LOS ANGELES COUNTY
COMMISSION ON HIV

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Standards and Best Practices Committee Meeting

Tuesday, May 2, 2023
10:00am-12:00pm (PST)

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

Agenda and meeting materials will be posted on our website at https://hiv.lacounty.gov/standards-and-best-practices-committee/

Notice of Teleconferencing Sites:
None

MEMBERS OF THE PUBLIC:
To Register + Join by Computer:
https://lacountyboardofsupervisors.webex.com/weblink/register/rc2faa3fc94c81e6ddde0861ec7be26df
To Join by Telephone: 1-213-306-3065
Password: STANDARDS Access Code: 2590 672 7257

Scan QR code* to download an electronic copy of the meeting agenda and packet on your smart device. Please note that hard copies of materials will not be made available during meetings unless otherwise determined by staff in alignment with the County's green initiative to recycle and reduce waste.

**Accessing meeting materials via the QR code: (1) Open your camera app on your smart device, (2) Select the rear-facing camera in Photo or Camera mode, (3) Center the QR code that you want to scan on the screen and hold your phone steady for a couple of seconds, and (4) Tap the notification that pops up to open the link.*

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LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave., 14th Floor, Los Angeles CA 90020
MAIN: 213.738.2816 EML: hivcomm@lachiv.org WEBSITE: https://hiv.lacounty.gov

AGENDA FOR THE REGULAR MEETING OF THE LOS ANGELES COUNTY COMMISSION ON HIV

STANDARDS AND BEST PRACTICES COMMITTEE

TUESDAY, MAY 2, 2023 | 10:00 AM – 12:00 PM

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

MEMBERS OF THE PUBLIC:
To Register + Join by Computer:
https://lacountyboardofsupervisors.webex.com/weblink/register/rc2faa3fc94c81e6ddde0861ec7be26df
To Join by Telephone: 1-213-306-3065
Password: STANDARDS Access Code: 2590 672 7257

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

AGENDA POSTED: April 26, 2023.

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

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

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

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

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

I. ADMINISTRATIVE MATTERS

1. Call to Order & Meeting Guidelines/Reminders		10:00 AM – 10:03 AM
2. Introductions, Roll Call, & Conflict of Interest Statements		10:03 AM – 10:05 AM
3. Assembly Bill 2449 Attendance Notification for "Emergency Circumstances"	**MOTION #1**	10:05 AM – 10:07 AM
4. Approval of Agenda	**MOTION #2**	10:07 AM – 10:08 AM
5. Approval of Meeting Minutes for 3/7/23 and 4/4/23	**MOTION #3**	10:08 AM – 10:10 AM

II. PUBLIC COMMENT

10:10 AM – 10:15 AM

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

III. COMMITTEE NEW BUSINESS ITEMS

7. Opportunity for 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

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

V. DISCUSSION ITEMS

11. MCC Workforce Survey Results Presentation 10:35 AM—11:20 AM
12. Universal Service Standards Review 11:20 AM—11:30 AM
13. Nutrition Support Services Standards Review 11:30 AM – 11:50 AM

VI. NEXT STEPS 11:50 AM – 11:55 AM

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

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

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

VIII. ADJOURNMENT 12:00 PM

17. Adjournment for the meeting of May 2, 2023

PROPOSED MOTIONS	
MOTION #1:	Approve remote attendance by members due to "emergency circumstances", per AB 2449.
MOTION #2	Approve the Agenda Order as presented or revised.
MOTION #3	Approve the Standards and Best Practices Committee minutes, as presented or revised.
MOTION #4	Announce a 30-day public comment period for the Universal Service Standards starting on 5/2/23 and ending on 6/2/23

HYBRID MEETING GUIDELINES, ETTIQUETTE & REMINDERS

(Updated 3.22.23)

☐ This meeting is a **Brown-Act meeting** and is being recorded.

- The conference room speakers are *extremely* sensitive and will pick up even the slightest of sounds, i.e., whispers. If you prefer that your private or side conversations, not be included in the meeting recording which, is accessible to the public, we respectfully request that you step outside of the room to engage in these conversations.
- Turn off your ringers/notifications on your smart devices so as not to disrupt the meeting.
- Your voice is important, and we want to ensure that it is captured accurately on the record. Please be respectful of one another and minimize crosstalk.

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

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

☐ **Public Comment** for members of the public can be submitted in person, electronically @ https://www.surveymonkey.com/r/public_comments or via email at hivcomm@lachiv.org. *For members of the public attending virtually, you may also submit your public comment via the Chat box. Should you wish to speak on the record, please use the "Raised Hand" feature or indicate your request in the Chat Box and staff will call upon and unmute you at the appropriate time. Please note that all attendees are muted unless otherwise unmuted by staff.*

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

☐ Committee members invoking **AB 2449 for "Just Cause" or "Emergency Circumstances**" must communicate their intentions to staff and/or co-chairs no later than the start of the meeting. Members requesting to join pursuant to AB 2449 must have their audio and video on, at all times, and disclose whether there is a person over the age of 18 in the room in order to be counted toward quorum and have voting privileges. For members joining virtually due to "Emergency Circumstances", a vote will be conducted by the Committee/COH for approval.

☐ Members will be required to explicitly state their agency's **Ryan White Program Part A and/or CDC prevention conflicts of interest** on the record (versus referring to list in the packet). A list of conflicts can be found in the meeting packet and are recorded on the back of members' name plates, courtesy of staff.

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 3/21/23

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

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
CAMPBELL	**Danielle**	UCLA/MLKCH	Oral Health Care Services
			Medical Care Coordination (MCC)
			Ambulatory Outpatient Medical (AOM)
			Transportation Services
CIELO	**Mikhaela**	LAC & USC MCA Clinic	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
CUMMINGS	**Mary**	Bartz-Altadonna Community Health Center	No Ryan White or prevention contracts
DAVIES	**Erika**	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DOAN	**Pearl**	No Affiliation	No Ryan White or prevention contracts
DONNELLY	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
FINDLEY	**Felipe**	Watts Healthcare Corporation	Transportation Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Oral Health Care Services
			Biomedical HIV Prevention
			STD Screening, Diagnosis and Treatment
FRAMES	**Arlene**	Unaffiliated consumer	No Ryan White or prevention contracts
FULLER	**LUCKIE**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			Nutrition Support
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
GONZALEZ	**Felipe**	Unaffiliated consumer	No Ryan White or Prevention Contracts
GORDON	**Bridget**	Unaffiliated consumer	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
GREEN	**Joseph**	Unaffiliated consumer	No Ryan White or prevention contracts
HALFMAN	**Karl**	California Department of Public Health, Office of AIDS	Part B Grantee
KOCHEMS	**Lee**	Unaffiliated consumer	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts
MAGANA	**Jose**	The Wall Las Memorias, Inc.	HIV Testing Storefront
			HIV Testing Social & Sexual Networks
MARTINEZ	**Eduardo**	AIDS Healthcare Foundation	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Medical Care Coordination (MCC)
			Mental Health
			Oral Healthcare Services
			STD Screening, Diagnosis and Treatment
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
			Medical Subspecialty
			HIV and STD Prevention Services in Long Beach
MARTINEZ (PP&A Member)	**Miguel**	Children's Hospital Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
			Promoting Healthcare Engagement Among Vulnerable Populations
MAULTSBY	**Leon**	Charles R. Drew University	HIV Testing Storefront
			HIV Testing Social & Sexual Networks

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MILLS	**Anthony**	Southern CA Men's Medical Group	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
MINTLINE (SBP Member)	**Mark**	Western University of Health Sciences (No Affiliation)	No Ryan White or prevention contracts
MOLLETTE	**Andre**	Southern CA Men's Medical Group	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
MURRAY	**Derek**	City of West Hollywood	No Ryan White or prevention contracts
NASH	**Paul**	University of Southern California	Biomedical HIV Prevention

