LOS ANGELES COUNTY
COMMISSION ON HIV

Visit us online: http://hiv.lacounty.gov
Get in touch: hivcomm@lachiv.org
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HIV PREVENTION PLANNING WORKGROUP Virtual Meeting

Agenda and meeting packet will be available prior to the meeting at http://hiv.lacounty.gov/Planning-Priorities-and-Allocations-Committee

Wednesday, September 27, 2023

4:00PM-5:30PM (PST)

JOIN VIA WEBEX ON YOUR COMPUTER OR SMART PHONE:
JOIN VIA WEBEX ON YOUR PHONE:

https://tinyurl.com/mw2yjdzj

To Join by Phone: +1-213-306-3065 US Toll

Access Code: 2534 812 0173

Password: PREVENT

Help prevent the spread of STDs and HIV. Let your voice be heard.

Your input will inform the planning of prevention services in your community.

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LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave, 14th Floor • Los Angeles, CA 90020 • TEL (213) 738-2816 • FAX (213) 637-4748
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PREVENTION PLANNING WORKGROUP
Virtual Meeting Agenda
Wednesday, September 27, 2023 @ 4:00 – 5:30pm

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AGENDA

1. **Welcome and Introductions (4:00-4:05 pm)**
2. **COH Executive Director/Staff Report (4:05-4:10 pm)**
    a. COH Annual Conference
3. **Co-Chairs' Report (4:10-4:15 pm)**
    a. Meeting Schedule
    b. Planning, Priorities and Allocations Committee Sept. 19 Meeting - Status Neutral Presentation
4. **Review Commission on HIV Harm Reduction Reports (4:15-4:35 pm)**
5. **Universal Standards Review – Status Neutral Recommendations (4:35-4:55 pm)**
6. **Continue Review of Prevention Planning Standards (4:55-5:20 pm)**
7. **Next Steps and Agenda Development for Next Meeting (5:20-5:25 pm)**
8. **Public Comment + Announcements (5:25-5:30 pm)**
9. **Adjournment (5:30 pm)**

SAVE THE DATE

Annual Conference

together.

WE CAN END HIV IN OUR
COMMUNITIES ONCE & FOR ALL

LOS ANGELES COUNTY
COMMISSION ON HIV

Vermont Corridor @ 510 S. Vermont Ave,
Los Angeles, CA 90020

NOV | 9th | 2023

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PREVENTION PLANNING WORKGROUP

Proposed Status Neutral Framework

Presentation to the Planning, Priorities and Allocations Committee

9/19/23 – For Review/Feedback

LOS ANGELES COUNTY
COMMISSION ON HIV

Objectives

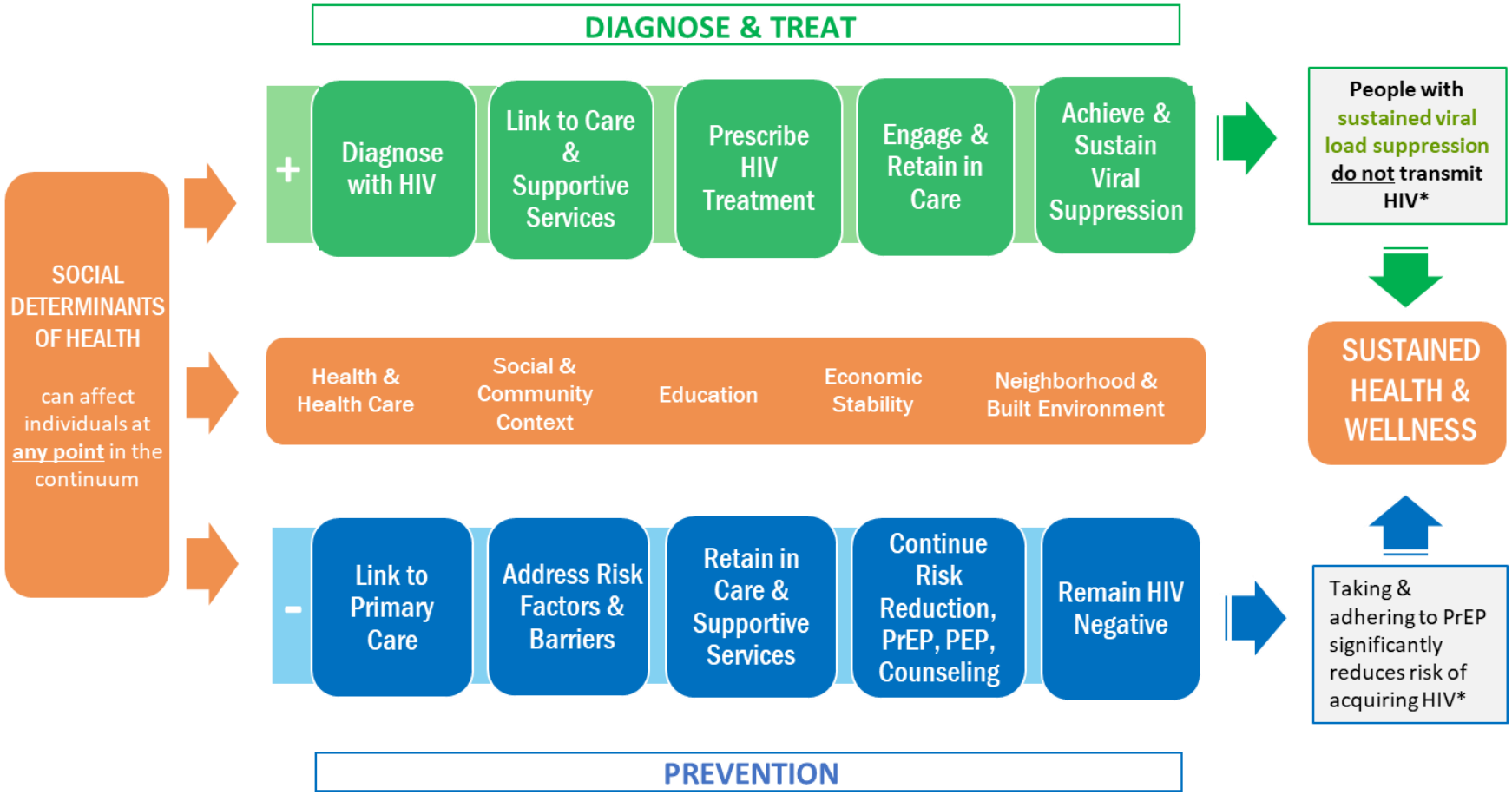
- Provide an update on the work and activities of the Prevention Planning Workgroup
- Seek input on a status neutral framework for HIV/STI services
- Discuss integration of prevention into the Planning, Priorities and Allocations Committee
- Promote ongoing awareness and community conversations on HIV/STI prevention needs

Background | Prevention Planning Workgroup (PPW)

- Formed Prevention Planning Workgroup in October 2020
- Goal of the workgroup is to improve and fully integrate prevention in the planning, priority setting and resource allocation process
- Workgroup has focused on assessing capacity building needs of the larger body, development of a framework to support integration of status neutral “concept” into the commission, and review of existing Prevention Standard of Care for recommendations.

Comprehensive HIV Continuum Framework

The HIV Continuum is a framework for people to stay healthy, have improved quality of life, and live longer. The Commission on HIV adapted the Continuum to demonstrate HIV, sexual health, and overall health are influenced by individual, social, and structural determinants of health. Individuals can enter and exit at any point in the Continuum. The Continuum guides the Commission on community planning and standards of care development.



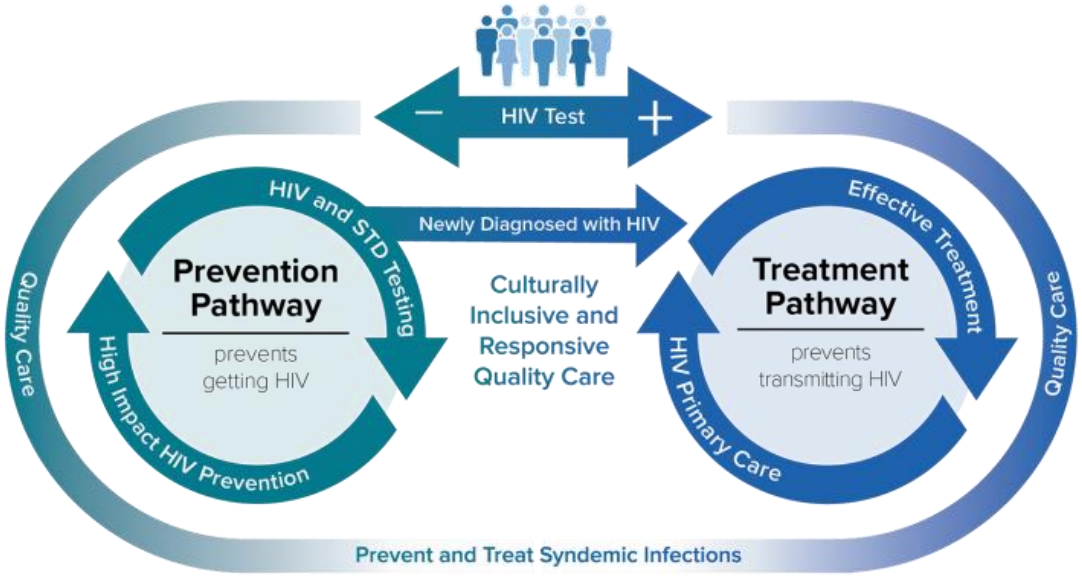
Revised 9/10/19; 11/17/20
Commission approved 9/12/19

*For more information visit https://www.cdc.gov/hiv/risk/estimates/preventionstrategies.html

CDC Status Neutral HIV Prevention and Care

Status Neutral HIV Prevention and Care is a *whole person* approach to HIV prevention and care that emphasizes high-quality care to engage and retain people in services regardless of if the services are for HIV treatment or prevention. This approach continually addresses the healthcare and social service needs of all people affected by HIV so that they can achieve and maintain optimal health and well-being.

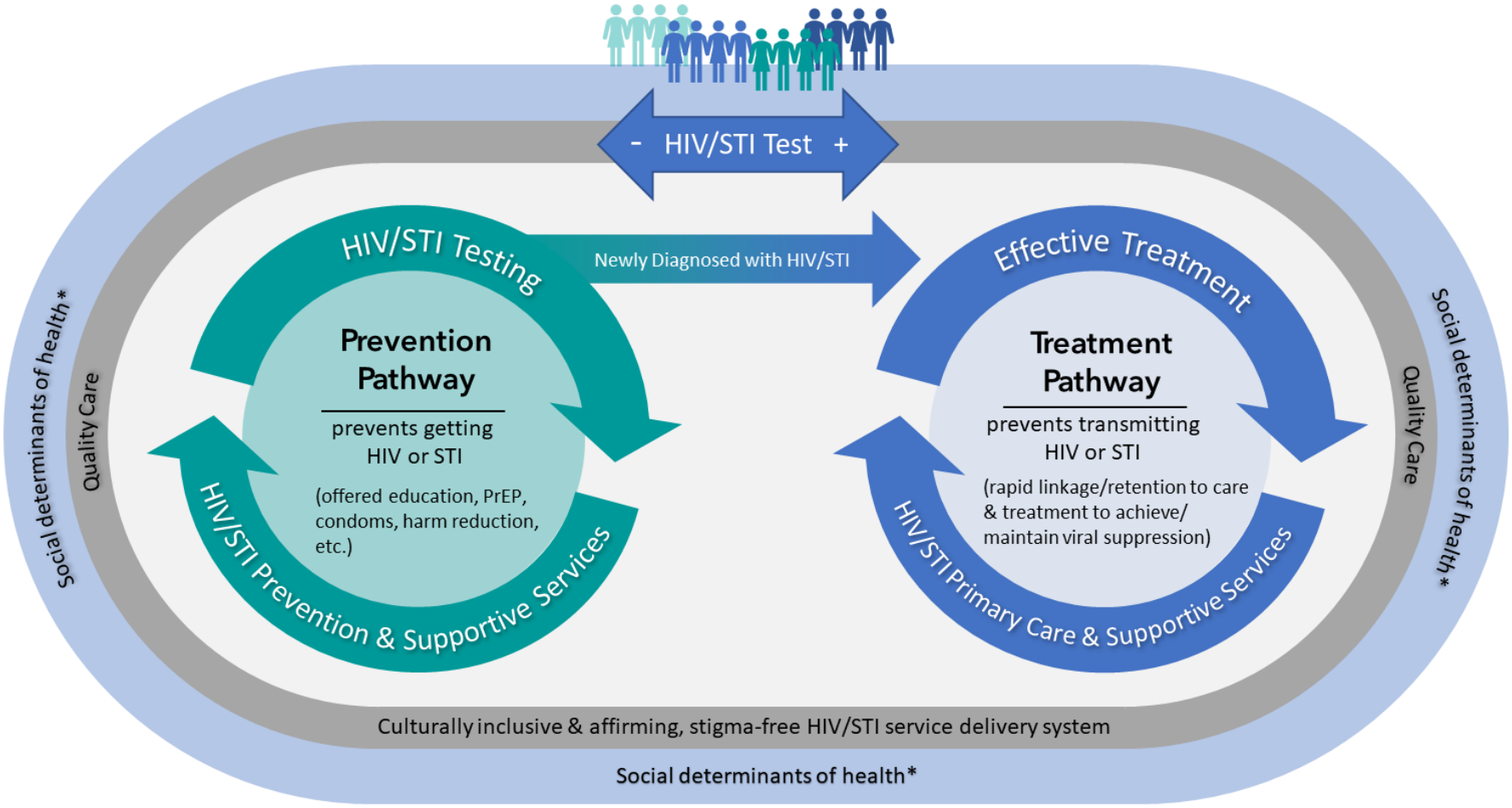
People whose HIV tests are negative are offered powerful prevention tools like PrEP, condoms, harm reduction (e.g. SSPs), and supportive services to stay HIV negative.



