LOS ANGELES COUNTY
COMMISSION ON HIV

Visit us online: http://hiv.lacounty.gov
Get in touch: hivcomm@lachiv.org

STANDARDS AND BEST PRACTICES COMMITTEE
Virtual Meeting

Tuesday, February 2, 2021
10:00AM-12:00PM (PST)

Agenda + Meeting Packet will be available on the Commission's website at:
http://hiv.lacounty.gov/Standards-and-Best-Practices-Committee

REGISTER VIA WEBEX ON YOUR COMPUTER OR SMART PHONE:
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Event #/Meeting Info/Access Code: 145 537 9198

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PUBLIC COMMENTS

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

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LOS ANGELES COUNTY
COMMISSION ON HIV

AGENDA FOR THE **VIRTUAL** MEETING OF THE

STANDARDS AND BEST PRACTICES COMMITTEE

TUESDAY, FEBRUARY 2, 2021, 10:00 AM – 12:00 PM

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

https://tinyurl.com/y38qv6py

or Dial

1-415-655-0001

Event Number/Access code: 145 537 9198

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

Standards and Best Practices (SBP) Committee Members			
Erika Davies *Co-Chair*	Kevin Stalter *Co-Chair*	Miguel Alvarez, *alternate*	Pamela Coffey
Wendy Garland, MPH	Grissel Granados, MSW	Thomas Green	Paul Nash, CPsychol AFBPsS FHEA
Katja Nelson, MPP	Joshua Ray (Eduardo Martinez, *alternate*)	Harold Glenn San Agustin, MD	Justin Valero, MA
Ernest Walker	Amiya Wilson		
QUORUM: 8			

AGENDA POSTED: January 28, 2021

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

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

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SUPPORTING DOCUMENTATION can be obtained at the Commission on HIV Website at: http://hiv.lacounty.gov. The Commission Offices are located in Metroplex Wilshire, one building west of the southwest corner of Wilshire and Normandie. Validated parking is available in the parking lot behind Metroplex, just south of Wilshire, on the west side of Normandie.

NOTES on AGENDA SCHEDULING, TIMING, POSTED and ACTUAL TIMES, TIME ALLOTMENTS, and AGENDA ORDER: Because time allotments for discussions and decision-making regarding business before the Commission's standing committees cannot always be predicted precisely, posted times for items on the meeting agenda may vary significantly from either the actual time devoted to the item or the actual, ultimate order in which

it was addressed on the agenda. Likewise, stakeholders may propose adjusting the order of various items at the commencement of the committee meeting (Approval of the Agenda), or times may be adjusted and/or modified, at the co-chairs' discretion, during the course of the meeting.

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

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

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

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

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

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

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

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

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

IV. REPORTS

5. Executive Director/Staff Report 10:15 AM – 10:20 AM

6. Co-Chair Report 10:20 AM – 10:45 AM
- a. New Committee Member Introductions
- b. Service Standards Refresher
- c. Standards Revision Tracker
- d. 2021 Workplan

7. Division of HIV & STD Programs (DHSP) Report 10:45 AM – 11:00 AM
- a. Quality Improvement Report

V. DISCUSSION ITEMS

8.	Engaging Private Health Plans & Providers		11:00 AM – 11:20 AM
9.	Universal Standards of Care	**MOTION #3**	11:20 AM – 11:45 AM
10.	Childcare Services Standards Updates		11:45 AM – 11:50 AM

VI. NEXT STEPS 11:50 AM – 11:55 AM

11. Task/Assignments Recap

12. Agenda development for the next meeting

VI. ANNOUNCEMENTS 11:55 AM – 12:00 PM

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

VII. ADJOURNMENT 12:00 PM

14. Adjournment for the virtual meeting of February 2, 2021

PROPOSED MOTIONS	
MOTION #1	**Approve the Agenda Order, as presented or revised.**
MOTION #2	**Approve the Standards and Best Practices Committee minutes, as presented or revised.**
MOTION #3	**Approve the updated Universal Service Standards, as presented or revised.**

LOS ANGELES COUNTY
COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov • *VIRTUAL WEBEX MEETING*

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

STANDARDS AND BEST PRACTICES (SBP) COMMITTEE MEETING MINUTES

December 1, 2020

Draft

MEMBERS PRESENT	MEMBERS PRESENT *(cont.)*	PUBLIC	COMM STAFF/ CONSULTANTS
Erika Davies, *Co-Chair*	Harold Glenn San Agustin, MD	Allison Doolittle	Cheryl Barrit, MPIA
Kevin Stalter, *Co-Chair*	Justin Valero, MA	Vanessa Porter	Carolyn Echols-Watson, MPA
Wendy Garland, MPH			Jane Nachazel
Felipe Gonzalez	**MEMBERS ABSENT**		Sonja Wright, MS, Lac
Grissel Granados, MSW	Miguel Alvarez *(Alt.)*		
Thomas Green *(Alt.)*	David Lee, MSW, LCSW, MPH		**DHSP STAFF**
Paul Nash, PhD, CPsychol	Joshua Ray, RN/Eduardo Martinez		Lisa Klein, RN, MSN, CPHQ
Katja Nelson, MPP	Amiya Wilson		

*Some participants may not have been captured electronically. Attendance can be corrected by emailing the Commission.

CONTENTS OF COMMITTEE PACKET

1) **Agenda**: Standards and Best Practices (SBP) Committee Meeting Agenda, *12/1/2020*
2) **Minutes**: Standards and Best Practices (SBP) Committee Meeting Minutes, *11/3/2020*
3) **Duty Statement**: Committee Co-Chair, *Approved 3/28/2017*
4) **Summary**: Child Care Services Consumer Listening Session, *10/18/2020, 10/23/2020, 10/25/2020,*
5) **Standards**: Child Care Standards of Care, *Draft - Updated 9/25/2020*
6) **Standards**: Ryan White Program Universal Standards of Care, *2020 Revisions Draft 11/16/2020*
7) **Standards**: Ryan White Program Universal Standards of Care, *2020 Revisions Draft with strikethroughs 11/16/2020*
8) **Standards**: Prevention Services Standards, *Approved 6/14/2018*
9) **Graphic**: Comprehensive HIV Continuum Framework, with and without strikethroughs, *9/12/2019*

CALL TO ORDER-INTRODUCTIONS-CONFLICT OF INTEREST STATEMENTS: Ms. Davies called the meeting to order at 10:05 am. She acknowledged World AIDS Day and those who have gone before us in this work.

I. ADMINISTRATIVE MATTERS

1. **APPROVAL OF AGENDA**
MOTION #1: Approve the Agenda Order, as presented ***(Passed by Consensus)***.

2. **APPROVAL OF MEETING MINUTES**
MOTION #2: Approve the 11/3/2020 Standards and Best Practices (SBP) Committee Meeting Minutes, as presented ***(Passed by Consensus)***.

II. PUBLIC COMMENT

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

III. COMMITTEE NEW BUSINESS ITEMS

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

IV. REPORTS

5. EXECUTIVE DIRECTOR/STAFF REPORT

- Ms. Barrit acknowledged World AIDS Day as well. It is also Giving Tuesday. If able, that offers an opportunity to help.

a. Planning Community HIV/AIDS Technical assistance Training program (CHATT) Webinar

- Ms. Barrit presented at the Health Resources and Services Administration (HRSA) 11/4/2020 CHATT on development of Standards of Care (SOCs). There were some 135 attendees from across the country.
- The coordinators requested the Commission on HIV offer an example of consumer engagement, especially engagement of Unaffiliated Consumers (UCs). Ms. Barrit highlighted the Emergency Financial Assistance (EFA) SOC. Feedback on the process, its speed, and consumer input was positive. New York City requested a copy of the EFA SOC to advocate for an increase in the amount for consumers. That was ironic since the Commission used their SOC in development as well.
- Of possible interest, the formal SOC approval process for the St. Louis HIV Planning Council includes approval by a body composed of their UCs before a SOC goes to their full body for approval.
- ➲ Enhance Consumer Caucus approval in SOC process by providing more time for review at meeting during public comment period and having at least one SBP Co-Chair attend that meeting to answer any questions.
- ➲ A link to the webinar was included in the Chat and will be available on the Commission website.

b. Committee, Caucus, Task Force Updates

- *Commission:* The next meeting will be 12/10/2020. DHSP will present on the local Ending the HIV Epidemic (EHE) Plan that was due to the Centers for Disease Control and Prevention (CDC) at the end of December 2020. The CDC requires local Planning Councils such as the Commission to provide a Letter of Concurrence as part of the Plan that demonstrates intentional review. This will be the final opportunity to offer input.
- *Planning, Priorities and Allocations (PP&A):* The last meeting of the year will be 12/15/2020 at 1:00 pm. The focus will be improved integration of prevention planning in the decision-making process. A Prevention Planning Work Group was developing recommendations for review at the meeting.
- *Transgender Caucus:* The next meeting will be 12/2/2020 at 10:00 am. The focus will be AB 2218 which establishes the Transgender Wellness and Equity Fund. The Caucus will be following up on pertinent implementation at the local level.
- *Black African American Community (BAAC) Task Force:* The next meeting will be 12/2/2020 at 1:00 pm.
- *Aging Task Force:* The next meeting will be 12/7/2020 from 9:00 to 11:00 am.
- *Public Policy:* The next meeting will be 12/7/2020 from 1:00 to 3:00 pm. Richard Zaldivar, Executive Director/Founder, The Wall Las Memorias Project (TWLMP), will discuss the new Act Now Against Meth campaign.

6. CO-CHAIR REPORT

- Ms. Davies thanked everyone for their hard work and contributions over the past year. Mr. Stalter also highlighted the subject matter experts who contributed to meetings and staff support.

a. Committee Co-Chair Elections

- Ms. Barrit noted the basic Co-Chair requirement is service on the pertinent Committee for 12 months.
- Mr. Gonzalez was nominated at the last meeting but, after consideration, respectfully declined. Ms. Davies and Mr. Stalter were nominated and accepted.

MOTION #3: Elect Erika Davies and Kevin Stalter as Co-Chairs, 2021 term, for the Standards and Best Practices (SBP) Committee, as nominated ***(Passed by Consensus)***.

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

- Ms. Garland noted DHSP developed a provider Childcare survey. Data should be available shortly. It was also reviewing Ryan White data to identify agencies with a high proportion of women of child bearing age who may need the service.
- At the Annual Meeting, DHSP presented on the Take Me Home HIV Test Kit Initiative. DHSP was now reviewing the protocol to distribute test kits to contracted HIV testing providers. Distribution was expected to begin by the end of the year.

