LOS ANGELES COUNTY
COMMISSION ON HIV

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STANDARDS AND BEST PRACTICES COMMITTEE

Virtual Meeting

Tuesday, June 7, 2022

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

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

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

REGISTER VIA WEBEX ON YOUR COMPUTER OR SMART PHONE:
https://tinyurl.com/8bzd8f46
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1-415-655-0001
Event #/Meeting Info/Access Code: 2597 572 3307
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PUBLIC COMMENTS

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

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LOS ANGELES COUNTY
COMMISSION ON HIV

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

STANDARDS AND BEST PRACTICES COMMITTEE

TUESDAY, JUNE 7, 2022, 10:00 AM – 12:00 PM

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

https://tinyurl.com/8bzd8f46

or Dial

1-415-655-0001

Event Number/Access code: 2597 572 3307

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

Standards and Best Practices (SBP) Committee Members			
Erika Davies *Co-Chair*	Kevin Stalter *Co-Chair*	Mikhaela Cielo, MD	Wendy Garland, MPH
Thomas Green	Mark Mintline, DDS	Paul Nash, PhD, CPsychol, AFBPsS, FHEA	Mallery Robinson
Harold Glenn San Agustin, MD	Reba Stevens	Ernest Walker, MPH	
QUORUM: 6			

AGENDA POSTED: June 2, 2022

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IV. REPORTS

5. Executive Director/Staff Report 10:15 AM – 10:25 AM
- a. Operational and Staffing Updates
- b. Comprehensive HIV Plan 2022-2026
- c. Special Populations Best Practices Project

6. Co-Chair Report 10:25 AM – 10:30 AM
   a. 2022 SBP Committee Workplan

7. Division of HIV & STD Programs (DHSP) Report 10:30 AM – 10:35 AM

V. DISCUSSION ITEMS

8. Service Standards Development 10:35 AM – 11:45 AM
   a. Approve the Benefits Specialty Services (BSS) service standards as presented or revised and forward to the Executive Committee. **MOTION #3**
   b. Oral Healthcare Service Standards Addendum Draft
   c. Home-based Case Management review
      - Review public comments

VI. NEXT STEPS 11:45 AM – 11:55 AM

9. Tasks/Assignments Recap

10. Agenda development for the next meeting

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

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

VIII. ADJOURNMENT 12:00 PM

12. Adjournment for the virtual meeting of June 7, 2022.

PROPOSED MOTIONS	
MOTION #1	**Approve the Agenda Order, as presented or revised.**
MOTION #2	**Approve the Standards and Best Practices Committee minutes, as presented or revised.**
MOTION #3	**Approve the Benefits Specialty Services service standards as presented or revised and forward to the Executive Committee.**

DRAFT

LOS ANGELES COUNTY
COMMISSION ON HIV

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

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

STANDARDS AND BEST PRACTICES (SBP) COMMITTEE MEETING MINUTES

May 3, 2022

COMMITTEE MEMBERS P = Present | A = Absent					
Erika Davies, *Co-Chair*	P	Thomas Green	P	Harold Glenn San Agustin, MD	EA
Kevin Stalter, *Co-Chair*	P	Mark Mintline, DDS	EA	Reba Stevens *(Alternate)*	P
Mikhaela Cielo, MD	EA	Paul Nash, PhD, CPsychol, AFBPsS, FHEA	A	Ernest Walker, MPH	A
Wendy Garland, MPH	P	Mallery Robinson	A		
COMMISSION STAFF AND CONSULTANTS					
Cheryl Barrit, Jose Rangel-Garibay					
DHSP STAFF					
Sona Oksuzyan					

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

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

CALL TO ORDER-INTRODUCTIONS-CONFLICT OF INTEREST STATEMENTS
The meeting was called to order at 10:05 am. Kevin Stalter led introductions.

I. ADMINISTRATIVE MATTERS

1. APPROVAL OF AGENDA
MOTION #1: Approve the agenda order, as presented ***(Postponed, no quorum)***.

2. APPROVAL OF MEETING MINUTES
MOTION #2: Approve the 4/5/2022 Standards and Best Practices (SBP) Committee meeting minutes, as presented ***(Postponed, no quorum).***

II. PUBLIC COMMENT

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

III. COMMITTEE NEW BUSINESS ITEMS

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

IV. REPORTS

5. **EXECUTIVE DIRECTOR/STAFF REPORT**
   a. **Operational Updates**
      - Cheryl Barrit, Executive Director, reported that the County Board of Supervisors (BOS) approved another motion to continue virtual meetings for the Board and all commissions under its authority for another 30 days. She reminded the committee to review the meetings packet for the April 2022 Commission meeting for updates on the Vermont Corridor.

   b. **Comprehensive HIV Plan (CHP) 2022-2026**
      - C. Barrit reported that AJ King, consultant, is busy writing the first section of the CHP and continues to meet with various stakeholders. He most recently met with a small group of COH and DHSP stakeholders to finalize the HIV workforce capacity survey. She added that the one survey will focus on front line staff and the other survey will elicit feedback from consumers and users of HIV prevention and care services. She is working with AJ to review calendars to conduct more community listening sessions.

   c. **Oral Healthcare Subject Matter Expert Panel**
      - Jose Rangel-Garibay reported that COH staff have completed a comprehensive summary of the feedback received during the Subject Matter Expert Panel held in February 2022. He will work with the discussion facilitator to develop a draft addendum and present the document at the June 6th SBP committee meeting.

   d. **Special Populations Best Practices Project**
      - J. Rangel-Garibay met with the Transgender Caucus on 4//26/22 and presented his findings and solicited feedback from the caucus. He also reported he will share his findings with the Consumer Caucus at their 5/12/22 meeting.

6. **CO-CHAIR REPORT**
   a. **2021 Workplan Review & Opportunities to Support Task Forces and Caucuses**
      - Erika Davies noted that the committee did not have quorum and would postpone voting on Motion #3 to approve the Benefits Specialty Service standards.

7. **DIVISION ON HIV AND STD PROGRAMS (DHSP) REPORT**
      - Wendy Garland introduced Sona Oksuzyan who presented a summary document for the Transitional Care Management (TMCP) in Los Angeles County Jails which included service utilization for Ryan White years 29-30. The intent of the document is to describe how DHSP operationalized the TMCP service standard in the past and provide data for determining any edits to the service. A copy of the document is included in the meeting packet.

V. DISCUSSION ITEMS

8. **SERVICE STANDARDS DEVELOPMENT**
   a. **Benefits Specialty Services (BSS) services standards**
      MOTION #3: Approve the BSS service standards as presented or revised and forward to the Executive Committee ***(Postponed, no quorum).***
   b. **Home-based Case Management (HBCM) Review**

The Committee announced a 30-day public comment period starting on May 6th and ending on June 6th for the HBCM service standards. COH will include guiding questions for reviewers to consider when providing comments. The document is included in the meeting packet and is available on the COH website.

c. **Transitional Case Management- Incarcerated/Post-Release (TCR-IPR) Review**
E. Davies led the committee in an overview of the TCM-IPR service standards. Highlights from the discussion include determining if the comprehensive assessment is unique to Youth TCM; identify appropriate terminology to replace "inmate" phrasing; and a recommendation for COH staff to research TCM standards at other jurisdictions.

