LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Avenue, 14th Floor, Los Angeles, CA 90020
MAIN: 213.738.2816 | EMAIL: hivcomm@lachiv.org | WEB: https://hiv.lacounty.gov

AGENDA FOR THE REGULAR MEETING OF THE STANDARDS AND BEST PRACTICES COMMITTEE

MONDAY, AUGUST 17, 2026 | 10:00 AM—12:00 PM

510 S. Vermont Ave.
Terrace Level Conference Room (9th Floor), Los Angeles, CA 90020
Validated Parking: 523 Shatto Place, Los Angeles, CA 90020

As a building security protocol, attendees entering the first-floor lobby must notify security personnel that they are attending a Commission on HIV meeting.

TO JOIN THE MEETING VIRTUALLY, PLEASE REGISTER USING THE LINK BELOW:
https://bos-lacounty-gov.zoom.us/webinar/register/WN_sPE75xvBQ4eleAj6IBN1hA

COMMITTEE CO-CHAIRS: Caitlin Dolan and Montana Volby

AGENDA POSTED: August 12, 2026

PUBLIC COMMENT: Public comment is an opportunity for members of the public to address the Commission on an agenda item or other matter within the Commission's subject matter jurisdiction. Comments may be provided in person or submitted electronically to https://forms.cloud.microsoft/g/sTQqRq5dH7

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 hivcomm@lachiv.org or leave a voicemail at 213.738.2816.

Los servicios de interpretación para personas con impedimento auditivo y traducción para personas que no hablan inglés están disponibles sin costo. Para pedir estos servicios, póngase en contacto con la Oficina de la Comisión al (213) 738-2816 (teléfono), o por correo electrónico a HIVComm@lachiv.org, por lo menos 72 horas antes de la junta.

SUPPORTING DOCUMENTATION: Supporting documents are available on the Commission's website https://hiv.lacounty.gov/meetings.

1. ADMINISTRATIVE MATTERS

A.	Call to Order and Roll Call		10:00 AM—10:05 AM
B.	Code of Conduct and Meetings Guidelines		10:05 AM—10:07 AM
C.	Approval of the Agenda	**MOTION #1**	10:07 AM—10:09 AM

D. Approval of Prior Meeting Minutes **MOTION #2** 10:09 AM—10:10 AM

2. **PUBLIC COMMENT** 10:10 AM—10:15 AM

Opportunity for members of the public to address the Commission on agenda items or other matters within the subject matter jurisdiction of the Commission. Comments may not exceed 2 minutes per person, per agenda item.

3. **COMMITTEE NEW BUSINESS ITEMS** 10:15 AM—10:20 AM

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.

4. **REPORTS**

A. Commission on HIV (COH) Staff Report 10:20 AM—10:25 AM

i. Operational and Commission Updates

B. Co-Chair Report 10:25 AM—10:35 AM

i. 2026 SBP Workplan and Meeting Calendar Updates

ii. Service Standard Review Calendar

C. Division of HIV and STD Programs (DHSP) 10:35 AM—10:45 AM

5. **DISCUSSION** 10:45 AM—11:50 AM

A. Assessment of the Efficiency of the Administrative Mechanism Updates

B. Universal Service Standards and Client Bill of Rights and Responsibilities Review

MOTION #3: *Approve the Universal Service Standards and the Client Bill of Rights and Responsibilities, as presented or revised, and elevate to the Executive Committee.*

C. Oral Health Service Standard Review

6. **NEXT STEPS** 11:50 AM—11:55 AM

A. Task/Assignment Recap

B. Agenda Development for the Next Meeting

7. **ANNOUNCEMENTS** 11:55 AM—12:00 PM

Opportunity for members of the public and Commission members to announce community events, workshops, trainings, and other related activities. Announcements will follow the same protocols as Public Comment.

8. **ADJOURNMENT** **12:00PM**

PROPOSED MOTION(S)/ACTIONS(S)	
MOTION #1	Approve the agenda order, as presented or revised.
MOTION #2	Approved the prior Committee meeting minutes, as presented or revised.
MOTION #3	Approve the Universal Service Standards and the Client Bill of Rights and Responsibilities, as presented or revised, and elevate to the Executive Committee.

STANDARDS AND BEST PRACTICES COMMITTEE MEMBERSHIP		
Gerardo	Almazan	Committee-Only Member
Oscar	Arellano	Committee-Only Member
Robert	Bolan, MD	Community-Based & AIDS Service Orgs (CBO/ASO)
Mikhaela	Cielo, MD	Ryan White Part D / CYF Providers
Anthony	Corona	Committee-Only Member
Johnny	Cross	Committee-Only Member
Caitlin	Dolan	Committee-Only Member
Arlene	Frames	Committee-Only Member
Lauren	Gersh	Committee-Only Member
Joseph	Green	Committee-Only Member
LeiLani	Johnson	Committee-Only Member **[LOA]**
Roberto	Lara	Committee-Only Member
Eric	Mattern	Substance Use Providers
Paul	Nash	HIV Academic Researcher
Byron	Patel, RN, ACRN	Health Care Providers (FQHCs)
Nolan	Samé-Weil, MBA	Board of Supervisors Office #4 Representative
Emmanuel	Sanchez-Ramos, DrPH, MPH	Affected & Disproportionately Impacted Communities
Draya	Santiago	Committee-Only Member **[LOA]**
Montana	Volby	Unaffiliated Representative - SPA 1
QUORUM: 8		

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COMMISSION ON HIV

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HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov

Approved by COH 6/8/23

CODE OF CONDUCT

APPROVED BY OPERATIONS COMMITTEE ON 05/25/23; COH 06/08/23
Approved (11/12/1998); Revised (2/10/2005; 9/6/2005); **Revised (4/11/19; 3/3/22, 3/23/23; 5/30/23)**

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

All participants and stakeholders should adhere to the following:

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

Hybrid Meeting Guidelines

(Updated 6.11.26)

- ☐ This meeting is a **Brown-Act meeting** and is being recorded.
  - Turn off your ringers/notifications on your smart devices so as not to disrupt the meeting.
  - Your voice is important and we want to ensure that it is captured accurately on the record. Please be respectful of one another and minimize crosstalk.

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

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

- ☐ **Public Comment** can be submitted in person or via email at hivcomm@lachiv.org. *Please indicate your name, the corresponding agenda item, and whether you would like to state your public comment during the meeting; if so, staff will call upon you appropriately. Public comments are limited to two minutes per agenda item. All public comments will be made part of the official record.*

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

- ☐ Attendees joining online should **remain muted** unless called upon.

- ☐ Commissioners and Committee-only members invoking **SB 707 for "Just Cause"** must communicate their intentions to staff no later than one hour before the meeting. Members requesting to join pursuant to SB 707 must have their audio and video on for the entire duration of the meeting and disclose whether there is a person over the age of 18 in the room in order to be counted toward quorum and have voting privileges.

- ☐ Members will be required to explicitly state their agency's **Ryan White Program Part A conflicts of interest** on the record. A list of conflicts can be found in the meeting packet, courtesy of staff.

If you experience challenges in logging into the virtual meeting, please contact Commission staff at hivcomm@lachiv.org for assistance. Please note that staff may have limited availability during meetings and responses may be delayed. We appreciate your patience and will follow up as soon as we're able.

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MINUTES FOR THE REGULAR MEETING OF THE STANDARDS AND BEST PRACTICES COMMITTEE

DATE: Monday, June 15, 2026 from 10:00 AM—12:00 PM.

LOCATION: 510 S. Vermont Ave. Terrace Level Conference Room (9th Floor), Los Angeles, CA 90020

CALL TO ORDER: COH staff called the meeting to order at 10:05am.

CO-CHAIRS: Caitlin Dolan and Montana Volby

SUPPORTING DOCUMENTATION: Supporting documents are available on the Commission's website https://hiv.lacounty.gov/standards-and-best-practices-committee/

STANDARDS AND BEST PRACTICES COMMITTEE MEMBERSHIP P = Present | A = Absent| SB707 = Remote Participation | PU = Public			
Gerardo Almazan	P	Joseph Green	EA
Oscar Arellano	EA	LeiLani Johnson	A
Robert Bolan, MD	P	Roberto Lara	P
Mikhaela Cielo, MD	EA	Eric Mattern	P
Anthony Corona	P	Byron Patel, RN, ACRN	P
Johnny Cross	SB707	Emmanuel Sanchez-Ramos, DrPH, MPH	P
Caitlin Dolan	P	Draya Santiago	A
Arlene Frames	SB707	Montana Volby	P
Lauren Gersh	EA		

ADMINISTRATIVE MATTERS	**MOTION #1**: Approval of the Agenda. *Approved by consensus.* **MOTION #2**: Approval of Prior Meeting Minutes. *Approved by consensus.*
PUBLIC COMMENT	There were no public comments.
COMMITTEE NEW BUSINESS ITEMS	There were no committee new business items.
REPORTS	**COMMISSION ON HIV (COH) STAFF REPORT** Jose Rangel-Garibay, COH staff, reminded commissioners to complete the Conflict-of-Interest form to help COH keep an updated list of conflicts of interest; a QR code to access the form is included in the meeting packet. He noted that the "Needs Assessment Overview and Priority Setting and Allocation (PSRA)" training took place on June 3, 2026. A recording of the training is available on the COH website; Commissioners are required to watch the recording and notify COH staff once completed. He added that the next COH meeting will be on July 9th, 2026, at the CA Endowment. Lastly, he shared

	that the next COH virtual training session will be on July 2, 2026, on "Service Standards Overview and Development". **CO-CHAIR REPORT** Caitlin Dolan, SBP committee co-chair, led an overview of the SBP committee 2026 workplan. She highlighted the committee's continued work on reviewing the Universal Service Standards and the Client Bill of Rights and Responsibilities. She also noted that the committee will review the survey tools for the Assessment of the Efficiency of the Administrative Mechanism (AEAM). A copy of the document is included in the meeting packet. **DIVISION ON HIV AND STD PROGRAMS (DHSP) REPORT** Paulina Zamudio, Chief of Contracted Community Services at the Division on HIV and STD Programs (DHSP), reported that DHSP is finalizing the staff assignment for the SBP committee. She noted that DHSP received their full HRSA Ryan White award and CDC EHE award and closed out to Request for Proposals (RFPs) in the past week; 1 for Nutrition Services and 1 for Residential Services. She added that the HRSA RW award ($45,531,463) was 1.7% less than previous years. Dawn McClendon-Musson, Interim-Executive Director of the COH, added that the decrease in HRSA RW award funds is due to the change in the formula HRSA used to calculate award amounts. The shifts in funds may require DHSP to consult the Planning, Priorities, and Allocations (PP&A) committee for possible fund reallocation.
DISCUSSION ITEMS	**ASSESSMENT OF THE EFFICIENCY OF THE ADMINISTRATIVE MECHANISM (AEAM) UPDATES** J. Rangel-Garibay led a detailed review of the draft survey tools for the Program Year (PY) 35 AEAM. The committee made the following recommendations: • Add a statement that makes the AEAM provider survey mandatory • Clarify who should complete the survey and stipulate that the survey is reviewed by the director of the program receiving funds COH staff will send out the AEAM provider survey, DHSP staff will follow-up with agencies requesting that they complete the survey and reinforce compliance. J. Rangel-Garibay noted that the AEAM Commissioner survey might have skewed results given that the survey will be sent to all current commissioners and some of the current commissioners were not part of the COH during PY 35 (March 1, 2025, February 28, 2026) or during the time the COH complete PSRA activities; there is a "Not Applicable" option. The survey will be sent to all commissioners including committee-only members. The deadline for both the Commissioner and Provider AEAM surveys is August 7, 2026. D. McClendon-Musson shared that in the past COH staff and consultants have conducted key informant interviews for the AEAM. For PY 35, COH staff will

	conduct the key informant interviews and will work with DHSP to determine the appropriate staff to interview for this portion of the AEAM. **MOTION #3:** Launch the Assessment of the Efficiency of the Administrative Mechanism for Ryan White Program Year 35 (March 1, 2025—February 28, 2026), as presented or revised. *Approved by roll call vote.* **Yes: G. Almazan, R. Bolan, J. Cross, A. Frames, R. Lara, E. Mattern, B. Patel, E. Sanchez-Ramos, C. Dolan, M. Volby.** **UNIVERSAL SERVICE STANDARDS AND CLIENT BILL OF RIGHTS AND RESPONSIBILITIES REVIEW** The committee reviewed updated drafts of the Universal Service Standards and the Client Bill of Rights and Responsibilities and made the following revisions: • Corrected minor editorial errors (e.g., HIPAA spelling) • Added expectations around gender-affirming practices • Clarified referral and case-closure requirements • Separate the Referrals and Case Closure into two separate sections. • Revise the links for Appendix C and Appendix D and include a screenshot of the website. **MOTION #4:** Announce a 60-day public comment period for the Universal Service Standards and the Client Bill of Rights and Responsibilities. *Approved by roll call vote.* **Yes: G. Almazan; R. Bolan; J. Cross; A. Frames; R. Lara; E. Mattern; B. Patel; E. Sanchez-Ramos; C. Dolan; M. Volby.**
ANNOUNCEMENTS	There were no announcements.
ACTION ITEMS	
RESPONSIBLE PARTY	**ITEM**
COH STAFF	• COH staff will launch the PY 35 AEAM commissioner and provider surveys. Survey links will be shared via email and posted on the SBP Committee webpage. • COH staff will post the Universal Service Standards and Client Bill of Rights and Responsibilities to the SBP Committee webpage and announce a public comment period ending on August 7, 2026. • COH staff will prepare a draft Service Standard review calendar for committee review.
NEXT MEETING	The next Standards and Best Practices Committee meeting is Monday August 17, 2026, from 10:00am—12:00pm at the Vermont Corridor.
ADJOURNMENT	The meeting adjourned at 11:30am.

PREPARED BY: Jose Rangel-Garibay	**APPROVAL DATE:**

LOS ANGELES COUNTY
COMMISSION ON HIV

2026 - 2027 Training Schedule

(Subject to change)

To meet the Ryan White HIV/AIDS Program (RWHAP) Part A requirements, the Commission on HIV must provide appropriate orientation and annual training that enables members to be fully active participants and to fulfill their legislative responsibilities. Training sessions will educate members to understand their roles, responsibilities, and expectations for participation, how work is undertaken, and how formal decisions are made.

- Training sessions listed below are **mandatory** for all Commissioners, Alternates, and Committee-only members. Additional sessions on topics not listed may be included as appropriate.
- Training sessions are open to the public.
- Training sessions will be held virtually, unless otherwise noted.
- Training session recordings will be made available on our website.
- Certificates of Completion will be provided and attendance will be recorded.
- For questions or assistance, contact Commission staff at hivcomm@lachiv.org.

CLICK ON THE TRAINING TOPIC TO REGISTER

TRAINING TITLE	DATE AND TIME
Commission on HIV Orientation	April 9, 2026 9am – 3pm (in person)
Co-Chair Orientation & Leadership Development	May 20, 2026 12pm - 1pm
Needs Assessment Overview and Priority Setting and Resource Allocation (PSRA)	June 3, 2026 12pm – 1pm
Service Standards Overview and Development	July 22, 2026 12pm – 1pm
Data Related Trainings	Summer/Fall 2026 TBD
Member Knowledge & Self-Assessment Survey	Released late September 2026
Refresher Training	November 4, 2026 12pm – 1pm

Revised 5/22/26

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 7/31/26

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

COMMISSION & COMMITTEE-ONLY MEMBERS		ORGANIZATION	SERVICE CATEGORIES
ALMANZAN	**Gerardo**	No affiliation	No Ryan White or prevention contracts
VAZQUEZ ALVAREZ	**Leo**	LACADA	No Ryan White or prevention contracts
ARRELANO	**Oscar**	Homeless Outreach Program Integrated Care System (HOPICS)	No Ryan White or prevention contracts
ARRINGTON	**Jayda**	Unaffiliated representative	No Ryan White or prevention contracts
BALLESTEROS	**Al**	JWCH, INC.	Benefits Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Mental Health
			Oral Health
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			HTS - Syphilis, DX Link TX - CSV
			Biomedical HIV Prevention
			Data to Care Services
			Medical Transportation Services
BARAJAS	**Jeronimo**	Unaffiliated Member	No Ryan White or prevention contracts
BIENEMAN	**Stevie**	AIDS Healthcare Foundation	Benefits Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Mental Health
			Oral Health
			Medical Transportation Services
			HIV & STD LB
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			Sexual Health Express Clinics (SHEx-C)
BLEA	**Leroy**	California Department of Public Health, Office of AIDS	Part B Grantee

COMMISSION & COMMITTEE-ONLY MEMBERS		ORGANIZATION	SERVICE CATEGORIES
BOLAN	**Robert**	LA LGBT Center	Core HIV Medical Services - AOM; MCC & PSS
			Vulnerable Populations (YMSM)
			Vulnerable Populations (Trans)
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			HTS - Social and Sexual Networks
			Biomedical HIV Prevention Services
			Medical Transportation Services
BROWN	**Jasmine**	Oasis Clinic (Charles R. Drew University/Drew CARES)	Core HIV Medical Services - PSS
			HTS - Storefront
			HTS - Social and Sexual Networks
CIELO	**Mikhaela**	Los Angeles General Hospital	No Ryan White or prevention contracts
CONTRERAS	**Robert**	Bienestar	Nutrition Support (Food Bank/Pantry Service)
			Vulnerable Populations (Trans)
			High Impact Prevention
			HTS - Storefront
			HTS - Social and Sexual Networks
			STD-SDTS
			Medical Transportation Services
			HIV Testing and Viral Hepatitis Services
COPELAND	**Raniyah**	Equity Impact Solutions	No Ryan White or prevention contracts
CORONA	**Anthony**	Watt's Healthcare	Core HIV Medical Services - MCC & PSS
			Biomedical HIV Prevention Services
			Oral Health
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			Medical Transportation Services
CORONA	**Ceasar**	Tarzana Treatment Center	Benefit Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Intensive Care Management
			Substance Use Transitional Hsg
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			HERR
			Biomedical HIV Prevention Services
			Medical Transportation Services

COMMISSION & COMMITTEE-ONLY MEMBERS		ORGANIZATION	SERVICE CATEGORIES
			HIV Testing and Viral Hepatitis Services
CROSS	**Johnny**	Men's Health Foundation	Core HIV Medical Services - AOM; MCC & PSS
			Biomedical HIV Prevention Services
			Vulnerable Population (YMSM)
			Sexual Health Express Clinics (SHEx-C)
			Data to Care Services
			Medical Transportation Services
DAVIES	**Erika**	City of Pasadena	No Ryan White or prevention contracts
DOLAN	**Caitlyn**	Men's Health Foundation	Core HIV Medical Services - AOM; MCC & PSS
			Biomedical HIV Prevention Services
			Vulnerable Poplulations (YMSM)
			Sexual Health Express Clinics (SHEx-C)
			Data to Care Services
			Medical Transportation Services
ALE-FERLITO	**Dahlia**	City of Los Angeles AIDS Coordinator	No Ryan White or prevention contracts
FRAMES	**Arlene**	Unaffiliated representative	No Ryan White or prevention contracts
GAMBOA	**Robert**	LA LGBT Center	Core HIV Medical Services - AOM; MCC & PSS
			Vulnerable Populations (YMSM)
			Vulnerable Populations (Trans)
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			HTS - Social and Sexual Networks
			Biomedical HIV Prevention Services
			Medical Transportation Services

