LOS ANGELES COUNTY
COMMISSION ON HIV

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STANDARDS AND BEST PRACTICES COMMITTEE

Virtual Meeting

Tuesday, October 4, 2022

10:00AM-12:00PM (PST)

Agenda + Meeting Packet will be available on the Commission's website at:

http://hiv.lacounty.gov/Standards-and-Best-Practices-Committee

REGISTER VIA WEBEX ON YOUR COMPUTER OR SMART PHONE:

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PUBLIC COMMENTS

Public Comments will open at the time referenced on the meeting agenda. For those who wish to provide live public comment, you may do so by joining the WebEx meeting through your computer or smartphone and typing PUBLIC COMMENT in the Chat box. You may also provide written public comments or materials by email to hivcomm@lachiv.org. Please include the agenda item and meeting date in your correspondence. All correspondence and materials received shall become part of the official record.

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LOS ANGELES COUNTY
COMMISSION ON HIV

AGENDA FOR THE VIRTUAL MEETING OF THE
LOS ANGELES COUNTY COMMISSION ON HIV (COH)

STANDARDS AND BEST PRACTICES COMMITTEE

TUESDAY, OCTOBER 4, 2022, 10:00 AM – 12:00 PM

******WebEx Information for Non-Committee Members and Members of the Public Only******

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or Dial

1-415-655-0001

Event Number/Access code: 2599 691 5007

(213) 738-2816 / Fax (213) 637-4748
HIVComm@lachiv.org http://hiv.lacounty.gov

Standards and Best Practices (SBP) Committee Members			
Erika Davies *Co-Chair*	Kevin Stalter *Co-Chair* (LoA)	Michael Cao, MD	Mikhaela Cielo, MD
Wendy Garland, MPH	Thomas Green	Mark Mintline, DDS	Paul Nash, PhD, CPsychol, AFBPsS, FHEA
Mallery Robinson	Harold Glenn San Agustin, MD		
QUORUM: 5			

AGENDA POSTED: September 28, 2022

VIRTUAL MEETINGS: Assembly Bill (AB) 361 amends California's Ralph M. Brown Act Section 54953 to allow virtual board meetings during a state of emergency. Until further notice, all Commission meetings will continue to be held virtually via WebEx. For a schedule of Commission meetings, visit https://hiv.lacounty.gov/meetings

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.

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 a HIVComm@lachiv.org, por lo menos setenta y dos horas antes de la junta.

SUPPORTING DOCUMENTATION can be obtained at the Commission on HIV Website at: http://hiv.lacounty.gov. The Commission Offices are at 510 S. Vermont Ave. 14th Floor, one block North of

Wilshire Blvd on the eastside of Vermont just past 6th Street. Free parking is available.

NOTES on AGENDA SCHEDULING, TIMING, POSTED and ACTUAL TIMES, TIME ALLOTMENTS, and AGENDA ORDER: Because time allotments for discussions and decision-making regarding business before the Commission's standing committees cannot always be predicted precisely, posted times for items on the meeting agenda may vary significantly from either the actual time devoted to the item or the actual, ultimate order in which it was addressed on the agenda. Likewise, stakeholders may propose adjusting the order of various items at the commencement of the committee meeting (Approval of the Agenda), or times may be adjusted and/or modified, at the co-chairs' discretion, during the course of the meeting.

If a stakeholder is interested in joining the meeting to keep abreast of or participate in consideration of a specific agenda item, the Commission suggests that the stakeholder plan on attending the full meeting in case the agenda order is modified or timing of the items is altered. All Commission committees make every effort to place items that they are aware involve external stakeholders at the top of the agenda in order to address and resolve those issues more quickly and release visiting participants from the obligation of staying for the full meeting. External stakeholders who would like to participate in the deliberation of discussion of a posted agenda item, but who may only be able to attend for a short time during a limited window of opportunity, may call the Commission's Executive Director in advance of the meeting to see if the scheduled agenda order can be adjusted accordingly. Commission leadership and staff will make every effort to accommodate reasonable scheduling and timing requests - from members or other stakeholders - within the limitations and requirements of other possible constraints.

Call to Order, Introductions, Conflict of Interest Statements 10:00 AM – 10:03 AM

I. ADMINISTRATIVE MATTERS 10:03 AM – 10:07 AM

1. Approval of Agenda **MOTION #1**

2. Approval of Meeting Minutes **MOTION #2**

II. PUBLIC COMMENT 10:07 AM – 10:10 AM

3. Opportunity for members of the public to address the Commission on items of interest that are within the jurisdiction of the Commission

III. COMMITTEE NEW BUSINESS ITEMS 10:10 AM – 10:15 AM

4. Opportunity for Commission 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

5. Executive Director/Staff Report 10:15 AM – 10:30 AM
- a. Operational and Staffing Updates
- b. Comprehensive HIV Plan 2022-2026
- c. Special Populations Best Practices Project Updates

6. Co-Chair Report 10:30 AM – 10:40 AM
- a. 2022 SBP Committee Workplan

7. Division of HIV & STD Programs (DHSP) Report 10:40 AM – 10:50 AM

V. DISCUSSION ITEMS

8. Transitional Case Management- Incarcerated/Post-Release 10:50 AM – 11:30 AM
a. Continue review of recommendations

9. Oral Healthcare Service Standards 11:30 AM – 11:50 AM
a. Begin initial review

VI. NEXT STEPS 11:50 AM – 11:55 AM

10. Tasks/Assignments Recap

11. Agenda development for the next meeting

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

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

VIII. ADJOURNMENT 12:00 PM

13. Adjournment for the virtual meeting of October 4, 2022.

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.**

DRAFT

LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave. 14th Floor • Los Angeles, CA 90020 • TEL (213) 738-2816 • FAX (213) 637-4748
HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov • *VIRTUAL WEBEX MEETING*

Presence at virtual 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

September 6, 2022

COMMITTEE MEMBERS P = Present | A = Absent					
Erika Davies, *Co-Chair*	P	Wendy Garland, MPH	EA	Mallery Robinson	A
Kevin Stalter, *Co-Chair*	EA	Thomas Green	P	Harold Glenn San Agustin, MD	P
Michael Cao, MD	P	Mark Mintline, DDS	P		
Mikhaela Cielo, MD	EA	Paul Nash, PhD, CPsychol, AFBPsS, FHEA	P		
COMMISSION STAFF AND CONSULTANTS					
Cheryl Barrit, Jose Rangel-Garibay, Catherine Lapointe					
DHSP STAFF					

**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 10:05 am. Erika Davies led introductions.

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 8/2/2022 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: There was no committee new business items.

IV. REPORTS

5. EXECUTIVE DIRECTOR/STAFF REPORT

a. Operational Updates

- Cheryl Barrit, Executive Director, reminded the Committee of the upcoming "Priority Setting & Resource Allocation" and "Service Standards Development" training taking place on September 15 at 3:00 pm – 4:30 pm. This training is part of the Mandatory Training series launched by the Operations Committee and trainings are mandatory for all Commissioners.
- C. Barrit reported that the Presidential Advisory Council on HIV/AIDS (PACHA) will hold an in-person full council meeting at the Martin Luther King Campus on September 19 and September 20. Those interested in participating in person should send a request to attend in person by the deadline. She highly encouraged committee members to attend the meeting and provide public comment as this is a great opportunity to have our federal partners and colleagues notes the work done here in Los Angeles. The meeting will also be livestreamed online for those wishing to participate virtually.
- C. Barrit remind the Committee to respond to the Prevention Planning Workgroup Knowledge, Skills, and Attitudes (KSA) survey which aims to assess the understanding and planning capacity of the Commission.

b. Comprehensive HIV Plan 2022-2026

- C. Barrit reported that the Comprehensive HIV Plan 2022-2026 is due to the Federal Government on December 3rd. AJ King, consultant, is busy writing the plan and will provide an update Thursday September 8th at the full Commission meeting. The document will also be presented to the Planning, Priorities, and Allocations (PP&A) Committee and staff at the Division of HIV and STD Programs (DHSP) for their approval and vetting before sharing the full document with the full Commission body. The PP&A Committee will meet on September 27th at 1pm.

6. CO-CHAIR REPORT

a. 2022 Workplan Updates

- E. Davies provided a review of the 2022 workplan and noted the following:
  -The completion date for the Benefits Specialty Services and Home-based Case Management service standards is now September 2022 due to the Executive Committee not having quorum at their July 28, 2022, meeting.
  -The committee will review public comments for the Targeted Review of the Oral healthcare standards today and at the next meeting. The Public Comment period ends on August 5, 2022.
  -The completion date for the Transitional Case Management Service Standards is now October 2022.
  -Item 10 "Update the Medical Case Management service standards" was added to the workplan with completion date set for 2023. This item was added in response to an agency submitting a public comment and requesting a review and update.

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

- Wendy Garland was not able to attend the meeting but sent a designee. There was no DHSP report.

V. DISCUSSION ITEMS

8. SERVICE STANDARDS DEVELOPMENT

a. Transitional Case Management- Incarcerated/Post-Release (TCM-I/PR)

Current Services Provided | Agency Presentations

Center for Health Justice, Cajetan Luna, Executive Director

- C. Luna provided a brief history of the Transitional Case Management program at the Center for Health Justice (CHJ) and shared recommendations for updating the TCM-I/PR service standards. He also submitted a written feedback for the Committee to consider. Below are highlights from the discussion. The meeting recording with the full presentation is available upon request.
- The CHJ is home to a service center and has capacity to provide curbside services and HIV testing in collaboration with Children's Hospital Los Angeles (CHLA) and other DHSP funded agencies. The CHJ also conducts condom distribution in the jails. The CHJ currently has 1 Case Manager working in the Jails; there are 8 total. During the COVID-19 pandemic, education services in the jails was deemed as necessary and essential in reducing violence within the jails. He stressed the importance of hiring previously justice-involved people for TCM positions and noted the process of getting clearance for someone previously justice-involved can take about 7 years.
- C. Luna noted that staff turnover is an issue given the increasing challenge that people do not want to provide face-to-face services and the difficulty in hiring people that want to work in jails, including physicians. There is a fear of violence, consequences of giving people notifications (HIV, HCV status), and some people are not prepared or do not have adequate training to work in jails. He also shared that it is difficult to find case managers that want to work in jails.
- C. Luna shared that CHJ is located across the street from MCJ. He added that CHJ's success comes from partnering with agencies to provide services in sites that are not close to Men's Central Jail (MCJ) to avoid triggering events because being incarcerated is a traumatic experience.
- C. Luna provided the following recommendations for improving service delivery:
    - Institutional Review Board (IRB) requires that consent forms need to be written at the 8th grade level and available in Spanish and English
    - Determine recent viral loads and medication availability on the discharge plan
    - Providing and supporting cell phone interventions in the jails because they are a good way to track people and make referrals
    - Employ "person first" language and respecting pronouns
    - Location of services is important. CHJ is close to Union Station and across the street from MCH which is an advantage and helpful for people being discharged at odd times
    - Consider the Department of Healthcare Services (DHS) Whole Person Care approach
    - Match TCM with someone that has the same cultural, racial characteristics
    - Advocate for a harm-reduction model and improve the speed of delivery of linkage to services
    - Train TCMs to develop comprehensive discharge plans with 2-3 alternatives to have options in case there are changes to resource availability or the person is discharge sooner/later than anticipated
    - Have TCMs follow-up with clients and partner agencies to ensure a warm hand-off, maintain good relationships with partner agencies, and improve linkage to care
    - Keep the Post-release follow-up time at 60 days; keep the case open to continue working with the client until the TCM can confirm successful linkage to care

Heluna Health, Johanna Britto, Project Supervisor

- J. Britto shared that Heluna Health has one TCM working in the jails. During the COVID-19 pandemic, the TCM was only going into the jail once a week and were not able to see the inmates. They are currently trying to see them again, but the challenge is that the jail deputies are not allowing the TCMs to see clients
- J. Britto recommended that TCMs should be more hands on with the clients inside the jails and the deputies are more helpful with allowing TCMs to see clients. C. Luna shared that one potential reason

the Sheriff's department has not been too responsive to requests is that during the COVID-19 pandemic, many deputies were deployed outside of the jails. The department shifted staff with no knowledge of clients, do not understand the needs of clients, and/or do not understand the role of the TCM in the jails. J. Britto added that TCMs do not disclose the reason for their visit with the client to protect the client's privacy. The TCMs say they are there to conduct a program with the client and try their best to provide services with the access they have.