VI. NEXT STEPS

9. **TASK/ASSIGNMENTS RECAP**:
   - The Committee will vote on Motion #3: Approve the BSS service standards as presented or revised and forward to Executive Committee.
   - COH staff will draft an addendum for the Oral health care standards regarding dental implants.
   - COH staff will send a notice regarding the 30-day public comments period for HBCM service standards via GovDelivery
   - COH staff will research and reach out to agencies that have TCM contracts to form mini review panel

10. **AGENDA DEVELOPMENT FOR NEXT MEETING**:
    - Report back updates on the Special Population Best Practices project
    - Review the draft addendum for the Oral health care standards regarding dental implants
    - Review comments received for HBCM service standards
    - Continue review of the TCMI-PR service standards

VII. ANNOUNCEMENTS

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

VIII. ADJOURNMENT

12. **ADJOURNMENT**: The meeting adjourned at 11:44am.

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 5/5/22

The following list identifies "conflicts-of-interest" for Commission members who represent agencies with Part A/B –and/or CDC HIV Prevention-funded service contracts with the County of Los Angeles. According to Ryan White legislation, HRSA guidance and Commission policy, Commission members are required to state their "conflicts-of-interest" prior to priority- and allocation-setting and other fiscal matters concerning the local HIV continuum of care, and to recuse themselves from discussions involving specific service categories for which their organizations have service contracts.

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
ALVAREZ	**Miguel**	No Affiliation	No Ryan White or prevention contracts
ALVIZO	**Everardo**	Long Beach Health & Human Services	Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			HIV and STD Prevention
			HIV Testing Social & Sexual Networks
			HIV Testing Storefront
ARRINGTON	**Jayshawnda**	Unaffiliated consumer	No Ryan White or prevention contracts
BALLESTEROS	**Al**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV)
			STD Screening, Diagnosis, and Treatment
			Health Education/Risk Reduction (HERR)
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
BURTON	**Alasdair**	No Affiliation	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
CAMPBELL	**Danielle**	UCLA/MLKCH	Oral Health Care Services
			Medical Care Coordination (MCC)
			Ambulatory Outpatient Medical (AOM)
			Transportation Services
CIELO	**Mikhaela**	LAC & USC MCA Clinic	Ambulatory Outpatient Medical (AOM)
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
DANIELS	**Michele**	Unaffiliated consumer	No Ryan White or prevention contracts
DARLING-PALACIOS	**Frankie**	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Transportation Services
DAVIES	**Erika**	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DONNELLY	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
FINDLEY	**Felipe**	Watts Healthcare Corporation	Transportation Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Oral Health Care Services
			Biomedical HIV Prevention
			STD Screening, Diagnosis and Treatment

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
FULLER	**Luckie**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			HIV Testing Specialty
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Health Education/Risk Reduction, Native American
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Nutrition Support
GARTH	**Gerald**	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Promoting Healthcare Engagement Among Vulnerable Populations
			Transportation Services
GATES	**Jerry**	AETC	Part F Grantee
GONZALEZ	**Felipe**	Unaffiliated consumer	No Ryan White or Prevention Contracts
GORDON	**Bridget**	Unaffiliated consumer	No Ryan White or prevention contracts
GREEN	**Joseph**	Unaffiliated consumer	No Ryan White or prevention contracts
GREEN	**Thomas**	APAIT (aka Special Services for Groups)	HIV Testing Storefront
			Mental Health
			Transportation Services
HALFMAN	**Karl**	California Department of Public Health, Office of AIDS	Part B Grantee
KOCHEMS	**Lee**	Unaffiliated consumer	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MAGANA	**Jose**	The Wall Las Memorias, Inc.	HIV Testing Storefront
			HIV Testing Social & Sexual Networks
MARTINEZ	**Eduardo**	AIDS Healthcare Foundation	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Medical Care Coordination (MCC)
			Mental Health
			Oral Healthcare Services
			STD Screening, Diagnosis and Treatment
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
			Medical Subspecialty
			HIV and STD Prevention Services in Long Beach
MARTINEZ (PP&A Member)	**Miguel**	Children's Hospital Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transitional Case Management - Youth
			Promoting Healthcare Engagement Among Vulnerable Populations
MILLS	**Anthony**	Southern CA Men's Medical Group	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
MINTLINE (SBP Member)	**Mark**	Western University of Health Sciences	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MORENO	**Carlos**	Children's Hospital, Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transitional Case Management - Youth
			Promoting Healthcare Engagement Among Vulnerable Populations
MURRAY	**Derek**	City of West Hollywood	No Ryan White or prevention contracts
NASH	**Paul**	University of Southern California	Biomedical HIV Prevention
			Oral Healthcare Services
NELSON	**Katja**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Health Education/Risk Reduction, Native American
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Nutrition Support
OROZCO	**Jesus ("Chuy")**	HOPWA-City of Los Angeles	No Ryan White or prevention contracts
PERÉZ	**Mario**	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
PRECIADO	**Juan**	Northeast Valley Health Corporation	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Medical Care Coordination (MCC)
			Oral Healthcare Services
			Mental Health
			Biomedical HIV Prevention
			STD Screening, Diagnosis and Treatment
			Transportation Services
ROBINSON	**Mallery**	We Can Stop STDs LA	No Ryan White or prevention contracts
RODRIGUEZ	**Isabella**	No Affiliation	No Ryan White or prevention contracts
ROSALES	**Ricky**	City of Los Angeles AIDS Coordinator	No Ryan White or prevention contracts
SATTAH	**Martin**	Rand Schrader Clinic LA County Department of Health Services	Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
SAN AGUSTIN	**Harold**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV)
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
SPENCER	**LaShonda**	Oasis Clinic (Charles R. Drew University/Drew CARES)	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			Medical Care Coordination (MCC)
STALTER	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
STEVENS	**Reba**	No Affiliation	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
THOMAS	**Damone**	T.H.E Clinic, JWCH, Inc. and AHF	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV)
			STD Screening, Diagnosis and Treatment
			Health Education / Risk Reduction (HERR)
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
			Sexual Health Express Clinics (SHEx-C)(AHF)
			Medical Subspecialty(AHF)
			HIV Prevention Services-Long Beach (AHF)
VALERO	**Justin**	No Affiliation	No Ryan White or prevention contracts
WALKER	**Ernest**	No Affiliation	No Ryan White or prevention contracts

Service Standards for

BENEFITS SPECIALTY SERVICES

BENEFITS SPECIALTY SERVICES
service standards

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

Ryan White HIV/AIDS Services: Determining Client Eligibility and Payor of Last Resort Program Clarification Notice (PCN) #21-02

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

INTRODUCTION

Service standards for the Ryan White HIV/AIDS Part A Program outline the elements and expectations a service provider should follow when implementing a specific service category. The standards are written for providers for guidance on what services may be offered when developing their Ryan White Part A programs. The standards set the minimum level of care Ryan White funded agencies offer to clients, however, providers are encouraged to exceed these standards.