COMMISSION & COMMITTEE-ONLY MEMBERS		ORGANIZATION	SERVICE CATEGORIES
GERSH	**Lauren**	APLA Health & Wellness	Benefit Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Intensive Case Managemenet Services
			Nutrition Support (Food Bank/Pantry Service)
			Oral Health
			STD-Ex.C
			High Impact Prevention
			Biomedical HIV Prevention Services
			Medical Transportation Services
			Data to Care Services
			Residential Facility For the Chronically Ill (RCFCI)
GONZALEZ	**Felipe**	Unaffiliated representative	No Ryan White or Prevention Contracts
GREEN	**Joseph**	Unaffiliated representative	No Ryan White or prevention contracts
GRIFFEN	**TJ**	Men's Health Foundation	Core HIV Medical Services - AOM; MCC & PSS
			Biomedical HIV Prevention Services
			Vulnerable Populations (YMSM)
			Sexual Health Express Clinics (SHEx-C)
			Data to Care Services
			Medical Transportation Services
GUTIERREZ	**Joaquin**	Unaffiliated representative	No Ryan White or prevention contracts
HARRIS	**Darryn**	St. John's Well Child and Family Center (SJW)	Core HIV Medical Services - AOM; MCC & PSS
			Oral Health
			HTS - Social and Sexual Networks
			Mental Health
			Biomedical HIV Prevention Services
			Medical Transportation Services
HUNT	**Angela**	Unaffilated Member	No Ryan White or prevention contracts
HERRERA	**Ismael "Ish"**	Unaffiliated representative	No Ryan White or prevention contracts
JOHNSON	**LeiLani**	Unaffilited Member	No Ryan White or prevention contracts
JOHNSON	**Stephanie**	Men's Health Foundation	Core HIV Medical Services - AOM; MCC & PSS
			Biomedical HIV Prevention Services
			Vulnerable Populations (YMSM)
			Sexual Health Express Clinics (SHEx-C)
			Data to Care Services
			Medical Transportation Services

COMMISSION & COMMITTEE-ONLY MEMBERS		ORGANIZATION	SERVICE CATEGORIES
LARA	**Roberto**	AMAAD	No Ryan White or prevention contracts
LESTER	**Rob**	Men's Health Foundation	Core HIV Medical Services - AOM; MCC & PSS
			Biomedical HIV Prevention Services
			Vulnerable Poplulations (YMSM)
			Sexual Health Express Clinics (SHEx-C)
			Data to Care Services
			Medical Transportation Services
LOCKLEAR	**Preston**	LA LGBT Center	Core HIV Medical Services - AOM; MCC & PSS
			Vulnerable Populations (YMSM)
			Vulnerable Populations (Trans)
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			HTS - Social and Sexual Networks
			Biomedical HIV Prevention Services
			Medical Transportation Services
MARTINEZ	**Miguel**	No affiliation	No Ryan White or prevention contracts
MATTERN	**Eric**	Tarzana Treatment Center	Benefit Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Intensive Care Management
			Substance Use Transitional Hsg
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			HERR
			Biomedical HIV Prevention Services
			Medical Transportation Services
			HIV Testing and Viral Hepatitis Services

COMMISSION & COMMITTEE-ONLY MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MCKINLEY	**Kiante**	LA LGBT Center	Core HIV Medical Services - AOM; MCC & PSS
			Vulnerable Populations (YMSM)
			Vulnerable Populations (Trans)
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			HTS - Social and Sexual Networks
			Biomedical HIV Prevention Services
			Medical Transportation Services
MENDOZA	**Vilma**	Unaffiliated representative	No Ryan White or prevention contracts
MILLER	**Jack**	Unaffiliated Member	No Ryan White or prevention contracts
MORRISON	**Donta**	UCLA CARE	No Ryan White or prevention contracts
MULLEN	**Sadie**	No affiliation	No Ryan White or prevention contracts
NASH	**Paul**	University of Southern California	No Ryan White or prevention contracts
NGUYEN	**Kevin**	Saban Community Clinic	No Ryan White or prevention contracts

COMMISSION & COMMITTEE-ONLY MEMBERS		ORGANIZATION	SERVICE CATEGORIES
NELSON	**Katja**	APLA Health & Wellness	Benefits Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Intensive Case Managemenet Services
			Nutrition Support (Food Bank/Pantry Service)
			Oral Health
			STD-Ex.C
			HERR
			Biomedical HIV Prevention Services
			Medical Transportation Services
			Data to Care Services
			Residential Facility For the Chronically Ill (RCFCI)
NWIZU	**Ujuonu**	Public Health Alliance	No Ryan White or prevention contracts
CERDA OROZCO	**David**	No affiliation	No Ryan White or prevention contracts
PACHECO	**Elizabeth**	Tarzana Treatment Center	Benefit Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Intensive Case Managemenet Services
			Substance Use Transitional Hsg
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			HERR
			Biomedical HIV Prevention Services
			Medical Transportation Services
			HIV Testing and Viral Hepatitis Services
PATEL	**Byron**	Los Angeles LGBT Center	Core HIV Medical Services - AOM; MCC & PSS
			Vulnerable Populations (YMSM)
			Vulnerable Populations (Trans)
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			HTS - Social and Sexual Networks
			Biomedical HIV Prevention Services
			Medical Transportation Services
PERÉZ	**Mario**	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee
PLEASANTS	**Shawn**	Unaffiliated Member	No Ryan White or prevention contracts
ROJAS	**David**	LAC Consumer & Business Affairs	No Ryan White or prevention contracts

COMMISSION & COMMITTEE-ONLY MEMBERS		ORGANIZATION	SERVICE CATEGORIES
SALAMANCA	**Ismael**	City of Long Beach	Benefits Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Biomedical HIV Prevention Services
			HTS - Social and Sexual Networks
			Medical Transportation Services
SANCHEZ-RAMOS	**Emmanuel**	APLA Health	Benefit Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Intensive Case Managemenet Services
			Nutrition Support (Food Bank/Pantry Service)
			Oral Health
			STD - ExC
			High Impact Prevention
			Biomedical HIV Prevention Services
			Medical Transportation Services
			Data to Care Services
			Residential Facility For the Chronically Ill (RCFCI)
SAN AGUSTIN	**Glen**	JWCH, INC.	Benefits Specialty
			Core HIV Medical Services - AOM; MCC & PSS
			Mental Health
			Oral Health
			STD Testing and STD Screening, Diagnosis & Treatment Services (STD-SDTS)
			HTS - Storefront
			HTS - Syphilis, DX Link TX - CSV
			Biomedical HIV Prevention Services
			Data to Care Services
			Medical Transportation Services
SAME-WEIL	**Nolan Ross**	Los Angeles Centers for Alcohol & Drug Abuse (L.A. CADA)	No Ryan White or prevention contracts
SANTIAGO	**Draya**	Unaffilited Member	No Ryan White or prevention contracts
SKELTON	**Maria**	No affiliation	No Ryan White or prevention contracts
SPENCER	**LaShonda**	Oasis Clinic (Charles R. Drew University/Drew CARES)	Core HIV Medical Services - PSS
			HTS - Storefront
			HTS - Social and Sexual Networks
WEBB	**Christopher**	REACH LA	HTS - Social and Sexual Networks

COMMISSION & COMMITTEE-ONLY MEMBERS		ORGANIZATION	SERVICE CATEGORIES
WEEDMAN	**Jonathan**	ViaCare Community Health	Biomedical HIV Prevention
			Core HIV Medical Services - AOM & MCC
VALENZUELA	**David**	LAC Department of Public Health	No Ryan White or prevention contracts
VOLBY	**Montana**	Unaffilited Member	No Ryan White or prevention contracts

LOS ANGELES COUNTY COMMISSION ON HIV

2026 STANDARDS AND BEST PRACTICES COMMITTEE MEETING CALENDAR *(Revised 8/13/26)*

MONTH	KEY ACTIVITIES
April 20, 2026 **10am-12pm**	• Nominate and elect committee co-chairs • Conduct committee orientation training • Review and adopt 2026 committee workplan
May 18, 2026 **10am-12pm**	• Review Assessment of the Efficiency of the Administrative Mechanism (AEAM) assessment tool • Develop service standard development schedule
June 15, 2026 **10am-12pm**	• Launch AEAM assessment tool for PY35 • Review of Universal Service Standards and Client Bill of Rights and Responsibilities
August 17, 2026 **10am-12pm**	• Finalize review of Universal Service Standards and Client Bill of Rights and Responsibilities • Initiate review of Oral Health Service Standards • Updates to PY35 AEAM
October 19, 2026 **10am-12pm**	• Review Oral Health Service Standards • Review AEAM report for PY35
November 16 2026 **PROPOSED**	• Finalize review of Oral Health Service Standards
December 2026 ****CANCELED****	Limited Executive Committee activity in recognition of the holiday period
January 11, 2027 **PROPOSED**	• Finalize review of Oral Health Service Standards
February 8, 2027 **10am-12pm**	• Draft 2027-28 committee workplan and meeting calendar • Draft service standard development schedule

LOS ANGELES COUNTY COMMISSION ON HIV

2026 STANDARDS AND BEST PRACTICES COMMITTEE MASTER WORKPLAN *(SUBJECT TO CHANGE)*

PURPOSE

To define the scope, priorities, and core activities of the **Standards & Best Practices (SBP) Committee** during the Ryan White Program Year (March 1, 2026 – February 28, 2027), in alignment with the revised Commission Bylaws, Ryan White HIV/AIDS Program (RWHAP) Part A legislative and program expectations, CDC/HRSA integrated planning guidance, and the Commission's restructured governance model. The SBP Committee leads the Commission's work to strengthen the quality, consistency, and effectiveness of the HIV service delivery system by supporting clinical quality management, developing and maintaining service standards, identifying best practices, assessing service effectiveness, and advancing service system improvements in coordination with DHSP and other Commission working units.

CRITERIA

Activities included in this workplan are selected based on their ability to:

- Fulfill SBP responsibilities defined in the Commission Bylaws;
- Support compliance with RWHAP Part A, HRSA expectations, CDC/HRSA integrated planning guidance, Brown Act, and County requirements;
- Strengthen quality management and performance/outcomes accountability across the HIV service continuum;
- Promote consistent, evidence-informed standards and best practices in HIV prevention and care;
- Identify service gaps and recommend feasible system improvements and directives; and
- Align with Commission and staff capacity, recognizing a bi-monthly meeting schedule.

CORE COMMITTEE RESPONSIBILITIES

The SBP Committee is responsible for:

- Supporting DHSP's Clinical Quality Management Plan and reviewing aggregate quality, utilization, and outcomes data to assess service effectiveness;
- Identifying, reviewing, and recommending service standards, best practices, and outcome measures across the HIV care continuum;
- Evaluating service effectiveness, including outcomes, cost effectiveness, capacity, access, and service models;
- Identifying service gaps, system inefficiencies, and improvement opportunities, and recommending corrective actions to DHSP and the Commission;
- Recommending service delivery improvements and implementation directives, in coordination with the Planning, Priorities & Allocations Committee;
- Conducting the Assessment of the Administrative Mechanism and overseeing implementation of adopted recommendations;
- Promoting consistency and quality in HIV services countywide through system-level review (not individual provider oversight); and
- Carrying out additional responsibilities as assigned by the Commission or Board of Supervisors.

Approved 5/18/26

2026 STANDARDS AND BEST PRACTICES COMMITTEE MASTER WORKPLAN *(SUBJECT TO CHANGE)*

ACRONYMS	
• **COH:** Commission on HIV • **DHSP:** Division on HIV and STD Programs • **BOS:** Board of Supervisors • **HRSA:** Health Resources and Services Administration • **MCE:** Membership and Community Engagement Committee • **PP&A:** Planning, Priorities, and Allocations Committee • **SBP:** Standards and Best Practices Committee	• **EO:** Executive Office • **CEO LAIR:** Chief Executive Office Legislative Affairs and Intergovernmental Relations • **OA:** California Office of AIDS • **CHIPTS:** Center for HIV Identification, Prevention, and Treatment Services.

#	OBJECTIVE	TASKS/ACTIVITIES	TIMELINE	NOTES/COMMENTS
1	Establish committee leadership.	• Hold nominations for committee co-chairs. • Elect committee co-chairs.	April	**COMPLETED**
2	Develop 2026 committee workplan.	• Review and adopt annual workplan *(subject to change).* • Establish meeting calendar *(subject to change).*	May	**COMPLETED**
3	Monitor progress on committee workplan.	• Provide monthly updates/reports to Executive Committee and COH.	Ongoing	
4	Conduct committee orientation.	• Review role, scope, and responsibilities of committee.	April	**COMPLETED**
5	Assist with development of the BOS Annual Report	• Outline SBP Committee key accomplishments and challenges • Submit accomplishments and challenges to Executive Committee for incorporation into BOS Annual Report.	Jan-Feb 2027	
6	Conduct review/revisions of service standards, as needed.	• Conduct review/revisions of service standards, as needed. • Develop schedule based on service rankings, DHSP RFP schedule, consumer/provider concern, or in response to changes in the HIV care continuum. • Review service utilization reports. • Collaborate with DHSP, COH committees and caucuses, and RWHAP Part A providers.	Ongoing	Finalize review of Universal Service Standards and Client Bill of Rights and Responsibilities. Initiate review of Oral Health Service Standards.
7	Conduct the Assessment of the Efficiency of the Administrative Mechanism.	• Review assessment tool, revise as needed. • Conduct assessment for PY 35 (Mar 1, 2025-Feb 28, 2026) • Collaborate with DHSP and RWHAP Part A providers. • Analyze and report findings.	May-Oct	Review survey findings and submit report to Executive Committee.

2026 STANDARDS AND BEST PRACTICES COMMITTEE MASTER WORKPLAN *(SUBJECT TO CHANGE)*

8	Review and monitor clinical quality management activities.	• Review report(s) on clinical quality management activities led by DHSP. • Review service category evaluation report(s). • Identify strategies for addressing findings. • Collaborate with DHSP; review service category evaluation report(s).	Ongoing	
9	Develop and monitor program directives.	• Develop and define directives for implementation of services and service models. • Ensure priorities and implementation efforts are consistent with needs, the HIV care continuum, and service delivery. • Develop strategies to address unmet need. • Collaborate with PP&A Committee.	Ongoing	
10	Compile best practices as related to HIV care and prevention.	• Identify, collect, and disseminate best practices for reducing HIV transmission, improving health outcomes, and optimizing quality of life and self-sufficiency for all PLWH.	Ongoing	

SERVICE STANDARDS REVISION DATE TRACKER FOR PLANNING PURPOSES

Last updated: 8/13/26

KEYWORDS AND ACRONYMS	
HRSA: Health Resources and Services Administration	**COH:** Commission on HIV
RWHAP: Ryan White HIV/AIDS Program	**DHSP:** Division on HIV and STD Programs
HAB PCN 16-02: HIV/AIDS Bureau Policy Clarification Notice 16-02 RWHAP: Eligible Individuals & Allowable Uses of Funds	**SBP Committee:** Standards and Best Practices Committee
	PLWH: People Living With HIV

GENERAL

Document Name	Description	Notes
Universal Service Standards	Apply to all services and covers areas such as non-discriminatory service delivery, client confidentiality, quality care, and grievance procedures. The SBP Committee reviews this document on a bi-annual basis or as needed per community stakeholder, service provider agency, or COH member request.	**Currently under review** **Last approved by COH: 1/11/2024**
Client Bill of Rights and Responsibilities	Empowers clients to advocate for themselves and work in partnership with their service providers to achieve the best possible HIV/AIDS care and treatment. Service provider agencies are required to provide clients with a copy of this document when receiving HRSA RWHAP services.	**Currently under review** **Last approved by COH: 1/11/2024**
Prevention Services	HIV and STI prevention services are those services used alone or in combination to prevent the transmission of HIV and STIs and may include Biomedical, Non-Biomedical, and Harm Reduction services.	Prevention standards **are not** required by CDC or HRSA but are developed by the COH to support inclusive, status-neutral prevention and care planning. **Last approved by COH: 1/11/2024**

CORE SERVICES

Service and Service Category	HRSA PCN 16-02 Service Description	Notes
Service Category: AIDS Drug Resistance Program Treatments	State-administered program authorized under RHWAP Part B to provide U.S. Food and Drug Administration (FDA)- approved medications to low-income clients living with HIW who have no coverage or limited health care coverage.	ADAP contracts directly with agencies and is administered by the California Department of Public Health, Office of AIDS.

LOS ANGELES COUNTY COMMISSION ON HIV

CORE SERVICES		
Service and Service Category	**HRSA PCN 16-02 Service Description**	**Notes**
Early Intervention Services (PH Clinics) *Service Category: Early Intervention Services*	EIS is a combination of services rather than a stand-alone service and must include: • Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be living with HIV • Referral services to improve HIV care and treatment services at key points of entry • Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse care. • Outreach services and Health Education/Risk Reduction related to HIV diagnosis	Currently funded for RW PY36 (3/1/2026-2/28/27). **Last approved by COH: 5/2/2017**
Home-Based Case Management *Service Category: Home and Community-Based Health Services*	Provided to an eligible client in an integrated setting appropriate to that client's needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider. Services include: • Appropriate mental health, developmental, and rehabilitation services • Day treatment or other partial hospitalization services • Durable medical equipment • Home health aide services and personal care services in the home	**Upcoming DHSP solicitation. Consider scheduling review in October 2026.** Currently funded for RW PY36 (3/1/2026-2/28/27). **Last approved by COH: 9/92022**
Service Category: Hospice Services	End-of-life care services provided to clients in the terminal stage of an HIV-related illness. Allowable services are: • Mental health counseling • Nursing care • Palliative therapeutics • Physician services • Room and board	**Last approved by COH: 5/2/2017**
Medical Care Coordination (MCC) *Service Category: Medical Case Management, including Treatment Adherence Services*	Provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities provided under this service category may be provided by an interdisciplinary team that includes specialty care providers. Medical Case Management includes all types of case management encounters	Currently funded for RW PY36 (3/1/2026-2/28/27). **MCC:** Last approved by the COH on 1/11/2024

CORE SERVICES		
Service and Service Category	**HRSA PCN 16-02 Service Description**	**Notes**
	(e.g. face-to-face, phone contact, and any other forms of communication). Key activities include: • Initial assessment of service needs • Development of a comprehensive, individualized care plan • Timely and coordinated access to medically appropriate levels of health and support services and continuity of care • Continuous client monitoring to assess the efficacy of the care plan • Re-evaluation of the care plan at least every 6 months with adaptations as necessary • Ongoing assessment of the client's and other key family members' needs and personal support systems • Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments • Client-specific advocacy and/or review of utilization of services May also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible.	**Treatment Education Services**: Last approved by the COH on 5/2/2017
Medical Nutrition Therapy *Service Category: Medical Nutrition Therapy*	Includes: • Nutrition assessment and screening • Dietary/nutritional evaluation • Food and/or nutritional supplements per medical provider's recommendation • Nutrition education and/or counseling These activities can be provided in individual and/or group settings and outside of HIV Outpatient/Ambulatory Health Services.	**Last approved by COH: 5/2/2017**
Mental Health Services *Service Category: Mental Health Services*	Provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a	**Upcoming DHSP solicitation. Consider scheduling review in October 2026.**

CORE SERVICES		
Service and Service Category	**HRSA PCN 16-02 Service Description**	**Notes**
	mental health professional licensed or authorized within the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.	Currently funded for RW PY36 (3/1/2026-2/28/27). **Last approved by COH: 5/2/5017.**
Oral Health Services *Service Category: Oral Health Care*	Activities include outpatient diagnosis, prevention, and therapy provided by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.	**Upcoming DHSP solicitation. Review scheduled for October 2026.** Currently funded for RW PY36 (3/1/2026-2/28/27). **Last approved by COH: 4/13/2023**
Ambulatory Outpatient Medical (AOM) services *Service Category: Outpatient/Ambulatory Health Services*	Provide diagnostic and therapeutic-related activities directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings may include clinics, medical offices, mobile vans, using telehealth technology, and urgent care facilities for HIV-related visits. Allowable activities include: • Medical history taking • Physical examination • Diagnostic testing (including HIV confirmatory and viral load testing), as well as laboratory testing • Treatment and management of physical and behavioral health conditions • Behavioral risk assessment, subsequent counseling, and referral • Preventative care and screening • Pediatric developmental assessment • Prescription and management of medication therapy • Treatment adherence • Education and counseling on health and prevention issues • Referral to and provision of specialty care related to HIV diagnosis, including audiology and ophthalmology.	**Last approved by COH: 2/13/2025**
Service Category: Substance Abuse Outpatient Care	Provision of outpatient services for the treatment of drug or alcohol use disorders. Activities under Substance Abuse Outpatient Care service category include:	**Last approved by COH: 1/13/2022**

LOS ANGELES COUNTY COMMISSION ON HIV

CORE SERVICES		
Service and Service Category	**HRSA PCN 16-02 Service Description**	**Notes**

	• Screening
	• Assessment
	• Diagnosis and/or
	• Treatment of substance use disorder, including:
	  ○ Pretreatment/recovery readiness programs
	  ○ Life-saving overdose prevention and response services or supplies such as opioid reversal supplies, substance test kits, and overdose reversal and training services
	  ○ Behavioral health counseling associated with substance use disorder
	  ○ Medication assisted therapy
	  ○ Neuro-psychiatric pharmaceuticals
	  ○ Relapsed prevention	

SUPPORT SERVICES		
Service and Service Category	**HRSA PCN 16-02 Service Description**	**Notes**
Child Care Services *Service Category: Child Care Services*	Intermittent Child Care Services for the children living in the household of PLWH who are HRSA RWHAP-eligible clients for the purpose of enabling those clients to attend medical visits, related appointments, and/or HRSA RWHAP-related meetings, groups, or training sessions.	**Last approved by COH: 7/8/2021**
Emergency Rental Assistance *Service Category: Emergency Financial Assistance*	Limited one-time or short-term payments to assist an HRSA RWHAP client with an urgent need for essential items or services necessary to improve health outcomes, including utilities, housing, food (including groceries and food vouchers), transportation, medication not covered by ADAP, or another HRSA RWHAP-allowable cost needed to improve health outcomes. EFA must occur as direct payment to an agency or through a voucher program.	Currently funded for RW PY36 (3/1/2026-2/28/27). **Last approved by COH: 2/13/2025** **Updates from DHSP:** Program currently only provides rental assistance. Clients must be facing eviction to qualify, the limit is $5,000 per year, per client, and applications are through Benefits Specialists.