People whose HIV tests are positive enter primary care and are offered effective treatment and supportive services to achieve and maintain viral suppression.

Follow CDC guidelines to test people for HIV. Regardless of HIV status, quality care is the foundation of HIV prevention and effective treatment. Both pathways provide people with the tools they need to stay healthy and stop HIV.

Status Neutral HIV and STI Service Delivery System



LOS ANGELES COUNTY COMMISSION ON HIV

Revised 6/1/23

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

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

Key Recommendations

- Focus on the Service Delivery System
- Expand beyond HIV to include STIs
  - HIV and STI testing, treatment, and prevention services
  - Biomedical and nonbiomedical strategies
- Emphasis on person-first, not disease first
  - Address the holistic needs of a person
  - Not centered solely on meeting disease-specific needs
- Supportive services provided regardless of HIV status
  - Resources to support high-risk HIV- individuals in need of supportive services (e.g., housing, mental health, etc.)
  - Address the social determinants of health

Key Recommendations

- Focus on priority populations identified via data (CHP)
  - Latinx men who have sex with men (MSM)
  - Black/African American MSM
  - Transgender persons
  - Cisgender women of color
  - People who inject drugs (PWID)
  - People under the age of 30
  - People living with HIV who are 50 years of age or older
- Culturally affirming, stigma-free HIV and STI delivery system
  - Goes beyond supportive providers trained to recognize and address implicit racial/ethnic, sexual orientation, and other biases
  - Calls for racially, culturally, & ethnically diverse providers and staff and individuals with lived experience

Key Recommendations

- Requires diverse funding streams
  - Multiple funding streams
  - Do not have disease specific eligibility requirements
- Requires diverse partners
  - Collaboration and coordination with community partners outside of HIV systems who also serve priority populations

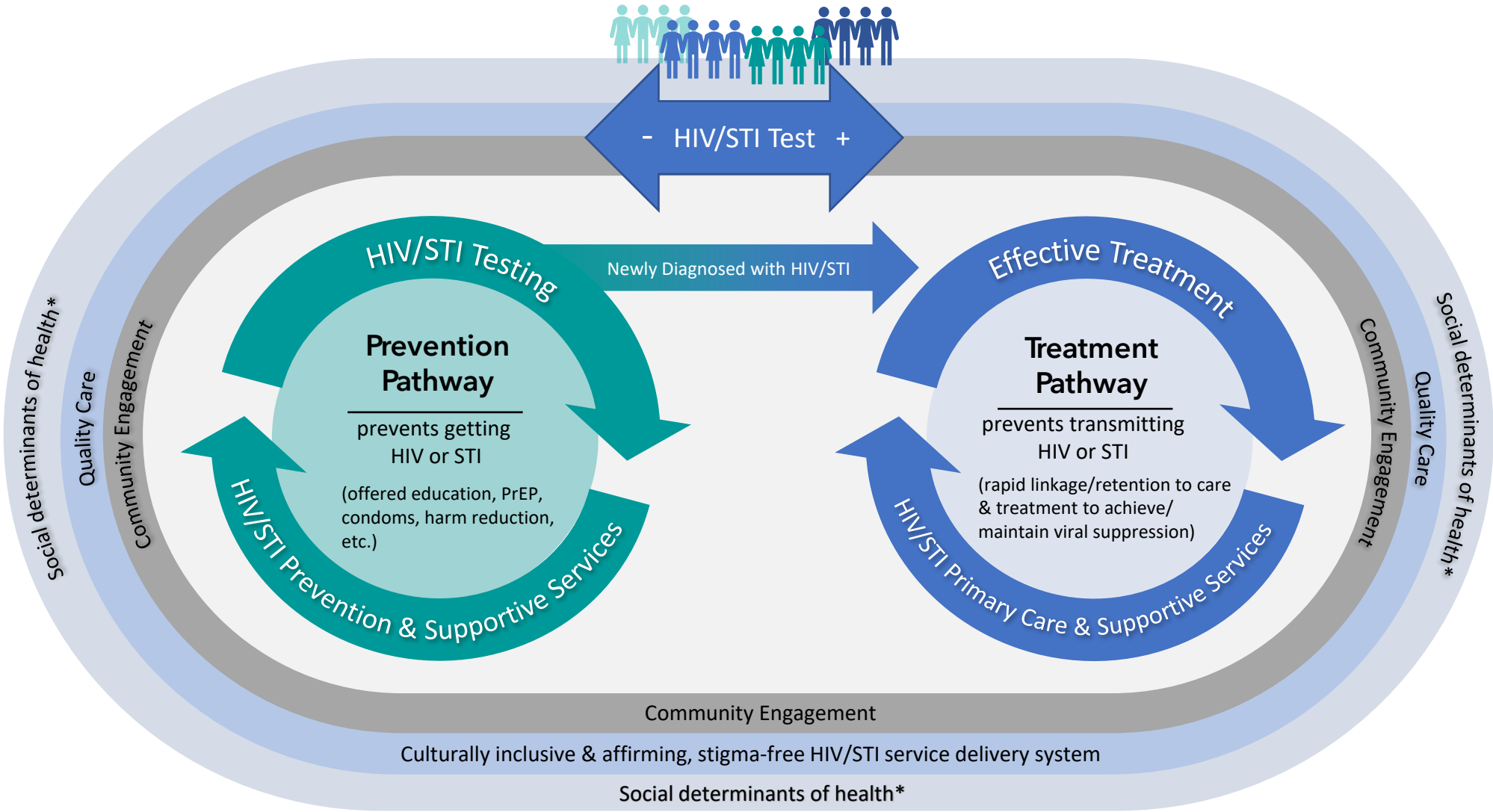
Other Suggestions

- *Restructure the Planning, Priorities and Allocations Committee to intentionally include prevention*
- Utilize Status Neutral Framework in all COH discussions
- Assess prevention funding and services within Los Angeles County to help inform PSRA process
- Update Prevention Standards to incorporate status neutral framework
- Identify opportunities to increase prevention efforts within existing DHSP programs
- Identify opportunities to increase prevention efforts within substance use disorder strategies/interventions

Discussion

- What do you think about the proposed Status Neutral framework?
- Are there elements that we need to add that address the needs of priority populations?
- How do we structure agenda of PP&A to reflect proposed framework?

Status Neutral HIV and STI Service Delivery System



LOS ANGELES COUNTY
COMMISSION ON HIV

Revised 9/21/23

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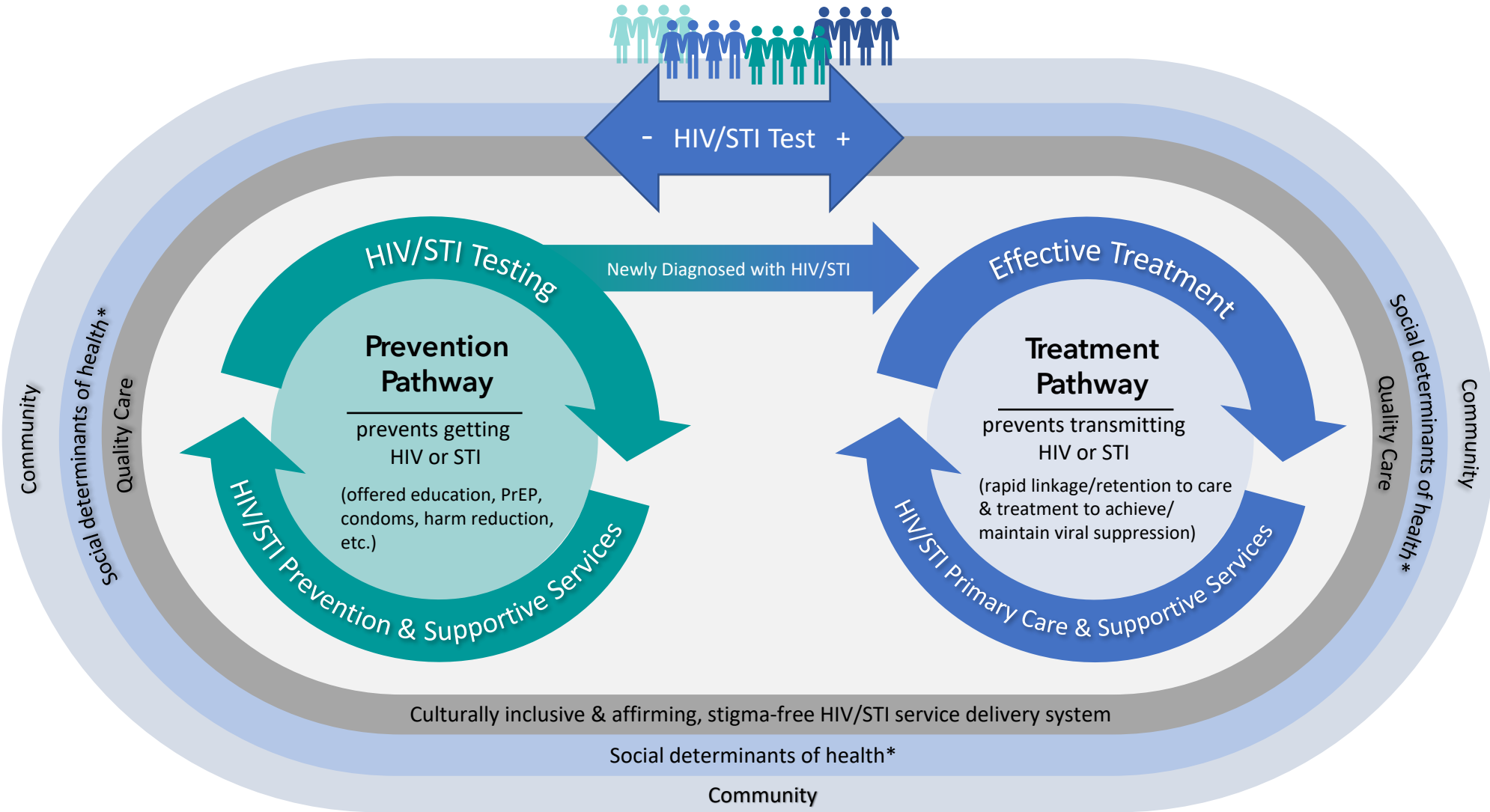
Status Neutral HIV and STI Service Delivery System