- J. Britto recommended to reinitiate case conference meetings between the TCM service provider agencies, the deputies, and clinical staff within the jails. Before the COVID-19 pandemic, there was a staff members within the Sheriff's department that would serve as a liaison and coordinate the meetings.
- J. Britto recommend that DHSP update the CaseWatch system to improve TCM provider agencies data reporting contract requirements. Data is important for tracking outcomes and having a system that is responsive to the needs of the provider agencies can improve overall service delivery.
- J. Britto recommend adding a "Case Closure" section to the service standards and echoed C. Luna's support for keep cases open for the full 60 days or until the case manager can confirm that the client attended their first appointment and scheduled a follow-up appointment.

The Committee will review the recommendations shared by C. Luna and J. Britto and will request the current contract requirements from DHSP.

b. Oral Healthcare Service Standards Addendum Draft Updates

J. Rangel-Garibay noted that Commission did not receive any additional public comments. E. Davies asked the Committee for any additional feedback on the document and proceeded with a vote on Motion #3. **MOTION #3:** Approve the Dental Implants Addendum to the Oral Healthcare Service Standards as presented or revised and move to the Executive Committee. ✓**Passed by Roll Call Vote** *(**Ayes:** G. San Agustin, P. Nash, M. Mintline, T. Green, M. Cao, E. Davies; **No:** 0; **Abstain:** M. Robinson, W. Garland, M. Cielo, K. Stalter)*

VI. NEXT STEPS

9. **TASK/ASSIGNMENTS RECAP**:
   - COH staff will send reminder of the upcoming and future Mandatory Trainings for Commissioners
   - COH staff will send meeting information for upcoming PACHA full-council meeting
   - COH staff will send reminder of the Prevention Planning Workgroup KSA survey
   - COH staff will send the BSS and HBCM service standards to the full Commission for approval
   - COH staff will request contract requirements for TCM services from the DHSP
10. **AGENDA DEVELOPMENT FOR NEXT MEETING**:
    - Continue to update the Committee workplan with progress notes
    - Continue review of the Transitional Case Management- Jails service standards

VII. ANNOUNCEMENTS

11. **OPPORTUNITY FOR PUBLIC AND COMMITTEE TO MAKE ANNOUNCEMENTS**: There were no announcements.

VIII. ADJOURNMENT

12. **ADJOURNMENT**: The meeting adjourned at 11:34 am.

LOS ANGELES COUNTY COMMISSION ON HIV SPECIAL POPULATIONS BEST PRACTICES COMPILATION

PURPOSE

The purpose of identifying Best Practices is to accumulate and apply knowledge of practices that are working to address needs or service delivery disparities for a designated population. A Best Practice can be anything that works to produce results and can be useful in providing lessons learned. Best Practices are intended to recommend specific strategies for modifying and improving service delivery practices of individual and organizational providers when those providers are serving the designated populations. The best practices outlined in the resulting guidance document are not requirements or mandates; instead, they are recommendations for addressing and accommodating the unique needs of a specific population in service delivery.

The TargetHIV website offers various technical assistance (TA) and trainings resources for HRSA's Ryan White HIV/AIDS Program (RWHAP). In October 2021 a Best Practice Compilation page was launched as a mechanism to support knowledge sharing between the RWHAP community. The Best Practices Compilation gathers and shared what works in RWHAP funded settings to improve outcomes for people with HIV and to support replication by others. Many of the best practices included in this document were found on the Best Practices Compilation. To learn how to navigate the Best Practice Compilation, visit https://targethiv.org/bestpractices/search and click on "How Do I search the Compilation?"

Designated population groups within the Commission on HIV: Consumer Caucus, Transgender Caucus, Aging Caucus, Women's Caucus, Black Caucus

Table 1. Delineation between the COH Service Standards and Best Practices.

Standards of HIV Care and Prevention	Special Population Best Practices for HIV Prevention and Care
• Ensure all subrecipients provide the same basic service components • Establish a minimal level of service of care for consumers throughout Los Angeles County • Service Standards must be available to subrecipients and consumers	• Encourage providers to adopt service and system innovations that specialize in clients from a designated population • Describe methods for enriching, modifying, or further developing services to respond more directly to the unique needs of a designated population • Recommend best practices shown effective in addressing barriers to HIV prevention and care for a designated population • Feature possible service and system enhancements to service delivery above the expected levels for a designated population

Table 4. Best Practices Matrix- Transgender Caucus

ID	Title	Description
1	Transgender Health Program Integrated Into HIV prevention and Care Poster presentation: OUTCOMES OF A TRANSGENDER HEALTH PROGRAM INTEGRATED INTO HIV PREVENTION AND CARE (targethiv.org) Rutgers Infectious Disease Practice: Gender-Affirming and Transgender Care – Infectious Diseases Practice (rutgers.edu)	Rutgers New Jersey Medical School created a transgender health program and integrated it into their Infectious Disease Practice. The program conducted community outreach to engage transgender men and women in care, trained all staff on gender affirming care, hired transgender staff, provided gender affirming care and hormone treatments onsite, and offered mental health support to patients. Programs that integrate gender-affirming practices and hormone therapy to address the complex medical and social needs of transgender persons can lead to better HIV prevention and treatment outcomes. **Core Elements** Gender-affirming hormone treatments included in HIV services Staff training Community outreach Hiring transgender staff Mental health support Referrals to behavioral health and social services **Lessons learned** Ongoing staff training is needed Leadership support for all-staff training on pronouns and gender-affirming care best practices is crucial Specificity and transparency regarding the roles and responsibilities of all staff is important. Retrieved from the TargetHIV Best Practices Compilation: Transgender Health Program Integrated Into HIV Prevention and Care | TargetHIV
2	Healthy Divas: E2i	Healthy Divas focused on empowering transgender women with HIV to achieve their personal health goals. Healthy Divas is an evidence-informed intervention is designed to address the barriers of stigma and discrimination by providing transgender women with the support and resources they need to make empowered and informed decisions regarding their gender-affirming care and HIV medical care. **Core Elements** Trans-identified peer counselor Peer counseling sessions Group workshop Engagement in care and supportive services

		Lessons Learned Build staff awareness of transgender women and their health needs Recruiting and retaining transgender women into Healthy Divas can be challenging Busy medical providers may have difficulty fitting group workshops into their schedules Expect and plan for barriers to session attendance Retrieved from the TargetHIV Best Practices Compilation: Healthy Divas: E2i | TargetHIV
3	Transgender Women Engagement and Entry to Care (T.W.E.E.T.): E2i	Transgender Women Engagement and Entry to Care (T.W.E.E.T) aims to engage transgender women in HIV care by combining weekly peer-based education and discussion groups, leadership training, community building, and the provision of supportive services. **Core Elements** Peer leaders Transgender Leader (TL) teach back sessions Community building Supportive services **Lessons Learned** Sites found recruiting peer leaders challenging Sites struggled with client recruitment Integrating T.W.E.E.T. activities into a clinical setting can allow for better coordination of care and support services needed by T.W.E.E.T. clients All sites widened the scope of T.W.E.E.T. to include transgender women without HIV Retrieved from the TargetHIV Best Practices Compilation: Transgender Women Engagement and Entry to Care (T.W.E.E.T): E2i | TargetHIV
4	Optimizing HIV Prevention and Care for Transgender Adults Optimizing HIV Prevention and Care	Highlights the recent acknowledgement of transgender women as an important risk group in HIV research and care. Describes epidemiological profile for HIV among transgender communities Describes social and structural contexts of HIV prevention and care. Discusses metabolic interactions between ART, FHT, and HIV. Resource for identifying areas for further research

	for Transgender Adults (nih.gov)	Calls for the development of HIV prevention interventions designed to address the behavioral and biological risks for HIV infection encountered by transgender men and women.
5	Best Practices for Trans HIV Prevention and Care: Addressing Social Determinants of Health CHPRC-Think-Tank-Transgender-Populations-Summary-Draft_Final.pdf	California HIV/AIDS Policy Research Centers (CHPRC) convened statewide group of stakeholders to discuss best practices for HIV prevention and car within transgender communities in California. Key Recommendations: 1. Create a hub or community at multiple geographic centers placing the needs of the most impacted transgender people 2. Expand existing efforts to increase economic empowerment of transgender individuals 3. Reimagine funding Focus was on addressing social determinants of health 1. Highlights implementation-related barriers to delivery of HIV prevention and treatment programs for transgender people across California
6	Additional Resources for Health Care Providers	HIV Prevention and Care for Transgender People Additional Resources | For Health Care Providers | Transforming Health | Clinicians | HIV | CDC
7	HIV Resource Library: Consumer Info Sheets	Collection of factsheets with basic information on HIV, PEP, PrEP, Safer Sex for HIV, HIV Testing, Living with HIV, HIV Treatment Can Prevent Sexual Transmission, HIV, and Injecting Drugs, How to Clean Your Syringes, HIV Consultation and Referral Services, HIV Content Syndication, HIV Social Media Resources, and HIV Web Resources Consumer Info Sheets | Resource Library | HIV/AIDS | CDC
8	HIV Basics: Living with HIV	Contains information on the topics such as: Newly Diagnosed with HIV, Understanding Care, HIV Treatment, AIDS and Opportunistic Infections, Telling Others, Protecting Others, Stigma and Mental Health, Healthy Living with HIV, Family Planning, Traveling with HIV, Resources for People with HIV, and a link to site where you can download “Living with HIV” materials. Resources for Persons Living with HIV | Living With HIV | HIV Basics | HIV/AIDS | CDC
9	A Guide to Consumer Involvement: Improving the Quality of Ambulatory HIV Programs FINALconsumer08_24_06.indd (ucsf.edu)	Collaboration between the New York State Department of Health AIDS Institute and the HRSA HIV/AIDS Bureau. Published in August 2006. Opportunity to develop training modules to promote and enhance consumer involvement. Consumer involvement programs should be designed to increase the involvement of consumers in decision-making and to provide input into the quality improvement process within an agency

10	Engaging People with HIV in Quality Improvement: Best Practices to Meaningfully Engage and Involve	Presentation learning objectives: At the end of this session, participants will: • Understand the importance of people with HIV participation in clinical quality management program activities • Learn effective strategies to overcome common barriers in engaging consumers in quality improvement activities • Know where to access resources to improve participation of people with HIV in quality improvement efforts • Develop hands-on strategies for receiving meaningful input by people with HIV to improve HIV care **Missouri Ladder**: Used as a guide to support consumer decision-making in involvement structures as well as an assessment of current involvement for improvement activities -Consumer involvement matrix -Highlight the impact support groups have on consumer involvement and engagement -Focus on Quality Improvement
11	US PLHIV Caucus Consumer Engagement Consumer Involvement Denver Principles Self-Empowerment	Outline a series of rights and responsibilities for healthcare professionals, people with AIDS and all who are concerned about the epidemic. It was the first time in the history of humanity that people who shared a disease organized to assert their right to a political voice in the decision-making that would so profoundly affect their lives.
12	AIDS United Consumer Involvement Meaningful Involvement Resources	A collection of resources that share best practices to incorporate MIPA/mechanisms for greater involvement of people living with HIV Related Webinar: MIPA and Young Adults: Focusing on Ageism and Adultism Webinar Embodying Meaningful Involvement of People Living with HIV: Putting the Pieces Together- Guide includes history and lessons learned from the community MIPA Fact Sheet (available in English/Spanish/French)

Best Practices Compilation for Transgender Caucus Updated 9/22/22

LOS ANGELES COUNTY COMMISSION ON HIV

LOS ANGELES COUNTY COMMISSION ON HIV 2022
STANDARDS AND BEST PRACTICES WORKPLAN (Updates in RED)

Co-Chairs: Erika Davies, Kevin Stalter

Approval Date: 2/1/22

Purpose of Work Plan: To focus and prioritize key activities for COH Committees and subgroups for 2022.