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
NELSON	**Katja**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			Nutrition Support
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Nutrition Support
OROZCO	**Jesus ("Chuy")**	HOPWA-City of Los Angeles	No Ryan White or prevention contracts
PERÉZ	**Mario**	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee
ROBINSON	**Mallery**	We Can Stop STDs LA (No Affiliation)	No Ryan White or prevention contracts
ROBINSON	**Redeem**	All Souls Movement (No Affiliation)	No Ryan White or prevention contracts
ROSALES	**Ricky**	City of Los Angeles AIDS Coordinator	No Ryan White or prevention contracts
SATTAH	**Martin**	Rand Schrader Clinic LA County Department of Health Services	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
SAN AGUSTIN	**Harold**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV)
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
SPENCER	**LaShonda**	Oasis Clinic (Charles R. Drew University/Drew CARES)	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
STALTER	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
VALERO	**Justin**	No Affiliation	No Ryan White or prevention contracts
WEEDMAN	**Jonathan**	ViaCare Community Health	Biomedical HIV Prevention

DRAFT

LOS ANGELES COUNTY
COMMISSION ON HIV

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

STANDARDS AND BEST PRACTICES (SBP) COMMITTEE MEETING MINUTES

March 7, 2023

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

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

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

CALL TO ORDER-INTRODUCTIONS-CONFLICT OF INTEREST STATEMENTS
The meeting was called to order at 10:04 am. Kevin Stalter led introductions.

I. ADMINISTRATIVE MATTERS

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

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

2. APPROVAL OF MEETING MINUTES
MOTION #3: Approve the 2/7/2023 SBP Committee meeting minutes, as presented ***(✓Passed by consensus).***

II. PUBLIC COMMENT

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

III. COMMITTEE NEW BUSINESS ITEMS

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

IV. REPORTS

5. **EXECUTIVE DIRECTOR/STAFF REPORT**

a. Return to In-Person Meetings

- Cheryl Barrit, Executive Director, reminded the Committee of the upcoming full-body Commission meeting taking place on Thursday March 9, 2023 from 9:00am to 1:00pm at the Vermont Corridor. She directed the Committee to review an email sent by COH staff regarding parking instructions and parking validation information. She reminded that once validated, attendees will have a 10-minute window to return to their vehicle and exit the parking structure. Additionally, the meeting will feature a 30 minute "meet and greet" reception starting at 9:00am.

b. Human Resources and Services Administration (HRSA) Site Visit

- Cheryl Barrit mentioned the Human Resources and Services Administration (HRSA) site visit took place on February 14 through February 17 which consisted of a comprehensive joint-review of the Ryan White Program Part A and the Ending the HIV Epidemic funding under HRSA. The site visit looked at the administrative functions related to the Division on HIV and STD Programs (DHSP), the Planning Council, also known as the Commission on HIV (COH). On February 16, HRSA staff held a closed-meeting with leadership representatives from the COH Executive Committee, and a closed-listening session with the COH Consumer Caucus. DHSP staff and COH staff were not invited to the meetings. HRSA also met separately with COH staff and asked for clarification about process and documentation. She noted that DHSP has not received an office site visit report, however Dr. Michael Green met with COH leadership staff and shared that the report can be expected 45 days from February 17th, 2023. C. Barrit has requested Dr. Green join the March Executive Committee meeting to provide the same high level overview pending receipt of the official site visit report. Once received, DHSP and COH have 30 days to submit a plan of corrective action. The Executive Committee will work with DHSP and COH staff to address any opportunities for improvement within the COH's processes and the way the COH conducts its operations as a planning council.

  Erika Davies asked if there were any questions related service standards. C. Barrit noted that the HRSA site visit reviewer asked COH staff about the service standards development process. The reviewer was interested in knowing about the level of Commissioner involvement in the process. C. Barrit shared that the SBP Committee is the lead Committee for the development of standards. The process is influenced by several factors including the DHSP solicitations schedule, the priorities set by the Planning, Priorities, and Allocations (PP&A) Committee, and public comment. Erika Davies asked if the reviewers asked about the frequency of reviews. C. Barrit also shared that the reviewers asked why some standards have not been updated for a while. COH staff responded by saying that some standards are not currently funded or have not been funded for a while. C. Barrit noted that COH staff member Jose Rangel-Garibay recommended updating the format of the older standards to maintain uniform formatting for all standards posted on the website.

  Kevin Stalter and E. Davies recommended including a table summarizing the changes made to the standards as a means to document the review process. K. Stalter also recommended removing any items from the standards that are already included in the Universal Standards to avoid redundancy. K. Stalter mentioned that he attended two of the closed-session meetings and shared that in one meeting a HRSA reviewer staff asked the group why the COH bylaws had not been updated since 2013 noting that the

diseased has changed a lot since 2013. The group responded by noting that the Ryan White Care Act has not been reauthorized or had any major changes since 2005. K. Stalter noted that the HRSA reviewers seemed more informed this time around compared to the last HRSA site visit in 2018. Wendy Garland added that on the first day of the site visit, DHSP staff provided an overview of the Los Angeles County to give context to the complexity of doing HIV work in Los Angeles County. She shared the example of understanding transportation challenges people face given the physical landscape of Los Angeles County.

6. **CO-CHAIR REPORT**
   - **2023 Workplan Development and Meeting Schedule Review**
     E. Davies provided an overview of the 2023 Workplan and Meeting Schedule. The Committee decided to consider cancelling or rescheduling the September 5, 2023 Committee meeting due to the Labor day Holiday landing on 9/4/23. The Committee also decided to Cancel the July 4, 2023 Committee meeting due to the Independence Day holiday landing on 7/4/23. The Committee will revisit the meeting calendar on a monthly basis and update the dates according to progress made on service standards reviews. The documents are included in the meeting packet.
7. **DIVISION ON HIV AND STD PROGRAMS (DHSP) REPORT**
   - **Presentation: Medical Care Coordination (MCC) Overview**
     Wendy Garland provided a presentation titled "Overview of the Medical Care Coordination (MCC) Program to Inform Service Standards Revision". The data presented demonstrated that the MCC program is grounded in the MCC standards and included a description of the framework used for standardized implementation. The data also demonstrated the following: intended patients are being reached, services are being delivered with fidelity, retention and viral suppression improved significantly after 12 months, and service continuity maintained during COVID-19 pandemic through addition of telehealth services. The presentation slides are available in the meeting packet.

V. DISCUSSION ITEMS

8. **Oral Health Care Services Standards**
   MOTION #4: Approve the Oral Health Care Services Standards, as presented or revised, and elevate to the Executive Committee. ***(✓Passed. Yes: 7)***.
9. **Universal Service Standards**
   - The Committee tabled the review of the Universal Service standards to the April meeting.

VI. NEXT STEPS

10. **TASK/ASSIGNMENTS RECAP**:
    - COH staff will elevate the Oral Health Services Standards to the Executive Committee
    - COH staff will prepare the Nutrition Support Service Standards for initial Committee review
    - COH staff will follow-up with Wendy Garland regarding the MCC survey results

10. **AGENDA DEVELOPMENT FOR NEXT MEETING**:
    - Continue review of Universal Service Standards
    - Initiate review of Nutrition Support Service Standards

VII. ANNOUNCEMENTS

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

VIII. ADJOURNMENT

12. **ADJOURNMENT**: The meeting adjourned at 11:46am.

