LOS ANGELES COUNTY
COMMISSION ON HIV

Visit us online: http://hiv.lacounty.gov
Get in touch: hivcomm@lachiv.org
Get connected to services: https://hivconnect.org/

STANDARDS AND BEST PRACTICES COMMITTEE

Virtual Meeting

Tuesday, August 2, 2022

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

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

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

REGISTER VIA WEBEX ON YOUR COMPUTER OR SMART PHONE:

https://tinyurl.com/5n7xyx5p

**Link is for non-Committee members only*

JOIN VIA WEBEX ON YOUR PHONE:

1-415-655-0001 US Toll Access Code: 2593 494 1235

For a tutorial on joining WebEx events, please check out:

https://www.youtube.com/watch?v=iQSSJYcrgIk

PUBLIC COMMENTS

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

REMINDER

Public comments needed for the Dental Implants Addendum to the Oral Healthcare Service Standards. The purpose of the addendum is to provide specific service delivery guidance to Ryan White Part A-funded agencies regarding the provision of dental implants. The document can be viewed at: https://hiv.lacounty.gov/service-standards Please email comments to hivcomm@lachiv.org by August 5, 2022.

Join the Commission on HIV Email Listserv, Click Here

Follow the Commission on HIV at

Interested in becoming a Commissioner? Click here for a Member Application.

LOS ANGELES COUNTY
COMMISSION ON HIV

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

STANDARDS AND BEST PRACTICES COMMITTEE

TUESDAY, AUGUST 2, 2022, 10:00 AM – 12:00 PM

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

https://tinyurl.com/5n7xyx5p

or Dial

1-415-655-0001

Event Number/Access code: 2593 494 1235

(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*	Michael Cao, MD	Mikhaela Cielo, MD
Wendy Garland, MPH	Thomas Green	Mark Mintline, DDS	Paul Nash, PhD, CPsychol, AFBPsS, FHEA
Mallery Robinson	Harold Glenn San Agustin, MD		
QUORUM: 6			

AGENDA POSTED: July 26, 2022

VIRTUAL MEETINGS: Assembly Bill (AB) 361 amends California's Ralph M. Brown Act Section 54953 to allow virtual board meetings during a state of emergency. Until further notice, all Commission meetings will continue to be held virtually via WebEx. For a schedule of Commission meetings, visit https://hiv.lacounty.gov/meetings

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

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

Servicios de interpretación para personas con impedimento auditivo y traducción para personas que no hablan inglés están disponibles sin costo. Para pedir estos servicios, póngase en contacto con Oficina de la Comisión al (213) 738-2816 (teléfono), o por correo electrónico a 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 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. Operational Updates
- b. Comprehensive HIV Plan 2022-2026
- c. Special Populations Best Practices Project

6. Co-Chair Report 10:30 AM – 10:40 AM
a. 2022 SBP Committee Workplan

7. Division of HIV & STD Programs (DHSP) Report 10:40 AM – 10:50 AM

V. DISCUSSION ITEMS

8. Service Standards Development 10:50 AM – 11:50 AM
a. Oral Healthcare Service Standards Addendum Draft Updates
Review public comments

b. Transitional Case-Management-Jails

VI. NEXT STEPS 11:50 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 August 2, 2022.

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.**

DRAFT

LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave. 14th Floor • Los Angeles, CA 90020 • TEL (213) 738-2816 • FAX (213) 637-4748
HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov • *VIRTUAL WEBEX MEETING*

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

STANDARDS AND BEST PRACTICES (SBP) COMMITTEE MEETING MINUTES

July 5, 2022

COMMITTEE MEMBERS P = Present | A = Absent					
Erika Davies, *Co-Chair*	P	Wendy Garland, MPH	P	Mallery Robinson	A
Kevin Stalter, *Co-Chair*	A	Thomas Green	P	Harold Glenn San Agustin, MD	A
Michael Cao, MD	P	Mark Mintline, DDS	P	Ernest Walker, MPH	LOA
Mikhaela Cielo, MD	P	Paul Nash, PhD, CPsychol, AFBPsS, FHEA	EA		
COMMISSION STAFF AND CONSULTANTS					
Cheryl Barrit, Jose Rangel-Garibay, Catherine Lapointe, Jeff Daniel					
DHSP STAFF					

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

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

CALL TO ORDER-INTRODUCTIONS-CONFLICT OF INTEREST STATEMENTS
The meeting was called to order at 10:05 am. Erika Davies led introductions.

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 4/5/2022, 5/3/2022, and 6/7/2022 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
JURISDICTION: Amy Croft from AIDS Healthcare Foundation submitted a public comment via email (included in meeting packet) in which she requests the SBP committee review the Medical Care Coordination (MCC) service standards to align with the updated goals for the MCC program. SBP co-chair E. Davies shared that the

committee would consider adding the item to the committee's workplan noting that the MCC service standard review may rollover to 2023.

III. COMMITTEE NEW BUSINESS ITEMS

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

IV. REPORTS

5. EXECUTIVE DIRECTOR/STAFF REPORT

a. Operational Updates

- Cheryl Barrit, Executive Director, reported that the County Board of Supervisors (BOS) approved another motion to continue virtual meetings for the Board and all commissions under its authority for another 30 days. Committee meetings will remain virtual until COH leadership receive further direction from the BOS. On June 24th, BOS chair, Supervisor Holly Mitchell released a statement to the public stating that the BOS is eager to start in-person Board meetings and will resume when the COVID-19 transmission rate in Los Angeles County remains in the low-level category as defined by the Centers for Disease Control and prevention (CDC) for 7 consecutive days.
- C. Barrit formally welcomed Dr. Michael Cao to the SBP committee; He is the Supervisorial District 5 Board representative.

b. Comprehensive HIV Plan (CHP) 2022-2026

- C. Barrit reported that AJ King, consultant, is currently soliciting feedback from frontline providers and consumer perspectives that utilize Ryan White HIV services. AJ is lining up listening sessions according to the Ending the HIV Epidemic (EHE) 7 populations of interest including the aging population. He is also planning additional sessions for Men who have Sex with Men (MSM) within the Black and Brown communities and transgender communities. AJ will provide an update to the full commission on 7/14. He will also provide a report at the July meeting of the Planning, Priority & Allocations (PP&A) Committee.

c. New Haven/Fairfield Planning Council Service Standards Template

- Jose Rangel-Garibay provided a brief overview of the Oral Healthcare Service Standards for the New Haven/Fairfield Planning Council document to provide the Committee with an example of how other jurisdictions organize their service standards documents and as a way to generate ideas for the SBP Committee to consider as they continue revising their service standards.

d. Special Populations Best Practices Project

- J. Rangel-Garibay provided an overview of the draft special populations best practices document and noted that he will share a final draft for Committee review in August.

6. CO-CHAIR REPORT

a. 2022 Workplan Updates

- E. Davies provided a review of the 2022 workplan and noted the following: The Committee will vote to approve the Benefits Specialty Services and Home-based Case Management service standards and move them to the Executive Committee. In addition, the Committee will continue review of the Transitional Case Management service standards in August.
- C. Barrit reminded the Committee that given the items listed for the 2022 year, the MCC service standard review may roll over to the 2023 workplan.

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

- There was no DHSP report. C. Barrit noted that the "Medi-Cal Expansion: Preliminary Analysis on the Impact to Los Angeles County's Ryan White Program" report is included in the meeting packet. The report was presented at the June 21st Planning, Priorities and Allocations (PP&A) Committee meeting and it provides a preliminary analysis of potential migration of people from the Ryan White Care system to Medi-Cal.