#	TASK/ACTIVITY	DESCRIPTION	TARGET COMPLETION DATE	STATUS/NOTES/OTHER COMMITTEES INVOLVED
1	Review and refine 2022 workplan	COH staff to review and update 2021 workplan monthly	Ongoing	Workplan revised/updated on: 12/22/21, 1/6/2022, 1/19/22, 1/26/22; 2/1/22; 2/24/22; 3/30/22; 4/27/22, 6/24/22, 7/26/22, 8/30/22, 9/28/22
2	Update Substance Use Outpatient and Residential Treatment service standards	Continuation of SUD service standards review from 2021.	Jan 2022 COMPLETED	During the 11/2021 meeting, the committee placed a temporary hold on approving the SUD service standards pending further review of the implications of CalAIM. COH staff will provide CalAIM updates and allow the committee to determine to approve or extend the hold on approving the SUD service standards. At the 12/7/21 meeting, the committee approved the SUD service standards and moved them to the Executive Committee for approval. Approved by the Executive Committee on 12/9/21 and on the Commission agenda for approval on 1/13/22 Approved by Commission on 1/13/22. COH staff sent transmittal letter to DHSP on 1/26/22.
3	Update Benefits Specialty service standards	Continuation of BSS service standards review from 2021.	~~Early 2022~~ October 2022	Committee extended the public comment period and now ends on January 21, 2022. The Committee reviewed public comments received at the February 2022 meeting. Committee placed a temporary hold on additional review of the BSS standards pending further instruction from DHSP. Approved by the Executive Committee on 8/29/22. Executive Committee approved the BSS standards and moved them to the Full Commission for approval. The Full Commission approved the BSS standards on 9/8/22. COH staff drafted the transmittal letters.
4	Update Home-based Case Management service standards	SBP prioritized HBCM for 2022 based on	~~July 2022~~ October 2022	DHSP presented a HBCM service utilization summary document at the January 2022 SBP Committee meeting Committee will announced a 30-

		recommendations from ATF and DHSP. 84% of HBCM clients are ages 50+		day Public Comment period starting on 5/4/22 and ending on 6/3/22. Approved by the Executive Committee on 8/29/22. Executive Committee approved the HBCM standards and moved them to the Full Commission for approval. The Full Commission approved the HBCM standards on 9/8/22. COH staff drafted the transmittal letters.
5	Conduct a targeted review of the oral health service standards and developing guidance for specialty dental providers related to dental implants.	Mario Perez (DHSP) recommended that the SBP committee conduct this specific addendum to the oral health standards for 2022	~~July 2022~~ October 2022	COH staff scheduled a planning meeting to elaborate details for an expert panel. The meeting is scheduled January 11, 2022. COH staff to identified Jeff Daniels as facilitator for Subject Matter Expert (SME) panel. COH staff requested service utilization summary document for Oral Health service standards from Wendy Garland [DHSP]. Dr. Younai provided literature review materials and COH staff will prepare an annotated bibliography. Paulina Zamudio provided list of dental providers contracted with DHSP. COH staff will draft SME panel invite letter. SME panel to convene in late February 2022. The COH convened an oral healthcare subject matter expert panel to support Commission staff in drafting a dental implant addendum to the current Ryan White Part A oral healthcare service standard. The addendum will provide clarification and guidance to the Commission's current oral healthcare service standard regarding to dental implants Commission staff will work with the panel facilitator Jeff Daniel, to compile a meeting summary to share with the panelists and will begin drafting an outline for the addendum. The plan is to have a draft addendum ready for the SBP committee to review for the April SBP meeting. Committee will vote to approve the addendum at the September meeting and move to the Executive Committee for approval. The Executive Committee did not vote on approving the document due to lack of quorum.

LOS ANGELES COUNTY COMMISSION ON HIV

LOS ANGELES COUNTY COMMISSION ON HIV 2022
STANDARDS AND BEST PRACTICES WORKPLAN (Updates in RED)

6	Update Oral healthcare Service Standards	Recommendation from DHSP	Early 2023	COH staff will provide an overview of the 2017 Oral Healthcare Service Standards at the October 2022 meeting to initiate the review process.
7	Update Transitional Case Management service standards	Recommendation from DHSP	November 2022	Committee will begin the review process at the March 2022 meeting. Committee will continue review process at October 2022 meeting.
8	Provide feedback on and monitor implementation of the local Ending the HIV Epidemic (EHE) plan	Develop strategies on how to engage with private health plans and providers in collaboration with DHSP	Ongoing, as needed	
9	Collaborate with the Planning, Priorities and Allocations Committee and AJ King (consultant) to shape the Comprehensive HIV Plan (CHP)	Contribute to the development of the CHP and advance the goals of the Comprehensive HIV Plan and Los Angeles County HIV/AIDS Strategy	Ongoing/ Late 2022	Added "CHP discussion" item for all SBP Committee meetings in 2022. COH staff and AJ King to provide updates on CHP progress and submit requests for information for the SBP Committee to address.
10	Engage private health plans in using service standards and RW services		TBD	
11	Update the Medical Case Management service standards	Committee received a public comment requesting for a review and update of the MCC services standards.	2023	
12	Update Consumer Bill of Rights	Committee received feedback during the oral healthcare dental implants subject matter expert panel to consider reviewing the Consumer Bill of Rights.	2023	

CAJETAN LUNA COMMENTS (pages 2-7)

Pre-release application for housing or necessary services

• Person-first language

• TRAUMA INFORMED CARE

SERVICE DESCRIPTION

Transitional Case Management-Incarcerated/Post-Release (TCM-IPR) is a client-centered activity that coordinates care for justice involved individuals who are living with HIV and are transitioning back to the community. TCM services include:

- Intake and assessment of available resources and needs
- Periodic reassessment of status and needs
- Development and implementation of Individual Release Plans
- Appropriate referrals to housing, community case management, medical, mental health, and substance use treatment, dental health
- Services to facilitate retention in care, viral suppression, and overall health for incarcerated/post-release individuals who are living with HIV and are transitioning back to the community
- Access to HIV and STI information, education, partner services, and behavioral and biomedical interventions (such as pre-exposure prophylaxis (PrEP)) to prevent acquisition and transmission of HIV/STIs)

RECOMMENDED TRAINING TOPICS FOR TRANSITIONAL CASE MANAGEMENT STAFF

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

- HIV/AIDS Medical and Treatment Updates
- Risk Behavior and Harm Reduction Interventions
- Addiction and Substance Use Treatment
- HIV Disclosure and Partner Services
- Mental health and HIV/AIDS including Grief and Loss
- Legal Issues, including Jails/Corrections Services
- Alternatives to Incarceration Training
- Integrated HIV/STI prevention and care services including Hepatitis C screening and treatment
- Sexual identification, gender issues, and provision of trans-friendly services
- Stigma and discrimination and HIV/AIDS
- Health equity and social justice
- Motivational interviewing
- Knowledge of available housing, food, and other basic need support services

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

SERVICE STANDARDS

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

SERVICE COMPONENT	STANDARD	DOCUMENTATION
Outreach	Transitional case management programs will conduct outreach to educate potential clients and HIV and STI services providers and other supportive service organizations about the availability and benefits of TCM services for justice-involved persons living with HIV.	Outreach plan on file at provider agency.
	Transitional case management programs will provide information sessions to incarcerated people living with HIV that facilitate enrollment into TCM services.	Record of information sessions at the provider agency. Copies of flyers and materials used. Record of referrals provided to clients.
	Transitional case management programs establish appointments (whenever possible) prior to release date.	Record of appointment date.
Client Intake	Initiate a client record	Client record to include: • Client name and contact information including: address, phone, and email • Written documentation of HIV/AIDS diagnosis • Proof of LAC Residency or documentation that client will be released to LAC residency • Verification of client's financial eligibility for services • Date of intake • Emergency and/or next of kin contact name, home address, and telephone number • Signed and dated Release of Information, Limits of

		Confidentiality, Consent, Client Rights and Responsibilities, and Grievance Procedures forms
Comprehensive Assessment	Comprehensive assessment and reassessment are completed in a cooperative process between the TCM staff and the client and entered into DHSP's data management system within 30 days of the initiation of services. Perform reassessments at least once per year or when a client's needs change or they have re-entered a case management program. Comprehensive assessment is conducted to determine the: • Client's needs for treatment and support services including housing and food needs • Client's current capacity to meet those needs • Client's Medical Home post-release and linkage to Medical Case Management (MCC) team prior to release to ensure continuity of care • Ability of the client's social support network to help meet client need • Extent to which other agencies are involved in client's care	Comprehensive assessment or reassessment on file in client chart to include: o Date of assessment/reassessment o Signature and title of staff person conducting assessment/reassessment o Client strengths, needs and available resources in the following areas: o Medical/physical healthcare o Medications and Adherence issues o Mental health o Substance use and substance use treatment o Nutrition/food o Housing and living situation o Family and dependent care issues o Access to hormone replacement therapy, gender reassignment procedures, name change/gender change clinics and other transition-related services. o Transportation o Language/literacy skills o Religious/spiritual support o Social support system o Relationship history o Domestic violence/Intimate

		Partner Violence (IPV) o Financial resources o Employment and Education o Legal issues/incarceration history o HIV and STI prevention issues
Individual Release Plan (IRP)	IRPs will be developed in conjunction with the client within two weeks of completing the assessment or reassessment The IRP should address, at minimum, the following: • Reasons for incarceration and prevention of recidivism • Transportation • Housing/shelter • Food • Primary health care • Mental health • Substance use treatment • Community-based case management IRPs will be updated on an ongoing basis.	IRP on file in client chart to includes: • Name of client and case manager • Date and signature of case manager and client • Date and description of client goals and desired outcomes • Action steps to be taken by client, case manager and others • Customized services offered to client to facilitate success in meeting goals, such as referrals to peer navigators and other social or health services. • Goal timeframes • Disposition of each goal as it is met, changed, or determined to be unattainable
Monitoring and Follow-up	Implementation, monitoring, and follow-up involve ongoing contact and interventions with (or on behalf of) the client to ensure that IRP goals are addressed and that the client is linked to and appropriately access and maintains primary health care and community-based supportive services identified on the IRP. Case managers will: • Provide referrals, advocacy and interventions based on the intake, assessment, and IRP	Signed, dated progress notes on file that detail (at minimum): • Description of client contacts and actions taken • Date and type of contact • Description of what occurred • Changes in the client's condition or circumstances • Progress made toward IRP goals • Barriers to IRPs and actions taken to resolve them • Linked referrals and interventions and current status/results of same

- Document discharge viral load
- Document discharge meds ordered

	• Monitor changes in the client's condition • Update/revise the IRP • Provide interventions and linked referrals • Ensure coordination of care • Help clients obtain health benefits and care • Conduct monitoring and follow-up to confirm completion of referrals and service utilization • Advocate on behalf of clients with other service providers • Empower clients to use independent living strategies • Help clients resolve barriers • Follow up on IRP goals • Maintain/attempt contact at a minimum of once every two weeks and at least one face-to-face contact monthly • Follow up missed appointments by the end of the next business day • Collaborate with the client's community-based case manager for coordination and follow-up when appropriate • Transition clients out of incarcerated transitional case management at six month's post-release.	• Barriers to referrals and interventions/actions taken • Time spent with, or on behalf of, client • Case manager's signature and title
Staffing Requirements and Qualifications	Case managers will have: • Knowledge of HIV//STIs and related issues • Knowledge of and sensitivity to incarceration and correctional settings and populations • Knowledge of and sensitivity to lesbian, gay, bisexual, and transgender persons	Resume, training certificates, interview assessment notes, reference checks, and annual performance reviews on file.