DRAFT

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COMMISSION ON HIV

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STANDARDS AND BEST PRACTICES (SBP) COMMITTEE MEETING MINUTES

April 4, 2023

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

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**Meeting minutes may be corrected up to one year from the date of Commission approval.*
***LOA: Leave of absence*

Meeting agenda and materials can be found on the Commission's website at
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CALL TO ORDER-INTRODUCTIONS-CONFLICT OF INTEREST STATEMENTS
The meeting was called to order at 10:15 am. Kevin Stalter led introductions.

I. ADMINISTRATIVE MATTERS

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

1. APPROVAL OF AGENDA
MOTION #2: Approve the agenda order, as presented ***(Postponed, no quorum)***.

2. APPROVAL OF MEETING MINUTES
MOTION #3: Approve the 3/7/2023 SBP Committee meeting minutes, as presented ***(Postponed, no quorum).***

II. PUBLIC COMMENT

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

III. COMMITTEE NEW BUSINESS ITEMS

4. **OPPORTUNITY FOR COMMISSIONERS TO RECOMMEND ITEMS FOR FUTURE AGENDAS, OR ITEMS REQUIRING IMMEDIATE ACTION DUE TO AN EMERGENCY, OR IF NEED FOR ACTION AROSE AFTER POSTING AGENDA**: Kevin Stalter recommend an item for future agendas related to a review of the Emergency Financial Assistance (EFA) program.

   Erika Davies requested a report back on what has been working well and what has not been working in particular to the maximum amount of assistance that can be provided. It is currently listed as up to $5,000 per client per year on the standard. Perhaps the Committee needs to revisit the amount and increase it based on the approved applications. Additionally, have the Committee consider adding language that clarifies what the funds can be used for such as grocery store gift cards. She added that the amount of concerns mentioned warrant a review to make sure that the service standards are not prohibiting people from accessing EFA services.

   C. Barrit suggested that the Committee consider hearing from the third-party administrators contracted by DHSP to administer the EFA program, from providers, case managers, and clients with success stories to get a fuller picture of how the program is working and shed light on why applications are denied or kicked back and length of time for case managers to respond to clients once the application is submitted and resolved. This would help the Committee identify areas that it can focus on for review and improve access, turnaround time, and use of the EFA program services.

IV. REPORTS

5. **EXECUTIVE DIRECTOR/STAFF REPORT**
   a. **Mandatory and Supplemental Training Series**

- Cheryl Barrit, Executive Director, reported that the Commission has launched the Mandatory and Supplemental Training series. She noted that the trainings are open to the public and encouraged Committee members to share the registration links for the virtual sessions with any interested stakeholders. The training schedule is available on the Commission website under the "Events" tab. She reminded commissioners that HRSA requires annual training for commissioners and that this training series covers that requirement. For those not able to attend the live training session, they can access the training recordings on the Commission website and notify Commission staff that they viewed the training to receive credit for the mandatory trainings.

  K. Stalter asked for clarification on whether or not Wendy Garland, as a DHSP representative, is considered a voting member and counts towards quorum given the discussion that took place during the HRSA site visit in February. C. Barrit noted that until the Commission's bylaws change, DHSP representatives that sit on the SBP, Executive, PP&A, and Public Policy committees count towards quorum and are voting members.

6. **CO-CHAIR REPORT**

- **2023 Workplan Development and Meeting Schedule Review**

  K. Stalter decided to skip agenda item 9a "Getting to Know You Activity" from the agenda due to low attendance. For agenda item 9b "Workplan development and meeting schedule review", K. Stalter noted that there were no changes since the March meeting. These changes include cancelling or rescheduling the July, September, and December meetings depending on the Committee's workload and likelihood of achieving quorum.

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

- **Medical Care Coordination (MCC) Workforce Survey Follow-Up**

Wendy Garland reported that about 2 years ago, a group of MCC team members from different agencies convened to develop a workforce survey designed to gain insights in to the MCC program and identify areas of improvement. She reached out to a couple of the people involved in the project and asked to have them present their findings from the January 2022 survey at a Committee meeting. W. Garland briefly described the survey as having different domains including the assessment process, care plan development, referral documentation, brief interventions, case conferencing, reporting mechanisms, and administrative processes that facilitate or hinder service delivery. She noted that the survey results can assist the Committee in determining areas to focus on when reviewing the MCC service standard. DHSP staff are working with the MCC workgroup to determine the changes that can be enacted quickly and develop a plan for the changes that may require more time and resources to implement. W. Garland shared that the current timeline for implementing the new and improved MCC program is March 2024.

V. DISCUSSION ITEMS

8. Medical Care Coordination (MCC) Review

- W. Garland suggested inviting members of the MCC workforce group to present key findings from their survey to the SBP Committee and discuss recommendations they have for updating the MCC service standards. Erika Davies suggested having the presentation at the May meeting to allow time for the Committee to discuss the findings and aim to complete the MCC service standard review by the October 2023 target date listed on the Committee workplan.

9. Universal Service Standards Review

- Jose Rangel-Garibay noted that the Committee left off on Appendix B, Section F in their review of the Universal Standards. Please refer to the meeting packet for a copy of the draft Universal Standards under review. E. Davies read through Section F and the following recommendations were made:
    - On item 3, replace "given" with "provided"
    - On item 4, replace "other treatments" to "alternative treatments"
    - On item 4, replace "accept the consequences of failing to adhere to the recommended course of treatment" to " understand the consequences of not adhering to the recommended treatment"
    - On item 9, separate into two items to read as follows: Revised Item 9, "Refrain from the use of profanity or abusive or hostile language; threats, violence or intimidations; carrying weapons of any sort; theft or vandalism." Item 10, "If you are a person living with a substance use disorder, please be open and honest with your provider about your substance use so that any issues can be properly addressed.

  The next step will be to present the changes to the Consumer Caucus and post the document for a 30-day public comment period at the May 2, 2023 SBP Committee meeting.

10. Nutrition Support Services Review

- Jose Rangel-Garibay noted that he took the Nutrition Support Services Standards document posted on the Commission website and transferred the content into the updated format. He also noted that he has not removed any repetitive content. C. Barrit added that a low hanging fruit update for this standard will be changing the income threshold for eligibility requirement from 135% to 500% of the federal poverty level.

  Erika Davies led a read through of the document; the Committee noted the following suggestions. Please refer to the meeting packet for a copy of the document.
    - Review the descriptions and qualifications listed for Certified Food Handlers (CFH), Registered Dietitians (RD), and Dietetic Technician, Registered (DTR) to ensure the standard is current; determine what are the requirements for participating in the challenge exam in lieu of the

education/experience requirements and if this is still a viable option for people to obtain their Food Handler certification. Additionally, include links to any challenge exam and any other credentialing exam required for Certified Food Handlers, Registered Dietitians, and Dietetic Technician Registered.

