LOS ANGELES COUNTY
COMMISSION ON HIV

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Standards and Best Practices Committee Meeting

Tuesday, June 6, 2023
10:00am - 12:00pm (PST)

510 S. Vermont Ave, Terrace Conference Room # TK11
Los Angeles, CA 90020
Validated Parking: 523 Shatto Place, LA 90020

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LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave., 14th Floor, Los Angeles CA 90020
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AGENDA FOR THE REGULAR MEETING OF THE LOS ANGELES COUNTY COMMISSION ON HIV

STANDARDS AND BEST PRACTICES COMMITTEE

TUESDAY, JUNE 6, 2023 | 10:00 AM – 12:00 PM

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

MEMBERS OF THE PUBLIC:
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Standards and Best Practices Committee (SBP) Members:			
Erika Davies *Co-Chair*	Kevin Stalter *Co-Chair*	Mikhaela Cielo, MD	Arlene Frames
Wendy Garland, MPH	Mark Mintline, DDS	Andre Molette	Mallery Robinson
Harold Glenn San Agustin, MD	Martin Sattah, MD		
QUORUM: 6			

AGENDA POSTED: June 1, 2023.

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

PUBLIC COMMENT: Public Comment is an opportunity for members of the public to comment on an agenda item, or any item of interest to the public, before or during the Commission's consideration of the item, that is within the subject matter jurisdiction of the Commission. To submit Public Comment, you may join the virtual meeting via your smart device and post your Public Comment in the Chat box -or- email your Public Comment to hivcomm@lachiv.org -or- submit your Public Comment electronically here. All Public Comments will be made part of the official record.

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

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

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I. ADMINISTRATIVE MATTERS

1.	Call to Order & Meeting Guidelines/Reminders		10:00 AM – 10:03 AM
2.	Introductions, Roll Call, & Conflict of Interest Statements		10:03 AM – 10:05 AM
3.	Assembly Bill 2449 Attendance Notification for "Emergency Circumstances"	**MOTION #1**	10:05 AM – 10:07 AM
4.	Approval of Agenda	**MOTION #2**	10:07 AM – 10:08 AM
5.	Approval of Meeting Minutes for 5/2/23	**MOTION #3**	10:08 AM – 10:10 AM

II. PUBLIC COMMENT

10:10 AM – 10:15 AM

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

III. COMMITTEE NEW BUSINESS ITEMS

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

IV. REPORTS

8.	Executive Director/Staff Report	10:15 AM – 10:20 AM
9.	Co-Chair Report	10:20 AM – 10:30 AM
	a. Getting to Know you Activity	
	b. 2023 Workplan and Meeting Schedule Review	
10.	Division on HIV and STD Programs (DHSP) Report	10:30 AM—10:35 AM

V. DISCUSSION ITEMS

11. Medical Care Coordination Service Standards Review 10:35 AM—11:00 AM
12. Universal Service Standards Review 11:00 AM—11:20 AM
13. Nutrition Support Services Standards Review 11:20 AM – 11:40 AM
14. Prevention Service Standards Review 11:40 AM – 11:50 AM
    - Status Neutral HIV and STI Service Delivery System Framework

VI. NEXT STEPS 11:50 AM – 11:55 AM

15. Task/Assignments Recap
16. Agenda development for the next meeting

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

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

VIII. ADJOURNMENT 12:00 PM

18. Adjournment for the meeting of June 6, 2023

PROPOSED MOTIONS	
MOTION #1:	Approve remote attendance by members due to "emergency circumstances", per AB 2449.
MOTION #2	Approve the Agenda Order as presented or revised.
MOTION #3	Approve the Standards and Best Practices Committee minutes, as presented or revised.

DRAFT

LOS ANGELES COUNTY
COMMISSION ON HIV

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Approved meeting minutes are available on the Commission's website; meeting recordings are available upon request.

STANDARDS AND BEST PRACTICES (SBP) COMMITTEE MEETING MINUTES

May 2, 2023

COMMITTEE MEMBERS P = Present | A = Absent					
Erika Davies, *Co-Chair*	P	Wendy Garland, MPH	EA	Harold Glenn San Agustin, MD	P
Kevin Stalter, *Co-Chair*	P	Mark Mintline, DDS	P	Martin Sattah, MD	P
Mikhaela Cielo, MD	P	Andre Molette	EA		
Arlene Frames	P	Mallery Robinson	A		
COMMISSION STAFF AND CONSULTANTS					
Cheryl Barrit, Jose Rangel-Garibay					
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 10:11 am. Kevin Stalter led introductions.

I. ADMINISTRATIVE MATTERS

1. ASSEMBLY BILL 2449 ATTENDANCE NOTIFICATION FOR "EMERGENCY CIRCUMSTANCES"
MOTION #1: Approve remote attendance by members due to "emergency circumstances," per AB 2449 (***No Committee members invoked attendance under AB 2449; no vote held).***

1. APPROVAL OF AGENDA
MOTION #2: Approve the agenda order, as presented ***(✓Passed by consensus)***.

2. APPROVAL OF MEETING MINUTES
MOTION #3: Approve the 3/7/23 and 4/4/23 SBP Committee meeting minutes, as presented ***(✓Passed by consensus).***

II. PUBLIC COMMENT

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

III. COMMITTEE NEW BUSINESS ITEMS

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

IV. REPORTS

5. **EXECUTIVE DIRECTOR/STAFF REPORT**

Mandatory and Supplemental Training Series

- J. Rangel-Garibay, COH staff, reminded attendees of the Commission's 2023 Training schedule and noted that recordings will be available on the Commission website for those unable to join live trainings. A copy of the document is included in the meeting packet.

Change of Venue for the May Commission on HIV (COH) Meeting

- J. Rangel-Garibay reported that on April 27th the Executive Committee meeting decided to move forward with the May Commission meeting. The meeting will take place on May 11 at the St. Anne's Conference Center

6. **CO-CHAIR REPORT**

"Getting to know you" activity

- K. Stalter shared a card game to determine the pairing for the next round of the "Getting to Know you" activity. Matched pairs will meet for lunch and talk with each other. At a future SBP Committee meeting, the matched pairs will take turns sharing the information they learned from each other.

2023 Workplan Development and Meeting Schedule Review

- There was no discussion on this item.

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

V. DISCUSSION ITEMS

8. **Medical Care Coordination (MCC) Workforce Survey Results Presentation**
   Lauren Gersh, Patient Care Manager at APLA Health, provided a presentation on the "MCC Feedback Survey" developed by the MCC Feedback Committee. The presentation included a description of the survey methodology, response rate, key findings, and recommendations/next steps. A copy of the presentation is included in the meeting packet. The following are key takeaways from the presentation:
   - Direct service providers recommend adjustments to the program to improve patient health outcomes and have more of their patient's needs met
   - The MCC Feedback Committee formed as a mechanism to share information between MCC teams across different agencies funded by DHSP to provide MCC services
   - Recommendation to shorten second assessment/reassessments and to add mental health question(s) to screener
   - Consider adding a referral process for additional services such as: therapist, housing specialist, enrollment specialist, harm reduction counselor, linkage to care coordinators
   - Harold San Agustin asked: At what point can MCC staff be involved in the care of newly diagnosed person? (e.g. a person who tests positive at a bathhouse or similar venue)
   - Recommendation to review DHSP requirements that limit MCC team involvement in these cases. Auditors need to receive uniform training and processes to ensure that agencies are receiving the same experience
   - Technical Assistance needs to go beyond critique and have it be more supportive of the work

- Recommendation to have more trainings, in particular on brief interventions, best practices, initial MCC training needs more focus on the actual work that happens (go beyond motivational interviewing)
- There needs to be a clear understanding of the different roles and responsibilities and the collaboration that can happen between the team members
- Recommendation to identify opportunities and clarification on how providers can be involved in the COH, beyond providing comments on items

9. Universal Service Standards Review

Committee members provided the following recommendations and edits for the Universal Service Standards and the Patient Bill of Rights:

- Under Appendix B, Section B, item 1: Edit to read "Department of Health and Human Services Guidelines"
- Under Appendix B, Section B, item 4: Edit to read "Have their phone calls and/or emails answered within 1-5 business days, based on the urgency of the matter"
- Under Appendix B, introduction: Edit to read "Patient Bill of Rights" and replace all other mentions to maintain consistency of phrasing
- Under "Referrals and Case Closure" section, standard 6.3 and 6.4: incorporate into the patient bill of rights phrasing regarding the procedure for case closures and the reasons for case closure

MOTION #4: Announce a 30-day public comment period for the Universal Service Standards starting on 5/5/23 and ending on 6/5/23. ***✓Passed by Roll Call Vote (Yes= M. Cielo, A. Frames, M. Mintline, H. San Agustin, M. Sattah, K. Stalter, E. Davies ; No = 0; Abstain = 0)***

10. Nutrition Support Services Review

Committee members provided the following recommendations and edits for the Nutrition Support Services standards:

- Add language explaining the use of gift cards as an add-on/supplement to nutrition support for the purchase of food items not typically found in food banks/food pantries (e.g. Ensure)
- Delete any items that a DHSP contract monitor would not be able to monitor
- Add page numbers to the document
- Add indent to the section labeled "Program Guidance"
- Combine the tables for food banks and food pantries into one table and add a column with the option to select a check box to denote when a standard applies to the respective service
- Fix typo for "HIV/AIDS" on the "Home Delivered Meals" section
- Add "All entries in client chart will be signed and dated"
- Add a requirement to have some sort of nutritional education as part of the service
- Clarify who is included in the phrase "Family members affected by HIV"
- Under the staffing section, edit the phrasing to read "clients living with HIV or affected by HIV"

VI. NEXT STEPS

11. TASK/ASSIGNMENTS RECAP:

- ➲ Commission staff will make suggested edits to Universal Standards and post for public comment by 5/5/23
- ➲ Commission staff will make suggested edits to Nutrition Support Service Standards
- ➲ Commission staff will follow-up with the MCC feedback committee to share resources and coordinate future collaboration for the upcoming review of the MCC Service Standards.

10. AGENDA DEVELOPMENT FOR NEXT MEETING:

- Initiate review of MCC Service Standards

- Review public comments received for Universal Service Standards
- Continue review of Nutrition Support 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 12:03pm.