LOS ANGELES COUNTY
COMMISSION ON HIV

Revised 9/21/23

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

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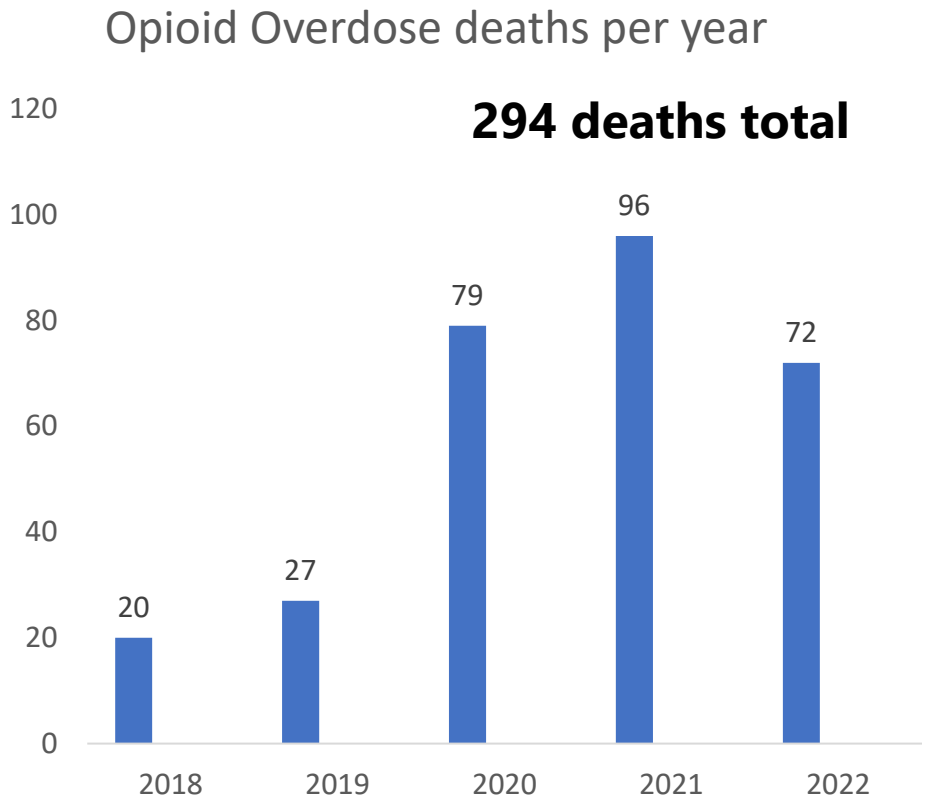
- Add medications (e.g. ART, PREP/PEP)
- Add care coordination

Harm Reduction in Long Beach

Settlement Funds

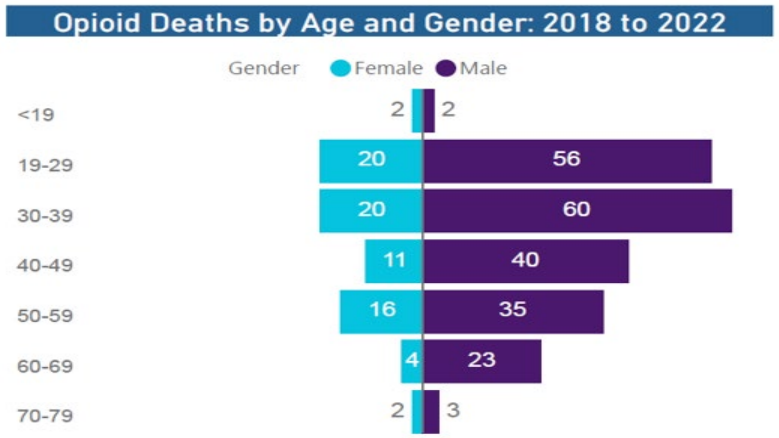
	High Impact Abatement Activity
1	Provision of matching funds or operating costs for substance use disorder facilities with an approved project within the Behavioral Health Continuum Infrastructure Program (BHCIP)
2	Creating new or expanded substance use disorder (SUD) treatment infrastructure
3	Addressing the needs of communities of color and vulnerable populations (including sheltered and unsheltered homeless populations) that are disproportionately impacted by SUD
4	Diversion of people with SUD from the justice system into treatment, including by providing training and resources to first and early responders (sworn and non-sworn) and implementing best practices for outreach, diversion and deflection, employability, restorative justice, and harm reduction
5	Interventions to prevent drug addiction in vulnerable youth
6	The purchase of naloxone for distribution and efforts to expand access to naloxone for opioid overdose reversals

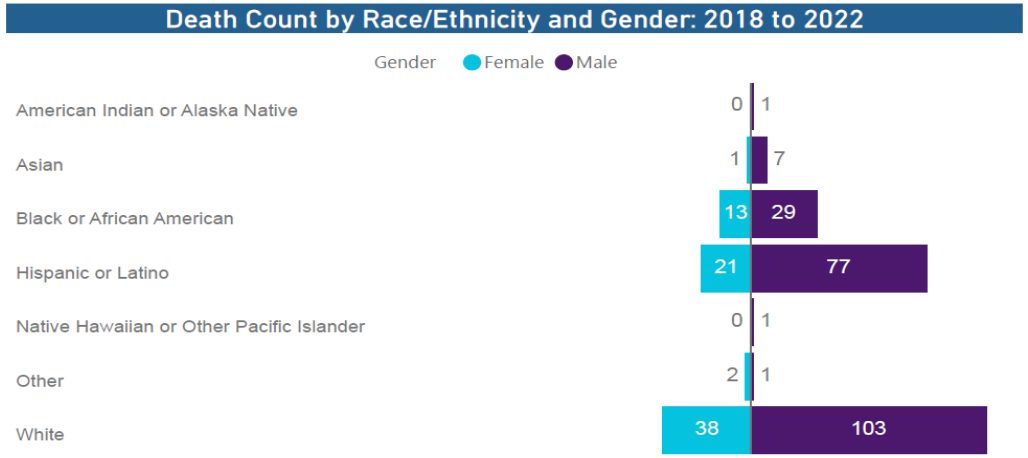


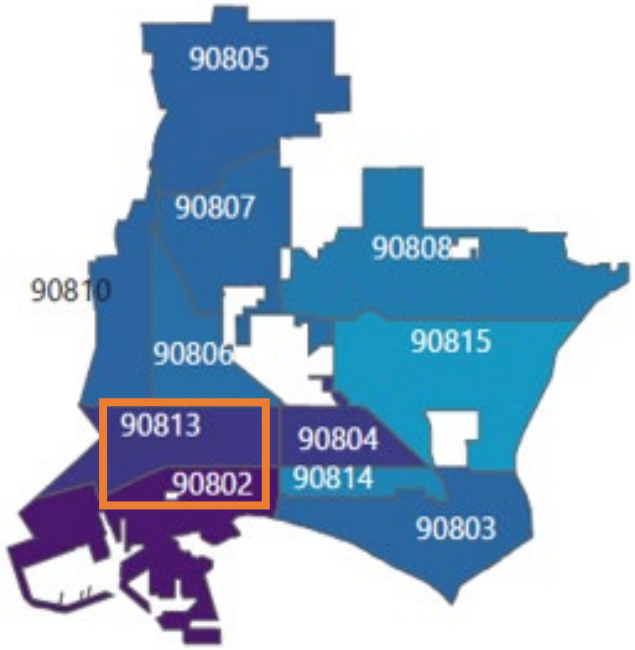
Opioid Deaths by Opioid Type	
	Total
Fentanyl	234
Heroin	40
Methadone	2
Morphine	6
Opiate	3
Opioid	1
Oxycodone	8
Total	294

Over 5 years, **80%** of the opioid related overdose deaths were caused by Fentanyl.