The Los Angeles County Commission on HIV developed the Benefits Specialty Services standards to establish the minimum standards of care necessary to ensure people living with HIV (PLWH) can receive quality Benefits Specialty Services when attending core medical and/or support services appointments and meetings. 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 Program (DHSP), members of the Los Angeles County Commission on HIV, Standards & Best Practices Committee, and the public-at-large.

BENEFITS SPECIALTY SERVICES (BSS): OVERVIEW

Benefits Specialty Services are client-centered activities that facilitate a client's access to public/private maintenance of health, social services, and disability benefits and programs. Benefits Specialty Services work to maximize public funding by helping clients identify all available health, social services, and disability benefits supported by funding streams in addition to Ryan White Part A funds. These services are designed to assist a client navigate care and social services systems outside of the service delivery network funded by the Ryan White Program, educate people living with HIV about public and private benefit programs, and aid in accessing and securing these benefits.

Benefits Specialty Services are unlicensed. All HIV Benefits Specialty Services will be provided in accordance with Commission on HIV guidelines and procedures, and local laws and regulations and will respect the inherent dignity of each person living with HIV they serve. In addition, BSS contractors must adhere to contractual requirements stipulated by DHSP.

Benefits Specialists will assist clients directly or through referral in obtaining the following (at minimum):

Table 1. BENEFIT SPECIALTY SERVICES LIST

Health Care	• AIDS Drug Assistance Program (ADAP)* • Patient Assistance Programs (Pharmaceutical Companies)
Insurance	• State Office of AIDS Health Insurance Premium Payment (OA-HIPP) • Covered California/Health Insurance Marketplace • Medicaid/Medi-Cal/MyHealthLA • Medicare • Medicare Buy-in Programs • Private Insurance
Food and Nutrition	• CalFresh • DHSP-funded nutrition programs (food banks or home delivery services)
Disability	• Social Security Disability Insurance (SSDI) • State Disability Insurance • In-Home Supportive Services (IHSS)
Unemployment/Financial Assistance	• Unemployment Insurance (UI) • Worker's Compensation • Ability to Pay Program (ATP) • Supplemental Security Income (SSI) • State Supplementary Payments (SSP) • Cal-WORKS (TANF) • General Relief/General Relief Opportunities to Work (GROW)
Housing	• Section 8, Housing Opportunities for People with AIDS (HOPWA) and other housing programs • Rent and Mortgage Relief programs
Other	• Women, Infants and Children (WIC) • Childcare • Entitlement programs • Other public/private benefits programs • DHSP-funded services

All contractors must meet the Universal Standards of Care in addition to the following Benefits Specialty Services service standards. Universal Standards of Care can be access at: http://hiv.lacounty.gov/Projects

Table 2. BENEFITS SPECIALTY SERVICES REQUIREMENTS

SERVICE COMPONENT	STANDARD	DOCUMENTATION
Outreach	Benefits specialty programs will outreach to potential clients/families and providers.	Outreach plan on file at provider agency.
	Benefits specialty programs will collaborate with primary health care and supportive services providers.	Memoranda of Understanding on file at the provider agency.
Intake	The intake process will begin during first contact with client.	Intake tool in client file to include (at minimum): • Documentation of HIV status • Proof of LA County residency or Affidavit of Homelessness • Verification of financial eligibility • Date of intake • Client name, home address, mailing address and telephone number • Emergency and/or next of kin contact name, home address and telephone number
	Confidentiality policy and Release of Information will be discussed and completed.	Release of Information signed and dated by client on file and updated annually.
	Consent for services will be completed.	Signed and dated Consent in client file.
	Client will be informed of Rights and Responsibility and Grievance Procedures.	Signed and dated forms in client file.
	When indicated, the client will provide Disclosure of Duty Statement.	Signed and date Disclosure of Duty Statement in client file.

	Client will be informed of limitations of benefits specialty services through Disclaimer form.	Signed and date Disclaimer in client file.
Benefits Assessment	Benefits assessments will be completed during first appointment.	Benefits assessment in client chart on file to include: • Date of assessment • Signature and title of staff person • Completed Assessment/Information form • Functional barriers • Notation of relevant benefits and entitlements and record of forms provided • Benefits service plans
Benefits Management	Benefits management services will be provided to clients who are enrolled in benefits programs and require advocacy to maintain their benefits.	Benefits assessment on file in client chart to include: • Date • Signature and title of staff person • Notation of relevant benefits and presenting issues(s) • Benefits service plan to address identifies benefits issue(s)
Benefits Service Plan (BSPs)	BSPs will be developed in conjunction with the client at the completion of the benefits assessment.	BSP on file in client chart that includes: • Name, date and signature of client and case manager • Benefits/entitlements for which to be applied • Functional barriers status and next steps • Disposition for each benefit/entitlement and/or referral
Appeals Counseling and Facilitation	As necessary, specialists will assist clients with appeals counseling and facilitation. Cases that require further	Signed, date progress notes on file that detail (at minimum): • Brief description of counseling provided

	legal assistance will be referred to Ryan White Program-funded or other legal service provider.	• Time spent with, or on behalf of, the client • Legal referrals (as indicated)
	Specialists will attempt to follow up missed appointments within one business day.	Progress notes on file in client chart detailing follow-up attempt.
Client Retention	Programs will develop a broken appointment policy to ensure continuity of service and retention of clients.	Written policy on file at provider agency.
	Programs will provider regular follow-up procedures to encourage and help maintain a client in benefits specialist services.	Documentation of attempts to contact tin signed, date progress notes. Follow-up may include: • Telephone calls • Written correspondence • Direct contact
	Programs will develop and implement a client contact policy and procedure for homeless clients and those with no contact information.	Contact policy on file at provider agency. Program review and monitoring to conform.
Case Closure	Clients will be formally notified of pending case closure.	Contact attempts and notification about case closure on file in client chart.
	Benefits cases may be closed when the client: • Successfully completes benefits and entitlement applications • Seeks legal representation for benefits • 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	Case closure summary on file in client chart to include: • Date and signature of benefits specialist • Date of case closure • Status of the BSP • Reasons for case closure

	• Uses the service improperly of has not complied with the client services agreement • Has died	
Staffing Development and Enhancement Activities	Benefits specialty programs will hire staff that have the ability to provide linguistically and culturally appropriate care to clients living with HIV. Staff meet the minimum qualifications for their job position and have the knowledge, skills, and ability to effectively fulfill their role. 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 people living with HIV in all facets of service delivery, whenever appropriate.	Hiring policy and staff resumes on file.
	All staff will be given orientation prior to providing services.	Record of orientation in employee file at provider agency.
	Benefits specialists will complete DHSP's certification training within three months of being hired and become ADAP and Ryan White/OA-HIPP certified in six months.	Documentation of Certification completion maintained in employee file.
	Staff will complete benefits specialty recertification training annually and will seek other training opportunities as available.	Documentation of training maintained in employee files to include: • Date, time, and location of training • Title of training • Staff members attending • Training provider • Training outline • Meeting agenda and/or minutes

	Benefits specialists will practice according to generally accepted ethical standards.	Program review and monitoring to confirm.
	Benefits specialists will receive a minimum of four hours of supervision per month.	Record of supervision on file at provider agency.