V. DISCUSSION ITEMS

8. SERVICE STANDARDS DEVELOPMENT

a. Benefits Specialty Services (BSS) services standards

MOTION #3: Approve the BSS service standards as presented or revised and forward to the Executive Committee ***(Passed by roll call vote, Yes = 6; Absent =5).***

b. Oral Healthcare Service Standards Addendum Draft

J. Rangel-Garibay provided an overview of the draft dental implant addendum for the oral healthcare services standards; the document is included in the packet. E. Davies read the proposed service standards and requested feedback from Committee and community members.

Dr. Piedad Suarez commented that the proposed standards should include a discussion between the referring clinician and the patient regarding the possibility of treatment failure to manage patient expectations of the dental implant treatment. She also recommended adding a note on the importance of routine care for maintaining dental implants.

Dr. Mark Mintline recommended to consider making the "evaluation" section vaguer regarding the expectation for clinicians to provide alternative treatment plans when referring patients for dental implants. The expectation is for the clinician to diagnose the condition and make a referral for specialty care if appropriate. The receiving clinician would evaluate the patient and determine if dental implants are an appropriate and feasible treatment plan for the patient.

The committee announced a public comment period for the draft dental implant addendum to the oral healthcare services standards set to end on August 5, 2022.

c. Home-Based Case Management (HBCM) Review

Committee members discussed the public comments submitted at the June meeting. E. Davies noted that the reasoning behind changing the staff qualification requirements for the Case Manager position from "MSW required" to "MSW preferred; or bachelor's degree with 2-3 years of experience" was due to high turnover and to allow applicants with significant experience that would translate to the position well and may not have had the opportunity to obtain an MSW. She recommended amending the language to "MSW Required. On a case-by-case basis, the agency may consider candidates with a bachelor's degree with 2-3 years of experience that would translated well to the position."

MOTION #4: Approve the HBCM service standards as presented or revised and forward to the Executive Committee ***(Passed by roll call vote, Yes = 6; Absent =5).***

VI. NEXT STEPS

9. TASK/ASSIGNMENTS RECAP:

- COH staff will announce a 30-day public comment period for the draft addendum to the Oral health care service standards regarding dental implants.
- COH staff will move the BSS and HBCM service standards to the Executive Committee for approval.
- COH staff will distribute the Special Populations Best Practices document to SBP committee members

10. **AGENDA DEVELOPMENT FOR NEXT MEETING**:
    - Review public comments received for the draft addendum to the oral health care service standards regarding dental implants
    - Review the SBP committee workplan to add MCC review
    - Continue review of the Transitional Case Management- Jails service standards

VII. ANNOUNCEMENTS

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

VIII. ADJOURNMENT

12. **ADJOURNMENT**: The meeting adjourned at 11:18am.

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 7/11/22

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

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
CAMPBELL	**Danielle**	UCLA/MLKCH	Oral Health Care Services
			Medical Care Coordination (MCC)
			Ambulatory Outpatient Medical (AOM)
			Transportation Services
CAO	**Michael**	Golden Heart Medical	No Ryan White or prevention contracts
CIELO	**Mikhaela**	LAC & USC MCA Clinic	Ambulatory Outpatient Medical (AOM)
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
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**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			HIV Testing 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
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
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
HALFMAN	**Karl**	California Department of Public Health, Office of AIDS	Part B Grantee
KOCHEMS	**Lee**	Unaffiliated consumer	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts
MAGANA	**Jose**	The Wall Las Memorias, Inc.	HIV Testing Storefront
			HIV Testing Social & Sexual Networks
MARTINEZ	**Eduardo**	AIDS Healthcare Foundation	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Medical Care Coordination (MCC)
			Mental Health
			Oral Healthcare Services
			STD Screening, Diagnosis and Treatment
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
			Medical Subspecialty
			HIV and STD Prevention Services in Long Beach
MARTINEZ (PP&A Member)	**Miguel**	Children's Hospital Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transitional Case Management - Youth
			Promoting Healthcare Engagement Among Vulnerable Populations

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MILLS	**Anthony**	Southern CA Men's Medical Group	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
MINTLINE (SBP Member)	**Mark**	Western University of Health Sciences (No Affiliation)	No Ryan White or prevention contracts
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
OROZCO	**Jesus ("Chuy")**	HOPWA-City of Los Angeles	No Ryan White or prevention contracts
PERÉZ	**Mario**	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee
ROBINSON	**Mallery**	We Can Stop STDs LA (No Affiliation)	No Ryan White or prevention contracts
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)

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

LOS ANGELES COUNTY COMMISSION ON HIV

LOS ANGELES COUNTY COMMISSION ON HIV 2022
STANDARDS AND BEST PRACTICES WORKPLAN (Updates in RED)

Co-Chairs: Erika Davies, Kevin Stalter				
Approval Date: 2/1/22				
Purpose of Work Plan: To focus and prioritize key activities for COH Committees and subgroups for 2022.				
#	**TASK/ACTIVITY**	**DESCRIPTION**	**TARGET COMPLETION DATE**	**STATUS/NOTES/OTHER COMMITTEES INVOLVED**
1	Review and refine 2022 workplan	COH staff to review and update 2021 workplan monthly	Ongoing	Workplan revised/updated on: 12/22/21, 1/6/2022, 1/19/22, 1/26/22; 2/1/22; 2/24/22; 3/30/22; 4/27/22, 6/24/22, 7/26/22
2	Update Substance Use Outpatient and Residential Treatment service standards	Continuation of SUD service standards review from 2021.	Jan 2022 COMPLETED	During the 11/2021 meeting, the committee placed a temporary hold on approving the SUD service standards pending further review of the implications of CalAIM. COH staff will provide CalAIM updates and allow the committee to determine to approve or extend the hold on approving the SUD service standards. At the 12/7/21 meeting, the committee approved the SUD service standards and moved them to the Executive Committee for approval. Approved by the Executive Committee on 12/9/21 and on the Commission agenda for approval on 1/13/22 Approved by Commission on 1/13/22. COH staff sent transmittal letter to DHSP on 1/26/22.
3	Update Benefits Specialty service standards	Continuation of BSS service standards review from 2021.	~~Early 2022~~ August 2022	Committee extended the public comment period and now ends on January 21, 2022. The Committee reviewed public comments received at the February 2022 meeting. Committee placed a temporary hold on additional review of the BSS standards pending further instruction from DHSP. Committee approved the BSS standards and moved them to the Executive Committee for approval at July 28 meeting.
4	Update Home-based Case Management service standards	SBP prioritized HBCM for 2022 based on recommendations from ATF	~~July 2022~~ August 2022	DHSP presented a HBCM service utilization summary document at the January 2022 SBP Committee meeting Committee will announced a 30-day Public Comment period starting on 5/4/22 and ending on 6/3/22.