- Review current nutritional guidelines set by the Association of Nutrition Services Agencies, Dietitians in AIDS Care, and the American Dietetic Association to ensure the standard is current.
- Investigate if the service category allows for the provision of food store gift cards or meal vouchers; determine if the service can be expanded beyond home delivered meals and food bank/pantry services. Commission staff will review the HRSA definition for the Nutrition Support service category. J. Rangel-Garibay noted that the HRSA Policy Clarification notice for Use of Ryan White Funds states that, "Home delivered meals, refer to the provision of actual food items, hot meals or a voucher program to purchase food. This also includes the provision of essential non-food items."
- Recommendation to frame the standard around the notion that "food is a basic need that needs to be addressed". C. Barrit reminded the Committee of their charge of developing service standards that set the minimum quality expectations for service provision and to guarantee clients' consistent care.
- Under the "Food Safety/Quality" service component, the standard reads "All nutrition support programs will follow HACCP Guidelines and local Los Angeles County Environmental Health Food Safety Guidelines" and the measure is "Inspection to confirm." E. Davies suggests seeking clarification on whose responsibility it is to confirm the provider agency is following the Food safety guidelines mentioned in the standard; this responsibility appears out of scope for DHSP to monitor. She added that the perhaps this should be removed from the standard or edited to clarify the agency responsible for inspection and describe DHSP's responsibility to ensure the agency has passed inspection. Recommended language for the measure is "Documentation on file." Commission staff will make this edit to any further mention of Food Safety inspections.
- E. Davies recommended creating a single table that contains the service standards and measures for both Home Delivered Meals and Food Banks/Pantries and add a column at the end that denotes which standards apply respectively to reduce the length of the document.
- Under the service component description for "HIV/AIDS Food Bank/Pantry Service" add "under-insured" to the list of eligibility qualifications.
- Under "Client Intake-- Food Banks/Pantries" delete the standard that reads "Case conferences held by RN and social worker (at minimum) will review and revise service plans at least every 60 days. Client or representative feedback will be sought" since it does not relate to the service category.
- Under "Staffing Requirements and Qualifications-- Food Banks/Pantries" verify if "stool screening" is a requirement for employment.
- Under "Staffing Requirements and Qualifications-- Food Banks/Pantries" combine the last two standards listed on the table. See meeting packet for a copy of the document.

VI. NEXT STEPS

11. TASK/ASSIGNMENTS RECAP:

- Commission staff will follow-up with DHSP staff to coordinate a review of the EFA program
- Commission staff will follow-up with DHSP staff to invite members of the MCC workforce group to present their survey findings to the Committee
- Commission staff will investigate items identified on the Nutrition Support service standards

10. AGENDA DEVELOPMENT FOR NEXT MEETING:

- MCC Workforce Survey presentation
- Continue review of Nutrition Support Services standards
- Post the Universal Standards for 30-day Public Comment

VII. ANNOUNCEMENTS

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

VIII. ADJOURNMENT

12. ADJOURNMENT: The meeting adjourned at 11:51am.

LOS ANGELES COUNTY
COMMISSION ON HIV

2023 Training Schedule

- All trainings are open to the public.
- Click on the training topic to register.
- Recordings will be available on our website for those unable to join live trainings.
- Certifications of Completion will be provided.
- All trainings are virtual.

Topic	Date
General Orientation and Commission on HIV Overview *	March 29 3:00 - 4:30 PM
Priority Setting and Resource Allocation Process & Service Standards Development *	April 12 3:00 - 4:30 PM
Tips for Making Effective Written and Oral Public Comments	May 24 3:00 - 4:00 PM
Ryan White Care Act Legislative Overview Membership Structure and Responsibilities *	July 19 3:00 - 4:30 PM
Public Health 101	August 16 3:00 - 4:30 PM
Sexual Health and Wellness	September 20 3:00 - 5:00 PM
Health Literacy and Self-Advocacy	October 18 3:00 - 4:30 PM
Policy Priorities and Legislative Docket Development Process *	November 15 3:00 - 4:30 PM
Co-Chair Roles and Responsibilities	December 6 4:00 - 5:00 PM

Mandatory core trainings for all commissioners.

LOS ANGELES COUNTY COMMISSION ON HIV 2023
STANDARDS AND BEST PRACTICES WORKPLAN (Updates in RED)

Co-Chairs: Erika Davies, Kevin Stalter				
Adopted on: 03/07/23				
Purpose of Work Plan: To focus and prioritize key activities for COH Committees and subgroups for 2023.				
#	**TASK/ACTIVITY**	**DESCRIPTION**	**TARGET COMPLETION DATE**	**STATUS/NOTES/OTHER COMMITTEES INVOLVED**
1	Review and refine 2023 workplan	COH staff to review and update 2023 workplan monthly	Ongoing, as needed	Workplan revised/updated on: 01/03/23, 02/02/23, 02/28/23, 03/21/23, 5/1/23
2	Provide feedback on implementation of the Comprehensive HIV Plan (CHP)	Collaborate with the PP&A Committee to support the implementation of the CHP	Ongoing, as needed	
3	Update the Oral Health Care service standards	Continue review initiated in 2022.	April 2023 Complete	The Committee announced a 30-day public comment period starting on 01/04/23 and ending on 02/05/23. The Committee approved the document and elevated it to the Executive Committee for approval at their 03/23/23 meeting.
4	Update Universal service standards and Consumer Bill of Rights	Annual review of the standards. Revise/update document as needed.	June 2023	Incorporate Mental health training and documentation needed for addressing the needs of people living with HIV 50+. Committee will announce a 30-day public comment period starting on 5/2/23 and begin sharing updates with COH caucuses.
5	Update Nutrition Support Service Standards	Review and revise/update document as needed	August 2023	Committee will continue its review in May.
6	Update the Medical Care Coordination (MCC) service standards	Committee received a public comment requesting for a review and update of the MCC services standards.	October 2023	Wendy Garland from DHSP delivered a presentation on the MCC program overview at the March meeting. Members that helped develop the MCC Workforce Survey will present key findings at May meeting.
7	Update Prevention Service standards	Review and revise/update document as needed	Late 2023	The Committee will review their meeting calendar in June to determine next steps for this item.
8	Update the Transitional Case Management: Youth service standards		Late 2023	The Committee will review their meeting calendar in June to determine next steps for this item.

9	Develop Transitional Case Management: 50+ service standards	Collaborate with the Aging Caucus to develop a TCM service standard that focused on healthcare navigation between the Ryan White Care System, Medi-Cal, and Medi-Care for people living with HIV 50+	Late 2023	The Committee will review their meeting calendar in June to determine next steps for this item.

LOS ANGELES COUNTY
COMMISSION ON HIV

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

STANDARDS AND BEST PRACTICES COMMITTEE 2023 MEETING SCHEDULE
PROPOSED/DRAFT FOR REVIEW (updated 04.26.23)

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

MCC FEEDBACK SURVEY

MCC FEEDBACK COMMITTEE

AGENDA

- Survey impetus
- Survey methodology
- Response rate
- Findings
- Recommendations / next steps
- Q & A

SURVEY IMPETUS

- Formation of MCC Feedback Committee
- Appreciation for MCC program
- Communication between DHSP and MCC teams
- Updates to program
- Committed MCC Feedback Committee participants

SURVEY METHODOLOGY / TIMELINE

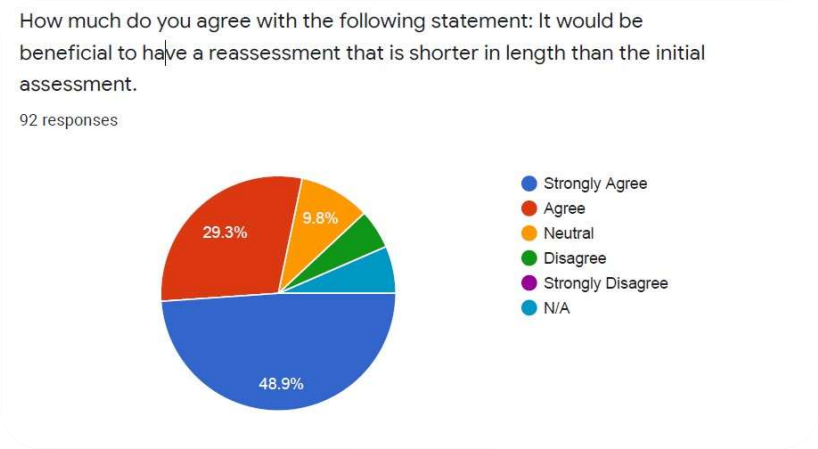
- Comprehensive review of all elements of MCC program (e.g. assessment, Casewatch, audit, etc.)
- Survey distributed January 2022
- Results analyzed by MCC Feedback Committee
- Agreeance findings de-identified and shared with DHSP