APPENDIX A: DEFINITIONS AND DESCRIPTIONS

Benefits Assessment is a cooperative and interactive face-to-face interview process during which the client's knowledge about and access to public and private benefits are identified and evaluated.

Benefits Management refers to benefits specialty services provided to individuals who are enrolled in various health and disability programs. The goal of benefits management is to provider advocacy that helps the individual maintain his or her benefits.

Case Closure is a systematic process of disenrolling clients form active benefits specialty services.

Client Intake is a process that determines a person's eligibility for benefits specialty services.

Entitlement Program are benefits that require financial contribution into the program prior to collecting from the program (e.g., State Disability Insurance (SDI) and Social Security Disability Insurance (SSDI)).

Legal Representation defines a process through which a consumer is represented by an attorney, paralegal and/or licensed/certified insurance adjustor. (Please see Legal Assistance Standard of Care.)

Outreach promotes the availability of and access to benefits specialty services to potential clients and services providers.

Public Benefits describe all financial and medical assistance programs funded by governmental sources.

DRAFT FOR REVIEW 5/13/2022

LOS ANGELES COUNTY
COMMISSION ON HIV

Meeting Name:	Oral Healthcare Subject Matter Expert (SME) Panel Discussion Regarding Dental Implants		
Date of Meeting:	February 24, 2022	**Time:**	9:00 a.m. PST to 11:00 a.m. PST
Summary Prepared by:	Jose Rangel-Garibay	**Location:**	Zoom Teleconference **https://us02web.zoom.us/j/85493140379**

Meeting Objective

The Oral Healthcare SME panel will support Commission staff in drafting a dental implant addendum to the current Ryan White Part A (RWPA) Oral Healthcare Service Standard. The addendum will provide clarification and guidance to the Commission's current Oral Healthcare Service Standard. In November 2022, the Commission will review the complete Oral Healthcare Service Standard.

Attendees

Arlet Arratoonian, *Dentist, Watts Health Center*
Maurilia Jimenez, *Dental Program Coordinator, Watts Health Center*
Mark Mintline, *Assistant Professor, Western University College of Dental Medicine*
Fariba Younai, *Professor of General and Specialty Care Dentistry, UCLA* School of Dentistry
Mark Davis, *Dental Director, AIDS Healthcare Foundation*
Samera Owhadian, *Dentist, AIDS Healthcare Foundation*
Mereyer Perez, *Special Project Manager, Herman Ostrow School of Dentistry USC*
Jennifer Torres, *Project Specialist, Herman Ostrow School of Dentistry USC*
Claudia Ortega, Project Specialist, *Special Patients Clinic, Herman Ostrow School of Dentistry USC*
Mario Perez, *Director, Div. of HIV & STD Programs (DHSP), LA County Dept. of Public Health (LA DPH)*
Michael Green, *Chief of Planning, Development, and Research, DHSP, LA DHP*
Pamela Ogata, *Strategic Planning Manager, DHSP, LA DPH*
Wendy Garland, *Chief Epidemiologist, DHSP, LA DPH*
Paulina Zamudio, *Chief Contracts, DHSP, LA DPH*
Cheryl Barrit, *Executive Director, Los Angeles County Commission on HIV (LACHIV)*
Jose Rangel-Garibay, *Health Program Analyst I, LACHIV*
Erika Davies, *Standards and Best Practices Co-Chair, LACHIV*
Kevin Stalter, *Standards and Best Practices Co-Chair, Unaffiliated Consumer, LACHIV*
Jeff Daniel, *Founder and CEO, Collaborative Research*

Agenda

Introductions	Jeff Daniel led introductions and asked participants to share their affiliations.
Meeting Purpose and Objectives:	a. Provide subject matter expert input to an addendum to the Commission's Oral Healthcare Service Standard specific to dental implants b. Identify client inclusion and exclusion criteria for dental implants c. Clarify subrecipient practices for dental implants
Review Service Category Definition for Oral Healthcare services	Cheryl Barrit, LACHIV, reiterated the purpose of the panel which is to develop a specific set of addendum service standards for Ryan White clients in Los Angeles County to strengthen oral healthcare services with regards to dental implants. J. Daniel added that achieving continuity across sub-recipients in providing dental implants is an important outcome of the panel discussion.

	Mario Perez, DHSP, recommend conducting a systematic review of the Oral Health service information at the disposal of DHSP to determine opportunities for improvement. He added the need to address the provider capacity issues due to an increasing number of clients requesting dental implants. He noted that agencies providing specialty dental services are receiving more referrals for dental implants than they can provider.
Review RWPA Oral Healthcare Service program summary	Mario Perez, DHSP, presented data that covers the Ryan White (RW) year 28 starting March 2018; year 29 starting in March 2019; and year 30 starting in March 2020. The data represents service utilization from 12 agencies contracted to provide general dental services and 4 agencies contracted to provide specialty dental services. In year 28, about 1,800 clients received specialty dental services and >1% received implants. In year 29, about 1,900 clients received specialty dental services and 1.9% received implants. In year 30, about 1,300 clients received specialty dental services and 5.5% received implants. The delivery of dental implant services is small compared to all other specialty dental services. However, a steady increase in implant services provided between RW Year 28 through RW Year 30 has been observed. Additionally, one agency is providing the highest proportion of dental implants (see attached presentation slides for data tables). Wendy Garland, DHSP, noted that the data had limitations since the data is agency reported. She added the following comments regarding the service utilization data reported: • DHSP does not receive information on whether a client received a service that they needed or that they were declined for a service that they needed • DHSP does not receive treatment plan data. DHSP cannot determine if there was a missed opportunity and would need to conduct a chart abstraction to receive additional data • The data included represent utilization patterns at contracted agencies and may not be generalizable to other providers outside of Ryan White • Need to identify dental codes that would be critical for the preparation, maintenance, and follow-up of dental implants that would help DHSP analyze service utilization patterns related to dental implant services
Facilitated discussion	J. Daniel facilitated a discussion using the following: <u>Thematic approaches:</u> 1. Frame and center the panel discussion in addressing PWH concerns regarding provider use of exclusion criteria for dental implants 2. Client treatment planning to strengthen and emphasize the importance of client/provider relationship in determining treatment plan options <u>Facilitation questions:</u> 1. What barriers currently exist in providing dental implants? 2. What conditions/clinical situations would lend to an exclusion for dental implants? 3. What conditions/clinical situations would lend to an inclusion for dental implants? 4. How would health outcomes be improved by dental implants?