		and DHSP. 84% of HBCM clients are ages 50+		Committee approved the HBCM standards and moved them to the Executive Committee for approval at July 28 meeting.
5	Conduct a targeted review of the oral health service standards and developing guidance for specialty dental providers related to dental implants.	Mario Perez (DHSP) recommended that the SBP committee conduct this specific addendum to the oral health standards for 2022	~~July 2022~~ August 2022	COH staff scheduled a planning meeting to elaborate details for an expert panel. The meeting is scheduled January 11, 2022. COH staff to identified Jeff Daniels as facilitator for Subject Matter Expert (SME) panel. COH staff requested service utilization summary document for Oral Health service standards from Wendy Garland [DHSP]. Dr. Younai provided literature review materials and COH staff will prepare an annotated bibliography. Paulina Zamudio provided list of dental providers contracted with DHSP. COH staff will draft SME panel invite letter. SME panel to convene in late February 2022. The COH convened an oral healthcare subject matter expert panel to support Commission staff in drafting a dental implant addendum to the current Ryan White Part A oral healthcare service standard. The addendum will provide clarification and guidance to the Commission's current oral healthcare service standard regarding to dental implants Commission staff will work with the panel facilitator Jeff Daniel, to compile a meeting summary to share with the panelists and will begin drafting an outline for the addendum. The plan is to have a draft addendum ready for the SBP committee to review for the April SBP meeting. Committee announced a 30-day public comment period and will vote to
6	Update Transitional Case Management service standards	Recommendation from DHSP	September 2022	Committee will begin the review process at the March 2022 meeting. Committee will continue review process at August 2022 meeting.
7	Provide feedback on and monitor implementation of the	Develop strategies on how to engage with private	Ongoing, as needed	

	local Ending the HIV Epidemic (EHE) plan	health plans and providers in collaboration with DHSP		
8	Collaborate with the Planning, Priorities and Allocations Committee and AJ King (consultant) to shape the Comprehensive HIV Plan (CHP)	Contribute to the development of the CHP and advance the goals of the Comprehensive HIV Plan and Los Angeles County HIV/AIDS Strategy	Ongoing/ Late 2022	Added "CHP discussion" item for all SBP Committee meetings in 2022. COH staff and AJ King to provide updates on CHP progress and submit requests for information for the SBP Committee to address.
9	Engage private health plans in using service standards and RW services		TBD	
10	Update the Medical Case Management service standards	Committee received a public comment requesting for a review and update of the MCC services standards.	2023	

Instructions and Guiding Questions for Public Comments for Dental Implants Addendum to Oral Healthcare Service Standards

The Los Angeles County Commission on HIV (COH) announces an opportunity for the public to offer comments for the draft addendum to the Oral Healthcare Service Standards regarding dental implants developed by the Standards and Best Practices Committee. The purpose of the addendum is to provide specific service delivery guidance to Ryan White Part A-funded agencies regarding the provision of dental implants. The attached draft addendum outlines the service expectations aimed at creating a standardized set of service components, specifically for dental implants (See Section VI. Proposed Oral Healthcare Service Addendum Regarding Dental Implants). Consumer, provider, and community feedback is critical for the service standards development process. We invite you to share your comments and distribute the document widely within your networks. The document can also be accessed at: https://hiv.lacounty.gov/service-standards

Please email comments to: HIVCOMM@LACHIV.ORG

THE PUBLIC COMMENT PERIOD ENDS ON AUGUST 5, 2022.

When providing public comment, consider responding to the following:

1. What barriers currently exist in providing dental implants? Do the proposed standards address these barriers?
2. What conditions/clinical situations would lend to an exclusion for dental implants? Please provide scientific research citations relevant to your comments.
3. What conditions/clinical situations would lend to an inclusion for dental implants? Please provide scientific research citations relevant to your comments.
4. Are the proposed standards reasonable and achievable for providers? Why or why not?
5. Is there anything missing regarding service delivery for dental implants under the Ryan White HIV/AIDS Program?
6. Do the proposed standards support the importance of client/provider relationship in determining treatment plan options? Why or why not?

ORAL HEALTH CARE SERVICE STANDARD ADDENDUM

I. INTRODUCTION

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

II. BACKGROUND

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

III. SUBJECT MATTER EXPERT PANEL FINDINGS AND RECOMMENDATIONS

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

a. Support and reinforce patient understanding, agreement, and education in the patient's treatment plan.
b. Ensure patient understanding that dental implants are for medical necessity (as determined by the dental provider through assessments and evaluation) and would lead to improved HIV health outcomes
c. Reinforce that RW funds cannot be used to provide dental implants for cosmetic purposes.
d. The treatment plan should be signed by both patient and doctor.
e. Engage and collaborate with the Consumer Caucus to revisit and strengthen the "Consumer Bill of Rights" document and consider reviewing the client responsibilities section to ensure it addresses the client's service expectations and the service provider's capacity to meet them within the limits of the contractual obligations as prescribed by DHSP.
f. Review the referral form(s) providers use to refer patients to specialty dental services
g. Develop a standard form/process referring providers can complete when referring
h. Train referring dental providers on how to adequately complete referral forms to allow more flexibility in treatment planning for receiving specialty dental providers.
i. Recommend that dental providers complete training modules and access training resources available on the Pacific AIDS Education and Training (PAETC) website.

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

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

V. PROGRAM SERVICE CATEGORY DEFINITION FOR ORAL HEALTH CARE SERVICES

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

VI. PROPOSED ORAL HEALTHCARE SERVICE ADDENDUM REGARDING DENTAL IMPLANTS

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

SERVICE COMPONENT	STANDARD	DOCUMENTATION
EVALUATION/ASSESSMENT	Obtain a thorough medical, dental, and psychosocial history to assess the patient's oral hygiene habits and periodontal stability and determine the patient's capacity to achieve dental implant success and the possibility of dental implant failure.	Client Chart/Treatment Plan/Provider Progress Notes
	Clinician, after patient assessment, will make necessary referrals to specialty programs including, but not limited to smoking cessation programs; substance use treatment; medical nutritional therapy, thereby increasing patients' success rate for receiving dental implants.	
	The clinicians referring patients to specialty Oral Healthcare services will complete a referral form, educate the patient, and discuss treatment plan alternatives with patient.	
TREATMENT PLANNING AND ORAL HEALTH EDUCATION	The receiving clinician will review the referral, consider the patient's medical, dental, and psychosocial history to	Referral in Client Chart/Treatment

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

	determine treatment plan options that offer the patient the most successful outcome based on published literature. The clinician will discuss with patient dental implant options with the goal of achieving optimal health outcomes including possibility of treatment plan failure.	Plan/Provider Progress Notes
	The clinician will consider the patient's perspective in deciding which treatment plan to use.	Client Chart/Treatment Plan/Provider Progress Notes
	The clinician will discuss treatment plan alternatives with the patient and collaborate with the patient to determine their treatment plan.	Client Chart/Treatment Plan/Provider Progress Notes
	The clinician and the patient will revisit the treatment plan periodically to determine if any adjustments are necessary to achieve the treatment goal.	Client Chart/Treatment Plan/Provider Progress Notes
	The clinician will educate patients on how to maintain dental implants and the importance of routine care.	Client Chart/Treatment Plan/Provider Progress Notes

