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STANDARDS AND BEST PRACTICES COMMITTEE

Virtual Meeting

Tuesday, October 5, 2021

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

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

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

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

STANDARDS AND BEST PRACTICES COMMITTEE

TUESDAY, October 5, 2021, 10:00 AM – 12:00 PM

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

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Event Number/Access code: 2596 800 3405

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

Standards and Best Practices (SBP) Committee Members			
Erika Davies *Co-Chair*	Kevin Stalter *Co-Chair*	Miguel Alvarez	Mikhaela Cielo, MD
Pamela Coffey *(Reba Stevens, Alternate)*	Wendy Garland, MPH	Grissel Granados, MSW	Thomas Green
Mark Mintline, DDS	Paul Nash, PhD, CPsychol AFBPsS FHEA	Katja Nelson, MPP	Joshua Ray (Eduardo Martinez, *Alternate*)
Mallery Robinson	Harold Glenn San Agustin, MD	Justin Valero, MA	Rene Vega, MSW, MPH
Ernest Walker, MPH	Amiya Wilson (LOA)*		
QUORUM: 9 *LOA: Leave of Absence			

AGENDA POSTED: September 30, 2021

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

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(213) 738-2816 (teléfono), o por correo electrónico á HIVComm@lachiv.org, por lo menos setenta y dos horas antes de la junta.

SUPPORTING DOCUMENTATION can be obtained at the Commission on HIV Website at: http://hiv.lacounty.gov. The Commission Offices are at 510 S. Vermont Ave. 14th Floor, one block North of Wilshire Blvd on the eastside of Vermont just past 6th Street. Free parking is available.

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

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

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

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

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

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

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

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

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

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

IV. REPORTS

5. Executive Director/Staff Report 10:15 AM – 10:30 AM

a. Commission and Committee Updates
b. Special Population Best Practices Template Update

6. Co-Chair Report 10:30 AM – 11:00 AM
a. 2021 Workplan Review & Opportunities to Support Task Forces/Caucuses
  - Request from Executive Committee to review Dental Service Standards
b. November and December Holiday Meeting Schedule
c. Committee Member Introductions/Getting to Know you
d. "So, You Want to Talk About Race" by I. Oluo Reading Activity
  - Brief Excerpts Only- from Chapters 12 or 13

7. Division of HIV & STD Programs (DHSP) Report 11:00 AM – 11:15 AM
a. Clinical Quality Management Dashboards

V. DISCUSSION ITEMS

8. Service Standards Development 11:15 AM – 11:55 AM
a. Substance Use Disorder & Residential Treatment Service Standards Public Comment Review
b. Benefits Specialty Service Standard Review

VI. NEXT STEPS 11:45 AM – 11:55 AM

9. Tasks/Assignments Recap

10. Agenda development for the next meeting

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

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

VIII. ADJOURNMENT 12:00 PM

12. Adjournment for the virtual meeting of October 5, 2021

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

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 7/06/21

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

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
CIELO	**Mikhaela**	LAC & USC MCA Clinic	Ambulatory Outpatient Medical (AOM)
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
COFFEY	**Pamela**	Unaffiliated consumer	No Ryan White or prevention contracts
DANIELS	**Michele**	Unaffiliated consumer	No Ryan White or prevention contracts
DARLING-PALACIOS	**Frankie**	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Transportation Services
DAVIES	**Erika**	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DONNELLY	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
FINDLEY	**Felipe**	Watts Healthcare Corporation	Transportation Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Oral Health Care Services
			Biomedical HIV Prevention
			STD Screening, Diagnosis and Treatment
FULLER	**Luckie**	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			HIV Testng Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Transportation Services
GARTH	**Gerald**	AMAAD Institute	No Ryan White or Prevention Contracts
GATES	**Jerry**	AETC	Part F Grantee

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
GONZALEZ	**Felipe**	Unaffiliated consumer	No Ryan White or Prevention Contracts
GORDON	**Bridget**	Unaffiliated consumer	No Ryan White or prevention contracts
GRANADOS	**Grissel**	Children's Hospital Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transitional Case Management-Youth
			Promoting Healthcare Engagement Among Vulnerable Populations
GREEN	**Joseph**	Unaffiliated consumer	No Ryan White or prevention contracts
GREEN	**Thomas**	APAIT (aka Special Services for Groups)	HIV Testing Storefront
			Mental Health
			Transportation Services
HACK	**Damontae**	Unaffiliated consumer	No Ryan White or prevention contracts
HALFMAN	**Karl**	California Department of Public Health, Office of AIDS	Part B Grantee
KAMURIGI	**Nestor**	No Affiliation	No Ryan White or prevention contracts
KOCHEMS	**Lee**	Unaffiliated consumer	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts
LEE	**David**	Charles R. Drew University of Medicine and Science	HIV Testing Storefront
			HIV Testing Social & Sexual Networks
MARTINEZ	**Eduardo**	AIDS Healthcare Foundation	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Medical Care Coordination (MCC)
			Mental Health
			Oral Healthcare Services
			STD Screening, Diagnosis and Treatment
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
			Medical Subspecialty
			HIV and STD Prevention Services in Long Beach

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MARTINEZ	**Miguel**	Children's Hospital Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transitional Case Management - Youth
			Promoting Healthcare Engagement Among Vulnerable Populations
MILLS	**Anthony**	Southern CA Men's Medical Group	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
MORENO	**Carlos**	Children's Hospital, Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transitional Case Management - Youth
			Promoting Healthcare Engagement Among Vulnerable Populations
MURRAY	**Derek**	City of West Hollywood	No Ryan White or prevention contracts
NASH	**Paul**	University of Southern California	Biomedical HIV Prevention
			Oral Healthcare Services

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
NELSON	**Katja**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Health Education/Risk Reduction, Native American
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Nutrition Support
PERÉZ	**Mario**	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee
PRECIADO	**Juan**	Northeast Valley Health Corporation	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Medical Care Coordination (MCC)
			Oral Healthcare Services
			Mental Health
			Biomedical HIV Prevention
			STD Screening, Diagnosis and Treatment
			Transportation Services
RAY	**Joshua**	Unaffiliated consumer	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
ROBINSON	**Mallery**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Health Education/Risk Reduction, Native American
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Nutrition Support
RODRIGUEZ	**Isabella**	No Affiliation	No Ryan White or prevention contracts
ROSALES	**Ricky**	City of Los Angeles AIDS Coordinator	No Ryan White or prevention contracts
SATTAH	**Martin**	Rand Schrader Clinic LA County Department of Health Services	Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
SAN AGUSTIN	**Harold**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV)
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
SPENCER	**LaShonda**	Oasis Clinic (Charles R. Drew University/Drew CARES)	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			Medical Care Coordination (MCC)
SPEARS	**Tony**	Capitol Drugs	No Ryan White or prevention contracts
STALTER	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
STEVENS	**Reba**	No Affiliation	No Ryan White or prevention contracts
THOMAS	**Damone**	No Affiliation	No Ryan White or prevention contracts
ULLOA	**Maribel**	HOPWA-City of Los Angeles	No Ryan White or prevention contracts
VALERO	**Justin**	California State University, San Bernardino	No Ryan White or prevention contracts
VEGA	**Rene**	Via Care Community Clinic	Biomedical HIV Prevention
VELAZQUEZ	**Guadalupe**	Unaffiliated consumer	No Ryan White or prevention contracts
WALKER	**Kayla**	No Affiliation	No Ryan White or prevention contracts
WALKER	**Ernest**	Men's Health Foundation	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
WILSON	**Amiya**	Unique Women's Coalition	No Ryan White or prevention contracts

DRAFT

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

STANDARDS AND BEST PRACTICES (SBP) COMMITTEE MEETING MINUTES

September 7, 2021

COMMITTEE MEMBERS P = Present | A = Absent					
Erika Davies, *Co-Chair*	P	Thomas Green	P	Justin Valero, MA	A
Kevin Stalter, *Co-Chair*	P	Mark Mintline, DDS	P	Rene Vega, MSW, MPH	A
Miguel Alvarez	P	Paul Nash, PhD, CPsychol, AFBPsS, FHEA	P	Ernest Walker, MPH	A
Mikhaela Cielo, MD	P	Katja Nelson, MPP	P	Amiya Wilson (LOA**)	EA
Pamela Coffey	A	Joshua Ray (Eduardo Martinez, *Alternate)*	A	Bridget Gordon (*Ex Officio)*	A
Wendy Garland	A	Mallery Robinson	P		
Grissel Granados, MSW	P	Harold Glenn San Agustin, MD	P		
COMMISSION STAFF AND CONSULTANTS					
Cheryl Barrit, Jose Rangel-Garibay, Sonja Wright					
DHSP STAFF					
Lisa Klein					

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

Meeting agenda and materials can be found on the Commission's website at http://hiv.lacounty.gov/LinkClick.aspx?fileticket=1UqT7GCD6QU%3d&portalid=22

CALL TO ORDER-INTRODUCTIONS-CONFLICT OF INTEREST STATEMENTS: The meeting to order at 10:05 am.