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COMMISSION ON HIV

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STANDARDS AND BEST PRACTICES COMMITTEE 2023 MEETING SCHEDULE
PROPOSED/DRAFT FOR REVIEW (updated 05.31.23)

DATE	KEY AGENDA ITEMS/TOPICS (subject to change; for planning purposes)
January 24 10am to 12pm Virtual	Elect Co-Chairs for 2023
February 7 1pm to 3pm Virtual	Draft 2023 Committee workplan
March 7 10am to 12pm In-Person	Adopt 2023 Committee workplan Approve Oral Health Care Services standards—SBP and Executive MCC program overview presentation--DHSP
April 4 10am to 12pm In-Person	Approve Oral Health Care Services standards—COH Continue review of Universal standards + Patient Bill Rights Initiate review of Nutrition Support service standards
May 2 10am to 12pm In-Person	Presentation: MCC Workforce Survey Results Announce public comment period for Universal Service standards Continue review of Nutrition Support service standards
June 6 10am to 12pm In-Person	Announce public comment period for Nutrition Support service standards Initiate review of MCC service standards Initiate review of Prevention Service Standards Approve Universal Service Standards—SBP and Executive
~~**July 4**~~ ~~10am to 12pm~~	Approve Universal Service Standards—COH Cancelled due to Independence Day Holiday 7/4/23
August 1 10am to 12pm In-Person	
September 5 10am to 12pm In-Person	Consider cancelling or rescheduling due to Labor Day Holiday 9/4/23 *Note: The United States Conference on HIV/AIDS (USCHA) 9/6/23-9/9/23*
October 3 10am to 12pm In-Person	
November 7 10am to 12pm In-Person	
December 5 10am to 12pm In-Person	Consider cancelling; poll committee members

Ryan White HIV/AIDS Program

Free or Low-Cost Services for People with HIV

What is the Ryan White HIV/AIDS Program?

The Ryan White HIV/AIDS Program (RWHAP) is a federal program under the Health Resources & Services Administration (HRSA) that supports a variety of free or low-cost services for people with HIV (PWH) in the United States. Eligible PLWH are able to receive medical care, HIV medications, and other support services to help them remain in care and achieve viral suppression. RWHAP services are available to anyone with HIV regardless of insurance, citizenship, and immigration status.

What are the goals of the RWHAP?

- Provide HIV medical care, treatment, and support services for PWH
- Help clients achieve viral suppression
- Reduce or eliminate HIV transmission

What medical and supportive services can I access through the RWHAP?

Medical Services	Description
Ambulatory Outpatient Medical (AOM) Services	HIV medical care accessed through a medical provider
Home-Based Case Management	Specialized home care for homebound clients
Medical Care Coordination (MCC)	HIV care coordination through a team of health providers to improve quality of life
Medical Specialty Services	Medical care referrals for complex and specialized cases
Mental Health Services	Psychiatry, psychotherapy, and counseling services
Oral Health Services (General & Specialty)	General and specialty dental care services

Supportive Services	Description
Benefits Specialty Services (BSS)	Assistance navigating public and/or private benefits and programs (health, disability, etc.)
Language Services	Translation and interpretation services for non-English speakers and deaf and/or hard of hearing individuals
Legal Services	Legal information, representation, advice, and services
Nutrition Support Services	Home-delivered meals, food banks, and pantry services
Residential Care Facility for the Chronically Ill (RCFCI)	Home-like housing that provides 24-hour care
Substance Use Disorder Transitional Housing (SUDTH)	Housing services for clients in recovery from drug or alcohol use disorders
Transitional Case Management	Support for incarcerated individuals transitioning from County jails back to the community
Transitional Residential Care Facility (TRCF)	Short-term housing that provides 24-hour assistance to clients with independent living skills
Transportation Services	Ride services to medical and social services appointments

Los Angeles County Department of Public Health
Division of HIV and STD Programs
www.publichealth.lacounty.gov/dhsp
(213) 351-8000

Revised: August 2022

County of Los Angeles Public Health

Ryan White HIV/AIDS Program

Free or Low-Cost Services for People with HIV

How do I access these services?

If you are interested in any of these services, please refer to the corresponding fact sheet for a list of providers. If you are not already receiving any of these services, our RWHAP agencies can help you confirm if you are eligible. They may ask you to provide documentation for the following:

- HIV diagnosis;
- Current income (if any and below the 500% Federal Poverty Level (FPL) for one person);
    - *500% FPL 2022 $67,950 – Please note this amount is adjusted every year.*
- Health insurance (if any) – If you do not have health insurance or have insurance and are responsible for out-of-pocket costs, including medication co-pays or coinsurance for office visits; and
- Live in Los Angeles County

RWHAP services are not included under public charge and are available to anyone with HIV, regardless of insurance, citizenship, and immigration status.

Los Angeles County Department of Public Health
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Revised: August 2022

County of Los Angeles Public Health

Standards of Care Proposals

1. Page 7: Follow up within one business day with patients who miss an MCC appointment
    a. Not realistic
2. Page 8: Intervention options: Add other items, such as substance use, housing
    a. Or: as long as it relates to overall patient wellness
3. Page 10: MCM should be open to LVN's
4. Page 11: ICP's should not have to be signed by patients if doing remotely
5. Page 13: More clarification about closing cases if no direct program contact in the past six months?
6. Aspects to add:
    a. The standards omit content that is supportive of the direct service workers. This deficit ignores the humanity and sustainability of these workers, which furthermore affects the patient care.
    b. Items to include:
        i. The MCC program should be routinely evaluated and updated at least every 5 years with the collaboration and input of direct service workers
            1. Updates impact the following:
                a. Updated meds and medical / MH conditions | DSM
                b. Updated language (e.g. gender / sexuality, dating, harm reduction, etc.)
                c. Trainings
                d. Topics (e.g. Food insecurity)
                e. Errors (e.g. in the software, discrepancies in the different guidelines, etc.)
                f. Time frames of when to complete tasks by
                g. Re-evaluation of contract goals (especially for annual hours and enrolled patients) and budgets
                h. Opportunities to indicate hours when patients have "assessment due" or "tracker due" status or have no eligibility documentation
                i. Software updates (i.e. Casewatch improvements)
                j. Audit rubrics reviewed and updated
        ii. Reassessments should not be longer in length than assessments
        iii. Reassessments should not happen more than 2x/year
        iv. All questions on reassessments should have the option to "decline to answer" so that pts are not required to answer the questions
        v. MCC teams and individuals should be recognized for service in on-going ways
        vi. Screener should include mental health question
        vii. The acuity should be adjustable based on MCC team understanding patient needs not captured on the assessment / reassessment
        viii. Audits should be returned to MCC teams within a certain time frame
        ix. More options for referrals

x. More options for Case Worker backgrounds
xi. Housing specialist and therapist on the team
xii. DHSP Communication / Relationship
    1. Improve meetings
    2. Improve trainings
    3. Improve and open up communication (e.g. regular email updates/information, master contact list sent out monthly)
    4. Provide opportunities for direct service providers to contribute to all changes / improvements to the program
    5. Regular feedback and review of monthly reports
    6. Requirements to include strengths and successes in audits

MEDICAL CARE COORDINATION STANDARDS OF CARE

Adopted February 14, 2019

Draft under review by the Standards and Best Practices Committee as of 5/1/2023

INTRODUCTION

Service standards outline the elements and expectations Ryan White service providers follow when implementing a specific service category. The purpose of the service standards is to ensure that all Ryan White service providers offer the same fundamental components of the given service category. The standards establish the minimal level of care that a Ryan White funded agency or provider may offer in Los Angeles County.

The Medical Care Coordination Services Standards of Care developed the Los Angeles County Commission on HIV to ensure people living with HIV (PLWH) receive coordinated medical and non-medical care regardless of where services are received in the County. The development of the Standards included review of and alignment with the *Guidelines for the Provision of HIV/AIDS Medical Care Coordination Services in Los Angeles County* and *Medical Care Coordination Services for Persons Living with HIV in Los Angeles County* (September 2017) from the Los Angeles County Department of Public Health - Division of HIV and STD Programs, as well as feedback from the Los Angeles County Commission on HIV – Standards & Best Practices Committee and experts in HIV treatment and care. All standards of care developed by the Commission on HIV align with the Universal Service Standards of Care approved by the Commission in April 2017.

MEDICAL CARE COORDINATION OVERVIEW

The Medical Care Coordination (MCC) model is an integrated service model that addresses patients' unmet medical and non-medical support needs (i.e. mental health, substance abuse, and housing) through coordinated case management activities to support continuous engagement in care and adherence to antiretroviral therapy. The Medical Care Coordination model aligns with the goals of the Los Angeles County HIV/AIDS Strategy, released by the Division of HIV and STD Programs in December 2017, of reducing annual infections to 500, increasing diagnoses to 90% and increasing viral suppression for people living with HIV to 90% by 2022. MCC services are provided by a team co-located in clinics across the County consisting of a Medical Care Manager, Patient Care Manager, Retention Outreach Specialist, and Case Worker(s).

Medical Care Coordination services include:

- Comprehensive assessment/reassessment
- Development and monitoring of an Integrated Care Plan
- Brief interventions
- Referrals
- Case conferences
- Patient retention services

The goals of medical care coordination include:

- Increase retention in HIV care
- Improve adherence to antiretroviral therapy (ART)
- Link patients with identified need to behavioral health, substance abuse, specialty care, and housing resources, and other support services
- Reduce HIV transmission through sexual risk reduction counseling and education

The terms *mental health* and *behavioral health* are often used interchangeably. For the purposes of the Medical Care Coordination service standard, *mental health* is used and is intended to encompass a broad range of related diagnoses and services necessary to achieve optimal patient health outcomes.

All programs will use available standards of care to inform clients of their services and will provide services in accordance with legal and ethical standards. Maintaining confidentiality is critical and all programs must comply with the Health Insurance Portability and Accountability Act (HIPAA) standards for information disclosure.