VII. REFERENCES

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

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

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

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

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

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

g. Rubinstein NC, Jacobson Z, McCausland GL, Dibart S. Retrospective study of the success of dental implants placed in HIV-positive patients. Int J Implant Dent. 2019 Jun 13;5(1):30. Link: Retrospective study of the success of dental implants placed in HIV-positive patients. - Abstract - Europe PMC
h. Sabbah A, Hicks J, MacNeill B, Arbona A, Aguilera A, Liu Q, Gelfond J, Gardner W. A retrospective analysis of dental implant survival in HIV patients. J Clin Periodontol. 2019 Mar;46(3):363-372. Link: A retrospective analysis of dental implant survival in HIV patients. - Abstract - Europe PMC
i. Neumeier TT, Reddy M, Geurs N, Hill J, Neumeier H.J Longitudinal Study of Dental Implants in HIV-Positive Patients. Prosthodont. 2021 Sep 8. doi: 10.1111/jopr.13421. Online ahead of print.PMID: 34496113. Link: Implants in HIV patients | British Dental Journal (nature.com)
j. Oliveira MA, Gallottini M, Pallos D, Maluf PS, Jablonka F, Ortega KL. The success of endosseous implants in human immunodeficiency virus-positive patients receiving antiretroviral therapy: a pilot study. J Am Dent Assoc. 2011 Sep;142(9):1010-6. Link: The success of endosseous implants in human immunodeficiency virus-positive patients receiving antiretroviral therapy: a pilot study. (medscape.com)
k. Prevalence of periodontitis, dental caries, and peri-implant pathology and their relation with systemic status and smoking habits: Results of an open-cohort study with 22009 patients in a private rehabilitation center. de Araújo Nobre M, Maló P. J Dent. 2017 Dec;67:36-42. Link: Prevalence of periodontitis, dental caries, and peri-implant pathology and their relation with systemic status and smoking habits: Results of an open-cohort study with 22009 patients in a private rehabilitation center - ScienceDirect
l. Oliveira MA, Pallos D, Mecca F, Ortega KL, Gallottini M, Costa AL, Kim YJ, Martins F. Dental implants in patients seropositive for HIV: A 12-year follow-up study..J Am Dent Assoc. 2020 Nov;151(11):863-869. Link: Dental implants in patients seropositive for HIV: A 12-year follow-up study - PubMed (nih.gov)
m. Guobis Z, Pacauskiene I, Astramskaite I. General Diseases Influence on Peri-Implantitis Development: a Systematic Review. J Oral Maxillofac Res. 2016 Sep 9;7(3):e5. Link: General Diseases Influence on Peri-Implantitis Development: a Systematic Review - PubMed (nih.gov)
n. Sivakumar I, Arunachalam S, Choudhary S, Mahmoud-Buzayan M, Tawfiq O, Sharan. Do Highly Active Antiretroviral Therapy Drugs in the Management of HIV Patients Influence Success of Dental Implants? J.AIDS Rev. 2020;22(1):3-8. Link: Do Highly Active Antiretroviral Therapy Drugs in the Management of HIV Patients Influence Success of Dental Implants? - PubMed (nih.gov)
o. Vidal F, Peres RV, de Souza RC, Gonçalves C, Pavan P, Gonçalves LS. Dental implants in individuals living with HIV-1: Results from a prospective study in patients undergoing highly active antiretroviral therapy. Spec Care Dentist. 2021 Sep 19. doi: 10.1111/scd.12646. Online ahead of print. Link: Dental implants in individuals living with HIV-1: Results from a prospective study in patients undergoing highly active antiretroviral therapy - Vidal - - Special Care in Dentistry - Wiley Online Library
p. Naujokat H, Kunzendorf B, Wiltfang J. Dental implants and diabetes mellitus-a systematic review. Int J Implant Dent. 2016 Dec;2(1):5. Link: Dental implants and diabetes mellitus-a systematic review - PubMed (nih.gov)
q. Jiang X, Zhu Y, Liu Z, Tian Z, Zhu S. Association between diabetes and dental implant complications: a systematic review and meta-analysis. .Acta Odontol Scand. 2021 Jan;79(1):9-18. Link: Association between diabetes and dental implant complications: a systematic review and meta-analysis - PubMed (nih.gov)

DRAFT UNDER REVIEW

SERVICE STANDARDS FOR TRANSITIONAL CASE MANAGEMENT-INCARCERATED/POST RELEASE

LOS ANGELES COUNTY
COMMISSION ON HIV

Under review by the SBP Committee. Current draft as of 8/2/22

Approved by the Commission on HIV on 4/13/2017

DRAFT

SERVICE STANDARDS: TRANSITIONAL CASE MANAGEMENT- INCARCERATED/POST-RELEASE

IMPORTANT: The service standards for Incarcerated/Post-Release Transitional Case Management Services adhere to requirements and restrictions from the federal agency, Health Resources and Services Administration (HRSA). The key documents used in developing standards are as follows:

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

HRSA HAB Policy Clarification Notice (PCN) # 18-02: The use of Ryan White HIV/AIDS Program Funds for Core Medical Services and Support Services for People Living with HIV Who Are Incarcerated and Justice Involved

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

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 (COH) developed the Incarcerated and Post-Release Transitional Case Management Services standards to establish the minimum services necessary to coordinate care for incarcerated/post-release individuals who are living with HIV and are transitioning back to the community. The development of the standards includes guidance from service providers, people living with HIV, the Los Angeles County Department of Public Health, Division of HIV and STD Programs (DHSP), members of the Los Angeles County Commission on HIV, Standards & Best Practices Committee, caucuses, and the public-at-large.

SERVICE DESCRIPTION

HIV Transitional Case Management (TCM) is a client-centered activity that coordinates care for incarcerated individuals who are living with HIV and are transitioning back to the community. TCM services include:

- Intake and assessment of available resources and needs
- Periodic reassessment of status and needs
- Development and implementation of Individual Release Plans
- Appropriate referrals to housing, community case management, medical, mental health, and substance use treatment
- Services to facilitate retention in care, viral suppression, and overall health for incarcerated/post-release individuals who are living with HIV and are transitioning back to the community
- Access to HIV and STI information, education, partner services, and behavioral and biomedical interventions (such as pre-exposure prophylaxis (PrEP)) to prevent acquisition and transmission of HIV/STIs)

RECOMMENDED TRAINING TOPICS FOR TRANSITIONAL CASE MANAGEMENT STAFF

Transitional Case Management staff should complete ongoing training related to the provision of TCM services. Staff development and enhancement activities should include, but not be limited to:

- HIV/AIDS Medical and Treatment Updates
- Risk Behavior and Harm Reduction Interventions
- Addiction and Substance Use Treatment
- HIV Disclosure and Partner Services
- Mental health and HIV/AIDS including Grief and Loss
- Legal Issues, including Jails/Corrections Services
- Alternatives to Incarceration Training
- Integrated HIV/STI prevention and care services including Hepatitis C screening and treatment
- Sexual identification, gender issues, and provision of trans-friendly services
- Stigma and discrimination and HIV/AIDS

The following are resources to assist agencies the health and social needs of this community:
https://wdacs.lacounty.gov/justive-involved-support-services/
https://careacttarget.org/sites/default/files/JailsLinkageIHIPPocketCard.pdf
https://www.cdc.gov/correctionalhealth/rec-guide.html
http://www.enhancelink.org/

SERVICE STANDARDS

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

SERVICE COMPONENT	STANDARD	DOCUMENTATION
Outreach	Transitional case management programs will conduct outreach to educate potential clients and HIV and STI services providers and other supportive service organizations about the availability and benefits of TCM services for incarcerated and post-released persons living with HIV.	Outreach plan on file at provider agency.
	Transitional case management programs will provide information sessions to incarcerated people living with HIV that facilitate enrollment into TCM services.	Record of information sessions at the provider agency. Copies of flyers and materials used. Record of referrals provided to clients.
	Transitional case management programs establish appointments (whenever possible) prior to release date.	
Client Intake	Initiate a client record that includes	Client record to include: • Client name and contact information including: address, phone, and email • Written documentation of HIV/AIDS diagnosis • Proof of LAC Residency or documentation that client will be released to LAC residency • Verification of client's financial eligibility for services • Date of intake • Emergency and/or next of kin contact name, home address, and telephone number • Signed and dated Release of Information, Limits of