- The telehealth collaborative to help build capacity for Medical Care Coordination (MCC) teams drew good attendance to its last webinar. DHSP will continue using monthly webinars to support the work of the MCC teams.
- Ms. Klein did not have a Continuous Quality Management (CQM) report this month, but expects to have one next month.
- Mr. Stalter noted there are usually about 1,800 new HIV cases per year and wondered how that compared to this year. Ms. Garland reported there were decreases in the number of cases, but there has also been a decrease in testing both due to COVID-19 and due to reporting delays as a result of some contract negotiations. Consequently, comparative data was not concrete at this time.
- ➲ Ms. Klein would appreciate a longer than the usual 10 minutes for her next report.

V. DISCUSSION ITEMS

8. CHILDCARE SERVICES STANDARDS UPDATES

- Ms. Davies reviewed the summary in the packet of the listening sessions hosted by DHSP in collaboration with the University of California at Los Angeles (UCLA); Los Angeles County + University of Southern California (LAC+USC) Medical Center/Maternal Child, and Adolescent/Adult Center (MCA); the Commission; and the Women's Task Force.
- Ms. Barrit noted some two months ago she reported DHSP was in consultation with County Counsel to determine any potential liability issues with childcare. DHSP provided County Counsel the draft Childcare SOC for review at that time.
- County Counsel has made the determination that Los Angeles County (LAC) can only support licensed childcare, nothing informal or unlicensed, due to liability issues. Consequently, she recommended deleting any unlicensed services.
- Mr. Stalter noted virtually all trainings, page 4, were starred as highly recommended, but he felt topics like HIV stigma reduction were not needed for childcare. Burdensome requirements can discourage agencies from participating. Ms. Barrit noted trainings were required of licensed agencies. They will be the only agencies covered now so the stars were moot.
- Ms. Klein asked about licensing of apps facilitating childcare, e.g., Bambino.com. Ms. Barrit clarified that apps are just sites while the actual contract is with the person providing the service. Licensed pertains to a license from the State of California.
- Prior to the pandemic, Commission staff were able to identify an organization, Los Angeles Educational Partnership, that provides offsite childcare. There is a problem with onsite childcare, e.g., liability at St. Anne's Conference is only for clients. The question is how to meet all the licensing and liability requirements.
- Ms. Klein noted training designations such as "Domestic violence" offer some flexibility to the agency, but is challenging to monitor for DHSP. Is such a training one class, four classes, a degree? Is training expected once or once per year?
- HRSA requires all contracted services to have service standards, but a secondary goal is education of providers overall.
- ➲ Retain current SOC draft in case unlicensed childcare can be funded in future.
- ➲ Delete all unlicensed service references.
- ➲ Delete all trainings already required by the state for childcare services since those are assumed.
- ➲ Add language noting that licensed childcare does not necessarily imply a site.
- ➲ Address awareness issue to ensure clients are aware of available childcare services.

9. UNIVERSAL STANDARDS OF CARE REVIEW

- Ms. Barrit thanked all those at DHSP who reviewed both the Childcare and Universal SOCs, both iterations in the packet.
- She reviewed the SOC starting with Section 7: Provider Quality Management Plan, as discussed. That is typically a grantee duty and DHSP reviewed the effort and identified it as outside the Commission's Scope of Work (SOW). She recommended deleting it, but continuing strong consumer engagement and Quality Improvement activities such as the MCC collaborative.
- She noted the most recent iteration of the People With HIV/AIDS Bill of Rights and Responsibilities was appended. Some feedback has been incorporated from the Consumer Caucus. DHSP also added assurance that patients understand rights.
- ➲ Delete Section 7: Provider Quality Management Plan.
- ➲ Page 21, D2: Revise "with respect to HIV counseling and testing services" to "with respect to all types of prevention and care services."
- ➲ Add description of Grievance Line.
- ➲ Retain "case closure," but define the term to reflect that a case may be closed for various reasons.
- ➲ Forward to Executive Committee while also returning to Consumer Caucus for any additional feedback.
- ➲ Ms. Davies and Mr. Stalter will review the Bill of Rights and Responsibilities with Ms. Barrit.

10. HIV CONTINUUM REVIEW

- ➲ Discussion postponed to next meeting.

11. ENGAGING PRIVATE HEALTH PLANS AND PRIVATE PROVIDERS

- The Co-Chairs and Ms. Barrit provided a brief training on SBP. It was suggested at the time that SBP consider how to share SOCs with the private health plans and providers.
- Mr. Valero suggested: acquiring or developing a provider contact list; determining how to attend to people transitioning in or out of Ryan White to avoid coverage gaps; and, determining how to support development of cultural competency.
- ➲ Agendize for next meeting. Members will consider topic in anticipation of discussion. The Co-Chairs, Mr. Valero, and Ms. Barrit will develop discussion questions, e.g., what are top goals/objectives, what is SOW that Commission can address.

VI. NEXT STEPS

12. TASK/ASSIGNMENTS RECAP: There were no additional items.

13. AGENDA DEVELOPMENT FOR NEXT MEETING: There were no additional items.

VII. ANNOUNCEMENTS

14. OPPORTUNITY FOR PUBLIC AND COMMITTEE TO MAKE ANNOUNCEMENTS: All offered best wishes to Mr. Valero who was recovering from COVID-19.

VIII. ADJOURNMENT

15. ADJOURNMENT: The meeting adjourned at 12:03 pm.

SERVICE STANDARDS

RYAN WHITE HIV/AIDS PROGRAMS

WHAT ARE SERVICE STANDARDS?

Service standards[1] outline the elements and expectations a RWHAP Service provider follows when implementing a specific service category. The purpose of service standards are to ensure that all RWHAP service providers offer the same fundamental components of the given service category across a service area. Service standards establish the minimal level of service or care that a RWHAP funded agency or provider may offer within a state, territory or jurisdiction.

Service standards must be consistent with applicable clinical and/or professional guidelines, state and local regulations and licensure requirements. The variability in state/local regulations and requirements prevents the adoption of national service standards for the RWHAP, and thus they must be set at the grantee level. Medical care service standards must be consistent with U.S. Department of Health and Human Services care and treatment guidelines as well as other clinical and professional standards. For non-clinical services, service standards may be developed using evidence-based best practices, the Part A and B National Monitoring Standards, and guidelines developed by the state and local government. As a result, service standards are essential in defining and ensuring that consistent quality care is offered to all clients.

Service standards set a benchmark by which services are monitored, and sub-grantee contracts are developed. Each funded service category must have a unique set of service standards. There may be some overlap of service standards among two or more service categories (ex. medical case management and non-medical case management may both assist with enrolling clients in insurance assistance programs).

[1] Service Standards applies to "standards of care' in RWHAP Parts A and B manuals. Outside of RWHAP services, "standard of care" has been used to refer to acceptable levels of medical care and treatment rendered. Therefore, the term "service standards" is used to encompass services offered through RWHAP funding.

What should be addressed in Service Standards?

Each categorical specific service standard should include:

- ✓ Service Category Definition
- ✓ Intake and Eligibility
- ✓ Key Services Components and Activities
- ✓ Personnel Qualifications (including licensure)
- ✓ Assessment and Service Plan*
- ✓ Transition and Discharge
- ✓ Case Closure Protocol
- ✓ Client Rights and Responsibilities
- ✓ Grievance Process
- ✓ Cultural and Linguistic Competency
- ✓ Privacy and Confidentiality (including securing records)
- ✓ Recertification Requirements*

** Where Applicable*

HOW ARE SERVICE STANDARDS DEVELOPED?

It is ultimately the responsibility of the grantee to ensure that service standards are in place for all funded service categories.

For RWHAP Part A grantees, developing service standards is a shared responsibility, typically led by the Planning Council. For Part B grantees, advisory committees and grantees are encouraged to obtain public input in the development of the service standards. Often this is done through a committee or workgroup body.

For Part A and B grantees, the development of service standards is a shared responsibility of the grantee and the planning body. Grantees and planning bodies may determine the order in which they are developed based on various criteria including: funding allocation level, service category prioritization, service utilization and changes in the national and local health service delivery systems. In addition, grantees and planning bodies should obtain input from providers, consumers and experts when developing standards to provide technical input and recommendations for service delivery, and to ensure that full consideration and diverse perspectives are included in service specific service standards. The roles and development process may vary for each jurisdiction.

For Parts A and B, service standards should, at minimum, also follow the programmatic and fiscal management requirements outlined in the Part A and B National Monitoring Standards. For Parts C and D, medical care standards should be based on the latest HHS HIV guidelines.

For Part C and D grantees, the development of service standards are done on the organizational or agency level and are often referred to as "Policies and Procedures." Each Part C and D grantee is expected to have policies and procedures in place on patient eligibility, enrollment, available services, as well as a patient grievance and discharge procedure. In addition, clinics and healthcare agencies are further guided by accrediting organizations (e.g. The Joint Commission) and regulations and guidance (e.g. Medicare Fee-For-Service Payment Regulations). All applicable standards and policies should be vetted by the legally responsible authority of the agency, usually the Board of Directors. Part C and D grantees are encouraged to refer to the most recent funding opportunity announcement for additional guidance on recommended policies and procedures.

WHY ARE SERVICE STANDARDS IMPORTANT?

Service standards are important to various stakeholders, with the goal to improve client and public health outcomes.

- ***Consumers*** - Service standards ensure the minimal expectation for consumers accessing or receiving RWHAP funded services within a state, territory or jurisdiction.
- ***Service Providers*** - Service standards define the core components of a service category to be included in the model of service delivery for each funded service category.
- ***Grantee*** - Grantees are responsible for ensuring the development, distribution, and use of the service standards. Service standards are important to ensure that services are provided to clients in a consistent manner across service providers.
- ***Quality Managers*** - Service standards are the foundation for the clinical quality management program, and provide the framework and service provision from which processes and outcomes are measured.
- ***Planning Bodies*** - Service standards assist planning bodies with understanding what activities are being provided

HOW OFTEN SHOULD SERVICE STANDARDS BE REVIEWED FOR ACCURACY AND RELEVANCE?

Service standards must be reviewed regularly and updated to reflect the most current nationally recognized guidelines in HIV care and treatment and local requirements. Therefore, planning bodies and grantees should build into their annual work plan a time to review existing standards. Service standards should be publically accessible so clients and providers can become familiar with them.