I. ADMINISTRATIVE MATTERS

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

2. **APPROVAL OF MEETING MINUTES**
   MOTION #2: Approve the 08/03/2021 Standards and Best Practices (SBP) Committee meeting minutes, as presented ***(Passed by Consensus)***.

II. PUBLIC COMMENT

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

III. COMMITTEE NEW BUSINESS ITEMS: There were no new Committee business items.

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

IV. REPORTS

5. **EXECUTIVE DIRECTOR/STAFF REPORT**

Cheryl Barrit, Executive Director (ED) reported the following.

- C. Barrit prompted committee members to review the memorandum sent on August 31 articulating the resumption of in-person Brown Act meetings of the Commission starting on October 1st. The memorandum also informs commissioners of the Board of Supervisor's Executive Order mandating county workers, volunteers, and commissioners to furnish proof of vaccination by October 1st. The memorandum will be sent to committee-only members after the committee adjourns.
- C. Barrit delivered a refresher training that explained the delineation of responsibilities between the Commission on HIV (COH) and the Division on HIV and STD Programs (DHSP). Presentation slides are available in the meeting packet as well as the COH website. Presentation highlights include:
  - DHSP is the recipient of the Ryan White HIV/AIDS Program Part A funding and the COH is the federally mandated HIV planning council
  - Responsibilities shared by both DHSP and the COH include carrying our needs assessment, completing comprehensive planning, evaluating effectiveness of care strategies, and doing quality management activities.
  - Setting priorities, allocating resources, and assessing the efficiency of the administrative mechanism are sole responsibilities of RWHAP Part A Planning Council. The COH is also responsible for member recruitment, retention, and training.
  - Managing procurement and monitoring contracts are sole responsibilities of the recipient, DHSP.
  - Communication, information sharing and collaboration between the recipient, COH and COH support staff is imperative for effectiveness
  - COH staff assist the COH to carry out its legislative responsibilities and to operate effectively as an independent planning body

6. **CO-CHAIR REPORT**

   a. **Ending the HIV Epidemic**
      - No update

   b. **2021 Workplan Review & Opportunities to Support Task Forces and Caucuses**
      - Kevin Stalter shared that the SBP committee co-chairs and COH staff met to discuss a response to the request from different groups to develop best practices specific to their populations.

   c. **Propose guiding questions for Caucuses/Task Forces to develop best practices/guidelines**
      - K. Stalter mentioned that COH staff is drafting guiding questions to share with the COH task forces, caucuses, and workgroups that they can use to develop best practice guidelines for special populations.
      - E. Davies added that the onus will be on the task forces and caucuses to develop the best practices for their respective groups because they have the expertise and lived experience. She also mentioned the SBP committee would develop a statement of solidarity in support of the best practices to be included in the Universal Standards.
      - C. Barrit added "Best Practices Across the Lifespan and Intersectionality" as a potential title for the completed document and reiterated the importance of engaging the members of the COH special populations groups to participate in this process and helping facilitate the conversation to align with the Universal Standards.
      - Jose Rangel-Garibay provided an overview of a draft "Special Populations Best Practices Guiding Principles" document. He also described a potential outline for how the document can be used. The document is included in the meeting packet.
      - Grissel Granados requested having a more formalized template for groups to have a standard format for

submitting their best practice recommendations to the SBP committee.
- Lisa Klein noted that the first bullet point on the document only listed "prevention" and requested clarification for why "care" was not included. J. Rangel-Garibay clarified that the statement should read "prevention and care services" and that he will correct the typo.
- C. Barrit provided background information on past iterations of the special populations' guideline development processes the SBP committee has completed for the COH.
- Glenn San Agustin suggested that the template document include a section where the different groups can provide feedback on the performance measure(s) they are hoping to improve upon with their best practices and clarifying what the purpose is and what the expected outcomes they hope to achieve.
- Committee members provided feedback and requested COH staff to prepare a template to share with Caucuses/Task Forces/workgroups. COH staff will review the feedback from the committee and develop a set of guiding questions and template.

d. Committee Member Introductions/Getting to Know you
- Dr. Cielo introduced herself as a new commission member. She is a Pediatric Infectious disease doctor at the Maternal, Child, and Adolescent clinic at the LA County/USC hospital. She describes her introduction to the HIV field as serendipity and really loves her interactions and taking care of young people, mothers, and children who are living with HIV. She also provided a brief update on the increase of congenital HIV due to rising cases of syphilis among pregnant women in Los Angeles County.

e. "So, You Want to Talk About Race" by I. Oluo Reading Activity
- There was no volunteer to read so the activity was deferred to the October meeting.

f. Division of HIV & STD Programs (DHSP) Report
- Wendy Garland reported there were no updates for this month. She also noted that DHSP staff are working on their annual progress report to the Centers for Disease Prevention and Control as well as the Ryan White Part A application due in October.

V. DISCUSSION ITEMS

7. Substance Use Disorder and Residential Treatment Services Standards of Care Review

a. COH staff will present all comments submitted during the 30-day public comment period at the October meeting.

8. Benefits Specialty Service Standard Review

a. J. Rangel-Garibay noted that a copy of the current Benefits Specialty Standards of Care is included in the packet.

b. K. Stalter explained the service standards review process typically involves reviewing a reformatted version of the current document for the committee to share their feedback and make edit suggestions.

c. C. Barrit added that the current version of the document is outdated and will undergo reformatting in alignment with the recommendations provided during the Standards development training led by Emily Gantz-McKay. These changes include the elimination of redundancies throughout the document, description of the service standard, and updating the acronyms for the benefit programs listed. She also requested for a representative from APLA to share feedback on the document. Scott Blackburn from APLA stated they will reach out to their Benefits Specialty staff leads.

d. W. Garland reminded the committee that the scope of work for the Benefits Specialists and MCC are both large and should be reviewed separately. L. Klein noted that there are 13 agencies that currently hold a contract for Benefits Specialty.

e. G. Granados recommended to include health literacy workshops to help consumers navigate the benefit system and enroll in benefits they are eligible for.

f. COH staff will draft a change document for the committee to review for the October meeting.

VI. NEXT STEPS

a. **TASK/ASSIGNMENTS RECAP**:

- Continue Getting to Know You activity.
- Continue reading activity with an excerpt from either Chapter 8 or 9 of the *So, You Want to Talk About Race* book.
- COH staff will email the Resumption of In-person Brown Act meeting memorandum to committee-only members

- COH staff will refine the guiding questions and draft a template for developing Special Population Best Practices
- COH staff will prepare a change document for the Benefits Specialty Standards of Care for committee to review
- COH staff will edit the Substance Use and Residential Treatment Standards document to reflect the comments reviewed during the meeting and post the document for a 30-day public comment period.

12. AGENDA DEVELOPMENT FOR NEXT MEETING:

- Begin review process for the Benefits Specialty and Home-based Case Management service standards

VII. ANNOUNCEMENTS

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

VIII. ADJOURNMENT

14. ADJOURNMENT: The meeting adjourned at 11:40 am.

Special Population Best Practices for HIV Prevention and Care
Instructions and Formatting

INTRODUCTION

Special Population Best Practices for HIV Prevention and Care are an integral component in the Commission on HIV's (COH) overall responsibility to ensure that services are both responsive to the needs of consumers and are delivered at levels of acceptable quality and effectiveness. Best Practices complement the COH's Service Standards for HIV Care and Prevention which are detailed summaries that outline system expectations for each of the services offered.

Table 1. Delineation between the COH Service Standards and Best Practices.

Standards of HIV Care and Prevention	Special Population Best Practices for HIV Prevention and Care
• Ensure all subrecipients provide the same basic service components • Establish a minimal level of service of care for consumers throughout Los Angeles County • Service Standards must be available to subrecipients and consumers	• Encourage providers to adopt service and system innovations that specialize in clients from a designated population • Describe methods for enriching, modifying, or further developing services to respond more directly to the unique needs of a designated population • Recommend best practices shown effective in addressing barriers to HIV prevention and care for a designated population • Feature possible service and system enhancements to service delivery above the expected levels for a designated population

PURPOSE

The purpose of identifying Best Practices is to accumulate and apply knowledge of practices that are working to address needs or service delivery disparities for a designated population. A Best Practice can be anything that works to produce results and can be useful in providing lessons learned. Best Practices are intended to recommend specific strategies for modifying and improving service delivery practices of individual and organizational providers when those providers are serving the designated populations.