Deaths due to Opioid Overdose in Long Beach

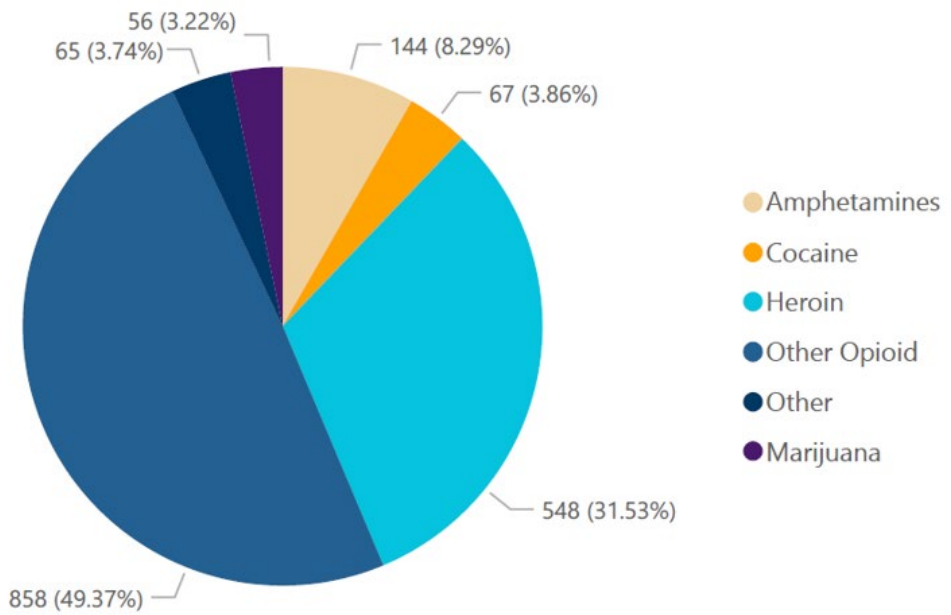




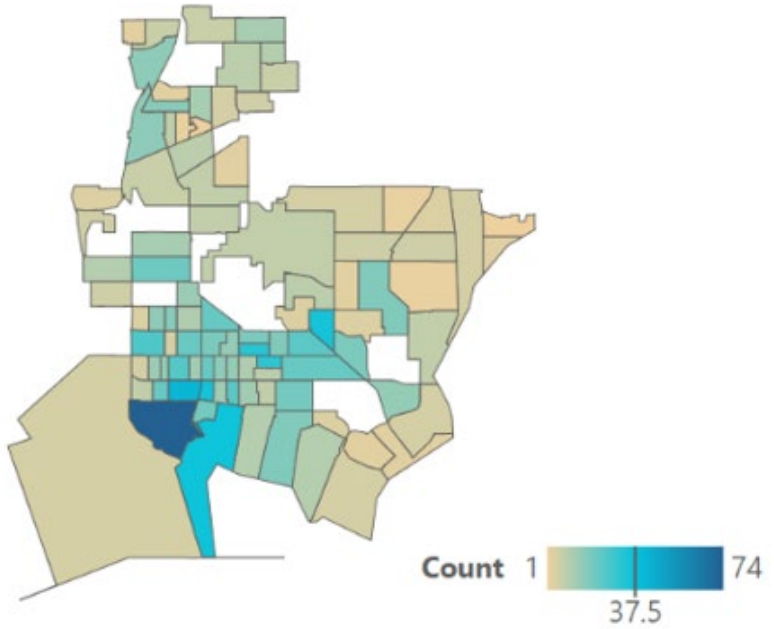


LONG BEACH HEALTH & HUMAN SERVICES

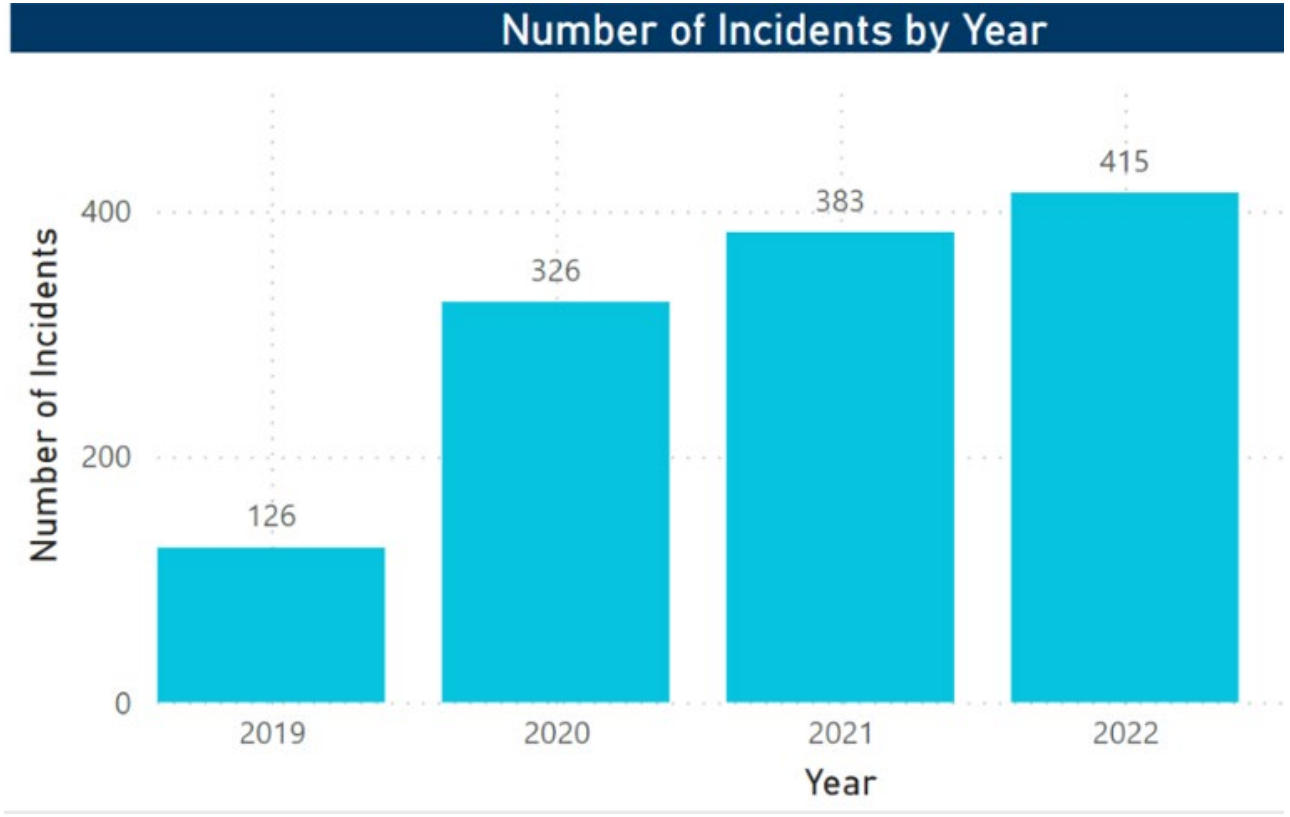
Suspected Drug Type



Number of Calls/Responses by Census Tract



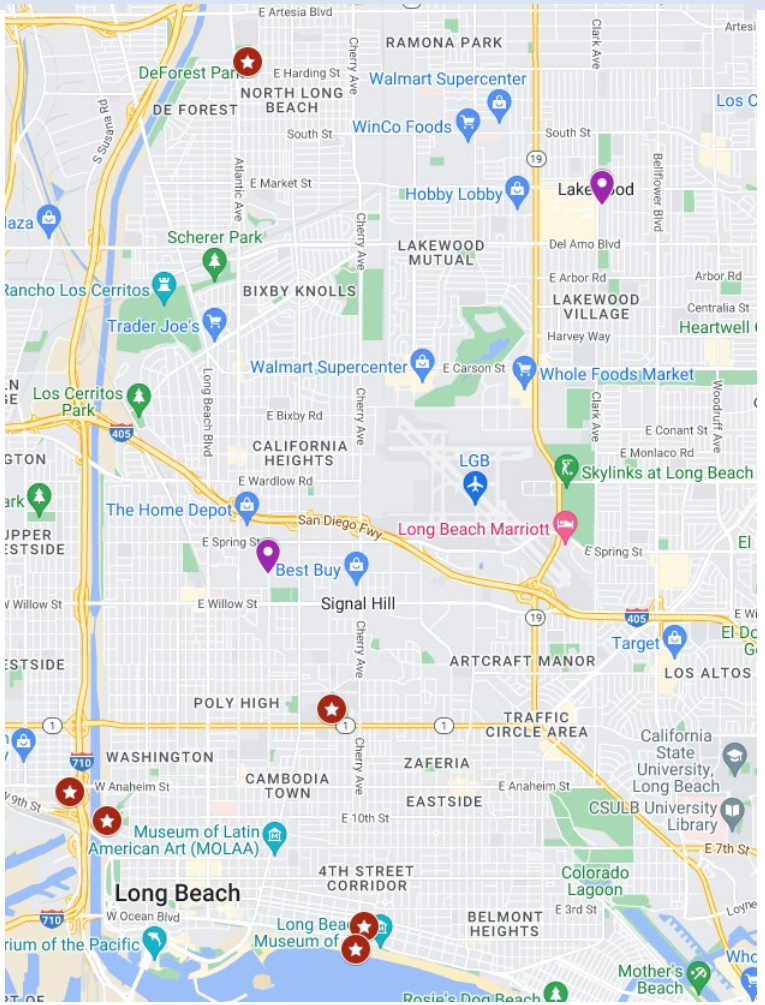
Opioid Overdose response calls by EMS/LBFD



Syringe Kiosks

8 Syringe kiosks located throughout the city of Long Beach to allow for people to dispose properly of their syringes/sharps to decrease re-use and risk of infection of HIV, Hep C, and other blood borne pathogens.

Our goal is to monitor/maintain these kiosks to determine best location and more accessibility for community that would use this service.



LONG BEACH HEALTH & HUMAN SERVICES

Fentanyl and Xylazine Test Strips

Our goal is to provide Fentanyl and Xylazine test strips to community partners and to the community. Free of charge.

They will be able to order through our direct website.

We plan to distribute these at community events as well.

Narcan/Naloxone

We are still figuring out how best to provide Narcan to the community based on budget and community impact.

Naloxone Distribution Program vs. Vending Machine

We will work with our community-based organizations that provide Narcan to help continue providing Narcan to the community.

Educational Workshops + Youth Outreach

Harm reduction is more than giving out items. Education is also harm reduction as it focuses on the person and provides information and skills for them to decrease harm themselves.

Education workshops will be provided to the community in partnership with some of our community-based organizations.
Topics include:

- Opioids 101
- Narcan/Naloxone Demonstrations and training
- Fentanyl test strips training

We are also working directly with the Long Beach Unified School District to provide a curriculum on Opioids (specifically Fentanyl) to the youth about prevention and misuse.

Community Collaboration

We have developed both a Syringe Services Program Workgroup and an HIV/STI/Substance Use Harm Reduction Strategy Task Force.

Both groups are composed of community-based organizations, public health department staff, and community stakeholders to provide input on how best to serve the Long Beach Community.

The HIV/STI/Substance Use Harm Reduction Strategy Task Force
-steer the overall production of the Long Beach HIV/STI/Substance Use Harm Reduction Strategy in partnership with consultant
-Host Listening Sessions to a diverse set of populations in Long Beach
-Produce plan with metrics and identify responsible parties
-Alignment at Federal, State, LA County level
-Impact on specific communities and metrics specific to that community

PASADENA

Public Health Department

Pasadena Public Health Department
Social and Mental Health Division

Background

Public Health Department

- Social and Mental Health Services Division has multiple programs supporting special populations, including people living with HIV, people experiencing homelessness, high-risk youth, and justice-involved individuals.
  - HIV Programs include storefront testing, take-home tests, ADAP and PrEP-AP enrollment, and linkages to treatment and PrEP through partner organizations
  - Pasadena Intervention and Prevention Program – working with youth affected by or involved in community violence and their families. Includes multi-dimensional family therapy (MDFT) and wraparound support services
  - Unhoused programs – GEM Link, TAY Link, PORT
  - Outreach – Narcan distribution, fentanyl test strip distribution, mental health training
- The City does not provide direct substance use treatment services at this time. However, the programs have several partnerships with community organizations for referrals, linkages, and warm hand-offs.

GEM and TAY Link

Public Health Department

- GEM – Geriatric Empowerment Model Link Program, working with people experiencing homelessness 60+
- TAY – Transition Age Youth Link Program, working with people experiencing homelessness 18-24 years old
- Case management and housing navigation for program clients. Linkage to substance use and mental health treatment.
- Basic needs services – showers, laundry, meals, clothing – for people experiencing homelessness of all ages. Often serves as first step into more intensive services.

PASADENA

Public Health Department

PORT

Pasadena Outreach Response Team

September 14, 2023

PORT's Mission

Public Health Department

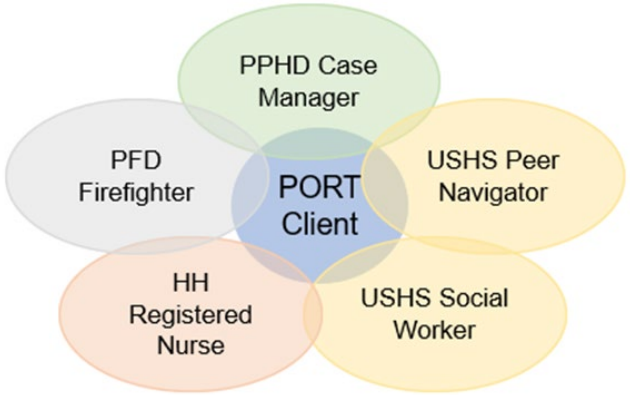
- **PORT's Scope:** Engaging, assessing, and providing services to individuals experiencing chronic homelessness with mental health and substance use disorder in the City of Pasadena.

PORT's Structure

Public Health Department

Pasadena Outreach Response Team

- **Program Coordinator & Case Manager** PPHD
- **Fire Fighter** PFD
- **Peer-Outreach Navigator** Union Station Homeless Services
- **Registered Nurse** Huntington Health



Field hours of operation: Mon-Friday 8:30-5pm

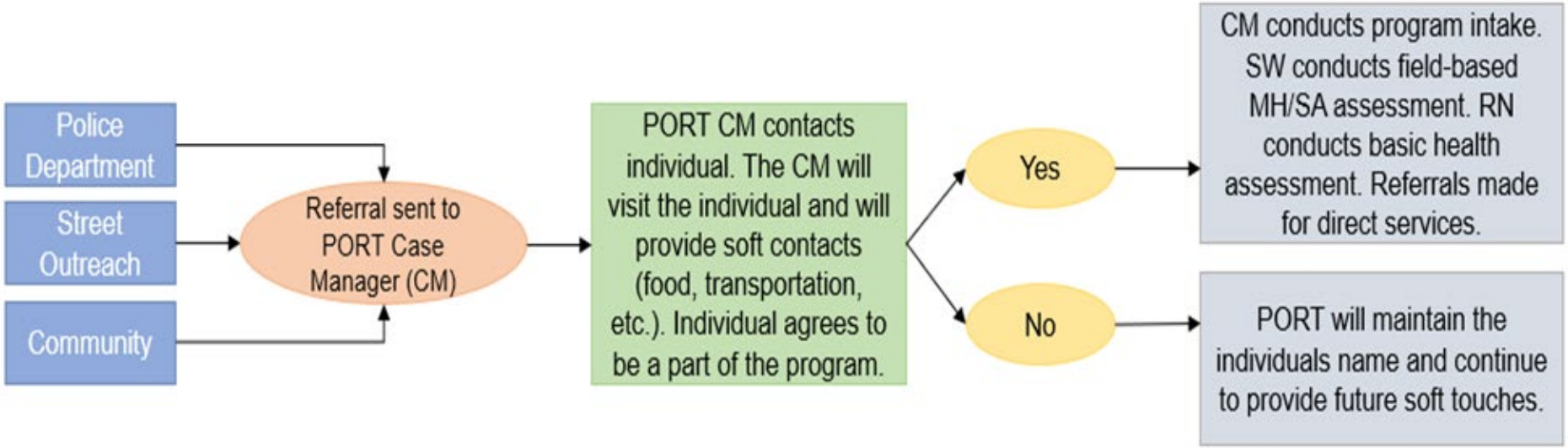
PORT's Approach

Public Health Department

- **PORT I:**
  - Coordinate, schedule, and facilitate transportation for clients to essential appointments.
    - Appointments cover a range of areas: housing readiness, health, and stability.
    - Services encompass medical, dental, mental health, substance use, occupational, and court-related needs.
- **PORT II:**
  - Connected to PPD Dispatch.
  - Responds to transient related call with a Fire Fighter and Case Manager.
  - Offers an alternative to armed officer presence, prioritizing a supportive approach to crisis intervention.