EVALUATION OF THE MEDICAL CARE COORDINATION MODEL

In 2017, the first comprehensive report on the implementation and evaluation of Medical Care Coordination (MCC) services was released by the Los Angeles County Department of Public Health – Division of HIV & STD Programs. The evaluation consisted of 1,204 patients enrolled in MCC in 2013 and demonstrated the success of the integrated service model. Key findings indicated that MCC was able to reach and serve vulnerable populations impacted by HIV, increase retention in HIV care, and increase viral suppression for patients. Given that there is minimal to no risk of transmitting HIV for patients that are able to achieve and maintain an undetectable viral load, the key findings align with LA County HIV/AIDS Strategy goals of increasing viral suppression to 90% and reducing annual infections to 500 by 2022.

In 2016, there were an estimated 60,946 persons living with HIV/AIDS with 1,881 newly diagnosed HIV cases in Los Angeles County. Of the 1,881 HIV cases that were newly diagnosed, 84% were men who have sex with men (MSM). HIV incidence is highest among MSM of color, young MSM (YMSM) ages 18-29, and transgender persons. Patients enrolled in MCC showed improvements in all health outcomes across all patient demographics and social determinants of health, particularly in those aged 16-24 years, transgender, uninsured and high/severe acuity. The evaluation results for MCC services demonstrates its effectiveness as an integrated medical and non-medical care program in improving health outcomes for people living with HIV, and was integral in the development of these Standards.

MEDICAL CARE COORDINATION MODEL

All patients receiving medical care in Ryan White-funded clinics are routinely screened for Medical Care Coordination based on clinical and psychosocial criteria. The patients who are identified as candidates

for MCC services or who are directly referred by their medical provider are then enrolled into the MCC program.

Physical co-location of the medical outpatient clinics and Medical Care Coordination programs and medical team is necessary and will be determined based on the needs of the program, the patient population, and the providers delivering the service. Medical Care Coordination programs must operate from a central location that serves as an administrative hub and primary program venue. Medical Care Coordination is an integrated approach to care, rather than a location where care is provided.

Medical Care Coordination teams are integrated into the medical home as part of the medical care team to ensure the Medical Care Manager, Patient Care Manager, Case Worker and Retention Outreach Specialist are able to work together and directly with the patient. The Medical Care Manager is responsible for the patient's clinical needs and will directly track and address all medical components of the Integrated Care Plan, which is developed by the MCC team and patient, for anyone eligible for the service. The Patient Care Manager will work with the Medical Care Manager to address the patient's psychosocial needs, and track and supervise these components of the Integrated Care Plan.

Case Workers are the liaison between HIV Counseling and Testing sites and the medical clinic to ensure that new patients are enrolled in medical care in a timely fashion. Case workers address the patient's socioeconomic needs and assists with patient monitoring and tracking outcomes. Depending on the size of the program and volume of patients, the program may employ additional case workers who are directly supervised by the care manager. In the case of a smaller program, the Medical and Patient Care Managers directly support all patients on an ongoing basis.

The retention outreach specialist will directly engage clients who are at-risk of falling out of care or are lost to care. The retention outreach specialist is responsible for reaching the patients through all available means of communication, including but not limited to phone calls, text messages, emails, physical mail, and street outreach to parks, food pantries, and shelters.

All members of the Medical Care Coordination team have a responsibility to serve as a contact to each patient for continued care and support. Care coordination programs may choose to engage additional providers for specific services (e.g., behavioral health, substance abuse,) or may establish comprehensive service agreements with such providers that will facilitate the program's access to those additional services. Memoranda of Understanding between the grantee and the provider/agency must be submitted to the Los Angeles County Department of Public Health - Division of HIV and STD Programs.

KEY SERVICE COMPONENTS

Medical Care Coordination services are patient-centered activities that focus on facilitating access to, utilization of, and engagement in primary health care services, as well as coordinating and integrating all services along the continuum of care for patients living with HIV. All Medical Care Coordination services should aim to increase the patient's sense of empowerment, self-advocacy and medical self-management, as well as enhance the overall health status of the patient. Programs must ensure patients are given the opportunity to ask questions and receive accurate answers regarding services provided by MCC staff and other professionals to whom they are referred. These discussions build the provider-patient relationship, serve to develop trust and confidence, and empower patients to be active partners in decisions about their health care. In addition, MCC services will be culturally and linguistically appropriate.

The overall emphasis of ongoing Medical Care Coordination services should be on facilitating the coordination, sequencing, and integration of primary health care, specialty care, and all other services in the continuum of care to achieve optimal health outcomes.

Medical Care Coordination services in Los Angeles County will include (at minimum):

- Comprehensive assessment/reassessment
- Integrated Care Plan
- Brief interventions
- Referrals, coordination of care, and linkages
- Case conferences
- Patient retention services

PATIENT ELIGIBILITY

Patient eligibility is determined at intake, which includes the collection of demographic data, emergency contact information, relative/significant other, and eligibility documentation. Although MCC is a Ryan White Program, patients do not need to be receiving Ryan White funded medical care to receive MCC services.

Ryan White Program eligibility includes individuals who:

- Reside in Los Angeles County
- Are age 12 years or older
- Have a household income equal to or below 500% Federal Poverty Level, and
- Are HIV-positive

An intake process, which includes registration and eligibility, is required for every patient's point of entry into the MCC service system. If an agency or other funded entity has the required patient information and documentation on file in the agency record or in the countywide data management system, further intake is not required. Patient confidentiality will be strictly maintained and enforced.

The client file will include the following information (at minimum):

- Date of intake
- Client name, mailing address and telephone number. For patients without an address, a signed affidavit declaring they are homeless should be kept on file.
- Written documentation of HIV status
- Proof of Los Angeles County residency
- Verification of financial eligibility for services
- Verification of medical insurance
- Emergency contact's name, home address and telephone number

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

- Release of Information (must specify what information is being released and to whom)
- Limits of Confidentiality (confidentiality policy)

- Consent to Receive Services
- Patient Rights and Responsibilities
- Patient Grievance Procedures
- Notice of Privacy Practices (HIPAA)

PATIENT ASSESSMENT/REASSESSMENT

The Medical Care Coordination assessment is the systematic and continuous collection of data and information about the patient and their need for Medical Care Coordination services. The assessment is a countywide standardized acute assessment tool and is used to identify and evaluate a patient's medical, physical, psychosocial, environmental and financial strengths, needs and resources. While the assessment helps guide discussion between the MCC team and the patient, and ensures specific domains are addressed, it is not exhaustive. The patient assessment and reassessments must be conducted collaboratively and in a coordinated manner by the Medical Care Manager and Patient Care Manager team. The medical information and medical assessment portions of the assessment and reassessment must be completed by the Medical Care Manager.

The comprehensive assessment determines the:

- Patient needs for treatment and support services, and capacity to meet those needs
- Integrated Care Plan
- Ability of the patient's social support network to help meet patient needs
- Involvement of other health and/or supportive agencies in patient care
- Areas in which the patient requires assistance in securing services

Patient acuity levels will be determined based on responses of the comprehensive assessment. Emergencies or medical and/or psychosocial crisis may require quick coordination decisions to mitigate the acute presenting issues before completing the entire intake/assessment. Acuity levels will be updated through reassessment dependent on patient need, but should be conducted annually at minimum.

The acuity levels are as follows:

- **Self-managed**: For patients presenting some need, but whose needs are easily addressed; refer to other Ryan White services.
- **Moderate acuity**: For patients presenting some need, but whose needs are relatively easily addressed;
- **High acuity**: For patients presenting the most complex and challenging needs; and
- **Severe acuity**: For patients presenting in crisis who require immediate, high frequency and/or prolonged contact.

INTEGRATED CARE PLAN

The Integrated Care Plan (ICP) is an individualized multidisciplinary service plan to be completed following the completion of the comprehensive assessment. The Integrated Care Plan is patient centered with the patient as an active participant in its development together with the Medical Care Manager and Patient Care Manager. The plan should be guided by needs identified by domains from the assessment, listed below, and additional information expressed to the MCC team.

Assessment domains are based on the following:

I. Health Status
II. Quality of Life/Self-Care
III. Antiretroviral Knowledge & Adherence
IV. Medical Access, Linkage and Retention
V. Housing
VI. Financial Stability
VII. Transportation
VIII. Legal Needs/End of Life Needs
IX. Support Systems and Relationships
X. Risk Behavior
XI. Substance use and Addiction
XII. Behavioral Health

In rare cases, due to the type of treatment, immediacy of services and/or their confidential nature (e.g., mental health, legal services), the ICP may be limited to referencing, rather than detailing, a specific treatment plan and/or the patient's agreement to seek and access those specific services.

PROGRESS NOTES/MONITORING PATIENT PROGRESS

ICP implementation and evaluation involve ongoing contact and interventions with, or on behalf of, the patient to ensure goals are addressed that work towards improving a patient's health and resolving psychosocial needs. Current dated and signed progress notes, detailing activities related to implementing and evaluating, will be kept on file in the patient record.

The following documentation is required (at minimum):

- Date, type, and description of all patient contact, attempted contact and actions taken on behalf of the patient
- Changes in the patient's condition or circumstances
- Progress made towards achieving goals identified in the ICP
- Barriers identified in reaching goals and actions taken to resolve them
- Current status, results, and barriers to linking referrals and interventions
- Time spent with, or on behalf of, the patient
- Care coordination staff's signature and professional title
- Follow up within one business day with patients who miss an MCC appointment. If follow-up activities are not appropriate or cannot be conducted within the prescribed time, care coordination staff will document reason(s) for the delay.
- Collaborating with the patient's other service providers for coordination and follow-up

BRIEF INTERVENTIONS

Brief interventions are short sessions that raise awareness of risks and motivates patient toward acknowledgement of an identified behavioral issue. The goal of the brief intervention is to help the patient see a connection between their behavior and their health and wellbeing. Based on the goals and objectives identified in the patient's ICP, MCC team members shall deliver brief interventions designed to promote treatment adherence and overall wellness for MCC patients. The brief interventions are not a substitute for long-term care for patients with a high level of need; referrals to more intensive care

may be warranted in those situations. For example, patients with severe or complex behavioral health needs should be referred to the appropriate specialist.
MCC intervention activities primarily focus on:

- Promoting Antiretroviral Therapy Adherence (ART)
- Risk Reduction Counseling
- Engagement in HIV care
- Behavioral Health

PATIENT SELF-EFFICACY AND CARE

MCC teams will teach patients and their caregiver's effective HIV disease self-efficacy skills to improve self-sufficiency health outcomes with attention to meeting the cultural needs and challenges of the patients. Staff will educate clientele and caregivers about maintaining an undetectable viral load will result in little to no risk of HIV transmission. MCC teams will educate and empower clients to interact effectively with all levels of service providers and to become increasingly informed and independent consumers.