Submit applications and

identify available familial or partner resources.

and gender fluid

	• Effective motivational interviewing and assessment skills • Ability to appropriately interact and collaborate with others • Effective written/verbal communication skills • Ability to work independently • Effective problem-solving skills • Ability to respond appropriately in crisis situations • Effective organizational skills Refer to list of recommend training topics for Transitional Case Management Staff	• PRIORITIZE CASELOAD • PATIENCE • MULTITASKING SKILLS
	Case managers will hold a bachelor's degree in an area of human services; high school diploma (or GED equivalent) and at least one year's experience working as an HIV case manager or at least two years' experience working within a related health services field. Prior experience providing services to justice-involved individuals is preferred. Personal life experience with relevant issues is highly valued and should be considered when making hiring decisions.	Resumes on file at provider agency documenting experience. Copies of diplomas on file.
	All staff will be given orientation prior to providing services.	Record of orientation in employee file at provider agency.
	Case management staff will complete DHSP's required case management certifications/training within three months of being hired. Case management supervisors will complete DHSP's required supervisor's certification/training within six months of being hired.	Documentation of certification completion maintained in employee file.
	Case managers will participate in	Documentation of training

RYAN WHITE TRANSITIONAL CARE MANAGEMENT PROGRAM (TMCP)
IN LOS ANGELES COUNTY JAILS
Ryan White Program Years 29-30

Background

The rate of diagnosed HIV infection among people with justice system involvement in state and federal prisons was more than three times greater than the rate among the general U.S. population (Maruschak L. HIV in Prisons, 2001–2010). People living with HIV who have justice system involvement, particularly those with significant health problems, that are not connected to services to support their reintegration into communities and HIV care, are more likely to return to jail and to potentially transmit HIV to others. In 2003, to address re-entry from jails of PLWH who were incarcerated in Los Angeles County (LAC), the Division of HIV and STD Programs (DHSP) implemented a Transitional Case Management program (TCMP) to assist PLWH with justice system involvement and prepare them for release back into the community in collaboration with community providers, Department of Health Services (DHS), DHSP, and Los Angeles County Sheriff's Department (LASD) custody staff.

The goal of TCMP is to improve the retention of PLWH with justice system involvement in outpatient medical care through social stabilization. The primary objectives of TCMP are:

- To assist PLWH recently incarcerated in the LAC jails system with linkage to and coordination of HIV and STD services with community medical providers and social services upon release
- To reduce HIV transmission by increasing access and adherence to antiretroviral therapy (ART) among PLWH while incarcerated and facilitating post-release linkage to HIV care and prevention education, and
- To develop a meaningful relationship with the released inmate to prevent subsequent recidivism

The current TCMP contracts started in Ryan White Program (RWP) Year 30 (April 1, 2020) and continue through RWP Year 32 (March 31, 2022). Five agencies are contracted to provide these services: Center for Health Justice, Inc., JWCH Institute, Inc., Minority AIDS Project, Public Health Foundation Enterprises, Inc., and Tarzana Treatment Centers, Inc. TCMP is considered a subcategory of RWP Non-Medical Case Management (NMCM) Services.

The following provides a description of TCMP based on details provided in the service contracts. The types of clients using the service and which service components they received is also presented. Finally, the allowable service activities, as defined by the Health Resources and Services Administration (HRSA), is provided to understand the scope of this service category. This purpose of this summary is to show how the service standards were translated into practice and how services are being used to aid in the development new or updated service standards.

Overview of TCMP Services

Contractor and staff requirements

1. The Nurse Case Manager, or Medical Case Manager (MCM) is a medical liaison between the HIV jails medical staff and Transitional Case Managers (TCM) and provides medical case management services to inmates living with HIV and linkage to care between community HIV clinics and LASD Jail Medical Services to ensure continuity of HIV care as inmates cycle between the community and the LAC Jail with the assistance of TCMS. The MCM should be a registered nurse (RN) in good standing and licensed in California by the State Board of

Registered Nursing. MCM should be under the supervision of the Correctional Health Services (CHS), the division of DHS.

2. Transitional Case Managers (TCM) should provide TCMP services to eligible clients in accordance with procedures formulated and adopted by Contractor's staff, consistent with laws, regulations, the LAC Commission on HIV Transitional Case Management Standards of Care, and the DHSP Transitional Case Management Program Guidelines. Educational requirements are:
    a) A Bachelor's Degree from an accredited institution in Social Work, Psychology, Health Education, Social Services, Human Services, Human Development (Including Child Development), Sociology, or Counseling and have completed a minimum of eight (8) hours of course work on the basics of HIV/AIDS prior to providing services to clients; or
    b) An Associate Degree plus one-year direct case management experience in health or human services; or
    c) A high school diploma or GED and a minimum of three years of experience providing direct social services to patients/clients within a medical setting or in the field of HIV.

Contractor should provide TCMs with ongoing training related to the provision of TCMP Services. Contractor should also ensure ongoing staff development of HIV/AIDS case management staff with at a minimum of 16 hours per year per TCM. Staff development and enhancement activities should include, but not be limited to:

A. Trainings or in-services related to case management issues on such topics should include but not be limited to:
    (1) HIV/AIDS Medical and Treatment Updates
    (2) Risk Behavior and Harm Reduction Interventions
    (3) Addiction and Substance Use Treatment
    (4) HIV Disclosure and Partner Services
    (5) Mental Health and HIV/AIDS
    (6) Legal Issues, including Jails/Corrections Services

B. Contractor should ensure that every case manager participates in DHSP's Case Manager Training Program and either DHSP's or the State of California's Partner Counseling and Referral Services/Disclosure Assistance Services training within 6 months of providing case management services.

Service Description:

To assist PLWH with current or recent involvement with justice system to link and stay engaged in HIV medical care in the community by doing the following:

- Identifying and addressing barriers to care (i.e., mental health problem, lack of transportation, lack of housing)
- Assisting clients in navigating complex health and social service systems
- Providing HIV health education and risk reduction counseling
- Making referrals or appointments to HIV medical providers who are culturally competent in the care of recently incarcerated persons, and
- Leveraging other community or jail-based resources available to PLWH to ease their transition back to the community.

Service Population: persons living with diagnosed HIV who are:

- Incarcerated at one of the following Los Angeles County Jails facilities:
  - Twin Towers Correctional Facility
  - Men's Central Jail
  - Century Regional Detention Facility

Note: Although North County Correctional Facility is included in the list of facilities where TCMP services are offered, PLWH, as well as people with other non-HIV medical comorbidities, are moved out of this facility usually to Men's Central Jail because there are not robust medical services at this site. Thus, this is not currently a site for TCM services.

Key Service Activities

1. *Client Intake* determines if a person is eligible to register as a TCMP client. If the person is registered as a TCMP client, the TCM will initiate a client record that includes:
   - Client name and contact information, such as address, phone, and email
   - Written documentation of HIV/AIDS diagnosis
   - Proof of LAC residency or documentation that client will be released to LAC residency
   - Verification of client's financial eligibility for services
   - Date of intake
   - Emergency and/or next of kin contact name, home address, and telephone number Signed and dated Release of Information, Limits of Confidentiality, Consent, Client Rights and Responsibilities, and Grievance Procedures forms

2. *Comprehensive Assessment* should be conducted for each TCMP client. This standardized assessment is a cooperative and interactive face-to-face interview process during which the client's medical, physical, psychosocial, environmental, and financial strengths, needs, and available resources are identified and evaluated. Information obtained from the comprehensive assessment shall be used to develop or update/revise the client's Individual Release Plan (IRP). The minimum required documentation to be maintained within the client record include:
   - Date of assessment/reassessment
   - Signature and title of staff person conducting assessment/reassessment
   - Client's strengths, needs, and available resources in the following areas:
     a. Medical/physical health care
     b. Medications and Adherence issues
     c. Risk behaviors and risk reduction needs
     d. Disclosure and partner notification
     e. Mental health
     f. Substance use and substance use treatment
     g. Nutrition/food
     h. Housing and living situation
     i. Family and dependent care issues
     j. Transportation
     k. Social support system
     l. Financial
     m. Legal
     n. Employment and education

3. *Individualized Release Plan (IRP)* determines anticipated needs of the client at time of release. IRPs should be based on intake and assessment information. IRPs should include, but not be limited to, the following required documentation within the client record: name of client and

case manager, their signatures, description of client goals (i.e., desired outcomes) and date goals were established. The IRP should address, at a minimum, the following:

- Reasons for incarceration and prevention of recidivism
- Transportation
- Housing/shelter
- Food
- Primary health care
- Mental health
- Substance use treatment, and
- Community-based case management

4. *Monitoring and Follow-Up*: Monitoring follow-up includes activities to ensure that client, upon release, is linked to and appropriately accesses the primary health care and community-based support services identified on the IRP. Follow-up activities should involve ongoing contact and interventions with or on behalf of the client to ensure client linkages to needed services identified in the IRP and to achieve the goals of the IRP. TCM should ensure the following:
   - Provide linked referrals, client advocacy, and appropriate interventions based on the intake, comprehensive assessment, and individual release plan information.
   - Conduct ongoing monitoring and follow-up with client and/or provider to confirm completion of referrals, service acquisition, maintenance of services, and adherence to services.
   - Documented follow-up within 24 hours with recently released TCM clients who have missed a case management appointment or reason why follow-up was not completed.

5. *Client Transition* When the client is successfully linked to community case management or at six (6) months post-release, clients should be transitioned out of the HIV/AIDS TCM program with linked referrals to primary health care, community-based case management, and other support services. Once client has been linked to community-based case management services, TCM should collaborate with the client's community-based case manager for coordination and meet in a team case conference to transition the case. TCMP services should be considered completed once client successfully transitions to community HIV/AIDS case management services.

6. *Progress Notes and Documentation* should be maintained by the Contractor in the client program records and should include, but not limited to the following required documentation:
   - Client contacts
   - Actions taken on behalf of the client
   - Barriers identified in completing IRP goals
   - Actions taken to resolve these barriers
   - Status of linked referrals
   - Interventions provided
   - Time spent on each action

Reimbursement Structure: Cost reimbursement

Service Unit Definition: Hours of service

Service Tracking Measures:

1. Number of unduplicated clients
2. Number of service hours delivered

Limits on service utilization: Expenditures should not exceed the amount specified in a contract.

Contractor Reporting Requirements

1. Narrative Reports
   - Monthly reports (written and summary CaseWatch reports)
     - Includes informational sessions

2. Client-level Data (reported through HIV CaseWatch)
   - Screening (eligibility) data
   - Demographic data
   - Service utilization data
   - Medical and support service outcomes
   - Service linkages/referrals to other service providers

TCMP Service Utilization Summary for Year 29-30

The data presented below describes TCMP clients and service utilization in RWP years 29 (March 1, 2019-February 28, 2020) and 30 (March 1, 2020-February 28, 2021).

The COVID-19 pandemic severely limited the provision of TCMP services starting in March 2020 due to limited access to jails for TCM providers and large-scale and frequent quarantines inside the facilities. As a result, most of the jail-based activities by TCMs (client intake, comprehensive assessment, IRP, some intervention activities) were halted until the second half of 2021. This resulted in a significant decrease in the number of clients utilizing TCM services from 805 in Year 29 to 476 in Year 30.