RESPONSE RATE

- 95 people responded out of approx. 170)
  - All roles represented (Program Manager, PCM, MCM, CW, ROS)
  - Most sites represented (AHF, AltaMed, APLA, Care Clinic, City of LB, DHS, EVCHC, El Proyecto, Esperanza, Harbor UCLA, JWCH, LGBT Center, LAC / USC, MHF, Oasis, NEVHC, THE Clinic, Tarzana, Venice Family Clinic, Watts Healthcare)
  - 23.9% of whom have worked in their MCC role for 5+ years

FINDINGS

- Out of 91 questions, respondents had agreeance with each other on 71 questions (defined as having 60%+)
- Examples of some questions include:



- Principal Conclusions
  - **Assessment**
  - Audit process
  - Casewatch
  - Communication and inclusion
  - Enhanced trainings

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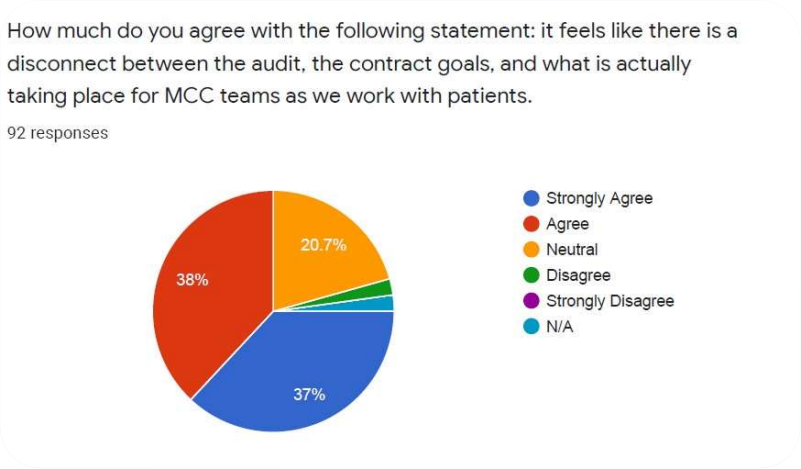

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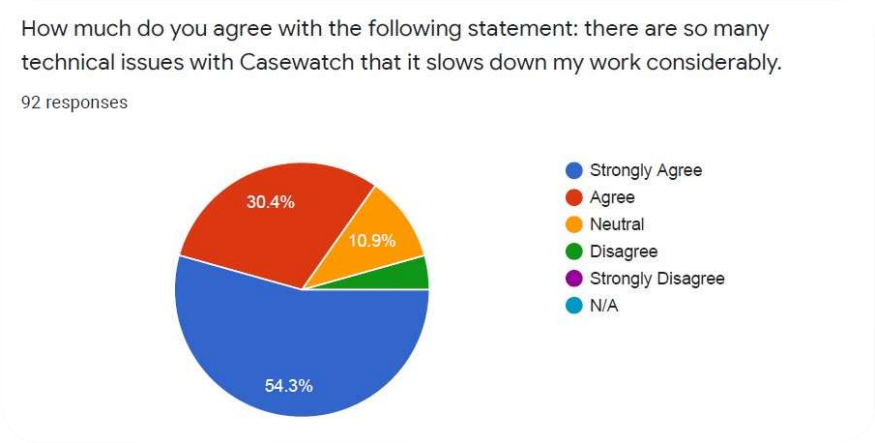

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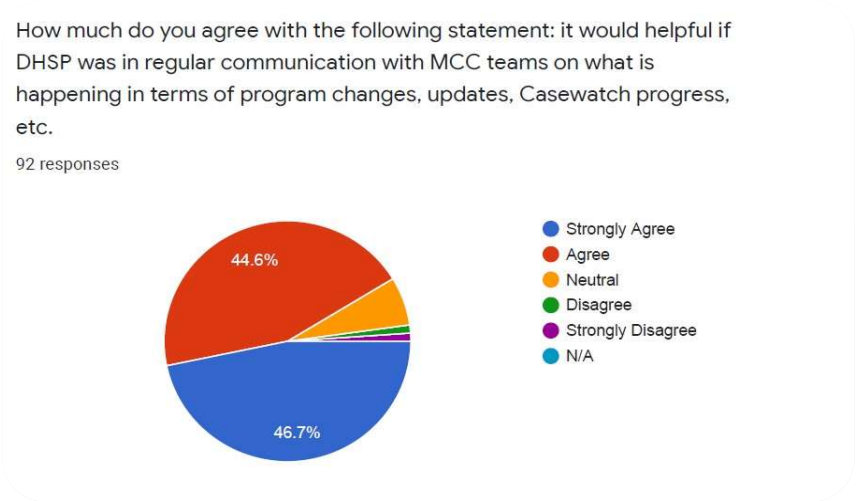

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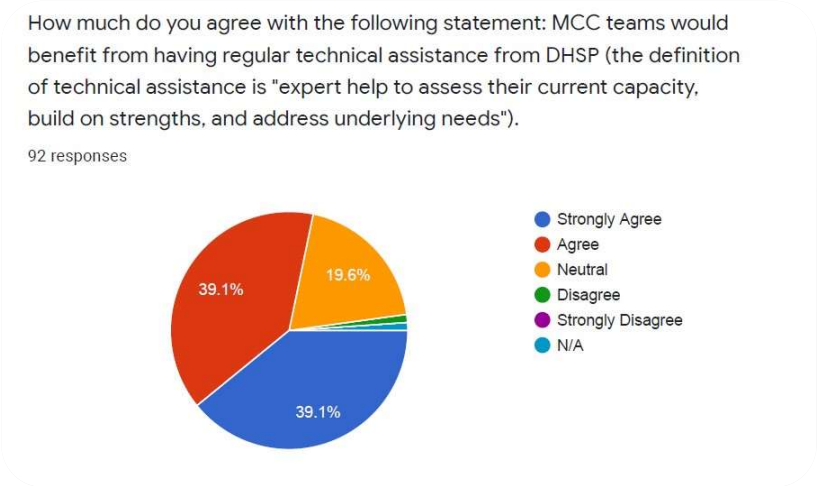

- Principal Conclusions
  - Assessment
  - Audit process
  - Casewatch
  - Communication and inclusion
  - **Enhanced trainings**

RECOMMENDATIONS / NEXT STEPS

- Recommendations
  - Maintain or increase momentum for programmatic updates
  - Timeline for updates
  - Continue to improve communication / inclusion

- Next Steps
  - Monthly meetings with DHSP stakeholders
  - Quarterly meetings with MCC teams

Q & A

LOS ANGELES COUNTY
COMMISSION ON HIV

Standards & Best Practices Committee Standards of Care Definition[1]

- Service standards are written for service providers to follow
- Service standards establish the minimal level of service or care that a Ryan White funded agency or provider may offer
- Service standards are essential in defining and ensuring consistent quality care is offered to all clients
- Service standards serve as a benchmark by which services are monitored and contracts are developed
- Service standards define the main components/activities of a service category
- Service standards do not include guidance on clinical or agency operations

SERVICE CATEGORIES

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

[1]Retrieved from https://targethiv.org/library/service-standards-guidance-ryan-white-hivaids-program-granteesplanning-bodies. December 2015.