HOW ARE SERVICE STANDARDS USED?

For Parts A and B grantees, service standards should be included in Requests for Proposals when service categories are competitively bid as the service standards outline the key components of each service category, guide the implementation of each service category, and form the basis for monitoring service delivery, including site visits and chart reviews. Grantees should use service standards when conducting programmatic site visits, chart reviews, and routine monitoring of sub- recipients to determine if service providers are meeting the minimal expectations and adhering to service standards.

For Parts C and D grantees, service standards can be used in establishing definitions for services in Memorandum of Understanding or contracts. In addition, Service Standards can be used in policies and procedures to define elements for monitoring in quality improvement activities and to implement change activities for service and clinical improvement.

WHAT RESOURCES EXIST WHEN DEVELOPING SERVICE STANDARDS?

- ✓ **RWHAP National Monitoring Standards**
  The National Monitoring Standards are designed to help RWHAP Part A and B (including AIDS Drug Assistance Program) grantees meet federal requirements for program and fiscal management, monitoring, and reporting to improve program efficiency and responsiveness.
  http://hab.hrsa.gov/manageyourgrant/granteebasics.html

- ✓ **HIV/AIDS Bureau TARGET Center**
  The TARGET Center has samples of 'standards of care' established by various grantees within the RWHAP Program which may be adapted to other jurisdictions.
  https://careacttarget.org

- ✓ **U.S. Department of Health and Human Services Clinical Guidelines for the Treatment of HIV/AIDS**
  The U.S. Department of Health and Human Services (HHS) issues a series of guidelines to help clinicians treat people with HIV in the United States. Clinical guidelines outline the science and recommendations for treatment of HIV disease (e.g., antiretroviral therapy, opportunistic infection treatment and prophylaxis) as well as guidelines for conducting HIV testing and counseling. Developed by various panels of clinical experts, these are frequently updated and should be accessed directly at the AIDSInfo Web site.
  http://aidsinfo.nih.gov/guidelines

LOS ANGELES COUNTY COMMISSION ON HIV

SERVICE STANDARDS REVISION DATE TRACKER

	Title	Date of Last Revision
1	AIDS Drug Assistance Program (ADAP) Enrollment	2009
2	Benefits Specialty	2009
3	Case Management, Transitional – Youth	4/13/2017
4	Case Management, Transitional – Incarcerated/Post Release	4/13/2017
5	Childcare	2009; currently being updated; latest draft revision date 12/14/2020
6	Emergency Financial Assistance Program (EFA)	6/11/2020
7	Home-Based Case Management	2009
8	Hospice	2009
9	Housing, Temporary (Hotel/motel and meal vouchers, Emergency shelter programs, Transitional housing, Income-based Rental Assistance, Residential Care Facility for the Chronically Ill, and Transitional Residential Care Facility)	2/8/2018
10	Housing Permanent Supportive	2/8/2018
11	Language Interpretation	2009
12	Legal	7/12/2018
13	Medical Care Coordination	2/14/2019
14	Mental Health, Psychiatry, and Psychotherapy	2009
15	Non-Medical Case Management	12/12/2019
16	Nutrition Support	2009
17	Oral Health ➢ Practice Guidelines for Treatment of HIV Patients in General Dentistry	2009 2015
18	Outreach	2009
19	Peer Support	2009; integrated in Psychosocial Support 9/10/2020
20	Permanency Planning	2009
21	Prevention Services (Assessment; HIV/STD Testing and Retesting; Linkage to HIV Medical Care and Biomedical Prevention; Referral and Linkages to Non-biomedical Prevention; Retention and Adherence to Medical Care, ART, and Other Prevention Services)	6/14/2018
22	Psychosocial Support	9/10/2020
23	Referral Services	2009
24	Residential Care and Housing	2009; integrated in Temporary and Permanent Supportive Housing 2/8/2018
25	Skilled Nursing Facilities	2009
26	Substance Use and Residential Treatment	4/13/2017
27	Transportation	2009
28	Treatment Education	2009
29	Universal Standards	9/12/2019; currently being updated; latest draft revision date 12/16/2020 released for public comments

STANDARDS AND BEST PRACTICES COMMITTEE 2021 WORK PLAN
DRAFT/FOR REVIEW and DISCUSSION ONLY (1.21.21)

Co-Chairs: Erika Davies & Kevin Stalter	
Approval Date:	**Revision Dates:**

Purpose of Work Plan: To focus and prioritize key activities for COH Committees and subgroups for 2021.
Prioritization Criteria: Select activities that 1) represent the core functions of the COH; 2) advance the goals of the local Ending the HIV Epidemic (EHE) Plan; and 3) align with COH staff and member capacities and time commitment; 4) ongoing COVID public health emergency response and recovery priorities.

#	TASK/ACTIVITY	TARGET COMPLETION DATE
1	Review BAAC and ATF charge and implement recommendations best aligned with the purpose and capacity of the Commission	Start Jan/Ongoing
2	Complete Universal service standards.	March-Executive Committee April- COH
3	Complete Childcare service standards. Waiting for DHSP on provider survey results/summary.	May
4	Recommendations on how to engage with private health plans and providers	May

Division of HIV and STD Programs

December 2020
Volume 1, Issue 1

Clinical Quality Management (CQM) Report

DHSP CQM PROGRAM UPDATES

The purpose of this newsletter is to provide stakeholders of the DHSP CQM Program with important updates and information regarding the EMA (eligible metropolitan area)-wide Clinical Quality Management (CQM) Program.

Per the federal Health Resources and Services Administration (HRSA) Policy Clarification Notice (PCN) 15-02 (Sept, 2020), all recipients and sub-recipients of Ryan White Program (RWP) funds must have a clinical quality management program that aims to improve the care, health outcomes and satisfaction of persons living with HIV (PLWH). Three required domains create a robust CQM program including: Infrastructure, Performance Measurement, and Quality Improvement.

RYAN WHITE PART B

DHSP continues to contribute to the California Department of Public Health's (CDPH) Office of AIDS (OA), RWP Part B CQM Program through participation in their performance measure data analysis process and the HIV Care Providers capacity building activities. OA also participates and provides routine updates on their CQM Program to the Los Angeles County Regional Quality Group (RQG).

INSIDE THIS ISSUE

SPECIAL POINTS OF INTEREST

- Updated Performance Measures
- Inside Mission Possible
- The Grievance Program
- Upcoming QI Activities

CQM INFRASTRUCTURE NEWS

CQM Committee – this committee is currently on hold due to DHSP staff COVID-19 reassignments; however, many CQM Program activities have continued. Quarterly meetings of DHSP's CQM Committee are scheduled to resume via a virtual format in 2021.

CQM Plan – the Plan was recently shared with sub-recipients and is currently undergoing a final review. Stay tuned as the final Plan will be distributed soon and posted to the DHSP website.

CQM Quality Improvement (QI) Activities - Many QI activities have continued despite the impact of COVID-19 including:

- **California Reginal Group (CARG);**
- **Los Angeles Regional Quality Group (RQG); and**
- **Mission Possible (MP), DHSP's HIV Quality Improvement Learning Collaborative for MCC Teams.**

Despite the impact of COVID-19 on County partners, the DHSP CQM Program aims to continue to support the delivery of responsive, evidence-based, high quality HIV services.

METRICS AND DEFINITIONS

Engagement in Care : ≥ 1 VL, CD4 or genotype test reported in the 12 months prior to the end of the quarter.

Retention in Care : ≥ 2 VL, CD4 or genotype tests (> 90 day apart) and reported in the 12 months prior to the end of the quarter.

Viral Load Suppression : VL <200 copies/ml at most recent test reported in the 12 months prior to the end of the quarter.

Durable Viral Load Suppression : VL of < 200 copies/ml for all tests throughout the measurement period.

Periodontal Screening/Treatment: (Oral Health (OH) Only): % clients who had a periodontal screening, or treatment ≥ 1 in the measurement period.

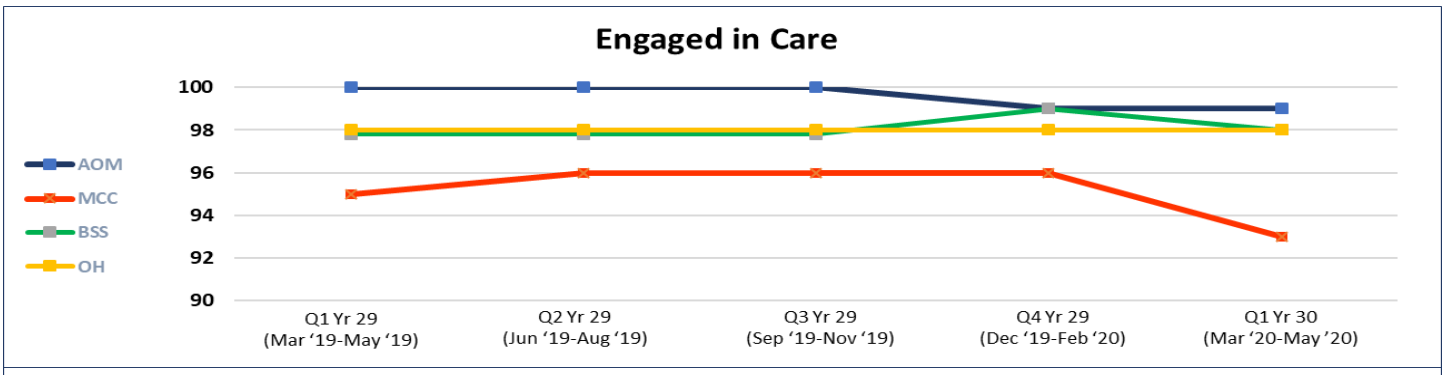
Oral Health Education (OH Only): % clients who received OH education ≥ 1 time in the measurement period.

RWP PERFORMANCE MEASURES—YR. 30 QTR. 1

Performance measurement is a vital part of quality improvement and allows DHSP to determine whether the care that clients receive meets or exceeds the desired quality as stipulated in contracts and established by local and national benchmarks. Performance measures provide the data necessary to identify opportunities for improvement and guide progress through tests of change.

As part of the DHSP CQM Program, service-specific performance measures have been developed in alignment with expectations as outlined in HRSA's PCN 15-02. Selection of these measures was based on the goals and objectives of the Los Angeles County HIV/AIDS Strategy for 2020 and Beyond (LACHAS) in combination with HRSA/HAB recommendations and other local, state and national initiatives including the national Ending the HIV Epidemic (EHE) initiative.