REFERRALS

Programs providing Medical Care Coordination services will actively collaborate with other agencies to maximize their capacity to provide referrals to the full spectrum of HIV-related services. Programs must maintain a comprehensive list of service providers (both internal and external), for the full spectrum of HIV-related and other services. The MCC team should refer patients to appropriate services based on needs identified in the assessment and reassessment, and described in the Integrated Care Plan.

Programs will develop written protocols, or use existing agency protocol, for referring patients to other providers, networks and/or systems. Referrals must be tracked and monitored to ensure linkage to referrals are documented. MCC teams are responsible for working with patients to increase follow through in linking referrals.

CASE CONFERENCES

Multidisciplinary case conferences, formal and informal, are a critical component of Medical Care Coordination services and help integrate the MCC team into the medical care team. Case conferences convene a patient's MCC team and other key care providers (e.g. physician, nurse practitioner, physician assistant) to assess progress in meeting the needs identified in the patient's ICP and to strategize further responses.

Case conferences are an opportunity to address major life transitions and changes in health status for the patient with other members of the care team and should be conducted when possible. Programs are expected to convene case conferences based on patient need and acuity level.

Documentation of case conferences shall be maintained within each patient record and include:

- Date of case conference
- Names and titles of participants
- Medical and psychosocial issues and concerns identified
- Description of recommended guidance
- Follow-up plan

- Results of implementing guidance and follow-up

PATIENT RETENTION

Agencies or medical homes providing Medical Care Coordination services will develop and implement a plan that guides the agency's efforts to re-engage patients into care:

- Patients at the clinic who have fallen out of care
- Patients who are aware of their HIV status, but not in care ("unmet need")
- Patients at risk for falling out of care

Retention Outreach Specialists (ROS) are responsible for following up with patients that the MCC team has not been able to engage or re-engage through existing resources. This includes attempting to locate patients that have missed an HIV medical or MCC appointment. Locating patients may entail visiting the patient's last known address and/or sites of frequent socialization (e.g. food pantry, parks, community centers), contacting patients' other service providers, researching whether the patient is incarcerated, or other methods to bring the patient back into HIV care.

Retention Outreach Specialist will:

- Identify clinic patients not engaged in HIV medical care within the past 7 months.
- Work as an integral part of the medical care coordination (MCC) services team, including participating in team meetings.
- Act as liaison for clinic patients recently released from incarceration to ensure timely reengagement into HIV medical care.
- Work with out of care clinic patients to identify and address potential and/or existing barriers to engagement in medical care.
- Utilize motivational interviewing techniques to encourage patients to engage in and/or reengage into HIV medical care.

Programs will strive to retain patients in medical care coordination services. To ensure continuity of service and retention of patients, programs should follow existing agency specific policies regarding broken appointments. Follow-up may include telephone calls, written correspondence and/or direct contact. Programs will demonstrate due diligence through multiple efforts to contact patients by phone or by mail and document efforts in progress notes within the patient record. In addition, programs will develop and implement a contact policy and procedure to ensure that patients who are homeless or report no contact information are not lost to follow-up.

CASE CLOSURE

Case closure is a systematic process for disenrolling patients from Medical Care Coordination services. The process includes formally notifying patients of pending case closure and completing a case closure summary to be kept on file in the patient record. All attempts to contact the patient and notifications about case closure will be documented in the patient file, along with the reason for case closure. Note that cases often remain open, and should not be closed, so that the Retention Outreach Specialists can locate and rescreen patients.

Cases may be closed when the client:

- Relocates out of the service area
- Has had no direct program contact in the past six months
- Is ineligible for the service
- Discontinues the service
- Uses the service improperly or has not complied with the client services agreement
- Is deceased
- No longer needs the service

When appropriate, case closure summaries will include a plan for continued success and ongoing resources to potentially be utilized. At minimum, case closure summaries will include:

- Date and signature of both the Medical and Patient Care Managers
- Date of case closure
- Status of the Integrated Care Plan
- Status of primary health care and support service utilization
- Referrals provided
- Reasons for disenrollment and criteria for reentry into services

STAFFING REQUIREMENTS AND QUALIFICATIONS

Individuals on the Medical Care Coordination team must be in good standing and hold all required licenses, registration, and/or degrees in accordance with applicable State and federal regulations as well as requirements of the Los Angeles County Department of Public Health, Division of HIV & STD Programs. At minimum, all Medical Care Coordination staff will be able to provide timely, linguistically and culturally competent care to people living with HIV. Medical Care Coordination staff will complete orientation through their respective hiring agency, including a review of established programmatic guidelines, and supplemental trainings as required by the Los Angeles County Department of Public Health, Division of HIV and STD Programs. Staff should also be trained by their agency on patient confidentiality and HIPAA regulations, and de-escalation techniques. It is recommended that Medical Care Coordination teams across agencies convene at least once a year to discuss best practices, outcomes, and exchange ideas on how to best provide patient care through MCC.

The minimum requirements for MCC staff are:

- **Medical Care Manager** must possess a valid license as a registered nurse (RN) in the state of California.
- **Patient Care Manager** must possess a Master's degree in one of these disciplines: Social Work, Counseling, Psychology, Marriage and Family Counseling, and/or Human Services.
- **Case Worker(s)** must possess a Bachelor's degree in Nursing, Social Work, Counseling, Psychology, Human Services; OR possess a license as a vocational nurse (LVN), or have demonstrated experience working in the HIV field.
- **Retention Outreach Specialist** shall possess the following requirements: 1) Experience in conducting outreach to engage individuals; and 2) Shall have good interpersonal skills; experience providing crisis intervention; knowledge of HIV risk behaviors, youth development, human sexuality, or substance use disorders; ability to advocate for clients; and be culturally and linguistically competent.

TRANSLATION/LANGUAGE INTERPRETERS

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

TABLE: MEDICAL CARE COORDINATION SERVICES STANDARDS

STANDARD	DOCUMENTATION
PATIENT ELIGIBILITY	
Eligibility determined by provider	Patient file includes: • Los Angeles County resident • Age 12 years or older • Household income equal to or below 500% FPL • HIV status
Required forms are discussed and completed	Signed and dated forms: • Release of information • Limits of confidentiality • Consent to receive services • Rights and Responsibilities • Grievance procedures • Notice of privacy practices (HIPAA)
PATIENT ASSESSMENT/REASSESSMENT	
Acuity level assigned to patient based on assessment results	Completed tool kept on file in patient record. Patient acuity level assigned as: • Self-managed • Moderate • High • Severe
Reassessments are conducted based on patient need, but annually at minimum to update patient acuity.	Program monitoring and reassessment on file
Patients unable to actively participate in Medical Care Coordination services will be referred to home-based case management, skilled nursing, psychiatric services, or hospice care	Documentation of linked referral on file in patient record
INTEGRATED CARE PLAN	
Integrated Care Plan will be developed collaboratively with the patient within 30 days of completing the assessment	Integrated Care Plan on file includes: • Patient Name • Patient Care Manager (PCM) Name • Medical Care Manager (MCM) Name • Date and patient signature • Date and PCM and MCM (Care Team) signatures
PROGRESS NOTES/MONITORING PATIENT PROGRESS	

MCC team will monitor: • Implementation of Integrated Care Plan (ICP) and progress made toward achieving goals • Changes in the patient's condition or circumstances • Lab results • Adherence to medication • Completion of referrals • Delivery of brief interventions • Barriers to care and engagement	Progress notes on file include: • Date, type, and description of all patient contact, attempted contact and actions taken on behalf of the patient • Changes in the patient's condition or circumstances • Progress made toward achieving goals • Barriers to reaching goals and actions taken to resolve them • Current status and results of recommended referrals • Current status and results of recommended interventions • Time spent with the patient • Care Team signatures
BRIEF INTERVENTIONS	
Brief interventions may focus on: • Promoting Antiretroviral Therapy Adherence (ART) • Risk Reduction Counseling • Engagement in HIV care • Behavioral Health	Documentation of recommended interventions in progress notes
PATIENT SELF-EFFICACY AND CARE	
MCC Team will educate patients on the importance of maintaining an undetectable viral load, the importance of adhering to care, and increase their capacity to engage their own care	Documentation of education on file in patient record
REFERRALS	
MCC team will provide referrals as needed based on assessment and reassessments. Agency or medical care home will maintain a comprehensive list of providers for full spectrum HIV-related and other service referrals	Identified resources for referrals at provider agency (e.g. lists on file, access to websites)
If needed, engage additional providers for specific support services (e.g. behavioral health, substance abuse)	Memoranda of Agreement (MOU) on file
CASE CONFERENCES	
MCC team will convene case conferences, formal and informal, to ensure coordination of care for patient	Documentation on file includes: • Date • Name/Titles of participants • Identified medical and psychosocial issues and concerns • Description of recommended guidance • Follow-up plan • Results of implemented guidance
PATIENT RETENTION	

Agency or medical home will develop procedures or follow existing agency-specific policies to work with patients: • At the clinic who have fallen out of care • Who are aware of HIV status, but not in care • At risk for falling out of care	Documentation of attempted patient contact on file
CASE CLOSURE	
MCC team will follow up with patients who have missed appointments and may be pending case closure	Number of attempts to contact and mode of communication documented in patient file
Cases may be closed when the patient: • Relocates out of the service area • Has had no direct program contact in the past six months • Is ineligible for the service • Discontinues the service • Uses the service improperly or has not complied with the client services agreement • Is deceased • No longer needs the service	Justification for case closure documented in patient file
STAFFING REQUIREMENTS	
Medical Care Coordination (MCC) team will include: • Medical Care Manager • Patient Care Manager • Case Worker(s) • Retention Outreach Specialist	Documentation of required licenses on file: • Medical Care Manager: RN license in State of CA • Patient Care Manager: Master's degree in Social Work, Counseling, Psychology, Marriage and Family Counseling, and/or related Human Services field • Case Worker(s): Bachelor's degree in Nursing, Social Work, Counseling, Psychology, Human Services OR possess a license as a vocational nurse (LVN) OR have demonstrated experience working in the HIV field • Retention Outreach Specialist: 1) Experience in conducting outreach to engage individuals; and 2) Shall have good interpersonal skills; experience providing crisis intervention; knowledge of HIV risk behaviors, youth development, human sexuality, or substance use disorders; ability to advocate for clients; and be culturally and linguistically competent.
TRANSLATION/LANGUAGE INTERPRETERS	
MCC Programs will develop, or utilize existing agency-specific, policies to provide interpretation services to patients at no cost	Policies on file at agency

REFERENCES

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Division of HIV and STD Programs, Los Angeles County Department of Public Health. Los Angeles County HIV/AIDS Strategy for 2020 and Beyond. December 2017. Retrieved from https://www.lacounty.hiv/about/.