MEDICAL CARE COORDINATION STANDARDS OF CARE

Adopted February 14, 2019

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

INTRODUCTION

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

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

MEDICAL CARE COORDINATION OVERVIEW

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

Medical Care Coordination services include:

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

The goals of medical care coordination include:

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

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

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

EVALUATION OF THE MEDICAL CARE COORDINATION MODEL

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

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

MEDICAL CARE COORDINATION MODEL

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

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

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

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

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

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

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

KEY SERVICE COMPONENTS

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

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

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

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

PATIENT ELIGIBILITY

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

Ryan White Program eligibility includes individuals who:

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

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

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

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

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

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

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

PATIENT ASSESSMENT/REASSESSMENT

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

The comprehensive assessment determines the:

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

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

The acuity levels are as follows:

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

INTEGRATED CARE PLAN

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

Assessment domains are based on the following:

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

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

PROGRESS NOTES/MONITORING PATIENT PROGRESS

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

The following documentation is required (at minimum):

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

BRIEF INTERVENTIONS

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

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

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

PATIENT SELF-EFFICACY AND CARE

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

REFERRALS

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

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

CASE CONFERENCES

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

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

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

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

- Results of implementing guidance and follow-up

PATIENT RETENTION

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

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

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

Retention Outreach Specialist will:

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

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

CASE CLOSURE

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

Cases may be closed when the client:

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

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

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

STAFFING REQUIREMENTS AND QUALIFICATIONS

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

The minimum requirements for MCC staff are:

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

TRANSLATION/LANGUAGE INTERPRETERS

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

TABLE: MEDICAL CARE COORDINATION SERVICES STANDARDS

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

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

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

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DEFINITIONS AND DESCRIPTIONS

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

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

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

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

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

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

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

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

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

DRAFT

LOS ANGELES COUNTY
COMMISSION ON HIV

RYAN WHITE PROGRAM
UNIVERSAL SERVICE STANDARDS

Approved by COH on 2/11/21

Draft under review by Standards and Best Practices Committee as of 5/01/2023

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.

GENERAL AGENCY POLICIES

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

1.0 GENERAL AGENCY POLICIES	
Standard	**Documentation**
1.1 Agency develops or utilizes an existing client confidentiality policy in accordance with state and federal laws to assure protection of client HIV status, behavioral risk factors, and/or use of services.	1.1 Written client confidentiality policy on file with specific information technology safeguards for confidentiality and patient information if using telehealth service modality.
1.2 Agency is responsible for informing the patient that they have the right to obtain copies of their medical and other health records maintained by the agency.	1.2 Written policy for informing the patient of their rights to receive a copy of their medical records. The policy should contain a description of the process for obtaining records, such as a verbal or written request and a reasonable timeframe for patients to receive the information.
1.3 Client determines what information of theirs can be released and with whom it can be shared. Services using telehealth modality are subject to consent by the patient. [1]	1.3 Completed *Release of Information Form* on file including: • Name of agency/individual with whom information will be shared • Information to be shared • Duration of the release consent • Client signature For agencies and information covered by the Health Insurance Portability and Accountability Act (HIPAA), form must be HIPAA disclosure authorization compliant. The form must also be compliant with the CA Medi-Cal telehealth policy. [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) Customer Support Program 1-800-260-8787. Additional ways to file grievances can be found at: DHSP_CSP_CustomerSupportForm_Website-ENG-Final_12.2022.pdf (lacounty.gov) DHSP Customer Support Program information is posted in a visible location on site or provided to the patient at the beginning of a telehealth encounter.

[1] 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.
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 should develop policies that strive to hire PLWH in all facets of	3.1 Hiring policy and staff resumes on file.

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, lived-experience 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 use, housing)	6.2 Agency establishes partnerships with agencies for referrals as needed. Memoranda of Understanding (MOU) on file.
6.3 For clients with missed appointments or pending case closure, staff will attempt to contact client. a. Cases may be closed if the client: • Relocates out of the service area • Is no longer eligible for the service • Discontinues the service • No longer needs the service • Puts the agency, service provider, or other clients at risk • Uses the service improperly or has not complied with the services agreement • Is deceased • Has had no direct agency contact, after repeated attempts, for a period of 12 months.	6.3 Attempts to contact client and mode of communication documented in file. a. Justification for case closure documented in client file
6.4 Agency has a transition procedure in place that is implemented for clients leaving services to ensure a smooth transition.	6.4 Completed transition summary in file, signed by client and supervisor (if possible). Summary should include reason for case closure; and a plan for transition to other services, if applicable, with confirmation of communication between referring and referral agencies, or between client and agency.
6.5 Agency develops or utilizes existing due process policy for involuntary removal of clients from services; policy includes a series of verbal and written warnings before final notice and case closure.	6.5 Due process policy on file as part of transition, and case closure policy described in the *Patient & Client Bill of Rights* document. (Refer to Appendix B).

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

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

SERVICE CATEGORIES

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

APPENDIX B: 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.)

E. Billing Information and Assistance

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

F. Patient/Client Responsibilities

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

1. Participate in the development and implementation of your individual treatment or service plan to the extent that you are able.
2. Provide your providers, to the best of your knowledge, accurate and complete information about your current and past health and illness, medications and other treatment and services you are receiving, since all of these may affect your care. Communicate promptly any changes or new developments.
3. Communicate to your provider whenever you do not understand information you are provided.
4. Follow the treatment plan you have agreed to and/or accept the consequences of failing to adhere to the recommended course of treatment or of using alternative 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; sexual harassment and misconduct.
10. If you are a person living with a substance use disorder, please be open and honest with your provider about your substance use so that any issues can be properly addressed.

For More Help or Information

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

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

DRAFT FOR SBP COMMITTEE REVIEW

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

LOS ANGELES COUNTY
COMMISSION ON HIV

DRAFT FOR SBP COMMITTEE REVIEW
AS OF 05/01/23

DRAFT FOR SBP COMMITTEE REVIEW

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

IMPORTANT: The service standards for Nutrition Support Services—Food Bank/Pantry Services and Home-Delivered Meals adhere to requirements and restrictions from the federal agency, Health Resources and Services Administration (HRSA). The key documents used in developing standards are as follows:

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

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

Service Standards: Ryan White HIV/AIDS Programs

INTRODUCTION

Service standards for the Ryan White HIV/AIDS Part A Program (RWHAP) outline the elements and expectations a service provider should follow when implementing a specific service category. The standards are written for providers for guidance on what services may be offered when developing their Ryan White Part A programs. The standards set the minimum level of care Ryan White-funded agencies offer to clients, however, providers are encouraged to exceed these standards. The Los Angeles County Commission on HIV (COH) developed Nutrition Support Services—Food Bank/Pantry Services and Home-Delivered Meals (Nutrition Support) standards to establish the minimum services necessary to provide Nutrition Support Services to people living with HIV. The development of the standards includes guidance from service providers, people living with HIV, the Los Angeles County Department of Public Health Division of HIV and STD Programs (DHSP), members of the Los Angeles County COH Standards and Best Practices Committee (SBP), caucuses, and the public-at-large.

SERVICE DESCRIPTION

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

Nutrition Support includes:

- Home delivered meals
- Food banks/pantry services

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

- Personal hygiene products
- Household cleaning supplies
- Water filtration/purification systems in communities where issues of water safety exist Program Guidance: Unallowable costs include household appliances, pet foods, and other non-essential products.

DRAFT FOR SBP COMMITTEE REVIEW

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

All programs will use available standards of care to inform clients of their services and will provide services in accordance with legal and ethical standards. Maintaining confidentiality is critical and its importance cannot be overstated. All programs must comply with the Health Insurance Portability and Accountability Act (HIPAA) standards for information disclosure.

PERSONNEL QUALIFICATIONS

All Nutrition Support will be provided in accordance with current United States Department of Agriculture (USDA) Dietary Guidelines for Americans, Food and Drug Administration (FDA), Centers for Disease Control and Prevention (CDC), and Los Angeles County guidelines and procedures, as well as with federal, State, and local laws and regulations. All programs will comply with City, County and/or State grocery and/or restaurant health code regulations. All programs will submit to voluntary health inspections annually (at minimum).