Performance measures are reviewed quarterly by the CQM committee and now as part of this newsletter. DHSP's intention is to share these quarterly measures with stakeholders and consumers and determine the need for service-specific and/or system-wide QI initiatives. Our goal is to also stratify these quarterly reports to better evaluate for disparities and target improvement activities.


Engaged in Care
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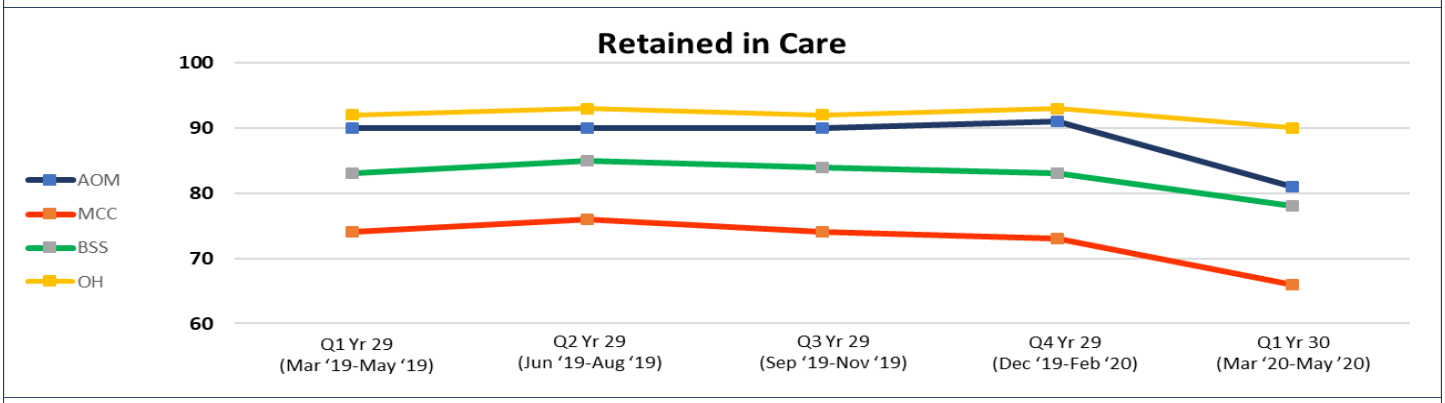
Q2 Yr 29 (Jun '19-Aug '19)
Q3 Yr 29 (Sep '19-Nov '19)
Q4 Yr 29 (Dec '19-Feb '20)
Q1 Yr 30 (Mar '20-May '20)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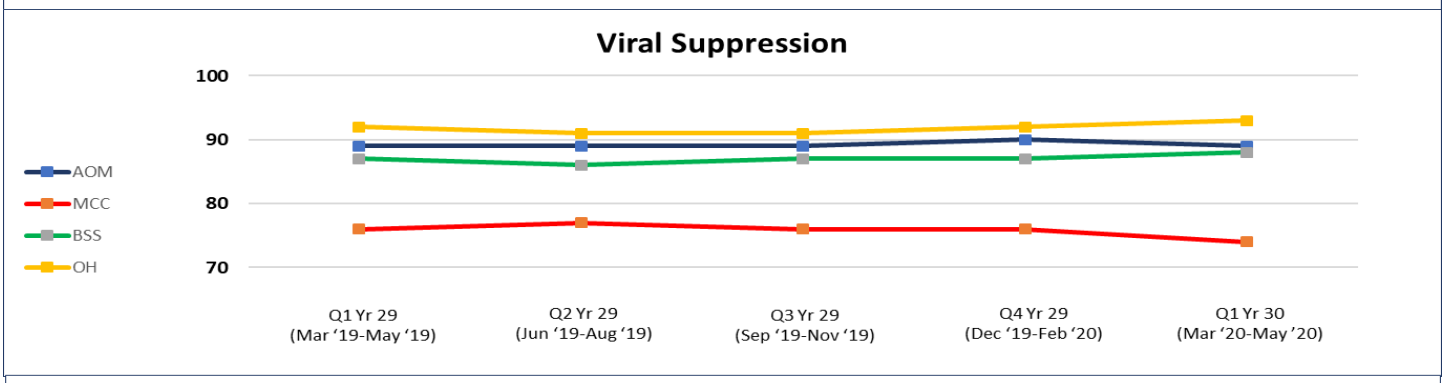
Viral Suppression
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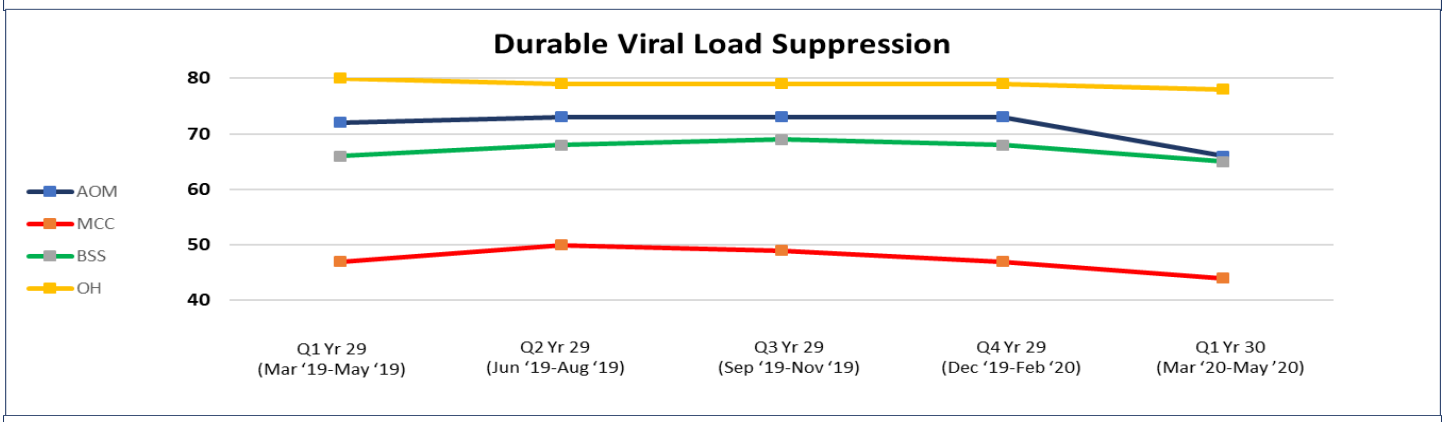
Durable Viral Load Suppression
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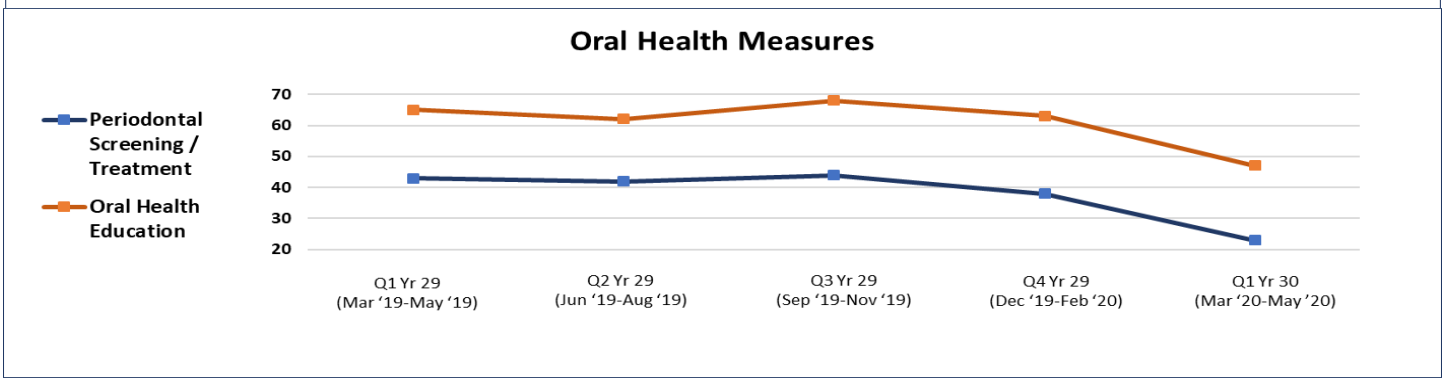
Oral Health Measures
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Periodontal Screening / Treatment
Oral Health Education
Q1 Yr 29 (Mar '19-May '19)
Q2 Yr 29 (Jun '19-Aug '19)
Q3 Yr 29 (Sep '19-Nov '19)
Q4 Yr 29 (Dec '19-Feb '20)
Q1 Yr 30 (Mar '20-May '20)

MISSION POSSIBLE: WHAT WAS IT ALL ABOUT?

ABOUT MISSION POSSIBLE

DHSP's QI Collaborative, Mission Possible, was developed to support Medical Care Coordination (MCC) teams in finding new and innovative ways to engage and retain LAC's most vulnerable clients in HIV care. The Collaborative's initial structure consisted of a six-month in-person and on-line collaborative design aimed at improving the MCC team's internal quality improvement capacity to identify and address barriers to care and low viral load suppression rates. However, due to the COVID-19 pandemic, the Mission Possible QI Collaborative quickly pivoted from its original design and focus to respond to the needs of both the MCC teams and PLWH given the global healthcare crisis. The result was a multi-session, virtual learning collaborative aimed at supporting MCC Teams in the transition to tele-health modalities using quality improvement tools and approaches.

- **March 27, 2020: Kick-off Meeting, Utilizing Telehealth Modalities to Support MCC Services During COVID-19**

  Number of Attendees: 152

  An initial session bringing together MCC teams to discuss the transition to tele-health modalities at the beginning of the COVID-19 pandemic and local stay-at-home orders. DHSP shared programmatic updates including a presentation on a new tele-health data collection option built into the CaseWatch system and an introduction to the on-line workspace, Glasscubes. Two agencies (MHF and LA LGBT) shared their early efforts transitioning MCC teams to tele-health. Elevation Health Partners (EHP) shared valuable tele-health resources and tools.

- **July 22, 2020: MCC Promising Practices in Telehealth Integration**

  Number of Attendees: 111

  Exploration of promising practices and strategies that have been established at community-based organizations; including in person vs. tele-phone or video outreach visits, assessments, and interventions. Teams shared protocols, promising practices, policies, workflows and other tools developed in the wake of the pandemic. Participants also shared their perspectives on the successes and challenges of delivering healthcare "virtually".