Developing a Best Practice guidance document for a designated population can also assist the Division on HIV and STD Programs (DHSP) to design and develop scopes of work for services to the designated populations. The best practices outlined in the resulting guidance document are not requirements or mandates; instead, they are recommendations for addressing and accommodating the unique needs of a specific population in service delivery. These may include how or what services are offered, what their facilities look like, how they promote their services, and many other key aspects of service delivery.

FRAMEWORK FOR DEVELOPING BEST PRACTICES

Use the table below to develop a Best Practices Guidance Document for a designated population. COH staff will assist each taskforce, workgroup, and caucus with completing the steps below.

Table 2. Outline for Developing Best Practices Guidance Document

<table>
<tr><th>Step One: Brainstorm Key Issues</th></tr>
<tr><td>This step serves to identify key issues --not already addressed in Service Standards and the Universal Standards of Care-- that the group wants to include in the Best Practice Guidance document. Discuss and identify barriers, challenges, areas of improvement, unmet needs, inequities, and disparities in systems and services that prevent members of the designated population from:
• Accessing HIV care and prevention services
• Enroll and engage in HIV care and prevention services
• Realize individual/population target health outcomes

Generate a list of the key issues identified during the brainstorm session. Please review the current Service Standards and Universal Standards of Care to ensure the key issues identified are not already addressed by either document.</td></tr>
<tr><th>Step Two: Research and Identifying Best Practices</th></tr>
<tr><td>This step serves to generate an inventory of existing materials and articles containing HIV care and prevention guidelines from various jurisdictions that serve the designated population. Assign items to different group members based on their background/expertise, preferences and/or interests and have them research and collect information on the item.

Consider the following guiding questions and format for organizing the information collected:
I. Title of Best Practice
Concise and reflective of the practice being documented.
II. Description
Provide context and justification for the practice and address the following:
a. What is the problem being addressed?
b. Which population is being affected?
c. How is the problem impacting on the population?
d. What were the objectives being achieved?
III. Implementation of the Practice
a. Where was the Best Practice implemented?
IV. Results of the Practice
a. What are the outcomes of the Best Practice?
V. Lessons Learned
a. Does the Best Practice influence something relevant for the population? What is it?
b. How effective is the Best Practice in achieving its goal/objectives?
VI. Conclusion
a. Why may that intervention be considered a Best Practice?
b. Can the Best Practice be replicated or adapted in provider settings across Los Angeles County?</td></tr>
<tr><th>Step Three: Select Best Practice and Draft Guidance Document</th></tr>
<tr><td>This step serves to develop a draft of the Best Practices guidance document. Group members review the Best Practices identified in Step Two and provide their insight and feedback. The group should</td></tr>
</table>

invite community members and providers with experience providing health and social services to the designated population as well as consumers of services that are members of the designated population to participate in the discussion. Once deliberations are complete, the group will select the Best Practices to include in the guidance document and use the format in Step Four.
Step Four: Format for Guidance Document
Use the following format to organize the Best Practices identified in Step Three: **I. Introduction** a. What is the problem being addressed? b. Which population is being affected? c. How is the problem impacting the population? d. What are the objectives of this guidance document? **II. Methodology** a. Describe the process the group employed to develop this document. **III. Key Issues Identified** a. Describe the key issues the group identified during the brainstorm session. **IV. Best Practices Identified** a. Describe the Best Practices the group identified. For this section use the same format outlined in Step Two. **V. Conclusion** a. Describe how the Best Practices included in the document address the Key Issues identified
Step Five: Submit Best Practice Guidance Document to Standards and Best Practices Committee

STANDARDS AND BEST PRACTICES COMMITTEE 2021 WORK PLAN
Updated 9/30/21 (Revisions in RED)

Co-Chairs: Erika Davies & Kevin Stalter		
Approval Date: 3/1/21	**Revision Dates: 3/10/21, 4/14/21, 9/2/21, 9/30/21**	
Purpose of Work Plan: To focus and prioritize key activities for COH Committees and subgroups for 2021. **Prioritization Criteria:** Select activities that 1) represent the core functions of the COH; 2) advance the goals of the local Ending the HIV Epidemic (EHE) Plan; and 3) align with COH staff and member capacities and time commitment; 4) ongoing COVID public health emergency response and recovery priorities.		

#	TASK/ACTIVITY	TARGET COMPLETION DATE
1	Review BAAC and ATF charge and implement recommendations best aligned with the purpose and capacity of the Commission • Work with the BAAC TF to explore feasibility of designating a member to attend SBP meetings. • Seek input from the Aging Task Force (ATF) on service standards. Benefits Specialty and Home-Based Case Management services were cited as examples. Committee will provide guiding questions for COH Task Forces, Caucuses, and Workgroups to develop best practices/guidelines for their respective groups. COH will share updates to Special Populations Best Practices Development document.	Start Jan/Ongoing
~~2~~	~~Complete Universal service standards.~~ COMPLETED	~~March-Executive Committee~~ ~~April- COH~~
3	Complete Childcare service standards. ~~Waiting for DHSP on provider survey results/summary.~~ Survey results presented on 4/6/21 COMPLETED	May
4	Provide feedback on and monitor implementation of the local Ending the HIV Epidemic (EHE) plan: • Develop strategies on how to engage with private health plans and providers in collaboration with DHSP	~~On hold~~ Ongoing
5	Update Substance use outpatient and residential treatment service standards. SUD service standards posted for a 30-public comment period starting 8/23 and ending on 9/22. Review comments receiving during Public Comment period.	July
6	Update Benefits Specialty service standards. Continue review process on 10/5/2021.	~~August~~ October
7	Update Home-based Case Management service standards. Committee will begin review process during November meeting.	~~September~~ November

SERVICE STANDARDS REVISION DATE TRACKER as of 3/16/2021

	Standard Title	DHSP Program(s)	Date of Last Standard Revision	Program Currently Funded	Contract Expiration Date	Notes
1	AIDS Drug Assistance Program (ADAP) Enrollment		2009			ADAP contracts directly with agencies
Non-Medical Case Management						
2	Benefits Specialty	Benefits Specialty Services	2009	X	February 28, 2022	
3	Case Management, Transitional – Youth	Transitional Case Management-Youth	4/13/2017		March 31, 2020	Last funded two providers for this service through March 31, 2020
4	Case Management, Transitional – Incarcerated/Post Release	Transitional Case Management-Jails	4/13/2017	X	February 28, 2022	
5	Non-Medical Case Management	Linkage Case Management	12/12/2019		March 31, 2017	No longer funded.
6	Childcare		2009; currently being updated; latest draft revision date 12/14/2020			Last funded in 2009.
7	Emergency Financial Assistance Program (EFA)	EFA	6/11/2020	X	February 28, 2022	

8	Home-Based Case Management	Home-Based Case Management	2009	X	June 30, 2021	Contracts to be renewed for an additional 12 months in June 2021.
9	Hospice		2009			
10	Housing, Temporary: • Hotel/motel and meal vouchers, • Emergency shelter programs, • Transitional housing, • Income-based Rental Assistance, • Residential Care Facility for the Chronically Ill, and • Transitional Residential Care Facility	• Transitional Residential Care facilities (TRCF) • Residential Care facilities for the Chronically Ill (RCFCI) • Substance Use Transitional Housing (SUTH)	2/8/2018	X	February 28, 2022	
11	Housing, Permanent Supportive	Permanent Supportive Housing	2/8/2018		N/A	No contracts in permanent housing only temporary and worked with other entities for permanent housing (eg. DHS Housing for Health MOU).
12	Language Interpretation		2009		February 28, 2021	Contract expired 2-28-21, no response from provider need to solicit for new services again.
13	Legal	Legal Services	7/12/2018	X	August 24, 2024	New provider started December 2020
14	Medical Care Coordination	Medical Care Coordination	2/14/2019	X	February 28, 2022	New contracts started 3-1-19
15	Mental Health, Psychiatry, and Psychotherapy	Mental Health	2009	X	February 28, 2022	New FFS model started 8-1-17

16	Nutrition Support	• Food Bank • Home Delivery	2009	X	February 28, 2022	
17	Oral Health • Practice Guidelines for Treatment of HIV Patients in General Dentistry	• General Oral Health • Specialty Oral Health	2009 2015	X	February 28, 2022	
18	Outreach		2009		N/A	Never funded as a stand-alone contract. but has been part of Health Education/Risk Reduction. Linkage and Re-engagement Program (LRP) and partner services were supported as HRSA Part A Outreach Services. No contract for LRP and partner services because these activities are conducted by DHSP staff.
19	Peer Support		2009; integrated in Psychosocial Support 9/10/2020		October 15, 2009	No longer funded. Terminated due to state cuts back in 2009.
20	Permanency Planning		2009		February 28, 2010	No longer funded. It can be addressed by either BSS or Legal. Merged under legal contract in 2010.
21	Prevention Services: • Assessment; • HIV/STD Testing and Retesting; • Linkage to HIV Medical Care and Biomedical Prevention;		6/14/2018		HERR; 06/30/2021 VP: 12/31/2022 HIV Testing: 12/31 2022	"Take Me Home" online self HIV testing kits distributed through MOU with NASTAD. Self HIV tests kits also pending distribution through HIV/STD Testing contracts and with non-traditional community partners through MOUs.

