive services designed to promote access to and utilization of HIV care by identifying and linking youth living with	Last approved by COH on Apr. 13, 2017.	Committee will review in 2024.

COH Standard Title	DHSP Service	Description	Date of Last Revision	Notes
		HIV/AIDS to HIV medical and support services.		
Transitional Case Management Services—Justice-Involved Individuals	Transitional Case Management	Support for incarcerated individuals transitioning from County Jails back to the community.	Last approved by COH on Dec. 8, 2022.	
Transitional Case Management—Older Adults	n/a	To be developed.	n/a	Consider for review in 2024.
Transportation	Transportation Services	Ride services to medical and social services appointments.	Last approved by COH in 2017.	Consider for review in 2024. Upcoming solicitation—Release Oct. 2024
Universal Standards and Client Rights and Responsibilities	n/a	Establish the minimum standards of care necessary to achieve optimal health among people living with HIV, regardless of where services are received in the County. These standards apply to all services.	Last approved by COH on Jan. 11, 2024.	Not a program—standards apply to all services. The Committee will review this document on a bi-annual basis or as necessary per community stakeholder, partner agency, or Commission request.

Ambulatory Outpatient Medical Services

for People with HIV

What are Ambulatory Outpatient Medical (AOM) Services?

Ambulatory Outpatient Medical (AOM) Services is a program that provides HIV specialty medical services for people with HIV (PWH). These services are provided by licensed health care professionals who have received advanced training in the management of HIV/AIDS.

What are the goals of the AOM Services program?

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

What services can I access through the AOM Services program?

The AOM Services program offers a variety of services which include medical exams and treatment, laboratory testing, nutrition education support, and sexually transmitted infection (STI) prevention and screening.

How do I access these services?

You can access these services by contacting any of the providers listed on the next page. If you are not already receiving services at one of the listed providers, you may need to confirm that you are eligible for the Ryan White HIV/AIDS Program (RWHAP). They may ask you to provide documentation confirming your HIV diagnosis, current income (if any), health insurance (if any), and that you live in Los Angeles County. AOM services are free for those with a qualifying income regardless of immigration status.

Continue to next page

Ambulatory Outpatient Medical Services

for People with HIV

Agency	Contact	Phone Number	Email Address/Webpage
AIDS Healthcare Foundation	Practice Managers	(888) 243-727	www.hivcare.org/contact-ahf/
AltaMed Health Services	Ernesto Vicencio	(323) 803-8425	giovhernandez@altamed.org
APLA Health & Wellness	Dr. Jerome de Vente (Long Beach) Dr. Kevin Tangonan (La Brea) Dr. Jay Gladstein (Olympic)	(562) 247-7740 (323) 239-9900 (323) 215-1725	info@apla.org
Children's Hospital Los Angeles	Jasmine Brown	(323) 361-3028	jasbrown@chla.usc.edu
East Valley Community Health Center	Deborah Lara Rivera	(909) 620-8088 x3200	dlara@evchc.org
El Proyecto del Barrio	Leopoldo Cabral Sandra Salazar	(818) 830-7181	lcabral@elproyecto.us ssalazar@elproyecto.us
JWCH Institute, Inc.	Call Center	(866) 733-5924	
Long Beach, Department of Health and Human Services	Rosie Tufuga Stephanie Silva	(562) 570-4316 (562) 570-4317	rosie.tufuga@longbeach.gov stephanie.silva@longbeach.gov
Los Angeles LGBT Center	Joseph Martinez	(323) 993-7495	jmartinez@lalgbtcenter.org
Men's Health Foundation	Virginia Cabrera	(310) 550-1010	virginia.cabrera@menshealthfound.org
Northeast Valley Health Corporation	Andrew Braga, RN	(818) 988-6335	andrewbraga@nevhc.org
St. John's Community Center	Xavier Laporte	(323) 541-1600 x1079	xsanchez@wellchild.org
St. Mary Medical Center	Eddie Felix	(562) 624-4999	careprogram@dignityhealth.org
Tarzana Treatment Centers	Christian Espinoza	(818) 432-5897 x2170	cespinoza@tarzanatc.org
The Los Angeles Free Clinic	Chassity Griffin	(323) 330-1654	cgriffin@sabancommunityclinic.org
T.H.E. Health & Wellness Centers	Tracy Horn Clinic General Line	(323) 730-1920 x3225 (323) 730-1920	thorn@tohelpeveryone.org
The Regents of the University of California (UCLA)	Rosa Ramos	(310) 557-2273; #3	AOM.carecenter@mednet.ucla.edu
Venice Family Clinic	Julie Garcia Joslynn Cerrato	(310) 382-6041 (310) 664-7994	juliegarcia@mednet.ucla.edu jcerratto@mednet.ucla.edu
Watts Healthcare Corporation	Anthony Corona Alicia Chavez	(323) 564-4331	anthony.corona@wattshealth.org alicia.chavez@wattshealth.org

Ryan White Program Year 32

Care Utilization Data Summary

Part 1 - Ambulatory Outpatient Medical and Medical Care Coordination

Aug 15, 2023
COH Planning, Priorities, and Allocations Committee

Sona Oksuzyan, PhD, MD, MPH
Division of HIV and STD Programs

Ambulatory Outpatient Medical (AOM) and Medical Care Coordination (MCC) Service Cluster

BACKGROUND

As a Ryan White Program (RWP) Part A recipient, the Division of HIV and STD Programs (DHSP) at the Los Angeles County (LAC) Department of Public Health receives grant funds from the Health Resources and Services Administration HIV/AIDS Bureau (HRSA-HAB) to increase access to core medical and related support services for people living with HIV (PLWH)[1]. The amount of the award is based on the number of PLWH residing in LAC. DHSP receives additional funding from HRSA-HAB to reduce disparities in health outcomes among persons of color living with HIV through the Minority AIDS Initiative (MAI) and discretionary funds from the LAC Department of Public Health (net county costs [NCC]). DHSP received a total of $45.9 million from HRSA-HAB in fiscal year 2022 that included $42.1 million for Part A and $3.8 million for MAI.

HRSA-HAB and the Centers for Disease Control and Prevention (CDC) require that local HIV planning bodies develop integrated HIV prevention plans in collaboration with the health department to guide prevention and care efforts within the jurisdiction[2]. HIV surveillance and supplemental surveillance along with program service data and unmet need estimates are used to identify priority populations of focus. In LAC, the populations of focus overlap with priority populations identified in the local "Ending the HIV Epidemic" strategic plan and shown in bold[3]. These include:

1. **Latino Cisgender Men Who Have Sex with Men (MSM)**
2. **Black Cisgender MSM**
3. **Cisgender Women of Color**
4. **Transgender Persons**
5. **Youth Aged 13-29**
6. PLWH ≥ Age 50
7. **Persons Who Inject Drugs (PWID)**
8. Unhoused RWP Clients

Though not identified as priority populations in the integrated or Ending the HIV Epidemic (EHE) plans, we include RWP clients 50 years of age and older and those experiencing homelessness as an important subpopulation living with HIV with need for RWP services in LAC.

[1] Ryan White HIV/AIDS Programs Parts & Initiatives. (2022). In ryanwhite.hrsa.gov. Retrieved July 20, 2023 from https://ryanwhite.hrsa.gov/about/parts-and-initiatives
[2] Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need, CY 2022-2026.(2021). In ryanwhite.hrsa.gov. Retrieved July 20, 2023 from https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/integrated-hiv-dear-college-6-30-21.pdf
[3] Ending the HIV Epidemic Plan for Los Angeles. (2021). In lacounty.hiv. Retrieved July 19, 2023 from https://www.lacounty.hiv/wp-content/uploads/2021/04/EHE-Plan-Final-2021.pdf

Ryan White Program Service Utilization Report, Contract Year 32 (March 1, 2022-February 28, 2023)

This report series summarizes utilization of medical and support services by RWP clients in Contract Year 32 (March 1, 2022-February 28, 2023) to inform the planning and allocation activities of the LAC Commission on HIV (COH). To inform focused discussion, we will present services in the following service clusters:

1. Ambulatory Outpatient Medical (AOM) and Medical Care Coordination (MCC) services
2. Mental Health and Substance Abuse (Residential) services
3. Housing, Emergency Financial Assistance and Nutrition services
4. General and Specialty Oral Health services
5. Case Management (CM) Services: Benefits Specialty, Transitional CM- Jails, Home-Based CM and the Linkage and Re-Engagement (LRP)

The data presented is intended to provide priority highlights of who is accessing RWP services in LAC (demographic and socio-economic characteristics, priority populations), the types of services accessed, funding sources, and how these services are delivered (in-person or telehealth). The detailed source tables are included in the appendix for reference.

Outcomes and Indicators

The following information will be used to describe service utilization and estimate expenditures. Each of the five service clusters to be presented will include:

- HIV Care Continuum Outcomes (engagement in care, Retention in Care (RiC) and viral suppression (VS) among EHE priority and RWP priority populations
- RWP service utilization and expenditure indicators by service category:
    - Total service units=Number of service units paid for by DHSP in the reporting period. *Service units vary by service category and may include visits, hours, procedures, days, or sessions*
    - Service units per client=Total service units/Number of clients
    - Total Expenditure= Total dollar amount paid by DHSP in the reporting period
    - Expenditures per Client= Total Expenditure/Number of clients

DATA SOURCES

- HIV Casewatch (local RWP data reporting system)
    - Client characteristics and service utilization data reported by RWP contracted service agencies
    - Data are manually entered or submitted through electronic data transfer
- Linkage Re-engagement Program (ACCESS Database)
- eHARS (HIV surveillance data system)
- DHSP Expenditure Reports

WHAT DATA CAN AND CANNOT TELL US

This report will estimate for the current reporting year:

- How many unique RWP clients were served?
- What types of clients accessed RWP services?
  - How many clients?
  - Which clients are we serving?
  - Which services did they access?
- How did clients use services?
  - Which services did they use?
  - How were they utilized?
  - How much of the service did they receive?
  - Were there differences or disparities in how clients received services?
- Are we making progress toward targets for local and federal HIV care continuum (HCC) outcomes?
  - How are RWP clients doing compared to LAC overall?
  - How are clients doing within service categories?
  - Are there differences/disparities in outcomes?

What we cannot estimate using this report:

- What services clients need compared to what they receive (service gaps)
- Why the number of clients may change over time
- How many PLWH in LAC are uninsured
- Why there are disparities in utilization or outcomes
- Characteristics of or service use among PLWH outside of the RWP

Ryan White Program Service Utilization Report, Contract Year 32 (March 1, 2022-February 28, 2023)

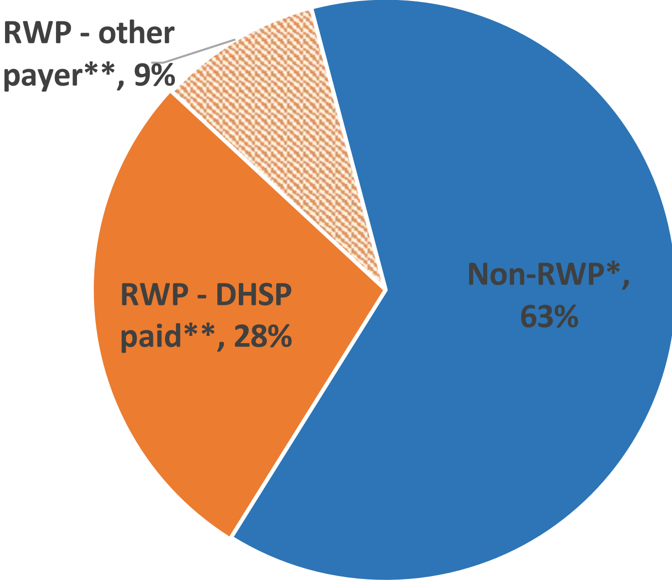
RYAN WHITE PROGRAM CLIENTS

Figure 1 below estimates RWP services use among people living with diagnosed HIV (PLWDH) in LAC in RWP Year 32 (March 1, 2022 - February 28, 2023).

- The orange section shows the percent of PLWDH who accessed RWP services that were paid for by DHSP RWP funds. This will be the population of focus for this report.
- The orange and white stripe section shows the percent of PLWDH who accessed RWP services that were ultimately paid for by another source such as Medi-Cal, Medi-Care, or other insurance
- The blue section shows the percent of PLWDH who did not use any RWP service. This means they receive medical care and other services through other systems of care.

In RWP Year 32, approximately 1 in 4 PLWDH received at least one RWP service paid by DHSP with RWP funds.