LOS ANGELES COUNTY COMMISSION ON HIV

SUPPORT SERVICES		
Service and Service Category	**HRSA PCN 16-02 Service Description**	**Notes**
Nutrition Support Services *Service Category: Food bank/Home Delivered meals*	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.	Currently funded for RW PY36 (3/1/2026-2/28/27). **Last approved by COH: 8/10/2023**
Service Category: Health Education/Risk Reduction	Provision of education to clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status.	**Last approved by COH: 4/10/2025**
Housing Services: Residential Care Facility for Chronically Ill (RCFCI) and Transitional Residential Care Facility (TRCF) *Service Category: Housing*	Provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services). Housing activities also include housing referral services, including assessment, search, placement, and housing advocacy service on behalf of the eligible client, as well as fees associated with these activities.	Currently funded for RW PY36 (3/1/2026-2/28/27) with RW Part B funds. **Last approved by COH: 4/10/2025**
Legal Services **Permanency Planning** *Service Category: Other Professional Services, Legal Services*	Provision of professional and consultant services rendered by members of particular professions licensed and/or qualified to offer such services by local governing authorities. Such services may include: Legal services provide to and/or on behalf of the HRSA RWHAP=eligible PLWH and involving legal matters related to or arising from their HIV disease, including: • Assistance with public benefits such as Social Security Disability Insurance (SSDI) • Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the HRSA RWHAP • Preparation of: ○ Healthcare power of attorney	**Upcoming DHSP solicitation. Consider scheduling review in October 2026.** Currently funded for RW PY36 (3/1/2026-2/28/27) with RW Part B funds. **Last approved by COH: 7/12/2018**

SUPPORT SERVICES		
Service and Service Category	**HRSA PCN 16-02 Service Description**	**Notes**
	○ Durable powers of attorney ○ Living wills Permanency planning to help clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including: • Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney • Preparation for custody, or adoption Income tax preparation services to assist clients in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits.	
Language Services *Service Category: Linguistic Services*	Include interpretation and translation activities, both oral and written to eligible clients. These activities must be provided by qualified linguistic services providers as a component of HIV service delivery between the healthcare provider and the client. These services are to be provided when such services are necessary to facilitate communication between the provider and client and/or support delivery of HRSA RWAHP-eligible services.	**Last approved by COH: 5/2/2017**
Medical Transportation *Service Category: Medical Transportation*	Provision of nonemergency transportation that enable an eligible client to access or be retained in core medical and support services.	Currently funded for RW PY36 (3/1/2026-2/28/27). **Last approved by COH: 2/13/2025**
Benefits Specialty Services (BSS) **Patient Support Services (PSS)** **Transitional Case Management (TCM): Justice-Involved Individuals, Youth, and Older Adults 50+** *Service Category: Non-Medical Case Management*	Provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. Non-Medical Case Management (NMCM) provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. NMCM Services may also include assisting eligible clients to obtain access to other public, private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans. NMCM Services includes all types of case management encounters (e.g., face-to-face, telehealth, phone	**BSS**: Currently funded for RW PY36 (3/1/2026-2/28/27). Last approved by COH 9/8/2022. **PSS:** Currently funded for RW PY36 (3/1/2026-2/28/27). Last approved by COH 12/11/2025 **TCM Justice-Involved, Youth, and Older Adults 50+:** Last approved by COH 10/9/2022

SUPPORT SERVICES		
Service and Service Category	**HRSA PCN 16-02 Service Description**	**Notes**
	contact, and many other forms of communication. Key activities include: Initial assessment of service needs; Development of a comprehensive, individualized care plan; Timely and coordinated access to medically appropriate levels of health and support services and continuity of care; client-specific advocacy and/or review of utilization services; continuous client monitoring to assess the efficacy of the care plan; Re-evaluation of the care plan at least every 6 months with adaptations as necessary; Ongoing assessment of the client's and other key family members' needs and personal support systems.	
Linkage and Reengagement Program *Service Category: Outreach Services*	Provide the following activities: 1) identification of people who do not know their HIV status and/or 2) linkage or re-engagement of PLWH who know their status into HRSA RWHAP services, including provision of information about health care coverage options.	Currently funded for RW PY36 (3/1/2026-2/28/27). **Last approved by COH: 5/2/2017**
Psychosocial Support Services *Service Category: Psychosocial Support Services*	Provide group or individual support and counseling services to assist HRSA RWHAP-eligible PLWH to address behavioral and physical health concerns. Activities provided under the Psychosocial Support Services category may include: • Bereavement counseling • Caregiver/respite support (HRSA RWHAP Part D) • Child abuse and neglect counseling • HIV support groups • Nutrition counseling provided by a non-registered dietitian • Pastoral care/counseling services	**Last approved by COH: 9/10/2020**
Referral Services *Service Category: Referral for Health Care and Support Services*	Directs a client to needed core medical or support services in person or through telephone, written, or other type of communication. Activities provided under this service category may include referrals to assist HRSA RWHAP-eligible clients to obtain access to other public and private programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other state or local health care and supportive services, or health insurance Marketplace plans.	**Last approved by COH: 5/2/2017**
Substance Use Disorder Transitional Housing	Activities provided for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder. Activities provided under the Substance Abuse Services (residential) service category include:	Currently funded for RW PY36 (3/1/2026-2/28/27) with RW Part B funds.

LOS ANGELES COUNTY COMMISSION ON HIV

SUPPORT SERVICES		
Service and Service Category	**HRSA PCN 16-02 Service Description**	**Notes**
Service Category: Substance Abuse Services (residential)	• Pretreatment/recovery readiness programs • Behavioral health counseling associated with substance use disorder • Medication assisted therapy • Neuro-psychiatric pharmaceuticals • Relapse prevention • Detoxification, if offered in a separate licensed residential setting	**Last approved by COH: 1/13/2022**

LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave. Floor 14, Los Angeles, CA 90020| (213) 738-2816 | hivcomm@lachiv.org

Public Comment Period for the draft
Universal Service Standards and Client Bill of Rights and Responsibilities

Posted: June 30, 2026

The Los Angeles County Commission on HIV (COH) announces an opportunity for the public to submit comments for the draft **Universal Service Standards and Client Bill of Rights and Responsibilities** revised by the Standards and Best Practices Committee. Comments from consumers, providers, HIV prevention and care stakeholders, and the public are welcome.

A draft of the document is posted to the COH website and can be found at: **https://hiv.lacounty.gov/standards-and-best-practices-committee/.**

Comments can be submitted via email to **HIVCOMM@LACHIV.ORG.**

Additionally, consumers of Ryan White Services can request that a physical copy of the service standards be mailed to their home address. For more information, please contact Jose Rangel-Garibay at **jgaribay@lachiv.org** or (213) 738-2816.

After reading the document, consider responding to the following questions when providing public comment:

1. Are the Universal Service Standards and Client Bill of Rights and Responsibilities reasonable and achievable for providers? Why or why not?

2. Do the Universal Service Standards and Client Bill of Rights and Responsibilities meet consumer needs? Why or why not? Give examples of what is working/not working.

3. Is there anything missing from the Universal Service Standards and Client Bill of Rights and Responsibilities related to HIV prevention and care?

4. Do you have any additional comments related to the Universal Service Standards and Client Bill of Rights and Responsibilities or Ryan White services?

Public comments are due by August 14, 2026.

LOS ANGELES COUNTY
COMMISSION ON HIV

UNIVERSAL SERVICE STANDARDS AND CLIENT BILL OF RIGHTS AND RESPONSIBILITIES

SERVICE STANDARDS FOR RYAN WHITE HIV/AIDS PROGRAM CARE AND TREATMENT SERVICES

Los Angeles County Commission on HIV
510 S. Vermont Ave. 14th Floor, Los Angeles, CA 90020
(213) 738-2816 | hivcomm@lachiv.org
REVISED: 06/10/26 | APPROVED BY COH: PENDING

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:

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

HRSA HAB Policy Clarification Notice (PCN) # 16-02: The use of Ryan White HIV/AIDS Program Funds for Core Medical Services and Support Services for People Living with HIV Who Are Incarcerated and Justice Involved

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

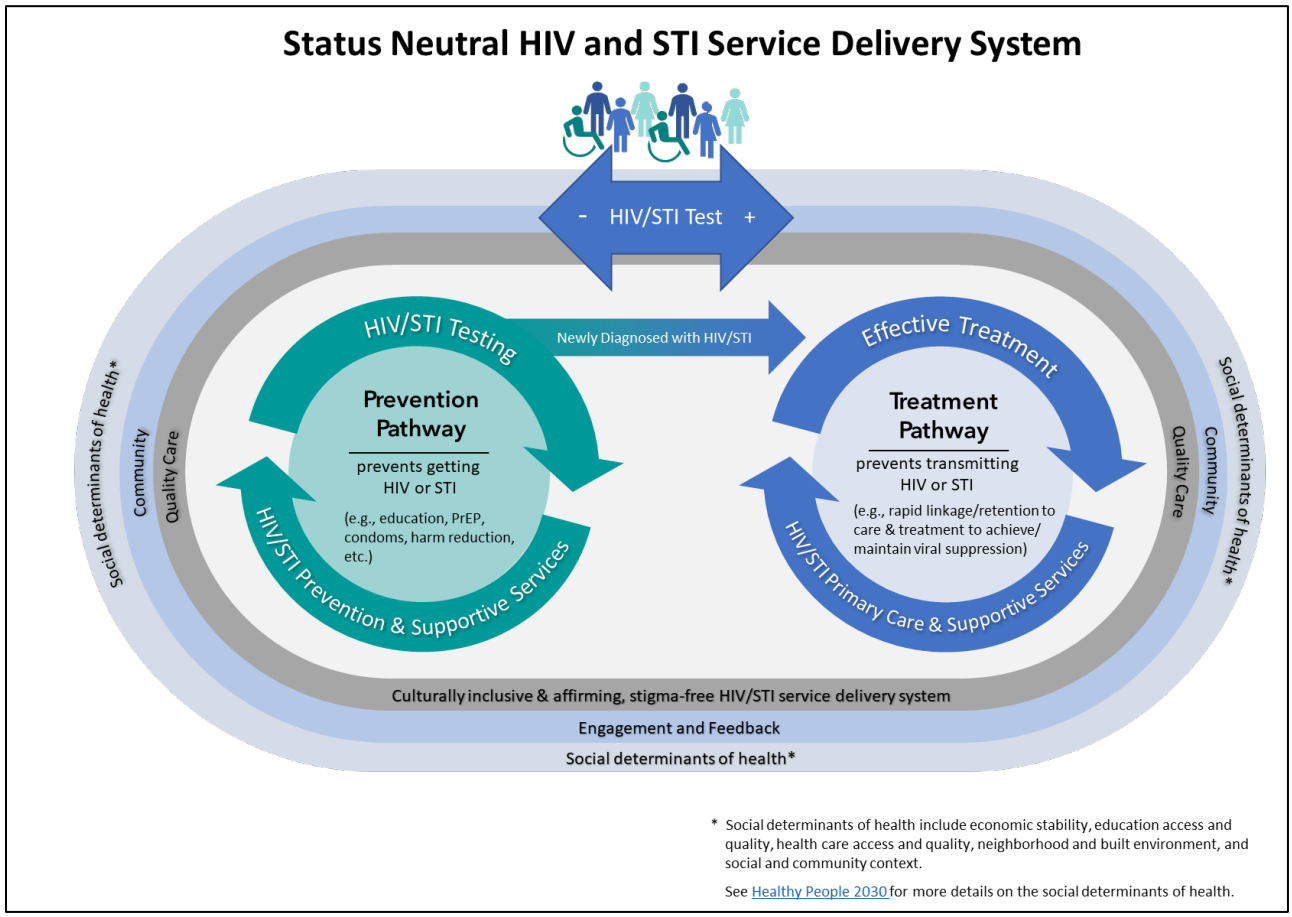
Service Standards: Ryan White HIV/AIDS Programs

Introduction

Ryan White HIV/AIDS Part A Program (RWHAP) service standards define the minimum expectations for how RWHAP service providers in Los Angeles County must deliver each service category, ensuring consistent, high-quality care across all funded agencies. Service providers are encouraged to exceed these minimums. The Universal Service Standards and the Client Bill of Rights Responsibilities were developed by the Los Angeles County Commission on HIV, incorporating input from service providers, consumers, and the Standards and Best Practices Committee, and reflect current national and federal HIV care guidelines to support optimal health for living with HIV (PLWH).

Service providers are encouraged to use a status-neutral framework that treats all clients the same, regardless of HIV or STI status, and connects them to appropriate prevention, care, and support services. This approach address social determinants of health, reduces disparities, and helps ensure rapid linkage to treatment for newly diagnosed clients and ongoing prevention for those who test negative. See Figure 1 for an example. More information on the status-neutral HIV and STI service delivery framework and related prevention standards is available here https://hiv.lacounty.gov/our-work under the “Ryan White Program Service Standards” tab.

Figure 1—Status Neutral HIV and STI Service Delivery System Framework
(*Adapted from the Centers for Disease Control and Prevention Status Neutral HIV Prevention and Care Framework)*



General Eligibility Requirements for Ryan White Services

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

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

Universal Service Standards Overview

The purpose of the Universal Service Standards is to ensure service providers:

- Provide accessible, nondiscriminatory services to all PLWH in Los Angeles County
- Educate staff and clients on the importance of maintaining an undetectable viral load
- Protect client rights and ensure quality of care
- Safeguard client confidentiality, support client autonomy, and maintain a fair grievance process

- Deliver client-centered, age-appropriate, culturally and linguistically competent services
- Accurately assess client needs and support active involvement in treatment planning
- Ensure high quality services through trained and experienced staff
- Ensure telehealth services match the quality of in-person care
- Comply with all federal, state, and local safety, sanitation, and public health requirements
- Prevent IT security risks and protect client data and records
- Inform clients about services, determine eligibility and collect necessary information during intake
- Coordinate care and provide referrals to meet client needs

Section 1.0—General Service Provider Agency Policies

GENERAL SERVICE PROVIDER AGENCY POLICIES	
STANDARD	**DOCUMENTATION**
Service provider agencies must have a client confidentiality policy that follows all local, state, and federal laws to protect client's HIV status, behavioral risk information, and use of services. The policy must also explain how confidentiality and patient information are protected when using telehealth, including required technology safeguards.	Written client confidentiality policy on file at service provider agency.
Service provider agencies must provide their service eligibility requirements upon request, and those requirements must follow DHSP guidance and HRSA's Policy Clarification Notice #16-02.	Written eligibility requirements on file at service provider agency.
Service provider agencies must have a Release of Information form that specifies the receiving party, the information shared, the duration of consent, and the client's signature. The form must meet HIPAA disclosure requirements and comply with the California Medi-Cal telehealth policy.	Completed Release of Information form on client file at service provider agency.
Service provider agencies must have a grievance policy that gives clients a way to address concerns about unfair treatment or poor service. The policy must outline how clients can file a grievance and include information about the Los	Written grievance policy on file at service provider agency.

Angeles County DHSP Customer Support Program (1-800-260-8787). This information must be visibly posted onsite or provided at the start of a telehealth visit.	
Client files must be securely stored—physically locked or password protected—and accessible only to authorized staff.	Written IT policies that outline how client information is protected on file at service provider agency.
Service provider agencies must keep clear, legible progress notes for each client that document every communication or service provided, including the date and the service delivered. Notes should also include any recommended referrals to needed services.	Progress notes maintained in individual client files at service provider agency.
Service provider agencies must have a crisis management policy that address how to respond to mental health crises and dangerous behaviors from clients or staff.	Written crisis management policy on file at service provider agency.
Service provider agencies must have a policy on Universal Precautions Procedures and maintain documentation that staff have been trained in these precautions.	Documentation of staff training in personnel files at service provider agency.
Service provider agencies must follow all relevant state and federal workplace and safety laws and all sites must meet ADA accessibility requirements.	Signed confirmation of compliance with applicable regulations on file at service provider agency.

Section 2.0—Client Rights and Responsibilities

CLIENT RIGHTS AND RESPONSIBILITIES	
STANDARD	**DOCUMENTATION**
Service provider agencies ensure services are accessible to all individuals who meet the service-specific eligibility criteria.	Written eligibility requirements on file at service provider agency.
Service provider agencies collect and incorporate input from PLWH to ensure services are client-centered.	Written documentation showing how client input is collected and used in service planning and evaluation.

Clients have the right to choose whether to use telehealth or in-person services (as applicable), and appointments must follow the client's preferred mode of care. Service provider agencies ensure clients receive the IT support and training needed to use telehealth services effectively.	Written checklists or "how-to" guides before telehealth visits, delivered by email or posted on the service provider agency website.
Service provider agencies provide clients with a copy of the Client Bill of Rights and Responsibilities (Appendix B).	Signed Client Bill of Rights and Responsibilities document on client file at service provider agency.

Section 3.0—Staff Requirements and Qualifications

STAFF REQUIREMENTS AND QUALIFICATIONS	
STANDARD	**DOCUMENTATION**
Staff meet the minimum qualifications for their positions and have the knowledge, skills, and abilities needed to effectively serve their communities. If a position requires a license, staff must hold the appropriate license to provide services. Service provider agencies must adopt policies that support hiring people living with HIV in all appropriate areas of service delivery.	Hiring policy, staff resumes and copy of license (as appropriate) on file at service provider agency.
Staff participate in training relevant to their job duties, program needs, and the Ryan White Program service category.	Documentation of completed training on file at service provider agency.
Staff must coordinate with both Ryan White-funded and non-funded programs to ensure all client needs are met.	Documentation of staff efforts to coordinate client services across systems kept on file at service provider agency.

Section 4.0—Cultural and Linguistic Competence

CULTURAL AND LINGUISTIC COMPETENCE	
STANDARD	**DOCUMENTATION**
Recruit, promote, and support a culturally and linguistically diverse workforce that reflects and responds to the population served.	Written policy and documentation at service provider agency.
Service provider agencies develop or use existing culturally and linguistically appropriate policies	Written policy and documentation at service provider agency.

and practices and provide ongoing training to ensure staff consistently apply them.	
Clearly inform clients—verbally and in writing, and in their preferred language—about available language assistance services. Ensure interpreters are competent; avoid using untrained individuals or minors.	Written policy and documentation at service provider agency.
Offer easy-to-understand print and multimedia materials and signage in the primary languages of the service population at all clinic entry points and client service areas.	Written policy and documentation at service provider agency.