	5. Regarding dental implants, what activities would be included in a client's treatment plan? 6. If no barriers to dental implants existed, what service would you offer clients?
Excerpts from the Discussion	**1. <u>What barriers currently exist in providing dental implants to clients?</u>** a. **M. Davis:** […] Not every patient is a candidate for dental implants, even though every candidate thinks they are a candidate. […] It is important to educate the patients as to the appropriateness of the treatment. b. **F. Younai:** [Patient] expectations are unrealistic, and the clinician needs to take into consideration the patient's ability to maintain a dental implant. […] discuss with the patient the need to demonstrate their ability to preserve 1-2 implants before discussing multiple implants in their treatment plan. Biggest barrier is time. Patients do not want to wait the time needed for them to demonstrate clinically that they can keep the implant(s) healthy. c. **Me. Perez**: [I] concur with the discussion points that patients arrive with unrealistic expectations and not all patients referred for implants are candidates due to their poor periodontal situation. d. **M. Davis:** Need to have some consistency between special dental providers so that agencies providing general dentistry services can also help manage patient's expectations. e. **Ma. Perez:** Need to streamline the guidelines so that they can mesh up better between the different agencies. f. **M. Davis:** Not aware how to navigate to other specialty providers [aside from USC and UCLA] offering implant services. g. **Ma. Perez:** [DHSP] will make an effort to help providers contracted to offer dental services understand how to navigate the referral process for specialty dental services. […] The Commission on HIV (COH) will update the standards with an addendum specific to implants and contracted agencies must adhere to those standards. h. **J. Daniel:** Based on the discussion so far, there is an administrative component that needs to be clarified: referrals to specialty clinics, the cost, amount of time, number of appointments required to complete implants, and explore further setting the correct expectation with the client [not every client is a candidate for dental implants]. **2. <u>What does the cost look like [for implants]?</u>** a. **F. Younai:** An average cost of a treatment plan of $12k-$13K per patient. b. **Group:** Denti-Cal does not pay for dentures or implant. Denti-Cal does not pay for any thing that comes before the implant. And in order for Denti-Cal to pay for partial dentures, the patient needs to have a certain number of missing teeth [missing 5 posterior teeth]. Denti-Cal has a lot of criteria to meet before paying for services. DHSP funded oral health services help mitigate the cost of providing services; without it, clients would not have any service payer. Medi-Care pays for nothing. **3. <u>Are there any clinical situations that would lend to an inclusion? What activities would be included in a client's treatment plan?</u>**

	a. **F. Younai:** [UCLA] do[es] not have exclusion criteria based on medical conditions, patients with HIV infection are assessed like any other patient with a medical condition. Based on the literature, there is no relation between CD4 count and success or failure of dental implants. […] Regardless of the patient's HIV status, any patient with a Hemoglobin A1C greater than 8 has a poor surgical risk. […] That is the only time that we may delay placement of an implant or extraction until they have better glycemic control. […] We do not use smoking as exclusion criteria, patients are encouraged to go through the cessation process, but we do not withhold implants. […] It is preferable that patients are not active drug users; we do have a criteria for people not showing up high to their appointment which is basically 3 days for Crystal Methamphetamine, no cocaine use within 24 hours and that is mostly due to local anesthetic interaction and that for safety of administration of local anesthetic. […] the predominant factor for implant failure is poor oral hygiene. So what our periodontal department and oral surgery department do is advise us: if you want to put more than one dental implant in a patient, lets guide them through oral hygiene, let us strategically place one, give them time, see if the patient can maintain it and if they are successful in preserving the dental implant then we can go to through the next phase and we can give them more implants. Patients have to demonstrate that they have the ability that they can preserve their dental implants. We do not have this written down anywhere. We say to our patients that we will treatment try you; we will look at your oral health needs, we will present you with options and alternatives and we will together come up with a treatment plan that best suits your needs. b. **M. Davis:** Those are important points because our patients did not lose their teeth because they have wonderful oral hygiene. So we need to get them [patients] periodontally stable and committed to their oral health. c. **Me. Perez:** USC has a different approach. We do have guidelines written down and send [them] to referring agencies. […] we go over their condition and they [patient] must have completed their periodontal therapy and we have considered their periodontal stability, must be Hep A compliant, cannot be [have] active use of cigarette, vaping, marijuana, smoking, for the last 6 months, so we will counsel them if they come in, provide smoking cessation for that. We will do 1 to 2 implants per patient generally. There can't be a need for a sinus augmentation. Then we also look at their medical history considerations. We do look at lab values, we do require a CD4 of over 500. We are looking at viral load and platelets and some of that has to do with surgery. And then we look at the A1C as well and has to be no greater than 7 for the last two lab periods, the past 6 months. No history of radiation therapy to the head or neck. d. **M. Davis:** And if I remember correctly, [in] the document that you sent, whereas UCLA doesn't have a limit on the number of implants they offer a patient, USC is pretty restrictive in the total amount that they will offer. e. **Me. Perez:** Yes, is it [the limit] is 1 to 2 implants. We do have a special program for selective patients going through full mouth reconstruction. […]

for general patients, there isn't a limit on the number of patients, it would be a limit on the number of implants.

f. **F. Younai:** […] we [UCLA] do[es] sinus lifts all the time before we do implants and of course the periodontal treatment, we complete it here. […] we are supposed to provide specialty services and agree that patients need to be periodontally stable, but we accept patients for comprehensive care. We do the periodontal phase first, and then we prepare patients for the implants, that is why it takes longer for us to get to that [implant] phase. [for platelets] more than 50, 000 so that they don't bleed to death, like any other patient. And again these are all in the dental guidelines that we all worked on together. It is 50,000 platelet count, it has nothing to do with HIV, most people do not want to treat anyone with platelet [count] less than 50,000 [because] they are poor surgical risks.

g. **J. Daniel:** One of the items that we need to work through with the Commission is exclusion criteria and standardize that, have some commonality. We want to have consistency in the service standards. […] one of the issues that consumers are having, it's that Provider A says, "As long as your A1C is above 8%, we are in pretty good shape; Provider B is saying "you can't have smoked for 6 months, we can only do 1 or 2" and it is not anyone on this meeting. But [for] the client, that is confusing.

h. **M. Davis:** It is also the comprehensiveness of the treatment plan being offered.

i. **F. Younai:** So there might actually be a philosophy of treatment plan, maybe we should explore it more.