	• Referral and Linkages to Non-biomedical Prevention; • Retention and Adherence to Medical Care, ART; and • Other Prevention Services				STD screening and Treatment: 12/31/2022 BIomedical: 6/30/2021	Currently evaluating extension of Biomedical contracts
22	Psychosocial Support		9/10/2020		August 31, 2017	No longer funded
23	Referral Services		2009		N/A	Not funded as a standalone service, included under various modalities
24	Residential Care and Housing		2009; integrated in Temporary and Permanent Supportive Housing 2/8/2018		(See #9 and 10)	
25	Skilled Nursing Facilities		2009		February 28, 2010	No longer funded replaced with RCFCI and TRCF- see under #24
26	Substance Use and Residential Treatment		4/13/2017		February 28, 2019	No longer funded. Funded by SAPC
27	Transportation		2009	X	February 28, 2023	New contracts began 6-1-20 and 9-1-20
28	Treatment Education		2009		October 15, 2009	No longer funded. Terminated due to state cuts. Activities incorporated into other programs (e.g. U=U social marketing)
29	Universal Standards		9/12/2019; currently being updated; latest draft		N/A	Not a program – standards that apply to all services

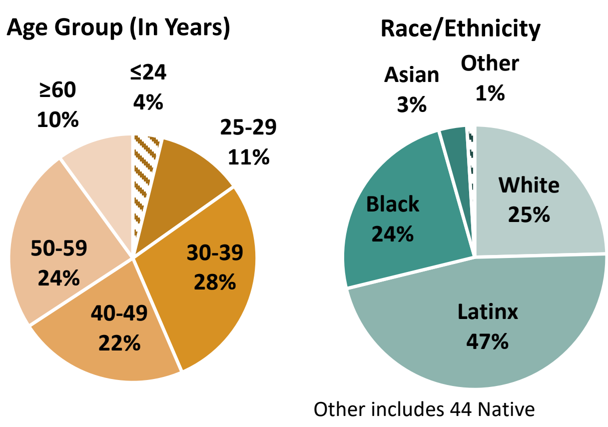
			revision date 12/16/2020 released for public comments			

Clinical Quality Management Program Performance Measure Dashboard

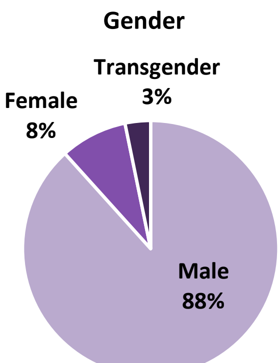
Medical Care Coordination (MCC) Services

Client Demographics

8,350 clients had at least one Medical Care Coordination service between March 1, 2020 - February 28, 2021 (RW Year 30)

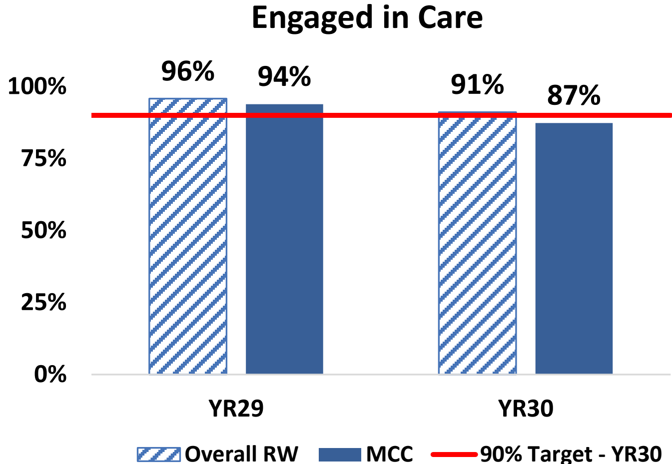


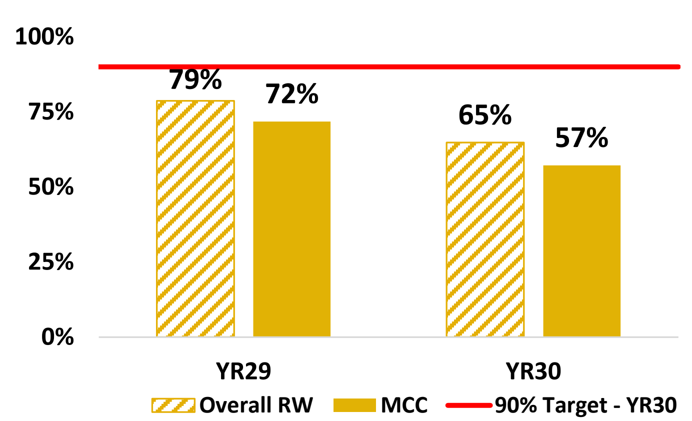
Other includes 44 Native Hawaiian/Pacific Islander and 26 Native American/Alaskan Native



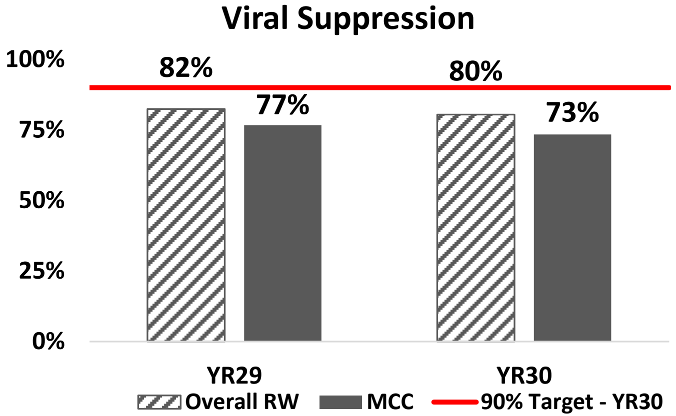
- 67% lived at or below the Federal Poverty Level (FPL)
- 15% experienced homelessness
- 10% were incarcerated within the past 24 months
- 77% were men who have sex with men
- 5% reported past injection drug use

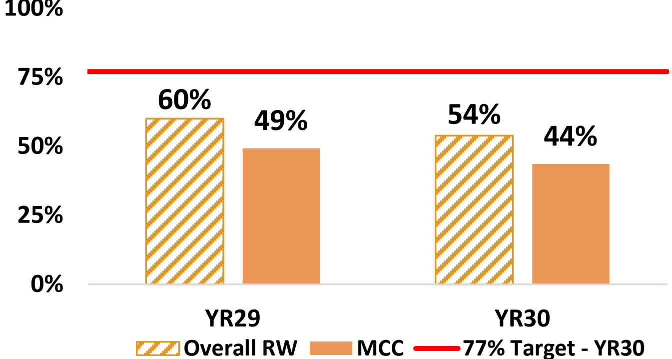
Engagement & Retention





Viral Suppression (VS)





Medical Care Coordination (MCC) Services

About

The Clinical Quality Management (CQM) Program Performance Measure Dashboards are intended to inform DHSP's quality improvement (QI) efforts and to be used to determine the efficacy and progress of quality improvement activities. Our hope is that consumers of HIV services and our subrecipient network providing these services will also benefit from these Dashboards and be able to use them to guide improvement efforts as well.

Medical Care Coordination (MCC) Services

MCC is a model of care designed to provide behavioral interventions and support services in coordination with medical care to fully respond to patients' needs, and to promote treatment adherence and health outcomes. The primary goals of the MCC program are to increase retention in HIV care; improve adherence to antiretroviral therapy (ART); link patients to mental health, substance abuse and housing support services; and reduce HIV transmission through sexual risk reduction counseling and education.