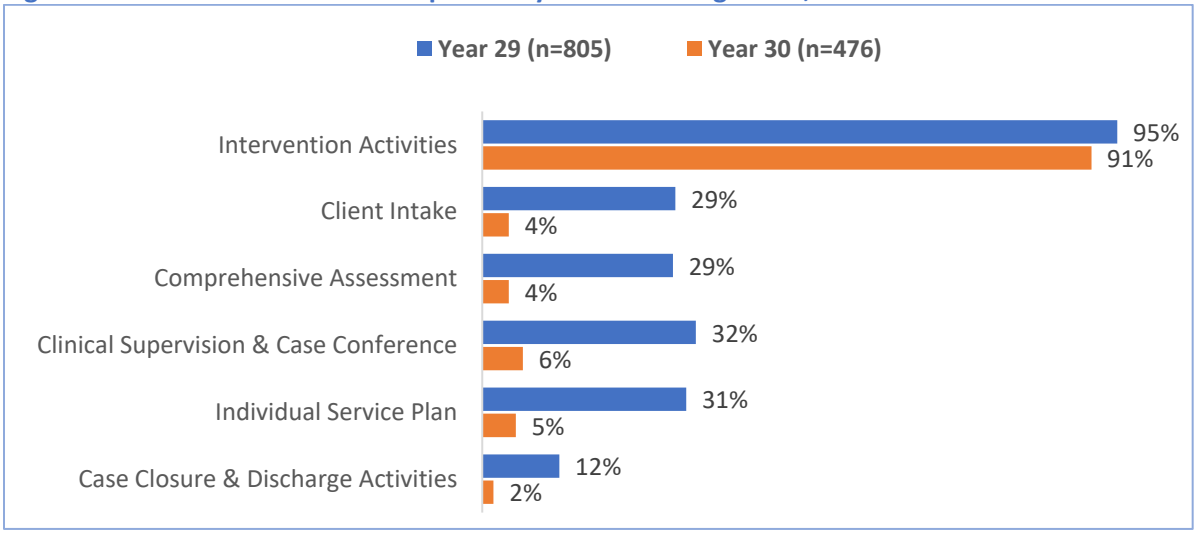
Despite the decrease in the number of clients, the characteristics of the clients did not change from Year 29 to Year 30. In Year 30, most TCMP clients were Black and Latinx (82%), identified as cisgender male (91%), and were between the ages of 18-39 (64%).

The low percentage of cisgender women using TCMP services may a reflect limited access to those services in the Women's jails given lower service need compared to men. Historically, given the low number of incarcerated women in LAC (about 10% of LAC jail population), especially women living with HIV identified at Century Regional Detention Facility (CRDF), TCMs have a limited schedule at the women's jail.

Limited access to the jails during COVID-19 also resulted in a decrease in the total number of service hours provided from 4,733 in Year 29 to 1,648 in Year 30, and a decrease in the number of services hours per client from 5.9 in Year 29 to 3.5 hours per client in Year 30.

In addition to service hours, specific TCMP service activities used by clients were reported for Years 29 and 30. Figure 1 below presents the percent of clients who received each type of activity each year. Year 29 is represented by the blue bars and Year 30 by the orange bars.

Figure 1: TCM Service Activities Reported by Contracted Agencies, Years 29-30



There was a notable decrease in the proportion of clients receiving all TCMP service activities from Year 29 to Year 30 apart from Intervention Activities. This may be due to the early release inmates from the LAC jail system in April-May 2020 because of COVID-19. During that time, the TCMs worked quickly to link newly released clients to community medical care, housing, social and many other services. Unlike the provision of other service activities that required TCMs access their clients in the jails, the interventional activities could be provided post-release, outside of the jail setting.

Unpredictable release from the jails before COVID-19 may have contributed to only about one-third of TCMP clients received intake, assessment, care planning and discharge services in Year 29. The difficulty of timely connection with clients before they were released was likely further exacerbated by the early release practices during COVID-19.

Scope of TCMP as a Non-Medical Case Management Service per HRSA PCN #16-02:

Non-Medical Case Management Services

Description:

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

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

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

Acknowledgements
This report was prepared by Sona Oksuzyan and Janet Cuanas and reviewed by Wendy Garland, Rebecca Cohen and Paulina Zamudio of the Division of HIV and STD Programs, County of Los Angeles, Department of Public Health.

DRAFT UNDER REVIEW

SERVICE STANDARDS FOR TRANSITIONAL CASE MANAGEMENT-INCARCERATED/POST RELEASE

LOS ANGELES COUNTY
COMMISSION ON HIV

Under review by the SBP Committee. Current draft as of 8/2/22

Approved by the Commission on HIV on 4/13/2017

DRAFT

SERVICE STANDARDS: TRANSITIONAL CASE MANAGEMENT- INCARCERATED/POST-RELEASE

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

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

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

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

INTRODUCTION

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

SERVICE DESCRIPTION

Transitional Case Management-Incarcerated/Post-Release (TCM-IPR) is a client-centered activity that coordinates care for justice involved individuals who are living with HIV and are transitioning back to the community. TCM services include:

- Intake and assessment of available resources and needs
- Periodic reassessment of status and needs
- Development and implementation of Individual Release Plans
- Appropriate referrals to housing, community case management, medical, mental health, and substance use treatment, dental health
- Services to facilitate retention in care, viral suppression, and overall health for incarcerated/post-release individuals who are living with HIV and are transitioning back to the community
- Access to HIV and STI information, education, partner services, and behavioral and biomedical interventions (such as pre-exposure prophylaxis (PrEP)) to prevent acquisition and transmission of HIV/STIs)

RECOMMENDED TRAINING TOPICS FOR TRANSITIONAL CASE MANAGEMENT STAFF

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

- HIV/AIDS Medical and Treatment Updates
- Risk Behavior and Harm Reduction Interventions
- Addiction and Substance Use Treatment
- HIV Disclosure and Partner Services
- Mental health and HIV/AIDS including Grief and Loss
- Legal Issues, including Jails/Corrections Services
- Alternatives to Incarceration Training
- Integrated HIV/STI prevention and care services including Hepatitis C screening and treatment
- Sexual identification, gender issues, and provision of trans-friendly services
- Stigma and discrimination and HIV/AIDS
- Health equity and social justice
- Motivational interviewing
- Knowledge of available housing, food, and other basic need support services

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

SERVICE STANDARDS

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

SERVICE COMPONENT	STANDARD	DOCUMENTATION
Outreach	Transitional case management programs will conduct outreach to educate potential clients and HIV and STI services providers and other supportive service organizations about the availability and benefits of TCM services for justice-involved persons living with HIV.	Outreach plan on file at provider agency.
	Transitional case management programs will provide information sessions to incarcerated people living with HIV that facilitate enrollment into TCM services.	Record of information sessions at the provider agency. Copies of flyers and materials used. Record of referrals provided to clients.
	Transitional case management programs establish appointments (whenever possible) prior to release date.	Record of appointment date.
Client Intake	Initiate a client record	Client record to include: • Client name and contact information including: address, phone, and email • Written documentation of HIV/AIDS diagnosis • Proof of LAC Residency or documentation that client will be released to LAC residency • Verification of client's financial eligibility for services • Date of intake • Emergency and/or next of kin contact name, home address, and telephone number • Signed and dated Release of Information, Limits of

		Confidentiality, Consent, Client Rights and Responsibilities, and Grievance Procedures forms
Comprehensive Assessment	Comprehensive assessment and reassessment are completed in a cooperative process between the TCM staff and the client and entered into DHSP's data management system within 30 days of the initiation of services. Perform reassessments at least once per year or when a client's needs change or they have re-entered a case management program. Comprehensive assessment is conducted to determine the: • Client's needs for treatment and support services including housing and food needs • Client's current capacity to meet those needs • Client's Medical Home post-release and linkage to Medical Case Management (MCC) team prior to release to ensure continuity of care • Ability of the client's social support network to help meet client need • Extent to which other agencies are involved in client's care	Comprehensive assessment or reassessment on file in client chart to include: ○ Date of assessment/reassessment ○ Signature and title of staff person conducting assessment/reassessment ○ Client strengths, needs and available resources in the following areas: ○ Medical/physical healthcare ○ Medications and Adherence issues ○ Mental health ○ Substance use and substance use treatment ○ Nutrition/food ○ Housing and living situation ○ Family and dependent care issues ○ Access to hormone replacement therapy, gender reassignment procedures, name change/gender change clinics and other transition-related services. ○ Transportation ○ Language/literacy skills ○ Religious/spiritual support ○ Social support system ○ Relationship history ○ Domestic violence/Intimate

		Partner Violence (IPV) ○ Financial resources ○ Employment and Education ○ Legal issues/incarceration history ○ HIV and STI prevention issues
Individual Release Plan (IRP)	IRPs will be developed in conjunction with the client within two weeks of completing the assessment or reassessment The IRP should address, at minimum, the following: • Reasons for incarceration and prevention of recidivism • Transportation • Housing/shelter • Food • Primary health care • Mental health • Substance use treatment • Community-based case management IRPs will be updated on an ongoing basis.	IRP on file in client chart to includes: • Name of client and case manager • Date and signature of case manager and client • Date and description of client goals and desired outcomes • Action steps to be taken by client, case manager and others • Customized services offered to client to facilitate success in meeting goals, such as referrals to peer navigators and other social or health services. • Goal timeframes • Disposition of each goal as it is met, changed, or determined to be unattainable
Monitoring and Follow-up	Implementation, monitoring, and follow-up involve ongoing contact and interventions with (or on behalf of) the client to ensure that IRP goals are addressed and that the client is linked to and appropriately access and maintains primary health care and community-based supportive services identified on the IRP. Case managers will: • Provide referrals, advocacy and interventions based on the intake, assessment, and IRP	Signed, dated progress notes on file that detail (at minimum): • Description of client contacts and actions taken • Date and type of contact • Description of what occurred • Changes in the client's condition or circumstances • Progress made toward IRP goals • Barriers to IRPs and actions taken to resolve them • Linked referrals and interventions and current status/results of same

	• Monitor changes in the client's condition • Update/revise the IRP • Provide interventions and linked referrals • Ensure coordination of care • Help clients obtain health benefits and care • Conduct monitoring and follow-up to confirm completion of referrals and service utilization • Advocate on behalf of clients with other service providers • Empower clients to use independent living strategies • Help clients resolve barriers • Follow up on IRP goals • Maintain/attempt contact at a minimum of once every two weeks and at least one face-to-face contact monthly • Follow up missed appointments by the end of the next business day • Collaborate with the client's community-based case manager for coordination and follow-up when appropriate • Transition clients out of incarcerated transitional case management at six month's post-release.	• Barriers to referrals and interventions/actions taken • Time spent with, or on behalf of, client • Case manager's signature and title
Staffing Requirements and Qualifications	Case managers will have: • Knowledge of HIV//STIs and related issues • Knowledge of and sensitivity to incarceration and correctional settings and populations • Knowledge of and sensitivity to lesbian, gay, bisexual, and transgender persons	Resume, training certificates, interview assessment notes, reference checks, and annual performance reviews on file.

	• Effective motivational interviewing and assessment skills • Ability to appropriately interact and collaborate with others • Effective written/verbal communication skills • Ability to work independently • Effective problem-solving skills • Ability to respond appropriately in crisis situations • Effective organizational skills Refer to list of recommend training topics for Transitional Case Management Staff	
	Case managers will hold a bachelor's degree in an area of human services; high school diploma (or GED equivalent) and at least one year's experience working as an HIV case manager or at least two years' experience working within a related health services field. Prior experience providing services to justice-involved individuals is preferred. Personal life experience with relevant issues is highly valued and should be considered when making hiring decisions.	Resumes on file at provider agency documenting experience. Copies of diplomas on file.
	All staff will be given orientation prior to providing services.	Record of orientation in employee file at provider agency.
	Case management staff will complete DHSP's required case management certifications/training within three months of being hired. Case management supervisors will complete DHSP's required supervisor's certification/training within six months of being hired.	Documentation of certification completion maintained in employee file.
	Case managers will participate in	Documentation of training

	recertification as required by DHSP and in at least 16 hours of continuing education annually. Management, clerical, and support staff must attend a minimum of eight hours of HIV/ AIDS/STIs training each year.	maintained in employee files to include: • Date, time, and location of function • Function type • Staff members attending • Sponsor or provider of function • Training outline, handouts, or materials • Meeting agenda and/or minutes
	Case management staff will receive a minimum of four hours of client care-related supervision per month from a master's degree-level mental health professional.	All client care-related supervision will be documented as follows (at minimum): • Date of client care-related supervision • Supervision format • Name and title of participants • Issues and concerns identified • Guidance provided and follow-up plan • Verification that guidance and plan have been implemented • Client care supervisor's name, title, and signature.
	Clinal Supervisor will provide general clinical guidance and follow-up plans for case management staff.	Documentation of client care-related supervision for individual clients will be maintained in the client's individual file.