4. **<u>Treatment Plan Philosophy discussion</u>**

a. **F. Younai:** Philosophy of treatment plan is very individualized; every dentist has their way of thinking.

b. **S. Owhadian:** A big chunk of our patients have pretty severe periodontal needs are going to end up in full dentures. […] a good starting point […] is to be able to have an implant supported denture top and bottom for patients that we know their [oral] hygiene is not going to allow for [implants] […] at least 2 implants on the top, and 2 on the bottom. 4 would be even better; 4 on top, 4 on bottom. And that would be lifechanging for a good chunk of people.

c. **F. Younai:** It is very interesting that you say that. We had to go back, and re-treatment plan a number of our patients, many of the patients that were referred to our HIV program a couple of years ago, and the treatment plans were starting to go over $30,000-$35,000 for all these fixed units, mainly for the cost and time it was taking and treatments failing […] they [director] decided that a lot of people are better off having implant supported dentures because that is the one thing, we know they can probably maintain. […] for many patients that is really the best option. the problem is you do not know much time we spent arguing with patients.

d. **C. Ortega:** Just to chime in here, unfortunately, the USC undergraduate implant department they will only treatment plan implants for the lower teeth for implant supported dentures.

	e. **J. Daniel:** I think it is important [to note] Los Angeles County [DHSP] and the contract is what stipulates what services are provided, not the sub-recipient. And I think that is critical. There are terms and conditions and service standards to follow […] From a monitoring perspective, subrecipients do not get to tell the County [recipient] what they are going to do. It shouldn't work that way. […] we talked about exclusions, and there is a lot of data that needs to go back to Commission and the Standards [and Best Practices] Committee. […] we just got to fix it to where it is consistent between Provider A, B, C, and D. […] we want to make sure that we have a standard saying this is the way oral health care services whether it is general, or specialty be delivered in the Ryan White Part A program in the Los Angeles EMA. […] would be helpful to get things written down from everybody and say, "this is my exclusionary" and go back to the Commission and have the Commission determine what to keep or remove while reviewing the general oral healthcare guidelines and relying on our subject matter experts as well. […] We are just trying to make it better for the clients. More access, easier access to improve health outcomes for people living with HIV in this category. f. **C. Barrit:** […] I would like to hear a little bit more about how we approach this conversation about the treatment plan. […] what would be those core concepts that would make it easier for you as dentists, as medical providers to create that space of collaboration with your patient? g. **F. Younai:** So Cheryl, I am going to turn this back to you, have you had this conversation with your medical providers? […] dentistry is not viewed as, unfortunately, as a medical service. Dental implants are a medical service. There are indications for people to get them and when providers sit there and try to explain to the patient why they should or shouldn't get them, it is not viewed as a medical opinion. That's the problem. […] What are the expectations in a medical appointment for that treatment planning conversation to happen? […] So we try to do that with our patients and yet have patients that insist on "I want this fancy, expensive, unrealistic treatment and this is what I want, and you cannot say no to me and if you don't do it, I am going to file a complaint with DHSP and that is the way it is going to be." So what do you say to that? h. **P. Zamudio:** […] it is across the board in most of our services. […] it is not the majority of clients but there is a percentage of clients that who have expectations that cannot be met by the services whether because of funding, guidelines of treatment, and take up a lot of the time from providers, from the consumer support line, so it does take up a lot of resources to deal with clients that come in with that expectation, unrealistic. […] that is a conversation we need to have with the Consumer caucus about setting expectations of services given funding sources and funding limitations and creating a more cooperative relationship with all providers. i. **Ma. Perez:** […] I think we are trying to balance multiple things. And I think we clearly need to reconcile the inclusion and exclusion criteria tied to implants. And I think Jeff's recommendation to document and go through each of those [criteria] and make a decision that we think is the best for the mission of the oral health program […] I think the other theme that I heard loud and clear this morning is the importance of periodontal stability. […] Our appetite to

support housing for people living with HIV who do not want to go to the doctor is gone. […] [DHSP] is going to be more clear about our expectations of the client across multiple service categories. […] this is an opportunity for us to introduce, sort of build on this idea Michael Green has talked about a couple years back, around dental case management. […] we have to make sure, Fariba, that you and your colleagues feel empowered and supported in daily negotiations with clients who make demands.

j. **F. Younai:** […] patient autonomy is a thing. […] We teach our students to respect patient autonomy, but we also have to teach them where does that end, and you have to actually be able to present a reasonably treatment plan to your patients. […] we are doing case management for our patients, and it is working really well. We are meeting so many more needs of our patients and it is making big difference in terms of their compliance with their dental care. […] including a section in the standards that address informed consent and treatment plan presentation, […] Which makes it a requirement for the provider to spend a little bit of time explaining the treatment plan to the patient. And of course you cannot be that prescriptive in terms of what the components are, but you should say that basically "treatment plans should be offered to the patient describing risks and benefits,"
k. **J. Daniel:** […] You have client roadmaps depending on what service they are accessing. And it needs to be the expectation that regardless of the service they are receiving, that this is informed consent, this is client expectations, and this is provider expectations. And that would a nice little thing to put in all services so that way it is universal. It is not just oral health. That would provide the consistency we are looking for across the everything.
l. **K. Stalter:** This is Kevin, co-chair of Standards [and Best Practices Committee] and also a consumer. […] I think that a lot of patients with issues that come up is substance use and the meth problem that we have. […] that is the issue that makes the patient go overboard. And that is something that we struggle as a community that is not going away any time soon. That is just a footnote to say that the vast majority of cases that are like that the issues of substance use, in particular meth. […] maybe there is preamble to that, the patient responsibility, the consumer responsibility, where some of this can be address. Yes, these are your rights, but these are some of your responsibilities as well.

5. **<u>If no barriers to dental implants existed, what services would you provide?</u>**
   a. **A. Arratoonian:** […] I think looking at it from the standard of care whatever you would do in private practice.
   b. **F. Younai:** I don't think we do anything different. We would probably do it for more patients. Increase access, but per patient, I think we would do the same thing we do now.
   c. **K. Stalter:** […] So, I have had so much work done, I can't imagine what is else is missing.

6. **Ma. Perez:** I have a question […] **<u>the implant-based denture, is this something that we should be doing more of</u>**, maybe as a sort of a happy medium that gets us closer to where we want to be?

	a. **F. Younai:** For the lower arch, it is great alternative to a full denture. […] as soon as you put in a couple of implants to anchor them, they have much better outcomes clinically. So, I think they are very good options for patients that do not have any teeth on the bottom. b. **M. Davis**: I echo that Fariba. I think that is so life changing, it would be life changing for the majority of patients, over dentures c. **Ma. Perez:** Could you just share the cost relative to the implant? Is it more expensive or less expensive? d. **F. Younai:** Well compared to a full denture, it is a lot more expensive because a full denture would be like $700, and if you add 2 implants to that to support it, you are talking about maybe, almost $4,000. e. **M. Davis:** I don't think we have had in the conversation is that we are talking about the implant, but are we talking about the restoration of these implants also? […] But in terms of the individual implants and the crowns on top of them, I mean there is huge cost that has to be looked at also in the overall treatment plan. f. **J. Daniel:** […] we talked about $18,000 to $20,000 for implants, $4,000 per single implant. g. **F. Younai:** the $18,000 to $20,000 was when you were including 3-4 implants plus crowns, so I was talking about an average treatment plan that included dental implants, plus bridges, fillings. h. **J. Daniel:** Right, and what is the cost of that specific treatment? i. **F. Younai:** It is probably about $5,000 for an implant supported lower denture. 7. **J. Daniel:** Thank you for that Fariba. Okay, [is there] anything else we want to discuss.? a. **F. Younai:** […] I think that in formulating the addendum to the standards, I implore you to use the methodology that the Commission always use for the standards. It has to be evidence-based, so expert opinion matters, but I think you should look at the literature and try to use evidence from the literature as much as possible. b. **M. Davis:** if you are provided with specialty funding for the oral surgeon, for the periodontists to place the implants but we have one of the schools having implants placed in the general student clinic, is that the same use of the specialty dollars? c. **Ma. Perez:** […] I think for the oral health services this tiered approach to having the undergraduates versus the more seasoned specialists is something that we are going to have to take a look at. Because if we expect services to be delivered, we may not have been as explicit on who should be delivering those services to meet the standards that we expect. So, I do think it is going to be an area we are going to have to circle back and review. d. **Me. Perez:** […] And for implants, it depends on the complexity and once they have their initial evaluation which is always with a specialist, then it moves to either our advanced periodontics clinic for oral surgery, or it goes to the undergraduate [clinic] it is really case dependent on the complexity.