		Confidentiality, Consent, Client Rights and Responsibilities, and Grievance Procedures forms
Comprehensive Assessment	Comprehensive assessment and reassessment are completed in a cooperative process between the TCM staff and the client and entered into DHSP's data management system within 30 days of the initiation of services. Perform reassessments at least once per year or when a client's needs change or they have re-entered a case management program. Comprehensive assessment is 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 • Client's Medical Home post-release and linkage to Medical Case Management (MCC) team prior to release to ensure continuity of care • Ability of the client's social support network to help meet client need • Extent to which other agencies are involved in client's care	Comprehensive assessment or reassessment on file in client chart to include: ○ Date of assessment/reassessment ○ Signature and title of staff person conducting assessment/reassessment ○ Client strengths, needs and available resources in the following areas: ○ Medical/physical healthcare ○ Medications and Adherence issues ○ Mental health ○ Substance use and substance use treatment ○ Nutrition/food ○ Housing and living situation ○ Family and dependent care issues ○ Access to hormone replacement therapy, gender reassignment procedures, name change/gender change clinics and other transition-related services. ○ Transportation ○ Language/literacy skills ○ Religious/spiritual support ○ Social support system ○ Relationship history ○ Domestic violence/Intimate

		Partner Violence (IPV) ○ Financial resources ○ Employment and Education ○ Legal issues/incarceration history ○ HIV and STI prevention issues
Individual Release Plan (IRP)	IRPs will be developed in conjunction with the client within two weeks of completing the assessment or reassessment The IRP should address, at minimum, the following: • Reasons for incarceration and prevention of recidivism • Transportation • Housing/shelter • Food • Primary health care • Mental health • Substance use treatment • Community-based case management IRPs will be updated on an ongoing basis.	IRP on file in client chart to includes: • Name of client and case manager • Date and signature of case manager and client • Date and description of client goals and desired outcomes • Action steps to be taken by client, case manager and others • Customized services offered to client to facilitate success in meeting goals, such as referrals to peer navigators and other social or health services. • Goal timeframes • Disposition of each goal as it is met, changed, or determined to be unattainable
Monitoring and Follow-up	Implementation, monitoring, and follow-up involve ongoing contact and interventions with (or on behalf of) the client to ensure that IRP goals are addressed and that the client is linked to and appropriately access and maintains primary health care and community-based supportive services identified on the IRP. Case managers will: • Provide referrals, advocacy and interventions based on the intake, assessment, and IRP	Signed, dated progress notes on file that detail (at minimum): • Description of client contacts and actions taken • Date and type of contact • Description of what occurred • Changes in the client's condition or circumstances • Progress made toward IRP goals • Barriers to IRPs and actions taken to resolve them • Linked referrals and interventions and current status/results of same

	• Monitor changes in the client's condition • Update/revise the IRP • Provide interventions and linked referrals • Ensure coordination of care • Help clients obtain health benefits and care • Conduct monitoring and follow-up to confirm completion of referrals and service utilization • Advocate on behalf of clients with other service providers • Empower clients to use independent living strategies • Help clients resolve barriers • Follow up on IRP goals • Maintain/attempt contact at a minimum of once every two weeks and at least one face-to-face contact monthly • Follow up missed appointments by the end of the next business day • Collaborate with the client's community-based case manager for coordination and follow-up when appropriate • Transition clients out of incarcerated transitional case management at six month's post-release.	• Barriers to referrals and interventions/actions taken • Time spent with, or on behalf of, client • Case manager's signature and title
Staffing Requirements and Qualifications	Case managers will have: • Knowledge of HIV/AIDS/STIs and related issues • Knowledge of and sensitivity to incarceration and correctional settings and populations • Knowledge of and sensitivity to lesbian, gay, bisexual, and transgender persons • Effective motivational	Resume, training certificates, interview assessment notes, reference checks, and annual performance reviews on file.

	interviewing and assessment skills • Ability to appropriately interact and collaborate with others • Effective written/verbal communication skills • Ability to work independently • Effective problem-solving skills • Ability to respond appropriately in crisis situations • Effective organizational skills Refer to list of recommend training topics for Transitional Case Management Staff	
	Case managers will hold a bachelor's degree in an area of human services; high school diploma (or GED equivalent) and at least one year's experience working as an HIV case manager or at least two years' experience working within a related health services field. Prior experience providing services to incarcerated individuals is preferred. Personal life experience with relevant issues is highly valued and should be considered when making hiring decisions	Resumes on file at provider agency documenting experience. Copies of diplomas on file.
	All staff will be given orientation prior to providing services.	Record of orientation in employee file at provider agency.
	Case management staff will complete DHSP's required case management certifications/training within three months of being hired. Case management supervisors will complete DHSP's required supervisor's certification/training within six months of being hired.	Documentation of certification completion maintained in employee file.
	Case managers will participate in recertification as required by DHSP	Documentation of training maintained in employee files to

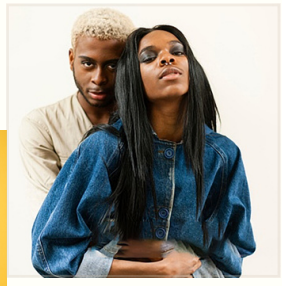
	and in at least 16 hours of continuing education annually. Management, clerical, and support staff must attend a minimum of eight hours of HIV/ AIDS/STIs training each year.	include: • Date, time, and location of function • Function type • Staff members attending • Sponsor or provider of function • Training outline, handouts, or materials • Meeting agenda and/or minutes
	Case management staff will receive a minimum of four hours of client care-related supervision per month from a master's degree-level mental health professional.	All client care-related supervision will be documented as follows (at minimum): • Date of client care-related supervision • Supervision format • Name and title of participants • Issues and concerns identified • Guidance provided and follow-up plan • Verification that guidance and plan have been implemented • Client care supervisor's name, title, and signature.
	Client care-related supervision will provide general clinical guidance and follow-up plans for case management staff.	Documentation of client care-related supervision for individual clients will be maintained in the client's individual file.

MEPS

About MEPS

The Mobile Enhanced Prevention Support (MEPS) study was designed to reach a vulnerable population during a critical point for increased risk of HIV infection: Men who have Sex with Men (MSM) and Transgender Women (TW) who have substance use issues and are leaving (or have recently left jail).

We are comparing two programs to determine which may be better at helping this community stay healthy after leaving jail. Participants are randomly assigned to either the MEPS Intervention Group, where they are paired with a peer mentor of their choice and make use of a mobile application to find services, or to the Control Group, where participants make use of services they already have access to while in jail and at the time of their release. The study for all participants takes place over a 9-month period.



Why is MEPS Important?

By identifying strategies we can use to prevent HIV infections in this population, we hope to contribute to ongoing efforts to reduce HIV infections. Communities at high-risk for HIV are also far more likely to be incarcerated compared to those who are not. Through reaching them at this critical point, we hope to reduce the chances of re-incarceration, HIV/STI infection, relapse, or overdose that the often unstable reentry period can lead to.

Learn more about MEPS in our Overview Video Here

Who is participating in MEPS ?

We aim to reach 300 individuals to join our study. Since November of 2019, and amid the COVID-19 pandemic, the MEPS team has successfully recruited **156** participants of which **39** have completed the study so far. We appreciate all of your referrals! Of the 145 participants:

- **83%** are Men who have Sex with Men (MSM)
- **12%** Transgender women (TG)
- **26 %** Black, African American
- **37%** Hispanic, Latinx
- **3%** Native Hawaiian or other Pacific Islander
- **17%** White
- **15 %** Other (bi or multiracial)

See what our participants are saying....