Section 5.0—Intake and Eligibility

INTAKE AND ELIGIBILITY	
STANDARD	**DOCUMENTATION**
Service provider agencies must have an intake procedure for determining client eligibility.	Written procedure describing intake workflow on file at service provider agency. Documentation must verify residency in Los Angeles County, Income at or below the Federal Poverty Level (FPL) set by the Division on HIV & STD Programs and confirmed HIV diagnosis.
Service provider agencies must complete an intake for clients which includes a review of client rights and responsibilities, explanation of available services, covers confidentiality and grievance policies, assess immediate needs, and obtains permission to release information as appropriate. Service provider agencies must begin intake process within 5 days of initial contact and be completed within 30 days. If the client does not complete intake within 30 days, document all contact attempts and the methods used in the client file.	Complete intake in client file at service provider agency.
Client intake forms must allow clients to indicate their preferred name and pronouns, and they must also explain the situations in which a legal name is required.	Written policy and documentation at Service Provider Agency.

Section 6.0—Referrals

REFERRALS AND CASE CLOSURE	
STANDARD	**DOCUMENTATION**
Service provider agencies will maintain a comprehensive list of providers for HIV-related and other service referrals. Staff will make referrals based on client assessments and reassessments, using identified agency resources.	All recommended referrals must be documented in client files at service provider agency.
Service provider agencies will follow-up with referrals made to ensure services were delivered as appropriate.	Documentation that the service provider agency follow-up with referrals.

Section 7.0—Case Closure

REFERRALS AND CASE CLOSURE	
STANDARD	**DOCUMENTATION**
Service provider agencies must establish a case closure procedure that includes documented justification and, when appropriate, a transition plan to other services or providers.	Written case closure procedure on file at service provider agency.
Cases may be closed if the client: • Relocates outside the service area • Is no longer eligible for RWHAP services • Discontinued services • No longer needs services • Poses a risk to the service provider agency, staff, or other clients • Misuses services or violates the service agreement • Is deceased • Has had no direct contact with the service provider agency for 12 months despite repeated outreach attempts	All contact attempts and communication methods must be documented, along with the justification for case closure.

Service provider agencies must have a transition procedure to support clients leaving services and ensure a smooth handoff.	Completed transition summary should be placed in the client file and signed by the client and supervisor when possible.
Service provider agencies will establish or use an existing due process policy for involuntary client removal, including a sequence of verbal and writer warnings before final notice and case closure.	Due Process policy kept on file at service provider agency.

Appendix A: Ryan White Part A Service Categories

The Ryan White HIV/AIDS Program Part A provides a comprehensive system of care for people living with HIV through two service categories:

- Core Medical services which are essential for the diagnosis, treatment, and management of HIV
- Support services which help clients achieve medical outcomes by addressing social, financial, and logistical barriers to care

Policy Clarification Notice (PCN) 16-02 provides program guidance for services categories for RWHAP services.

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

Appendix B: Client Bill of Rights and Responsibilities

Service provider agencies are responsible to provide clients with a copy of the "Client Bill of Rights and Responsibilities" in all service settings, including telehealth. The purpose of this document is to empower clients to advocate for themselves and work in partnership with their service providers to achieve the best possible HIV/AIDS care and treatment.

Developed by people living with HIV in Los Angeles County, this Bill of Rights and Responsibilities affirms that individuals entering or receiving HIV/AIDS care, treatment, or support services have the right to:

1. Respective Treatment and Preventive Services
    a. Receive considerate, respectful, professional, confidential, and timely care and preventive services (including screenings and vaccinations) in a safe, client-centered, trauma informed environment without bias.
    b. Receive equal, unbiased care appropriate to your age and needs, in compliance with federal and state laws and regulations.
    c. Receive information about your providers' qualifications, including their experience with HIV/AIDS care.
    d. Be informed of the names and work phone numbers of the staff responsible for your care.
    e. Have safe accommodations to protect personal property while receiving services.
    f. Receive culturally and linguistically appropriate services, including clear explanations in your preferred language and dialect.
    g. Review your medical records and obtain copies upon request, subject to reasonable service provider agency policies and applicable fees.
2. Competent, High-Quality Care
    a. Have your care provided by competent, qualified professionals who follow HIV treatment stands as set forth by the U.S. Department of Health and Human Services, the Centers for Disease Control and Prevention, the California Department of Health Services, and the County of Los Angeles Department of Public Health.
    b. Have access to these professionals at convenient times and locations.
    c. Receive appropriate referrals to other medical, mental health, or care services.
    d. Have their phone calls and/or emails answered within 1-5 business days based on the urgency of the matter.
3. Participate in Treatment Decision-Making Process
    a. Receive clear, up-to-date information in understandable terms about your diagnosis, treatment options, medications (including common side effects), and expected outcomes.
    b. Actively participate with your providers in discussing treatment choices.
    c. Make the final treatment decision after receiving all relevant information and your provider's recommendations.
    d. Access patient-specific education and reliable self-management resources.

e. Refuse any recommended treatment, be informed of potential health impacts, and consequences, and retain the right to change your mind later.
f. Be informed about and offered the chance to participate in eligible clinical research studies.
g. Refuse to participate in research without any penalty.
h. Decline services or end participation in any program without bias or negative impact on your care.
i. Be informed of service provider agency procedures for addressing misunderstandings, complaints, or grievances.
j. Receive a response to any complaint or grievance withing 45 days.
k. Be informed about external ombudsman or advocacy resources, including how to reach relevant federal complaint centers (CMS).

4. Confidentiality and Privacy
    a. Receive a copy of the service provider agency's Notice of Privacy Policies and Procedures.
    b. Have your HIV status kept confidential and receive an explanation of confidentiality policies and any exceptions.
    c. Request restricted access to specific parts of your medical record.
    d. Authorize or withdraw permission for others to access your medical record, except for providers and billing.
    e. Question information in your medical record and request written corrections (your provider may accept or decline with explanation).
5. Billing Information and Assistance
    a. Receive clear information about all potential charges and provider payment policies.
    b. Receive information about financial assistance programs and help accessing any benefits for which you may qualify.
6. Client Responsibilities

    To support your care, you are responsible for:
    a. Participating in creating and following your treatment or service plan to the best of your ability.
    b. Providing accurate, complete information about your health history, medications, and other treatments; reporting changes promptly.
    c. Telling your provider when you do not understand information given to you.
    d. Following the agreed-upon treatment plan and understanding the consequences of non-adherence or using alternative treatments.
    e. Understanding that cases may be closed if the client:
        i. Moves out of the service area
        ii. Is no longer eligible for RWHAP services
        iii. Discontinue services
        iv. No longer need services
        v. Pose a risk to the service provider agency, staff, or other clients
        vi. Misuse services or violate the service agreement

vii. Is deceased
viii. Has no direct contact with the agency for 12 months despite repeated outreach

f. Keeping appointments or notifying the agency promptly if unable to attend.
g. Keeping the service provider agency informed of how to reach you confidentially.
h. Following service provider agency rules and conduct guidelines.
i. Treating providers and other clients with respect.
j. Avoiding profanity, abusive language, threats, violence, weapons, theft, vandalism, and any form of sexual harassment or misconduct.
k. If living with substance use disorder, being open with your provider about your substance use so appropriate support can be provided.

For more help or information:

Start by discussing any complaint or grievance with your provider or the service provider agency's client services representative or patient advocate. If the issue is not resolved in a reasonable timeframe, or if you prefer to speak with someone outside the service provider agency, you may call the number below for confidential, independent assistance.

Division on HIV and STD Programs, Customer Support Program 1-800-260-8787, 8am-5pm, Monday—Friday

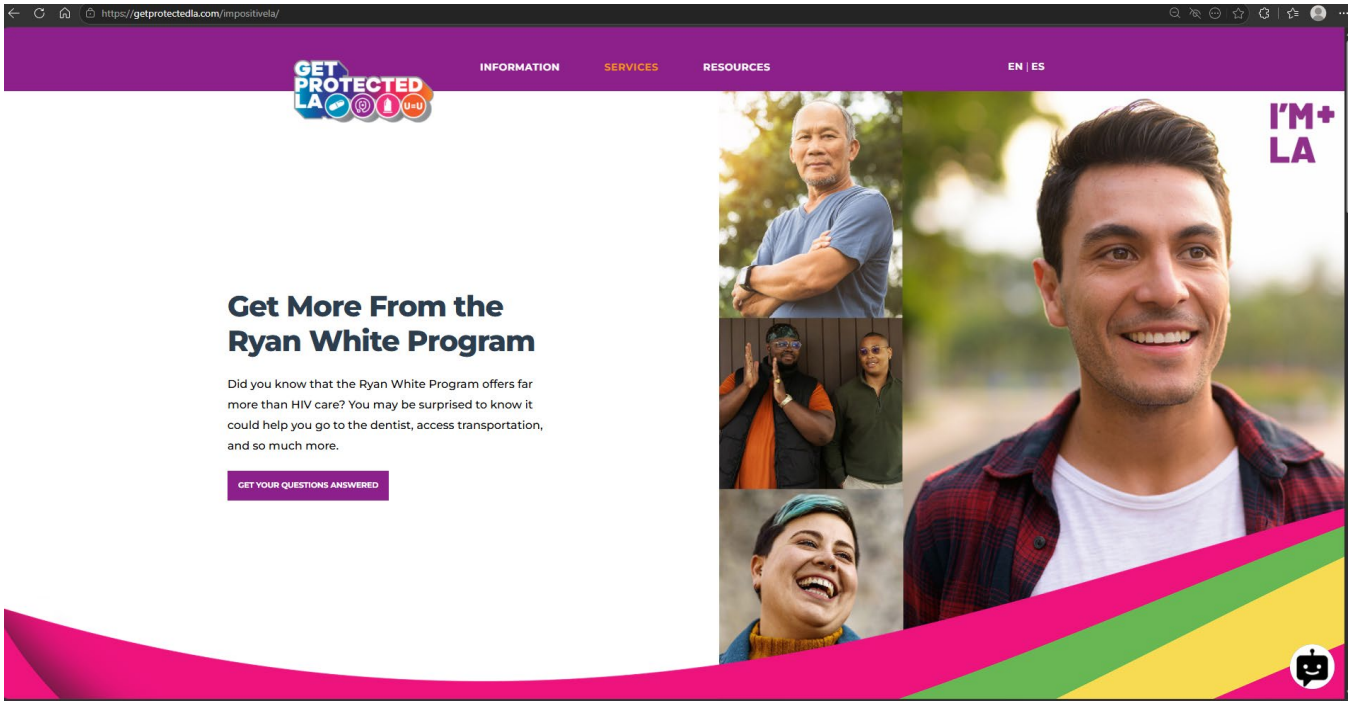
Appendix C: Division on HIV and STD Programs Customer Support Program

The Division of HIV and STD Programs (DHSP) Customer Support Program helps clients who experience difficulty accessing services form DHSP-funded providers in Los Angeles County. If you or someone you know is having trouble obtaining HIV or STD services or has concerns about service quality, the program can assist.

Contact the Customer Support Program by email at dhspsupport@ph.lacounty.gov, online at http://publichealth.lacounty.gov/dhsp/QuestionServices.htm, or by phone at 1-800-260-8787. Reaching out will not affect your access to services, and your name and personal information can be kept confidential.

Appendix D: Get Protected LA and I'M+ LA Online Resources

The Division of HIV and STD Programs (DHSP) offers Get Protected LA and I'M+ LA, online resources with information about free or low-cost HIV care and support services available through the Ryan White Program for eligible people living with HIV in Los Angeles County regardless of insurance status. Visit: https://getprotectedla.com/impositvela/



SERVICE STANDARDS FOR ORAL HEALTH CARE SERVICES

LOS ANGELES COUNTY
COMMISSION ON HIV

APPROVED BY THE COH ON 04/13/23

SERVICE STANDARDS: ORAL HEALTH CARE SERVICES

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

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

HRSA HAB, 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 Oral Health Care Services standards to establish the minimum services necessary to provide oral health care 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

Oral health care services are an integral part of primary medical care for all people living with HIV. Most HIV infected patients can receive routine, comprehensive oral health care in the same manner as any other person. All treatment will be administered according to published research and available standards of care. In addition, the COH developed a Dental Implants addendum to provide specific service delivery guidance to Ryan White Part A-funded agencies regarding the provision of dental implants. For more information, see the Oral Health Care Service Standard Addendum.

Service shall include (but not limited to):

- Routine dental care and oral health education and counseling
- Obtaining a comprehensive medical and oral hygiene history and consulting primary medical providers as necessary
- Providing educational, prophylactic, diagnostic and therapeutic dental services to patients with a written confirmation of HIV status

- Providing medication appropriate to oral health care services, including all currently approved drugs for HIV-related oral manifestations
- Providing or referring patients, as needed, to health specialists including, but not limited to, periodontists, prosthodontists, endodontists, oral surgeons, oral pathologists, oral medicine practitioners and registered dietitians
- Maintaining individual patient dental records in accordance with current standards
- Complying with infection control guidelines and procedures established by the California Occupation Safety and Health Administration (Cal-OSHA)

The following are priorities for HIV oral health treatment:

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

Recurring themes in this standard include:

- Good oral health is an important factor in the overall health management of people living with HIV.
- Treatment modifications should only be used when a patient's health status demands them.
- Comprehensive evaluation is a critical component of appropriate oral health care services.
- Treatment plans should be made in conjunction with the patient.
- Collaboration with primary medical providers is necessary to provide comprehensive dental treatment.
- Prevention and early detection should be emphasized.

GENERAL CONSIDERATIONS: <u>There is no justification to deny or modify dental treatment based on the fact that a patient has tested positive for HIV</u>. Further, the magnitude of the viral load is not an indicator to withhold dental treatment for the patient. If, however, a patient's medical condition is compromised, treatment adjustments, as with any medically compromised patient, may be necessary.

<u>SERVICE/ORGANIZATIONAL LICENSURE CATEGORY</u>

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

Dentists: A dentist must complete a four-year dental program and possess a Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) degree. Additionally, dentists must pass a

three-part examination as well as the California jurisprudence exam and a professional ethics exam. Dentists are regulated by the California Dental Board (please see Dental Board of California for further information).

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

Unlicensed Dental Assistants (DA): Unlicensed dental assistants are not licensed by the Dental Board of California, but they are subject to certain laws governing their conduct. Section 150.1 is the statute governing the duties that unlicensed dental assistants are allowed to perform. Unless a specific duty is listed in that regulations, the dental assistant is NOT allowed to perform that duty. A dental assistant may only expose radiographs after successful completion of a board-approved radiation safety course. Dental assistants with certain experience or educational backgrounds may qualify to apply for Registered Dental Assistant (RDA) licensure.

Registered Dental Assistants in Extended Functions (RDAEF)[1]: RDAEF holds a current licensure as a Registered Dental Assistant or has completed the requirements for licensure as a RDA, completed a Board-approved course in the application of Pit & Fissure Sealants, completed a Board-approved RDAEF program, passed a written examination administered by the Board, and submitted fingerprint clearances from both the Department of Justice and the Federal Bureau of Investigation. RDAEFs are regulated by the California Dental Board (please see Dental Board of California for further information).

Registered Dental Hygienists (RDH): RDHs must have been granted a diploma or certificate in dental hygiene from an approved dental hygiene educational program. RDHs are regulated by the California Dental Board (please see Dental Board of California for further information).

Registered Dental Hygienists in Extended Functions (RDHEF)[2]: RDHEF holds a current license as a registered dental hygienist in California, completed clinical training approved by the dental hygiene board in a facility affiliated with a dental school under the direct supervision of the dental school faculty, performed satisfactorily on an examination required by the dental hygiene board, and completed an application form and paid all application fees required by the dental hygiene board. RDHEF are regulated by the California Dental Board (please see Dental Board of California for further information).

[1] Registered Dental Assistant in Extended Functions Applicants - Dental Board of California

[2] Codes Display Text (ca.gov)

SERVICE STANDARDS

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

SERVICE COMPONENT	STANDARD	DOCUMENTATION
INTAKE	Intake process will begin during first contact with client.	Intake took 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 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 Responsibilities and the Division on HIV and STD Programs (DHSP) Customer Support Program[3].	Signed, dated forms in client file.
EVALUATION When presenting for dental services, people living with HIV should be given a comprehensive oral evaluation. When indicated,	A comprehensive oral evaluation will be given to patients living with HIV and will include: • Documentation of patient's presenting complaint • Caries charting	Signed, dated evaluation on file in patient chart.

[3] The program aims to assist consumers of HIV and STD services who have experienced difficult accessing services from DHSP-funded providers throughout Los Angeles County.

diagnostic tests relevant to the evaluation of the patient should be performed and used in diagnosis and treatment planning. In addition, full medical status information from the patient's medical provider, including most recent lab work results, should be obtained, and considered by the dentist	• Radiographs or panoramic and bitewings and selected periapical films • Complete periodontal exam or PSR (Periodontal Screening Record) • Comprehensive head and neck exam • Complete intra-oral exam, including evaluation for HIV-associated lesions • Pain assessment	
	As indicated, diagnostic tests relevant to the evaluation will be used in diagnosis and treatment planning. Biopsies of suspicious oral lesions will be taken.	Signed, dated evaluation in patient chart to detail additional tests.
	Full medical status information will be obtained from the patient's medical provider and considered in the evaluation. The medical history and current medication list will be updated regularly to ensure all medical and treatment changes are noted.	Signed, dated evaluation in patient chart to detail medical status information.
	Obtain a thorough medical, dental, and psychosocial history to assess the patient's oral hygiene habits and periodontal stability and determine the patient's capacity to achieve dental implant success and the possibility of dental implant failure.	Client Chart/Treatment Plan/Provider Progress Notes
	Clinician, after patient assessment, will make necessary referrals to specialty programs including, but not limited to smoking cessation programs; substance use	

	treatment; medical nutritional therapy, thereby increasing patients' success rate for receiving dental implants.	
	The clinicians referring patients to specialty Oral Healthcare services will complete a referral form, educate the patient, and discuss treatment plan alternatives with patient.	
TREATMENT PLANNING In conjunction with the patient, each dental provider shall develop a comprehensive, multidisciplinary treatment plan. The patient's primary reason for the visit should be considered by the dental professional when developing the dental treatment plan. Treatment priority should be given to the management of pain, infection, traumatic injury, or other emergency conditions. Dental provider will support and reinforce patient understanding, agreement, and education in the patient's treatment plan. Ensure patient understanding that dental implants are for medical necessity (as determined by the dental provider through assessments and evaluation) and would lead to improved HIV health outcomes. Reinforce that Ryan White	A comprehensive, multidisciplinary treatment plan will be developed in conjunction with the patient.	Treatment plan dated and signed by both the provider and patient in patient file.
	Patient's primary reason for dental visit should be addressed in treatment plan.	Treatment plan dated and signed by both the provider and patient in the patient file to detail.
	Patient strengths and limitations will be considered in development of treatment plan.	Treatment plan dated and signed by both the provider and patient in patient file to detail.
	Treatment priority will be given to pain management, infection, traumatic injury, or other emergency conditions.	Treatment plan dated and signed by both the provider and patient in patient file to detail.
	Treatment plan will include consideration of the following factors: • Tooth and/or tissue supported prosthetic options • Fixed protheses, removable prostheses or combination • Soft and hard tissue characteristics and morphology, ridge relationships, occlusion and occlusal forces, aesthetics, and parafunctional habits • Restorative implications, endodontic status, tooth	Treatment plan dated and signed by both the provider and patient in file to detail.

funds cannot be used to provide dental implants for cosmetic purposes.	position and periodontal prognosis • Craniofacial, musculoskeletal relationships	
	Six-month recall schedule will be used to monitor any changes. A three-month recall schedule may be considered to limit disease progression and maintain healthy periodontal tissues in advanced cases of periodontitis or caries.	Signed, dated progress note in patient file to detail.
	Treatment plans will be updated as deemed necessary.	Signed, dated progress note in patient file to detail.
	The receiving clinician will review the referral, consider the patient's medical, dental, and psychosocial history to determine treatment plan options that offer the patient the most successful outcome based on published literature. The clinician will discuss with patient dental implant options with the goal of achieving optimal health outcomes.	Referral in Client Chart/Treatment Plan/Provider Progress Notes
	The clinician will consider the patient's perspective in deciding which treatment plan to use.	Client Chart/Treatment Plan/Provider Progress Notes
	The clinician will discuss treatment plan alternatives with the patient and collaborate with the patient to determine their treatment plan.	
	The clinician and the patient will revisit the treatment plan periodically to determine if any adjustments are necessary to achieve the treatment goal.	