	e. **M. Davis:** If I am going to go for root canal, I am going to go to a board-certified endodontist, and I am not going to go to a general dentist who is providing endodontic care with specialty dollars. f. **Mark Mintline:** I would just be very cautious with this because a dental implant is procedure not actually a specialty. There can be a wide range of dental specialists and general dentists can theoretically provide this service. g. **Ma. Perez:** Two things, quickly. One, I just wanted to thank you for guiding us this morning and keeping us moving. And the second is, I just wanted to thank everyone for working with us to constantly evolve and make our Ryan White system of care more responsive; we are doing this for a number of service categories, not just oral health. Thank you for the partnership.
Recap, Next Steps, and Thank you!	J. Daniel summarized the panel discussion points and thanked participants for their time and contributions. Commission staff will develop a meeting summary and will draft an Oral Healthcare Service Standard addendum regarding dental implants and send to the Standards and Best Practices Committee for review. Commission staff will also send the draft addendum to SMEs for review and feedback.

LOS ANGELES COUNTY
COMMISSION ON HIV

HOME-BASED CASE MANAGEMENT SERVICES SERVICE STANDARDS

DRAFT FOR PUBLIC COMMENT

PUBLIC COMMENT PERIOD:

May 6, 2022—June 6, 2022

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 (LACHIV) announces an opportunity for the public to offer comments for the draft service standards for **Home-based Case Management (HBCM)** being updated by the Standards and Best Practices Committee. Consumer, provider, and community feedback is critical for the service standards development process. We invite you to share your comments and distribute the document widely within your 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, 2022.**

When providing public comment, consider responding to the following:

1. Are the Home-based Case Management (HBCM) 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. Will the services meet consumer needs for HBCM? Why or why not?

4. Are the proposed HBCM standards client-centered? Is there anything missing related to HIV prevention and care?

5. Is there anything missing regarding accessing Home-based Case Management Services under Ryan White HIV/AIDS Program funding?

Changes discussed at the Standards and Best Practices Committee are denoted by italics and are highlighted in yellow.

DRAFT FOR PUBLIC COMMENT

LOS ANGELES COUNTY COMMISSION ON HIV

HOME-BASED CASE MANAGEMENT SERVICES
SERVICE STANDARDS

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

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

Service standards for the Ryan White HIV/AIDS Part A Program outline the elements and expectations a service provider should follow when implementing a specific service category. The standards are written for providers for guidance on what services may be offered when developing their Ryan White Part A programs. The standards set the minimum level of care Ryan White funded agencies offer to clients, however, providers are encouraged to exceed these standards.

The Los Angeles County Commission on HIV developed the Home-Based Case Management Services standards to establish the minimum standards of care necessary to ensure people living with HIV (PLWH) can receive quality Home-Based Case Management services when attending core medical and/or support services appointments and meetings. 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 Program (DHSP), members of the Los Angeles County Commission on HIV, Standards & Best Practices Committee, Women's Caucus, and the public-at-large.

SERVICE INTRODUCTION

Home-based case management services are client-centered case management and social work activities that focus on care for people living with HIV who are functionally impaired and require intensive home and/or community-based care. Services are conducted by qualified Registered Nurse (RN) case managers and master's [1]degree-level social workers who facilitate optimal health outcomes for functionally impaired people living with HIV through advocacy, liaison, and collaboration.

Home-based case management services may include:

- Assessment
- Service planning
- Attendant care
- Homemaker services
- Medical case management
- Care coordination
- Psychosocial case management
- Mental health therapy

The goals of home-based case management for functionally impaired people living with HIV include:

- Assessing and facilitating in-home services
- Helping clients locate needed health care and supportive services
- Helping service providers coordinate care for clients
- Helping clients understand and manage their medical diagnoses, including comorbidities and other health-related diagnoses that impact HIV care treatment
- Educating clients on reducing risks for HIV infection
- Helping patients adhere to medical regimens and drug therapies
- Helping clients transition appropriately to self-management and care
- Providing appropriate, quality, cost-effective care

All service providers receiving funds to provide Home-based Case Management services are required to adhere to the standards outline in Table 2.

[1] *Social workers providing home-based case management services will hold an MSW (or related degree) or BA in social work with 1-2 years of experience and practice according to State and Federal guidelines and the Social Work Code of ethics.*

Table 2. HOME-BASED CASE MANAGEMENT SERVICE REQUIREMENTS

SERVICE COMPONENT	STANDARD	DOCUMENTATION
OUTREACH	Home-based case management programs will outreach to potential patients and providers.	Outreach plan on file at provider agency.
INTAKE	Intake process will begin during first contact with client.	Intake tool, completed and in client file, to include (at minimum): • Documentation of HIV status • Proof of LA County residency • Verification of financial eligibility • Date of intake • Client name, home address, mailing address and telephone number • Emergency and/or next of kin contact name, home address and telephone number
	Confidentiality Policy and Release of Information will be discussed and completed.	Release of Information signed and date by client on file and updated annually.
	Consent for Services will be completed.	Signed and dated Consent in client file.
	Client will be informed of Rights and Responsibility and Grievance Procedures.	Signed and dated forms in client file.
ASSESSMENT	Assessments will be completed within 30 days following intake. Updates to the assessment will be done on a continuous basis, but no less than once every 90 days.	Assessment or update on file in client record to include: • Date • Signature and title of staff person • Client's educational needs related to treatment • Assessment of psychological adjustment and coping • Consultation (or documented attempts) with health care and