Figure 1. Use of RWP services among PLWDH in LAC (N=53,577), Year 32*



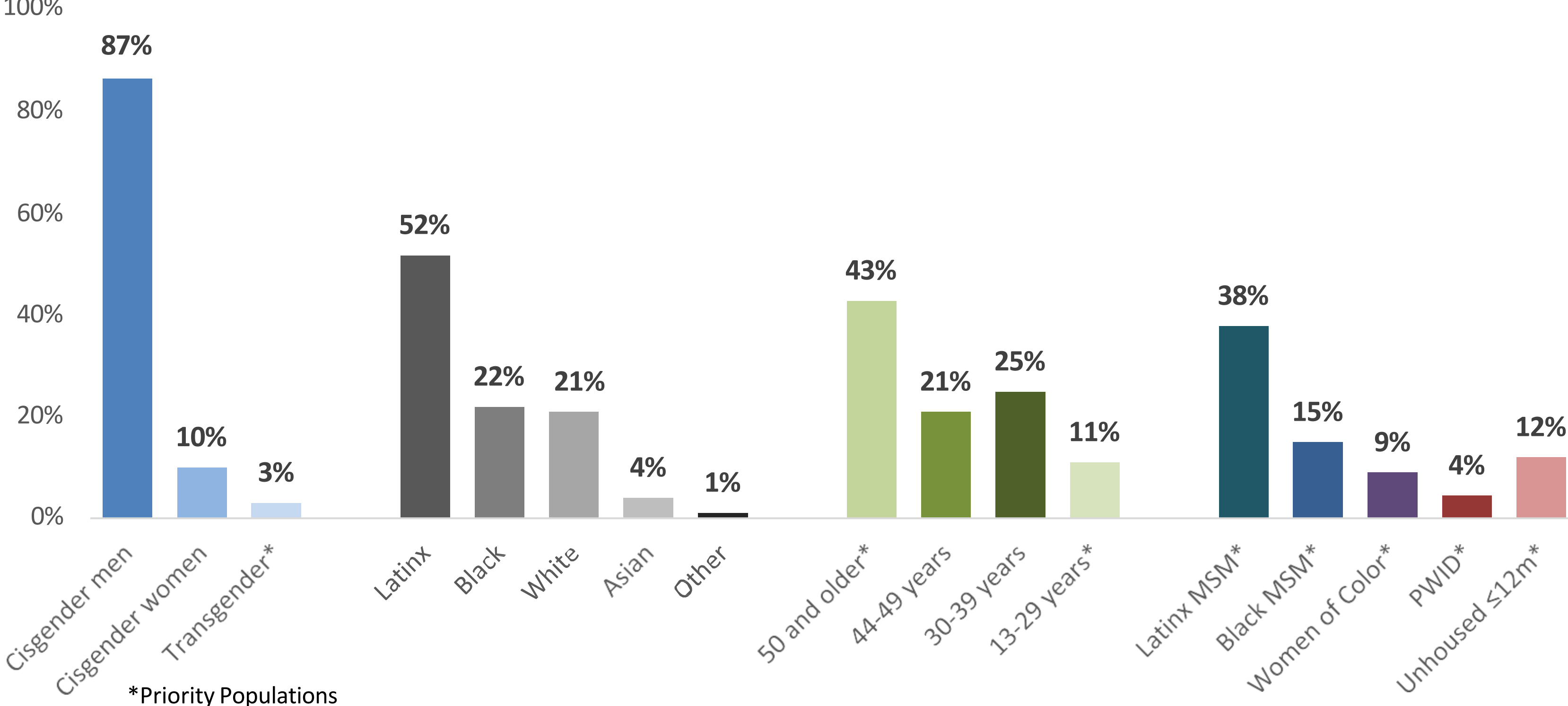
*LAC surveillance data for calendar year 2022 (Jan-Dec 2022)
**CaseWatch data for RWP year 32 (Mar 2022-Feb 2023)

Socio-Demographic Characteristics and Social Determinants of Health among RWP Clients

Of the 14,772 RWP clients **who** accessed RWP funded services in Year 32, 24% received at least one RWP-supported medical care visit in the reporting period.

In Year 32, the majority of RWP clients were Latinx or Black/African American (52% and 22%, respectively), cisgender male (87%), PLWH ≥ Age 50 (43%), living at or below the Federal Poverty Level (63%), MSM (71%) and residing in Hollywood-Wilshire Health District (19%). (Figure 2, Supplemental Table 1)

Figure 2. Demographic Characteristics and Priority Populations among RWP Clients in LAC, Year 32

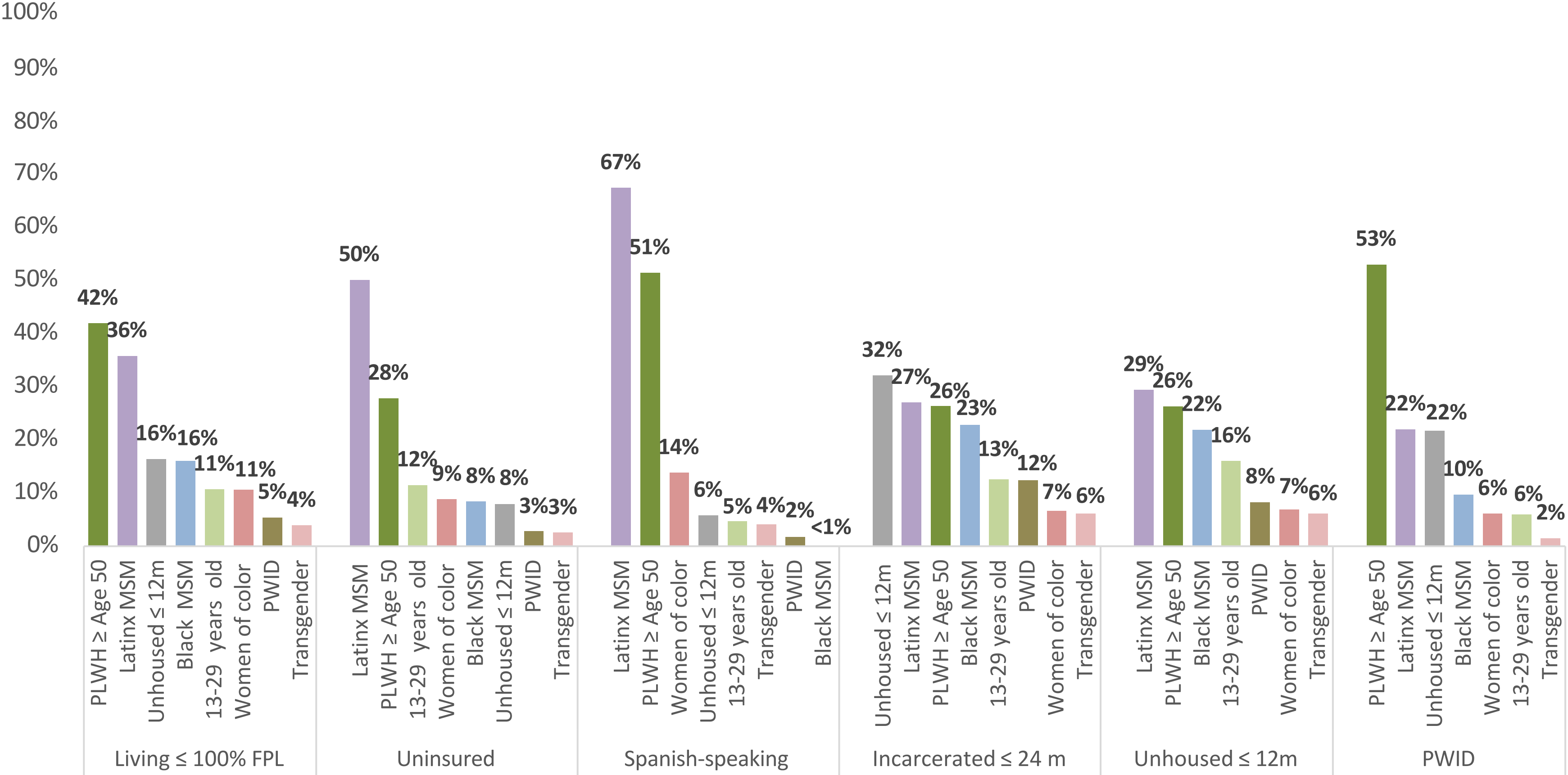


The demographic characteristics of RWP clients have remained stable over the past five RWP years *except for age*. The percent of clients aged 50 and older has increased overtime, reflecting the aging HIV epidemic locally and across the US. For more information about client characteristics over time, please refer to Supplemental Table 1.

Figure 3 presents key determinants of health by priority population:

- **Living at or below FPL**: highest among PLWH ≥ Age 50 (42%) followed by Latinx MSM (36%)
- **Uninsured**: highest among Latinx MSM (50%) followed by PLWH ≥ Age 50 (28%)
- **Primary Spanish-Speakers**: highest among Latinx MSM (67%) followed by PLWH ≥ Age 50 (51%)
- **Recent Incarceration**: highest among unhoused in past 12 m (325) followed by Latinx MSM (27%)
- **Unhoused in the Reporting Period**: highest among Latinx MSM (29%) followed by PLWH ≥ Age 50 (26%)
- **PWID**: highest among PLWH ≥ Age 50 (53%) followed by Latinx MSM and unhoused in past 12 m (22% each)

Figure 3. Social Determinants of Health by Priority Populations among RWP Clients in LAC, Year 32

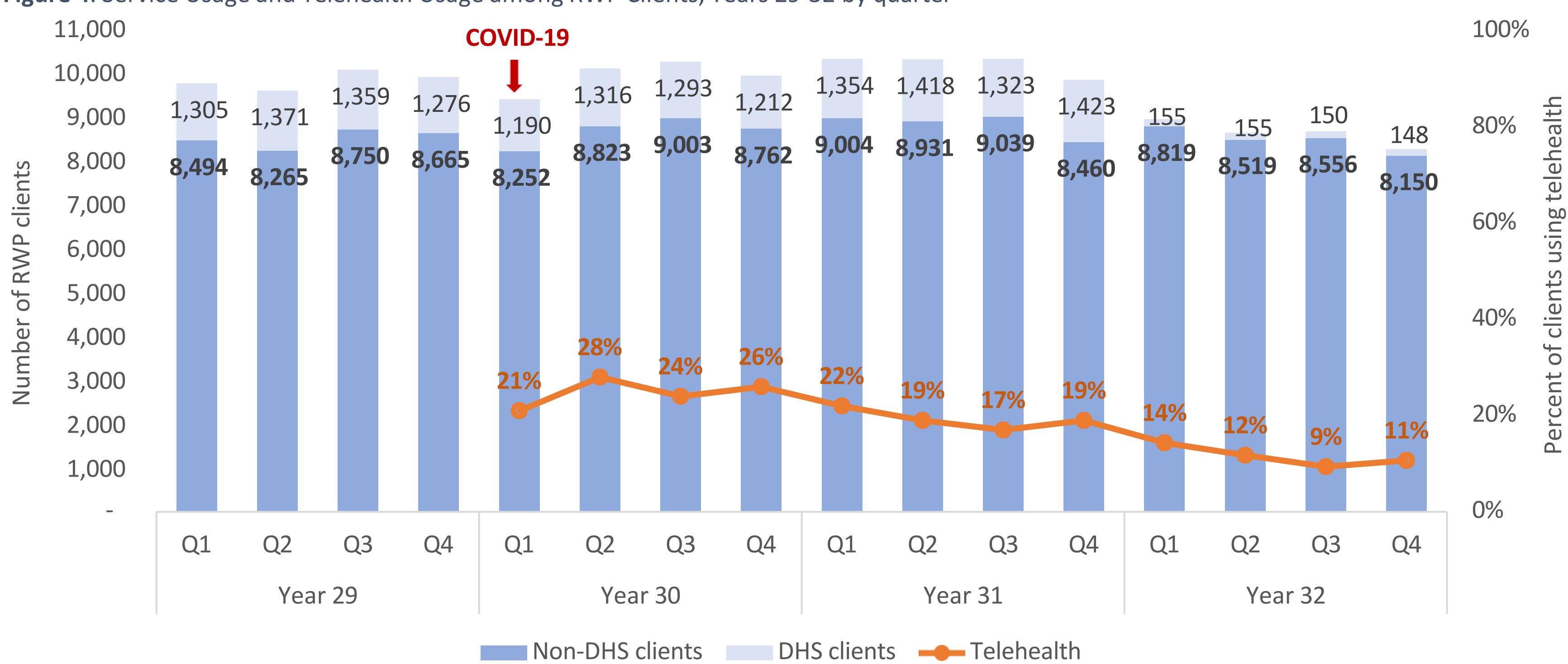


SERVICE UTILIZATION

Figure 4 below shows the number of RWP clients accessing services for RWP Years 29-32 (March 1, 2019 – February 28, 2023) by quarter to show the impact of the COVID-19 pandemic on utilization as well as the departure of the LAC Department of Health Services (DHS) from the RWP system in Year 32. Each bar represents the total number of clients by quarter. The light blue part of the bar shows the number of DHS clients. The darker blue part of the bar shows the number of all other (non-DHS) clients. We can see that the total number of clients decreased starting in quarter 1 of Year 32 however we can see the utilization of RWP by non-DHS clients has remained stable.

The orange line shows the percent of RWP services that were utilized through telehealth modalities. Telehealth was a critical strategy to promote continuity of care for RWP clients during the COVID-19 pandemic. MCC, AOM, Non-Medical Case Management (NMCM), Mental Health (MH), and Home-Based Case Management (HBCM) continued to be offered to clients with a telehealth option through Year 32. About 25% of RWP clients received at least one of the RWP services via telehealth in Year 32 (43% in Year 31). RWP services with the highest usage of telehealth were MH (51%), MCC (35%), and AOM (23%). Supplemental Table 2 provides more detail about telehealth services.