PORT's Approach

Public Health Department



Pasadena Homeless Count

Public Health Department

Team Success

Public Health Department

- July 2019 - July 2023:
  - **71** housed
  - **108** Detox Rehab
  - **488** Clinical Appointments (Doctor, Dental, Mental Health)
    - **177** On Field Assessments
  - **1044** Dispatch calls
  - **248** Total Enrolled
  - **4470** Encounter

Team Success

Public Health Department

Contact

Public Health Department

General Line: 626.604.6693
Nathan Press (PC): 626.243.8430
Tony Zee (PORT I): 626.243.8086
Chris Figueroa (PORT II): 626.344.5075
GEM&TAY: 626.744.7200

AIDS COORDINATOR'S OFFICE

WWW.ACO.LACITY.GOV

BACKGROUND

- The syringe exchange program was established in 1994 when the LA City Council declared a local public health emergency related to injection drug use and HIV.
- The declaration directed City departments to take all steps permitted by law to ensure uninterrupted operation of syringe exchange programs.
- The ACO worked with the City Attorney, local researchers, providers, and drug users to develop the program.

RELATIONSHIP WITH LAPD

- LAPD Memo
  - Contents
  - Renewal
- Training
- Notification

SERVICE DELIVERY

- Mobile Based
  - Van, Car
- Storefront
- Backpack
  - Encampments

PROVIDERS

- Funded Providers
  - Homeless Healthcare
  - Bienestar
  - Community Health Project
  - AIDS Project Los Angeles
  - Center for Health Justice
  - AADAP
  - Being Alive
- Certified Providers
  - Homeless Outreach Program Integrated Care System (HOPICS)
  - The Sidewalk Project
  - Minority AIDS Project

SERVICES PROVIDED

- Residential Treatment
- Outpatient Treatment
- Employment Access
- Substance Abuse Prevention Education with youth and other at-risk communities
- Youth and Family Programs
- Case management
- Peer Navigation
- Food Bank
- Health Fairs & Community Events
- Patient Advisory Group
- Advocacy
- Medical Detoxification
- NSS-2 Bridge For Opioid Withdrawal Treatment
- Community Outreach
- Court-Related Services
- Domestic Violence Supportive Services
- Housing Services
- HIV/STI Prevention Services
- Support groups
- Overdose prevention education and naloxone
- Health care and insurance enrollment
- Hepatitis C testing and treatment
- Provider training and technical assistance
- Dental
- Vision
- Integrative Medicine
- Pharmacy
- Street Medicine

OVERDOSE PREVENTION

- Overdose trainings and provision of Naloxone
  - Tracking Overdoses and Reversals
- Drug Testing (New)
  - Technology and strips
- Safer Consumption Sites (Future)
  - Support from LA City Council
  - Ongoing discussions with other City and outside partners

PROGRAM HIGHLIGHTS FOR FY 22/23

37,375 unduplicated clients

17,638 contacts with unhoused individuals

Collected 2,021,694 used syringes from city streets

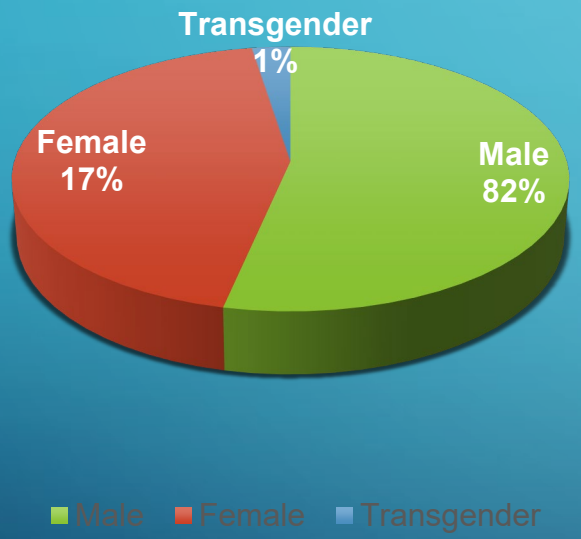
5,265 individuals trained in overdose prevention

6,875 reported instances of overdose reversals

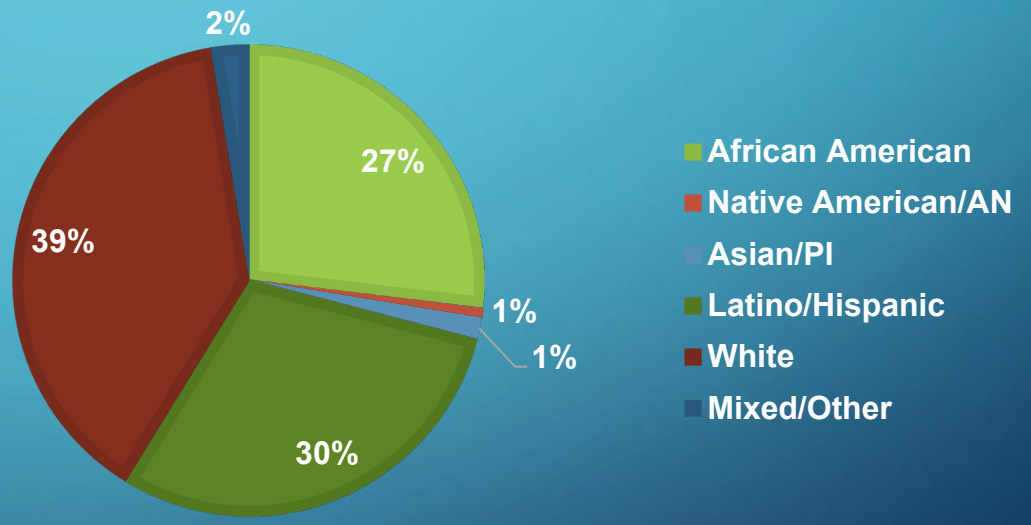
27,041 fentanyl test strips distributed

DEMOGRAPHIC BREAKDOWN

GENDER



RACE/ETHNICITY



THANK YOU!

- RICKY ROSALES – AIDS COORDINATOR
- DAHLIA ALE-FERLITO – MANAGEMENT ANALYST
- GINA LOMBARDO – MANAGEMENT ANALYST
- PETER SOTO – MANAGEMENT ANALYST
- JULIANA SOTO – ADMINISTRATIVE CLERK
- EVELINE BRAVO-AYALA - STUDENT PROFESSIONAL WORKER

Harm Reduction Presentation: 9/13/23

- West Hollywood is a small city of about 1.9 sq. miles with a population of around 37,000 people.
- Approximately 80% of residents are renters.
- Close to half of the population identifies (43%) as LGBTQ+ and approx.. 11% of the population are living with HIV.
- The City offers the highest minimum wage in the nation at $19.08. The minimum living wage for any contractor with the city is $20.12.
- West Hollywood is a contract City, which means every service, such as law enforcement, trash, maintenance, and social services are provided by outside vendors.
- In 1984, the AIDS crisis and the incorporation of the City coincided, which led to a devastating number of deaths during the early days of Cityhood. Since the beginning of the crisis, the City Council has prioritized the health and well-being of all its community members, which includes residents, workers, and those who are unhoused in the city.
- Currently, WeHo budgets approximately 7 million for social services and 3 million for transportation services. The city has taken a forward-thinking and proactive approach to caring for and supporting community members. In addition to residents, workers, and unhoused community members, we support harm reduction programming that benefits anyone who comes into to the city.

Substance Use

- The City has a long history of contracting with providers for substance use prevention and treatment services, including detox, residential, outpatient, support groups, and sober living.
- In 2018, after a number of fentanyl overdoses that occurred in and around the City, the City began allocating dollars for fentanyl test strip distribution. We purchased strips for providers to distribute at their clinics and among the nightlife scene. The City continues to purchase strips and gives them to any community based organization that serves the City. We distribute strips at large scale events, such a Pride. This year's Pride festival, we distributed over 10,000 fentanyl test strips.
- In 2019, the first syringe exchange in WeHo in over a decade opened with support from the City. Our 30-year agency partner, Being Alive, runs a weekly syringe services program, from 2:30 to 6:30pm in what's known historically as Vaseline Alley, which is in the parking lot behind the AHF Pharmacy at 8212 Santa Monica Blvd.
- The syringe services program offers needle exchange, safe disposal, nasal spray Narcan, injectable naloxone, condoms, wound care kits, and safer smoking supplies. These supplies include pipes (to dissuade people from injecting substances), mouthpieces (to protect mouth injuries from burns), and well as cleaning and other supplies. From October 1, 2022, through June 30, 2023, there have been 2,054 visits, 2,028 Nasal Narcan doses have been distributed as well as 1,804 fentanyl test strips.

- Through another contract we have with our street medicine provider, we will have a medical van stationed at the exchange, at least once a month, to provide wound care, STI testing and treatment, and other medical interventions.
- In 2021, all U.S. cities had the option to opt into a national settlement with the distributors and manufacturers of opioids. We will be receiving around $10k per year and that money will go directly to purchase Narcan for the exchange and for outreach providers who work in the city. Narcan is also available at the AHF mobile testing van on Hilldale and Santa Monica, daily from 7pm-2:30am.
- The City's partners, Institute for Public Strategies, and Being Alive are offering free training and Narcan to any organization, businesses, or community group to learn how to administer this lifesaving medication. IPS will be working with local bars, such as Mickeys, to train staff on when and how to use Narcan if there is an overdose in the bar.
- Our mobile street medicine team is available 7 days a week from 7am to 7pm and they provide a range of medical, mental health, and substance use treatment for unhoused community members within the city limits. They provide Narcan, needle exchange, as well as medication assisted treatment, such as naltrexone and suboxone (opioid blockers).
- There are 90+ recovery support groups occurring at the West Hollywood Recovery Center with thousands of clients coming in per year. The City purchased the historic Log Cabin across the street and will build it out for additional prevention and recovery space.
- The City also hosts two large sober events, such as SIZZLE and BOOM. Boom is the sober New Years Event and Sizzle is the sober space at Pride.

Nightlife Safety

- The City of West Hollywood became the first city in California to pass an Ordinance, in late 2021, to require Bystander Intervention training for personnel in business establishments that serve alcohol for onsite consumption. The Bystander Intervention training program launched in March 2022. Provided by the Rape Treatment Center (RTC) at UCLA Santa Monica Medical Center, the training is an educational course that addresses the issue of drug-facilitated sexual assaults and date rape drugs. The training also promotes the proactive role that onsite alcoholic beverage sales establishments can take in the prevention of sexual assaults, including the distribution of GHB test strips.
- In 2022, the City began a campaign to educate the public about drink spiking. We entered into a contract with the LGBT Center's WeHo Life program to start mass distribution among bars, clubs, and restaurants in the Rainbow District and at the Sunset Strip. These strips will detect the presence of GHB and Ketamine in a drink. From October 1, 2022, through June 30, 2023, there are 60 participating businesses and providers and 29,228 test kits have been distributed.

Law Enforcement

- A few years ago, the City Council decided to become less dependent on the Sherriff's Dept.

- We have a WeHo Care Team that is now online. It's a mobile crisis response, 24/7/365 to residents having a mental health crisis. They provide substance use referrals, welfare checks, suicide prevention, supportive counseling, crisis intervention, and safety planning.
- As previously mentioned, we have a mobile street medicine team who can address unhoused community members acute and longer term needs. They can provide medical procedures, medications, and behavioral health services wherever the community member is at.
- The City also expanded the Block by Block security ambassador program. It's a highly visible uniformed presence at the street level who patrol neighborhoods and the nightlife district and they are also stationed at kiosks throughout the City.
- Lastly, the City Council adopted a resolution to declare sex as a low priority for the Sherriff's Dept., so they can focus on violent crimes.