"In general I enjoyed it. I got really busy with work and wasn't able to be engaged enough. The study helped me a lot in terms of my sexuality and being part of a community that understands and are willing to help." - ***MEPS Intervention participant***

"My experience was amazing, small things were big to me like working and having a copy of my passport. It was helpful to see it every time." - ***MEPS, Control participant***

About the PI

Nina T. Harawa, PhD, MPH

Dr. Nina Harawa is a Professor of Medicine and Epidemiology at UCLA. She also holds a faculty appointment at Charles R. Drew University of Medicine and Science where she serves as Associate Director of Research for the university's Center for AIDS Research, Education and Services (Drew CARES).

Trained in epidemiology, Dr. Harawa's research involves developing and testing holistic interventions for encouraging prevention, care, and treatment for HIV, STIs, and substance use disorders and leading efforts to examine the impact of various policies on racial/ethnic health disparities. She also directs the Policy Impact Core of the NIMH-funded UCLA Center for HIV Identification Prevention and Treatment Services (CHIPTS), which examines how proposed and enacted policies may support or hinder efforts to end the HIV epidemic. Because of her commitment to health equity, Dr. Harawa started REACH UCLA Health, a faculty group dedicated to increasing access to the UCLA Health system for people of color and those with publicly funded insurance.

A look at our participants experience:

"James enrolled in MEPS at the age of 32 following his release from 2 years of incarceration for drug possession. James' history of use includes meth, crack cocaine, alcohol, marijuana, club drugs and prescription opiates. He is currently in a mandated substance abuse treatment program and has 30 days of sobriety. James identifies as same gendering loving. Generally, he has sex with other men, sometimes with trans- and cis-women. He had sex with one partner in jail who injects drugs and did not know their HIV status. James tested negative for HIV when he was incarcerated but reports no knowledge of PrEP or PEP. He is open to learning about how they might be of value to him. Although James cannot obtain work until he completes his treatment program, he has a history of working for a catering company that serves the film industry. He is eager to get back to work with them or a similar company and begin saving money and achieving some the stability that eluded him during the months leading up to his incarceration.*

James is also addressing personal challenges--his parents have a restraining order against him, and his partner no longer trusts him and has not responded to any of his attempts to reach out and make amends since being released. James feels isolated and alone but is working on accepting his past behavior and focusing on improving his own emotional well-being as a hopeful starting place to eventually rebuilding his past relationships. James has repeatedly expressed to his Peer Mentor how much he appreciates that he understands him and is there for him while he works to put his life back together. He also appreciates how the Wellness Passport helped him organize his thinking toward his 4 primary goals at this point in his life: 1) maintaining his newfound sobriety, 2) finding meaningful work again, 3) obtaining affordable, stable housing and 4) rebuilding his damaged relationships."

***James is not an actual participant, but reflects the kind of experience our participants face.**
This story was put together by Dr. Charles Hilliard, our MEPS Co-investigator and Clinical supervisor.

Community Outreach

In efforts to reach and serve our target population, our MEPS team has committed their time to connect and partner with community organizations dedicated to serving and bettering the health and livelihood of marginalized communities.

Gregory Victorianne, MEPS Recruitment and Retention Coordinator

Gregory Victorianne Recruitment/ Retention Coordinator has actively connected with and shared about MEPS with numerous organizations in LA county. Most recently, he also participated in street outreach in LA county including, Community Based Organizations and places where potential participants may go for services.

A few organizations Gregory has outreached to include:

- Friends Community Center
- AMAAD Institute
- APLA Health Center CDU/MLK Medical Campus and Baldwin Hills Campus
- Los Angeles LGBT Center
- JWCH East Hollywood
- Children's Hospital
- Men's Health Foundation: SoCal Club
- Watts Healthcare
- Children's Hospital Los Angeles
- God's Property Sober Living
- Unique Women's Coalition

One great thing about the COVID-19 pandemic easing is that people are gathering, including at health and resource fairs that have long been used to reach the community with information, resources, and linkages to services and research opportunities.

Mabel Garcia (*left*) and Alyssa (right) tabling at Gender Wonderfest 2022

In March, our Peer Mentor, **Mabel Garcia,** along with **Alyssa Gallo**, an LA CADA peer specialist and housing navigator tabled at Gender Wonder Fest, an event hosted by the LGBTQ Center of Long Beach.

Karina Fing, MEPS Research Associate at the Rooted and Rising community health fair, 2022

This May **Karina Fing,** one of our research associates tabled at the Rooted and Rising community health fair, hosted by The Wall Las Memorias Project.

Charles McWells, BA
MEPS Co-Investigator

Charles McWells is Co-Principal Investigator/ Project Director of the Passport to Wellness research project, and Program Manager of the Many Men, Many Voices program at L.A. CADA. Charles oversees HIV prevention, intervention and health literacy services with a focus on gay, bisexual, and other Black men who have sex with men. In addition, he is a part of the Community Faculty Program at Charles R. Drew University of Medicine and Science, where he conducts research, this and other HIV/AIDS and related health disparities in communities of color.

Charles is Co-Dean of Strength for the journey, a faith based organization that supports HIV prevention. He is also co-host of Good News Radio Magazine, a weekly program focusing on healthcare, broadcasted on Wednesdays from 1-2 pm on acceleratedradio.net. Charles has a Bachelor's degree in Political Science from Claremont McKenna College.

Presentations

MEPS has offered a series of **12** seminars to residential recovery facilities and community partners on a variety of health topics and has reached 100's of residents and staff. We work with individual houses to tailor the subject matter to their interests and needs.

Will Schlesinger, a medical student volunteer, has given the presentations, along with **Lawrence Dotson**, one of our MEPS recruiters. Lawrence also follows up with anyone interested in learning more about joining MEPS. Will, will soon be transitioning back into his clinical rotations at UCLA, but has been working to develop a program with rotating medical school student volunteers to continue the presentations and sustain them long term.

Lawrence Dotson (Left) and Will Schlesinger (Right)

Will Schlesinger presenting on HIV 101 at LA CADA Art House in Pasadena

Schedule Overview

7.23.2020 - God's Property: COVID 19
12.10.2020 - God's Property: COVID Vaccines

2.2.2021 - LA CADA Staff: PrEP & PEP
10.1.2021 - God's Property: HIV/AIDS Basics
11.5.2021 - God's Property: PrEP & PEP
11.19.2021 - ART House: HIV 101
11.19.2021 - START House: HIV 101
12.10.2021 - God's Property: Sexually Transmitted Infections
12.15.2021 - Nuestra Casa: PrEP & PEP

1.4.2022 - God's Property: Hepatitis C
1.14.2022 - House of Uhuru: HIV 101
2.4.2022 - God's Property: HIV 101
3.4.2022 - God's Property: Hepatitis C

Meet our Team

Top row (L-R):
Lawrence Dotson, Michael Murrley, Charles Parker, Dr. Gabriel Edwards

Middle row (L-R):
Dr. Nina Harawa, Dr. Katrina Schrode, Mabel Garcia, Gregory Victorianne, Will Schlesinger

Bottom row (L-R):
Vasthy Amilibia, Charles McWells, Karina Fing, Dr. Rob Weiss, Dr. Charles Hilliard

Stay in touch with us:

Email: mepsprojectla@gmail.com
Phone: (424) 501 - 4829
Address: 11015 Bloomfield Avenue, Santa Fe Springs, CA 90670