  Additional topics and objectives of the meeting included:

  - Prioritization of in-person services for MCC teams
  - Understanding patient preferences in MCC service modalities
  - Strengthening understanding of disparities and equitable care in tele-health HIV services
  - Sharing input on evolving solutions for obtaining "virtual" patient consent
  - Exploring/compiling promising practices for MCC teams

- **August 19, 2020: Patient Perspectives on MCC Telehealth Services**

  Number of Attendees: 104

  Results from a patient survey were shared with attendees to highlight the patient experience with current MCC tele-health practices. Prioritization of patient preference for in person, telephonic, and video visits was promoted and workflows and practices for how to honor these preferences were explored.

  Additional topics and objectives of the meeting included:

  - Learn and provide input about the new Ryan White Program-funded Emergency Financial Assistance Program
  - Explore the role of health professionals in addressing structural racism and supporting Black lives

MISSION POSSIBLE: WHAT WAS IT ALL ABOUT?

- **September 16, 2020: Empathy Training for MCC Telephonic Encounters**

  Number of Attendees: 136

  EHP provided a training in empathic communication skills tailored for the telephone encounter.

  Additional topics and objectives of the meeting included:

  - Understanding what empathy in healthcare is and the benefits of listening with empathy
  - Becoming familiar with techniques used for listening to underlying feelings, needs and values
  - Studying listening, language and tone skills to strengthen connection in telephone interactions with patients
  - Feeling more comfortable or confident in engaging patients over the phone

- **October 21, 2020: MCC Telephone Workflow: A Deep Dive into MCC Practice**

  Number of Attendees: 115

  After individual coaching sessions were conducted with EHP and MCC teams at two agencies (AltaMed and AHF), EHP helped produce workflows to describe the teams' work and to share with the larger learning collaborative. This session demonstrated the value of workflow development and allowed for exchange of best practices amongst the teams.

  Additional topics and objectives of the meeting included:

  - Expanding workflow process knowledge and review tools to help create useful workflows
  - Engaging with peers on effective telephone workflow strategies for outreach, initial assessments, and re-assessments among Retention Outreach Specialist (ROS), Medical Care Manager, and Patient Care Manager roles
  - Better understanding the needs of ROS and feel more confident in ROS strategies during COVID-19

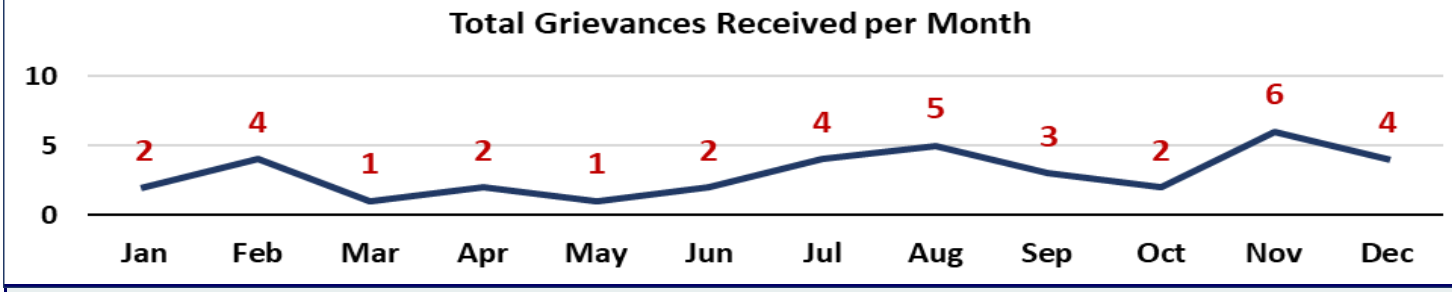
- **November 18, 2020: Closing Celebration**

  Number of Attendees: 111

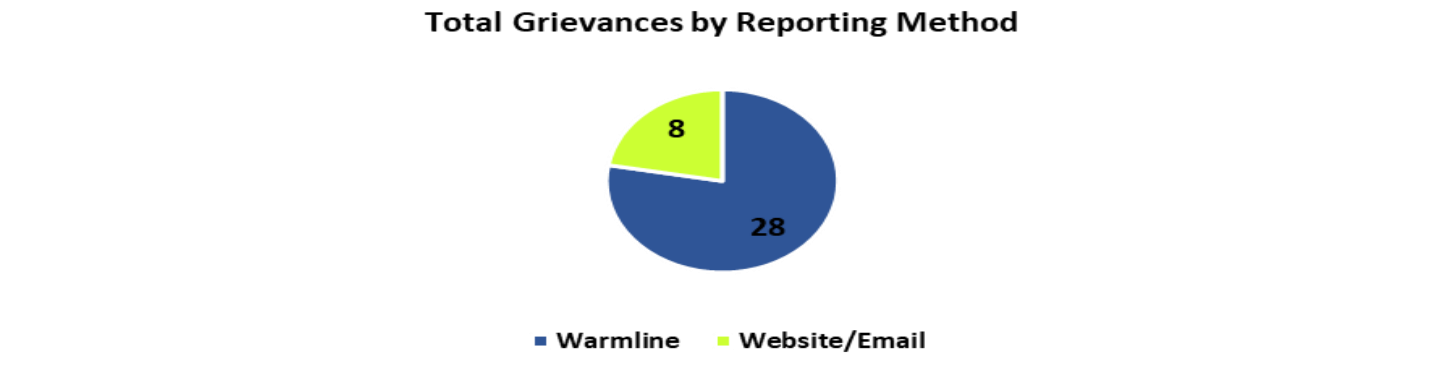
  To celebrate the end of the Mission Possible Collaborative, EHP led the group through a review of the impact of MCC teams during the pandemic and celebrated their hard work and commitment to PLWH. Also on hand, Raniyah Copeland of the Black AIDS Institute shared strategies for how to end the HIV epidemic in Black communities and how to empower clients to be change agents to end the HIV epidemic in their communities.

GRIEVANCE MANAGEMENT PROGRAM

The DHSP Grievance Management Program aims to resolve grievances and/or quality of care issues identified at DHSP funded partner organizations. Grievances are received via DHSP's Grievance Warm-line, website, email or through other agency oversight activities (e.g., contract monitoring) and may include grievances reported by clients, client representatives, agency or DHSP staff, community partners and other stakeholders. DHSP staff work directly with the agency to resolve the grievance through a variety of communication and investigation activities including the development of corrective actions, as appropriate. Every effort is made to resolve grievances within 60 days of receipt.



Grievances Received by Service Category	1Q 20	2Q 20	3Q 20	4Q 20
AOM	3	1	1	2
Substance Abuse	1	1		
RCFCI			1	1
TRCF		2	1	
Mental Health				1
Nutritional Support				1
Unknown/Unstated, Other/Non-jurisdictional	3	1	9	7
Grievances Received by Complaint Category				
Inappropriate/Unprofessional Behavior	1	1	6	4
Substandard Care/Service or Facility		2	2	3
Delayed Care/Service	1	1		2
Denial of Service	2	1		1
Excessive Wait Time	2			
Housing Assistance			2	
Other Assistance Needed, Unknown, Non-jurisdictional	1		2	2



WHAT'S UP NEXT?

DHSP is developing plans to participate in CQII's newest national QI learning collaborative, Create+Equity, and will be partnering with RWP partner agencies AltaMed Health Services and AIDS Healthcare Foundation to focus on unstably housed MCC clients.

REGIONAL QUALITY UPDATES

Los Angeles Regional Quality Group - The Los Angeles Regional Quality Group (RQG) is one of many groups aimed at improving sub-recipient capacity for Clinical Quality Management and committed to furthering the goals and objectives of the Los Angeles County HIV/AIDS Plan (LACHAS) and the national Ending the HIV Epi-demic (EHE) initiative. The RQG is hosted by DHSP and is comprised of one or more staff from RWP-supported HIV care agencies. The RQG meets quarterly to exchange best practices, promote peer learning through sharing of RWP sub-recipient quality initiatives.

Originally an in-person meeting, the group quickly pivoted to a virtual format in response to the COVID-19 pandemic with much of the discussions focused on improving the capacity of RWP sub-recipients to provide care and services using on-line or tele-medicine formats. The group also serves as a forum to share CQM Program updates and activities from CDPH-OA, CARG, and DHSP.

California Regional Group - As part of CQII's End+Disparities ECHO Collaborative, LAC RWP recipients and sub-recipients demonstrated strong involvement in the collaborative to eliminate disparities among highly affected subpopulations: MSM of Color, Youth, Woman of Color, and Transgender Persons. The End+Disparities ECHO Collaborative officially ended in 2019 but California-based participants including DHSP have continued meeting as a regional group, working toward the established viral suppression goals.

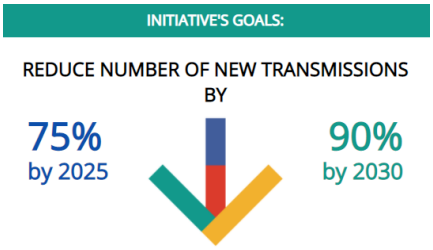
Department of Public Health's Performance Counts

During this unprecedented time, the Department of Public Health's (DPH) Performance Counts report has been adjusted to minimize data collection burden on DPH programs. The following data was reported to DPH in November 2020.

Indicators	Actual CY 2017	Actual CY 2018	Actual CY 2019	Projected CY 2020
% of PLWH who are retained in medical care.	53%	54%	52%	51%
% of PLWH who are virally suppressed.	61%	60%	61%	60%
% of RW PLWH who are retained in medical care.	82.2%	79.1%	78.7%	80%
% of RW PLWH who are virally suppressed.	83.4%	81.6%	82.4%	82.5%

ENDING THE HIV EPIDEMIC (EHE)

Ending the HIV epidemic locally requires the significant scale up and expanded reach of proven and new interventions that work towards overarching goals and are under-girded by overarching strategies.



EHE ACTIVITIES

Linkage to HIV medical care (LTC) is one of the six EHE indicators and is calculated as the percentage of people with HIV diagnosed in a given year who have received medical care for their HIV infection within one month of diagnosis.

As a central feature of the LAC EHE Plan, a new rapid linkage to care and HIV treatment initiation project is underway. While our goal is to improve linkage for all persons newly diagnosed with HIV across LAC, we aim to ensure meeting the needs of groups demonstrating the greatest disparities including cis-gender women, Black/African Americans, youth age 13-19, and persons who inject drugs.