LOS ANGELES COUNTY
COMMISSION ON HIV

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?

STANDARDS OF CARE

Los Angeles County Commission on HIV

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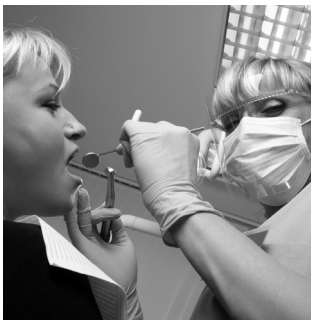
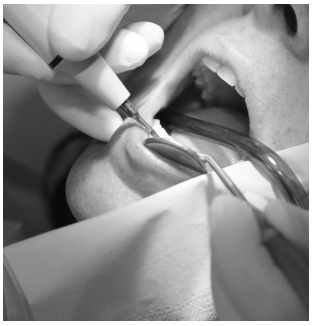




STANDARDS OF CARE

Los Angeles County Commission on HIV

ORAL HEALTH CARE SERVICES

EXECUTIVE SUMMARY

SERVICE INTRODUCTION

Oral health care services should be an integral part of primary medical care for all people living with HIV. Most HIV-infected patients can receive routine, comprehensive oral health care in the same manner as any other person. All treatment will be administered according to published research and available standards of care.

Services shall include (but not be limited to):

- Identifying appropriate clients for HIV oral health care services through eligibility screening
- Obtaining a comprehensive medical history and consulting primary medical providers as necessary
- Providing educational, prophylactic, diagnostic and therapeutic dental services to patients with a written confirmation of HIV disease
- Providing medication appropriate to oral health care services, including all currently approved drugs for HIV related oral manifestations
- Providing or referring patients, as needed, to health specialists including, but not limited to, periodontists, endodontists, oral surgeons, oral pathologists, oral medicine practitioners and registered dietitians
- Maintaining individual patient dental records in accordance with current standards
- Complying with infection control guidelines and procedures established by the California Occupation Safety and Health Administration (Cal-OSHA)

The following are priorities for HIV oral health treatment:

1. Prevention of oral and/or systemic disease where the oral cavity serves as an entry point
2. Elimination of presenting symptoms
3. Elimination of infection
4. Preservation of dentition and restoration of functioning

SERVICE/ORGANIZATIONAL LICENSURE CATEGORY

HIV/AIDS oral health care services shall be provided by dental care professionals who have applicable professional degrees and current California State licenses. Dental staff can include: dentists, dental assistants and dental hygienists. Clinical supervision shall be performed by a licensed dentist responsible for all clinical operations.

SERVICE CONSIDERATIONS

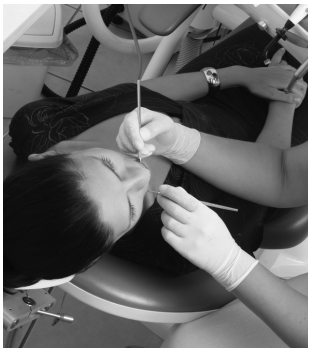
General Considerations: There is no justification to deny or modify dental treatment based on the fact that a patient has tested positive for HIV. Further, the magnitude of the

viral load is not an indicator to withhold dental treatment for the patient. If, however, a patient's medical condition is compromised, treatment adjustments, as with any medically compromised patient, may be necessary.

Evaluation: When presenting for dental services, people living with HIV should be given a comprehensive oral evaluation. When indicated, diagnostic tests relevant to the evaluation of the patient should be performed and used in diagnosis and treatment planning. In addition, full medical status information from the patient's medical provider, including most recent lab work results, should be obtained and considered by the dentist

Treatment Planning: In conjunction with the patient, each dental provider shall develop a comprehensive, multidisciplinary treatment plan. The patient's primary reason for the visit should be considered by the dental professional when developing the dental treatment plan. Treatment priority should be given to the management of pain, infection, traumatic injury or other emergency conditions.

Informed Consent: Patients will sign an informed consent document for all dental procedures. This informed consent process will be ongoing as indicated by the dental treatment plan.



Oral health is an integral part of primary care.

Treatment Standards: All treatment will be administered according to published research and available standards of care.

Medical Consultation: The dental provider should consult with the patient's primary care physician when additional information is needed to provide safe and appropriate care.

Encouraging Primary Care Participation: Dentists can play an important part in reminding patients of the need for regular primary medical care (cluster designation 4 (CD4) and viral load tests every three to six months depending on the past history of HIV infection and level of suppression achieved) and encouraging patients to adhere to their medication regimens. If a patient is not under the regular care of a primary care physician, he or she should be urged to seek care and a referral to primary care will be made.

Prevention/Early Intervention: Dental professionals will emphasize prevention and early detection of oral disease by educating patients about preventive oral health practices, including instruction in oral hygiene. In addition, dental professionals may provide counseling regarding behaviors (e.g., tobacco use, unprotected oral sex, body piercing in oral structures) and general health conditions that can compromise oral health. The impact of good nutrition on preserving good oral health should be discussed.

Program Records: HIV oral health providers will maintain adequate health records consistent with good dental and professional practice in accordance with the California Code of Regulations on each individual patient.

Triage/Referral/Coordination: It is incumbent upon dental health providers to refer appropriate patients to additional providers including: periodontists, endodontists, oral surgeons, oral pathologists and oral medicine practitioners. Also vital is the coordination of oral health care with primary care medical providers.

Linkages and Marketing: Programs providing dental care for people living with HIV will market their services through known linkages and direct outreach.

Client Retention: Programs shall strive to retain patients in oral health treatment services.

A broken appointment policy and procedure to ensure continuity of service and retention of patients is required.

STAFFING REQUIREMENTS AND QUALIFICATIONS

Prior to performing HIV/AIDS oral health care services, all dental staff will be oriented and trained in policies and procedures of the general practice of dentistry and, specifically, the provision of dental services to people living with HIV.

These training programs shall include (at minimum):

- Basic HIV information
- Orientation to the office and policies related to the oral health of people living with HIV
- Infection control and sterilization techniques
- Methods of initial evaluation of the patient living with HIV disease
- Education and counseling of patients regarding maintenance of their own health
- Recognition and treatment of common oral manifestations and complications of HIV disease
- Recognition of oral signs and symptoms of advanced HIV disease, including treatment and/or appropriate referral

STANDARDS OF CARE

Los Angeles County Commission on HIV

ORAL HEALTH CARE SERVICES

SERVICE INTRODUCTION

Oral health care services should be an integral part of primary medical care for all people living with HIV. Most HIV-infected patients can receive routine, comprehensive oral health care in the same manner as any other person.

Oral health services include:

- Obtaining a comprehensive medical history and consulting primary medical providers as necessary
- Providing educational, prophylactic, diagnostic and therapeutic dental services to patients with a written confirmation of HIV disease
- Providing medication appropriate to oral health care services, including all currently approved drugs for HIV related oral manifestations
- Providing or referring patients, as needed, to health specialists including, but not limited to, periodontists, endodontists, oral surgeons, oral pathologists and oral medicine practitioners

Poor oral care can negatively impact quality of life.

All interventions must be based on proven clinical methods and in accordance with legal and ethical standards. Maintaining confidentiality is critical, and its importance cannot be overstated. All programs must comply with the Health Insurance Portability and Accountability Act (HIPAA) standards for information disclosure.

Our expert panel agreed upon the following priorities for HIV oral health treatment:

1. Prevention of oral and/or systemic disease where the oral cavity serves as an entry point
2. Elimination of presenting symptoms
3. Elimination of infection
4. Preservation of dentition and restoration of functioning

Recurring themes in this standard include:

- Good oral health is an important factor in the overall health management of people living with HIV.
- Treatment modifications should only be used when a patient's health status demands them.
- Comprehensive evaluation is a critical component of appropriate oral health care services.

- Treatment plans should be made in conjunction with the patient.
- Collaboration with primary medical providers is necessary to provide comprehensive dental treatment.
- Prevention and early detection should be emphasized.

The Los Angeles County Commission on HIV (COH) and the Division of HIV and STD Programs (DHSP)—formerly referred to as the Office of AIDS Programs and Policy (OAPP)—have developed this standard of care to set minimum quality expectations for service provision and to guarantee clients consistent care, regardless of where they receive services in the County.

This document represents a synthesis of published standards and research, including:

- *Oral Health Care Exhibit,* Office of AIDS Programs and Policy, 2004
- *Practice Guidelines for the Treatment of HIV Patients in General Dentistry,* LA County Commission on HIV Services, 2002
- *Oral Health Care for People with HIV Infection,* AIDS Institute, New York State Department of Health, 2001
- Standards of care developed by several other Ryan White Title 1 Planning Councils. Most valuable in the drafting of this standard were Florida Community Planning Group (2002); Denver, CO (2004); and Chicago, IL (2002)

SERVICE/ORGANIZATIONAL LICENSURE CATEGORY

HIV/AIDS oral health care services shall be provided by dental care professionals who possess the applicable professional degrees and current California state licenses. Dental staff can include: dentists, dental assistants and dental hygienists. Clinical supervision shall be performed by a licensed dentist responsible for all clinical operations.

Dentists: A dentist must complete a four-year dental program and possess a Doctor of Dental Surgery (DDS) degree. Additionally, dentists must pass a three-part examination as well as the California jurisprudence exam and a professional ethics exam. Dentists are regulated by the California Dental Board (please see **(http://www.dbc.ca.gov/index.html)** for further information).

Registered Dental Assistants (RDA): RDAs must possess a diploma or certificate in dental assisting from an educational program approved by the California Dental Board, or 18 months of satisfactory work experience as a dental assistant. RDAs are regulated by the California Dental Board (please see **(http://www.dbc.ca.gov/index.html)** for further information).

Registered Dental Hygienists (RDH): RDHs must have been granted a diploma or certificate in dental hygiene from an approved dental hygiene educational program. RDHs are regulated by the California Dental Board (please see **(http://www.dbc.ca.gov/index.html)** for further information).

DEFINITIONS AND DESCRIPTIONS

Client registration and intake is the process that determines a person's eligibility for oral services.

Registered Dental Assistant (RDA) is a licensed person who may perform all procedures authorized by the provisions of these regulations and in addition may perform all functions which may be performed by a dental assistant under the designated supervision of a licensed dentist.

Registered Dental Hygienist (RDH) is a licensed person who may perform all procedures authorized by the provisions of these regulations and in addition may perform all functions which may be performed by a dental assistant and RDA under the designated supervision of a licensed dentist.

Oral prophylaxis is a preventive dental procedure that includes the complete removal of calculus, soft deposits, plaque and stains from the coronal portions of the tooth. This treatment enables a patient to maintain healthy hard and soft tissues.

Direct supervision is supervision of dental procedures based on instructions given by a licensed dentist who must be physically present in the treatment facility during performance of those procedures.

General supervision is the supervision of dental procedures based on instructions given by a licensed dentist, but not requiring the physical presence of the supervising dentist during the performance of those procedures.

Basic supportive dental procedures are the fundamental duties or functions which may be performed by an unlicensed dental assistant under the supervision of a licensed dentist because of their technically elementary characteristics, complete reversibility and inability to precipitate potentially hazardous conditions for the patient being treated.

Standard precautions are an approach to infection control that integrates and expands the elements of universal precautions (human blood and certain human body fluids treated as if known to be infectious for HIV, Hepatitis B Virus (HBV) and other blood-borne pathogens). Standard precautions apply to contact with all body fluids, secretions and excretions (except for sweat), regardless of whether they contain blood, and to contact with non-intact skin and mucous membranes.

HOW SERVICE RELATES TO HIV

At the end of 2013, approximately 60,050 people were estimated to be living with HIV infection in Los Angeles County. Los Angeles County comprises 40% of the total AIDS cases in the State of California (Epidemiologic Profile of HIV in Los Angeles County, 2013).