	The clinician will educate patients on how to maintain dental implants and the importance of routine care.	
INFORMED CONSENT Patients will sign an informed consent document for all dental procedures. This informed consent process will be ongoing as indicated by the dental treatment plan.	As part of the informed consent process, dental professionals will provide the following before obtaining consent: • Diagnostic information • Recommended treatment • Alternative treatment • Benefits and risks of treatment • Limitations of treatment	Signed, dated progress note or informed consent in patient field to detail.
	Dental providers will describe all options for dental treatment and allow the patient to be part of the decision-making process.	Signed, dated progress note or informed consent in client file to detail.
	After the informed consent discussion, patients will sign an informed consent for all dental procedures.	Signed, dated informed consent in client file.
	This informed consent process will be ongoing as indicated by the dental treatment plan.	Ongoing signed, dated informed consents in client file (as needed).
MEDICAL CONSULTATION AND PRIMARY CARE PARTICIPATION Dentists can play an important part in reminding patients of the need for regular primary medical care and CBC, CD4, viral load tests every three to six months depending on the past history of HIV infection and level of suppression achieved and encouraging patients to adhere to their medication	Primary care physicians will be consulted when providing dental treatment.	Signed, dated progress note to detail consultations.
	Primary care physicians will be consulted when providing dental treatment depending on the medical needs of the patient. Consultation with medical providers will be: • To obtain the necessary laboratory test results • When there is any doubt about the accuracy of the information provided by the patient	Signed, dated progress note to detail consultations.

regimens. However, even the highest number of viral copies has no impact on the provision of dental care. If a patient is not under the regular care of a primary care physician, the patient should be urged to seek care and a referral to primary care will be made.	• When there is a change in the patient's general health, determine the severity of the condition and the need for treatment modifications • If after evaluating the patient's medical history and the laboratory tests, the oral health provider decides that treatment should occur in a hospital setting • New medications are indicated to ensure medication safety and prevent drug/drug interactions • Oral opportunistic infections are presents	
	Dentists will encourage consistent medical care in their patients and provide referrals as necessary. Under certain circumstances, dental professionals may require further medical information to determine safety and appropriateness of care.	Signed, dated progress notes to detail referrals and discussion.
	Programs may decide to discontinue oral health services if a client has not engaged in primary medical care. Patients will be made aware of this policy at time of intake into the program.	Signed, dated progress notes to detail referrals and discussion. Policy on file at provider agency. Intake materials will also state this policy.
	Under certain circumstances, dental professionals may require further medical information to determine safety and appropriateness of care.	Signed, dated progress notes to detail discussion.

PREVENTION/EARLY INTERVENTION Dental professionals will emphasize prevention and early detection of oral disease by educating patients about preventive oral health practices, including instruction in oral hygiene. In addition, dental professionals may provide counseling regarding behaviors (e.g., tobacco use, unprotected oral sex, body piercing in oral structures) and general health conditions that can compromise oral health. The impact of good nutrition on preserving good oral health should be discussed.	Dental professionals will educate patients about preventive oral health practices.	Signed, dated progress note in patient file to detail education efforts.
	Routine examinations and regular prophylaxis will be scheduled twice a year.	Signed, dated progress note or treatment plan in patient file to detail schedule.
	Dental professionals will provide basic nutritional counseling to assist in oral health maintenance. Referrals to an RD and others will be made, as needed.	Signed, dated progress note to detail nutrition discussion and referrals made.
	Root planing/scaling will be offered as necessary, either directly or by referral.	Signed, dated progress note or treatment plan in patient file to detail.
SPECIAL TREATMENT CONSIDERATIONS	As indicated, the following modifications to standard dental treatment should be considered: • Bleeding tendencies may determine whether or not to recommend full mouth scaling and root planning or multiple extractions in one visit. • In severe cases, patients may be treated more sagely in a hospital environment where blood transfusions are available. • Deep block injections should be avoided in patients with bleeding tendencies. • A pre-treatment antibacterial mouth rinse should be used for those	Signed, dated process note or treatment plan in patient file to detail treatment modifications and referrals.

	patients with periodontal disease. • Patients with salivary hypofunction should be closely monitored for caries, periodontitis, soft tissue lesions and salivary gland disease. • Fluoride supplements should be prescribed for those with increase caries and salivary hypofunction. Referral to dental professional experiences in oral mucosal and salivary gland diseases should be made in severe cases of xerostomia.	
	Routine examinations and regularly prophylaxis will be scheduled twice a year.	Signed, dated progress note or treatment plan in patient file to detail scheduled.
	Root planning/scaling will be offered as necessary, either directly or by referral.	Signed, dated progress note or treatment plan in patient file to detail.
TRIAGE, REFERRAL, COORDINATION On occasion, patients will require a higher level of oral health treatment services than a given agency is able to provide. Coordinating oral health care with primary care medical providers is vital. Regular contact with a client's primary care clinic will ensure integration of services and better client care. Train referring dental providers on how to adequately complete referral	As needed, dental providers will refer patients to full range of oral health care providers, including: • Periodontists • Endodontists • Prosthodontists • Oral surgeons • Oral pathologists • Oral medicine practitioners	Signed, dated progress note to document referrals in patient chart.
	Providers will attempt to contact a client's primary care clinic if required or as clinically indicated to coordinate and integrate care.	Documentation of contact with primary medical clinics and providers to be placed in progress notes. In

forms to allow more flexibility in treatment planning for receiving specialty dental providers.		
OUTREACH Programs providing dental care for people living with HIV will actively promote their services through known linkages and direct outreach.	Programs will promote dental services for people living with HIV through linkages or outreach.	Service promotion/outreach plan on file at provider agency.
CLIENT RETENTION	Programs shall develop a broken appointment policy to ensure continuity of service and retention of clients.	Written policy on file at provider agency.
	Programs shall provide regular follow-up procedures to encourage and help maintain a client in oral health treatment services.	Documentation of attempts to contact in signed, dated progress notes. Follow-up may include: • Telephone calls • Written correspondence • Direct contact • Text messaging
STAFFING REQUIREMENTS AND QUALIFICATIONS	Provider will ensure that all staff providing oral health care services will possess applicable professional degrees and current California state licenses.	Documentation of professional degrees and licenses on file.
	Providers shall be trained and oriented before providing oral health care services both in general dentistry and HIV specific oral health services. Training will include: • Basic HIV information • Office and policy orientation • Infection control and sterilization techniques	Training documentation on file maintained in personnel record.

	• Methods of initial evaluation of the patient living with HIV disease • Health maintenance education and counseling • Recognition and treatment of common oral manifestations and complications of HIV disease • Recognition of oral signs and symptoms of advanced HIV disease	
	Oral health care providers will practice according to California state law and the ethical codes of their respective professional organizations.	Chart review will ensure legally and ethically appropriate practice.
	Dentist in charge of dental operations shall provide clinical supervision to dental staff.	Documentation of supervision on file.
	Dental care staff will complete documentation required by program.	Periodic chart review to confirm.
	Providers will seek continuing education about HIV disease and associated oral health treatment considerations.	Documentation of trainings in employee file.

ACRONYMS

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

DEFINITIONS AND DESCRIPTIONS

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

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

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

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

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

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

REFERENCES

American Dental Association. Human Immunodeficiency Virus (HIV) https://www.ada.org/resources/research/science-and-research-institute/oral-health-topics/hiv#:~:text=Nearly%20all%20patients%20with%20HIV,and%20procedures%2C%20including%20oral%20surgery.&text=Still%2C%20dental%20treatment%20planning%20must,and%20their%20physician%20as%20appropriate. Accessed December 29, 2022.

American Dental Association. Infection Control and Sterilization. https://www.ada.org/resources/research/science-and-research-institute/oral-health-topics/infection-control-and-sterilization. Accessed December 29, 2022.

Bosh KA, Hall HI, Eastham L, Daskalakis DC, Mermin JH. Estimated Annual Number of HIV Infections – United States, 1981-2019. MMWR Morb Mortal Wkly Rep 2021;70(22):801-06.

Centers for Disease Control and Prevention. Infection Prevention and Control in Dental Settings: Bloodborne Pathogens & Aerosols. U.S. Department of Health and Human Services. https://www.cdc.gov/oralhealth/infectioncontrol/faqs/bloodborne-exposures.html. Accessed December 29, 2022.

Centers for Disease Control and Prevention. Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care. In: Services DoHaH, editor. Atlanta, GA: Centers for Disease Control and Prevention; 2016. https://www.cdc.gov/oralhealth/infectioncontrol/pdf/safe-care2.pdf. Accessed December 29, 2022.

Centers for Disease Control and Prevention. Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis. MMWR 2001;50(RR-11).

Parish C, Siegel K, Pereyra M, Liguori T, Metsch L. Barriers and facilitators to dental care among HIV-Infected adults. Spec Care Dentist. 2015 Nov-Dec;35(6):294-302. doi: 10.1111/scd.12132. Epub 2015 Sep 4. PMID: 26336866; PMCID: PMC5838363.

Reznik DA. Oral manifestations of HIV disease. Top HIV Med 2005;13(5):143-8.

Riddle MW. HIV screening in dental settings: Challenges, opportunities, and a call to action. Oral Dis. 2020 Sep;26 Suppl 1:9-15.

Shiels MS, Islam JY, Rosenberg PS, et al. Projected Cancer Incidence Rates and Burden of Incident Cancer Cases in HIV-Infected Adults in the United States Through 2030. Ann Intern Med 2018;168(12):866-73.

Workowski KA, Bolan GA; Centers for Disease Control and Prevention. Sexually transmitted diseases treatment guidelines, 2015. MMWR Recomm Rep. 2015 Jun 5;64(RR-03):1-137. Erratum in: MMWR Recomm Rep. 2015 Aug 28;64(33):924.

World Health Organization. HIV/AIDS. https://www.who.int/news-room/fact-sheets/detail/hiv-aids Accessed December 28, 2022.

ORAL HEALTH CARE SERVICE STANDARD ADDENDUM

Approved by the Commission on HIV on 12/8/22.

I. INTRODUCTION

The purpose of the addendum is to provide specific service delivery guidance to Ryan White Part A-funded agencies regarding the provision of dental implants. The service expectations are aimed at creating a standardized set of service components, specifically for dental implants. Dental implants are an oral health care procedure and not a specialty service. Subrecipients funded by the Los Angeles County Division of HIV and STD Programs (DHSP) must adhere to all service category definitions and service standards for which they are funded.

II. BACKGROUND

On February 24th, 2022, the Los Angeles County Commission on HIV convened an Oral Health Care subject matter expert panel to discuss an addendum to the EMA's Oral Health Care service standard specifically to address dental implants. The panel consisted of dental providers and dental program administrators from agencies contracted by the Division on HIV and STD Programs (DHSP) to provide dental and specialty dental services under the Ryan White Program Part A. Among the participating agencies, there were the UCLA School of Dentistry, USC School of Dentistry, Western University, AIDS Healthcare Foundation, and Watts Health.

III. SUBJECT MATTER EXPERT PANEL FINDINGS AND RECOMMENDATIONS

Recommendations for improving dental implant services for Ryan White Part A specialty dental providers:

a. Support and reinforce patient understanding, agreement, and education in the patient's treatment plan.
b. Ensure patient understanding that dental implants are for medical necessity (as determined by the dental provider through assessments and evaluation) and would lead to improved HIV health outcomes
c. Reinforce that RW funds cannot be used to provide dental implants for cosmetic purposes.
d. The treatment plan should be signed by both patient and doctor.
e. Engage and collaborate with the Consumer Caucus to revisit and strengthen the "Consumer Bill of Rights" document and consider reviewing the client responsibilities section to ensure it addresses the client's service expectations and the service provider's capacity to meet them within the limits of the contractual obligations as prescribed by DHSP.

f. Review the referral form(s) providers use to refer patients to specialty dental services
g. Develop a standard form/process referring providers can complete when referring
h. Train referring dental providers on how to adequately complete referral forms to allow more flexibility in treatment planning for receiving specialty dental providers.
i. Recommend that dental providers complete training modules and access training resources available on the Pacific AIDS Education and Training (PAETC) website.

IV. HEALTH RESOURCES SERVICE ADMINISTRATION (HRSA) SERVICE CATEGORY DEFINITION FOR ORAL HEALTH CARE SERVICES[1]

Oral Health Care activities include outpatient diagnosis, prevention, and therapy provided by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants

V. PROGRAM SERVICE CATEGORY DEFINITION FOR ORAL HEALTH CARE SERVICES

Service Considerations (as listed on 2015 Oral Healthcare Service Standards) Oral healthcare services should be an integral part of primary medical care for all people living with HIV. Most HIV-infected patients can receive routine, comprehensive oral healthcare in the same manner as any other person. All treatment will be administered according to published research and available standards of care (for additional information please see: Oral Health Care Standards of Care).

VI. ORAL HEALTHCARE SERVICE ADDENDUM REGARDING DENTAL IMPLANTS

General Consideration: There is no justification to deny or modify dental treatment based on the fact that a patient has tested positive for HIV. Further, the magnitude of the viral load is not an indicator to withhold dental treatment for a patient. If, however, a patient's medical condition is compromised, treatment adjustments, as with any medically compromised patient, may be necessary.

SERVICE COMPONENT	STANDARD	DOCUMENTATION
EVALUATION/ASSESSMENT	Obtain a thorough medical, dental, and psychosocial history to assess the patient's oral hygiene habits and periodontal stability and determine the patient's capacity to achieve dental implant success and the possibility of dental implant failure.	Client Chart/Treatment Plan/Provider Progress Notes

[1] *HRSA Policy Clarification Notice (PCN) #16-02*

	Clinician, after patient assessment, will make necessary referrals to specialty programs including, but not limited to smoking cessation programs; substance use treatment; medical nutritional therapy, thereby increasing patients' success rate for receiving dental implants.	
	The clinicians referring patients to specialty Oral Healthcare services will complete a referral form, educate the patient, and discuss treatment plan alternatives with patient.	
TREATMENT PLANNING AND ORAL HEALTH EDUCATION	The receiving clinician will review the referral, consider the patient's medical, dental, and psychosocial history to determine treatment plan options that offer the patient the most successful outcome based on published literature. The clinician will discuss with patient dental implant options with the goal of achieving optimal health outcomes.	Referral in Client Chart/Treatment Plan/Provider Progress Notes
	The clinician will consider the patient's perspective in deciding which treatment plan to use.	Client Chart/Treatment Plan/Provider Progress Notes
	The clinician will discuss treatment plan alternatives with the patient and collaborate with the patient to determine their treatment plan.	Client Chart/Treatment Plan/Provider Progress Notes
	The clinician and the patient will revisit the treatment plan periodically to determine if any adjustments are necessary to achieve the treatment goal.	Client Chart/Treatment Plan/Provider Progress Notes
	The clinician will educate patients on how to maintain dental implants and the importance of routine care.	Client Chart/Treatment Plan/Provider Progress Notes

VII. REFERENCES

a. Rubinstein, N.C., Jacobson, Z., McCausland, G.L. et al. Retrospective study of the success of dental implants placed in HIV-positive patients. Int J Implant Dent 5, 30 (2019). https://doi.org/10.1186/s40729-019-0174-6Ata-Ali J, Ata-Ali F, Di-Benedetto N, Bagán L, Bagán JV. Does HIV infection have an impact upon dental implant osseointegration? A systematic review. Med Oral Patol Oral Cir Bucal. 2015 May; 20(3): e347–e356. Link: Does HIV infection have an impact upon dental implant osseointegration? A systematic review (nih.gov)

b. Sivakumar I, Arunachalam S, Choudhary S, Buzayan MM.J Does HIV infection affect the survival of dental implants? A systematic review and meta-analysis.

c. J Prosthet Dent. 2021 Jun;125(6):862-869. Link: Does HIV infection affect the survival of dental implants? A systematic review and meta-analysis - ScienceDirect

d. Vidal F, Vidal R, Bochnia J, de Souza RC, Gonçalves LS. Dental implants and bone augmentation in HIV-infected patients under HAART: Case report and review of the literature. Spec Care Dentist. 2017 May;37(3):150-155. Link: (PDF) Dental extraction in patients with HIV/AIDS: report of two cases (researchgate.net)

e. Aghaloo T, Pi-Anfruns J, Moshaverinia A, Sim D, Grogan T, Hadaya D. The Effects of Systemic Diseases and Medications on Implant Osseointegration: A Systematic Review. Int J Oral Maxillofac Implants. 2019 Suppl;34:s35-s49. Link: The Effects of Systemic Diseases and Medications on Implant Osseointegration: A Systematic Review - PubMed (nih.gov)

f. Lemos CAA, Verri FR, Cruz RS, Santiago Júnior JF, Faverani LP, Pellizzer EP. Survival of dental implants placed in HIV-positive patients: a systematic review. Int J Oral Maxillofac Surg. 2018 Oct;47(10):1336-1342. Link: PRIME PubMed | Survival of dental implants placed in HIV-positive patients: a systematic review (unboundmedicine.com)

g. Rubinstein NC, Jacobson Z, McCausland GL, Dibart S. Retrospective study of the success of dental implants placed in HIV-positive patients. Int J Implant Dent. 2019 Jun 13;5(1):30. Link: Retrospective study of the success of dental implants placed in HIV-positive patients. - Abstract - Europe PMC

h. Sabbah A, Hicks J, MacNeill B, Arbona A, Aguilera A, Liu Q, Gelfond J, Gardner W. A retrospective analysis of dental implant survival in HIV patients. J Clin Periodontol. 2019 Mar;46(3):363-372. Link: A retrospective analysis of dental implant survival in HIV patients. - Abstract - Europe PMC

i. Neumeier TT, Reddy M, Geurs N, Hill J, Neumeier H.J Longitudinal Study of Dental Implants in HIV-Positive Patients. Prosthodont. 2021 Sep 8. doi: 10.1111/jopr.13421. Online ahead of print.PMID: 34496113. Link: Implants in HIV patients | British Dental Journal (nature.com)

j. Oliveira MA, Gallottini M, Pallos D, Maluf PS, Jablonka F, Ortega KL. The success of endosseous implants in human immunodeficiency virus-positive patients receiving antiretroviral therapy: a pilot study. J Am Dent Assoc. 2011 Sep;142(9):1010-6. Link: The success of endosseous implants in human immunodeficiency virus-positive patients receiving antiretroviral therapy: a pilot study. (medscape.com)

k. Prevalence of periodontitis, dental caries, and peri-implant pathology and their relation with systemic status and smoking habits: Results of an open-cohort study with 22009 patients in a private rehabilitation center. de Araújo Nobre M, Maló P. J Dent. 2017 Dec;67:36-42. Link: Prevalence of periodontitis, dental caries, and peri-implant pathology and their relation with systemic status and smoking habits: Results of an open-cohort study with 22009 patients in a private rehabilitation center - ScienceDirect

l. Oliveira MA, Pallos D, Mecca F, Ortega KL, Gallottini M, Costa AL, Kim YJ, Martins F. Dental implants in patients seropositive for HIV: A 12-year follow-up study..J Am Dent Assoc. 2020 Nov;151(11):863-869. Link: Dental implants in patients seropositive for HIV: A 12-year follow-up study - PubMed (nih.gov)

m. Guobis Z, Pacauskiene I, Astramskaite I. General Diseases Influence on Peri-Implantitis Development: a Systematic Review. J Oral Maxillofac Res. 2016 Sep 9;7(3):e5. Link: General Diseases Influence on Peri-Implantitis Development: a Systematic Review - PubMed (nih.gov)

n. Sivakumar I, Arunachalam S, Choudhary S, Mahmoud-Buzayan M, Tawfiq O, Sharan. Do Highly Active Antiretroviral Therapy Drugs in the Management of HIV Patients Influence Success of Dental Implants? J.AIDS Rev. 2020;22(1):3-8. Link: Do Highly Active Antiretroviral Therapy Drugs in the Management of HIV Patients Influence Success of Dental Implants? - PubMed (nih.gov)

o. Vidal F, Peres RV, de Souza RC, Gonçalves C, Pavan P, Gonçalves LS. Dental implants in individuals living with HIV-1: Results from a prospective study in patients undergoing highly active antiretroviral therapy. Spec Care Dentist. 2021 Sep 19. doi: 10.1111/scd.12646. Online ahead of print. Link: Dental implants in individuals living with HIV-1: Results from a prospective study in patients undergoing highly active antiretroviral therapy - Vidal - - Special Care in Dentistry - Wiley Online Library
p. Naujokat H, Kunzendorf B, Wiltfang J. Dental implants and diabetes mellitus-a systematic review. Int J Implant Dent. 2016 Dec;2(1):5. Link: Dental implants and diabetes mellitus-a systematic review - PubMed (nih.gov)
q. Jiang X, Zhu Y, Liu Z, Tian Z, Zhu S. Association between diabetes and dental implant complications: a systematic review and meta-analysis. .Acta Odontol Scand. 2021 Jan;79(1):9-18. Link: Association between diabetes and dental implant complications: a systematic review and meta-analysis - PubMed (nih.gov)

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

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Can I call anonymously?