Data Methodology

The Quality Improvement dashboards were developed with data reported in the HIV Casewatch system by Ryan White-funded agencies in Los Angeles County. This report reflects outcomes for clients who utilized Ryan White (RW) MCC services during the reporting period from March 1, 2020 to February 28, 2021. This service category was selected based on Health Resources and Services Administration (HRSA) criteria to monitor performance measures for services that are used by at least 16% of all RW clients.

In order to estimate outcomes, HIV laboratory data (viral load, CD4, and genotype tests) were obtained for RW clients from the Los Angeles County HIV Surveillance system. The HIV-related outcomes and their definitions are based on HRSA HIV/AIDS Bureau recommendations and the U.S. Department of Health and Human Services guidelines.

● Engagement in HIV Care: ≥1 viral load, CD4 or genotype test reported in the 12 months before the end of the reporting period.

● Retention in HIV Care: ≥2 viral load, CD4 or genotype tests reported at >90 days apart in the 12 months before the end of the reporting period.

● Viral Suppression: viral load of <200 copies/ml at most recent test reported in the 12 months before the end of the reporting period. Clients with missing viral load tests are considered to have unsuppressed viral load in the time period.

● Sustained Viral Suppression: of clients with at least two viral load tests, all viral load test results are <200 copies/ml in the 12 months before the end of the reporting period. Clients with missing results or with less than two viral load tests are considered to have non-sustained viral suppression in the time period.

Summary and Analysis

● 8,350 clients, or 49%, of the 16,960 RWP clients received MCC services in YR 30.

● There were more White and Black clients (25% and 24% respectively) receiving MCC services compared to overall RWP clients (21% White and 22% Black). 47% of MCC patients served were Latinx while they made up 53% of overall RWP clients.

● More MCC clients were younger than age 40 (44%) than overall RWP clients (35%).

● MCC clients had lower percentages of engagement in care, retention in care, viral suppression, and sustained viral suppression compared to overall RWP clients in YR 30.

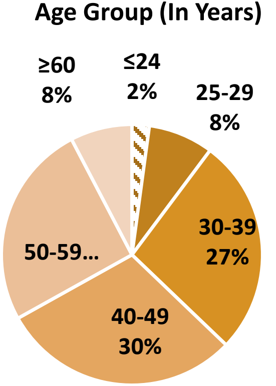
● Engagement in care, retention in care, and viral suppression outcomes decreased among MCC clients in YR 30 compared to clients who received MCC services in YR 29.

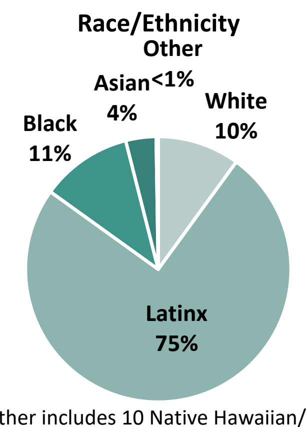
Clinical Quality Management Program Performance Measure Dashboard

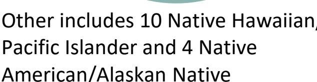
Ambulatory Outpatient Medical (AOM) Services

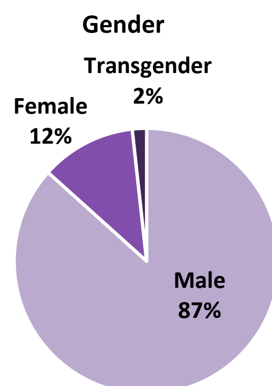
Client Demographics

5,653 clients had at least one Medical Outpatient service between March 1, 2020 - February 28, 2021 (RW Year 30)



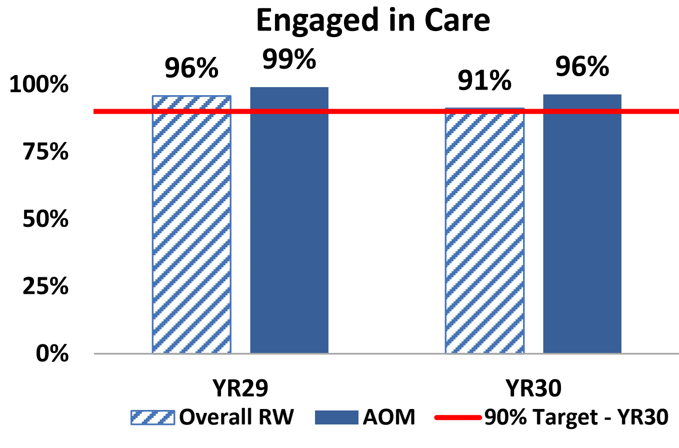


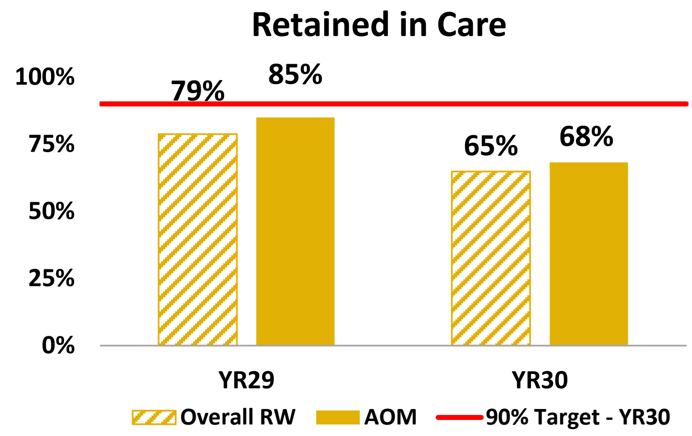




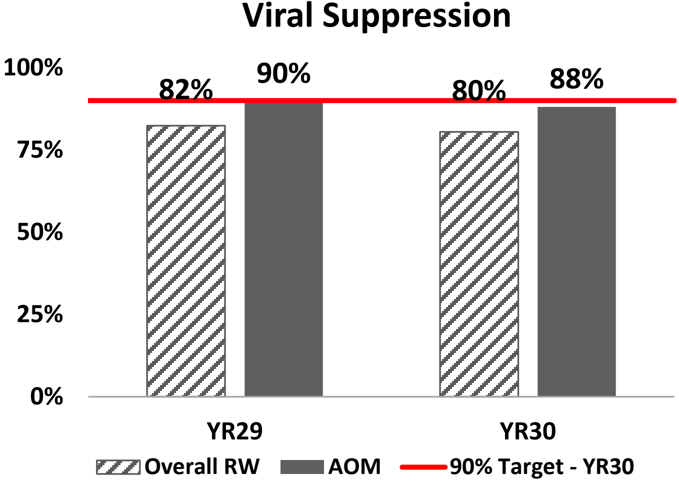
- 56% were living at or below the Federal Poverty Level (FPL)
- 5% experienced homelessness
- 3% were incarcerated within the past 24 months
- 71% were men who have sex with men
- 2% reported past injection drug use

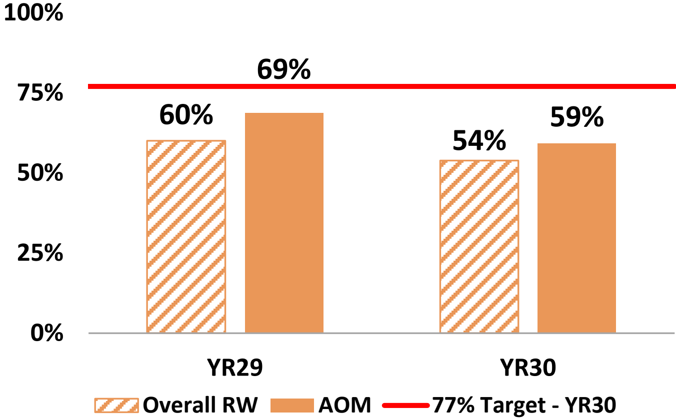
Engagement & Retention





Viral Suppression (VS)





Ambulatory Outpatient Medical (AOM) Services

About

The Clinical Quality Management (CQM) Program Performance Measure Dashboards are intended to inform DHSP's quality improvement (QI) efforts and to be used to determine the efficacy and progress of quality improvement activities. Our hope is that consumers of HIV services and our subrecipient network providing these services will also benefit from these Dashboards and be able to use them to guide improvement efforts as well.

Ambulatory Outpatient Medical (AOM) Services

AOM services provide evidenced-based preventive, diagnostic, and therapeutic HIV medical services through outpatient medical visits to Ryan White Program (RWP) eligible people living with HIV. AOM services are expected to interrupt or delay the progression of HIV disease; prevent and treat opportunistic infections; promote optimal health and quality of life; and reduce further HIV transmission through education and support for appropriate risk reduction strategies.