		related social service providers • Assessment of need for home-health care services • *Assessment of need for housing stability* A client's primary support person should also be assessed for ability to serve as client's primary caretaker.
SERVICE PLAN	Home-based case management service plans will be developed in conjunction with the patient.	Home-based case management service plan on file in client record to include: • Name of client, RN case manager and social worker • Date/signature of RN case manager and/or social worker • Documentation that plan has been discussed with client • Client goals, outcomes, and dates of goal establishment • Steps to be taken to accomplish goals • Timeframe for goals • Number and type of client contacts • Recommendations on how to implement plan • Contingencies for anticipated problems or complications
IMPLEMENTATION AND EVALUATION OF SERVICE PLAN	RN case managers and social workers will: • Provide referrals, advocacy and interventions based on the intake, assessment, and case management plan • *Provide referrals for housing assistance to clients that may need*	Signed, dated progress notes on file to detail (at minimum): • Description of client contacts and actions taken • Date and type of contact • Description of what occurred

	them based on housing stability assessment conducted on intake • Monitor changes in the client's condition • Update/revise the case management plan • Provide interventions and linked referrals • Ensure coordination of care • Conduct monitoring and follow-up • Advocate on behalf of clients • Empower clients to use independent living strategies • Help clients resolve barriers • Follow up on plan goals • Maintain ongoing contact based on need • Be involved during hospitalization or follow-up after discharge from the hospital • Follow up on missed appointments by the end of the next business day • Ensuring that State guidelines regarding ongoing eligibility are followed	• Changes in the client's condition or circumstances • Progress made toward plan goals • Barriers to plan and actions taken to resolve them • Linked referrals and interventions and current status/results of same • Barriers to referrals and interventions/actions taken • Time spent • RN case manager's or social worker's signature and title
ATTENDANT CARE	Attendant care will be provided under supervision of a licensed nurse, as necessary.	Record of attendant care on file in client chart.
	When possible, programs will subcontract with at least Home Care Organizations (HCO) or Home Health Agencies (HHA).	Contracts on file at provider agency.
HOMEMAKER SERVICES	Homemaker services will be provided under the supervision of a licensed nurse, as necessary.	Record of homemaker services on file in client record.

	Homemaker services will be monitored at least once every 6 months.	Record of monitoring on file in the client record.
	When possible, programs will subcontract with at least HCOs or HHAs.	Contracts on file at provider agency.
HIV PREVENTION, EDUCATION AND COUNSELING	RN case manager and social worker will provide prevention and risk management education and counseling to all clients, partners, and social affiliates.	Record of services on file in client medical record.
	RN case managers and social workers will: • Screen for risk behaviors • Communicate prevention messages • Discuss sexual practices and drug use • Reinforce safer behavior • Refer for substance abuse treatment • Facilitate partner notification, counseling, and testing • Identify and treat sexually transmitted diseases including Hepatitis C *Consider expanding the clinical scope of RN case managers to include home-based testing for communicable infections such as Sexually Transmitted Infections (STIs), Hepatitis C, COVID-19, blood pressure and blood glucose, and urinalysis.*	Record of prevention services on file in client record.
	When indicated, clients will be referred to appropriately credentialed/licensed professionals for prevention education and counseling.	Record of linked referral on file in client record.

REFERRAL AND COORDINATION OF CARE	Home-based case management programs will maintain a comprehensive list of providers for full spectrum HIV-related services referrals.	Referral list on file at provider agency.
	Home-based case management programs will collaborate with other agencies and providers to provide effective, appropriate referrals.	Memoranda of Understanding detailing collaborations on file at provider agency.
	Home-based case management programs will develop procedures and protocols for referrals.	Written procedures and protocols on file at provider agency that includes process for tracking and monitoring referrals.
CASE CONFERENCE	Case conferences held by RN case managers and social workers, at minimum, will review and revise services plans at least every 60 days. Client or representative feedback will be sought.	Documentation of case conferences on file in client record to include names and titles of those participating in the review and client or representative input.
PATIENT RETENTION	Programs will develop a broken appointment policy to ensure continuity of service and retention of clients.	Written policy on file at provider agency.
	Programs will provide regular follow-up procedures to encourage and help maintain a client in home-based case management.	Documentation of attempts to contact in signed, dated progress notes. Follow-up may include: • Telephone calls • Written correspondence • Direct contact
CASE CLOSURE	Clients will be formally notified of pending case closure.	Contact attempts and notification about case closure on file in client record
	Home-based case management cases may be closed when the client: • Has achieved their home-based case management service plan goals • Relocates out of the service area	Case closure summary on file in client chart to include: • Date and signature of RN case manager and/or social worker • Date of case closure • Service plan status • Statue of primary health care and service utilization

	• 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	• Referrals provided • Reason for closure • Criteria for re-entry into services
POLICIES, PROCEDURES AND PROTOCOLS	Home-based case management programs will have written policies procedures and protocols, including eligibility criteria.	Policies, procedures, and protocols on file at provider agency.
STAFFING REQUIREMENTS AND QUALIFICATIONS	RNs providing home-based case management services will: • Hold a license in good standing form the California State Board of Registered Nursing • Have graduated from an accredited nursing program with a BSN or two-year nursing associate degree • Have two year's post-degree experience and one year's community or public health nursing experience • Practice within the scope defined in the California Business & Professional Code, Section 2725	Resumes on file at provider agency to verify experience. Program review and monitoring to confirm.
	Social workers providing home-based case management services will hold an MSW (or related degree) *or BA in social work with 1-2 years of experience and practice*	Resumes on file at provider agency to verify experience. Program review and monitoring to confirm.

	according to State and Federal guidelines and the Social Work Code of ethics	
	RN case managers and social workers will attend an annual training/briefing on public/private benefits.	Documentation of attendance in employee files.
	Staff will maintain licenses by completing continuing education requirements of their respective professional boards.	Record of continuing education in employee files at provider agency.

DEFINITIONS AND DESCRIPTIONS

Assessment is a comprehensive evaluation of each client's physical, psychological, social, environmental, and financial status to determine the type and level of service needs. Assessments will be performed in accordance with guidelines set forth by the California Department of Public Health (CDPH) Case Management Program (CMP).

Attendant Care includes the provision of non-medical personal care by a home health aide or nurse assistant certified by the CDPH. Services are provided under the direct supervision of a licensed nurse.

Home Care Organization (HCO) is an entity that provides attendant care and/or homemaker services only. HCOs are not licensed by the CDPH and are not subject to State-issued service standards or criteria.

Home Health Agency (HHA) is a public or private entity that provides skilled nursing and other therapeutic services to clients in their place of residence under a treatment plan prescribed by an attending physician. HHAs must be qualified and licensed by the CDPH as a home health agency.

Homemaker Services include general household activities performed when the client is unable to manage home care for himself or herself at home. Services are provided under the direct supervision of a licensed nurse.

Registered Nurse (RN) Case Management Services include the provision of comprehensive medical case management for people living with HIV who require intensive home and/or community-based services.

Service Plan is a written document identifying a client's problems and needs, intended interventions, and expected results, including short- and long-range goals written in measurable terms.

Social Work Case Management Services include the provision of comprehensive social work case management services including, but not limited to, psychosocial, financial, housing, and related concerns for people living with HIV who require intensive home- and/or community-based services.

Social Workers, as defined in this standard, are individuals who hold a master's degree in social work (or related field) *or BA in social work with 1-2 years of experience from an accredited program.*