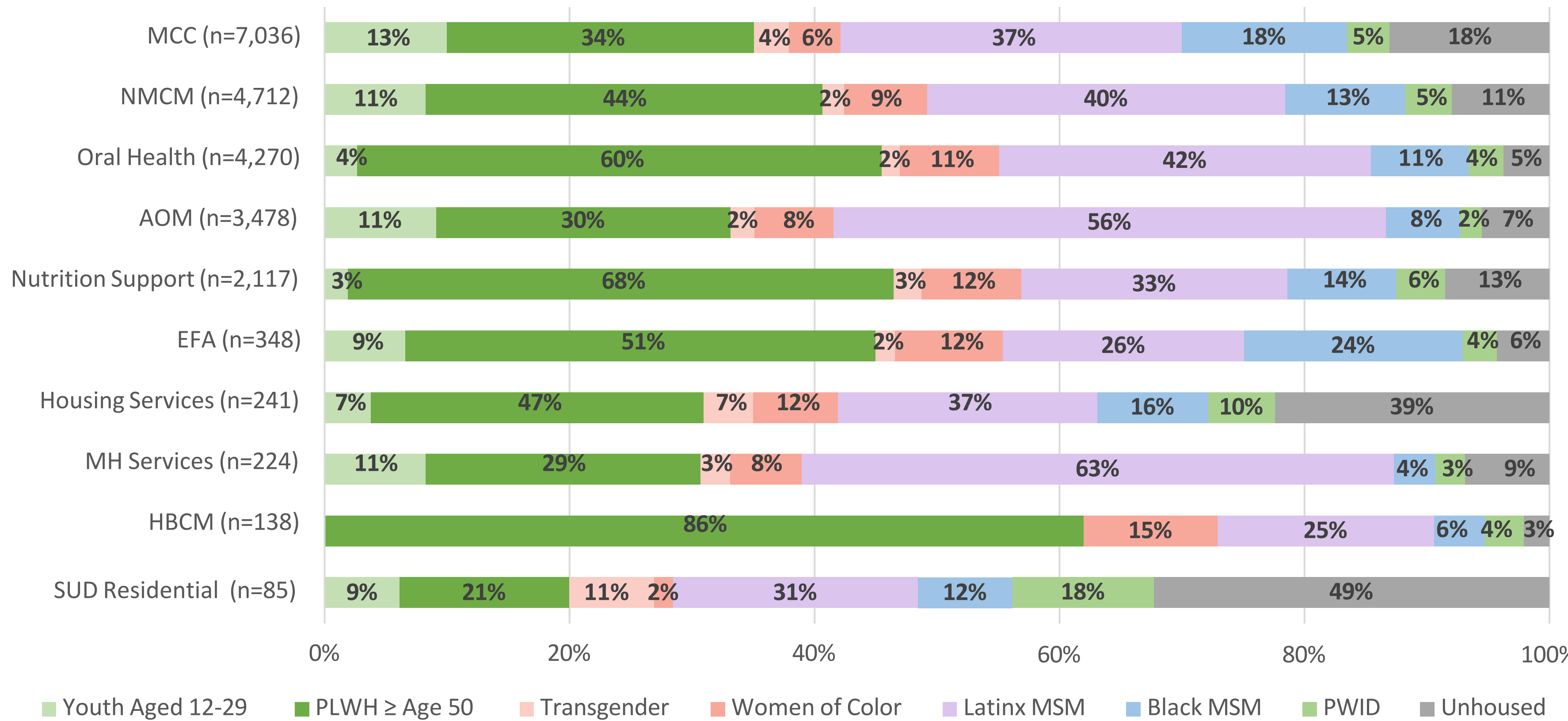
Figure 4. Service Usage and Telehealth Usage among RWP Clients, Years 29-32 by quarter



SERVICE UTILIZATION AMONG PRIORITY POPULATIONS

In Year 32, the MCC, Non-Medical Case Management (NMCM) and Oral Health services were used by the highest number of RWP clients. The figure below presents use of each service category by priority populations.

Figure 5. Utilization of RWP Services by Service Categories and by Priority Populations, LAC, Year 32

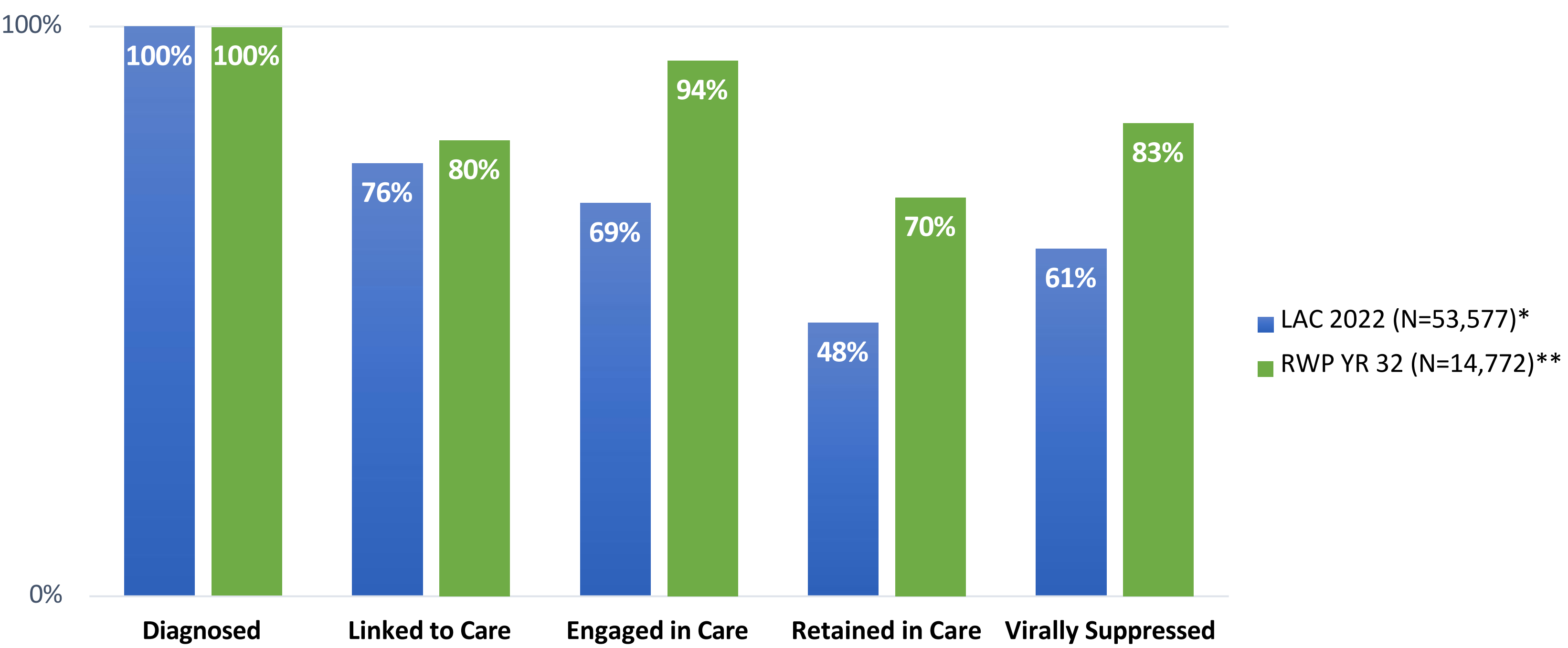


Among priority populations, the highest usage of all services was among Latinx MSM and/or PLWH ≥ Age 50, with the exception of Housing and SUD Residential services where the highest percentage of people utilizing these services was among unhoused people.

HIV CARE CONTINUUM FOR RWP CLIENTS

Figure 6 below shows Health Care Continuum (HCC) outcomes for RWP clients compared to all PLWH in LAC. Higher proportions of RWP clients were linked to care within 30 days of diagnoses, engaged in care, retained in care (RiC) and achieved viral suppression (VS) in RWP Year 32 compared to all PLWH in LAC. Of the 14,772 clients who received RWP services in Year 32, 94% were engaged in care, 70% were retained in care (RiC), and 83% achieved viral suppression (VS) in the past 12 months.

Figure 6: HIV Care Continuum Comparing People Living with Diagnosed HIV and Ryan White Program Clients in Year 32, Los Angeles County

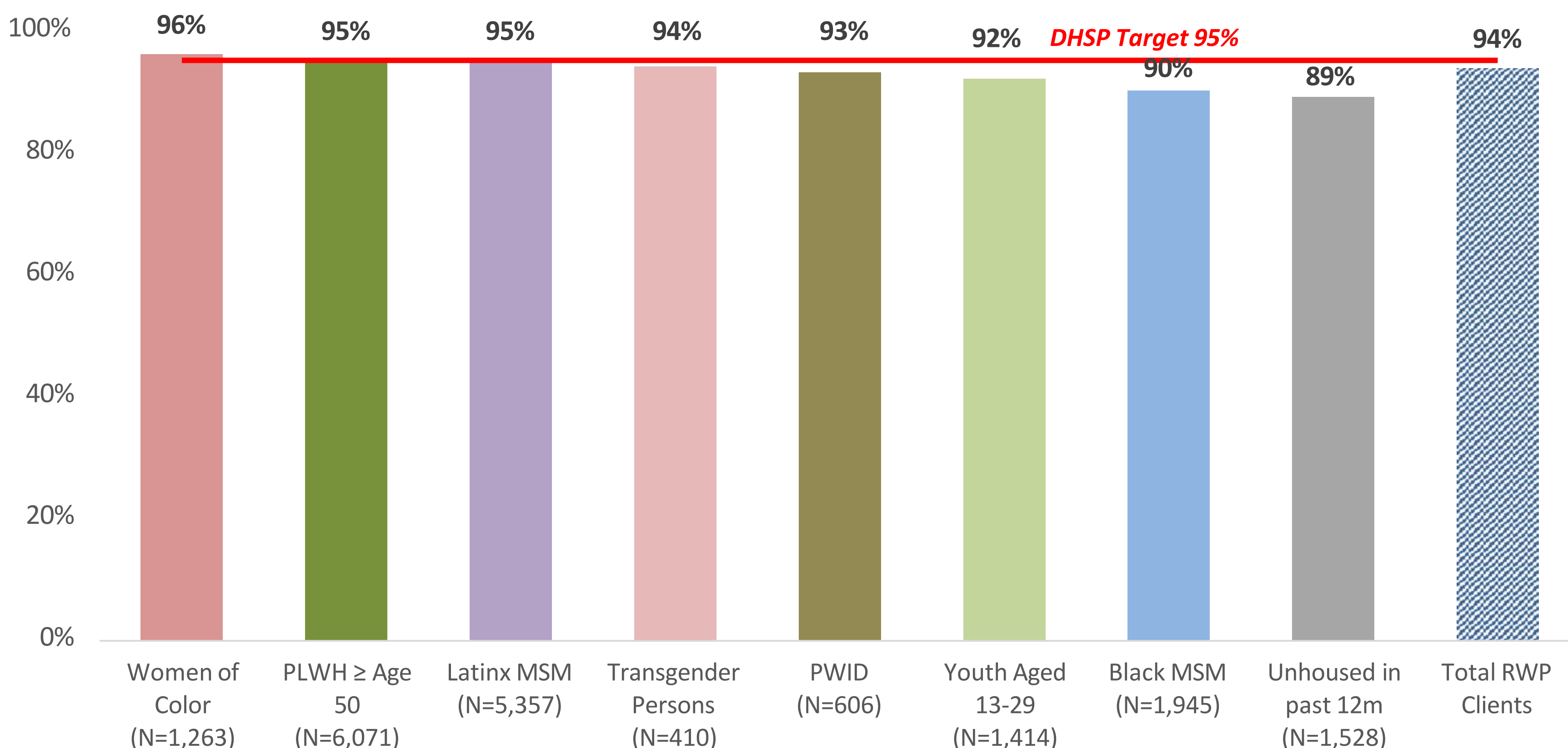


*LAC surveillance data for calendar year 2022 (Jan-Dec 2022)
**CaseWatch data for RWP year 32 (Mar 2022-Feb 2023)

- ***Engagement in HIV Care***

Figure 7 shows engagement in HIV care defined as having ≥1 HIV laboratory test (viral load, CD4 or genotype test) reported in the 12 months before the end of the reporting period among priority populations. Engagement in care for RWP clients was the highest among women of color (96%), following by PLWH ≥ 50 year of age and Latinx cisgender MSM (95% each). Engagement in care was lowest for Black cisgender MSM (90%) and unhoused in past 12 months (89%).

Figure 7: Engagement in HIV Care among Priority Populations Served by Ryan White Program in Year 32, Los Angeles County[1]

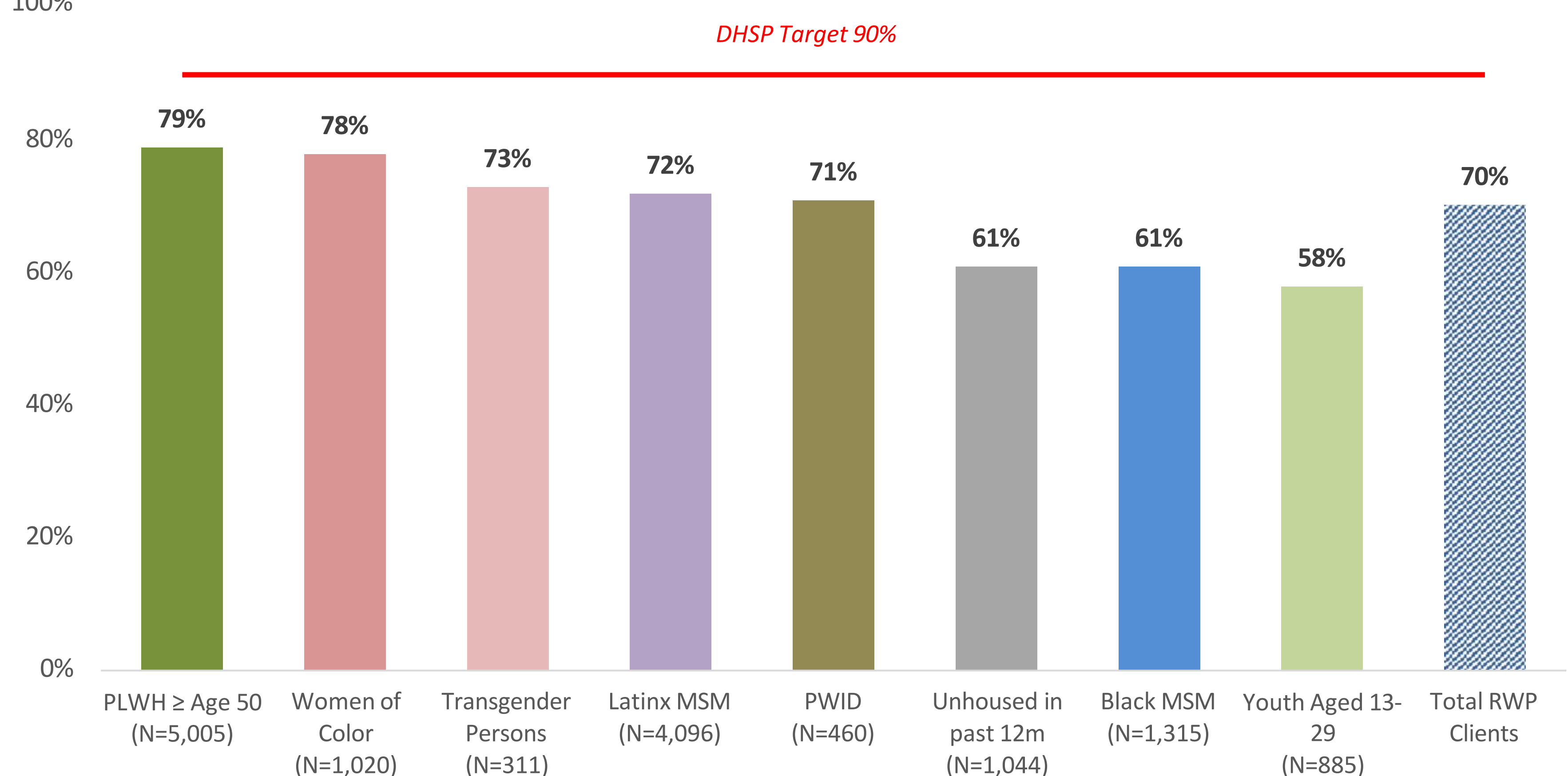


[1]CaseWatch Data for RWP year YR32 (from 03/01/2022 – 02/28/2023)