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DEFINITIONS AND DESCRIPTIONS

Assessment is a cooperative and interactive face-to-face interview process during which the patient's medical, physical, psychosocial, environmental and financial strengths, needs and resources are identified and evaluated.

Intake determines a person's eligibility for Medical Care Coordination services.

Medical Care Coordination (MCC) integrates the efforts of medical and social service providers by developing and implementing an integrated care plan.

Medical Care Managers will be licensed RNs and be responsible for the patient's clinical needs and will directly track and address all medical components of the Integrated Care Plan.

Retention Outreach Specialists promote the availability of and access to Medical Care Coordination services to service providers and patients at higher risk of falling out of continuous care or are lost to care.

Patient Care Managers will hold a Master's degree in social work (MSW) or related degree (e.g., psychology, human services, counseling) and are responsible for the patient's psychosocial needs ad will track, address and or supervise these components of the Integrated Care Plan.

Case Workers must possess either a Bachelor's degree in Nursing (BSN), Social Work, Counseling, Psychology, Marriage and Family Counseling (requires a Master's degree), Human Services, a license as a vocational nurse (LVN) or demonstrated experience working in the HIV field. Case workers address the patient's socioeconomic needs and assists with patient monitoring and tracking outcomes. Case Workers are the liaison between HIV Counseling and Testing sites and the medical clinic to ensure that new patients are enrolled in medical care in a timely fashion.

Reassessment is a periodic assessment of a patient's needs and progress in meeting the objectives as established within the Integrated Care Plan.

Case closure is a systematic process of disenrolling patients from active Medical Care Coordination.

DRAFT

LOS ANGELES COUNTY
COMMISSION ON HIV

RYAN WHITE PROGRAM

UNIVERSAL SERVICE STANDARDS

Approved by COH on 2/11/21

DRAFT FOR PUBLIC COMMENT

PUBLIC COMMENT PERIOD: May 5, 2023- June 5, 2023

Email comments to HIVComm@lachiv.org

LOS ANGELES COUNTY
COMMISSION ON HIV

Service Standard Review
Guiding Questions for Public Comments

The Los Angeles County Commission on HIV announces an opportunity for the public to submit comments for the draft **Universal Service Standards for HIV Care** being updated by the Standards and Best Practices Committee. We welcome feedback from consumers, providers, community members, and any HIV stakeholders interested in improving HIV care in Los Angeles County. Please distribute the document widely within you networks. The document is included below and can accessed at: **https://hiv.lacounty.gov/service-standards**

Please email comments to: HIVCOMM@LACHIV.ORG
The public comment period ends on **June 6, 2023.**

When providing public comment, consider responding to the following:

1. Are the Universal Service Standards presented 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? Why or why not?

3. Are the proposed Universal Services Standards client-centered? Is there anything missing related to HIV prevention and care?

LOS ANGELES COUNTY
COMMISSION ON HIV

TABLE OF CONTENTS

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

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

INTRODUCTION

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

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

UNIVERSAL STANDARDS OVERVIEW

The objectives of the Universal Standards are to ensure agencies:

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

1. GENERAL AGENCY POLICIES

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

1.0 GENERAL AGENCY POLICIES	
Standard	**Documentation**
1.1 Agency develops or utilizes an existing client confidentiality policy in accordance with state and federal laws to assure protection of client HIV status, behavioral risk factors, and/or use of services.	1.1 Written client confidentiality policy on file with specific information technology safeguards for confidentiality and patient information if using telehealth service modality.
1.2 Agency is responsible for informing the patient that they have the right to obtain copies of their medical and other health records maintained by the agency.	1.2 Written policy for informing the patient of their rights to receive a copy of their medical records. The policy should contain a description of the process for obtaining records, such as a verbal or written request and a reasonable timeframe for patients to receive the information.
1.3 Client determines what information of theirs can be released and with whom it can be shared. Services using telehealth modality are subject to consent by the patient.	1.3 Completed *Release of Information Form* on file including: • Name of agency/individual with whom information will be shared • Information to be shared • Duration of the release consent • Client signature For agencies and information covered by the Health Insurance Portability and Accountability Act (HIPAA), form must be HIPAA disclosure authorization compliant. The form must also be compliant with the CA Medi-Cal telehealth policy.[1]
1.4 Agency develops or utilizes an existing grievance procedure to ensure clients have recourse if they feel they are being treated in an unfair manner or feel they are not receiving quality services.	1.4 Written grievance procedure on file that includes, at minimum: • Client process to file a grievance • Information on the Los Angeles County Department of Public Health, Division of HIV & STD Programs (DHSP) Customer Support Program 1-800-260-8787. Additional ways to file grievances can be found at: DHSP_CSP_CustomerSupportForm_Website-ENG-Final_12.2022.pdf (lacounty.gov) DHSP Customer Support Program information is posted in a visible location on site or provided to the patient at the beginning of a telehealth encounter.

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

2. CLIENT RIGHTS AND RESPONSIBILITIES

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

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

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

3. STAFF REQUIREMENTS AND QUALIFICATIONS

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

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

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

4. CULTURAL AND LINGUISTIC COMPETENCE

Ryan White funded agencies must provide services that are culturally and linguistically competent based on the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. As noted in the CLAS Standards, ensuring culturally and linguistically appropriate services advances health equity, improves quality, and helps eliminate health care disparities by establishing a blueprint for health and health care organizations. For the purpose of these standards, culture is defined as the integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics (Source: National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice. Office of Minority Health, US Department of Health and Human Services. April 2013 https://www.thinkculturalhealth.hhs.gov/clas/standards). The standards below are adapted directly from the National CLAS Standards.

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

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

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

4.0 CULTURAL AND LINGUISTIC COMPETENCE	
Standard	**Documentation**
4.1 Recruit, promote, and support a culturally and linguistically diverse workforce that are responsive to the population served.	4.1 Documentation of how staff demographics reflect the demographics of clients served on file (e.g. race, gender identity, age, sexual orientation, lived experience etc.)

4.2 Agency develops or utilizes existing culturally and linguistically appropriate policies and practices. Agency educates and trains workforce on culturally and linguistically appropriate practices on an ongoing basis.	4.2 Written policy and practices on file Documentation of completed trainings on file.
4.3 Provide resources onsite to facilitate communication for individuals who experience impairment due to a challenging medical condition or status (e.g. augmentative and alternative communication resources or auxiliary aids and services)	4.3 Resources on file a. Checklist of resources onsite that are available for client use. Type of accommodations provided documented in client file.
4.4 Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.	4.4 *Signed Patient & Client Bill of Rights* document on file that includes notice of right to obtain no-cost interpreter services.
4.5 Ensure the competence of individuals providing language assistance a. Use of untrained individuals and/or minors as interpreters should be avoided Ensure quality of language skills of self-reported bilingual staff who use their non-English language skills during client encounters	4.5 Staff resumes and language certifications, if available, on file.
4.6 Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area in clinic points of entry (e.g. registration desks, front desks, reception, waiting rooms, etc.) and areas where work with client is performed (e.g. clinic rooms, meeting rooms, etc.)	4.6 Materials and signage in a visible location and/or on file for reference.

5. INTAKE AND ELIGIBILITY

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

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

6. REFERRALS AND CASE CLOSURE

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

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

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

APPENDIX A: RYAN WHITE PART A SERVICE CATEGORIES

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

SERVICE CATEGORIES

CORE MEDICAL SERVICES	SUPPORT SERVICES
Outpatient/Ambulatory Health Services	Non-Medical Case Management Services
AIDS Drug Assistance Program Treatments	Child Care Services
AIDS Pharmaceutical Assistance	Emergency Financial Assistance
Oral Health Care	Food Bank/Home Delivered Meals
Early Intervention Services (EIS)	Health Education/Risk Reduction
Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals	Housing
Home Health Care	Other Professional Services
Home and Community-Based Services	Linguistic Services
Hospice Services	Medical Transportation
Mental health Services	Outreach Services
Medical Nutrition Therapy	Psychosocial Support Services
Medical Case Management, including Treatment Adherence	Referral for Health Care and Support Services
Substance Abuse Outpatient Care	Rehabilitation Services
	Respite Care
	Substance Abuse Services (residential)

APPENDIX B: PATIENT & CLIENT BILL OF RIGHTS AND RESPONSIBILITIES

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

A. Respectful Treatment and Preventative Services

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

B. Competent, High-Quality Care

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

C. Participate in the Decision-making Treatment Process

1. Receive complete and up-to-date information in words you understand about your diagnosis, treatment options, medications (including common side effects and complications) and prognosis that can reasonably be expected.
2. Participate actively with your provider(s) in discussions about choices and options available for your treatment.
3. Make the final decision about which treatment option is best for you after you have been given all relevant information about these choices and the clear recommendation of your provider.
4. Have access to patient-specific education resources and reliable information and training about patient self-management.
5. Refuse any and all treatments recommended and be told of the effect that not taking the treatment may have on your health, be told of any other potential consequences of your refusal and be assured that you have the right to change your mind later.
6. Be informed about and afforded the opportunity to participate in any appropriate clinical research studies for which you are eligible.
7. Refuse to participate in research without prejudice or penalty of any sort.

8. Refuse any offered services or end participation in any program without bias or impact on your care.
9. Be informed of the procedures at the agency for resolving misunderstandings, making complaints, or filing grievances.
10. Receive a response to a complaint or grievance within 30-45 days of filing it.
11. Be informed of independent ombudsman or advocacy services outside the agency to help you resolve problems or grievances (see number at bottom of this form), including how to access a federal complaint center within the Center for Medicare and Medicaid Services (CMS).