Data Methodology

These dashboards were developed with data reported in the HIV Casewatch system by Ryan White-funded agencies in Los Angeles County. This report reflects outcomes for clients who utilized Ryan White (RW) AOM services during the reporting period from March 1, 2020 to February 28, 2021. This service category was selected based on the Health Resources and Services Administration's (HRSA) criteria to monitor performance measures for services that are used by at least 16% of all RW clients.

In order to estimate outcomes, HIV laboratory data (viral load, CD4, and genotype tests) were obtained for RW clients from the Los Angeles County HIV Surveillance system. The HIV-related outcomes and their definitions are based on HRSA HIV/AIDS Bureau recommendations and the U.S. Department of Health and Human Services guidelines.

● Engagement in HIV Care: ≥1 viral load, CD4 or genotype test reported in the 12 months before the end of the reporting period.

● Retention in HIV Care: ≥2 viral load, CD4 or genotype tests reported at >90 days apart in the 12 months before the end of the reporting period.

● Viral Suppression: viral load of <200 copies/ml at most recent test reported in the 12 months before the end of the reporting period. Clients with missing viral load tests are considered to have unsuppressed viral load in the time period.

● Sustained Viral Suppression: of clients with at least two viral load tests, all viral load test results are <200 copies/ml in the 12 months before the end of the reporting period. Clients with missing results or with less than two viral load tests are considered to have non-sustained viral suppression in the time period.

Summary and Analysis

● 5,653 clients, or 33%, of the 16,960 RWP clients received AOM services in YR 30.

● Compared to RWP clients overall, the percentage of Latinx clients receiving AOM services was much higher at 75% (53% overall).

● Engagement and viral suppression outcomes did not change substantially compared to YR 29; retention and sustained viral suppression decreased.

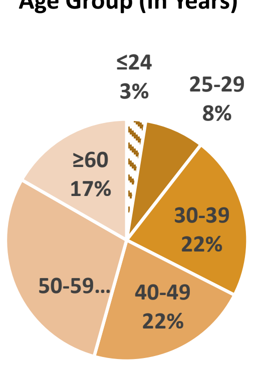
● Compared to RWP clients overall served in YR 30, AOM clients had higher engagement in care, retention in care, viral suppression and sustained viral suppression.

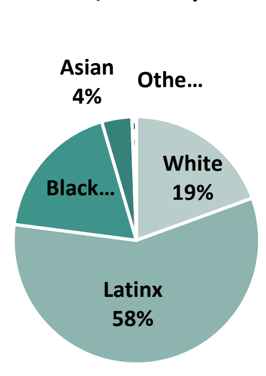
Clinical Quality Management Program Performance Measure Dashboard

Benefit Specialty Services (BSS)

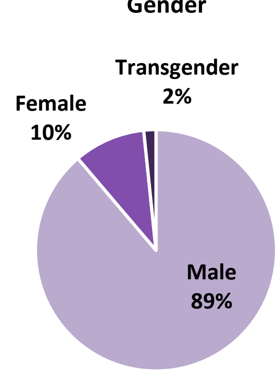
Client Demographics

4,542 clients had at least one Benefits Specialty Services between March 1, 2020 - February 28, 2021 (RW Year 30)



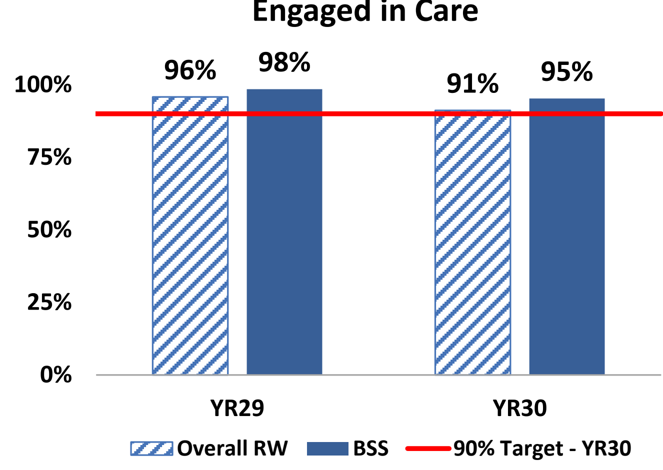


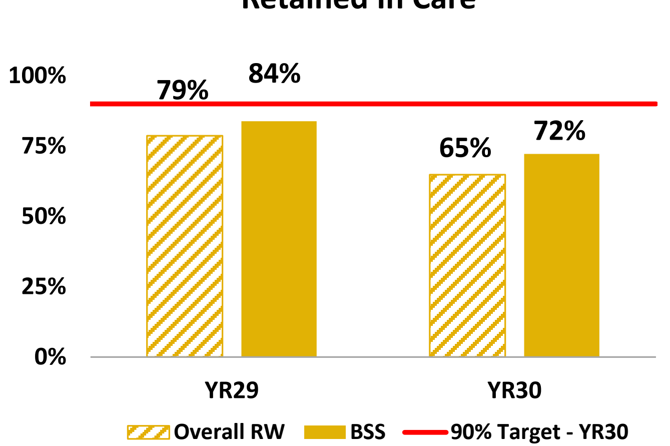
Other includes 13 Native Hawaiian/Pacific Islander and 13 Native Hawaiian/Alaskan Native



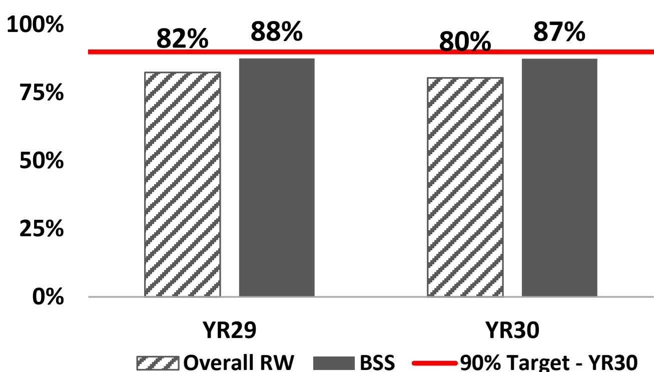
- 53% were living at or below the Federal Poverty Level (FPL)
- 6% experienced homelessness
- 5% were incarcerated within the past 24 months
- 75% were men who have sex with men
- 4% reported past injection drug

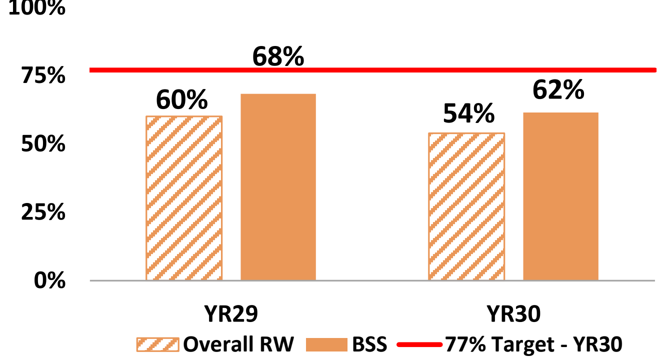
Engagement & Retention





Viral Suppression (VS)





Clinical Quality Management Program Performance Measure Dashboard

Benefit Specialty Services (BSS)

About

The Clinical Quality Management (CQM) Program Performance Measure Dashboards are intended to inform DHSP's quality improvement (QI) efforts and to be used to determine the efficacy and progress of quality improvement activities. Our hope is that consumers of HIV services and our subrecipient network providing these services will also benefit from these Dashboards and be able to use them to guide improvement efforts as well.

Benefit Specialty Services (BSS)

BSS facilitate a client's access to public/private health and disability benefits and programs. Benefits specialty services work to maximize public funding by helping clients identify all available health and disability benefits supported by funding streams other than the Ryan White Part A funds.

Data Methodology

The Quality Improvement dashboards were developed with data reported in the HIV Casewatch system by Ryan White-funded agencies in Los Angeles County. This report reflects outcomes for clients who utilized Ryan White (RW) BSS services during the reporting period from March 1, 2020 to February 28, 2021. This service category was selected based on Health Resources and Services Administration (HRSA) criteria to monitor performance measures for services that are used by at least 16% of all RW clients.

In order to estimate outcomes, HIV laboratory data (viral load, CD4, and genotype tests) were obtained for RW clients from the Los Angeles County HIV Surveillance system. The HIV-related outcomes and their definitions are based on HRSA HIV/AIDS Bureau recommendations and the U.S. Department of Health and Human Services guidelines.

● Engagement in HIV Care: ≥1 viral load, CD4 or genotype test reported in the 12 months before the end of the reporting period.