- ***Retention in Care***

Figure 8 shows retention in care (having ≥2 HIV laboratory tests (viral load, CD4 or genotype test) reported at >90 days apart in the 12 months before the end of the reporting period) among priority populations. The percent of RWP clients retained in care was the highest for PLWH aged 50 and older (79%) and cisgender women of color (78%). Retention in care was lowest among youth aged 13-29 (58%).

Figure 8: Retention in Care among Priority Populations Served by Ryan White Program in Year 32, Los Angeles County[1]

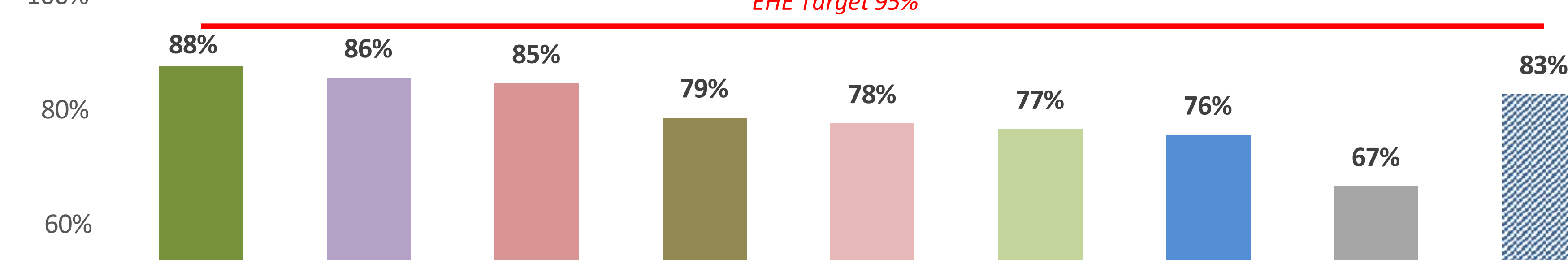


[1]CaseWatch Data for RWP year YR32 (from 03/01/2022 – 02/28/2023)

- ***Viral Suppression***

Figure 9 shows viral suppression (viral load <200 copies/ml at most recent test reported in the 12 months before the end of the reporting period) among priority populations. Among priority populations, the percent of RWP clients who were virally suppressed was the highest for clients aged 50 and older (88%), and the lowest for people who were experiencing homelessness in past 12 months (67%).

Figure 9: Viral Suppression among Priority Populations Served by Ryan White Program in Year 32, Los Angeles County[1]



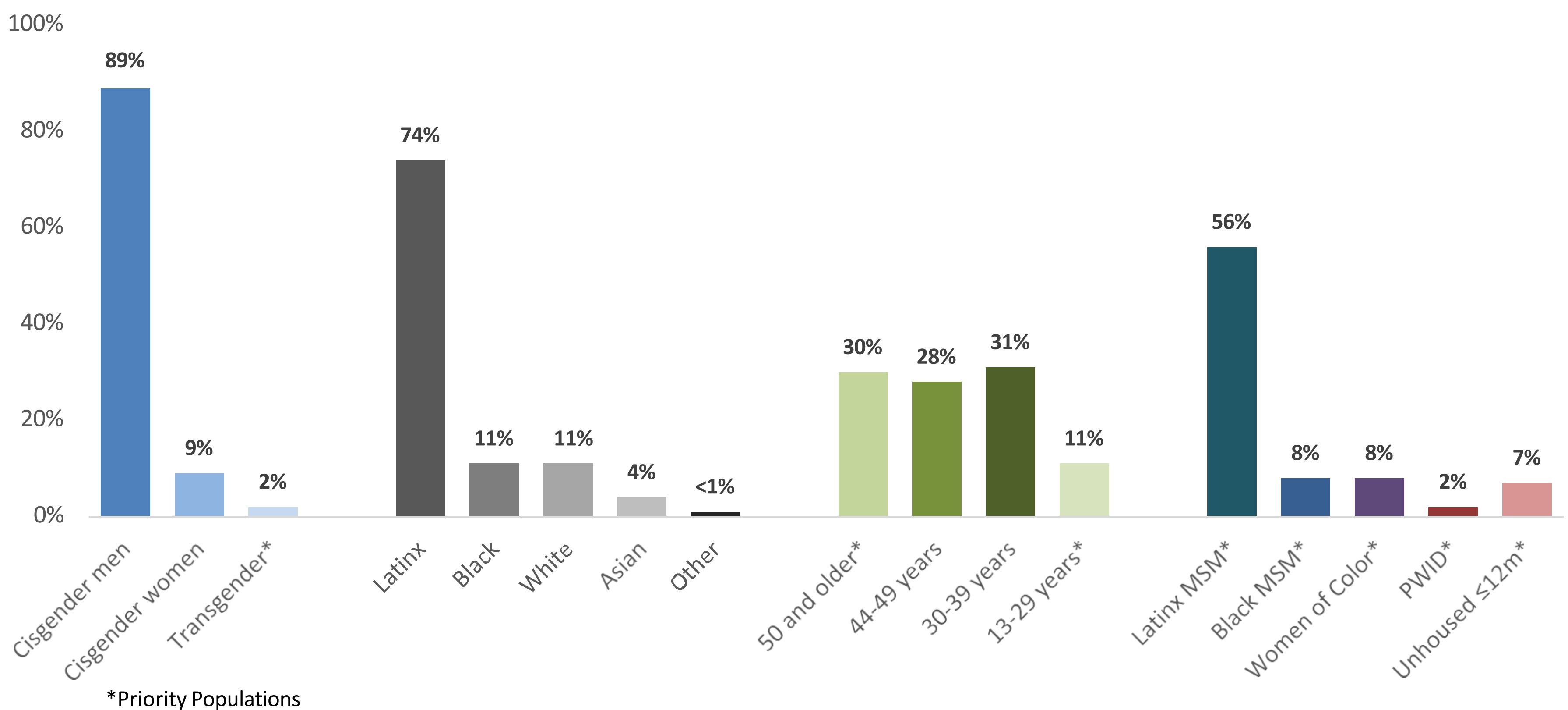
[1]CaseWatch Data for RWP year YR32 (from 03/01/2022 – 02/28/2023)

Please see the supplemental tables for details on changes in HCC outcomes over time.

AMBULATORY OUTPATIENT MEDICAL (AOM)

- ***Population Served:***
  - 3,478 clients received AOM services in Year 32.
  - Among those the highest percentages of clients receiving AOM services were among cisgender men, Latinx, aged 30-39 years old and PLWH ≥ Age 50, MSM, and residing in Hollywood-Wilshire HD.
  - By priority populations the highest percentage receiving AOM services was among Latinx MSM (56%) followed by clients aged 50 years and older (30%). (Figure 10)

Figure 10. Demographic Characteristics and Priority Populations among AOM Clients in LAC, Year 32

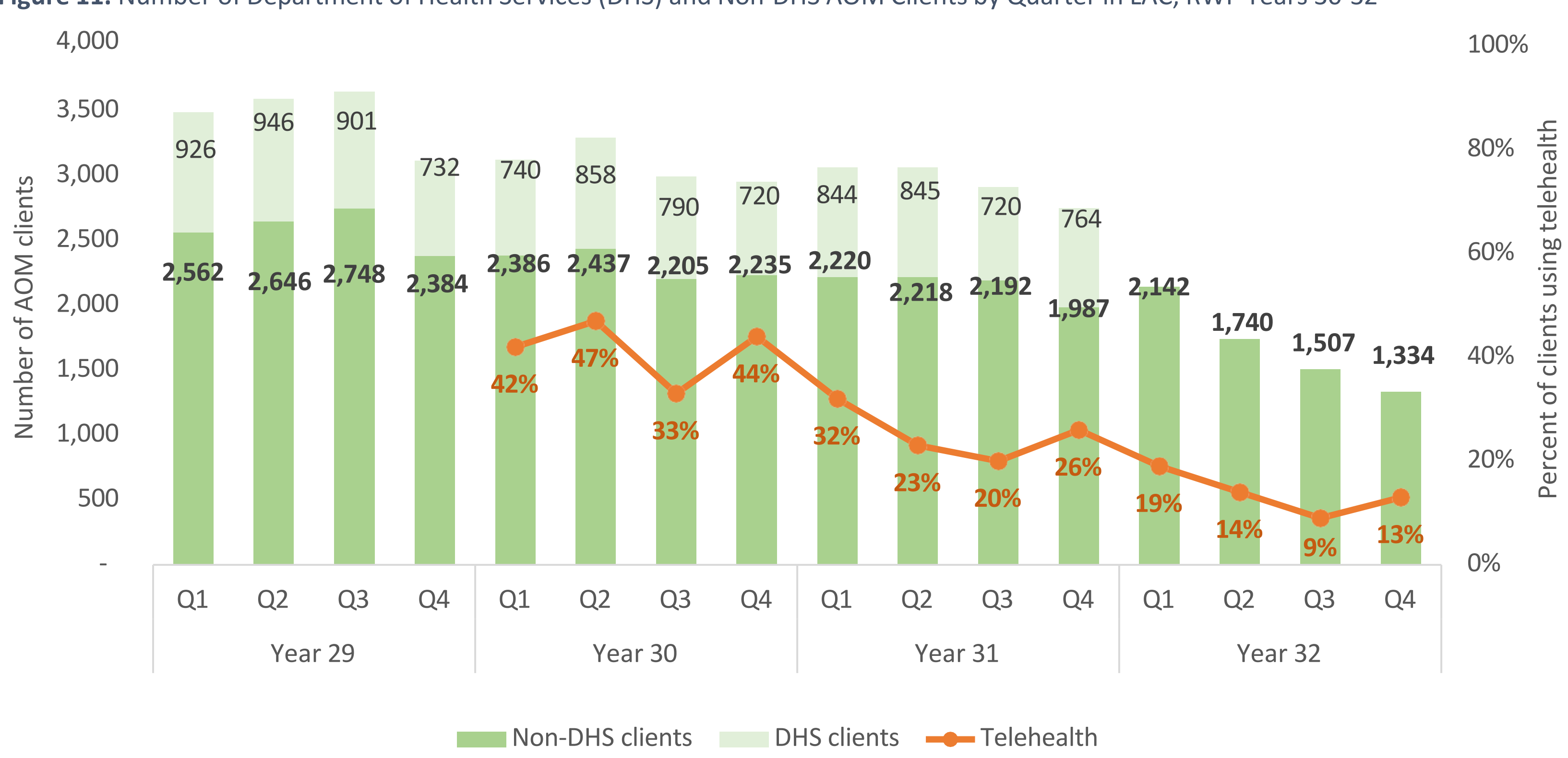


- ***Telehealth:***

Figure 11 below shows the number of RWP clients accessing AOM services in Years 29-32 by quarter to show the impact of the COVID-19 pandemic on AOM utilization as well as the departure of the LAC Department of Health Services (DHS) from the RWP system in Year 32. The light green part of the bar shows the number of DHS clients. The darker green part of the bar shows the number of all other (non-DHS) clients. The total number of AOM clients decreased starting in quarter 1 of Year 32; however, we can see the utilization of AOM services by non-DHS clients has decreased.

The orange line shows the percent of AOM services that were utilized through telehealth modalities. About 23% of AOM visits were offered via telehealth in Year 32. This is lower than telehealth percentage in Year 31 (39%), however it remains an important mode of healthcare for certain populations, including White (27%), non-binary/non-conforming gender identity (50%), incarcerated ever (37%), people experiencing homelessness (22%), PWID (32%), and residing in Hollywood-Wilshire HD (27%).