All programs providing food distribution services will operate in collaboration with a Registered Dietitian (RD) consistent with California state law. Such RD will have current knowledge of nutrition issues for people living with HIV.

All volunteers and staff delivering food shall have a valid driver's license.

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

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

SERVICE COMPONENTS

ELIGIBILITY

Home delivered meal programs will develop eligibility criteria to include:

- Proof of residency in LA County
- Proof of income
- Proof of HIV diagnosis
- Proof of nutrition need

HOME DELIVERED MEALS

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

CLIENT INTAKE – HOME DELIVERED MEALS

Programs providing home delivered meals will:

- **Develop and implement client eligibility requirements** which give priority to clients living at or below 500% of poverty level and with the greatest nutrition need. There are additional eligibility requirements, including documentation of a client's HIV status, income level, proof of residency in Los Angeles County and screening for nutrition need by a case manager and/or primary care provider.
- **Conduct a client intake**, to be updated annually, which gathers demographic information and determines client need and eligibility for services (as outlined above) in the intake process and throughout nutrition support service delivery, client confidentiality will be strictly maintained and enforced. All programs will follow HIPAA guidelines and regulations for confidentiality. As needed, Release of Information forms will be gathered. These forms detail the specific person/s or agencies to or from whom information will be released as well as the specific kind of information to be released. New forms must be added for individuals not listed on the most current Release of Information (specification should indicate the type of information that can be released).
- **Coordinate with primary health care providers and case managers** to assess a client's need and eligibility for nutrition support and to ensure that the client's nutrition needs are being addressed.
- **Provide an initial nutrition intake and annual screening** performed by an RD DTR or nutrition student under the supervision of an RD under conditions:
    - Set forth by the nutrition support provider agency and agreed to by both agencies
    - Followed by a subsequent, supplementary onsite intake and screening by the RD once the client has accessed services.
    - Initial nutrition intake and annual screening may be conducted onsite, in-person, telephonically or videoconferencing in the spirit of making the service accessible and easy to use for the client.

Additional nutrition intakes will be provided as required by a given client's health status. Information gathered in the intake will help the RD advise the program on general meal menus and make recommendations for special meals as necessary. Nutrition intakes will be documented in client chart and shared with the client's primary care physician whenever possible.

Such intakes (initial, or initial plus supplementary) will include, at minimum:

- Medical considerations (HIV and others)
- Food allergies/intolerances
- Interactions between medicines, foods, and complimentary therapies
- Dietary restrictions including special diets and cultural and religious considerations

- Assessment of nutrition intake vs. estimated need Client's body mass index (BMI)
- Client's nutritional concerns
- Ability to complete Activities of Daily Living
- Any HIV-related illnesses diagnosed in the last six months
- Any chronic illness with date of diagnosis
- Family members and caregivers (relationship to consumer/gender/date of birth/race/ethnic origin/primary language) and if they need HDM service as well (add to footnote -- Affected individuals (people not identified with HIV) may be eligible for HRSA RWHAP services in limited situations, but these services for affected individuals must always benefit PLWH. See HRSA PCN 16-02.
- Current nutrition issues (ex. lack of appetite, nausea/vomiting, involuntary weight loss, diarrhea, inability to prepare or procure food due to health issues, etc.)
- Medications and/or Treatments/Therapies

- **Provide nutrition education** that pertains specifically to nutrition needs identified in the annual nutrition intake. Individualized nutrition education will be provided annually, at minimum, by a trained staff under the supervision of an RD or Nutrition and Dietetic, Registered When appropriate, clients will be referred for medical nutrition therapy.
- **Develop and implement a client services agreement** that includes client rights and responsibilities, grievance procedures and the conditions of home delivered meal services. This agreement will be signed and dated by both the client and an agency representative and will be kept in each client file.

SERVICE STANDARDS—NUTRITION SUPPPORT: HOME-DELIVERED MEALS

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

SERVICE COMPONENT	STANDARD	MEASURE
CLIENT INTAKE	Home delivered meal programs will conduct a client intake.	Client intake in client file updated annually.
	Client confidentiality will be strictly maintained. As necessary, Release of Information will be signed to exchange information with other providers.	Signed, dated Release of Information in client chart.
	Home delivered meal programs will coordinate with client's primary care providers and case managers to assess need for service and to ensure nutrition needs are being addressed.	Records of communication with medical providers and case managers in client chart.
MEAL PRODUCTION/DELIVERY	Programs providing home delivered meals will develop menus with the help of RDs.	Menu cycle on file at provider agency that considers the nutrition needs of the client, special diet restrictions, portion control and client, community, and cultural

		preference. Menu cycle will be changed as necessary.
	Programs providing home delivered meals will prepare and ensure the delivery of meals to clients. Meals will be planned by a chef under the supervision of an RD. Food and water safety measures will be strictly enforced.	Plans on file at provider agency.
	Programs providing home delivered meals will distribute meals to CBOs for delivery to clients.	MOUs with CBOs on file at provider agency.
	Programs will deliver meals directly to clients within an expected delivery time if CBOs are not able to distribute meals.	Delivery policy on file at provider agency. Daily delivery records on file at provider agency
	Programs will train volunteers in proper food handling techniques and HIV sensitivity.	Volunteer training curriculum and records of volunteer trainings on file at provider agency.
	Programs providing home delivered meals will develop menus with the help of RDs.	Menu cycle on file at provider agency that considers the nutrition needs of the client, special diet restrictions, portion control and client, community, and cultural preference. Menu cycle will be changed as necessary.
	Programs providing home delivered meals will prepare and ensure the delivery of meals to clients. Meals will be planned by a chef under the supervision of an RD. Food and water safety measures will be strictly enforced.	Plans on file at provider agency.
	Programs providing home delivered meals will distribute meals to CBOs for delivery to clients.	MOUs with CBOs on file at provider agency.
	Programs will deliver meals directly to clients within an expected delivery time if CBOs are not able to distribute meals.	Delivery policy on file at provider agency. Daily delivery records on file at provider agency
	Programs will train volunteers in proper food handling techniques and HIV sensitivity.	Volunteer training curriculum and records of volunteer trainings on file at provider agency.
PROMOTION/LINKAGES	Programs providing home delivered meals will promote the availability of their services.	Promotion plan on file at provider agency

	Programs will network with CBOs to identify appropriate clients.	Record of outreach and networking efforts on file at provider agency
	Programs will develop MOUs with ASOs that provide food delivery services.	MOUs on file at provider agency that include: • Days and times food will be delivered and distributed to clients • Persons responsible for ensuring that food is delivered appropriately • Persons responsible for the actual delivery of food (e.g., staff, volunteers) • Geographic areas to be served
PROGRAM RECORDS	Programs providing home delivered meals will maintain client files.	Client chart on file at provider agency that includes: • Client intake • Review and evaluation of updated determination of nutrition need and plan to meet nutrition needs • Client services agreement • Documentation of referrals • Documentation of annual reassessment of eligibility • Initial nutrition intake and annual screening All entries in client chart will be signed and dated.