DRAFT

LOS ANGELES COUNTY
COMMISSION ON HIV

RYAN WHITE PROGRAM
UNIVERSAL STANDARDS

Approved by COH on 2/11/21

Draft as of 08/01/23 for

Executive Committee Review.

LOS ANGELES COUNTY
COMMISSION ON HIV

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

1. GENERAL AGENCY POLICIES

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

1.0 GENERAL AGENCY POLICIES	
Standard	**Documentation**
1.1 Agency develops or utilizes an existing client confidentiality policy in accordance with state and federal laws to assure protection of client HIV status, behavioral risk factors, and/or use of services.	1.1 Written client confidentiality policy on file with specific information technology safeguards for confidentiality and patient information if using telehealth service modality.
1.2 Agency is responsible for informing the patient that they have the right to obtain copies of their medical and other health records maintained by the agency.	1.2 Written policy for informing the patient of their rights to receive a copy of their medical records. The policy should contain a description of the process for obtaining records, such as a verbal or written request and a reasonable timeframe for patients to receive the information.
1.3 Client determines what information of theirs can be released and with whom it can be shared. Services using telehealth modality are subject to consent by the patient.	1.3 Completed *Release of Information Form* on file including: • Name of agency/individual with whom information will be shared • Information to be shared • Duration of the release consent • Client signature For agencies and information covered by the Health Insurance Portability and Accountability Act (HIPAA), form must be HIPAA disclosure authorization compliant. The form must also be compliant with the CA Medi-Cal telehealth policy.[1]
1.4 Agency develops or utilizes an existing grievance procedure to ensure clients have recourse if they feel they are being treated in an unfair manner or feel they are not receiving quality services.	1.4 Written grievance procedure on file that includes, at minimum: • Client process to file a grievance • Information on the Los Angeles County Department of Public Health, Division of HIV & STD Programs (DHSP) Customer Support Program[2] 1-800-260-8787. 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] California Department of Health Care Services Telehealth Provider Manual can be accessed here https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/mednetele.pdf

[2] More information on the Customer Support Program can be found here: DHSP_CSP_CustomerSupportForm_Website-ENG-Final_12.2022.pdf (lacounty.gov)

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[3]	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[4,5]. Staff members are trained in universal precautions.	1.10 Written policy or procedure on file. Documentation of staff training in personnel file.
1.10 Agency ensures compliance with Americans with Disabilities Act[6] (ADA) criteria for programmatic accessibility (e.g. building and design accessibility, parking, etc.). For agencies with multiple sites, all sites must comply with the ADA requirements.	1.10 ADA criteria on file at all sites.
1.11 Agency complies with all applicable state and federal workplace and safety laws and regulations, including fire safety.	1.11 Signed confirmation of compliance with applicable regulations on file.

[3] PCN 16-02 RWHAP Services Eligible Individuals and Allowables Uses of Funds (hrsa.gov)
[4] Bloodborne Infectious Diseases | NIOSH | CDC
[5] Bloodborne Pathogens - Worker protections against occupational exposure to infectious diseases | Occupational Safety and Health Administration (osha.gov)
[6] Laws, Regulations & Standards | ADA.gov

2. CLIENT RIGHTS AND RESPONSIBILITIES

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

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

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

3. STAFF REQUIREMENTS AND QUALIFICATIONS

Staff must be well qualified and, if necessary, hold all required licenses, registration, and/or degrees in accordance with applicable State and federal regulations as well as requirements of the Los Angeles County Department of Public Health, Division of HIV & STD Programs. At minimum, all staff will be able to provide timely, linguistically, and culturally competent care to people living with HIV. Staff will complete orientation through their respective hiring agency, including a review of established programmatic guidelines, and supplemental trainings as required by the Los Angeles County Department of Public Health, Division of HIV and STD Programs. The AIDS Education Training Center (AETC)[7] offers a variety of training for the HIV workforce.

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

[7] Welcome | AIDS Education and Training Centers National Coordinating Resource Center (AETC NCRC) (aidsetc.org)

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. Continuing to take HIV medications as directed is imperative to stay undetectable. b. Staff should have experience in or participate in trainings on: • LGBTQ+/Transgender community and HIV Navigation Services (HNS)[8] provided by Centers for Disease Control and Prevention (CDC). • Trauma informed care • Providing care for older adults • Mental Health First Aid	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-level 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[9] (CLAS) in Health and Health Care. As noted in the CLAS Standards[10], 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,

[8] HIV Navigation Services | Treat | Effective Interventions | HIV/AIDS | CDC
[9] Culturally and Linguistically Appropriate Services - Think Cultural Health (hhs.gov)
[10] CLAS Standards - Think Cultural Health (hhs.gov)

ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics. The standards below are adapted directly from the National CLAS Standards.

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

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

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

4.0 CULTURAL AND LINGUISTIC COMPETENCE	
Standard	**Documentation**
4.1 Recruit, promote, and support a culturally and linguistically diverse workforce that are responsive to the population served.	4.1 Documentation of how staff demographics reflect the demographics of clients served on file (e.g. race, gender identity, age, sexual orientation, lived experience etc.)
4.2 Agency develops or utilizes existing culturally and linguistically appropriate policies and practices. Agency educates and trains workforce on culturally and linguistically appropriate practices on an ongoing basis.	4.2 Written policy and practices on file Documentation of completed trainings on file.
4.3 Provide resources onsite to facilitate communication for individuals who experience impairment due to a challenging medical condition or status (e.g. augmentative and alternative communication resources or auxiliary aids and services)	4.3 Resources on file a. Checklist of resources onsite that are available for client use. b. Type of accommodations provided documented in client file.

4.4 Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.	4.4 *Signed Patient & Client Bill of Rights and Responsibilities* document on file that includes notice of right to obtain no-cost interpreter services.
4.5 Ensure the competence of individuals providing language assistance a. Use of untrained individuals and/or minors as interpreters should be avoided Ensure quality of language skills of self-reported bilingual staff who use their non-English language skills during client encounters	4.5 Staff resumes and language certifications, if available, on file.
4.6 Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area in clinic points of entry (e.g. registration desks, front desks, reception, waiting rooms, etc.) and areas where work with client is performed (e.g. clinic rooms, meeting rooms, etc.)	4.6 Materials and signage in a visible location and/or on file for reference.

5. INTAKE AND ELIGIBILITY

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

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

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 Customer Support Program[11].

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.

[11] DHSP_CSP_CustomerSupportForm_Website-ENG-Final_12.2022.pdf (lacounty.gov)

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 and Responsibilities* document. (Refer to Appendix B).

APPENDIX A: RYAN WHITE PART A SERVICE CATEGORIES

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

Core Medical Services	**Description**
Ambulatory Outpatient Medical (AOM) Services	HIV medical care access through a medical provider.
Home-based Case Management	Specialized home care for homebound clients.
Medical Care Coordination (MCC)	HIV care coordination through a team of health providers to improve quality of life.
Medical Specialty Services	Medical care referrals for complex and specialized cases.
Mental Health Services	Psychiatry, psychotherapy, and specialized cases.
Oral Health Services (General & Specialty)	General and specialty dental care services.
Supportive Services	**Description**
Benefits Specialty Services	Assistance navigating public and/or private benefits and programs (health, disability, etc.).
Language Translation Services	Translation services for non-English speakers and deaf and/or hard of hearing individuals.
Legal Services	Legal information, advice, and services.
Nutrition Support Services	Home-delivered meals, food banks, and pantry services.
Residential Care Facility for the Chronically Ill (RCFCI)	Home-like housing that provides 24-hour care.
Substance Use Disorder Transitional Housing (SUDTH)	Housing services for clients in recovery form drug or alcohol use disorders.
Transitional Case Management	Support for incarcerated individuals transitioning from County jails back to the community.
Transitional Residential Care Facility (TRCF)	Short-term housing that provides 24-hour assistance to clients with independent living skills.
Transportation Services	Ride services to medical and social services appointments.

APPENDIX B: PATIENT & CLIENT BILL OF RIGHTS AND RESPONSIBILITIES

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

A. Respectful Treatment and Preventative Services

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

B. Competent, High-Quality Care

1. Have your care provided by competent, qualified professionals who follow HIV treatment standards as set forth by the U.S. Department of Health and Human Services[12] (HHS), the Centers for Disease Control and Prevention[13] (CDC), the California Department of Health Services[14], and the County of Los Angeles Department of Public Health[15].
2. Have access to these professionals at convenient times and locations.
3. Receive appropriate referrals to other medical, mental health or care services.
4. Have their phone calls and/or emails answered with 1-5 business days based on the urgency of the matter.

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.

[12] HIV Treatment Guidelines | NIH
[13] Guidelines and Recommendations | Clinicians | HIV | CDC
[14] HIV Care Program
[15] LA County Department of Public Health

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[16] (CMS).

D. Confidentiality and Privacy

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

E. Billing Information and Assistance

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

F. Patient/Client Responsibilities

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

1. Participate in the development and implementation of your individual treatment or service plan to the extent that you are able.
2. Provide your providers, to the best of your knowledge, accurate and complete information about your current and past health and illness, medications and other treatment and services you are receiving, since all of these may affect your care. Communicate promptly any changes or new developments.
3. Communicate to your provider whenever you do not understand information you are provided.
4. Follow the treatment plan you have agreed to and understand the consequences of failing to adhere to the recommended course of treatment or of using alternative treatments.
5. Understand that cases may be closed if the client:
    i. Relocates out of the service area
    ii. Is no longer eligible for the service(s)
    iii. Discontinues the service(s)
    iv. No longer needs the service(s)

[16] Home - Division of Appeals Policy (lmi.org)

v. Puts the agency, service provider, or other clients at risk
vi. Uses the service(s) improperly or has not complied with the services agreement
vii. Is deceased
viii. Has had no direct agency contact, after repeated attempts, for a period of 12 months

6. Keep your appointments and commitments at this agency or inform theagency promptly if you cannot do so.
7. Keep your provider or main contact informed about how to reach you confidentiallyby phone, mail, or other means.
8. Follow the agency's rules and regulations concerning patient/client care and conduct.
9. Be considerate of your providers and fellow clients/patients and treat them withthe respect you yourself expect.
10. Refrain from the use of profanity or abusive or hostile language; threats, violence, or intimidations; carrying weapons of any sort; theft or vandalism; sexual harassment and misconduct.
11. If you are a person living with a Substance Use Disorder, please be open and honest with your provider about your substance use so that any issues can be properly addressed.

For More Help or Information

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

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

APPENDIX C: TELEHEALTH RESOURCES

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

LOS ANGELES COUNTY COMMISSION ON HIV PREVENTION SERVICES STANDARDS

Approved the Commission on HIV 06/14/18

INTRODUCTION

Prevention Standards outline the elements and expectations a 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 agencies should offer to clients. The Standards are intended to help agencies meet the needs of their clients. Providers are encouraged to exceed these standards. The Los Angeles County Commission on HIV developed the Prevention Standards to reflect current guidelines from federal and national agencies on HIV and STI prevention, and to establish the minimum standards of service delivery necessary to achieve optimal health among people with increased risk of HIV and STIs, regardless of where services are received in the County. Because there are many different types of organizations that may provide prevention services, not every category of prevention standards described herein will be applicable to all agencies. For example, an agency that provides HIV/STI testing only, will not necessarily be expected to provide adherence services for clients who are accessing PrEP.