Figure 11. Number of Department of Health Services (DHS) and Non-DHS AOM Clients by Quarter in LAC, RWP Years 30-32



- ***Service Utilization and Expenditures:***
  - Year 32 Funding Sources: **RWP Part A (100%)**
  - Percentage of RWP Clients Accessing AOM in Year 32: **24%**
  - Unit of Service: **Visits**

Table 1. AOM Service Utilization and Expenditures among RWP Clients in LAC, Year 32

Priority Populations	Unique Clients	% of Clients	Total Visits	% of Visits	Visits per Client	Estimated Expenditures per Client	Estimated Expenditures by Subpopulation
Total AOM clients	*3,478*	*100%*	*8,891*	*100%*	*2.6*	*$1,692*	*$5,884,932 (Part A)*
Latinx MSM	1,961	**56%**	5,306	**60%**	**2.7**	**$1,791**	$3,511,936
PLWH ≥ Age 50	1,045	30%	2,622	29%	2.5	$1,661	$1,735,450
Youth Aged 12-29	397	11%	844	9%	2.1	$1,407	$558,627
Women of Color	282	8%	756	9%	**2.7**	**$1,774**	$500,381
Black MSM	263	8%	513	6%	2.0	$1,291	$339,544
Unhoused in past 12 m	241	7%	529	6%	2.2	$1,453	$350,135
Transgenders Persons	84	2%	202	2%	2.4	$1,592	$133,700
Persons who inject drugs (PWID)	75	2%	193	2%	2.6	**$1,703**	$127,743

Table 1 Highlights

- *Population Served:* Approximately two-thirds of clients accessing AOM services were MSM of color (64%): 56% Latinx MSM and 8% Black MSM.
- *Service Utilization:*
  - About two-thirds of the total AOM visits were attended by MSM of color (66%): 60% by Latinx MSM and 6% by Black MSM.
  - Visits per client were highest among Latinx MSM and women of color (2.7 visits per client each) and lowest among Black MSM (2.0 visits per client) compared to total AOM clients and other subpopulations.
  - The percent of AOM visits was higher relative to their population size among Latinx MSM and women of color represented (56% vs 60% and 8% vs 9%).
- *Expenditures:*
  - Latinx MSM, women of color, and PWID had higher expenditures per client than the average for all AOM clients ($1,692)
  - Compared to the percent out of total AOM clients, Latinx MSM, women of color, and PWID (1-2%) had disproportionally higher expenditures per client

- ***Health Care Continuum (HCC) Measures***

Table 2 below shows HCC outcomes for RWP clients receiving AOM services in Year 32. AOM clients had better HCC outcomes compared to RWP clients who did not receive AOM services.

Table 2. HIV Care Continuum Outcomes for AOM Clients and non-AOM Clients in LAC, Year 32

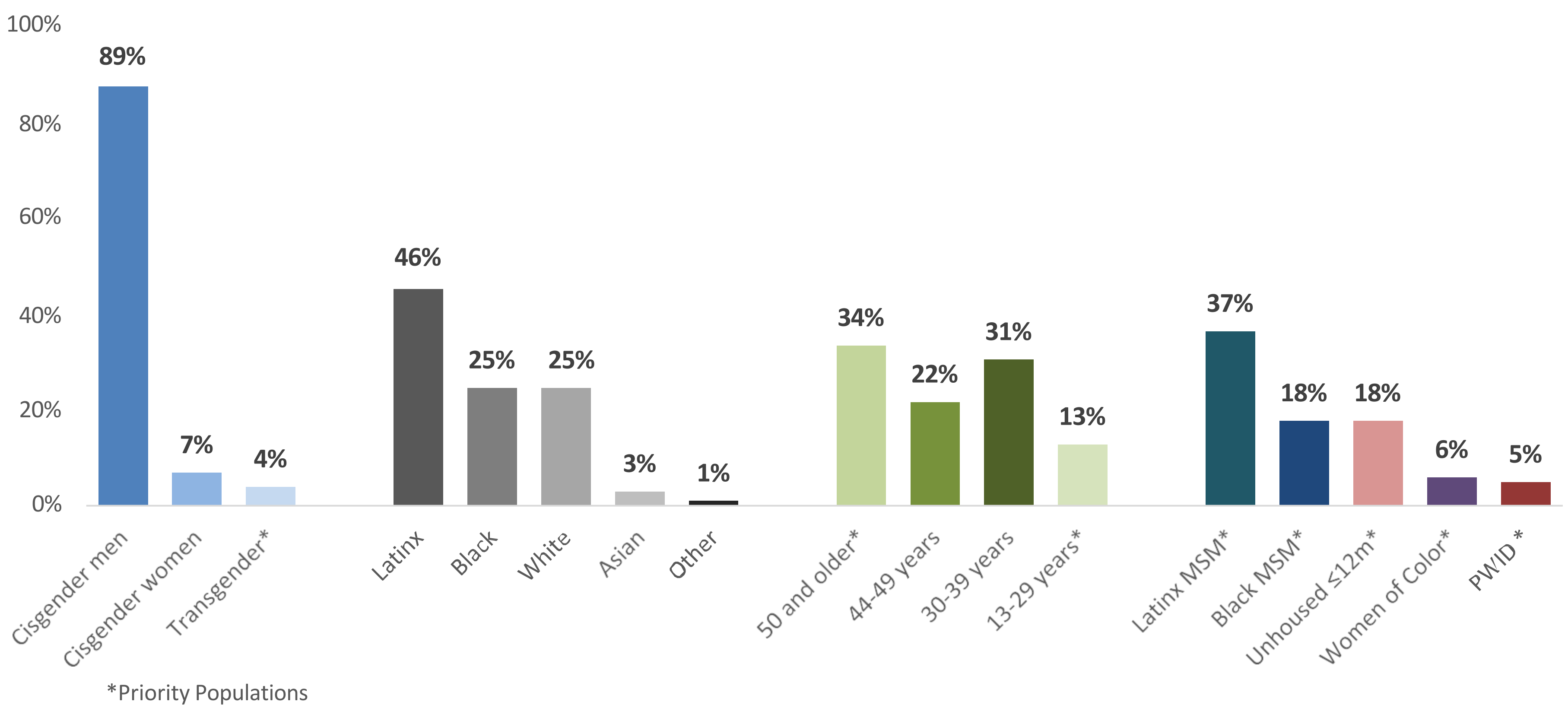
HCC Measures	AOM clients		Non-AOM clients	
	N	Percent	N	Percent
Engaged in HIV Care [a]	3,421	98%	10,425	92%
Retained in HIV Care[b]	2,586	74%	7,795	69%
Suppressed Viral Load at Recent Test[c]	2,164	89%	9,170	81%

[a]Defined as having ≥1 HIV laboratory test (viral load, CD4 or genotype test) reported in the 12 months before the end of the reporting period
[b]Defined as having ≥2 HIV laboratory tests (viral load, CD4 or genotype test) reported at >90 days apart in the 12 months before the end of the reporting period
[c]Defined as viral load <200 copies/ml at most recent test reported in the 12 months before the end of the reporting period

MEDICAL CARE COORDINATION (MCC)

- ***Population Served:***
  - 7,036 clients received MCC services in Year 32.
  - Among those the highest percentages of clients receiving MCC services were among cisgender men, Latinx, aged 50 and older, MSM, and residing in Hollywood-Wilshire HD.
  - By priority populations the highest percentage receiving MCC services was among Latinx MSM (37%) and PLWH ≥ Age 50 (34%). (Figure 12)

Figure 12. Demographic Characteristics and Priority Populations among MCC Clients in LAC, Year 32

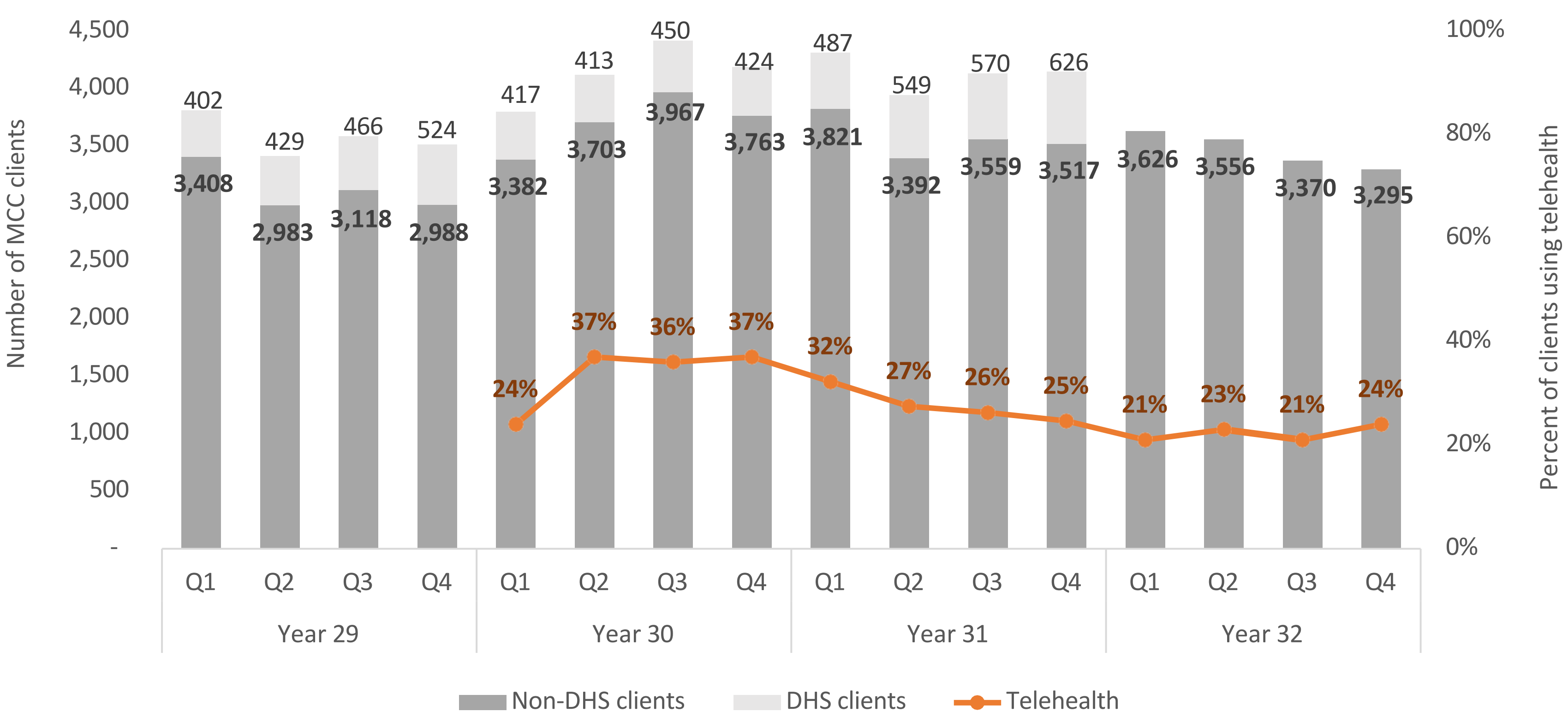


- ***Telehealth:***

Figure 12 below shows the number of RWP clients accessing MCC services in Years 29-32 by quarter to show the impact of the COVID-19 pandemic on MCC utilization as well as the departure of the LAC Department of Health Services (DHS) from the RWP system in Year 32. The light grey part of the bar shows the number of DHS clients. The darker grey part of the bar shows the number of all other (non-DHS) clients. The total number of MCC clients decreased starting in quarter 1 of Year 32; however, we can see the utilization of MCC services by non-DHS clients has remained stable.

The orange line shows the percent of MCC services that were utilized through telehealth modalities. About 35% of MCC visits were offered via telehealth in Year 32. Although it is lower than the telehealth percentage in Year 31 (46%), it remains an important mode of healthcare for certain populations, such as Latinx (37%), transgender (48%), incarcerated over 2 years ago (38%), and unhoused in past 12 m (38%), PWID (74%), and residing in Hollywood-Wilshire HD (34%).

Figure 12. Telehealth Usage among MCC Clients, Years 30-32 by Quarter, LA County



- ***Service Utilization and Expenditures:***
  - Year 32 Funding Sources: **RWP Part A (92%), MAI (8%)**
  - Percentage of RWP Clients Accessing MCC in Year 32: **48%**
  - Unit of Service: **Hours**

Table 3. MCC Service Utilization and Expenditures among RWP Clients in LAC, Year 32

Priority Populations	Unique Clients	% of Clients	Total Hours	Hours per Client	Percent of Hours	Expenditures per Client	Estimated Expenditures by subpopulation
Total MCC clients	***7,036***	***100%***	***91,401***	***13.0***	***100%***	***$1,375***	***$8,918,584 (Part A), $752,548 (MAI)***
Latinx MSM	2,628	37%	33,835	12.9	37%	$1,361	$3,577,401
PLWH ≥ Age 50	2,369	34%	33,470	14.1	37%	$1,494	$3,538,809
Black MSM	1,276	18%	14,957	11.7	16%	$1,239	$1,581,415
Unhoused in past 12 m	1,234	**18%**	22,235	18.0	**24%**	**$1,905**	$2,350,924
Youth (29 years and younger)	942	13%	12,122	12.9	13%	$1,361	$1,281,668
Women of Color	403	6%	7,498	**18.6**	8%	**$1,967**	$792,769
Persons who inject drugs (PWID)	330	5%	6,674	**20.2**	7%	**$2,138**	$705,647
Transgender Persons	265	4%	4,131	15.6	5%	$1,648	$436,774

Table 3 Highlights

- *Population Served:* Over half of clients using MCC services in Year 30 were MSM of color - 37% were Latinx MSM and 18% were Black MSM.
- *Service Utilization:*
  - Over half of the total MCC hours were used by MSM of color (53%): 37% by Latinx MSM and 16% by Black MSM.
  - Hours per client were highest among PWID (20.2 hours per client) and women of color (18.6 hours per client), and the lowest among Black MSM (11.7 hours per client) compared to total MCC clients and other subpopulations.
  - Unhoused MCC clients representing 18% of all MCC clients used the higher number of MCC hours per client (24%).
  - The percent of MCC hours was higher relative to their population size among women of color, transgender, PLWH ≥ Age 50, and PWID
  - The percent of MCC hours was lower relative to their population size among Black MSM
- *Expenditures:*
  - PWID had the highest expenditures per client ($2,138), followed by women of color ($1,967) and unhoused ($1,905)
  - PWID, women of color, unhoused, transgender, PLWH ≥ Age 50 had higher expenditures per client than the average for all MCC clients
  - Compared to the population size, unhoused people, PLWH ≥ Age 50, women of color and PWID had disproportionally higher expenditures per client

- ***Health Care Continuum (HCC) Measures***

Table 4 below shows HCC outcomes for RWP clients receiving MCC services in Year 32. RWP clients receiving MCC services in Year 32 had worse HCC outcomes compared to RWP clients who were not enrolled in the MCC program.