● Retention in HIV Care: ≥2 viral load, CD4 or genotype tests reported at >90 days apart in the 12 months before the end of the reporting period.

● Viral Suppression: viral load of <200 copies/ml at most recent test reported in the 12 months before the end of the reporting period. Clients with missing viral load tests are considered to have unsuppressed viral load in the time period.

● Sustained Viral Suppression: of clients with at least two viral load tests, all viral load test results are <200 copies/ml in the 12 months before the end of the reporting period. Clients with missing results or with less than two viral load tests are considered to have non-sustained viral suppression in the time period.

Summary

● 4,542 clients, or 27%, of the 16,960 clients received RW funded BSS in RW YR 30.

● The percentage of Latinx clients receiving BSS was higher (58%) compared to the percentage of overall Latinx RW clients (53%).

● Engagement and suppression outcomes did not change substantially between YR29 and YR30 among BSS clients; retention and sustained viral suppression decreased.

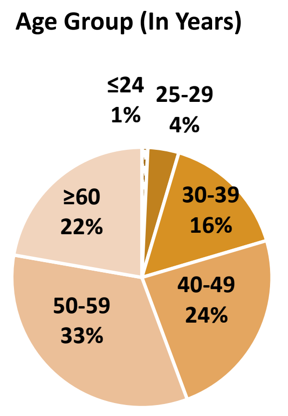
● The proportion of BSS clients engaged and retained in care, virally suppressed and with sustained viral suppression was higher than the respective proportions of RW clients overall.

Oral Health (General and Specialty)

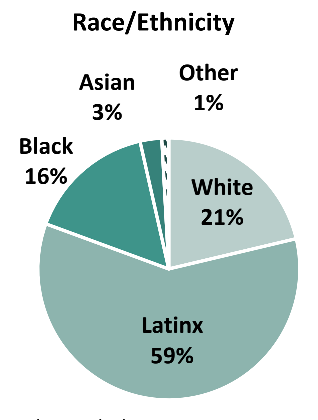
Client Demographics

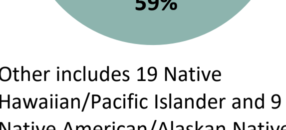
3,377 clients received at least one Oral Health service between March 1, 2020 - February 28, 2021 (RW Year 30)

Age Group (In Years)



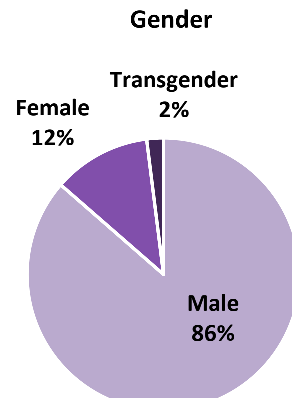
Race/Ethnicity





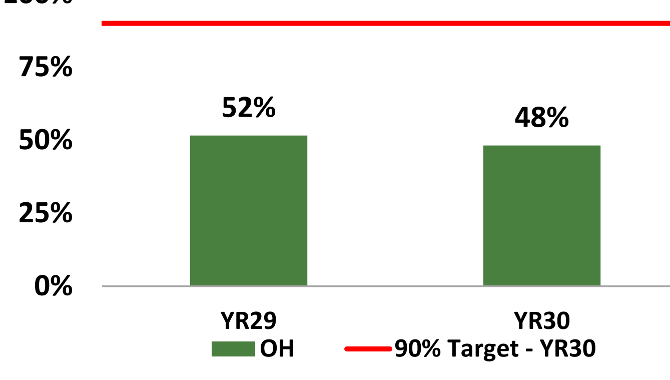
Other includes 19 Native Hawaiian/Pacific Islander and 9 Native American/Alaskan Native

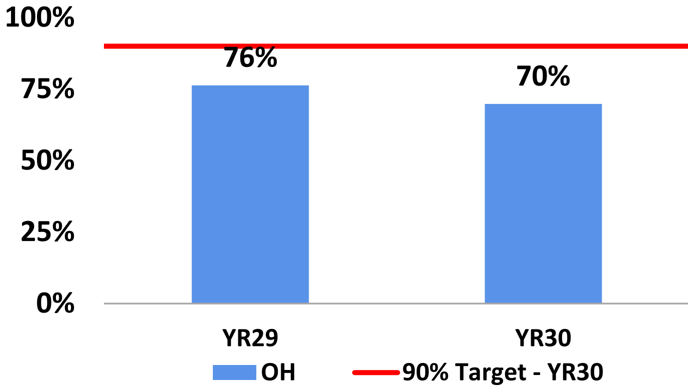
Gender



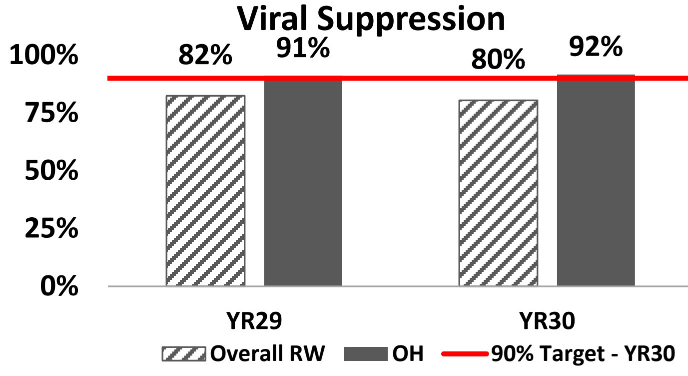
- 54% were living at or below the Federal Poverty Level (FPL)
- 5% experienced homelessness
- 4% were incarcerated within the past 24 months
- 75% were men who have sex with men
- 3% reported past injection drug use

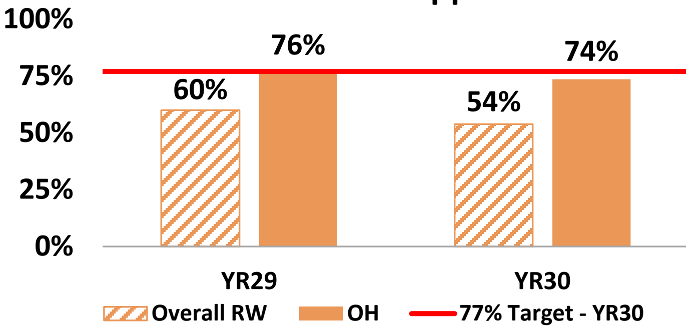
Performance Measures





Viral Suppression





Oral Health (General and Specialty)

About

The Clinical Quality Management (CQM) Program Performance Measure Dashboards are intended to inform DHSP's quality improvement (QI) efforts and to be used to determine the efficacy and progress of quality improvement activities. Our hope is that consumers of HIV services and our subrecipient network providing these services will also benefit from these Dashboards and be able to use them to guide improvement efforts as well.

Oral Health (OH) Services

Oral health is an integral part of primary medical care for all people living with HIV (PLWH). The data included in this report represents data from both the General and Specialty Dental Services.

General Dentistry Services (GOS) includes diagnostic, prophylactic, and therapeutic dentistry services rendered by licensed dentists, registered dental hygienists, registered dental assistants, and other similarly trained professional practitioners. Specialty Dentistry Services (SOS) are those oral health care services beyond the scope of GOS, where advanced knowledge and skills are essential to maintain or restore oral function and healing.

Data Methodology

These dashboards were developed with data reported in the HIV Casewatch system by Ryan White-funded agencies in Los Angeles County (LAC). This report reflects outcomes for clients who utilized Ryan White (RW) OH services during the reporting period from March 1, 2020 to February 28, 2021. This service category was selected based on Health Resources and Services Administration's (HRSA) criteria to monitor performance measures for services that are used by at least 16% of all RW clients.

In order to estimate outcomes, HIV laboratory data (viral load, CD4, and genotype tests) were obtained for RW clients from the Los Angeles County HIV Surveillance system. The HIV-related outcomes and their definitions are based on HRSA HIV/AIDS Bureau recommendations and the U.S. Department of Health and Human Services guidelines. Targets for OH specific measures are based on LAC Commission on HIV's Oral Health Care Standards of Care.

● Received Periodontal Services: Percentage of OH clients who had a periodontal screening, examination and treatment at least once in the measurement year.

● Received Oral Health Education: Percentage of OH clients who received oral health education at least once in the measurement year.

● Viral Suppression: viral load of <200 copies/ml at most recent test reported in the 12 months before the end of the reporting period. Clients with missing viral load tests are considered to have unsuppressed viral load in the time period.