CQM will be involved in tracking our progress through the use of the AHEAD dashboards (along with other states and jurisdictions involved in EHE.) The national goal is LTC at 95% by 2025. The LAC LTC performance level was at 69.9% in 2017, 76.1% in 2018, and showing further improvement witha 2020 Q1 rate of 85.7%.

In 2011, in keeping with National efforts to better integrate HIV and STD public health efforts, the Department of Public Health combined the HIV Epidemiology Program, the Office of AIDS Programs and Policy, and the Sexually Transmitted Disease Program to form the Division of HIV and STD Programs (DHSP). DHSP continues to work closely and collaboratively with community-based organizations, other governmental offices, advocates, and people living with HIV/AIDS as it seeks to control the spread of HIV and sexually transmitted diseases, monitor HIV/AIDS and STD morbidity and mortality, increase access to care for those in need, and eliminate HIV-related health inequalities.

Division of HIV and STD Programs
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Los Angeles, CA 90005

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COUNTY OF LOS ANGELES
Public Health

LOS ANGELES COUNTY COMMISSION ON HIV | STANDARDS AND BEST PRACTICES COMMITTEE
RECOMMENDATIONS FOR ENGAGING PRIVATE HEALTH PROVIDERS FOR A STRONGER HIV RESPONSE
DRAFT FOR DISCUSSION PURPOSES ONLY (1.26.21)

Question for SBP: Who are you making these recommendations to?

Background and Purpose

This document outlines recommendations for engaging local private health providers with the Los Angeles County Ryan White system of care. Private health providers play a critical role in achieving the national goal of ending HIV by 2030. The Ryan White HIV/AIDS Program has proven to be an effective model of comprehensive care for people living with HIV. Individuals enrolled in the Ryan White (RW) program achieve better viral suppression rates compared to those in other systems of care. Coupled with advances in biomedical prevention such as pre-exposure prophylaxis (PrEP) and expanded access to HIV testing in clinics and thru home test kits, the opportunity exists to engage private health partners in a stronger HIV response.

The Ryan White HIV/AIDS Program, first enacted in 1990, is the largest federal program designed specifically for people with HIV, serving over half of all those diagnosed.[1,2] It is a discretionary, grant program dependent on annual appropriations from Congress". It is the nation's safety net for people with HIV providing outpatient HIV care and treatment to those without health insurance and filling in gaps in coverage and cost for those with insurance.

Most Ryan White clients are low-income, male, people of color, and sexual minorities. The program is the third largest source of federal funding for HIV care in the U.S., following Medicare and Medicaid. While the Affordable Care Act (ACA), has expanded coverage for many people with HIV, Ryan White continues to remain a critical component of the nation's response to HIV, proving HIV care and treatment to those who remain uninsured and bolstering access for those with insurance.

1. Increase awareness of the local Ryan White system of care among private providers through the Community Clinics Association of Los Angeles County (CCALAC), Los Angeles County Medical Association (LACMA), and Hospital Association of Southern California. These organizations convene trainings and events for their members and may be used as an avenue for service promotion and partnership development.

2. Enlist the support of the Association of American Medical Colleges to inform medical schools and students about HIV and the Ryan White system of care.

3. Convene a private provider summit to 1) introduce them to the Ryan White program; 2) provide information on services and enrollment process; 3) share HIV continuum care of data comparing outcomes for RW patients with private health care systems; 4) and share service standards.

4. Disseminate Ryan White program fact sheets with a list of services covered and contracted agencies to healthcare providers required by law to report HIV cases to the Division of HIV and STD Programs. Encourage healthcare providers to promote RW services to their patients. By State law, HIV infection is a reportable condition in California. This requires laboratories, health care providers, and testing providers to report all cases of HIV infection to their local health department. This reporting requirement is necessary to timely monitor current trends in the epidemic and to ensure continued funding by federal and State funding agencies for local HIV treatment and prevention services.

5. Private/Public Transition - To ensure that those who age out of their parent's insurance at 26, or those who lose their employer based private insurance, are able to get timely access to information and resources in order to prevent linkage to care and preserve drug adherence.

6. Larger Private Engagement - To encourage private care providers to gain partnership/ownership in the county's Ending the Epidemic efforts.

7. Cultural Competencies - To share best practices and methods to engaging the diverse communities that private health providers serve. We at the commission tend to be acutely aware of the issues of key demographics and issues that LGBTQ+ consumers face. It is imperative for us to not all into the fallacy of mirror imaging and assume that private providers are equally aware. We should prioritize facilitating a dialogue about how private providers can better address specific needs that they might not necessarily be aware of.

Motion #3/SBP 02.02.21

LOS ANGELES COUNTY
COMMISSION ON HIV

RYAN WHITE PROGRAM
UNIVERSAL SERVICE STANDARDS
Final Draft for Standards and Best Practices Committee Approval 2/2/21

TABLE OF CONTENTS

IMPORTANT: Service standards must adhere to requirements and restrictions from the federal agency, Health Resources and Services Administration (HRSA). The key documents used in developing standards are as follows:
Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18)
HIV/AIDS Bureau, Division of Metropolitan HIV/AIDS Programs National Monitoring Standards for Ryan White Part A Grantees: Program – Part A
Service Standards: Ryan White HIV/AIDS Programs

INTRODUCTION

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

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

UNIVERSAL STANDARDS OVERVIEW

The objectives of the Universal Standards are to ensure agencies:

- Provide services that are accessible and non-discriminatory to all people living with HIV in Los Angeles County with a focus on highly impacted populations
- Educate staff and clients on the importance of receiving care, treatment as prevention, and how people who are completely, durably suppressed will not sexually transmit HIV.
- Protect client rights and ensure quality of care
- Provide client-centered, age appropriate, culturally and linguistically competent care
- Provide high quality services through experienced and trained staff
- Meet federal, state, and county requirements regarding safety, sanitation, access, and public health.
- Guarantee client confidentiality, protect client autonomy, and ensure a fair process of addressing grievances
- Prevent information technology security risks and protect patient information and records
- Inform clients of services, establish eligibility, and collect information through an intake process
- Effectively assess client needs and encourage informed and active participation

- Address client needs through coordination of care and referrals to needed services
- Ensure that the quality of service and materials given to patients during telehealth encounter is similar with in-person visits.

1. GENERAL AGENCY POLICIES

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

1.0 GENERAL AGENCY POLICIES	
Standard	**Documentation**
1.1 Agency develops or utilizes an existing client confidentiality policy in accordance with state and federal laws to assure protection of client HIV status, behavioral risk factors, and/or use of services.	1.1 Written client confidentiality policy on file with specific information technology safeguards for confidentiality and patient information if using telehealth service modality.
1.2 Agency is responsible for informing the patient that they have the right to obtain copies of their medical and other health records maintained by the agency.	1.2 Written policy for informing the patient of their rights to receive a copy of their medical records. The policy should contain a description of the process for obtaining records, such as a verbal or written request and a reasonable timeframe for patients to receive the information.
1.3 Client determines what information of theirs can be released and with whom it can be shared. Services using telehealth modality are subject to consent by the	1.3 Completed *Release of Information Form* on file including: • Name of agency/individual with whom information will be shared • Information to be shared • Duration of the release consent • Client signature For agencies and information covered by the Health Insurance Portability and Accountability Act (HIPAA), form must be HIPAA disclosure authorization compliant. The form must also be compliant with the

patient.[1]	CA Medi-Cal telehealth policy.[2]
1.4 Agency develops or utilizes an existing grievance procedure to ensure clients have recourse if they feel they are being treated in an unfair manner or feel they are not receiving quality services.	1.4 Written grievance procedure on file that includes, at minimum: • Client process to file a grievance • Information on the Los Angeles County Department of Public Health, Division of HIV & STD Programs (DHSP) Grievance Line 1-800-260-8787. Additional ways to file grievances can be found at http://publichealth.lacounty.gov/dhsp/QuestionServices.htm DHSP Grievance Line is posted in a visible location on site or provided to the patient at the beginning of a telehealth encounter.

[1] https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthFAQ.aspx
[2] https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/mednetele.pdf

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

[4] https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

Standard	Documentation
1.11 Agency complies with all applicable state and federal workplace and safety laws and regulations, including fire safety.	1.11 Signed confirmation of compliance with applicable regulations on file.

2. CLIENT RIGHTS AND RESPONSIBILITIES

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

2.0 CLIENT RIGHTS AND RESPONSIBILITIES	
Standard	**Documentation**
2.1 Agency ensures services are available to any individual who meets the eligibility requirements for the specific service category.	2.1 Written eligibility requirements on file. Client utilization data made available to funder.
2.2 Agency includes input from people living with HIV/AIDS in the design and evaluation of services to ensure care is client-centered.	2.2 Written documentation of how input was received to inform service planning and evaluation in regular reports. Lists may include: • Consumer Advisory Board meetings • Participation of people living with HIV in HIV program committees or other planning bodies • Needs assessments • Anonymous patient satisfaction surveys. Discreet drop off boxes should be available in various sites throughout the agency and/or anonymous electronic follow-up surveys emailed to patients after their appointment. • Focus groups

2.3 Agency ensures that clients receive information technology support and training on how to use telehealth services.	2.3 Written checklists and/or "how to" guides are provided to patients prior to their telehealth appointment. Materials may be emailed to patient and/or posted on the agency website. The document should contain at least the following information: • Instructions on how to use telehealth tools (i.e., phone, laptop, tablets, etc.) in plain language and available in the patient's preferred language. • Telephone number for technical support or trouble shooting available before, during and after the telehealth appointment.
2.4 Agency ensures that clients retain the right to accept or decline a telehealth visit. The ultimate decision on the mode of service delivery, whether in-person or telehealth, must be determined by the client first before an appointment is made.	2.4 Written procedures and telehealth acceptance or denial form completed by patients prior to the appointment.

Standard	Documentation
2.5 Agency provides each client a copy of the *Patient Bill of Rights & Responsibilities (Appendix B)* document that informs them of the following: • Confidentiality policy • Expectations and responsibilities of the client when seeking services • Client right to file a grievance • Client right to receive no-cost interpreter services • Client right to access their file (if psychotherapy notes cannot be released per clinician guidance, agency should provide a summary to client within 30 days) • Reasons for which a client may be removed from services and the process that occurs during involuntary removal	*2.5 Patient Bill of Rights* document is signed by client and kept on file.