Table 4. Health Care Continuum among MCC Clients and non-MCC Clients in LAC, Year 32

HCC Measures	MCC clients		Non-MCC clients	
	N	Percent	N	Percent
Engaged in HIV Care[a]	6,395	91%	7,451	96%
Retained in HIV Care[b]	4,380	62%	6,001	78%
Suppressed Viral Load at Recent Test[c]	6,836	77%	5,441	88%

[a]Defined as having ≥1 HIV laboratory test (viral load, CD4 or genotype test) reported in the 12 months before the end of the reporting period
[b]Defined as having ≥2 HIV laboratory tests (viral load, CD4 or genotype test) reported at >90 days apart in the 12 months before the end of the reporting period
[c]Defined as viral load <200 copies/ml at most recent test reported in the 12 months before the end of the reporting period

SUMMARY OF FINDINGS

Service use and expenditures vary by service category and by priority populations. This variation may be influenced by the priority population size, underlying characteristics within each priority and priority population such as health status, income, housing status or neighborhood of residence, service need or service access and others. Main findings for service utilization are presented below in Table 5.

Table 5. Summary of Findings for RWP Service Utilization in LAC, Year 32

	RWP	AOM	MCC
Primary Populations Served	• Latinx and Black • Cisgender male • PLWH ≥ Age 50 • MSM	• Latinx • Cisgender male • PLWH aged 30-39 and ≥ Age 50 • MSM	• Latinx • Cisgender male • PLWH ≥ Age 50 • MSM
Utilization over time	• Decreased over time by 6% from Year 28 and 13% from Year 31 due to exit of DHS from RWP	• 35% lower number of RWP clients in Year 32 compared to Year 31 due to DHS exit from RWP	• 15% decrease in the number of MCC clients in Year 32 compared to Year 31, due to DHS exit from RWP
Telehealth	• Telehealth usage decreased to 25% compared to Year 31 (43%). The highest telehealth usage among: - Latinx - Non-binary and transgender clients - PWID - Unhoused	• 23% of AOM services provided via telehealth. The highest telehealth usage among: - Non-binary clients - Unhoused - PWID	• About 35% of MCC services were provided via telehealth in Year 32. The highest telehealth usage among: - Transgender people - Women of Color - Unhoused - PWID
HCC outcomes	• The lowest percentage of engagement in care was among unhoused people and Black MSM • The lowest percentage of RWP clients RiC was among youth aged 13-29, Black MSM and unhoused • The lowest percentage of VS was among unhoused	• AOM clients had higher engagement and RiC and VS compared to non-AOM clients	• MCC clients had lower engagement, RiC and VS compared to non-MCC clients
Service Units per Client	N/A (units vary)	3 visits per client	13 hours per client
Expenditures	$45.9 million: $42.1 million - Part A $3.8 million - MAI	Total $5,884,932 (Part A) $1,692 per client	$8,918,584 (Part A), $752,548 (MAI) $1,375 per client

Latinx MSM	• The largest populations receiving RWP services • About 25% of Latinx MSM received RWP services via telehealth • The 3rd highest percentage of engagement in HIV care • The 2nd highest percentage of VS • The highest percentage of Spanish-speakers • The highest percentage of uninsured	• Represented over a half of all AOM clients (56%) and accounted for about 60% percentage of services provided • Among priority populations average numbers of visits and expenditures were higher than respective average numbers for all AOM clients • The highest per client visits and expenditures among priority populations	• 37% MCC clients and accounted for the same percentage of services provided • Average number of visits and expenditures were slightly lower than respective average numbers for all MCC clients
Black MSM	• About 4% of all RWP clients in • About 25% received RWP services via telehealth • Over 2/3 were living ≤ FPL	• 8% of all AOM clients and accounted for about 6% percentage of services provided • Average number of visits and expenditures were lower than respective average numbers for all AOM clients • The lowest per client visits and expenditures among priority populations • Reasons for slightly low AOM service utilization are unclear but may reflect poor service engagement, low service access, ineffective service provision, stigma or other client-provider or system-level determinants.	• 18% of all MCC clients and accounted for about 16% of services provided • Average number of visits and expenditures were lower than respective average numbers for all MCC clients • The lowest per client visits and expenditures among priority populations • Reasons for slightly low MCC service utilization are unclear but may reflect poor service engagement, low service access, ineffective service provision, stigma or other client-provider or system-level determinants.
Youth 13-29 years old	• 12% of all RWP clients • A quarter of youth used RWP via telehealth • The 3rd highest percentage of uninsured among priority populations • The lowest percentage of RiC among priority populations	• 11% of all AOM clients but accounted for 9% of AOM services • Lower per client service units (visits) and expenditures than average for all AOM clients • Reasons for low AOM service utilization are unclear but may reflect	• 13% of all MCC clients and accounted for the same percentage of service hours provided • Lower per client service hours and expenditures than the average for all MCC clients

		poor service engagement, low service access, ineffective service provision, stigma or other client-provider or system-level determinants.	• One of the lowest utilizers of MCC services as demonstrated by the percentage of total visits they received and average hours per client.
PLWD ≥ Age 50	• Over a third of all RWP clients • 22% received RWP services via telehealth • The 2nd highest percentage of engagement in care among priority populations • The highest percentage of RiC and VS among priority populations • The highest percentage of people living ≤ FPL and PWID • The 2nd highest percentage of uninsured, Spanish-speaking, and unhoused people	• 30% of all AOM clients and accounted for 29% of AOM services • One of the highest utilizers of AOM services as demonstrated by the percentage of total visit. • Moderately lower per client service units (visits) and expenditures than respective average for all AOM clients	• 34% of all MCC clients and accounted for 37% of services provided • One of the highest utilizers of MCC services as demonstrated by the percentage of total hours they received and average hours per client • Expenditures per client were above the average for all MCC clients
Women of Color	• 8% of RWP clients • About 20% received RWP services via telehealth • The highest percentage of engagement in HIV care among priority populations • The 2nd highest percentage of RiC among priority populations	• 8% of all AOM clients and accounted for 9% of services provided • The second highest utilizers of AOM services as demonstrated by the number of visits per client. • The second highest per client expenditures for AOM services among priority populations	• 6% of all MCC clients and accounted for 8% of services provided • The highest utilizers of MCC services as demonstrated by the number of hours per client • The 2nd highest per client expenditures for MCC services among priority populations
Transgender clients	• 4% of all RWP clients • 20% received RWP services via telehealth • The highest percentage of unhoused people • The 2nd highest percentage of people living ≤ FPL	• 2% of all AOM clients and accounted for the same percentage of services provided • Lower per client visits and expenditures than respective averages for all AOM clients	• 4% of MCC clients and accounted for 5% of services provided • Average number of service hours and expenditures were considerably higher than respective average numbers for all MCC clients

		• Reasons for slightly low AOM service utilization are unclear but may reflect poor service engagement, low service access, ineffective service provision, stigma or other client-provider or system-level determinants.	
Unhoused in past 12m	• 18% of all RWP clients • About 22% received RWP services via telehealth • The highest percent of people living ≤ FPL and PWID	• 7% of clients receiving AOM service and 6% percentage of services provided • Average number of visits and expenditures were lower than respective average numbers for all AOM clients	• 18% of clients receiving MCC service and accounted for 24% percentage of services provided • Average number of visits and expenditures were considerably higher than respective average numbers for all MCC clients • High utilization of MCC services by unhoused people may be reflective of complexity of social and behavioral issues in this subpopulation.
PWID	• 5% of RWP clients • About 16% received RWP services via telehealth • The 2nd highest percentage of unhoused in past 12 m	• 2% of clients receiving AOM service and accounted for the same percentage of services provided • Average number of visits and expenditures were higher than respective average numbers for all AOM clients • The 2nd highest number of per client AOM visits among priority populations • The 3rd highest per client expenditures for AOM services among priority populations	• 5% of clients receiving MCC service and accounted for 7% of services provided • Average number of visits and expenditures were considerably higher than respective average numbers for all MCC clients • The highest number of per client hours of MCC service among priority populations • The highest per client expenditures for MCC services among priority populations

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AMBULATORY OUTPATIENT MEDICAL (AOM) SERVICE STANDARDS

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

SERVICE INTRODUCTION

HIV/AIDS medical outpatient --referred to as "Ambulatory Outpatient Medical" herein—services are up-to-date educational, preventive, diagnostic and therapeutic medical services provided by licensed health care professionals with requisite training in HIV/AIDS. Such services will include care for people living with HIV (PLWH) throughout the entire continuum of the disease.

Ambulatory Outpatient Medical (AOM) services include:

- Medical evaluation and clinical care including sexual history taking
- Medical specialty services
- Medical care coordination
- Adherence counseling
- Laboratory testing (including drug resistance and other specialized tests)
- Nutrition therapy
- HIV prevention in ambulatory/outpatient settings
- Sexually transmitted infection (STI) prevention and testing

The goals of MO services include:

- Interrupting or delaying the progression of HIV disease and STIs
- Preventing and treating opportunistic infections
- Promoting optimal health
- Interrupting further HIV and STI transmission by providing the background for appropriate behavioral change

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

MEDICAL SPECIALTY SERVICES

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

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

Facilities providing MO services must be:

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

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

MEDICAL SPECIALTY SERVICES

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

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

ADHERENCE COUNSELING

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

NUTRITION SCREENING AND REFERRAL

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

Either the provider's own medical nutrition therapy program or a program to which they refer will operate under the direct supervision of a registered dietitian or nutritionist consistent with California Business and Professions Code section 2585-2586.8. Registered dietitians providing medical nutrition

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

SERVICE CONSIDERATIONS

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

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

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

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

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

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

Medical Care Coordination Services: All MO programs must partner with medical care coordination services, either directly or through cooperative agreements. Medical care coordination services are supervised and overseen by a team consisting of a registered nurse and a master’s level patient care manager.

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

Common Service Components: Common service components include:

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

SERVICE COMPONENTS

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

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

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

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

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

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

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

- Initial assessment and reassessment
- Follow-up treatment visits
- Additional assessments
- Laboratory assessment and diagnostic screening (including drug resistance testing)
- Medication service
- Antiretroviral (ARV) therapy
- Treatment adherence counseling
- Health maintenance
- Clinical trials
- Primary HIV nursing care
- Medical specialty services
- Nutrition screening and referral

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

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

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

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

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

MEDICAL EVALUATION AND CLINICAL CARE

MO programs must confirm the presence of HIV infection and provide tests to diagnose the extent of immunologic deficiency in the immune system. Additionally, programs must provide diagnostic and therapeutic measures for preventing and treating the deterioration of the immune system and related

conditions that conform to the most recent clinical protocols. At minimum, these services include regular medical evaluations; appropriate treatment of HIV infection; and prophylactic and treatment interventions for complications of HIV infection, including opportunistic infections, opportunistic malignancies and other AIDS defining conditions.