Follow us on Instagram and Facebook →

Thank You to our wonderful community partners, our community and research team

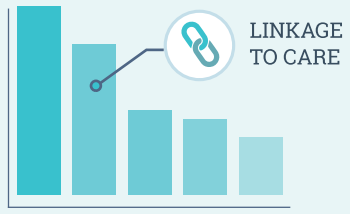
UNIQUE WOMAN'S COALITION @THEUWCOFFICIAL
L.A. CADA A Path to Recovery and Healthy Living
CDU
UCLA David Geffen School of Medicine
God's Property Sober Living Foundation
FRI FRIENDS RESEARCH INSTITUTE

Transitional Care Coordination

From Jail Intake to Community HIV Primary Care

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

Intervention Summary



Collaborations between public health agencies, community-based organizations, and jail health services have implications for public health and safety efforts and have been proven to facilitate linkage to care after incarceration.[1] Medical screenings that happen for all inmates through the jail intake process offer an opportunity to implement such interventions, as do booking processes and intervention intake.[2,3,4] Jordan et al., introduce the concept of "Warm Transitions" as an integral part of implementing their HIV Continuum of Care Model by "applying social work tenets to public health activities for those with chronic health conditions including HIV-infection."[5] Absent "a caring and supportive warm transition approach," pre-existing barriers to care and other stressors that come with the experience of incarceration and cycling in and out of correctional facilities will continue or be exacerbated after incarceration.[6] Without transition assistance, people living with HIV who are released from jails are at risk of unstable housing; lack of access to health insurance and medication; overdose due to period of detoxification; exacerbation of mental health conditions due to increased stress; and lack of social supports, when exposed to the same high risk communities from which they were incarcerated.[7]

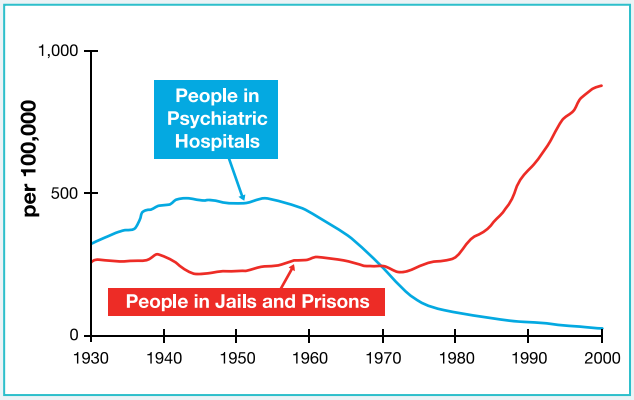
This intervention is intended for organizations, agencies, and individuals considering strengthening connections between community and jail health care systems to improve continuity of care for HIV-positive individuals recently released from jails. The following information is meant to provide an overview of the Transitional Care Coordination intervention to implement a new linkage program to for PLWH to support their care retention and engagement post-incarceration and as they re-enter the community.

Professional Literature

The United States has the highest incarceration rates of any industrialized country in the world.[8,9] Approximately 1 out of every 100 people in the United States is incarcerated;[10] and, if rates persist, 1 in 15 Americans will have been incarcerated at some point in their lives.[11]

The U.S. Criminal Justice System includes Law Enforcement (police, sheriff, highway patrol, FBI, and others), Adjudication (courts), and Corrections (jails, prisons, probation, and parole).[12] Most incarcerated individuals (85%) pass solely through jails. Yet most corrections spending is in state prisons, rather than in jails, which are dependent on local funding.[13,14]

FIGURE 1 **De-Institutionalization?**
Harcourt 2006



If rates persist,

1 in 15

Americans will have been incarcerated at some point in their lives.

Jails are often the *de facto* health provider of last resort where people with low income, mental illness, unstable housing, substance use issues, and a range of social and health problems are concentrated.[15,16] Further, while historic arrest rates tend to mirror the racial and ethnic demographics of the local community, the incarcerated population is predominantly men of color.[17,18]

Prior to jail admission, many individuals may have had barriers to accessing health care and support services due to structural inequalities, including poverty, unstable housing, limited educational attainment, and un- or under- employment.[19,20] Co-occurring health and behavioral health conditions (e.g., substance abuse and mental illness) further exacerbate access to care issues (see also Figure 1).[21,22] Additionally, people are less equipped to address health issues when faced with competing compelling needs related to survival, such as food and shelter.[23] In these same communities, health inequities lead to higher rates of both incarceration and HIV.[24] As a result, public health professionals working in jail settings have a unique opportunity to engage a population living with HIV and not engaged in care, in need of supportive services to access care after incarceration to achieve viral load suppression.[25,26,27]

Jail-based health services treat populations at high risk for acquiring HIV and offer people an opportunity to know their HIV status. They may also provide transitional care coordination to facilitate linkage and re-engagement with the health care system after incarceration.[28,29] Jail-based health services have the opportunity to:

- **Offer universal HIV testing**, particularly in jurisdictions with hyper endemic rates of incarceration, so that the offer of HIV testing in correctional health care settings mirrors that in community health settings;[30]
- **Implement interventions** to prevent HIV transmission among populations that move into, dwell in, or leave correctional facilities, while delivering general interventions that decrease intimate partner/sexual violence, promote harm reduction and medication adherence, and address substance use;
- Ensure that health services in jails follow **international guidelines** for HIV care, including for the management of HIV comorbidities that occur at high frequency in incarcerated populations;
- Promote 2-way, **comprehensive communication** between correctional and community HIV providers to ensure that there are no gaps in care, treatment, and supportive services as people transition to and from their communities and correctional facilities.

The CDC strongly recommends jail-based HIV testing.[31] Routine HIV screening in jails is also consistent with the National HIV/AIDS Strategy.[32] Nonetheless, many HIV positive persons in jails are unaware of their HIV status or were not in HIV primary care at the time of jail admission. The majority of people pass through jail and are never sentenced to prison but return to the communities that they left.[33,21,34] The transition period from incarceration back to the community is known to be a high risk period for: increased deaths,[35] discontinuity of care and treatment (including ART), unstable housing, and opiate overdose. The adverse health outcomes that occur in this high risk period further underscore the need for transitional care coordination and support services.[36,37,28,38] As such, health

departments, local healthcare providers, and community-based organizations have a vested interest in the provision of HIV testing, treatment, and linkage to both care and treatment during and after incarceration. It is useful for health care and correctional staff to view jails as part of the continuum of care rather than independently, since this approach may help encourage strategic retention-in-care planning.

Theoretical Basis

A behavioral change theory is a combination of, "interrelated concepts, definitions, and propositions that present a systematic view of events or situations by specifying relations amount variables, in order to explain or predict the events or situations."[39] By grounding an intervention in theory, the component parts are intentionally sequenced to build off of one another to facilitate a change in health behavior.

The original **Transitional Care Coordination** intervention was grounded in the Transtheoretical Model of Behavior Change (using Stages of Change to lead to behavior change).[40] The Stages of Change framework explains an individuals' readiness to change, and provides strategies at six levels of behavior change (**precontemplation**, **contemplation**, **determination**, **action**, **relapse**, and **maintenance**) to move the individual into adopting the new health behavior. The Transtheoretical Model of Behavior Change builds off of the Stages of Change by adding 10 processes of change that address the process of overcoming barriers, reducing internal resistance to change, and commitment to a new health behavior. These processes are consciousness raising, dramatic relief, self-reevaluation, environmental reevaluation, self-liberation, helping relationships, counter conditioning, reinforcement management, stimulus control, and social liberation. The Model also includes decisional balance (the benefits and costs of changing) and self-efficacy (confidence in the ability to change health behavior and temptation to engage in unhealthy behavior) as core constructs.