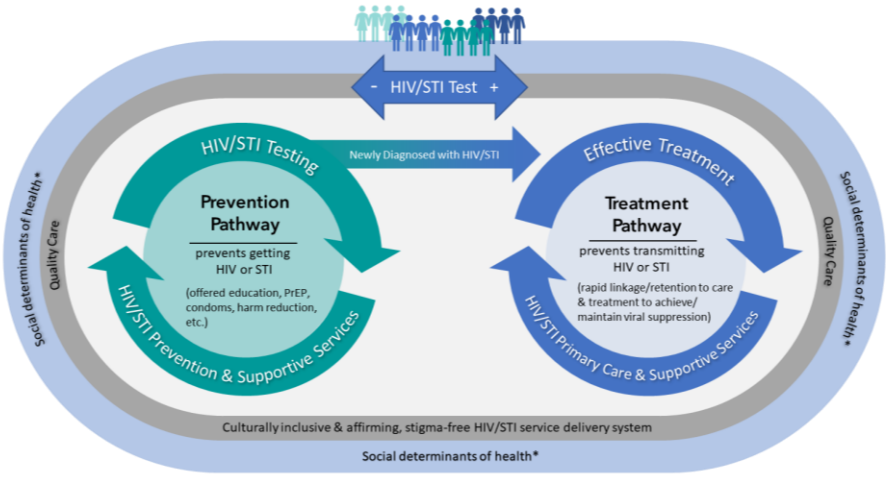
The development of the Standards includes guidance from service providers, the Los Angeles County Department of Public Health, Division of HIV and STD Programs (DHSP), and members of the Los Angeles County Commission on HIV, Prevention Planning Workgroup.

SERVICE DESCRIPTION

Prevention Services are those services used alone or in combination to prevent the transmission of HIV and STIs. The early diagnosis and treatment of STIs is vital to interrupting of transmission of not only STIs but as well as HIV. Prevention Services include HIV and STI screening, biomedical interventions, and non-biomedical/behavioral interventions.

The Los Angeles County Commission on HIV's *Status Neutral HIV and STI Service Delivery System Framework,* depicted in Figure 1, below, was used to guide the development of the HIV & STI Prevention Service Standards. The *Status Neutral HIV and STI Service Delivery System Framework* functions to provide comprehensive support and care to address the social determinants of health that create disparities, especially as they relate to HIV and STIs. Continuous preventive, medical care and supportive services are highlighted as part of an ongoing effort by patient and provider to maintain engagement in clinical preventive care or treatment. A status-neutral approach to HIV care means that all people, regardless of HIV status, are treated in the same way. It all starts with an HIV test. Any result, positive or negative, kicks off further engagement with the healthcare system, leading to a common final goal, where HIV is neither acquired nor passed. The end point is not a final state but a dynamic one requiring continued attention by all parties. The figure emphasizes the consistent return among the uninfected to HIV testing, with a resultant trajectory into and through the continuum, as appropriate, depending on test results (and on the appropriateness of PrEP for those testing negative). When done effectively, rapidly linking newly diagnosed people to HIV treatment and those who test negative to ongoing prevention programs will help us to dramatically reduce new HIV infections, support positive people to thrive with and beyond HIV and reduce health disparities where they continue to exist.

Status Neutral HIV and STI Service Delivery System



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

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

The status neutral framework reaches beyond established HIV prevention & care systems and works to create pathways to vital medical and supportive services that meet the holistic needs of individuals regardless of their HIV or STI status. It addresses the holistic needs of the person and is not centered solely around meeting disease specific needs. The benefits of a status neutral approach include: a reduction in institutionalized stigma for people with HIV (PWH), increased efficiencies that improves resource utilizations, gained knowledge/insight from various service deliveries and naturally become person-focused rather than disease focused.

BACKGROUND

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

A multitude of factors at the structural-, environmental-, interpersonal-, and individual-level impact the risk of HIV and STI infection. Therefore, a multitude of strategies (e.g. housing, employment, social marketing, counseling, condom distribution, etc.) may also serve to prevent

the acquisition of HIV and STIs. Because it is not feasible to create standards for every potential prevention service, the HIV and STI Prevention Service Standards described in this document focus on ensuring that every individual at risk of acquiring or transmitting HIV infection and/or STIs is successfully connected to and retained in the prevention service(s) that are appropriate for them at any given point in time.

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

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

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

Given these scientific breakthroughs, the central tenets of today's HIV prevention efforts focus on biomedical prevention interventions, including the viral suppression of HIV-positive individuals and widespread access to PrEP, particularly for populations that are disproportionately impacted by HIV disease (i.e., Black and Latinx gay/bisexual/same-gender loving men, and transgender women of color).

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

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

UNIVERSAL STANDARDS

Commented [ML1]: Include staff and training requirements.

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

UNIVERSAL STANDARDS OVERVIEW
The objectives of the Universal Standards are to ensure agencies:

- Provide services that are accessible and non-discriminatory to all people with a focus on highly impacted populations
- Educate staff and clients on the importance of screening, biomedical prevention, and non-biomedical prevention to reduce the risk of HIV and STI transmission
- Protect client rights and ensure quality of services
- Provide client-centered, age appropriate, culturally, and linguistically competent service delivery
- 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 and protect client autonomy
- Prevent information technology security risks and protect patient information and records
- Inform clients of services 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.

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

Address the social determinants of health: Social determinants of health are the economic and social conditions that influence the health of individuals and communities.[6] Because HIV and STI disparities are inextricably linked to social determinants, interventions or services that focus on social determinants (e.g. racism, homophobia, transphobia, housing, education, employment, healthcare, etc.) are necessary to reduce these disparities. The implementation of such structural interventions typically requires a great deal of time and effort on behalf of multiple stakeholders, given that social determinants are deeply entrenched and institutionalized in our society. For this reason, many HIV prevention agencies may not have the capacity to implement structural or social level interventions. However, HIV and STI prevention services should

minimally reflect an understanding of the role of social determinants in their design (e.g. consider a client's competing priorities related to housing and employment).

Strength-Based: A strength-based approach to service design and provision seeks to understand and develop clients' strengths and capabilities that can lead to improved health and quality of life. Services that focus solely on individuals' deficits, needs, problems, or pathologies tend to focus only on what a client needs to "fix" about themselves, thus emphasizing negative behaviors rather than emphasizing resiliency and protective factors. A strength-based approach focuses on individuals' strengths, resources and the ability to recover from adversity; allowing a client to focus on opportunities and solutions rather than problems and hopelessness.

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

Sex-Positive: When services are delivered from a "sex-positive" framework or attitude, they are free from judgment about clients' sexual behaviors, including the behavior itself (as long as it is consensual); the number and type of sexual partners; and the frequency of sexual behaviors (Center for Positive Sexuality). A sex-positive attitude also serves to destigmatize sex, and may also serve to reduce other forms of stigma experienced by clients related to being gay, being transgender, living with, or being at risk for HIV, etc.

Trauma-Informed:
Trauma-informed care shifts the focus from "What's wrong with you?" to "What happened to you?" A trauma-informed approach acknowledges that prevention providers need to have a complete picture of a patient's life situation — past and present — in order to provide effective services with a healing orientation. Adopting trauma-informed practices can potentially improve patient engagement, and health outcomes, as well as provider and staff wellness.

Trauma-informed care seeks to:

- Realize the widespread impact of trauma and understand paths for recovery;
- Recognize the signs and symptoms of trauma in patients, families, and staff;
- Integrate knowledge about trauma into policies, procedures, and practices; and
- Actively avoid re-traumatization.

A comprehensive approach to trauma-informed services must be adopted at all organizational levels. Too frequently, providers attempt to implement trauma-informed care at the direct service level without the proper supports necessary for broad organizational culture change. This can lead to uneven, and often unsustainable, shifts in day-to-day operations. This narrow focus also fails to recognize how staff, such as front desk workers and security personnel, often have significant interactions with clients and can be critical to ensuring that clients feel safe.

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

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

Cultural competence and acknowledging implicit bias rely on behaviors, attitudes, and policies that come together in a system, agency, or among individuals that reduces stigma and enables effective delivery of services. Linguistic competence is the ability to communicate effectively with clients, including those whose preferred language is not the same asthe 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.

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

CORE PREVENTION COMPONENTS

Summary of Core Prevention Service Components: The HIV and STI Prevention Service Standards seek to ensure the provision of a core set of integrated HIV and STI prevention services aimed at preventing the acquisition and transmission of HIV and STIs. The Core Prevention Service Components are: Screening and Assessments, Biomedical Prevention, and Behavioral Prevention. These Core Prevention Service Components and complementary and should be used collectively to maximize prevention efforts.

SERVICE COMPONENT	STANDARD	DOCUMENTATION
Intake	Initiate a client record	Intake tool in client file to include (at minimum): • Documentation of HIV status (if applicable) • Proof of LA County residency or Affidavit of Homelessness • Verification of financial eligibility • Date of intake • Client name, home address, mailing address and telephone number • Emergency and/or next of kin contact name, home address and telephone number Signed and dated Release of Information, Limits of 4 | Page Confidentiality, Consent, Client Rights and Responsibilities
Assessment	Comprehensive assessments are completed in a cooperative process between staff and the client during first visit/ appointment. Alternatively, clients may complete online assessments prior to their first visit. Comprehensive assessment is	Comprehensive assessment on file in client chart to include: • Date of assessment • Signature and title of staff person conducting assessment • Completed assessment form • Client strengths, needs and available resources in the following areas: o Medical/physical

	conducted to determine the: • Client's needs for treatment and support services including housing and food needs • Client's current capacity to meet those needs/identify barriers that address needs • Client's Medical Home • Ability of the client's social support network to help meet client needs • Extent to which other agencies are involved in client's care	healthcare o Medications and Adherence issues (if diagnosed with HIV) o Mental health o Substance use and/or substance use treatment o HCV/HIV dual diagnosis, if applicable o Nutrition/food o Housing and living situation o Family and dependent care issues o Access to hormone replacement therapy, gender reassignment procedures, name change/gender change clinics and other transition-related services. o Transportation o Language/literacy skills o Religious/spiritual support o Social support system o Relationship history o Domestic violence/Intimate Partner Violence (IPV) o History of physical or emotional trauma o Financial resources o Employment and Education o Legal issues/incarceration history o Knowledge/beliefs about HIV/STIs o Agencies that serve the client and/or household

	Staff will conduct reassessments with the client as needed.	• Date of reassessment • Signature and title of staff person conducting reassessment • Completed reassessment form
Testing	Staff will conduct appropriate HIV and/or STI tests based on sexual health history or client request.	Documentation of HIV/STI testing in client files and data management system.
	HIV/STI testing must be voluntary and free from coercion. Patients/ clients must not be tested without their knowledge/ written consent.	
	Provide immediate and, if necessary, repeated, linkage services to persons with a preliminary positive HIV test result or a confirmed HIV diagnosis	
	Identify opportunities to offer community-based testing outside of clinic	

Biomedical Prevention

SERVICE COMPONENT	**STANDARD**	**DOCUMENTATION**
Treatment as Prevention (for PLWDH)	Provide antiretroviral treatment (ART) to persons with diagnosed HIV within 3 days of diagnosis.	
	For patients who choose to postpone treatment, periodically reoffer ART after informing them of the benefits and risk of currently recommended regimens.	
	Help persons enroll in health insurance or medical assistance	

	programs that provide HIV care or cover costs of care	
	Offer navigation assistance and support to encourage active participation in care	
	Establish procedures to identify patients at risk for lapses in care or services that support their continued care	
Treatment of STIs	Assess patients risk for STI acquisition	
	Provide treatment for patients to test positive for an STI	
	Ensure client is linked to services that cover the cost of treatment	
	Conduct follow up testing 3 months after positive test to ensure STI has been treated appropriately	
	Provide vaccination for HPV and HCV, as recommended	
PrEP/PEP	Assess a client's risk of HIV acquisition	
	Provide clients with a PrEP/PEP Navigator/ Navigation Services	
	Provide PrEP prescription that addresses the specific needs of the client	
DoxyPEP	Assess a client's risk of STI acquisition	
	Provide DoxyPEP prescription to clients at risk of STI acquisition	
Partner Services	Identify client's recent sexual and/or injection drug use partner(s)	
	Notify partner(s) of potential exposure to HIV and/or STI	
	Offer appropriate HIV and/or STI treatment and care plan to partner(s)	

	Conduct follow up to ensure partner(s) adherence to treatment/care	
Harm Reduction for People Who Inject Drugs (PWID)		

Non-biomedical/Behavioral Prevention

SERVICE COMPONENT	STANDARD	DOCUMENTATION
Education/Counseling	Provide HIV and STI education. Sessions will focus on Health Education/Risk Reduction Prevention, Behavior Change Skills Building and increasing knowledge of access to care services based on the client's risk assessment. Sessions can be provided on a one-to-one basis or group setting depending on the client's preference, need and/or environment. Sessions can be conducted on an ongoing basis, depending on need, and can be from 1 to 3 weekly or semi-monthly sessions.	
	Provide PrEP/PEP education and counseling for clients at risk of HIV acquisition	
	Provide DoxyPEP education and counseling for clients at risk of STI acquisition	
	Provide education for PLWDH on the importance of maintaining an undetectable viral load, the importance of adhering to care, and increase their capacity to engage their own care	
	Offer free or low cost internal and external condoms and dental dams	
Supportive Services	Assess the client's need for supportive services	
	Provide referrals and assist with	

	linkage to supportive services. Services may include: • syringe exchange • housing services • mental health services • substance abuse services • food and nutrition support • employment services • unemployment financial assistance • drug assistance programs • health insurance navigation • childcare • legal assistance • other services, as identified and needed • health literacy education • peer support	
	Referrals should be to local facilities, clinics, and service providers in the area of the client minimizing transportation barriers.	
Social Marketing and Outreach	Outreach to potential clients/families and providers	
	Collaborate with community partners and health care providers to promote services	
Navigation Services	Provide navigation assistance for linkage to supportive services	
	Health Navigators will canvas the target areas to identify and document all available service providers that can be used as referral sources for clients.	
	Health Navigators will become familiar with the access, referral, and intake process in order to educate clients of this process when providing referral for services.	
	Follow up session should be conducted to re-access clients' current situation and, if needed, additional services.	