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

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

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

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

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

INITIAL ASSESSMENT AND REASSESSMENT

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

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

General medical histories should include (at minimum):

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

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

- HIV treatment history and staging
    - Most recent viral load and CD4 count
    - Nadir CD4 and peak viral load
    - Current and previous ARV regimens
    - Previous adverse ARV drug reactions
    - Previous adverse reactions to drugs used for opportunistic infection prophylaxis
- History of HIV-related illness and opportunistic infections
- History of sexually transmitted diseases (STDs)
- History of tuberculosis (TB)
- History of hepatitis and hepatitis vaccines
- Psychiatric history
    - Diagnosed psychiatric diseases
    - Previous/current treatment for psychiatric diseases
    - Disability related to psychiatric disease
    - Homicidality and suicidality

- Sociocultural assessment
- Transfusion or blood product history, especially before 1985
- Review of sources of past medical care (obtaining past medical records whenever possible)
- HIV-specific review of systems
    - Skin
    - Eyes
    - Ear, nose, and throat
    - Stomatognathic
    - Pulmonary
    - Cardiovascular
    - Gastrointestinal/hepatic
    - Endocrine
    - Genitourinary
    - OB/GYN
    - Dermatologic
    - Musculoskeletal
    - Neurologic
    - Hematopoietic
    - Metabolic
- Sexual history
    - Sexual activity
    - Sexual practices
    - Gender identity
    - Past and current partners
    - Risk behavior assessment
- Substance use history
    - Past and current use and types of drugs, including alcohol
    - Frequency of use and usual route of administration
    - Risk behavior assessment
    - History of treatment
- Tobacco use history

Comprehensive physical exams should include (at minimum):

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

- Abdominal examination
- Genital examination
- Rectal examination
- Neurological examination

STANDARD		DOCUMENTATION
	Comprehensive baseline assessment will be completed by physician, NP, PA, or RN and updated, as necessary.	Comprehensive baseline assessment and updates/ follow-up treatment (as necessary) in patient medical chart to include: • General medical histories (at minimum): • History of present illness • Past hospitalizations, illnesses • Past immunizations • Travel history, place of birth • Sexual history • Occupational history • Pets/animal exposures • Current treatment, medicines • Allergies • Full review of systems • Mental health • Comprehensive HIV-related histories (at minimum): • HIV treatment history and staging • History of HIV-related illness and infections • History of sexually transmitted diseases • History of TB • History of hepatitis and vaccines • Psychiatric history • Sociocultural assessment • Transfusion/blood product history • Past medical care review and obtaining medical records • HIV-specific review of systems • Sexual history • Substance use history • Tobacco use history • Comprehensive physical exams (at minimum): • Temperature, vital signs, height, and weight • Pain assessment • Ophthalmologic • Ears, nose, and throat • Dermatological

		• Lymph node • Oral • Pulmonary • Cardiac • Abdominal • Genital • Rectal • Neurological

FOLLOW-UP TREATMENT VISITS

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

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

Follow-up visits should record and address:

- Temperature, vital signs, height, and weight
- Problems list status and updates including sexual history
- Pain assessment
- Adherence with the treatment plan
- In addition to regularly scheduled viral load measurements (see Laboratory Assessment and Diagnostic Screening), viral load also should be measured according to prevailing medical standards and current guidelines.
- Resistance testing should be performed (if feasible) for patients when viral failure to ARV has been demonstrated and/or when suboptimal suppression of viral load occurs (see more detailed discussion in Drug Resistance Testing)
- Laboratory tests (as outlined in Laboratory Assessment and Diagnostic Screening)
- Prophylaxis for opportunistic infections offered to each patient as indicated by immune status. Refer to current guidelines and prevailing standards for prophylaxis of opportunistic infections from DHHS Guidelines for Opportunistic Infections (www. aidsinfo.nih.gov/). Documentation of current therapies should be maintained on all patients receiving prophylaxis.
- HIV-infected women should have a documented cervical Pap smear dated within the last year. Normal smears should be followed with a second smear in six months. If both results are negative, subsequent Pap smears should be performed annually. Smears showing severe inflammation or reactive changes should be reevaluated within three to six months.

- Diagnosis of SIL or atypical squamous cells of undetermined significance should be followed with colposcopic examination of the lower genital tract. Inquire about last menstrual period and contraception, when appropriate.
- Regular discussions of family planning and contraception should be conducted with female patients. For patients who are pregnant, the medical provider should discuss pregnancy and treatment options.
- Anal and rectal exams should be performed at least annually. Baseline and periodic anal Pap smears for high-risk populations may be considered, with appropriate referral to specialists for high resolution anoscopy for those patients with abnormal results. (As this is an area of emerging data, any newly adopted national guidelines are recommended if/when they are disseminated.)
- For patients who have no history of TB or positive PPD tests, a PPD test or Interferon Gamma Release Assay (IGRA) should be performed at least annually, with results recorded. Record attempts to follow up with patients who do not return for PPD reading. For all positive IGRA tests and PPD tests of at least five millimeters of induration, a chest X-ray should be obtained to rule out active pulmonary disease, and, if appropriate, prophylaxis should be given. If there is a history of a positive PPD or IGRA, any record of prophylactic treatment should be noted in the chart. Risk assessment for TB should be assessed annually with a symptom screen to detect acute disease.
- Advance directives, durable powers of attorney, living wills and other planning documents, including POLST (physician's orders for life sustaining treatment) and DNR (do not resuscitate) status, should be addressed at the beginning of treatment and at any appropriate time in the course of the illness.
- Patients with CD4 counts below 50 should be referred for ophthalmic examination by a trained retinal specialist for screening or as recommended by that specialist, according to prevailing medical standards and current guidelines.
- Follow-up should be conducted as recommended by the specialist or clinical judgment.
- Documentation of discussions of safer sex practices for both men and women. Patients in sero-discordant relationships should be educated about options for HIV pre-exposure prophylaxis (PrEP) or post-exposure prophylaxis (PEP) for their partners. Referrals for PrEP and PEP should be made for these partners.

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

- Providing brief HIV and STI prevention messages (asking patients about risk behaviors, and positively reinforcing patient's report of risk reduction behavior)
- Asking patients about problems and concerns with medication adherence and making suggestions to support adherence (such as pill boxes, alarms)
- Screening patients' nutritional needs and referring them for medical nutrition therapy services when and as needed
- Asking patients about their social living conditions, ensuring that lack of housing, food or other social needs do not become a barrier to treatment adherence

- Providing patient education on HIV disease, symptoms, medications, and treatment regimens to increase patient participation in treatment decision-making (see www. IHI.org for Institute for Healthcare Improvement guidelines on "Self-Management"); patient education on medications will include instructions, risks and benefits, compliance, side effects and drug interaction
- Building and maintaining patient relationships, increasing the likelihood that patients may ask for needed emotional support, or talk with practitioners about substance abuse issues

STANDARD		**DOCUMENTATION**
	Follow-up visits for patients receiving ARV therapy should be scheduled every three to four months, except at the practitioner's discretion when a patient has demonstrated long-term stability and adherence in his/her medical regime. Follow-up visits should be scheduled every three to six months for patients who are not receiving ARV therapy. U.S. Public Health Standards require at least two visits annually. Follow-up visits should be scheduled more frequently at entry to care, when starting or changing ARV regimens, or for management of acute problems.	Patient medical chart to confirm frequency.
	Follow-up visits should include (at minimum): • Temperature, vital signs, height, and weight • Problems list and updates including sexual history • Pain assessment • Treatment plan adherence • Viral load at regular intervals and prior to and after ARV treatment initiation • Resistance testing (if necessary) for ARV viral failure • Suboptimal viral load suppression • Laboratory tests • Opportunistic infection prophylaxis and documentation • Annual (at minimum) cervical Pap smears for women • Annual (at minimum) anal and rectal exams • Annual (at minimum) PPD test, chest X-ray and • prophylaxis as indicated • Advance directives and planning documents addressed at treatment initiation and as indicated • Referral for ophthalmic examination for patients with CD4 counts below 50	Patient medical chart to confirm referrals and/or content of follow-up visits.

	• Family planning/contraception (for women) and safer sex discussions and documentation	
	Each patient encounter will include: • HIV and STI prevention messages • Treatment adherence counseling and support as needed • Nutrition screening, and referrals as needed • Social living conditions review • Patient education on HIV disease, symptoms, medications, and treatment regimens	Progress notes in patient chart to confirm.

OTHER ASSESSMENTS

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

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

The assessment should include:

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

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

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

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

performed as baseline, and follow-up screenings performed and documented in the medical charts at least annually.

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

LABORATORY ASSESSMENT AND DIAGNOSTIC SCREENING (INCLUDING DRUG RESISTANCE SCREENING)

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

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

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

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

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

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

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

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

<u>DRUG RESISTANCE TESTING</u>

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

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

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

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

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

MEDICATION SERVICES

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

STANDARD	DOCUMENTATION

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

ANTIRETROVIRAL (ARV) THERAPY

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

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

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

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

MEDICATION ADHERENCE ASSESSMENT

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

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

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

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

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

ONE-ON-ONE PATIENT EDUCATION

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

STANDARD		DOCUMENTATION
	Medical provider or treatment adherence counselors may provide one-on-on patient	Progress notes on file in patient chart to include (at minimum):

	support contacts to support patients as they seek and receive services. Support can include: • Accompanying patients to medical visits and clinical trials visits • Helping patients understand HIV disease and treatment options • Helping patients with adherence issues • Providing emotional support	• Date, time spent, type of contact • What occurred during the contact • Signature and title of the person providing the contact • Referrals provided, and interventions made (as appropriate) • Results of referrals, interventions and progress made toward goals in the individual service plan (as appropriate)

ONE-ON-ONE PATIENT SUPPORT

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

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

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

STANDARD HEALTH MAINTENANCE

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

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

- Cancer screening (cervical, breast, rectal — per American Cancer Society guidelines)
- Influenza vaccine
- Tetanus/diphtheria update
- Pneumovax

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

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

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

COMPLEMENTARY, ALTERNATIVE AND EXPERIMENTAL THERAPIES

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

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

CLINICAL TRIALS

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

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

PRIMARY HIV NURSING CARE

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

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

STANDARD		DOCUMENTATION
	RNs and/or other appropriate licensed health care providers in MO programs will provide primary HIV nursing care to include (at minimum): • Nursing assessment, evaluation, and follow-up	Documentation of primary HIV nursing care service provision on file in patient medical chart.

	• Triage • Consultation/communication with primary practitioner • Patient counseling • Patient/family education • Services requiring specialized nursing skill • Preventive nursing procedures • Service coordination in conjunction with medical care coordination	

MEDICAL SPECIALTY SERVICES HIV/AIDS

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

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

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

MEDICAL SPECIALTY REFERRAL

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

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

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

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

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

COORDINATION OF SPECIALTY CARE

It is imperative that MO programs and medical specialists coordinate their care to ensure integration of specialty treatment with primary HIV medical care. As noted above, MO programs must provide pertinent background clinical information in their referrals to medical specialists. In turn, specialists within the County-contracted system must provide to MO programs a written report of their findings within two weeks of seeing a referred patient. Medical specialists within the County-contracted system

must telephone MO programs within one business day in the event that urgent matters arise, to follow up on unusual findings or to plan a required hospitalization.

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

LETTERS OF AGREEMENT (LOAS)

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

LOAs should outline (at minimum):

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

STANDARD		DOCUMENTATION
	MO programs will have written LOAs or contracts with all medical specialists utilized.	LOAs or contracts on file at provider agency that include (at minimum): • Description of services • Fees • Restrictions on services • Confidentiality expectations and safeguards • Procedures for sharing client information

		• Timeframes • Follow-up requirements • Contact person • Policies and procedures • Reporting requirements • Participation in networks, case conferences or other meetings • Quality management activities

NUTRITION SCREENING AND REFERRAL

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

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

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

Changes in diagnosis requiring nutrition intervention

A referral to medical nutrition therapy must include:

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

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

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

STANDARD		DOCUMENTATION
	MO practitioners should screen all patients for nutrition-related concerns for all at-risk patients.	Record of screening for nutrition related problems noted in patient's medical chart.
	MO practitioners will provide a written prescription for all at-risk patients for medical nutrition therapy within six months of an individual becoming an active patient.	Record of screening for nutrition related problems noted in patient's medical chart.

	When indicated, patients will also be referred to nutrition therapy for: • Physical changes/weight concerns • Oral/GI symptoms • Metabolic complications and other medical conditions • Barriers to nutrition • Behavioral concerns or unusual eating behaviors • Changes in diagnosis	Record of linked referral on file in patient medical chart.
	Referral to medical nutrition therapy must include: • Written prescription, diagnosis, and desired nutrition outcome • Signed copy of patient's consent to release medical information • Results from nutrition-related lab assessments	Record of linked referral on file in patient medical chart.

MEDICAL CARE COORDINATION (MCC) SERVICES

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

MCC services shall include:

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

For additional details, please see the Medical Care Coordination Standard of Care, Los Angeles Commission on HIV, 2008.

STANDARD		DOCUMENTATION
	MO programs will provide medical care coordination services either directly or through cooperative agreement. Services are	Documentation of medical care coordination services and/or referral on file in patient medical chart.

	supervised by an RN and a master's level patient care manager and include: • Outreach • Intake • Comprehensive assessment/reassessment • Patient acuity assessment • Comprehensive treatment plan • Implementation and evaluation of comprehensive treatment plan • Referral and coordination of care • Case conferences • Benefits specialty services • HIV prevention, education, and counseling • Patient retention services	

HIV PREVENTION IN AMBULATORY/OUTPATIENT MEDICAL SETTINGS

HIV prevention is a critical component to ongoing care for people living with HIV. Prevention services provided in MO clinics include HIV counseling, testing and referral; partner counseling; prevention and medical care; and referral for intensive services.

PREVENTION AND MEDICAL CARE

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

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

HIV COUNSELING, TESTING AND REFERRAL FOR PARTNERS AND SOCIAL AFFILIATES

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

PARTNER COUNSELING AND REFERRAL SERVICES (PCRS)

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

REFERRAL FOR INTENSIVE SERVICES

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

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

	Programs must develop written prevention referral policies, procedures and protocols.	Prevention referral policies and procedures on file at provider agency.

PATIENT INTAKE

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

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

- Written documentation of HIV status
- Proof of Los Angeles County residency
- Verification of financial eligibility for services
- Date of intake
- Client name, home address, mailing address and telephone number
- Emergency and/or next of kin contact name, home address and telephone number

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

Completed forms are required for each patient:

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

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

	Consent for Services completed	Signed and dated Consent in patient file.
	Patient is informed of Rights and Responsibility and Grievance Procedures.	Signed and dated forms in patient file.

REFERRAL

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

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

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

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

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

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

	• Medical nutrition therapy • Oral health assessment and screening Annual referral to oral health care is required.	

PATIENT EDUCATION

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

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

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

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

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

PATIENT RECORDS

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

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

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

- Documentation of HIV disease or AIDS diagnosis
- Complete medical, sexual, and social history
- Completed physical examination and assessment signed by a licensed health care professional
- Differential diagnosis
- Current and appropriate treatment plan
- Current problem list
- Progress notes documenting patient status, condition and response to interventions, procedures, and medications
- Documentation of all contacts with patient, including date, time, services, provided, referrals given and signature and title of person providing services

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

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

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

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

STANDARD		DOCUMENTATION
	Patient records will be kept in accordance with the California Code of Regulations.	Program review and monitoring to confirm.
	Patient unit records will include: • Documentation of HIV disease or AIDS diagnosis • Medical, sexual, and social history • Physical exam and assessment signed by licensed professional • Differential diagnosis • Current treatment plan • Current problem list • Progress notes • Documentation of all contacts with patient, including date, time, services, provided, referrals given and signature and title of person providing services Additional documentation including: • Specialty-specific assessment, diagnosis and treatment plan • Special tests • Clinical assessments or diagnoses • Health education and risk reduction activities • Referrals and consults • Patient education • Patient and family contact information and identifiers	Program review of patient unit records to confirm.