D. Confidentiality and Privacy

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

E. Billing Information and Assistance

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

F. Patient/Client Responsibilities

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

1. Participate in the development and implementation of your individual treatment or service plan to the extent that you are able.
2. Provide your providers, to the best of your knowledge, accurate and complete information about your current and past health and illness, medications and other treatment and services you are receiving, since all of these may affect your care. Communicate promptly any changes or new developments.
3. Communicate to your provider whenever you do not understand information you are provided.
4. Follow the treatment plan you have agreed to and understand the consequences of failing to adhere to the recommended course of treatment or of using alternative treatments.
5. Understand that cases may be closed if the client:
    i. Relocates out of the service area
    ii. Is no longer eligible for the service(s)
    iii. Discontinues the service(s)
    iv. No longer needs the service(s)
    v. Puts the agency, service provider, or other clients at risk
    vi. Uses the service(s) improperly or has not complied with the services agreement
    vii. Is deceased
    viii. Has had no direct agency contact, after repeated attempts, for a period of 12 months
6. Keep your appointments and commitments at this agency or inform the agency promptly if you cannot do so.
7. Keep your provider or main contact informed about how to reach you confidentially by phone, mail, or other means.

8. Follow the agency's rules and regulations concerning patient/client care and conduct.
9. Be considerate of your providers and fellow clients/patients and treat them with the respect you yourself expect.
10. Refrain from the use of profanity or abusive or hostile language; threats, violence, or intimidations; carrying weapons of any sort; theft or vandalism; sexual harassment and misconduct.
11. If you are a person living with a Substance Use Disorder, please be open and honest with your provider about your substance use so that any issues can be properly addressed.

For More Help or Information

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

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

APPENDIX C: TELEHEALTH RESOURCES

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

DRAFT FOR SBP COMMITTEE REVIEW

SERVICE STANDARDS FOR NUTRITION SUPPORT SERVICES – FOOD BANK/PANTRY SERVICES AND HOME-DELIVERED MEALS

LOS ANGELES COUNTY
COMMISSION ON HIV

DRAFT FOR SBP COMMITTEE REVIEW

DRAFT AS OF 06/01/23

DRAFT FOR SBP COMMITTEE REVIEW

SERVICE STANDARDS: NUTRITION SUPPORT SERVICES – FOOD BANK/PANTRY SERVICES AND HOME-DELIVERED MEALS

IMPORTANT: The service standards for Nutrition Support Services—Food Bank/Pantry Services and Home-Delivered Meals 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, Division of Metropolitan HIV/AIDS Programs: National Monitoring Standards for Ryan White Part A Grantees: Program – Part A

Service Standards: Ryan White HIV/AIDS Programs

INTRODUCTION

Service standards for the Ryan White HIV/AIDS Part A Program (RWHAP) 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 Nutrition Support Services—Food Bank/Pantry Services and Home-Delivered Meals (Nutrition Support Services) standards to establish the minimum services necessary to provide Nutrition Support Services to people living with HIV. 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 COH Standards and Best Practices Committee (SBP), caucuses, and the public-at-large.

SERVICE DESCRIPTION

Nutrition Support Services for people living with HIV attempt to improve and sustain a client's health, nutrition and food security and quality of life. Good nutrition has been shown to be a critical component of overall measures of health, especially among people living with HIV. Nutrition Support Services include Food banks/pantry services and Home delivered meals.

Food Bank/Pantry Services and Home Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following:

- Personal hygiene products
- Household cleaning supplies
- Water filtration/purification systems in communities where issues of water safety exist

FOOD BANK/PANTRY SERVICES

Food bank/pantry services are distribution centers that warehouse food and related grocery items including nutritional supplements and other miscellaneous items. Only medically indigent (uninsured, underinsured, and/or ineligible for health care coverage) persons living with HIV/ AIDS and their eligible family members residing within Los Angeles County qualify.

HOME DELIVERED MEALS

Home delivered meals are provided for clients experiencing physical or emotional difficulties related to HIV/AIDS that render them incapable of preparing nutritional meals for themselves. These services are offered to medically indigent (uninsured, underinsured, and/or ineligible for health care coverage) persons with HIV/AIDS and their eligible family members residing within Los Angeles County. Family will be broadly defined to include any individual affected by HIV disease through their relationship and shared household with a person living with HIV. Meals may be delivered in a dwelling place, identified by the client as their home.

PERSONNEL QUALIFICATIONS

All Nutrition Support Services will be provided in accordance with current United States Department of Agriculture (USDA) Dietary Guidelines for Americans, Food and Drug Administration (FDA), Centers for Disease Control and Prevention (CDC), and Los Angeles County guidelines and procedures, as well as with federal, State, and local laws and regulations. All programs will comply with City, County and/or State grocery and/or restaurant health code regulations. All programs providing food distribution services will operate in collaboration with a Registered Dietitian (RD) consistent with California state law. Such RD will have current knowledge of nutrition issues for people living with HIV.

Each agency is responsible for establishing comprehensive job descriptions that outline the duties and responsibilities for each of the positions proposed in their program. All staff must be given and will sign a written job description with specific minimum requirements for their position. Agencies are responsible for providing staff with supervision and training to develop capacities needed for effective job performance.

1. **Chefs:** involved in food production and menu design. Must have at least a high school diploma or GED and be professionally trained/certified with a current food protection and handling license/certification in accordance with applicable State, Federal and local laws, and regulations. Chefs must be familiar with the multi-cultural and dietetic needs of the population. Experience in food preparation and cooking for bulk-meal services preferred.
2. **Dieticians/Nutritionists**: involved in meal planning and menu design. Must be registered and licensed, as required by State and Los Angeles County.
3. **Food Service Workers/Volunteers:** must be professionally trained/certified with a current food protection and handling license/certification.
4. **Food Delivery Drivers**: must have a valid driver's license, familiarity with the geographic region being served and possess good interpersonal communication and writing skills.

SERVICE STANDARDS—NUTRITION SUPPPORT SERVICES (HDM)

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

SERVICE COMPONENT	HDM [1]	FOOD BANK/ PANTRY	STANDARD	MEASURE
CLIENT INTAKE	☒	☒	Nutrition Support programs will conduct a client intake performed by an RD, DTR[2] or nutrition student under supervision of an RD. Initial nutrition intake and annual screening may be conducted onsite, in-person, telephonically or videoconferencing set forth by the nutrition support provider agency and agreed to by both parties. Nutrition screenings will be shared with the client's primary medical provider when possible.	Client intake in client file updated annually. Signed, dated nutrition screen on file in client chart. Initial and additional intake screenings will include, at minimum: • Medical considerations • Food allergies/intolerances • Interactions between medicines, foods, and complimentary therapies • Dietary restrictions including special diets and cultural and religious considerations • Assessment of nutrition intake vs. estimated need • Client's nutritional concerns • Ability to complete Activities of Daily Living

[1] HDM: Home Delivered Meals
[2] DTR: Dietetic Technician, Registered

SERVICE COMPONENT	HDM [1]	FOOD BANK/ PANTRY	STANDARD	MEASURE
				• Any HIV-related illnesses diagnose in the last six months • Any chronic illness with date of diagnosis • Family members and caregivers and if they need HDM service as well[3] • Current nutrition issues such as: lack of appetite, nausea/vomiting, involuntary weight loss, diarrhea, inability to prepare or procure food due to health issues, etc. • Medications and/or treatments/therapies
	☒	☒	Client confidentiality will be strictly maintained. As necessary, Release of Information will be signed to exchange information with other providers.	Signed, dated Release of Information in client chart.
	☒	☒	Nutrition Support programs will coordinate with client's primary care providers and case managers to assess need for service and to ensure nutrition needs are being addressed.	Records of communication with medical providers and case managers in client chart.
	☒	☒	Nutrition education will be provided by an RD or Dietetic Technician, Registered (DTR)	Documentation of education and referral on file in client chart.

[3] Affected individuals (people not living with HIV) may be eligible for HRSA Ryan White HIV/AIDS Program services in limited situations, but these services for affected individuals must always benefit People Living with HIV. See HRSA PCN-16-02

SERVICE COMPONENT	HDM [1]	FOOD BANK/ PANTRY	STANDARD	MEASURE
			or nutrition student under the supervision of RD to appropriate clients identified through screening process. When needed, clients will be referred for medical nutrition therapy.	
MEAL PRODUCTION AND DELIVERY	☒	☐	Programs providing home delivered meals will develop menus with the help of RD(s).	Menu cycle on file at provider agency that considers the nutrition needs of the client, special diet restrictions, portion control and client, community, and cultural preference. Menu cycle will be changed as necessary.
	☒	☐	Programs providing home delivered meals will prepare and ensure the delivery of meals to clients. Meals will be planned by a chef under the supervision of an RD. Food and water safety measures will be strictly enforced.	Plans on file at provider agency.
	☒	☐	Programs providing home delivered meals will distribute meals to Community-Based Organizations (CBO)s for delivery to clients.	Memorandum of Understanding (MOU)s with CBOs on file at provider agency.
	☒	☐	Programs will deliver meals directly to clients within an expected delivery time if CBOs are not able to distribute meals.	Delivery policy on file at provider agency. Daily delivery records on file at provider agency
	☒	☐	Programs will train volunteers in proper food handling techniques and HIV sensitivity.	Volunteer training curriculum and records of volunteer trainings on file at provider agency.
PROGRAM OPERATIONS	☐	☒	Programs providing food bank/pantry services will	Menu cycle on file at provider agency that considers the:

SERVICE COMPONENT	HDM [1]	FOOD BANK/ PANTRY	STANDARD	MEASURE
			develop menus and food choices with the help of RD(s).	• Nutrition needs of the client • Special diet restrictions • Portion control • Client, community • Cultural preference
	☐	☒	Programs providing food bank/pantry services will purchase and maintain a nutritional food supply. Food/ water safety and handling measures will be strictly enforced.	Plans on file at provider agency.
	☐	☒	Programs will distribute food to provider agencies for delivery to clients.	MOUs with CBOs on file at provider agency.
	☐	☒	Programs will distribute food directly to clients.	Distribution policy and daily distribution records on file at provider agency.
	☐	☒	Programs will train volunteers in proper food handling techniques and HIV sensitivity.	Volunteer training curriculum and records of volunteer trainings on file at provider agency.
PROMOTION AND LINKAGES	☒	☒	Nutrition Support programs will promote the availability of their services.	Promotion plan on file at provider agency
	☒	☒	Nutrition Support programs will network with CBOs to identify appropriate clients.	Record of outreach and networking efforts on file at provider agency
	☒	☐	Programs providing Home-delivered Meals will develop MOUs with provider agencies that provide food delivery services.	MOUs on file at provider agency that include: • Days and times food will be delivered and distributed to clients • Persons responsible for ensuring that food is delivered appropriately • Persons responsible for the actual delivery

SERVICE COMPONENT	HDM [1]	FOOD BANK/ PANTRY	STANDARD	MEASURE
				of food (e.g., staff, volunteers) • Geographic areas to be served
	☐	☒	Programs providing food bank/pantry services will develop MOUs with CBOs that collaborate on food distribution.	MOUs on file at provider.
PROGRAM RECORDS	☒	☒	Nutrition Support programs will maintain client files.	Client chart on file at provider agency that includes: • Client intake • Review and evaluation of updated determination of nutrition need and plan to meet nutrition needs • Client services agreement • Documentation of referrals • Documentation of annual reassessment of eligibility • Initial nutrition intake and annual screening All entries in client chart will be signed and dated.
FOOD SAFETY AND QUALITY	☒	☒	Nutrition support programs will follow Los Angeles County Environmental Health Food Safety Guidelines[4]	Documentation on file.