Yes.

Can I contact you through other ways?

Yes.

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dhspsupport@ph.lacounty.gov

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

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

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Línea de Atención al Cliente

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¿Por qué debería llamar?

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

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

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

¿Puedo llamar de forma anónima?

Si.

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

Si.

Por correo electronico:
dhspsupport@ph.lacounty.gov

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

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

From: Jeffrey Young
Sent: Tuesday, June 30, 2026 9:26 PM
To: HIV Comm <HIVComm@lachiv.org>
Subject: Comment on the Draft Universal Service Standards and Client Bill of Rights and Responsibilities

I reviewed the draft against the actual state and federal rules it's supposed to follow. Most of it doesn't match. Two problems matter most.

First, the income cutoff on page 5 is wrong: the state raised it over a year ago, so some people who actually qualify could be turned away by mistake.

Second, the draft never explains that a client's immigration status doesn't affect their eligibility and won't be shared with immigration enforcement: that's a real rule that should be written plainly so people aren't afraid to sign up.

There are other gaps too, like a service listed on page 12 that actually has a much stricter, unstated set of requirements, and a complaint line on page 13 that sends people to the wrong federal agency.

I also looked at whether anyone is actually tracking how long it takes a client to get from referral to their first appointment. Nobody is. The county's public reports track something different and broader, so a slow, badly run intake process could exist, and it wouldn't show up anywhere.

I am willing to sit down with the Committee and go through what I found, item by item, before this gets finalized.

JEFFREY YOUNG

Public Comment in re:
Universal Service Standards and Client Bill of Rights

Commenter: Jeffrey Young

Submitted on: August 16, 2026

EXECUTIVE SUMMARY

Per the Commission's "Reviewing Service Standards" factsheet, this comment follows the document's own Standard/Documentation table format, section by section, noting for each standard whether it meets consumer needs, and if not, what specifically is missing, with the governing authority cited for each example.

I specifically reviewed these against consumer expectations set forth based on policy and practices guidance in the Calfornia Department of Public Health Office of AIDS' "**HIV Care Program (HCP) Service Standards**" which was revised March 21, 2022, based on the issuance of **HRSA PCN-2102 "Determining Client Eligibility & Payor of Last Resort in the Ryan White HIV/AIDS Program**", superseding HRS PCN 13-02. Both resources were conspicuously absent in the reference list for the proposed draft. I have attached copies to this public comment as Attachments A and B respectively.

After reading the document, I think the Universal Service Standards and Client Bill of Rights and Responsibilities:

Do not meet consumer needs. Here's why, with specific examples of what's missing:

1. The **income cutoff on page 5** says 500% of the Federal Poverty Level, but the state raised this to 600% over a year ago. Someone who actually qualifies for services could be told they don't, based on the wrong number.

2. There's **nothing in the document telling clients that immigration status doesn't affect their eligibility and won't be shared with immigration enforcement**. This is a real, existing protection under state and federal policy, but a client reading this document would have no idea it exists, which could keep eligible people from signing up out of fear.

3. **Page 12 lists "Home and Community-based Health Services" as something a client can access**, but doesn't mention that this specific service, when funded a certain way, has much stricter requirements, including a nursing-facility-level medical certification. A client could be told they qualify, then be denied later without ever understanding why.

4. The **complaint process on page 13 tells clients to contact "federal complaint centers (CMS)" for help. CMS does not oversee the Ryan White Program** and can't actually help with a Ryan White complaint. Clients following this instruction would hit a dead end.

5. There is **no standard anywhere in the document requiring recertification of a client's eligibility after their first enrollment**, even though the state requires this to happen every year on the client's birthday.

6. There is **no standard requiring follow-up when a client misses an appointment,** even though the state says this follow-up should happen within 24 hours because missed appointments are linked to worse health outcomes down the line.

Some parts do meet or exceed consumer needs.

The document's **general workplace safety and disability access requirements** (page 7, Section 1.0) are solid and match what state and federal disability law actually requires.

The document also **allows a full 12 months of no contact before a client's case can be closed** for disappearing from care, which is more generous to the client than the state's own 3-month minimum, giving people more time and more chances to come back before being closed out.

Beyond the document itself, the County's own public HIV data reports do not currently track how long it takes a client to get from a referral to their first appointment, even though the state sets a 10-day standard for this. The closest thing the County tracks is a broader, one-month measure starting from diagnosis, not from referral, and even that broader measure shows the County missing its own target in every single Health District. Without measuring the actual referral-to-appointment window, there is no way to know whether providers are meeting the 10-day standard, or how far off some of them might be.

I would welcome the opportunity to walk through these examples and the detailed review attached with the Committee before the standards are finalized.

TABLE OF CONTENTS

STAGE 1: STANDARDS GOVERNING IDENTIFYING CLIENTS FOR CARE

Introduction, Status-Neutral Framework

STANDARD (as written)	DOCUMENTATION (as written)
"This approach... helps ensure rapid linkage to treatment for newly diagnosed clients."	None specified.

Does not meet consumer needs. This describes a goal but not an actual operating rule. HRSA Policy Clarification Notice 21-02 sets a specific, usable standard: agencies are expected to start services, including antiretroviral medication, for a newly diagnosed or re-engaging client before their paperwork is finished, and confirm eligibility afterward. The document never states this. Missing: a rule saying a newly diagnosed client can start treatment now and get their eligibility confirmed later, rather than waiting on paperwork first.

Section 6.0, Referrals

STANDARD (as written)	DOCUMENTATION (as written)
"Staff will make referrals based on client assessments and reassessments, using identified agency resources."	"All recommended referrals must be documented in client files."

Does not meet consumer needs. The CDPH Common Standards require screening for eight specific needs (medical care, case management, housing, food, mental health, substance use, transportation, benefits counseling) and require a "warm hand-off," meaning staff actually connect the client to the next provider rather than just handing over a name or number. Missing: the list of required screening areas, and the warm hand-off requirement, both of which reduce the chance a referral gets dropped.

Section 5.0, First Appointment Timing

STANDARD (as written)	DOCUMENTATION (as written)
"Service provider agencies must begin intake process within 5 days of initial contact and be completed within 30 days."	"Complete intake in client file."

Does not meet consumer needs, as written. The state's actual standard measures something different: the appointment itself must be offered within 10 calendar days of the referral. The document's "5 days to begin intake" is not the same measurement, and it's unclear if agencies are even tracking the right thing. Missing: the correct 10-day, referral-to-appointment metric that the state actually monitors against.

Missed Appointments

STANDARD (as written)	DOCUMENTATION (as written)
Not present anywhere in the document.	Not present.

Does not meet consumer needs. This is a complete gap. The state standard requires agencies to have a process for following up on a missed appointment, ideally within 24 hours, specifically

because missed appointments are linked to worse health outcomes later. Missing: any standard at all addressing what happens after a client misses an appointment.

Section 7.0, Lost-to-Follow-Up Outreach

STANDARD (as written)	DOCUMENTATION (as written)
"Has had no direct contact with the service provider agency for 12 months despite repeated outreach attempts."	"All contact attempts and communication methods must be documented."

Does not meet consumer needs, as written. The 12-month window itself is actually better for clients than the state's 3-month minimum, giving people more time to come back before their case closes. But the document never says how many outreach attempts are required or how often. Without that, an agency could technically comply by contacting a client only once a month for a year, which is much slower than the state's own minimum pace of three attempts per month. Missing: a required minimum number and pace of outreach attempts, not just a longer time window.

STAGE 2: STANDARDS GOVERNING WHO QUALIFIES FOR SERVICES

General Eligibility Requirements, Income

STANDARD (as written)	DOCUMENTATION (as written)
"Have an income at or below 500% of Federal Poverty Level."	"Provide documentation to verify eligibility."

Does not meet consumer needs. This number is wrong. The state raised the income limit to 600% of the Federal Poverty Level effective January 1, 2025, under CDPH HCP Management Memo 25-01. A client between 500% and 600% FPL, who actually qualifies, could be turned away based on this outdated figure. Missing: the correct, current 600% FPL threshold.

Recertification of Eligibility

STANDARD (as written)	DOCUMENTATION (as written)
Not present anywhere in the document.	Not present.

Does not meet consumer needs. This is a complete gap. State policy requires eligibility to be re-checked once a year, on the client's birthday, replacing an older six-month check-in requirement. Without a stated standard, agencies could default to the outdated, more burdensome six-month cycle, or fail to recertify clients at all. Missing: any recertification standard.

Self-Attestation and Existing Records

STANDARD (as written)	DOCUMENTATION (as written)
"Service provider agencies are expected to follow the... DHSP guidance for using self-attestation forms."	Not specified further.

Does not meet consumer needs, as written. The document only mentions one documentation shortcut, self-attestation. State policy also allows agencies to use existing records already on file with ADAP, Medi-Cal, or state tax filings to confirm eligibility, without making the client produce new paperwork. Missing: the option to use existing state records instead of new documentation.

HIV Status and Residency Documentation

STANDARD (as written)	DOCUMENTATION (as written)
"Be diagnosed with HIV or AIDS with verifiable documentation... Be a resident of Los Angeles County."	"Provide documentation to verify eligibility, including HIV diagnosis, income level, and residency."

Does not meet consumer needs, as written. "Verifiable documentation" isn't defined. The state's actual list is specific and includes a protective rule: a single positive HIV antibody test should not delay a client's access to care, since most people with one positive test do have HIV. Missing: the specific list of acceptable documents, and the single-test rule that prevents unnecessary delay for newly diagnosed clients.

Appendix A, Home and Community-Based Health Services

STANDARD (as written)	DOCUMENTATION (as written)
Listed simply as a Core Medical Service, with no separate eligibility note.	Not specified.

Does not meet consumer needs. When this specific service is funded through the state's Medi-Cal Waiver Program, it comes with much stricter requirements: full Medi-Cal eligibility, a nursing-facility-level care certification, and a cognitive/functional score at or below 60. A client could be told they qualify for this service, then be denied later once these separate criteria are applied. Missing: a note explaining that this specific service has its own, stricter eligibility gate.

Immigration Status

STANDARD (as written)	DOCUMENTATION (as written)
Not present anywhere in the document.	Not present.

Does not meet consumer needs. This is a complete gap, and possibly the most consequential one. Both HRSA PCN 21-02 and the state's Common Standards affirmatively state that immigration status does not affect eligibility, and that this information should not be shared with immigration enforcement. None of this appears anywhere in a document that's supposed to reassure clients about how to access care. Missing: a plain, written statement of this protection.

Veterans and Indian Health Service Clients

STANDARD (as written)	DOCUMENTATION (as written)
Not present anywhere in the document.	Not present.

Does not meet consumer needs. Federal policy specifically prohibits denying services to a veteran with VA benefits, or to an eligible American Indian/Alaska Native client, just because they could also get care elsewhere. Neither protection appears in the document. Missing: both named protections.

Insurance Screening / Payer of Last Resort

STANDARD (as written)	DOCUMENTATION (as written)
Not stated as an actual intake step anywhere in the document.	Not specified.

Does not meet consumer needs, as written. Ryan White funding is only supposed to be used when no other coverage, like Medi-Cal or Covered California, can pay first. The state requires an actual insurance-status screening and documentation step to prove this. The document never turns this into an actual task for intake staff. Missing: a real insurance-screening and documentation requirement.

STAGE 3: STANDARDS GOVERNING HOW CARE IS ACTUALLY DELIVERED

Section 2.0, Telehealth Choice

STANDARD (as written)	DOCUMENTATION (as written)
"Clients have the right to choose whether to use telehealth or in-person services... and appointments must follow the client's preferred mode of care."	"Written checklists or 'how-to' guides before telehealth visits."

Partially meets consumer needs. The core right to choose is correctly stated and matches state law (Welfare and Institutions Code § 14132.725). But the state's fuller policy also says telehealth must never replace in-person care a client actually needs, and must not cut a client off from their community. Missing: the explicit rule that telehealth is a choice, not a substitute for necessary in-person care.

Section 1.0, Confidentiality and Release of Information

STANDARD (as written)	DOCUMENTATION (as written)
"Service provider agencies must have a Release of Information form that specifies the receiving party, the information shared, the duration of consent, and the client's signature."	"Completed Release of Information form on client file."

Does not meet consumer needs. The state actually requires three separate consent forms for three separate purposes, not one form covering everything. More importantly, the state has an absolute rule that mental health, substance use, and legal services information is never shared between providers, no matter what the client consents to. This document doesn't mention that protection at all. Missing: the three-form structure, and the absolute non-sharing rule for the most sensitive categories of information.

Section 4.0, Interpreters

STANDARD (as written)	DOCUMENTATION (as written)
"Ensure interpreters are competent; avoid using untrained individuals or minors."	Written policy and documentation at service provider agency.

Partially meets consumer needs. Correctly bans untrained interpreters and minors. But the state adds two conditions this document skips: HIPAA-covered services must use HIPAA-compliant interpretation, and even outside of that, family or friends should only interpret as a last resort and only with the client's specific permission. Missing: both of those conditions.

Section 3.0, Staff Training

STANDARD (as written)	DOCUMENTATION (as written)
"Staff participate in training relevant to their job duties, program needs, and the Ryan White Program service category."	"Documentation of completed training on file."

Does not meet consumer needs. No deadline, no required topics. The state requires training within 60 days of hire covering four specific areas (general HIV knowledge, navigating the local system of care, confidentiality/security, and cultural competence), plus a confidentiality agreement staff must re-sign every year. None of that is in this document. Missing: the 60-day deadline, the four required topics, and the annual confidentiality re-signature.

Unallowable Costs

STANDARD (as written)	DOCUMENTATION (as written)
Not present anywhere in the document.	Not present.

Does not meet consumer needs. This is a complete gap. Ryan White funds specifically cannot pay for PrEP, non-occupational PEP, cash payments to clients, and several other categories. This matters because the document's own status-neutral framework promotes connecting HIV-negative clients to PrEP, without ever saying this funding source can't pay for it. Missing: any list of what these funds cannot cover, and a note on where to actually get PrEP paid for instead.

Section 1.0, Workplace Safety and ADA Compliance

STANDARD (as written)	DOCUMENTATION (as written)
"Service provider agencies must follow all relevant state and federal workplace and safety laws and all sites must meet ADA accessibility requirements."	"Signed confirmation of compliance with applicable regulations."

Meets consumer needs. This correctly and fully requires compliance with disability access and workplace safety law without any gap that would put a client at risk. No missing element identified here.

Progress Notes / ARIES

STANDARD (as written)	DOCUMENTATION (as written)
"Service provider agencies must keep clear, legible progress notes for each client that document every communication or service provided."	"Progress notes maintained in individual client files."

Does not meet consumer needs, as written. This never mentions ARIES, the state's required system that other agencies rely on to coordinate a shared client's care, or the state's two-week data-entry deadline. Missing: a standard connecting progress notes to timely ARIES entry.

STAGE 4: STANDARDS GOVERNING HOW CLIENTS ARE FOLLOWED UP WITH AND PROTECTED

Appendix B, Grievance Response Time

STANDARD (as written)	DOCUMENTATION (as written)
"Receive a response to any complaint or grievance withing 45 days."	Not specified further.

Partially meets consumer needs. Fine for a purely Ryan White complaint. But a client whose issue also touches their Medi-Cal managed care plan has a shorter, 30-day appeal deadline under federal Medicaid rules, and could lose that window while still waiting on the 45-day response here. Missing: a note that Medi-Cal-related complaints may have a shorter, separate deadline.

Appendix B, Complaint Channel

STANDARD (as written)	DOCUMENTATION (as written)
"Be informed about external ombudsman or advocacy resources, including how to reach relevant federal complaint centers (CMS)."	Not specified further.

Does not meet consumer needs. CMS does not oversee the Ryan White Program and cannot actually help with a Ryan White complaint. The correct contact is HRSA's HIV/AIDS Bureau, or, for Medi-Cal Waiver-funded services specifically, a State Fair Hearing. Missing: the correct agency name, and the separate State Fair Hearing pathway for Waiver-funded services.

Section 7.0, Case Closure Window

STANDARD (as written)	DOCUMENTATION (as written)
"Has had no direct contact with the service provider agency for 12 months."	Documented contact attempts.

Meets and exceeds consumer needs. As noted in Stage 1 above, the 12-month window itself is more generous than the state's 3-month minimum, giving clients more time before a case can be closed. The related gap, missing attempt-frequency requirements, is addressed separately above.

"Inactive" Status for Temporary Absences

STANDARD (as written)	DOCUMENTATION (as written)
Not present anywhere in the document.	Not present.

Does not meet consumer needs. The state allows a middle option, marking a file "inactive" rather than permanently closing it, specifically for situations like incarceration where a client is expected to come back. This document only has one tool: permanent closure. Missing: an inactive-status option, which matters most for clients returning from incarceration, exactly when they need continuity of care most.

Section 7.0, Notice Before Disenrollment

STANDARD (as written)	DOCUMENTATION (as written)
"A sequence of verbal and writer[sic] warnings before final notice and case closure."	Due Process policy kept on file.

Does not meet consumer needs, as written. Too vague. The state requires at least 10 days' notice before a forced disenrollment, and a specific letter stating the exact date, the exact reason, and how to appeal. This document doesn't require any of those specifics. Missing: the 10-day minimum notice, and the required letter contents.

Record Retention and Destruction

STANDARD (as written)	DOCUMENTATION (as written)
Not present anywhere in the document.	Not present.

Does not meet consumer needs. This is a complete gap. The state requires closed client files to be kept for at least three years plus the current year, then destroyed securely, such as by cross-cut shredding. This document only addresses security for active files, not what happens after a case closes. Missing: a retention period and secure destruction standard for closed files.

Section 2.0, Client Input

STANDARD (as written)	DOCUMENTATION (as written)
"Service provider agencies collect and incorporate input from PLWH to ensure services are client-centered."	Written documentation showing how client input is collected and used.

Does not meet consumer needs, as written. States a goal without a method. The state requires this on an annual basis and names three acceptable mechanisms: a client advisory board, a locked suggestion box, or a satisfaction survey. Missing: the annual requirement and the specific mechanism options.

Transition from the Medi-Cal Waiver Program

STANDARD (as written)	DOCUMENTATION (as written)
Not present anywhere in the document.	Not present.

Does not meet consumer needs. This is a complete gap. The state's own Medi-Cal Waiver Program document names Ryan White as the intended next stop for a client who is disenrolled after hitting their $33,937 annual cost cap. This document has no corresponding standard for receiving those clients quickly or coordinating the handoff. Missing: an expedited-intake standard for clients arriving after a Medi-Cal Waiver cost-cap disenrollment.

CLOSING STATEMENT

Lastly, I have the following additional comments related to the Universal Service Standards and Client Bill of Rights and Responsibilities:

None of the standards reviewed above can currently be checked against real-world performance, because the County's own public HIV surveillance reports, the 2025 HIV Snapshot and the 2024 Annual HIV Surveillance Report, do not track the specific 10-day referral-to-appointment window, the specific eligibility criteria discussed above, or most of the other gaps identified in this comment. The closest public measure, one-month linkage to care from diagnosis, already shows the County missing its own target in every Health District, which raises real concern about what a more precise, referral-specific measure would show.

I would welcome the opportunity to walk through these examples, section by section, with the Committee before the standards are finalized.

Respectfully submitted this 16th day of August 2026.