FOOD BANK/PANTRY SERVICES

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

CLIENT INTAKE – FOOD BANKS/PANTRIES

Programs providing food bank/pantry services will:

- **Develop and implement client eligibility requirements** which give priority to clients living at or below 500% of poverty level and with the greatest nutrition need. There are additional eligibility requirements including documentation of a client's HIV status, income level, proof of residency in Los Angeles County and screening for nutrition need by a case manager and/or primary care provider.
- **Conduct an intake evaluation**, to be updated annually, which gathers demographic information and determines client need and eligibility for services (as outlined above). In the intake process and throughout food distribution service delivery, client confidentiality will be strictly maintained and enforced. All programs will follow HIPAA guidelines and regulations for confidentiality. As needed, Release of Information forms will be gathered. These forms detail the specific person/s or agencies to or from whom information will be released as well as the specific kind of information to be released. New forms must be added for individuals not listed on the must current Release of Information (specification should indicate the type of information that can be released).
- **Coordinate with primary health care providers and/or case managers** to assess a client's need and eligibility for nutrition support and to ensure that the client's nutrition needs are being addressed.
- **Provide an initial nutrition intake and annual screening** performed by a RD, dietetic technician or other health care provider trained by nutrition professional. Additional screenings will be provided as required by client's health status. Screenings will be documented in client chart and shared with the client's primary care physician whenever possible.
- **Provide nutrition education that pertains specifically** to nutrition needs identified in the annual nutrition screening. Individualized nutrition education will be provided by an RD, dietetic technician, registered or nutrition students under the supervision of a dietitian. When appropriate, clients will be referred for medical nutrition therapy.
- **Develop and implement a client services agreement** that includes client rights and responsibilities, grievance procedures and conditions of food bank/pantry services. This agreement will be signed and dated by both the client and an agency representative and will be kept in each client file.

DRAFT FOR SBP COMMITTEE REVIEW

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

SERVICE STANDARDS—NUTRITION SUPPPORT: FOOD BANK/PANTRY SERVICES

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

SERVICE COMPONENT	STANDARD	MEASURE
CLIENT INTAKE	Food bank/pantry programs will conduct a client intake.	Client intake in client file updated annually.
	Client confidentiality will be strictly maintained. As necessary, Release of Information will be signed to exchange information with other providers.	Signed, dated Release of Information in client chart.
	Food bank/pantry programs will coordinate with client's primary care providers and case managers to assess need for service and to ensure nutrition needs are being addressed.	Records of communication with medical providers in client chart.
	When indicated, an annual nutrition screening will be conducted by or under the supervision of an RD to ensure appropriateness of service. Nutrition screenings will be shared with client's primary medical care provider when possible.	Signed, dated nutrition screen on file in client chart.
	Nutrition education will be provided by an RD or DTR or nutrition student under the supervision of RD to appropriate clients identified through screening process. When needed, clients will be referred for medical nutrition therapy.	Documentation of education and referral on file in client chart.
PROGRAM OPERATIONS	Programs providing food bank/pantry services will develop menus and food choices with the help of RDs.	Menu cycle on file at provider agency that considers the: • Nutrition needs of the client • Special diet restrictions • Portion control • Client, community • Cultural preference

	Programs providing food bank/pantry services will purchase and maintain a nutritional food supply. Food/ water safety and handling measures will be strictly enforced.	Plans on file at provider agency.
	Programs will distribute food to ASOs for delivery to clients.	MOUs with CBOs on file at provider agency.
	Programs will distribute food directly to clients.	Distribution policy and daily distribution records on file at provider agency.
	Programs will train volunteers in proper food handling techniques and HIV sensitivity.	Volunteer training curriculum and records of volunteer trainings on file at provider agency.
PROMOTION/LINKAGES	Programs providing food bank/pantry services will promote the availability of their services.	Promotion plan on file at provider agency.
	Programs will network with CBOs to identify appropriate clients.	Record of outreach and networking efforts on file at provider agency.
	Programs will develop MOUs with CBOs that collaborate on food distribution.	MOUs on file at provider.
PROGRAM RECORDS	Programs providing food bank/pantry services will maintain client files.	Client chart on file at provider agency that includes •Intake •Client services agreement • Documentation of referrals • Initial nutrition intake and annual screening All entries in client chart will be signed and dated.

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

SERVICE STANDARDS—NUTRITION SUPPPORT: FOOD BANK/PANTRY SERVICES AND HOME-DELIVERED MEALS

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

SERVICE COMPONENT	STANDARD	MEASURE
FOOD SAFETY/QUALITY Nutrition support services will follow local Los Angeles County Environmental Health Food Safety Guidelines http://www.lapublichealth.org/eh/.	All nutrition support programs will follow Los Angeles County Environmental Health Food Safety Guidelines.	Documentation on file
	Programs will be responsible to develop an Infection Control Program.	Infection Control Program on file at provider agency that includes education, promotion and inspection of proper hand washing, personal hygiene and safe food handling practices by staff and volunteers.
	Programs will be responsible for developing a Food Quality Control Program.	Food Quality Control Program on file at provider agency that includes these requirements (at minimum): • Proper food temperature is maintained at all times • Food inventory is updated and rotated as appropriate on a first-in, first-out basis • Facilities and equipment have capacity for proper food storage and handling • A procedure for discarding unsafe food is posted • Providers and vendors maintain proper licenses • Programs will also maintain quality control logs including, but not limited to: • Hot holding temperature log • Manual/mechanical dishwashing log • Quality control log • Equipment checklist log • Food temperature log • Freezer/refrigerator temperature logs

	Programs will develop a nutrition support manual.	Food Service Manual on file at provider agency which addresses food service and preparation standards; sanitation; safety; food storage; distribution; and volunteer training.
	Programs will conduct an annual client survey.	Client survey results on file at provider agency and agency plan of action to address concerns.
TRIAGE/REFERRAL	Clients applying for nutrition support services who do not have a case manager will be referred to a case manager.	Record of referral on file in client chart.
	Clients will be referred to other medical and support services as needed.	Referrals to treatment advocacy, peer support, medical treatment, dental treatment, etc., recorded in client chart.
	Referrals will be made to other food sources as needed.	Record of referral on file in client chart.
CASE CLOSURE	Nutrition support programs will develop case closure criteria and procedures.	Program cases may be closed when the client: • Relocates out of the service area • Has had no direct program contact in the past six months • Is ineligible for the service • No longer needs the service • Discontinues the service • Is incarcerated long term • Uses the service improperly or has not complied with the client services agreement • Has died
	Patients will be formally notified of pending case closure.	Contact attempts and notification about case closure on file in client record.
STAFFING REQUIREMENTS AND QUALIFICATIONS	At minimum, all nutrition support staff will be able to provide age and culturally appropriate care to clients infected with and affected by HIV.	Staff resume and qualifications on file at provider agency.
	All employees involved in the preparation of meals will undergo a health screening as a condition of	Copy of health clearance in employee file.

	employment which includes TB test and stool screening.	
	All staff and volunteers will be given orientation prior to providing services.	Orientation curriculum on file at provider agency which includes: • Basic HIV/AIDS education • Client confidentiality and HIPAA regulations Basic overview of food and water safety • Food protection protocols including hand washing, cross contamination, cooling/heating/cooling, hot and cold reheating, temperature danger zones • Service provider personal hygiene • Work safety • Proper receiving and storing of food and supplies
	In-service trainings will be provided quarterly by an RD or other qualified professional.	Record of quarterly training (including date, time, topic, presenter and attendees) on file at provider agency.
	Any nutrition support employee having direct contact with daily food preparation will hold a current certification in food handling.	Certifications on file at provider agency.
	Volunteers will be supervised by a staff person. All staff will be reviewed by their supervisor annually, at minimum.	Supervision plan and annual staff reviews on file at provider agency.
	RDs working with HIV food distribution programs will have the following: • Broad knowledge of principles and practices of nutrition and dietetics • Advanced knowledge in the nutrition assessment, counseling, evaluation, and care plans of people living with HIV • Advanced knowledge of current scientific information regarding nutrition assessment and therapy	Resume and training verification on file at provider agency.

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