Many new HIV infections occur in populations whose oral health is among the poorest in the nation (Marcus, et al., 2000; Zabos, 1999). Shiboski, et al., 1999 and the Agency for Healthcare Research and Quality, 2000, have documented the unmet oral health needs of people living with HIV. People who experience more HIV symptoms have a greater need for dental care than those with fewer symptoms, though their more pressing needs for primary medical and mental health care limit their access to appropriate oral health services (Dobalian, et al., 2003). Although great progress has been made in providing dental services to people living with HIV, educating oral health professionals to ensure appropriate, non-judgmental care continues to be a critical priority.

Good dental care is an important factor in the overall health management of people living

with HIV infection. Poor oral health can negatively impact quality of life, create nutritional and psychosocial problems, complicate the management of other medical conditions, and negatively impact medication treatment adherence (U.S. Department of Health and Human Services, 2000). Access to dental evaluation, prophylaxis and care significantly improves oral health and quality of life for people living with HIV (Brown, et al., 2002).

SERVICE COMPONENTS

HIV/AIDS oral health care services are provided by fully registered dental health care professionals authorized to perform dental services under the laws and regulations of the state of California. Components include educational, prophylactic, diagnostic and therapeutic services. These services will be provided to medically indigent (uninsured and/or ineligible for health care coverage) people living with HIV residing within Los Angeles County.

Services will include (but not be limited to):

- Identifying appropriate clients for HIV oral health care services through eligibility screening
- Obtaining a comprehensive medical history and consulting primary medical providers as necessary
- Providing educational, prophylactic, diagnostic and therapeutic dental services to patients with a written confirmation of HIV disease
- Providing medication appropriate to oral health care services, including all currently approved drugs for HIV related oral manifestations
- Providing or referring patients, as needed, to health specialists including, but not limited to, periodontists, endodontists, oral surgeons, oral pathologists, oral medicine practitioners and registered dietitians
- Maintaining individual patient dental records in accordance with current standards
- Complying with infection control guidelines and procedures established by the California Occupation Safety and Health Administration (Cal-OSHA)

INTAKE

Client intake determines eligibility and includes demographic data, emergency contact information, next of kin and eligibility documentation. When possible, client intake will be completed in the first contact with the potential client. Programs will assess individuals in crisis to determine what other interventions are appropriate, either within the agency, or by immediate referral.

In the intake process and throughout oral health services, client confidentiality will be strictly maintained and enforced. All programs will follow HIPAA guidelines and regulations for confidentiality. As needed, Release of Information forms will be gathered. These forms detail the specific person/s or agencies to or from whom information will be released as well as the specific kind of information to be released. New forms must be added for individuals not listed on the most current Release of Information (specification should indicate the type of information that can be released).

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 contract 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 client and will be kept on file in the client chart:

- 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
- Client Rights and Responsibilities
- Client Grievance Procedures

STANDARD	MEASURE
Intake process will begin during first contact with client.	Intake tool 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 will be discussed and completed.	Release of Information signed and dated by client on file and updated annually.
Consent for Services will be completed.	Signed and dated Consent in client file.
Client will be informed of Rights and Responsibility and Grievance Procedures.	Signed and dated forms in client file.

GENERAL CONSIDERATIONS

There is no justification to deny or modify dental treatment due to a patient testing positive for HIV. Further, the magnitude of the viral load is not an indicator to withhold dental treatment for the patient. If, however, a patient's medical condition is compromised, treatment adjustments for that individual, as with any medically compromised patient, may be necessary

There is no evidence to support the need for routine antibiotic coverage to prevent bacteremia or septicemia arising from dental procedures for the HIV-infected patient. When indicated, the American Heart Association guidelines for antibiotic prophylaxis for bacterial endocarditis should be followed when working with HIV-infected patients. The primary care physician should be consulted before utilizing procedures likely to cause bleeding and bacteremia in HIV-infected patients with neutrophil counts below 500 cells/mm3, who are not already taking antibiotics as prophylaxis against opportunistic infections.

STANDARD	MEASURE
Routine antibiotic treatment for bacteremia or septicemia is not indicated in working with the HIV-infected patient.	Signed, dated progress note and/or treatment plan to detail treatment.
If clinically indicated, the American Heat Association guidelines for antibiotic prophylaxis for bacterial endocarditis should be followed.	Signed, dated progress note and/or treatment plan to detail treatment.
When a patient who is not already taking antibiotic prophylaxis, has a neutrophil count below 500 cells/ mm3, the primary care physician will be consulted before initiating procedures likely to cause bleeding or bacteremia.	Signed, dated progress note and/or treatment plan to detail treatment.

EVALUATION

When presenting for dental services, people living with HIV should be given a comprehensive oral evaluation including:

- Documentation of patient's presenting complaint
- Caries charting
- Full mouth radiographs or panoramic and bitewings and selected periapical films,
- Complete periodontal exam or PSR (periodontal screening record)
- Comprehensive head and neck exam
- Complete intra-oral exam, including evaluation for HIV-associated lesions
- Pain assessment

When indicated, diagnostic tests relevant to the evaluation of the patient should be performed and used in diagnosis and treatment planning. Biopsies of suspicious oral lesions should be taken; patients should be informed about the results of such tests.

In addition, full medical status information from the patient's medical provider, including most recent lab work results should be obtained and considered by the dentist. This information may assist the dentist in identifying conditions that may affect the diagnosis and management of the patient's oral health. The medical history and current medication list should be updated regularly to ensure all medical and treatment changes are noted.

STANDARD	MEASURE
A comprehensive oral evaluation will be given to people with HIV presenting for dental services. The evaluation will include: • Documentation of patient's presenting complaint • Caries charting • Radiographs or panoramic and bitewings and selected periapical films • Complete periodontal exam or PSR (periodontal screening record) • Comprehensive head and neck exam • Complete intra-oral exam, including evaluation for HIV-associated lesions • Pain assessment	Signed, dated oral evaluation on file in patient chart.
As indicated, diagnostic tests relevant to the evaluation will be used in diagnosis and treatment planning. Biopsies of suspicious oral lesions will be taken.	Signed, dated evaluation in patient chart to detail additional tests.
Full medical status information will be obtained from the patient's medical provider and considered in the evaluation. The medical history and current medication list will be updated regularly to ensure all medical and treatment changes are noted.	Signed, dated evaluation in patient chart to detail medical status information. Signed, dated progress note to detail updated medical information in patient chart

TREATMENT PLANNING

In conjunction with the patient, each dental provider shall develop a comprehensive, multidisciplinary treatment plan. Treatment plans including the above-listed information will be reviewed with and signed by the patient. The behavioral, psychological, developmental and physiologic strengths and limitations of the patient should be considered by the dental professional when developing the treatment plan. The patient's ability to withstand treatment for an extended amount of time or return for sequential visits should be determined when a treatment plan is prepared or a dental procedure initiated.

The patient's primary reason for the visit should be considered by the dental professional when developing the dental treatment plan. Treatment priority should be given to the management of pain, infection, traumatic injury or other emergency conditions. The dentist should attempt to manage the patient's pain, anxiety and behavior during treatment to facilitate safety and efficiency. The goal of treatment should be to maintain the most optimal functioning possible.

When developing a treatment plan, the dentist should consider:

- Tooth and/or tissue supported prosthetic options
- Fixed prostheses, removable prostheses or a combination of these options
- Soft and hard tissue characteristics and morphology, ridge relationships, occlusion and occludal forces, aesthetics and parafunctional habits
- Restorative implications, endodontic status, tooth position and periodontal prognosis
- Craniofacial, musculosketal relationships, including the clinically apparent status of the temporomandibular joints

Treatment plans will include appropriate recall/follow-up schedules. A six-month recall schedule is necessary to monitor any oral changes. If the patient's CD4 count is below 100, a three-month recall schedule should be considered. Treatment plans will be updated as necessary as determined by the dental provider or director of the dental program.

STANDARD	MEASURE
A comprehensive, multidisciplinary treatment plan will be developed in conjunction with the patient.	Treatment plan dated and signed by both the provider and patient in patient file.
Patient's primary reason for dental visit should be addressed in treatment plan.	Treatment plan dated and signed by both the provider and patient in patient file to detail.
Patient strengths and limitations will be considered in development of treatment plan.	Treatment plan dated and signed by both the provider and patient in patient file to detail.
Treatment priority will be given to pain management, infection, traumatic injury or other emergency conditions.	Treatment plan dated and signed by both the provider and patient in patient file to detail.
Treatment plan will include consideration of following factors: • Tooth and/or tissue supported prosthetic options • Fixed prostheses, removable prostheses or combination • Soft and hard tissue characteristics and morphology, ridge relationships, occlusion and occludal forces, aesthetics and parafunctional habits • Restorative implications, endodontic status, tooth position and periodontal prognosis • Craniofacial, musculosketal relationships	Treatment plan dated and signed by both the provider and patient in patient file to detail.
Six-month recall schedule will be used to monitor any changes. If a patient's CD4 count is below 100, a three-month recall schedule will be considered.	Signed, dated progress note in patient file to detail.

STANDARD	MEASURE
Treatment plans will be updated as deemed necessary.	Updated treatment plan dated and signed by both the provider and patient in patient file.

INFORMED CONSENT

As part of the informed consent process, dental professionals will discuss with the patient:

- Appropriate diagnostic information
- Recommended treatment
- Alternative treatment and sources of funding
- Costs (if any)
- Benefits and risks of treatment
- Limitations of treatment based on health status and available resources

Dental providers will describe all options for dental treatment (including cost considerations), and allow the patient to be part of the decision-making process. After the informed consent discussion, patients will sign an informed consent document for all dental procedures. This informed consent process will be ongoing as indicated by the dental treatment plan.

STANDARD	MEASURE
As part of the informed consent process, dental professionals will provide the following before obtaining informed consent: • Diagnostic information • Recommended treatment • Alternative treatment and sources of funding • Costs (if any) • Benefits and risks of treatment • Limitations of treatment	Signed, dated progress note or informed consent in patient file to detail.
Dental providers will describe all options for dental treatment (including cost considerations), and allow the patient to be part of the decision-making process.	Signed, dated progress note or informed consent in client file to detail.
After the informed consent discussion, patients will sign an informed consent for all dental procedures.	Signed, dated informed consent in client file.
This informed consent process will be ongoing as indicated by the dental treatment plan.	Ongoing signed, dated informed consents in client file (as needed).

TREATMENT STANDARDS

All treatment will be administered according to published research and available standards of care, including the following:

- *The New York AIDS Institute Oral Health Guidelines,* 2001 (available at: http://www.hivguidelines.org/public_html/center/clinical-guidelines/oral_care_guidelines/oral_health_book/oral_health.htm)
- *The LA County Commission on HIV Practice Guidelines for the Treatment of HIV Patients in General Dentistry*
- *Dental Management of the HIV-infected Patient, Supplement to JADA,* American Dental Association, Chicago, 1995
- *Clinician's Guide to Treatment of HIV-infected Patients, Academy of Oral Medicine,* 3rd Edition, Ed. Lauren L. Patton, Michael Glick, New York, 2002

- *Principles of Oral Health Management for the HIV/AIDS* Patient, A *Course for Training the Oral Health Professional,* Department of Human Services, Rockville, Maryland, 2001

STANDARD	MEASURE
Treatment will be administered according to published research and available standards of care.	Signed, dated progress notes in patient chart to detail treatment.

MEDICAL CONSULTATION

The dental provider should consult with the patient's primary care physician when additional information is needed to provide safe and appropriate care. This consultation is:

- To obtain the necessary laboratory test results
- When there is any doubt about the accuracy of the information provided by the patient
- When there is a change in the patient's general health, do determine the severity of the condition and the need for treatment modifications
- If after evaluating the patient's medical history and the laboratory tests, the oral health provider decides that treatment should occur in a hospital setting
- New medications are indicated to ensure medication safety and prevent drug/drug interactions
- Oral opportunistic infections are present

ENCOURAGING PRIMARY CARE PARTICIPATION

Dentists can play an important role in encouraging patients to seek regular primary medical care (CD4 and viral load tests every three to six months) and adhere to their medication regimens. If a patient is not under the regular care of a primary care physician, he or she should be urged to seek care and a referral to primary care will be made. If, after six months, a patient has not become engaged in primary medical care, programs may decide to discontinue oral health services. Patients should be made aware of this policy at time of intake into the program. Under certain circumstances, dental professionals may require further medical information or laboratory results to determine the safety and appropriateness of contemplated dental care. In that case, the dentist may require the information before going forward to offer the care.