3. STAFF REQUIREMENTS AND QUALIFICATIONS

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

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

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

4. CULTURAL AND LINGUISTIC COMPETENCE

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

Agencies should also strive towards acknowledging implicit bias, how it plays a role in service delivery, and how it can be addressed and countered. Agencies must provide services that align with strategies to reduce implicit bias by the Institute for Healthcare Improvement.[7] For the purpose of the standards, implicit bias refers to the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner. These biases, which encompass both favorable and unfavorable assessments, are activated involuntarily and without an individual's awareness or intentional control. Residing deep in the subconscious, these biases are different from known biases that individuals may choose to conceal for the purposes of social and/or political correctness.[8]

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

Federal and State language access laws require health care facilities that receive federal or state funding to provide competent interpretation services to limited English proficiency patients at no cost, to ensure equal and meaningful access to health care services.[9] Interpretation refers to verbal communication where speech is translated from a speaker to a

receiver in a language that the receiver can understand. Translation refers to the conversion of written material from one language to another.

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

[7] http://www.ihi.org/communities/blogs/how-to-reduce-implicit-bias

[8] http://kirwaninstitute.osu.edu/research/understanding-implicit-bias/

[9] Title VI of the Civil Rights Act of 1964 and California's 1973 Dymally-Alatorre Bilingual Services Act

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

5. INTAKE AND ELIGIBILITY

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

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

6. REFERRALS AND CASE CLOSURE

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

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

Standard	Documentation
6.4 Agency has a transition procedure in place that is implemented for clients leaving services to ensure a smooth transition.	6.4 Completed transition summary in file, signed by client and supervisor (if possible). Summary should include reason for case closure; and a plan for transition to other services, if applicable, with confirmation of communication between referring and referral agencies, or between client and agency.
6.5 Agency develops or utilizes existing due process policy for involuntary removal of clients from services; policy includes a series of verbal and written warnings before final notice and case closure.	6.5 Due process policy on file as part of transition, and case closure policy described in the *Patient & Client Bill of Rights* document. (Refer to Appendix B).

Federal and National Resources:

HRSA's Ryan White HIV/AIDS Program Expanding HIV Care Through Telehealth CARE Action Newsletter October 2019:
https://hab.hrsa.gov/sites/default/files/hab/Publications/careactionnewsletter/telehealth.pdf

Telehealth Discretion During Coronavirus:

AAFP Comprehensive Telehealth Toolkit:
https://www.aafp.org/dam/AAFP/documents/practice_management/telehealth/2020-AAFP-Telehealth-Toolkit.pdf

ACP Telehealth Guidance & Resources: https://www.acponline.org/practice-resources/business-resources/telehealth

ACP Telemedicine Checklist: https://www.acponline.org/system/files/documents/practice-resources/health-information-technology/telehealth/video_visit_telemedicine_checklist_web.pdf

AMA Telehealth Quick Guide: https://www.ama-assn.org/practice-management/digital/ama-telehealth-quick-guide

CMS Flexibilities for Physicians: https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf - "Under the CARES Act, CMS is waiving the requirements of section 1834(m)(1) of the ACT and 42 CFR § 410.78(a)(3) for use of interactive telecommunications systems to furnish telehealth services, to the extent they require use of video technology, for certain services. This waiver allows the

use of audio-only equipment to furnish services described by the codes for audio-only telephone evaluation and management services, and behavioral health counseling and educational services."

CMS Flexibilities for RHCs and FQHCs: https://www.cms.gov/files/document/covid-rural-health-clinics.pdf - "Medicare telehealth services generally require an interactive audio and video telecommunications system that permits real-time communication between the practitioner and the patient. (During the PHE, some telehealth services can be furnished using audio-only technology.)"

CMS Fact Sheet on Virtual Services: https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency

Using Telehealth to Expand Access to Essential Health Services during the COVID-19 Pandemic

7. APPENDICES

APPENDIX A: RYAN WHITE PART A SERVICE CATEGORIES

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

Core medical services include the following categories:

- AIDS Drug Assistance Program
- AIDS pharmaceutical assistance
- Early intervention services
- 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
- Mental health services
- Oral health
- Outpatient and ambulatory medical care
- Substance abuse outpatient care

Support services include the following categories:

- Case Management (Non-Medical)
- Childcare Services
- Emergency Financial Assistance
- Food Bank/Home Delivered Meals
- Health Education/Risk Reduction
- Housing Services
- Legal Services
- Linguistic Services

- Medical Transportation
- Outreach Services
- Psychosocial Support Services
- Referral
- Rehabilitation
- Respite Care
- Substance Abuse Residential
- Treatment Adherence Counseling

APPENDIX B: PEOPLE WITH HIV/AIDS BILL OF RIGHTS AND RESPONSIBILITIES

It is the provider's responsibility to provide clients a copy of the Patient Bills of Rights and Responsibilities in all service settings, including telehealth.

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

A. Respectful Treatment and Preventative Services

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

B. Competent, High-Quality Care

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

C. Participate in the Decision-making Treatment Process

1. Receive complete and up-to-date information in words you understand about your diagnosis, treatment options, medications (including common side effects and complications) and prognosis that can reasonably be expected.
2. Participate actively with your provider(s) in discussions about choices and options available for your treatment.
3. Make the final decision about which treatment option is best for you after you have been given all relevant information about these choices and the clear recommendation of your provider.
4. Have access to patient-specific education resources and reliable information and training about patient self-management.
5. Refuse any and all treatments recommended and be told of the effect that not taking the treatment may have on your health, be told of any other potential consequences of your refusal and be assured that you have the right to change your mind later.
6. Be informed about and afforded the opportunity to participate in any appropriate clinical research studies for which you are eligible.
7. Refuse to participate in research without prejudice or penalty of any sort.
8. Refuse any offered services or end participation in any program without bias or impact on your care.
9. Be informed of the procedures at the agency for resolving misunderstandings, making complaints or filing grievances.
10. Receive a response to a complaint or grievance within 30-45 days of filing it.
11. Be informed of independent ombudsman or advocacy services outside the agency to help you resolve problems or grievances (see number at bottom of this form), including how to access a federal complaint center within the Center for Medicare and Medicaid Services (CMS).

D. Confidentiality and Privacy

1. Receive a copy of your agency's Notice of Privacy Policies and Procedures. (Your agency will ask you to acknowledge receipt of this document.)
2. Keep your HIV status confidential. Have information explained to you about confidentiality policies and under what conditions, if any, information about HIV care services may be released.
3. Request restricted access to specific sections of your medical records.
4. Authorize or withdraw requests for your medical record from anyone else besides your health care providers and for billing purposes.
5. Question information in your medical chart and make a written request to change specific documented information. (Your physician has the right to accept or refuse your request with an explanation.)
6.

E. Billing Information and Assistance

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

F. Patient/Client Responsibilities

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

1. Participate in the development and implementation of your individual treatment or service plan to the extent that you are able.
2. Provide your providers, to the best of your knowledge, accurate and complete information about your current and past health and illness, medications and other treatment and services you are receiving, since all of these may affect your care. Communicate promptly any changes or new developments.
3. Communicate to your provider whenever you do not understand information you are given.
4. Follow the treatment plan you have agreed to and/or accept the consequences of failing to adhere to the recommended course of treatment or of using other treatments.
5. Keep your appointments and commitments at this agency or inform the agency promptly if you cannot do so.
6. Keep your provider or main contact informed about how to reach you confidentially by phone, mail or other means.
7. Follow the agency's rules and regulations concerning patient/client care and conduct.
8. Be considerate of your providers and fellow clients/patients and treat them with the respect you yourself expect.
9. Refrain from the use of profanity or abusive or hostile language; threats, violence or intimidations; carrying weapons of any sort; theft or vandalism; intoxication or use of illegal drugs; sexual harassment and misconduct.

For More Help or Information

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

Division of HIV and STD Programs Client Grievance Line
(800) 260-8787 8:00 am – 5:00 Monday – Friday

State of Pennsylvania
Service Standards
Effective July 2018

I. CHILD CARE SERVICES

Intermittent child care services for the children living in the household of HIV-infected clients for the purpose of enabling clients to attend medical visits, related appointments, and/or RWHAP-related meetings, groups, or training sessions.

Allowable use of funds includes:

1. A licensed or registered child care provider to deliver intermittent care
2. Informal child care provided by a neighbor, family member, or other person (with the understanding that existing federal restrictions prohibit giving cash to clients or primary caregivers to pay for these services)

3. Subrecipient shall ensure proper documentation is maintained including:

a. Date and duration of each unit of child care service provided
b. Determination of client eligibility
c. Reason why child care was needed e.g., client medical or other appointment or participation in a Ryan White – related meeting, group, or training session
d. Any recreational and social activities including documentation that they were provided only within a certified or licensed provider setting.

4. Where informal child care arrangements are obtained, subrecipient must ensure:

a. Documentation of compliance with grantee-required mechanism for handling payments for informal child care arrangements
b. Appropriate liability release forms are obtained that protect the client, provider and the Ryan White program
c. Documentation that no cash payments are being made to clients or primary care givers
d. Documentation that payment is for actual costs of service.