	• Signed Consent for treatment and prevention services • Signed releases of information • Provider signatures • Viral measures, drug allergies and drug resistances • TB, hepatitis or STD screening • Coordination activities • Mental health and substance abuse service assessments • Referral to or provision of medical care coordination • Health care maintenance to include: • Influenza vaccine • Tetanus/diphtheria update • Pneumovax • Meningococcal vaccine for high-risk MSM and those who request it • Pap screening • Hepatitis screening, vaccination • TB screening • Family planning • Counseling on safer sex and STD screening • Counseling on food and water safety • Counseling on nutrition • Harm reduction for alcohol and drug use	

PATIENT RETENTION IN CARE

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

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

STANDARD		DOCUMENTATION
	Programs will develop a broken appointment policy to ensure continuity of service and retention of patients.	Written policy on file at provider agency.
	Programs shall provide regular follow-up procedures to encourage and help maintain a patient in MO services.	Documentation of attempts to contact in signed, dated progress notes. Follow-up may include:

		• Telephone calls • Written correspondence • Direct contact
	If broken or failed appointments persist, patients must be referred to specialized adherence services and/or medical care coordination.	Documentation of referral in patient record.

CASE CLOSURE

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

- Relocates out of the service area
- Has had no direct program contact in the past six months
- Is ineligible for the service
- No longer needs the service
- Discontinues the service
- Changes his or her primary care provider
- Is incarcerated long term
- Uses the service improperly or has not complied with the client services agreement
- Has died

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

STAFFING REQUIREMENTS AND QUALIFICATIONS

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

Programs will develop personnel policies and procedures that require and support the continuing education of all HIV/AIDS health care professionals. Programs are expected to budget costs for HIV/AIDS continuing education specifically in HIV prevention and disease management, to purchase practice guidelines in formats easily accessible and usable for practitioners, and to provide practitioners routine access to computerized educational and prevention/care treatment problem solving (e.g., The Body at www.thebodypro.com; HIV InSite at www.hivinsite.ucsf.edu; Johns Hopkins AIDS Service at www.hopkins-aids.edu; or, Medline Plus – AIDS at www.nlm.nih.gov/medlineplus/aids.html).
Programs will develop consultation protocols to assist MO health care professionals seeking expert advice and consultation whenever needed. Seeking expert advice and using the many local or regional university-based consultation services is evidence of competent prevention and disease management.

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

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

STANDARD		DOCUMENTATION
	MO staff will be able to provide linguistically, and culturally age-appropriate care and complete documentation as required by their positions.	Resumes and record of training in employee file to verify.
	Staff will receive an agency orientation, HIV training within three months of employment and oriented and trained in confidentiality and HIPAA compliance.	Record of orientation and training in employee file.
	Staff will receive consistent supervision in clinical, administrative, psychosocial, developmental, and programmatic issues on a monthly basis.	Supervision record on file at provider agency.
	Programs will budget costs for HIV/AIDS continuing education.	Budget review to confirm.

	Programs will develop consultation protocols.	Consultation protocols on file at provider agency.
	MO providers are expected to practice in accordance with state and federal regulations, statutes, and laws, as well as codes of ethics and with any special HIV/ AIDS policies from their respective national professional associations.	Program review and monitoring to confirm.

HEALTH CARE PROFESSIONALS

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

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

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

STAFF QUALIFICATIONS

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

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

- Is in a fellowship or other training program under the supervision of a physician who meets these criteria

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

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

The NP works under the supervision of an HIV/AIDS specialist physician. Physician supervision must include regular chart review, as well as oversight of scheduled direct patient care. Programs will develop, implement, and maintain standardized procedures for all medical functions to be performed by the NP using the Guidelines for Developing Standardized Procedures produced by the California Board of Registered Nursing and the Medical Board of California. The NP must work within the scope of practice defined by Section 2834 Nurse Practitioner, California Code of Regulations 1435, 1470, and 1480 (www.rn.ca.gov/policies/pdf/ npr-b-23.pdf).

- **PA HIV/AIDS Specialist:** A PA providing MO services must have graduated from a medical training program approved by the California Physician Assistant Committee and must have passed the Physician Assistant National Certifying Examination (PANCE) offered by the National Commission on Certification of Physician Assistants (NCCPA). PAs must be licensed by the Physician Assistant Committee, Department of Consumer Affairs' Medical Board of California, and must be credentialed as an HIV/AIDS specialist by the American Academy of HIV Medicine (www.aahivm.org) or have a credible plan to complete HIV/AIDS specialist criteria within one year. The PA works under the direct supervision of an HIV/AIDS specialist physician. Physician supervision must include regular chart review, as well as oversight of scheduled direct patient care. (For regulations specifying physician accountabilities, supervision requirements and a description of a PA's scope of practice, see: www.physicianassistant.ca.gov.) The state-required Delegation of Services Agreement between the supervising physician and PA must specify HIV/AIDS medical services delegated to the PA and must be available for review (www.physicianassistant.ca.gov/delegation.pdf). PAs authorized by supervising physicians to issue written "drug orders" for medication and medical devices must do so in compliance with the amended (January 1, 2000) Physician Assistant Practice Act (BPC, Section 3502.1).
- **Medical Specialists:** MO programs are responsible for recruiting medical specialists who have demonstrated experience in HIV/AIDS specialty/subspecialty care. Ideally, medical specialists will already be providing care for people living with HIV in their current practices and have the requisite training and certification in his or her respective medical specialty or subspecialty. Medical specialists must maintain their licenses by fulfilling the continuing education requirements established by their respective professional state and national boards. Additionally,

medical specialists must be board-certified or board-eligible in their specialty. MO programs are encouraged to pass along educational opportunities and materials to their contracted specialists to improve their HIV knowledge and expertise. All medical specialists are expected to practice in accordance with applicable state and federal regulations, statutes, and laws. Medical specialists must comply with codes of ethics and with any special HIV/AIDS policies from their respective national professional associations.

- **RN:** An RN providing MO services must hold a license in good standing from the California State Board of Registered Nurses, be a graduate from an accredited nursing program with a Bachelor of Science in Nursing (BSN) or two-year nursing associate's degree. Prior to employment, a BSN must have experience providing direct care to HIV-infected individuals, and an RN with an associate degree must have practiced one year in an HIV/AIDS clinic setting providing direct care to HIV-positive patients (see: Association of Nurses in AIDS Care www.anacnet.org). The RN must practice within the scope of practice defined in the California Business & Professional Code, Section 2725 RN Scope of Practice (www.rn.ca.gov).

STANDARD		DOCUMENTATION
	Physicians (MD or DO) providing MO services hold state of California license (Medical Board of California or California Board of Osteopathic Examiners) and be credentialed as an HIV/AIDS specialist, have a credible plan to complete HIV/AIDS specialist criteria within one year or meet strict experience criteria.	Resumes and verification of specialist or experience criteria on file at provider agency.
	NP HIV/AIDS specialists practitioners providing MO services must hold: • Licensure as an RN • NP certificate or master's degree from an accredited school • Credential as an HIV/AIDS specialist or credible plan to complete credential in one year	Resumes and verification of specialist and experience criteria on file at provider agency
	NPs prescribing medications must hold a DEA license.	Practitioner furnishing certificates on file at provider agency.
	NPs must be supervised by an HIV/AIDS specialist physician, including chart review and oversight of scheduled direct patient care. Programs will develop standardized procedures for medical functions performed by the NP.	Record of physician supervision on file at provider agency. NP standardized procedures on file at provider agency.
	NPs must work within the scope of practice defined by Section 2834 Nurse Practitioner, California Code of Regulations 1435, 1470, and 1480.	Program review and monitoring to confirm.
	PAs providing MO services must have:	Resumes and verification of specialist and experience criteria on file at provider agency

	• Graduated from an approved medical training program • Passed the Physician Assistant National Certifying Examination (PANCE) • A license from the Physician Assistant Committee • A credential as an HIV/AIDS specialist, or have a credible plan to complete credential in one year	
	PAs must be supervised by an HIV/AIDS specialist physician, including chart review and oversight of scheduled direct patient care.	Record of physician supervision on file at provider agency.
	PAs issuing drug orders must do so in compliance with the amended (January 1, 2000) Physician Assistant Practice Act (BPC, Section 3502.1).	Program review and monitoring to confirm.
	It is preferred that medical specialists will have demonstrated experience in HIV specialty care, including providing care to people living with HIV in current practice.	Documentation of experience on file at provider agency.
	Medical specialists must maintain licenses and requirements established by their respective professional state and national boards and will be board-certified or board-eligible in their specialty.	Specialists licenses and board status documentation on file at provider agency.
	Medical specialists are expected to practice in accordance with state and federal regulations, statutes, and laws, as well as codes of ethics and with any special HIV/AIDS policies from their respective national professional associations.	Program review and monitoring to confirm.
	RNs providing MO services must: • Hold a license in good standing from the California State Board of Registered Nurses • Be a graduate from an accredited nursing program with a BSN or two-year nursing associate degree • Have experience providing direct HIV care (BSNs) • Have practiced one year in an HIV/AIDS clinic setting providing direct care to HIV-positive patients (associate degrees) • Practice within the scope defined in the California Business & Professional Code, Section 2725	Resumes on file at provider agency to verify experience. Program review and monitoring to confirm.

EDUCATION AND LICENSING

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

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

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

CERTIFICATIONS

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

Certification requirements include:

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

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

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

STAFFING RATIOS SERVICES

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

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

ADDITIONAL OUTPATIENT STAFF—MEDICAL CARE COORDINATION

MEDICAL CARE MANAGERS

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

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

PATIENT CARE MANAGERS

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

CASE WORKERS

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

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

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

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

	Medical specialty case workers will be an LVN or certified medical assistant with at least one year's HIV experience or have an LVN license and at least three years' experience within a related health services field.	Resumes on file at provider agency to verify experience. Program review and monitoring to confirm.

MEDICAL NUTRITION THERAPY (OPTIONAL)

REGISTERED DIETITIAN

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

- Broad knowledge of principles and practices of nutrition and dietetics
- Advanced knowledge in the nutrition assessment, counseling, evaluation, and care plans of people living with HIV
- Advanced knowledge of current scientific information regarding nutrition assessment and therapy and the ability to distill and communicate this information to clients and other service providers

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

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

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

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

STANDARD		DOCUMENTATION
	At minimum, all medical nutrition therapy staff will be able to provide appropriate care to people living with HIV, complete documentation as required by their positions	Staff resumes and qualifications on file at provider agencies.

	and maintain appropriate licensure if applicable.	
	Registered dietitians will have the following (at minimum): • Broad knowledge of principles and practices of nutrition and dietetics • Advanced knowledge in the nutrition assessment, counseling, evaluation, and care plans of people living with HIV • Advanced knowledge of current scientific information regarding nutrition assessment and therapy	Staff resumes, qualifications and records of training on file at provider agencies.
	Registered dietitians will practice according to their code of ethics.	Performance review to confirm.
	Registered dietitians will maintain membership in the HIV/AIDS Dietetic Practice Group.	Record of membership in employee file.
	Registered dietitians will maintain current professional education (CPE) units/hours, primarily in HIV nutrition and other related medical topics as administered by the Commission on Dietetic Registration.	Training record in employee file.

MEDICAL OUTPATIENT-SPECIFIC PROGRAM REQUIREMENTS

TB SCREENING

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

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

OCCUPATIONAL POSTEXPOSURE PROPHYLAXIS (PEP)

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

STANDARD	DOCUMENTATION

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

STATE-MANDATED HIV REPORTING

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

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

PATIENT/STAFF/COLLEAGUE COMMUNICATION

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

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

TRANSLATION/LANGUAGE INTERPRETERS

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

STANDARD		DOCUMENTATION
	MO programs must develop policies and procedures to address the provision of	Interpretation policies and procedures on file at provider agency.

	competent interpretation services to LEP patients at no cost.	

POLICY AND PROCEDURE MANUAL

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

STANDARD		DOCUMENTATION
	MO programs must develop policies and procedures manual to address mandatory policies, procedures, protocols, and standards	Policies and procedures manual on file at provider agency that addresses (at minimum): • Coordination of care • Patient hospitalization • Home health care • Referrals to support services

DEFINITIONS AND DESCRIPTIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

MO visits are defined as face-to-face encounters between licensed primary health care professionals (physician, registered nurse (RN), nurse practitioner (NP), or (PA)) and patients involving evaluation, diagnosis, and treatment. Procedures (e.g., drawing blood, collecting specimens, performing laboratory tests, taking X-rays, filling, or dispensing prescriptions) without a face-to-face patient/practitioner encounter do not constitute a separate MO visit.

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

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

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

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

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

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

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

<u>REFERENCES</u> --PENDING--

2024 TRAINING SCHEDULE

SUBJECT TO CHANGE

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

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

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?

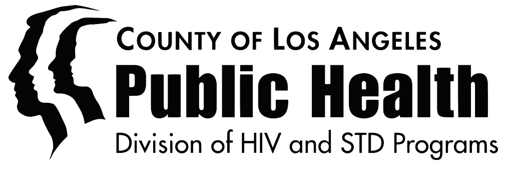
Yes.

Can I contact you through other ways?

Yes.

By Email:
dhspsupport@ph.lacounty.gov

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



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