[4] Environmental Health | Los Angeles County Department of Public Health (lapublichealth.org) (http://www.lapublichealth.org/eh/)

SERVICE COMPONENT	HDM [1]	FOOD BANK/ PANTRY	STANDARD	MEASURE
	☒	☒	Nutrition Support programs will be responsible to develop an Infection Control Program.	Infection Control Program on file at provider agency that includes education, promotion and inspection of proper hand washing, personal hygiene and safe food handling practices by staff and volunteers.
	☒	☒	Nutrition Support programs will be responsible for developing a Food Quality Control Program.	Food Quality Control Program on file at provider agency that includes these requirements (at minimum): • Proper food temperature is maintained at all times • Food inventory is updated and rotated as appropriate on a first-in, first-out basis • Facilities and equipment have capacity for proper food storage and handling • A procedure for discarding unsafe food is posted • Providers and vendors maintain proper licenses • Programs will maintain quality control logs
	☒	☒	Nutrition Support programs will develop a nutrition support manual.	Food Service Manual on file at provider agency which addresses food service and preparation standards; sanitation; safety; food

SERVICE COMPONENT	HDM [1]	FOOD BANK/ PANTRY	STANDARD	MEASURE
				storage; distribution; and volunteer training.
	☒	☒	Nutrition Support programs will conduct an annual client survey.	Client survey results on file at provider agency and agency plan of action to address concerns.
TRIAGE AND REFERRAL	☒	☒	Clients applying for nutrition support services who do not have a case manager will be referred to a case manager.	Record of referral on file in client chart.
	☒	☒	Clients will be referred to other medical and support services as needed.	Referrals to treatment advocacy, peer support, medical treatment, dental treatment, etc., recorded in client chart.
	☒	☒	Referrals will be made to other food sources as needed.	Record of referral on file in client chart.
CASE CLOSURE	☒	☒	Nutrition Support programs will develop case closure criteria and procedures.	Program cases may be closed when the client: • Relocates out of the service area • Has had no direct program contact in the past six months • Is ineligible for the service • No longer needs the service • Discontinues the service • Is incarcerated long term • Uses the service improperly or has not complied with the client services agreement • Has died

SERVICE COMPONENT	HDM [1]	FOOD BANK/ PANTRY	STANDARD	MEASURE
			Patients will be formally notified of pending case closure.	Contact attempts and notification about case closure on file in client record.
STAFFING REQUIREMENTS AND QUALIFICATIONS	☒	☒	At minimum, all nutrition support staff will be able to provide age and culturally appropriate care to clients living with HIV or affected by HIV.	Staff resume and qualifications on file at provider agency.
	☒	☒	All employees involved in the preparation of meals will undergo a health screening as a condition of employment which includes TB test and stool screening.	Copy of health clearance in employee file.
	☒	☒	All staff and volunteers will be given orientation prior to providing services.	Orientation curriculum on file at provider agency which includes: • Basic HIV/AIDS education • Client confidentiality and HIPAA regulations Basic overview of food and water safety • Food protection protocols including hand washing, cross contamination, cooling/heating/cooling, hot and cold reheating, temperature danger zones • Service provider personal hygiene • Work safety

SERVICE COMPONENT	HDM [1]	FOOD BANK/ PANTRY	STANDARD	MEASURE
				• Proper receiving and storing of food and supplies
	☒	☒	In-service trainings will be provided quarterly by an RD or other qualified professional.	Record of quarterly training (including date, time, topic, presenter, and attendees) on file at provider agency.
	☒	☒	Any nutrition support employee having direct contact with daily food preparation will hold a current certification in food handling.	Certifications on file at provider agency.
	☒	☒	Volunteers will be supervised by a staff person. All staff will be reviewed by their supervisor annually, at minimum.	Supervision plan and annual staff reviews on file at provider agency.
	☒	☒	RDs working with HIV food distribution programs will have the following: • Broad knowledge of principles and practices of nutrition and dietetics • Advanced knowledge in the nutrition assessment, counseling, evaluation, and care plans of people living with HIV • Advanced knowledge of current scientific information regarding nutrition assessment and therapy	Resume and training verification on file at provider agency.

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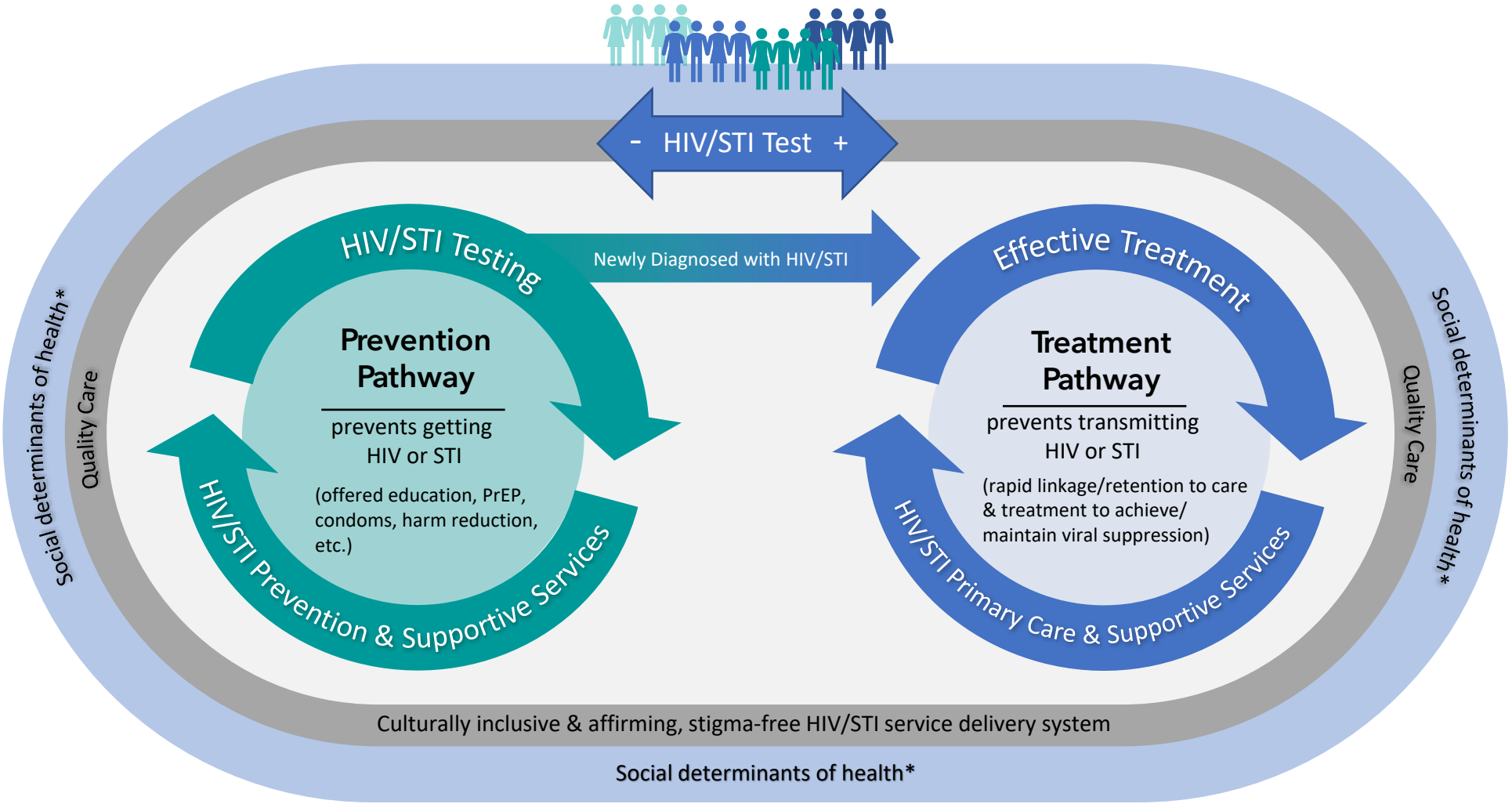
Status Neutral HIV and STI Service Delivery System



LOS ANGELES COUNTY COMMISSION ON HIV

Revised 6/1/23

* Social determinants of health include economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context.

See Healthy People 2030 for more details on the social determinants of health.

PREVENTION SERVICES STANDARDS

Approved the Commission on HIV 06/14/18

Under Review by the Standards and Best Practices Committee. Version as of 06/01/23.