South Carolina Ryan White

Part B Program Service Standards

December 2018

STANDARD	PERFORMANCE MEASURE/METHOD	PROVIDER/SUBGRANTEE RESPONSIBILITY	DATA SOURCE
	that such services are provided either as part of discharge planning or for individuals who are in the correctional system for a brief period		
3. Funding for **Child Care Services** for the children of HIV-positive clients, provided intermittently, only while the client attends medical or other appointments or Ryan White HIV/AIDS Program-related meetings, groups, or training sessions May include use of funds to support: • A licensed or registered child care provider to deliver intermittent care • Informal child care provided by a neighbor, family member, or other person (with the understanding that existing Federal restrictions prohibit giving cash to clients or primary caregivers to pay for these services) Such allocations to be limited and carefully monitored to assure: • Compliance with the prohibition on direct payments to eligible individuals • Assurance that liability issues for the funding source are carefully weighed and addressed through the use of liability release forms designed to protect the client, provider, and the Ryan White Program	Documentation of: • The parent's eligibility as defined by the grantee, including proof of HIV status • The medical or other appointments or Ryan White HIV/AIDS Program-related meetings, groups, or training sessions attended by the parent that made child care services necessary • Appropriate and valid licensure and registration of child care providers under applicable State and local laws in cases where the services are provided in a day care or child care setting Assurance that • Where child care is provided by a neighbor, family member, or other person, payments do not include cash payments to clients or primary caregivers for these services • Liability issues for the funding source are addressed through use of liability release forms designed to protect the client, provider, and the Ryan White Program • Any recreational and social activities are provided only in	Maintain documentation of: • Date and duration of each unit of child care service provided • Determination of client eligibility • Reason why child care was needed – e.g., client medical or other appointment or participation in a Ryan White-related meeting, group, or training session • Any recreational and social activities, including documentation that they were provided only within a certified or licensed provider setting Where provider is a child care center or program, make available for inspection appropriate and valid licensure or registration as required under applicable State and local laws Where the provider manages informal child care arrangements, maintain and have available for grantee review: • Documentation of compliance with grantee-required mechanism for handling payments for informal child care arrangements • Appropriate liability release forms obtained that protect the client, provider, and the Ryan White program • Documentation that no cash payments are being made to clients or primary care givers • Documentation that payment is for actual costs of service	• Subgrantee contract and scope of work • Subgrantee budget and budget justification • Implementation Plan • Implementation Plan Report • Monthly invoices and backup documentation • EMR/EHR/Paper Client Chart • Provide Enterprise • Licensure or provider setting • Liability release form • Monthly Invoices for child care services

STANDARD	PERFORMANCE MEASURE/METHOD	PROVIDER/SUBGRANTEE RESPONSIBILITY	DATA SOURCE
May include **Recreational and Social Activities** for the child, if provided in a licensed or certified provider setting including drop-in centers in primary care or satellite facilities • Excludes use of funds for off-premise social/recreational activities	a licensed or certified provider setting		
4. Support **for Emergency Financial Assistance (EFA**) for essential services including utilities, housing, food (including groceries, food vouchers, and food stamps), or medications, provided to clients with limited frequency and for limited periods of time, through either: • Short-term payments to agencies • Establishment of voucher programs **Note:** Direct cash payments to clients are not permitted	Documentation of services and payments to verify that: • EFA to individual clients is provided with limited frequency and for limited periods of time, with frequency and duration of assistance specified by the grantee • Assistance is provided only for the following essential services: utilities, housing, food (including groceries, food vouchers, and Food Stamps), or medications • Payments are made either through a voucher program or short-term payments to the service entity, with no direct payments to clients • Emergency funds are allocated, tracked, and reported by type of assistance • Ryan White is the payer of last resort	Maintain client records that document for each client: • Client eligibility and need for EFA • Types of EFA provided • Date(s) EFA was provided • Method of providing EFA Maintain and make available to the grantee program documentation of assistance provided, including: • Number of clients and amount expended for each type of EFA • Summary of number of EFA services received by client • Methods used to provide EFA (e.g., payments to agencies, vouchers) Provide assurance to the grantee that all EFA: • Was for allowable types of assistance • Was used only in cases where Ryan White was the payer of last resort • Met grantee specified limitations on amount and frequency of assistance to an individual client • Was provided through allowable payment methods	• Subgrantee contract and scope of work • Subgrantee budget and budget justification • Monthly invoices and backup documentation • Implementation Plan • Implementation Plan Report • Subgrantee budget and budget justification • EMR/EHR/Paper Client Chart • Provide Enterprise • Financial Records • Monthly Invoices for EFA services
5. Funding for **Food Bank/Home-delivered Meals** that may include: • The provision of actual food items • Provision of hot meals	Documentation that: • Services supported are limited to food bank, home-delivered meals, and/or food voucher	Maintain and make available to grantee documentation of: • Services provided by type of service, number of clients served, and levels of	• Subgrantee contract and scope of work • Subgrantee budget and budget justification

CHILDCARE

STANDARDS OF CARE

DRAFT—UPDATED 12/14/20

LOS ANGELES COUNTY COMMISSION ON HIV

CHILDCARE SERVICES STANDARDS OF CARE

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

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

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

Service Standards: Ryan White HIV/AIDS Programs

INTRODUCTION

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

The Los Angeles County Commission on HIV developed the Childcare Services Standards of Care to establish the minimum standards of care necessary to ensure people living with HIV (PLWH) can receive quality childcare services when attending core medical and/or support services appointments and meetings. The development of the Standards includes guidance from service providers, people living with HIV, the Los Angeles County Department of Public Health, Division of HIV and STD Program (DHSP), members of the Los Angeles County Commission on HIV, Standards & Best Practices Committee, Women's Caucus, and the public-at-large.

CHILDCARE SERVICES OVERVIEW: ALLOWABLE USE OF FUNDS

HRSA allows the use of Ryan White Part A funding for childcare services for the children of clients living with HIV, provided intermittently, **only while** the client attends in person, telehealth, or other appointments and/or Ryan White HIV/AIDS Program-related meetings, groups, or training sessions. Part A funded childcare services cannot be used while the patient is at school or work. Only Ryan White Part A community advisory board meetings and Part A funded support groups are covered in these standards. The goal of childcare services is to reduce barriers for clients in accessing, maintaining and adhering to primary health care and related support services. Childcare services are to be made available for all clients using Ryan White Part A medical and support services. "**Licensed**" means childcare providers who are

licensed by the State of California and are required to maintain minimum standards related to physical size of the facility, safety features, cleanliness, staff qualifications, and staff-to-child ratios.

Childcare services may include recreational and social activities for the child/children, if provided in a licensed childcare setting including drop-in centers in primary care or satellite facilities. However, funds may not be used for off-premise social/recreational activities or gym membership. Existing Federal restrictions prohibit giving cash to clients or primary caregivers to pay for these services.

All service providers receiving funds to provide childcare services are required to adhere to the following standards.

Table 1. CHILDCARE SERVICE REQUIREMENTS

SERVICE COMPONENT	STANDARD	DOCUMENTATION
Eligibility and Need	Eligibility for Ryan White and need for childcare service are identified at intake and assessments by agencies providing licensed childcare.	Documentation of eligibility and in the client's primary record must reflect the appointment and/or meeting/group/training session attended.
Licensed Child Care Centers and Family Child Care Homes	Licensed childcare facilities must carry a valid active license as a childcare provider in the State of California. Services must be delivered according to California State and local childcare licensing requirements which can be found on the California Department of Social Services, Community Care Licensing Division website.[1]	a. Appropriate liability release forms are obtained that protect the client, provider, and the Ryan White program b. Providers must develop policies, procedures, and signed agreements with clients for childcare services. c. Documentation that no cash payments are being made to clients or primary care givers
Training	Agencies providing childcare are responsible for ensuring	Record of trainings on file at provider agency.

[1] https://cdss.ca.gov/inforesources/child-care-licensing

	childcare providers are trained appropriately for their responsibilities. In addition to State-required training for licensed childcare providers, childcare staff must complete the following training: • Domestic violence • HIPAA and confidentiality • Cultural diversity • HIV stigma reduction • LGBTQ 101 • Ryan White programs and service referral	
Language	Whenever possible, childcare should be delivered in the language most familiar to the child or language preferred by the patient. If this is not possible, interpretation services must be available in cases of emergency.	Appropriate language noted in client or program file.
Confidentiality	Agencies coordinating and providing childcare services must ensure client confidentiality will always be maintained. HIV status shall never be disclosed to anyone.	Written confidentiality and HIPAA policy in place. Documentation of notice of privacy and confidentiality practices provided to clients and/or family members before the start of service. Signed confidentiality policy and agreements for all employees on file and reviewed during new hire orientation and annually.
Service Promotion	Agencies coordinating licensed childcare services are expected to promote the availability of childcare to potential clients, external partners, and other	Program flyers, emails, or website documenting that childcare services was promoted to clients and HIV service providers.

	DHSP-funded Ryan White service providers.	
Referrals	Programs coordinating childcare services will provide referrals and information about other available resources to adults living with HIV who have the primary responsibility for the care of children. Special consideration should be given to helping clients find longer term or additional childcare options and resources.[2] Whenever appropriate, program staff will provide linked referrals demonstrating that clients, once referred, have accessed services. Staff are required to coordinate across Ryan White funded and non-funded programs to ensure clients' needs are met.	Documentation of referral efforts will be maintained on file by coordinating agency. Description of staff efforts of coordinating across systems in client file (e.g. referrals to

[2] Los Angeles County Department of Public Health, Office for the Advancement of or Early Care and Education: https://childcare.lacounty.gov/resources-for-families-and-communities/

	Follow up with client in 30 days to track referrals related to care coordination.	housing case management services, etc.). Documentation of follow up in client file.
Transportation	Clients who demonstrate a need for transportation to and from the childcare site, must be provided transportation support. Agencies must follow transportation programmatic guidance and requirements from DHSP. Childcare must be provided in a manner that is more accessible and convenient for the client.	
Physical Environment	The design and layout of the physical environment have a profound impact on children's safety, learning, behavior and on the client's ability to focus on their medical and support services appointments. Childcare environments must have: • Internet access and computers for children to use to complete schoolwork or participate in virtual classes if the parent/caregiver Ryan White appointment occurs during school hours • Age-appropriate educational supplies • Healthy food/snacks • Masks and personal protective equipment (PPEs) especially designed for children • A variety of inviting equipment and play materials accessible to children • Kid-friendly and visually appealing space with sufficient and uncluttered space for active play with an additional cozy space set aside for individual and quiet play • Kid-friendly videos available to watch • Available 5 days a week	

Appendix A: Examples of Childcare Resources

California Department of Social Services, Childcare Licensing
https://www.cdss.ca.gov/inforesources/child-care-licensing
The State of California requires licensed childcare providers to complete trainings in First Aid/CPR; fire and electrical safety; child development; waste disposal procedures; child abuse (includes sexual abuse); Health Insurance Portability and Accountability Act of 1996 (**HIPAA**) and confidentiality; infection control and preventative health measures; and the American Disabilities Act (ADA). Visit the website for additional information on childcare licensing rules and regulations.

Child Care Alliance Los Angeles offers voucher-based services for low income families.
https://www.ccala.net/

Los Angeles County Department of Public Health, Office for the Advancement of or Early Care and Education: https://childcare.lacounty.gov/resources-for-families-and-communities/

Los Angeles Education Partnership
www.laep.org
LAEP offers childcare for parent workshops, meetings, conferences, and other activities on a fee-for-service basis. LAEP brings all the necessary materials and supplies, including snacks.