/s/ Jeffrey Young

Jeffrey Young
INVANTAS Solutions LLC
1001 Wilshire Boulevard #1299
Los Angeles, CA 90017-2821
E-mail: jeffrey.young@invantasllc.com
Telephone: 323-784-0100

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH (CDPH) OFFICE OF AIDS (OA)

HIV CARE PROGRAM (HCP) SERVICE STANDARDS

Common Standards

Version #	Implemented By	Revision Date	Approved By	Approval Date	Reason
1.0	*OA Workgroup*	*6/10/2018*	*Marjorie Katz*	*6/10/2018*	*First public working draft*
1.1	*OA Workgroup*	*5/1/2020*	*Jessica Heskin*	*7/31/2020*	*Final public version*
1.2	*Care Program Section*	*2/4/2022*	*Karl Halfman*	*3/21/2022*	*Changes due to PCN 21-02*

* Areas that have been changed are highlighted yellow

Table of Contents

Introduction

This document describes the “Common Standard” for all services of the HIV Care Program (HCP), a program of the California Department of Public Health (CDPH), Office of AIDS (OA), funded through the Health Resources and Services Administration (HRSA), Ryan White HIV/AIDS Program (RWHAP) Part B.

This document highlights each of the requirements and standards that must be followed by any provider receiving HIV Care Program (HCP) (RWHAP Part B) funding. Common standards addressed here include client eligibility and consent, staffing, cultural and linguistic competency, service management and closure, and quality assurance. These standards must be met or exceeded for all HCP services in all jurisdictions.

Providers must adhere to any service category-specific standards described in the service standard for that service category. Users should refer to service category-specific standards for more detailed or additional requirements. Monitoring is conducted on a yearly basis through desk review and onsite monitoring.

How This Document is Organized

Within this document, the Common Standards are described in terms of (1) Use of HCP Funds and (2) Requirements.

Use of HCP Funds

1. All clients served by providers funded by HCP shall receive services that:
    - Are accessible to all persons living with HIV who qualify and meet eligibility requirements
    - Include a comprehensive intake process that establishes client eligibility, collects client information, and comprehensively informs them about available services
    - Maintain the highest standards of care, including providing experienced, trained, and (as appropriate) licensed staff
    - Are culturally and linguistically competent
    - Guarantee client confidentiality, protect client autonomy, and protect the rights of persons living with HIV
    - Promote continuity of care, client monitoring, and follow-up
    - Ensure a fair process of grievance review and advocacy
2. Providers must make reasonable efforts to secure non-RWHAP funds whenever possible for services to eligible clients (i.e., RWHAP must be the “payer of last resort”).

3. HCP funds are intended to support only the HIV-related needs of eligible individuals. An explicit connection must be made between any service supported with HCP funds and the intended client's HIV status.
4. Affected individuals (partners and family members not living with HIV) may be eligible for HCP services in limited situations, but these services for affected individuals must always directly benefit people living with HIV. For more information see HRSA PCN 16-02 and ARIES Policy Notice C5.

Unallowable Costs

HCP funds may not be used to make cash payments to intended clients of HCP-funded services. This prohibition includes cash incentives and cash intended as payment for HCP core medical and support services.

Other unallowable costs include:

- Clothing
- Employment and Employment-Readiness Services,
- Funeral and Burial Expenses
- Property Taxes
- Pre-Exposure Prophylaxis (PrEP)
- non-occupational Post-Exposure Prophylaxis (nPEP)
- Materials, designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual
- International travel
- Travel outside of California
- The purchase or improvement of land
- The purchase, construction, or permanent improvement of any building or other facility

Requirements

Eligibility Determination

The eligibility determination process verifies that a client's HIV status, residency, and income meet HCP eligibility requirements. HCP subrecipients are expected to establish, implement, and monitor eligibility determination policies and procedures for their providers.

Frequency

Eligibility must be determined at initial enrollment and recertified at the client's birthdate following initial enrollment and every year thereafter.

Rather than using the enrollment date, HCP now aligns with the AIDS Drug Assistance Program's (ADAP) use of the client's birthdate for recertification. This change may require two eligibility determinations within the client's first year of service. To illustrate:

Client Birthdate	Initial Enrollment Date	First Recertification Occurs	Subsequent Recertifications
January 15	April 15, 2022	January 15, 2023 (at 9 months)	Every 12 months thereafter on birthdate
April 15		April 15, 2023 (at 12 months)	
July 15		July 15, 2022 (at 3 months)	
October 15		October 15, 2022 (6 months)	

Though HRSA's Policy Clarification Notice 21-02 eliminated the six-month recertification requirement, it is strongly recommended that subrecipients adopt best practices to periodically check for changes to clients income or residence throughout the year. Such practices may include updating language in Client Rights and Responsibility form (see page 13) to require clients to report changes in their income or residence, asking clients when they check in at each visit if there are changes in eligibility, etc.

General Principles for Documentation

Complete eligibility documentation is required for annual recertification. Documentation does not need to be presented by the client in person. Clients may provide legible original, scanned, or photocopied documents via fax, e-mail, or in person. Documents do not need to be notarized.

HCP providers may also use data from "ex parte" sources to determine eligibility for any of the three eligibility requirements detailed below. Ex parte data sources may include state tax filings, Medi-Cal enrollment information, and AIDS Drug Assistance Program (ADAP)[1] eligibility information. HCP providers who utilize ex parte data must:

[1] Health and Safety Code (HSC) § 120970 states in part: "All types of information, whether written or oral, concerning a[n ADAP] client, made or kept in connection with the administration of ADAP services… shall be confidential, and shall not be used or disclosed except for any of the following: … (2) For coordinating client eligibility with programs funded by the federal Ryan White HIV/AIDS Program (Ryan White HIV/AIDS Treatment Extension Act of 2009)…"

- Maintain a copy of the document from the ex parte data source in the client's paper or digital chart for inspection during site monitoring and
- Enter the individual data elements from the ex parte data source into ARIES so that the data may be reported to HRSA in the provider's annual Ryan White Services Report (RSR). For example, because the provider must be able to report a client's actual FPL, that a client is enrolled in ADAP is not sufficient information for the RSR.

Eligibility Criteria

Eligibility certification includes documentation of the following:

- **HIV-positive status:** At the initial enrollment, clients must provide proof of HIV-positive status. Once HIV status is verified, providers should not request HIV documentation during future recertifications. Acceptable documentation includes the following:
    - HIV positive lab results (antibody test, qualitative HIV detection test, or detectable viral load). Lab results with undetectable viral loads that do not indicate a positive HIV diagnosis will not be accepted during initial enrollment as proof of positive HIV diagnosis.
        - ***Note:*** Having positive results from only one HIV antibody test should not be a barrier to linkage to care to a RWHAP-funded clinic, or other HIV care providers, since the majority of people receiving a positive result from a single test have HIV infection and would benefit from quick linkage to ongoing care and prevention services. The receiving medical clinic must be informed of the individual's unconfirmed preliminary positive HIV test result and the need for confirmation. RWHAP-funded clinics that receive such individuals may choose to arrange an abbreviated first appointment during which the individual receives counseling about HIV testing and a limited evaluation that includes confirmatory HIV testing and potentially other HIV labs. For more information, see *Dear Colleague Letter of February 25, 2013.*
    - Letter from the client's physician or licensed health care provider. Acceptable letters of diagnosis must be on the physician's or health care provider's letterhead with the National Provider Identifier (NPI) number or California license number, and the physician's or a licensed health care provider's signature verifying the client's HIV status.
        - Letters already in client charts that do not meet this standard are grandfathered in; this requirement for letters applies to new intakes conducted after April 1, 2018.

- Diagnosis Form (CDPH 8440) completed and signed by the client's physician or licensed health care provider. Any diagnosis form that contains pertinent information is also allowed.

- **Residence:** Individuals eligible for HCP services must reside in the State of California. Acceptable residency verification consists of the client's name and address on one of the following:
  - California driver's license or California Identity Card
  - Dated within the last 30-days:
    - California rent or mortgage receipt
    - Current utility bill with the service address listed in California (a cell phone bill is not acceptable)
    - Employment paycheck stub
  - Dated within one year:
    - Rental/lease agreement or annual lease renewal documentation
    - Voter registration card
    - Vehicle registration (not expired)
    - W-2 or 1099 (prior tax year documents will be accepted until February 15th. After February 15th, only current tax year documents will be accepted.)
    - Social Security/Disability Award Letter (SSI, SSDI)
    - California Employment Development Department (EDD) award letter
    - Filed State or Federal tax return
    - Public housing letter on official letterhead from Housing and Urban Development (HUD) or a county agency
    - Notice of Action from the Department of Health Care Services
    - Medi-Cal beneficiary letter
    - School records
    - Property tax receipt
    - Unemployment document
  - Letter from a shelter, social service agency, or clinic verifying individuals' identity, length of residency, and location designated as

their residence. The letter must be on letterhead and signed by a staff person affiliated with the service agency or clinic

- If no other methods of verification are possible, a completed Residency Verification Affidavit (CDPH 8727, CDPH 8727 SP) or a letter signed and dated by the client that indicates they are homeless with no connection to any other service provider. In this situation, a referral to assist the client in securing shelter or housing should be a priority.
- ***Note:*** *Immigration status is irrelevant for the purposes of eligibility for HCP services. HCP subrecipients or subcontractors should not share immigration status with immigration enforcement agencies.*

- **Income:** Clients must provide documentation of all forms of income and meet the income requirements. HCP financial eligibility matches the financial eligibility defined by ADAP in HSC § 120960. Currently, HSC § 120960 defines income eligibility as clients with modified adjusted gross income which does not exceed 500 percent of the federal poverty level (FPL) per year based on family size and household income. Acceptable income verification includes one of the following:
  - Pay stubs
    - Three consecutive months of current paystubs, or
    - If employed more than one year, one paystub showing Year-To-Date (YTD) earnings that includes at least three months of income, or
    - If employed less than one year, one paystub showing YTD earnings that includes at least three months of income and lists the employment start date
  - Private disability award letter (dated within one year)
  - Supplemental Security Income (SSI) award letter (dated within one year)
  - Social Security Disability Income (SSDI) award letter (dated within one year)
  - Bank statement showing direct deposit of Unemployment Insurance, SSI/SSDI benefits. Statement must be dated within one month and clearly identify the deposit/income source (e.g., US Treasury, SSA)
  - State Disability Insurance (SDI) award letter (dated within one year)
  - Social Security Retirement Benefit award letter (dated within one year)

- Retirement/Pension award letter (dated within one year)
- Unemployment Insurance (UI) award letter (dated within one year)
- Spousal support court documentation
- Worker's Compensation award letter (dated within one year)
- Investment income documentation (e.g., statement or portfolio summary dated within one month)
- Veteran's Administration (VA) Benefits award letter (dated within one year)
- Rental income documentation (e.g., a signed rental agreement dated within the last year or three current bank statements showing rental income deposits)
- If self-employed, provide a completed Self-Employment Affidavit form (CDPH 8726, CHPH 8726 SP)
- If no other methods of verification are possible, a completed Income Verification Affidavit (CDPH 8441, CDPH 8441 SP) or a letter signed and dated by the client that indicates zero income, or attests to earned income not otherwise confirmed by the above..

- **Screening for Services Needs:** At the time of client intake into any HCP service, the client shall be screened for the need for other services, including but not limited to: medical care, case management, housing, food, mental health, substance use issues, transportation, and benefits counseling. Screening for services can be done using the tools and/or scales of the local jurisdiction, but tools/scales must be consistent within the jurisdiction. Referrals should be made for any services identified as needed but not offered by the screening agency; referrals should be performed utilizing a warm hand off when possible. All referrals must be documented.

ARIES Reference

Proof of Diagnosis Eligibility Tab Eligibility Documents Sub-tab Pick one: 1. HIV Letter of Diagnosis 2. Proof of Diagnosis Upload copy of corresponding document	Residency Eligibility Tab Eligibility Documents Sub-tab Pick one: 1. Picture ID 2. Proof of Residency

ARIES Policy Notice No. C3	
Income Eligibility Tab Financial Sub-tab Enter: Household Monthly Income # of People in Household	Insurance Eligibility Tab Insurance Sub-tab Click *New* Enter: Start Date Source Payer *ARIES Policy Notice No. C4*

Monitoring

Eligibility Screening - Client eligibility, including HIV-positive status, residency, income, and insurance status must be entered into ARIES. Documentation of service needs must be documented in client chart(s) and made available during site visits

Annual Recertification - Annual recertification of residency, income, and insurance status must be documented in ARIES. Agencies must have updated documentation of these elements in client chart(s), available for review upon request.

Fiscal Responsibility

Payer of Last Resort

Federal legislation states that RWHAP funds are the payer of last resort. This means that no HCP funds can be used for services that could reasonably be paid for or provided by another funding source.

While insurance status is not a program eligibility requirement, providers must screen all clients who receive services that may be billed to third parties. Documentation of insurance status must be entered into ARIES. Acceptable verification of clients' insurance status includes any of the following:

- Copy of current insurance card, including Medi-Cal Beneficiary Identification Card (BIC) if applicable
- Dated screenshots of client insurance status verification using an official insurance screening system
- Denial letter from Medi-Cal
- Statement signed and dated by the client indicating they are not covered by insurance. If client is employed, the statement must include the reason the employer does not provide insurance

Providers should document their efforts to "vigorously pursue" enrolling clients in comprehensive health care coverage (such as Medi-Cal or Covered California). For

more information, please see Management Memo 14-01. All providers should refer clients to Covered California if there is no other insurance option available and the client does not qualify for Medi-Cal. Consult with the Covered California website for specific enrollment periods and special circumstances for client enrollment. Providing benefits counseling to clients must involve working with eligibility workers from other programs to assist HCP clients with the process of signing up for those programs.

Department of Veterans Affairs (VA) – HCP service providers may not deny services, including prescription drugs, to a veteran with VA benefits who is otherwise eligible to receive HCP services. HCP can pay for services that are unavailable from the VA. For more information see HRSA Policy Clarification Notice 16-01.

Indian Health Services (IHS) – Any American Indian or Alaska Native who is otherwise eligible to receive RWHAP-funded services may request and must receive those services regardless of whether or not they are also eligible to receive the same services from the IHS. For more information see HRSA Policy Clarification Notice 07-01.

RWHAP may be utilized to pay for services even if covered by another entity in special situations, such as a medically necessary appointment that is not available in a timely manner, necessary services beyond a client's current health coverage, or copays not covered by a client's insurance. Service providers must provide documentation of the need for additional services beyond what the client's health care coverage or other benefits provide.

PCN 21-02 clarifies subrecipients "are expected to develop protocols to facilitate the rapid delivery of RWHAP services, including the provision of antiretrovirals for those newly diagnosed or re-engaged in care. If services are initiated prior to eligibility being established, RWHAP subrecipients must conduct a formal eligibility determination within a reasonable timeframe and reconcile (i.e., properly account for) any RWHAP funds to ensure that they are only used for allowable costs for eligible individuals."

Monitoring

Compliance with "Payer of Last Resort" requirements and verification of clients' insurance status will be monitored via discussion and clients' chart review during site visits.

Consents

Prior to receiving services, clients must sign the following consent forms:

- **Agency Consent for Service:** At the initiation of services the client must sign a consent form indicating they consent to receiving services from the agency.

- **ARIES Consent:** Providers must obtain a completed ARIES Consent Form for each client and log the form into the Eligibility Documents screen in ARIES. Clients must indicate whether they want to share their ARIES data with other ARIES-using agencies at which they receive services. Information shared may include demographics, contact information, medical history, and service data. However, data related to mental health, substance use issues, and legal services are never shared between service providers regardless of the client's share choice.
    - The form must be renewed once every three years or whenever clients want to change their data-sharing choice. For more information, refer to ARIES Policy Notice C1 on Client Consent and Share Options.

On an as-needed basis, the following must also be documented via forms signed by the client:

- **Consent to Release Confidential Information (not the same as ARIES Consent Form):** When disclosure of confidential information is requested by the client or required for care coordination or other necessary components of high-quality service provision, the client must be informed of this intent to share information and must provide written consent before the information is shared. All documentation of consent to release confidential information should specifically note what information can be shared, to whom it may be shared, and the time-limit within which the sharing may take place.
- **Authorization to Exchange Confidential Information (not the same as ARIES Consent Form)**: Similar to the consent to release confidential information, when appropriate, clients may also provide consent for regular exchange of information about their case between providers as it helps with care coordination. Again, the client must provide written consent **before the information is shared**. All documentation of consent to release confidential information should specifically note what information can be shared, to whom it may be shared, and the time-limit within which the sharing may take place.
    - **Note:** Case conferencing between staff of the same organization which takes place on a regular basis and is a standard part of many HCP services does not require additional authorization. However, if staff from outside the organization are needed to conduct thorough case conferencing, prior authorization to exchange information would be required.

All signed consents must be kept in the client's file, and the client must receive a copy.

ARIES Reference

ARIES Consent Form

Eligibility Tab

Eligibility Documents Sub-tab

Pick ARIES Consent Form / Enter date

Share Option

Agency Specifics Tab

Agrees to Share Date / Select Yes or No

Monitoring

Agency Consent for Service - Signed consent forms shall either (1) be uploaded to ARIES, or (2) retained in client chart(s) and available for review upon request.

ARIES Consent - ARIES Consent Forms must be logged into ARIES and the Share option must reflect the client's choice as reflected on the form. For more specifics, see ARIES Policy Notice C1.

Authorization to Exchange Confidential Information - Documentation of consent to release or exchange confidential information must be retained in client chart(s) and available for review upon request.

Notifications

As a part of HCP services, clients should be notified of the following:

- **Case conferencing** among staff involved in the provision of any of their care occurs regularly as a standard part of HCP services
- **Re-engagement services** are routinely provided by this provider and/or the county health department to ensure that clients have uninterrupted access to care services. This requires sharing of contact information as needed for these services
- **After-hours or weekend options** that are available to clients during an emergency (i.e. an on-call number, answering service, or alternative contacts in other agencies)
- **HIPAA:** Clients must be informed of their health information privacy rights under the Health Insurance Portability and Accountability Act (HIPAA) where applicable
- **Client Grievance Procedures:** Clients must be informed of the grievance procedures within their local jurisdiction, and assured that no negative actions will be taken toward them as a client in response to their filing of a grievance

- **Client Rights and Responsibilities**: Clients must receive notice of their rights and responsibilities relative to HCP service provision. This must include the minimum rights and responsibilities outlined later in this Common Standards document.

Clients must receive a written copy of all notifications provided during their first appointment.

Monitoring

Client Notification - Client notification of case conferencing, re-engagement services, and after-hours / weekend emergency options must be documented through submission of agency written forms related to these notifications.

Client Notification with Signature - Client notification of HIPAA, client grievance procedures, and rights and responsibilities must be documented in client chart(s) and available upon request for review. There must be documentation that the client has received these notifications; documentation shall be through client signature that they have received and acknowledged these notifications.

Client Registration into ARIES

ARIES is a centralized, secure, online HIV client management system that allows for coordination of client services among medical care, treatment, and support providers and provides comprehensive data for program reporting and monitoring. ARIES is used by RWHAP-funded service providers throughout California to plan, manage, and report on client data. HCP frequently uses ARIES to conduct monitoring of these Services Standards.

HCP providers must report on the HCP clients they serve using ARIES.

For new clients, HCP providers must explain the "share" options to the client and obtain a signed ARIES Consent Form (see **ARIES Policy Notice C1**). Providers shall also collect the client's identifiers to initiate client registration in ARIES. Identifiers include all of the following:

- First Name
- Middle Initial
- Last Name
- Mother's Maiden Name (see **ARIES Policy Notice C2**)
- Date of Birth
- Current Gender

To initiate ARIES registration, the HCP provider enters these identifiers into ARIES. If the client already exists in ARIES as a share client, ARIES will open the existing client

record for the provider. If the client is non-share or new to ARIES, ARIES will create a new client record for the provider.

While the client is enrolled in the agency, the HCP provider is required to collect and enter into ARIES certain data elements for the annual Ryan White Services Report (RSR). These data elements are identified with large red asterisks in ARIES. For more details about and provider requirements for the RSR, please visit https://careacttarget.org/category/topics/ryan-white-services-report-rsr.