● Sustained Viral Suppression: of clients with at least two viral load tests, all viral load test results are <200 copies/ml in the 12 months before the end of the reporting period. Clients with missing results or with less than two viral load tests are considered to have non-sustained viral suppression in the time period.

Summary and Analysis

● 3,377 clients, or 20%, of the 16,960 RWP clients received OH services in YR 30.

● There was a slightly higher proportion of Latinx clients receiving OH services (59%) compared to the proportion of overall RWP Latinx clients (53%).

● The proportion of older clients (over age 40) receiving OH services (80%) was higher compared to that of overall RWP clients (65%).

Standards & Best Practices Committee
Standards of Care

- ❖ Service standards are written for service providers to follow

- ❖ Service standards establish the minimal level of service or care that a Ryan White funded agency or provider may offer

- ❖ Service standards are essential in defining and ensuring consistent quality care is offered to all clients

- ❖ Service standards serve as a benchmark by which services are monitored and contracts are developed

- ❖ Service standards define the main components/activities of a service category

- ❖ Service standards do not include guidance on clinical or agency operations

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

Standards of Care Review
Guiding Questions

1. Are the standards up-to-date and consistent with national standards of high quality HIV and STD prevention services?

2. Are the standards reasonable and achievable for providers?

3. Will the services meet consumer needs? Are the proposed standards client-centered?

4. What are the important outcomes we expect for people receiving this service? How can we measure whether or not the service is working for them?

5. Is there anything missing from the standards related to HIV prevention and care?

6. Is there anything missing in regard to other topics such as reducing stigma, social determinants of health, immigration issues, support around insurance and housing, etc.?

7. Are the references still relevant?

BENEFITS SPECIALTY

DRAFT FOR REVIEW

10/5/2021

Benefits Specialty
SERVICE STANDARDS

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

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

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

Service Standards: Ryan White HIV/AIDS Programs

INTRODUCTION

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

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

BENEFITS SPECIALTY SERVICES: OVERVIEW

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

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Benefits Specialty Services are unlicensed. All HIV Benefits Specialty Services will be provided in accordance with Commission on HIV guidelines and procedures, and local laws and regulations and will respect the inherent dignity of each person living with HIV they serve. Specialists will explore as possible options for their clients the following benefits (at minimum):

Table 1. BENEFIT SPECIALTY SERVICES LIST

AIDS Drug Assistance Program (ADAP)	Ability to Pay Programs (ATP)
Cal-WORKS	CARE/Health Insurance Premium Payment (CARE/HIPP)
Food Stamps	General Relief/General Relief Opportunities to Work (GROW)
In Home Supportive Services (IHSS)	Insurance Continuation (COBRA, OBRA, HIPAA)
Healthy Families Program	Major Risk Medical Insurance Program (MRMIP)
Managed Cared Systems	Medicaid/Medi-Cal
Medi-Cal/Health Insurance Premium Payment Program (Medi-Cal/HIPP)	Medicare
Medical Savings Programs	Pharmaceutical Patient Assistance Programs (PAPs)
Private Insurance	Social Security Programs
Social Security Disability Insurance (SSDI)	Supplemental Security Income (SDI)
Social Security Retirement	State Disability Insurance (SDI)
Temporary Aid to Needy Families (TANF)	Unemployment Insurance (UI)
Veteran's Administration Benefits (VA)	Women, Infants, and Children (WIC)
Worker's Compensation	Other public/private benefit programs

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

Table 2. BENEFITS SPECIALTY SERVICE REQUIREMENTS

SERVICE COMPONENT	STANDARD	DOCUMENTATION
Outreach	Benefits specialty programs will outreach to potential clients/families and providers.	Outreach plan on file at provider agency.
Outreach	Benefits specialty programs will collaborate with primary health care and supportive services providers.	Memoranda of Understanding on file at the provider agency.
Intake	The intake process will begin during first contact with client.	Intake tool in client file to include (at minimum): • Documentation of HIV status

		• Proof of LA County residency or Affidavit of Homelessness • Verification of financial eligibility • Date of intake • Client name, home address, mailing address and telephone number • Emergency and/or next of kin contact name, home address and telephone number
Intake	Confidentiality policy and Release of Information will be discussed and completed.	Release of Information signed and dated by client on file and updated annually.
Intake	Consent for Services will be completed.	Signed and dated Consent in client file.
Intake	Client will be informed of Rights and Responsibility and Grievance Procedures.	Signed and dated forms in client file.
Intake	When indicated, the client will provide Disclosure of Duty Statement.	Signed and date Disclosure of Duty Statement in client file.
Intake	Client will be informed of limitations of benefits specialty services through Disclaimer form.	Signed and date Disclaimer in client file.
Benefits Assessment	Benefits assessments will be completed during first appointment.	Benefits assessment in client chart on file to include: • Date of assessment • Signature and title of staff person • Completed Assessment/Information form • Functional barriers • Notation of relevant benefits and entitlements

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		and record of forms provided • Benefits service plans
Benefits Management	Benefits management services will be provided to clients who are enrolled in benefits programs and require advocacy to maintain their benefits.	Benefits assessment on file in client chart to include: • Date • Signature and title of staff person • Notation of relevant benefits and presenting issues(s) • Benefits service plan to address identifies benefits issue(s)
Benefits Service Plan (BSPs)	BSPs will be developed in conjunction with the client at the completion of the benefits assessment.	BSP on file in client chart that includes: • Name, date and signature of client and case manager • Benefits/entitlements for which to be applied • Functional barriers status and next steps • Disposition for each benefit/entitlement and/or referral
Appeals Counseling and Facilitation	As necessary, specialists will assist clients with appeals counseling and facilitation. Cases that require further legal assistance will be referred to Ryan White Program-funded or other legal service provider.	Signed, date progress notes on file that detail (at minimum): • Brief description of counseling provided • Time spent with, or on behalf of, the client • Legal referrals (as indicated)
Appeals Counseling and Facilitation	Specialists will attempt to follow up missed appointments within one business day.	Progress notes on file in client chart detailing follow-up attempt.
Client Retention	Programs will develop a broken appointment policy to ensure continuity of service and retention of clients.	Written policy on file at provider agency.
Client Retention	Programs will provider regular follow-up procedures to encourage and help maintain	Documentation of attempts to contact tin signed, date progress notes. Follow-up may include:

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	a client in benefits specialist services.	• Telephone calls • Written correspondence • Direct contact
Client Retention	Programs will develop and implement a client contact policy and procedure for homeless clients and those with no contact information.	Contact policy on file at provider agency. Program review and monitoring to conform.
Case Closure	Clients will be formally notified of pending case closure.	Contact attempts and notification about case closure on file in client chart.
Case Closure	Benefits cases may be closed when the client: • Successfully completes benefits and entitlement applications • Seeks legal representation for benefits • Relocates out of the service area • Has had no direct program contact tin the past six months • Is ineligible for the service • No longer needs the service • Discontinues the service • Is incarcerated long term • Uses the service improperly of has not complied with the client services agreement • Has died	Case closure summary on file in client chart to include: • Date and signature of benefits specialist • Date of case closure • Status of the BSP • Reasons for case closure
Staffing Development and Enhancement Activities	Benefits specialty programs will hire staff that have the ability to provider linguistically and culturally appropriate care to clients infected with and affected by HIV.	Resume on file at provider agency to confirm.
Staffing Development and Enhancement Activities	All staff will be given orientation prior to providing services.	Record of orientation in employee file at provider agency.
Staffing Development and Enhancement Activities	Benefits specialists will complete DHSP's certification training within three months	Documentation of Certification completion maintained in employee file.

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	of being hired and become ADAP and Ryan White/HIPP certified in six months.	
Staffing Development and Enhancement Activities	Staff will complete benefits specialty recertification training annually and will seek other training opportunities as available.	Documentation of training maintained in employee files to include: • Date, time, and location of function • Function type • Staff members attending • Sponsor or provider of function • Training outline • Meeting agenda and/or minutes
Staffing Development and Enhancement Activities	Benefits specialists will practice according to generally accepted ethical standards.	Program review and monitoring to confirm.
Staffing Development and Enhancement Activities	Benefits specialists will receive a minimum of four hours of supervision per month.	Record of supervision on file at provider agency.

Unit of service: Units of service defined as reimbursement for benefits specialty services are based on services provided to eligible clients.

- ***Benefits assessment and service plan units:*** calculated in number of hours provided
- ***Application assistance units:*** calculated in number of hours provided
- ***Appeals counseling and facilitation units:*** calculated in number of hours provided

Number of clients: Client numbers are documented using the figures for unduplicated clients within a given contract period.

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Appendix A: Definitions and Descriptions

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

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

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

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

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

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

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

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

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