LOS ANGELES COUNTY COMMISSION ON HIV PREVENTION SERVICES STANDARDS

Approved the Commission on HIV 06/14/18

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BACKGROUND

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

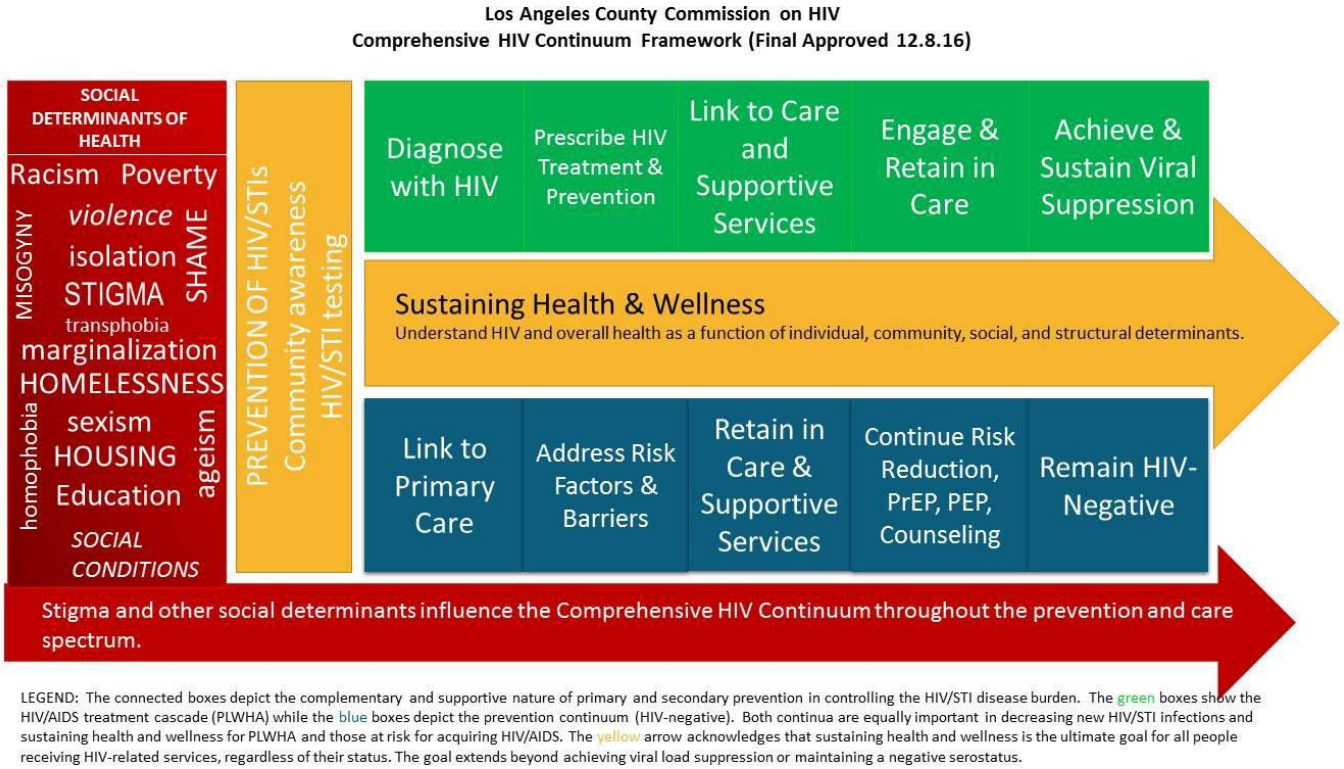
- Persons who inject drugs (PWID)
- Youth (18-29 years)
- Cisgender women
- Transgender persons
- Blacks/African Americans
- American Indians/Alaska Natives

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

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

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

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



LEGEND: The connected boxes depict the complementary and supportive nature of primary and secondary prevention in controlling the HIV/STI disease burden. The green boxes show the HIV/AIDS treatment cascade (PLWHA) while the blue boxes depict the prevention continuum (HIV-negative). Both continua are equally important in decreasing new HIV/STI infections and sustaining health and wellness for PLWHA and those at risk for acquiring HIV/AIDS. The yellow arrow acknowledges that sustaining health and wellness is the ultimate goal for all people receiving HIV-related services, regardless of their status. The goal extends beyond achieving viral load suppression or maintaining a negative serostatus.

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

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

1. Are the standards up-to-date and consistent with national standards of high-quality HIV and STD[5] prevention services?
2. Are the standards reasonable and achievable for providers?
3. Will the services meet consumer needs?
4. Are proposed standards client-centered?
5. What are the important outcomes we expect for people receiving these services? How can we measure whether or not the service is working for them?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CORE PREVENTION COMPONENTS

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

Table 1: Summary of Core Prevention Service Components

Core Prevention Service Components	Data Indicators	Documentation Needs	Population- Based Outcomes
1. Assessment	• Number of clients/patients who complete assessments • Number of participants screened for: connection to a medical home; primary care engagement; insurance coverage; HIV status; STDs; immunizations; pregnancy; mental health; substance abuse; experiences of trauma and violence; housing and employment status; and sexual and needle- sharing behaviors that may increase their risk of HIV acquisition or transmission	• Completed assessments indicating specific areas or topics assessed and type of assessments used	• Decrease the number of new HIV infections • Decrease the number of STDs • Increase the number of persons with known HIV status • Increase the number of persons treated for STDs • Increase the number of newly diagnosed clients that have their first HIV medical visit within 72 hours of their diagnosis. • All service provides should strive towards linking newly- diagnosed PLWHA to anti-retroviral therapy within 72 hours of diagnosis.
2. HIV/STD Testing and Retesting	• Number of persons tested/screened for HIV and STDs • Number of persons tested/screened for HIV and STDs who have never tested/screened before • Number of persons who test positive for an STD who are treated or referred to treatment • Percentage of high-risk[9] negative clients having documentation of HIV/STD testing every 3 months • Type and number of • outreach and recruitment methods	• Documentation of HIV/STD testing in client files and data management system Documentation of type and frequency of outreach and recruitment methods • Documentation of clients treated for STDs or referred to treatment	

Core Prevention Service Components	Data Indicators	• Documentation Needs	• Population- Based Outcomes
3. Linkage to HIV Medical Care and Biomedical Prevention Services	**HIV-positive individuals:** • Number of HIV- positive clients linked to HIV medical care within 72 hours of receiving a HIV- positive test result. • Number of HIV- positive clients lost to care who re-engage in HIV medical care within 30 days of interaction with provider **HIV-negative individuals:** • Number of high-risk HIV-negative clients receiving education on PrEP • Number of high-risk[10] HIV-negative clients who are interested in PrEP • Number of high-risk HIV-negative clients interested in PrEP that are linked to a PrEP Navigator. • Number of high-risk HIV-negative clients who received a PrEP prescription • Number of high-risk HIV-negative clients receiving education on PEP • Number of high-risk HIV-negative clients who received PEP within 72 hours of exposure • Number of high-risk HIV-negative clients who accessed PEP and transitioned to PrEP	• Documentation of linkage to HIV medical care • Documentation of re-engagement in HIV medical care • Documentation of PrEP and PEP education • Documentation of client interest in learning more about PrEP (i.e. responded affirmatively to the question, "Would you like to learn more about PrEP or PEP?") • Documentation of linkage to a PrEP services (may be internal or external linkage) • If available, documentation of PrEP or PEP prescription (may be client self-report) • Documentation of former PEP clients who currently access PrEP • Documentation of PrEP and PEP clients who are referred to medication adherence services	• Increase the number of out-of-care previously diagnosed clients that are re-engaged in HIV medical care within 30 days of their identification. • Increase the number of HIV positive clients that have at least 2 medical visits per year at least 3 months apart. Increase the number of HIV-positive persons that are virally suppressed (<200 copies/ml) • Increase the number of HIV negative clients that are given accurate PrEP and PEP information • Increase the number of high-risk HIV negative individuals accessing HIV PrEP and HIV PEP, as needed

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

Core Prevention Service Components	Data Indicators	Documentation Needs	Population- Based Outcomes

4. **Referral and Linkage to Non- Biomedical Prevention Services**	• Number of high-risk HIV-negative and HIV- positive clients that are referred to needed non-biomedical prevention services, as indicated via the assessment process. This may include referrals to:
	  • behavioral interventions
	  • risk-reduction education
	  • syringe exchange
	  • housing services
	  • mental health services
	  • substance abuse services
	  • food pantries
	  • employment services
	  • health insurance navigation
	• Number of high-risk HIV-negative clients who have not accessed primary care in over one year linked to primary care medical visit within 90 days of assessment.[11]
	• Number of external and internal[12] condoms distributed free of charge
		• Documentation of referrals in client files and data management system
		• Documentation of linkage to primary care (may be client self-report)
		• Documentation of condom availability or distribution
			Same as above

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

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

Core Prevention Service Components	Data Indicators	Documentation Needs	Population- Based Outcomes (from CHP)
5. Retention and Adherence to HIV Medical Care, ART, and Other Prevention Services	• Number of HIV- positive clients who receive HIV medical care at least 2 times per year, at least 3 months apart • Number of HIV- positive clients who adhere to their HIV medications • Number of HIV- positive clients who remained engaged in prevention service as needed • Number of PrEP and PEP clients referred to medication adherence interventions or support services. • Number of PrEP and PEP clients who access medication adherence interventions or support services. • Number of HIV- negative clients who remained engaged in prevention service as needed • Number of PrEP clients who adhere to PrEP medication per adherence plan determined with PrEP provider • Number of PEP clients who adhere to PEP for 28-day course	• Documentation of provision of service(s) • Documentation of client engagement in service(s) • Documentation of adherence to ART, PrEP or PEP medication (optimal adherence for PrEP is 90% and 95% for ART of prescribed doses) • Documentation of PrEP and PEP clients who access medication adherence services	Same as above

ASSESSMENT

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

Standards for Assessment:

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

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

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

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

The assessment should highlight clients' skills, competencies and resilience in addition to their challenges and needs. Included below are some examples of strength-based questions[13] that may be asked during an assessment, or over the course of multiple assessments, as appropriate:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

HIV/STD TESTING AND RETESTING

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

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

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

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

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

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

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

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

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

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

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

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

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

LINKAGE TO HIV MEDICAL CARE AND BIOMEDICAL PREVENTION SERVICES

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

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

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

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

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

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

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

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

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

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

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

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

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

REFERRALS AND LINKAGES TO NON-BIOMEDICAL PREVENTION SERVICES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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