STANDARD	MEASURE
Primary care physicians will be consulted when providing dental treatment.	Signed, dated progress note to detail consultations.
Consultation with medical providers will be: • To obtain the necessary laboratory test results • When there is any doubt about the accuracy of the information provided by the patient • When there is a change in the patient's general health, do determine the severity of the condition and the need for treatment modifications • If after evaluating the patient's medical history and the laboratory tests, the oral health provider decides that treatment should occur in a hospital setting • New medications are indicated to ensure medication safety and prevent drug/drug interactions • Oral opportunistic infections are present	Signed, dated progress note to detail consultations.

STANDARD	MEASURE
Dentists will encourage consistent medical care in their patients and provide referrals as necessary. Under certain circumstances, dental professionals may require further medical information to determine safety and appropriateness of care.	Signed, dated progress notes to detail referrals and discussion.
Programs may decide to discontinue oral health services if a client has not engaged in primary medical care. Patients will be made aware of this policy at time of intake into the program.	Signed, dated progress notes to detail referrals and discussion. Policy on file at provider agency. Intake materials will also state this policy.
Under certain circumstances, dental professionals may require further medical information to determine safety and appropriateness of care.	Signed, dated progress notes to detail discussion.

PREVENTION/EARLY INTERVENTION

Dental professionals will emphasize prevention and early detection of oral disease by educating patients about preventive oral health practices, including instruction in oral hygiene. In addition, dental professionals may provide counseling regarding behaviors (e.g., tobacco use, unprotected oral sex, body piercing in oral structures) and general health conditions that can compromise oral health. The impact of good nutrition on preserving good oral health should be discussed. Basic nutritional counseling may be offered to assist patients in maintaining oral health; when appropriate, a referral to an RD or other qualified person should be made. Patients will be scheduled for routine examinations and regular prophylaxis twice a year. Other procedures, such as root planning/scaling will be offered as necessary, either directly or by periodontal referral.

STANDARD	MEASURE
Dental professionals will educate patients about preventive oral health practices.	Signed, dated progress note in patient file to detail education efforts.
Routine examinations and regular prophylaxis will be scheduled twice a year.	Signed, dated progress note or treatment plan in patient file to detail schedule.
Dental professionals will provide basic nutritional counseling to assist in oral health maintenance. Referrals to an RD and others will be made, as needed.	Signed, dated progress note to detail nutrition discussion and referrals made.
Root planning/scaling will be offered as necessary, either directly or by referral.	Signed, dated progress note or treatment plan in patient file to detail.

SPECIAL TREATMENT CONSIDERATIONS

Most HIV patients can be treated safely in a typical dental office or clinic. Under certain circumstances, however, modifications of dental therapy should be considered:

- Bleeding tendencies may determine whether or not to recommend full mouth scaling and root planning or multiple extractions in one visit. A tooth-by tooth approach is recommended to evaluate risk of hemorrhage.
- In severe cases, patients may be treated more safely in a hospital environment where blood transfusions are available.
- Deep block injections should be avoided in patients with a recent history or laboratory results indicating bleeding tendencies.
- A pre-treatment antibacterial mouth rinse will reduce intraoral bacterial load, especially for those patients with periodontal disease.
- When salivary hypofunction is present, the patient should be closely monitored for

caries, periodontitis, soft tissue lesions and salivary gland disease.
- Fluoride supplements, in the form of a rinse and/or toothpaste, should be prescribed for those with increased caries and salivary hypofunction. In severe cases of xerostomia, appropriate referral should be made to a dental professional experienced in dealing with oral mucosal and salivary gland diseases.

STANDARD	MEASURE
As indicated, the following modifications to standard dental treatment should be considered: • Bleeding tendencies may determine whether or not to recommend full mouth scaling and root planning or multiple extractions in one visit. • In severe cases, patients may be treated more safely in a hospital environment where blood transfusions are available. • Deep block injections should be avoided in patients with bleeding tendencies. • A pre-treatment antibacterial mouth rinse should be used for those patients with periodontal disease. • Patients with salivary hypofunction should be closely monitored for caries, periodontitis, soft tissue lesions and salivary gland disease. • Fluoride supplements should be prescribed for those with increased caries and salivary hypofunction. Referral to a dental professional experienced in oral mucosal and salivary gland diseases should be made in severe cases of xerostomia.	Signed, dated progress note or treatment plan in patient file to detail treatment modifications and referrals,
Routine examinations and regular prophylaxis will be scheduled twice a year.	Signed, dated progress note or treatment plan in patient file to detail schedule.
Root planning/scaling will be offered as necessary, either directly or by referral.	Signed, dated progress note or treatment plan in patient file to detail

PROGRAM RECORDS

HIV oral health providers will maintain adequate health records consistent with good dental and professional practice in accordance with the California Code of Regulations on each individual patient. Individual patient records will include (but not be limited to):
- Documentation of HIV disease
- Complete dental assessment signed by a licensed dental care professional
- Current and appropriate treatment/management plan
- Progress notes detailing patient status, condition and response to interventions, procedures and medications
- Documentation of all contacts with client including date, time, service provided, referrals given and signature and professional title of person providing services
- Documentation of consultations with and referrals to other health care providers

STANDARD	MEASURE
Providers will maintain adequate health records consistent with good dental and professional practice in accordance with the California Code of Regulations on each individual patient. Records will include: • Documentation of HIV disease • Complete dental assessment signed by a licensed dental care professional • Current and appropriate treatment/management plan • Progress notes detailing patient status, condition and response to interventions, procedures and medications • Documentation of all contacts with client including date, time, service provided, referrals given and signature and professional title of person providing services • Documentation of consultations with and referrals to other health care providers	Required documentation on file in patient chart.

TRIAGE/REFERRAL/COORDINATION

On occasion, patients will require a higher level of oral health treatment services than a given agency is able to provide. In such cases, dental health providers should refer these patients to additional oral care providers, including: periodontists, endodontists, oral surgeons, oral pathologists and oral medicine practitioners. Coordinating oral health care with primary care medical providers is vital. Regular contact with a client's primary care clinic will ensure integration of services and better client care.

STANDARD	MEASURE
As needed, dental providers will refer patients to full range of oral health care providers, including: • Periodontists • Endodontists • Oral surgeons • Oral pathologists • Oral medicine practitioners	Signed, dated progress note to document referrals in patient chart.
Providers will attempt to make contact with a client's primary care clinic at a minimum of once a year, or as clinically indicated, to coordinate and integrate care.	Documentation of contact with primary medical clinics and providers to be placed in progress notes.

LINKAGES AND MARKETING

Programs providing dental care for people living with HIV will market their services through known linkages and direct outreach.

STANDARD	MEASURE
Programs will market dental services for people living with HIV through linkages or outreach.	Marketing/outreach plan on file at provider agency.

CLIENT RETENTION

Programs shall strive to retain patients in oral health treatment services. To ensure continuity of service and retention of clients, 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 client's participation in care. Such efforts shall be documented in the progress notes within the client record.

STANDARD	MEASURE
Programs shall develop a broken appointment policy to ensure continuity of service and retention of clients.	Written policy on file at provider agency
Programs shall provide regular follow-up procedures to encourage and help maintain a client in oral health treatment services	Documentation of attempts to contact in signed, dated progress notes. Follow-up may include: • Telephone calls • Written correspondence • Direct contact

STAFFING REQUIREMENTS AND QUALIFICATIONS

HIV/AIDS oral health care services will be provided by dental care professionals possessing applicable professional degrees and current California state licenses. Dental care staff can include dentists, dental assistants and dental hygienists. A dentist will be responsible for all clinical operations, including the clinical supervision of other dental staff.

Prior to performing HIV/AIDS oral health care services, all dental staff will be oriented and trained in policies and procedures of the general practice of dentistry, and specifically, the provision of dental services to persons living with HIV.

These training programs will include (at minimum):

- Basic HIV information
- Orientation to the office and policies related to the oral health of people living with HIV
- Infection control and sterilization techniques
- Methods of initial evaluation of the patient living with HIV disease
- Education and counseling of patients regarding maintenance of their own health
- Recognition and treatment of common oral manifestations and complications of HIV disease
- Recognition of oral signs and symptoms of advanced HIV disease, including treatment and/or appropriate referral

Providers are encouraged to continually educate themselves about HIV disease and associated oral health treatment considerations.

STANDARD	MEASURE
Provider will ensure that all staff providing oral health care services will possess applicable professional degrees and current California state licenses.	Documentation of professional degrees and licenses on file.
Providers shall be trained and oriented before providing oral health care services to include policies and procedures both in general dentistry and HIV specific oral health services. Training will include: • Basic HIV information • Office and policy orientation • Infection control and sterilization techniques • Methods of initial evaluation of the patient living with HIV disease • Health maintenance education and counseling • Recognition and treatment of common oral manifestations and complications of HIV disease • Recognition of oral signs and symptoms of advanced HIV disease	Training documentation on file maintained in personnel record.

STANDARD	MEASURE
Oral health care providers will practice according to California state law and the ethical codes of their respective professional organizations,	Chart review will ensure legally and ethically appropriate practice.
Dentist in charge of dental operations shall provide clinical supervision to dental staff.	Documentation of supervision on file,
Dental care staff will complete documentation required by program,	Periodic chart review to confirm,
Providers will seek continuing education about HIV disease and associated oral health treatment considerations.	Documentation of trainings in employee files.

UNITS OF SERVICE

Unit of service: Units of service defined as reimbursement for oral health treatment services are based on number of diagnostic, prophylactic procedures, dental procedures and dental visits.

- ***Diagnostic dental procedure units:*** calculated in number of procedures
- ***Prophylactic dental procedure units:*** calculated in number of procedures
- ***Dental procedure units:*** calculated in number of procedures

Number of clients: Client numbers are documented using the figures for unduplicated clients within a given contract period.

REFERENCES

Agency for Healthcare Research and Quality, Health Resources and Services Administration. (2000) *Access to Quality Health Services. Healthy People 2010.* Available at http://www.health.gov/healthypeople/document/HTML/Volume1/01Access.html.

Brown, J.B., Rosenstein, D., Mullooly, J., O'Keeffe, R.M., Robinson, S., Chiodo, G. (2002). Impact of intensified dental care on outcomes in human immunodeficiency virus infection. *AIDS Patient Care,* 16 (10), 479-486.

Dobalian, A., Andersen, R.M., Stein, J.A., Hays, R.D., Cunningham, W.E., Marcus, M. (2003).The impact of HIV on oral health and subsequent use of dental services. *Journal of Public Health Dentistry,* 63 (2), 78-85.

Marcus, M., Freed, J.R., Coulter, I.D., Der-Martirosian, C., Cunningham, W., & Andersen, R. (2000). Perceived unmet need for oral treatment among a national population of HIV-positive medical patients: Social and clinical correlates. *American Journal of Public Health,* 90, 1059-1063.

Shiboski, C.H., Palacio, H., Neuhaus, J.M., Greenblatt, R.M. (1999) Dental care access and use among HIV-infected women. *American Journal of Public Health,* 89, 834-839.

U.S. Department of Health and Human Services. (2000). *Oral Health in America: A Report of the Surgeon General—Executive Summary,* Washington, DC: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health. Available at: http://www.nidr.nih.gov/sgr/execsumm.html.

Zabos, G.P. (1999). Meeting primary oral health care needs of HIV-infected women. *American Journal of Public Health,* 89, 818-819.

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
CAL-OSHA	California Occupation Safety and Health Administration
CD4	Cluster Designation 4
DDS	Doctor of Dental Surgery
DHSP	Division of HIV and STD Programs
HBV	Hepatitis B Virus
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
RDA	Registered Dental Assistant
RDH	Registered Dental Hygienists
STD	Sexually Transmitted Disease