Timeframe

The first appointments for new clients should be made as soon as possible to avoid potential drop out. Appointments must be offered no later than 10 calendar days from first client referral. A referral can be from another professional or self-referral. Agencies must have a tracking method to record when first contact was made so it can be tracked. As clients may miss appointments, agencies must have a process in place to ensure timely follow-up, preferably within 24 hours as client missed appointments have been linked to future poor health outcomes. Missed appointments and attempts to reschedule must be documented in the tracking log or the client chart. For appointments offered later than 10 days from first client referral, the reason for the delay must be documented in client chart.

Monitoring
Timeframe- Procedures for ensuring the first appointment for new clients is offered within 10 days will be reviewed through submission of agency written procedures

Service Access, Management, and Closure

Client Access

Services must be planned and implemented in a way that ensures an accessible environment. Services must:

- Provide adequate accommodation for actual or potential physical, psychological, and psychosocial disabilities and/or impairments
- Not be restricted on the basis of age, gender, sexual orientation, race, ethnicity, disability, past or current health condition, ability to pay fees, residence, or any other discriminatory factors, as applicable, under the California Unruh Civil Rights Act and Disabled Persons Act (except as required for eligibility purposes.)

Service Management

Services must take into account client needs and remove barriers to clients' ability to meet the requirements of their care/treatment plans, as follows:

- Services must be managed to achieve:
    - Accessibility
    - Effectiveness
    - Reliability
    - Timeliness
    - Appropriateness to the needs of clients

Monitoring
Accessibility - Existence of adequate physical accommodation(s) for disabilities and/or impairments of clients, will be verified during site visits.

- Services must include activities and educational resources that promote, facilitate, and encourage client self-management and self-sufficiency, including but not limited to:
    - Access to non-HCP-funded services
    - Resource guides to low-cost/free medical and support services, including those not offered as part of HCP

In addition, services must be transparent and fiscally responsible:

- Services should be planned, managed, and monitored to avoid the need for:
    - Urgent or emergency services
    - Service interruption
    - Needing emergency or unplanned funding to continue services during contract periods.
- Data collection and documentation of all services must be manually entered or imported into ARIES for accounting, reporting, compliance, and evaluation purposes. The optimum goal for entering data into ARIES is in real-time. Some providers may not be able to meet this goal due to staffing levels, lack of computers, or other business practices. Providers that are unable to enter data in real-time have up to two weeks from the service date to enter the data. For more information, please see **ARIES Policy Notice E1**.
- Program directors and managers shall ensure contract compliance with all relevant laws, regulations, policies, procedures, and other requirements designed to enforce service standards and quality.
- Service providers must have a way to obtain client input and feedback on an annual basis. The ideal method would be a “client advisory board” that consists of representation of the population served and provides input to the

delivery of services. In lieu of an advisory board, providers can provide a visible suggestion box which is locked or other similar client input mechanism such as client satisfaction survey.

Monitoring
Client Input – Copies of minutes from annual client advisory board meetings, or client suggestions or surveys will be reviewed during site visit.

Case Closure

In some cases (e.g. a client who is incarcerated for longer than 6 months) a client file may be made "inactive," able to easily be returned to "active" status when the client returns to services as expected. A client file may be permanently "closed" under certain conditions. The reason for and circumstances around all closure actions must be documented in the client file or in ARIES. Acceptable reasons for client file closure include but not limited to:

- The client has requested transfer of services to another agency
- The client has died or moved out of California
    - Providers are strongly encouraged to report clients who have died or moved out of California to the HIV surveillance coordinator at the local public health department. This will allow the coordinator to update the surveillance system and ensure that the county's data accurately reflect who is in care.
    - Providers should attempt to assist the client with identifying a source of care in the jurisdiction they are moving to.
- The client is lost to follow-up if the client cannot be located after at least three documented attempts per month over a period of three consecutive months. Attempts to contact the client must take place on different days and times of the day during this time period.
    - Providers are strongly encouraged to refer clients who are lost to follow-up to the local public health department for further outreach and re-engagement in care activities.
- RWHAP subrecipients should not disenroll clients until a formal confirmation has been made that the client is no longer eligible
- The client's actions have put the agency, staff, and/or other clients at risk
- There is evidence of client fraud or deliberate misuse of services

- Additional service-specific circumstances for closing a client file may be found in the Service Standard for an individual service.

How to Close a File: Agencies should close a client's file according to the written procedures established by the agency.

- **Prior to closure** (for reasons other than death), the agency must attempt to inform the client of the appeal process and re-entry requirements into the system, make clear to the client the consequences of closing the case, and offer to facilitate transfer of information to a new provider.
- **Prior to forced disenrollment and case closure due to evidence of abusive behavior, client fraud, deliberate misuse of services, or program ineligibility**, the client must:
    - Be given at least 10 days' notice before disenrollment, except in cases of abusive behavior that poses serious physical danger to staff or clients
    - Be sent a letter that verifies the disenrollment date and reason for the action, along with information about the procedure for grievance/appeals. This letter must be legible, signed, and dated, and a copy must be kept in the client record

Record Maintenance: Client files must be retained in a secure place for a minimum of three years plus the current year, or later as is required by law for your facility type, after a case is closed. After that time period, they must be disposed of securely through confidential means such as cross cut shredding and pulverizing.

Monitoring

File Closure - Appropriateness of file closure will be monitored via chart review during in-person site visits. Agency procedures for file closure, as well as compliance with record maintenance standards, will be monitored through agency submission of applicable written procedures.

Client Right and Responsibilities

Information in this section must be included in a client Rights and Responsibilities form. Clients must sign an acknowledgement of having received this information.

<u>All eligible clients have the right to:</u>

- Request and receive approved services consistent with their care/treatment plan
- Receive services that are reliable, timely, respectful, and appropriate to their situation, culture, health status, and level of disability

- Clients have the right to freedom from discrimination because of age, race, ethnicity, gender, disability, religion, sexual orientation, veteran status, or any other protected class.
- Receive accurate and easily understood information about their care plan, health care professionals, and health care facilities
- Participate in decisions about their care and obtain information about treatment options
- Refuse care
- Have their healthcare information be treated confidentially
- Review their client records (including medical records) and request that any inaccurate, irrelevant, or incomplete information be changed as per local policies and procedures.

Clients are responsible for:

- Providing documentation to verify their eligibility for HCP services
- Being involved in their healthcare and adhering to their treatment plan
- Disclosing relevant information
- Clearly communicating their wants and needs
- Treating service providers appropriately and with respect at all times
- Arranging services in a way that avoids emergencies whenever possible
- Maintaining periodic contact with their relevant service provider
- Following provider written policies and procedures and guidelines
- Following written or verbal instructions regarding treatments, activities, safety policies, and utilization of services

Monitoring

Client Rights and Responsibilities – A copy of the client form outlining Client Rights and Responsibilities must be provided. Review of client acknowledgment will be done via chart reviews.

Staffing Requirements and Qualification

Education/Experience/Supervision

All staff must hold the appropriate degrees, certification, licenses, permits or other qualifying documentation as required by Federal, State, County, local authorities, or HCP Service Standards. See each specific service standard for detailed requirements by service.

Monitoring

Staff Education and Experience - Proof of required staff degrees, certification, licenses, permits, or other qualifying documentation must be available for review during site visits.

Staff Orientation and Training

Initial: All staff providing direct services to clients or making decisions about HIV service must complete an initial training session related to their job description and serving those with HIV. Training should be completed within 60 days of hire. Time and cost associated with training can be charged to the service category under which the staff is billed in the budget. Topics must include:

- General HIV knowledge, such as transmission, care, and prevention
- Navigation of the local HIV system of care, including ADAP
- Confidentiality and Security
- Cultural sensitivity, including but not limited to LGBTQ cultural competence, cultural humility, and social determinants of health

Other topics may include:

- Psychosocial issues
- Health maintenance for people living with HIV
- Client service expectations

Ongoing: Staff must also receive ongoing annual HIV training as appropriate for their position. Confidentiality agreements by staff must be reviewed and re-signed annually. Training requirements and updated confidentiality agreements must be clearly documented and completed trainings must be tracked for monitoring purposes.

Monitoring

Staff Orientation and Training - Agencies must maintain a comprehensive list of staff with hire date, all trainings provided, dates of trainings, and dates of refreshed confidentiality agreements; this list must be available for review during site visits or upon request.

Cultural and Linguistic Competency

According to the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards), culturally and linguistically competent services are those that “provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs

and practices, preferred languages, health literacy and other communication needs." Providers shall provide services that:

- Treat people living with HIV with respect, and are skilled and culturally-appropriate for the communities served
- Reflect the culture of the community served
- Comply with American Disabilities Act (ADA) criteria
- Are in a location and have hours that make it accessible to the community served
- Are provided in the client's primary language. If that language is not English, interpretation must be provided by a staff member or other means
- Are provided in areas with posted and written materials in appropriate languages for the clients served
- Provide interpreters or access to real-time interpreter services (including phone, Skype, etc.) For HIPAA covered services, interpretation services must follow HIPAA requirements; family and friends should not be used for interpretation. For non-HIPAA covered services, family and friends should only provide interpretation as a last resort and with the prior permission of the client.

Monitoring

Culturally and Linguistic Competency - Compliance with CLAS Standards, including ADA criteria and accessible location/hours of services, will be monitored via discussion during site visits.

Quality Assurance

Service Evaluation

Each service provider is responsible for evaluating and reporting its performance relative to care standards, and is subject to client chart, utilization, and other types of audits. Service providers must:

- Collect and examine client satisfaction data, and have a process to act on the information reported
- In response to any findings as part of routine HCP monitoring, develop and implement a Corrective Action Plan (CAP)
- Maintain a grievance procedure which provides for the objective review of client grievances and alleged violations of care and service standards

- Clients must be routinely informed about and assisted in utilizing this procedure
- Clients must not be discriminated against for utilizing the grievance procedure

- Have a client complaint procedure which addresses issues not appropriate to the grievance procedure. Complaints will be investigated and responded to in a timely and respectful manner according to local written policies and procedures. Documentation of investigation and response should be maintained in writing and kept separate from the regular client file

Monitoring

Quality Assurance –A copy of the Grievance Policy must be provided to HCP. Oversight of submitted client grievances will occur during site visits. The Grievance Policy may be incorporated into the Client Rights and Responsibility form

Clinical Quality Management- For clinical services, comply with requirements in the California Ryan White Part B Clinical Quality Management Plan

HIPAA Compliance and Non-HIPAA/HITECH Contractors/Providers

- All providers of HIPAA-covered services will comply with the HIPAA of 1996. All HIPAA regulations must be followed when interacting with or on behalf of a client, and with regards to record maintenance.
- All non-HIPAA covered contractors and providers (including tax preparation professionals, accountants, law firms, etc.) must comply with the Information Privacy and Security Requirements set forth in the HCP/Minority AIDS Initiative contract.
- All contractors, sub-contractors and providers must have their employees and volunteers sign the Agreement by Employee/Contractor to Comply with Confidentiality Requirements (CDPH 8689) upon hire prior to having access to any confidential information and on an annual basis thereafter.

Monitoring

Confidentiality Compliance - Signed agreements to comply with confidentiality requirements (CDPH 8689) must made available during site visits.

Determining Client Eligibility & Payor of Last Resort in the Ryan White HIV/AIDS Program

Policy Notice 21-02 (Revised 03/13/25)
Replaces Policy Number 13-02 Clarifications on Ryan White Program Client Eligibility Determinations and Recertification Requirements

Effective Date

The effective date of this PCN is October 19, 2021.

Scope of Coverage

This PCN applies to RWHAP Parts A, B, C, D, and Part F when funding supports direct care and treatment services. As of the effective date, this PCN applies to competing continuation, non-competing continuation, and new awards.

Purpose of Policy Clarification Notice

This Policy Clarification Notice (PCN) outlines the Health Resources and Services Administration's (HRSA) HIV/AIDS Bureau (HAB) guidance for Ryan White HIV/AIDS Program (RWHAP) recipients and subrecipients for determining client eligibility and complying with the payor of last resort requirement, while minimizing administrative burden and enhancing continuity of care and treatment services. RWHAP recipients (including the Part B AIDS Drug Assistance Program) and subrecipients may adopt additional requirements for eligibility as necessary for program administration, considering this purpose.

Eligibility Requirements for RWHAP Services

People are eligible to receive RWHAP services when they meet each of the following factors:

1. *HIV Status*
   - A documented[1] diagnosis of HIV. (Note: People who do not have an HIV diagnosis are eligible to receive certain services as outlined in HRSA HAB PCN

[1] HIV Clinical Guidelines: Adult and Adolescent ARV. https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/whats-new-guidelines

16-02 *Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds*,[2] and as otherwise stipulated by HRSA HAB.)

2. *Low- Income*
   - The RWHAP recipient defines low-income. Low-income may be determined based on percent of Federal Poverty Level (FPL),[3] which can be measured in several ways (e.g., Modified Adjusted Gross Income,[4] Adjusted Gross Income, Individual Annual Gross Income, and Household Annual Gross Income).

3. *Residency*
   - The RWHAP recipient defines its residency criteria, within its service area.

Guidance on Determining RWHAP Eligibility

Policies and Procedures for Establishing RWHAP Eligibility

HRSA HAB expects all RWHAP recipients and subrecipients to establish, implement, and monitor policies and procedures to determine client eligibility based on each of the three factors outlined above, including documentation requirements.[5]

RWHAP recipients and subrecipients are expected to develop protocols to facilitate the rapid delivery of RWHAP services, including the provision of antiretrovirals for those newly diagnosed or re-engaged in care. If services are initiated prior to eligibility being established, RWHAP recipients and subrecipients must conduct a formal eligibility determination within a reasonable timeframe and reconcile (i.e., properly account for) any RWHAP funds to ensure that they are only used for allowable costs for eligible individuals.

Policies and Procedures for Confirming RWHAP Eligibility

RWHAP recipients and subrecipients must conduct an eligibility confirmation, in accordance with their policies and procedures, to assess if the client's income and/or residency status has changed. RWHAP recipients and subrecipients are permitted to accept a client's self-attestation of "no change" when confirming eligibility, although HRSA HAB does not recommend that recipients and subrecipients rely solely on client self-attestation indefinitely. RWHAP recipients and

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[2] HRSA HAB Policy Clarification Notice 16-02 *Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds.* https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

[3] U.S. Federal Poverty Guidelines Used to Determine Financial Eligibility for Certain Federal Programs. https://aspe.hhs.gov/poverty-guidelines

[4] HRSA HAB Policy Clarification Notice 13-03 *Ryan White HIV/AIDS Program Client Eligibility Determinations: Considerations Post Implementation of the Affordable Care Act*. https://hab.hrsa.gov/sites/default/files/hab/Global/pcn1303eligibilityconsiderations.pdf

[5] HRSA HAB does not require documentation to be provided in-person nor be notarized.

subrecipients should not disenroll clients until a formal confirmation has been made that the client is no longer eligible.

Best Practices to Promote Continuity of Services and Care in the RWHAP
RWHAP recipients and subrecipients should consider adopting the following best practices when designing their eligibility policies and procedures.

RWHAP recipients and subrecipients should conduct periodic checks to identify any potential changes that may affect eligibility and require clients to report any such changes. Recipients and subrecipients should use electronic data sources to collect and verify client eligibility information, such as income[6] and health care coverage (that includes income limitations), when possible. RWHAP recipients and subrecipients should first use available data sources to confirm client eligibility before requesting additional information from the client. If the RWHAP client still meets the eligibility criteria based on recent, reliable, available data, recipients and subrecipients may renew that client's eligibility without requesting additional information from the individual.

RWHAP recipients and subrecipients should identify opportunities to streamline eligibility determination policies and procedures across service categories and RWHAP parts within the service area. In addition, RWHAP recipients and subrecipients are encouraged to develop data-sharing strategies with other RWHAP recipients and relevant entities to reduce administrative burden across programs.

Payor of Last Resort

Once a client is eligible to receive RWHAP services, the RWHAP is considered the payor of last resort, and as such, funds may not be used for any item or service "to the extent that payment has been made, or can reasonably be expected to be made under. . . any State compensation program, under an insurance policy, or under any Federal or State health benefits program. . . , or by an entity that provides health services on a pre-paid basis."[7]

Guidance on Complying with the Payor of Last Resort Requirement
RWHAP recipients and subrecipients must ensure that reasonable efforts are made to use non-RWHAP resources whenever possible, including establishing, implementing, and monitoring policies and procedures to identify any other possible payers to extend finite RWHAP funds.
RWHAP recipients and subrecipients must maintain policies and document their efforts to ensure that they assist clients to vigorously pursue enrollment in health

[6] Federal Low-Income Programs: Use of Data to Verify Eligibility Varies Among Selected Programs and Opportunities Exist to Promote Additional Use. https://www.gao.gov/products/gao-21-183
[7] Sections 2605(a)(6), 2617(b)(7)(F), 2664(f)(1) of the Public Health Service (PHS) Act. See also 2671(i) of the PHS Act. The Indian Health Service is statutorily exempted from the payor of last resort provision.

care coverage and that clients have accessed all other available public[8] and private[9] funding sources for which they may be eligible. RWHAP recipients and subrecipients can continue providing services funded through RWHAP to a client who remains unenrolled in other health care coverage so long as there is rigorous documentation that such coverage was vigorously pursued. RWHAP recipients and subrecipients should conduct periodic checks to identify any potential changes to clients' health care coverage that may affect whether the RWHAP remains the payor of last resort and require clients to report any such changes.

Coverage of Services by the Ryan White HIV/AIDS Program

RWHAP funds may be used to fill in coverage gaps for individuals in order to maintain access to care and treatment services as allowable and defined by the RWHAP. RWHAP funds may be used for core medical and support services if those services are not covered or are only partially covered by another payer, even when those services are provided at the same visit.

This guidance does not have the force and effect of law and is not meant to bind the public in any way, except as authorized by law or as incorporated into a contract. It is intended only to provide clarity to the public regarding existing requirements under the law or agency policies.

[8] HRSA HAB Policy Clarification Notice 13-01 *Clarifications Regarding Medicaid-Eligible Clients and Coverage of Services by the Ryan White HIV/AIDS Program*. https://hab.hrsa.gov/sites/default/files/hab/Global/1301pcnmedicaideligible.pdf

[9] HRSA HAB Policy Clarification Notice 13-04 *Clarifications Regarding Clients Eligible for Private Health Insurance and Coverage of Services by Ryan White HIV/AIDS Program*. https://hab.hrsa.gov/sites/default/files/hab/Global/pcn1304privateinsurance.pdf

Public Comment submitted by Joseph Green on 8/17/26 regarding the Universal Service Standards and Client Bill of Rights and Responsibilities

1. **LA does not have NYC's formal Quality Management framework.** This is probably the biggest gap. Your LA document says providers must deliver "high-quality services" and maintain trained staff, but it doesn't establish a comprehensive quality management system with measurable outcomes. NYC requires providers to participate in quality-improvement processes that examine client feedback, barriers to access, intersectional data, stigma, workforce issues and other factors.
2. **But compared with NYC and San Francisco, LA is missing several important system-level requirements**—especially:
    a. Measurable quality-management and health-outcome requirements
    b. Specific client re-engagement requirements
    c. Formal warm handoffs and closed-loop referral tracking
    d. Regular reassessment of client needs/acuity
    e. Explicit accessibility/self-management standards
    f. Detailed facility standards
    g. Emergency preparedness
    h. Explicit stigma, racism, implicit-bias and health-equity requirements
    i. Peer support and meaningful consumer experiences measurement
    j. More detailed payor-of-last resort/insurance requirements
    k. Specific requirements for serving priority and disproportionately affected populations
    l. Specific requirements for client crisis planning
    m. More explicit requirements concerning data collection, monitoring and continuous quality improvement
3. **Recommendation for LA:** Add a Quality Management and Continuous Quality Improvement section requiring:
    a. Annual quality-management plans;
    b. Measurable performance indicators;
    c. Client satisfaction/experience surveys;
    d. Monitoring of access and timelines;
    e. Monitoring of referral completion;
    f. Monitoring of retention/re-engagement;
    g. Corrective action when standards aren't met
    h. Continuous quality improvement using client-level and aggregate data