TABLE OF CONTENTS

BACKGROUND

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[2] Los Angeles County Commission on HIV and the Los Angeles County Department of Public Health Division of HIV and STD Programs. Los Angeles County Comprehensive HIV Plan (2017-2021), September 2016.
[3] The National HIV/AIDS Strategy for the United States: Updated to 2020. https://www.aids.gov/federal-resources/national-hiv-aids-strategy/nhas-update.pdf
[4] High-Impact HIV Prevention: CDC's Approach to Reducing HIV Infections in the United States. https://www.cdc.gov/hiv/policies/hip/hip.html

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

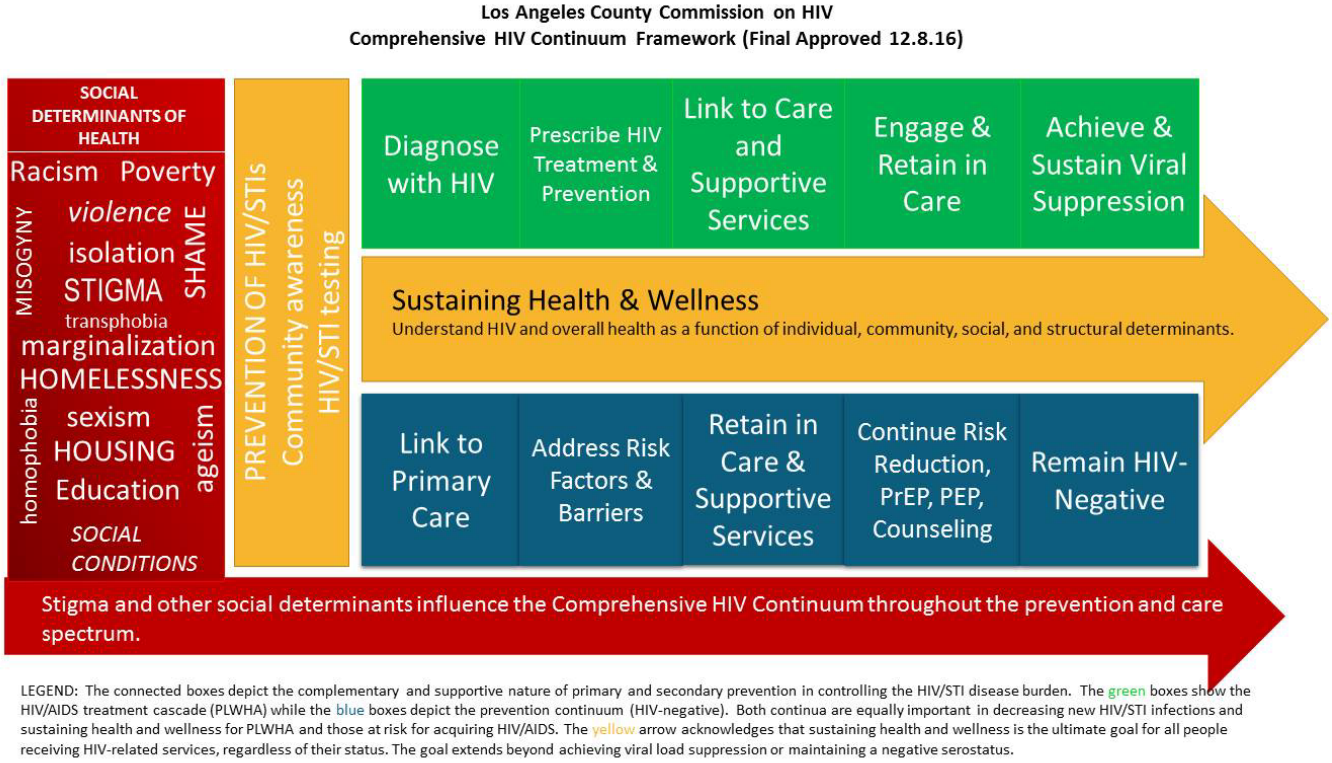
- Persons who inject drugs (PWID)
- Youth (18-29 years)
- Cisgender women
- Transgender persons
- Blacks/African Americans
- American Indians/Alaska Natives

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

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

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

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



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

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

1. Are the standards up-to-date and consistent with national standards of high quality HIV and STD[5] prevention services?

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

2. Are the standards reasonable and achievable for providers?
3. Will the services meet consumer needs?
4. Are proposed standards client-centered?
5. What are the important outcomes we expect for people receiving these services? How can we measure whether or not the service is working for them?

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

UNIVERSAL STANDARDS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CORE PREVENTION COMPONENTS

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

Table 1: Summary of Core Prevention Service Components

Core Prevention Service Components	Data Indicators	Documentation Needs	Population-Based Outcomes
1. Assessment	• Number of clients/patients who complete assessments • Number of participants screened for: connection to a medical home; primary care engagement; insurance coverage; HIV status; STDs; immunizations; pregnancy; mental health; substance abuse; experiences of trauma and violence; housing and employment status; and sexual and needle-sharing behaviors that may increase their risk of HIV acquisition or transmission	• Completed assessments indicating specific areas or topics assessed and type of assessments used	• Decrease the number of new HIV infections • Decrease the number of STDs • Increase the number of persons with known HIV status • Increase the number of persons treated for STDs • Increase the number of newly diagnosed clients that have their first HIV medical visit within 72 hours of their diagnosis.
2. HIV/STD Testing and Retesting	• Number of persons tested/screened for HIV and STDs • Number of persons tested/screened for HIV and STDs who have never tested/screened before	• Documentation of HIV/STD testing in client files and data management system • Documentation of type and frequency of outreach and recruitment	

	• Number of persons who test positive for an STD who are treated or referred to treatment • Percentage of high-risk[9] negative clients having documentation of HIV/STD testing every 3 months • Type and number of outreach and recruitment methods	methods • Documentation of clients treated for STDs or referred to treatment	• All service provides should strive towards linking newly-diagnosed PLWHA to anti-retroviral therapy within 72 hours of diagnosis.
Core Prevention Service Components	**Data Indicators**	**Documentation Needs**	**Population-Based Outcomes**
3. Linkage to HIV Medical Care and Biomedical Prevention Services	**HIV-positive individuals:** • Number of HIV-positive clients linked to HIV medical care within 72 hours of receiving a HIV-positive test result. • Number of HIV-positive clients lost to care who re-engage in HIV medical care within 30 days of interaction with provider **HIV-negative individuals:** • Number of high-risk HIV-negative clients receiving education on	• Documentation of linkage to HIV medical care • Documentation of re-engagement in HIV medical care • Documentation of PrEP and PEP education • Documentation of client interest in learning more about PrEP (i.e. responded affirmatively to the question, "Would you like to learn more about PrEP or PEP?") • Documentation of linkage to a PrEP services(may be	• Increase the number of out-of-care previously diagnosed clients that are re-engaged in HIV medical care within 30 days of their identification. • Increase the number of HIV positive clients that have at least 2 medical visits per year at least 3 months apart. • Increase the

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

	PrEP • Number of high-risk[10] HIV-negative clients who are interested in PrEP • Number of high-risk HIV-negative clients interested in PrEP that are linked to a PrEP Navigator. • Number of high-risk HIV-negative clients who received a PrEP prescription • Number of high-risk HIV-negative clients receiving education on PEP • Number of high-risk HIV-negative clients who received PEP within 72 hours of exposure	internal or external linkage)	number of HIV-positive persons that are virally suppressed (<200 copies/ml)
	• Number of high-risk HIV-negative clients who accessed PEP and transitioned to PrEP	• If available, documentation of PrEP or PEP prescription (may be client self-report) • Documentation of former PEP clients who currently access PrEP • Documentation of PrEP and PEP clients who are referred to medication adherence services	• Increase the number of HIV negative clients that are given accurate PrEP and PEP information • Increase the number of high-risk HIV negative individuals accessing HIV pre-exposure prophylaxis (PrEP) and HIV post-

10

			exposure prophylaxis (PEP), as needed
Core Prevention Service Components	**Data Indicators**	**Documentation Needs**	**Population-Based Outcomes**

4. Referral and Linkage to Non-Biomedical Prevention Services	• Number of high-risk HIV-negative and HIV-positive clients that are referred to needed non-biomedical prevention services, as indicated via the assessment process. This may include referrals to:
	  • behavioral interventions
	  • risk-reduction education
	  • syringe exchange
	  • housing services
	  • mental health services
	  • substance abuse services
	  • food pantries
	  • employment services
	  • health insurance navigation
	• Number of high-risk
		• Documentation of referrals in client files and data management system
		• Documentation of linkage to primary care (may be client self-report)
		• Documentation of condom availability or distribution
			Same as above

	HIV-negative clients who have not accessed primary care in over one year linked to primary care medical visit within 90 days of assessment.[11] • Number of external and internal[12] condoms distributed free of charge		
Core Prevention Service Components	**Data Indicators**	**Documentation Needs**	**Population-Based Outcomes (from CHP)**
5. Retention and Adherence to HIV Medical Care, ART, and Other Prevention Services	• Number of HIV-positive clients who receive HIV medical care at least 2 times per year, at least 3 months apart • Number of HIV-positive clients who adhere to their HIV medications • Number of HIV-positive clients who remained engaged in prevention service as needed • Number of PrEP and PEP clients referred to medication adherence interventions or support services. • Number of PrEP and PEP clients who access medication	• Documentation of provision of service(s) • Documentation of client engagement in service(s) • Documentation of adherence to ART, PrEP or PEP medication (optimal adherence for PrEP is 90% and 95% for ART of prescribed doses) • Documentation of PrEP and PEP clients who access medication adherence services	Same as above

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

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

	adherence interventions or support services. • Number of HIV-negative clients who remained engaged in prevention service as needed • Number of PrEP clients who adhere to PrEP medication per adherence plan determined with PrEP provider • Number of PEP clients who adhere to PEP for 28-day course		

ASSESSMENT

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

Standards for Assessment:

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

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

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

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

The assessment should highlight clients' skills, competencies and resilience in addition to their

challenges and needs. Included below are some examples of strength-based questions[13] that may be asked during an assessment, or over the course of multiple assessments, as appropriate:

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

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

34. What kind of supports have you used that have been helpful to you? How did the supports improve things for you?
35. Tell me about any creative, different solutions you have tried. How did this work out?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

HIV/STD TESTING AND RETESTING

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

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

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

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

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

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

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

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

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

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

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

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

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

LINKAGE TO HIV MEDICAL CARE AND BIOMEDICAL PREVENTION SERVICES

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

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

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

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

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

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

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

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

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

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

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

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

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

REFERRALS AND LINKAGES TO NON-BIOMEDICAL PREVENTION SERVICES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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