Intervention Components and Activities

The central aim of the Care Transitional Coordination intervention is to facilitate the linkage of a client living with HIV to community-based care and treatment services after incarceration. Intervention activities include identifying and engaging people living with HIV during the jail stay, identifying "right fit" community resources, developing a client plan for their time during and post-incarceration, and coordinating activities needed to facilitate linkage to care after incarceration. These activities need to occur quickly because jail stays are often brief and the uncertainty around discharge dates presents a shorter window of opportunity to reach people leaving jail settings.[41]

Transitional Care Coordination includes the following key activities while clients are incarcerated (pre-release):

1. HIV testing or self-disclosure information as well as mental health and substance abuse information after medical intake screening (occurring in the jail);
2. Recruitment (including informed consent) and enrollment into the intervention/program after medical intake screening;
3. Intensive case management intervention and individualized discharge plans (typically, within 24 hours and at least within 48 hours of medical intake);
4. HIV education, including risk reduction and treatment adherence counseling, ongoing during the jail stay;

5. Health Insurance and ADAP assistance for post-release submission;
6. Discharge medications / prescription scripts at the time of jail release, including arrangements for those released from court;
7. Providing a health liaison to the courts, which involves collaboration with court advocates, judges and prosecutors, to provide health information to facilitate placement in community programs (including skilled nursing facility, hospice, drug treatment program) and alternatives to incarceration programs;

Transitional Care Coordination includes the following key activities after the clients are released (post-release):

1. Patient navigation (accompaniment, home visiting, transportation assistance) and re-engagement in care after incarceration;
2. Intensive case management after incarceration to facilitate linkage to care for at least 90 days: address needs for food, clothing, and shelter; verify linkages to HIV primary care within 30 days of returning to the community; address ongoing mental health and substance abuse treatment needs, as assessed; consistent access to health insurance and medication; ongoing care management and social supports after 90 days.

Staffing Requirements

The following staff positions need to be developed and filled in order to successfully implement the intervention.

STAFF TITLE	DESCRIPTION
Linkage staff	
PROJECT MANAGER	The **Project Manager** coordinates all aspects of the intervention with jail and community-based staff and community partners. The Project Manager is responsible for: ▸ being the point of contact for the intervention and providing oversight of the project; ▸ providing administrative supervision to the care coordinators and the data manager; ▸ serving as the health liaison to the courts; and ▸ serving as the liaison with local jail administration, the Dissemination and Evaluation Center (DEC), and the Implementation Technical Assistance Center (ITAC).
CARE COORDINATOR	The care coordinator has five primary responsibilities: patient engagement, patient education, discharge planning, care coordination, and facilitating a warm transition to the community and linking a client to care. ***Patient engagement during incarceration.*** The Care Coordinator is responsible for: ▸ client engagement and assessment during the client's jail stay; and ▸ conducting care coordination with jail- and community-based organizations. ***Patient education.*** The Care Coordinator is responsible for: ▸ providing patient education on HIV, including treatment adherence, risk reduction as well as a range of other health-related topics (e.g. STI, hepatitis, and TB overviews; prevention strategies and safe sex negotiation; relapse prevention; symptoms evaluation, etc.). ***Discharge planning.*** The Care Coordinator is responsible for: ▸ assessing client needs; ▸ developing a plan with client to address basic needs; ▸ identifying resources to facilitate access to community health care; and ▸ scheduling initial linkage appointment.

	Care coordination for care upon release. The Care Coordinator is responsible for: ▸ completing patient assessment and discharge plan to initiate the process of coordinating care upon release, meeting the person in jail and initiating follow-up to verify linkage to care after incarceration; ▸ arranging discharge medications and prescriptions; and ▸ obtaining consent to collaborate with external entities and individuals (e.g. community health providers, social service programs, courts). ***Facilitating a warm transition to the community and linking a client to care.*** The care coordinator is responsible for: ▸ accompanying individuals who are newly released to appointments to ensure connection to care; ▸ coordinating community-based HIV care linkage services; ▸ providing home visits, appointment accompaniment, or transportation; ▸ conducting, arranging, or coordinating outreach activities to find individuals who fall out of care and facilitate re-engagement in community care; ▸ assessing and addressing basic needs like housing, food, clothing, etc.; and ▸ transitioning the client to the standard of care after 90 days post-incarceration.
CLINICAL SUPERVISOR	The **Clinical Supervisor** is responsible for: ▸ Participating in case conferencing (as needed); ▸ Providing monthly (or as requested) individual clinical supervision to care coordinators; and ▸ Providing monthly group clinical supervision to intervention team (as needed)
DATA MANAGER	This position is responsible for: ▸ Consenting patients into the study; ▸ Collecting and submitting data required for multi-site evaluation; ▸ Coordinating the collection of patient surveys, encounter forms, basic chart data abstraction, and implementation measures, and reporting them to the Dissemination and Evaluation Center (DEC); and ▸ Providing quality assurance reports and updates to intervention team about study referrals, enrollment retention, etc.
Staff Characteristics	
	All staff involved in the intervention need to be: ▸ able to deliver **culturally appropriate** services. ▸ **non-judgmental** and demonstrate empathy, professionalism, boundaries around personal philosophy/belief systems. ▸ genuinely **interested in working** with people incarcerated in jails. ▸ **reflective of racial and ethnic backgrounds** of client population with language ability as appropriate to meet client needs (as practicable). ▸ able to meet Department of Corrections' **security clearance** criteria. ▸ willing to conform to Department of Corrections' **policies** and are cognizant of **guidelines** regarding justice-involved persons working in jail.

Programmatic Requirements

The following are programmatic requirements that need to be addressed prior to implementation (prior to enrollment of clients in the jails) in order to facilitate a successful implementation:

- Establish relationships with the Jail and Department of Corrections to insure ongoing cooperation and support throughout implementation.
  - Assess what related work is already taking place within the jail.
  - Receive clearance for intervention implementation. Understand what materials and resources are or are not permissible within the jail and plan your program accordingly (for example, some jails do not allow laptops inside).
  - Invite corrections to join the collaboration and obtain a commitment for correction officers to provide escort services. Ideally assigned and dedicated officers will work in partnership with the team.
  - Negotiate for dedicated space to conduct intervention activities. Appropriate work space is essential to maintain patient confidentiality.
  - Determine role of jail security staff in project implementation and involve them in planning.
- Visit jail facilities to conduct a flow analysis. Walk through the health services unit and other relevant spaces to learn where services are delivered to identify space amenable to your program.
- Strengthen existing relationships with community-based organizations that are willing to work with HIV-positive individuals leaving jail.
  - Address need for telephone or in-person case conferences with community-based organizations during the jail stay (to facilitate a warm transition).
  - Develop mutual Memorandum of Understanding (MOU) Linkage Agreement with each community partner that includes a commitment to provide data that verifies linkage to care.
  - Assess organizational capacity at community-based organizations to insure their ability to consistently provide culturally competent transitional social supports to each inmate post-incarceration.
- Identify how access to health records and any Electronic Health Record (EHR) systems (including RSR data).
  - Establish a process for communication and information sharing of participating Ryan White care providers during and post-incarceration to streamline the client process and activities each client engages in. Providers should be prepared to address the operational issues involved in working with multiple jail-based and community-based providers of health care as patients are frequently transferred among jails, between jails and prisons, from jail to court, and from jail to the community.
- Additionally, DEII performance sites must assess their capacity to conduct process and outcome evaluation activities during the funding period.

Costs

The SPNS Jail Linkages projects were deemed cost-effective from a societal perspective[42] with an average cost per client at $4,219. In an analysis of nine sites, the mean cost to sustain linkage to care post-incarceration for 6 months was $4,670.[43] Health outcomes impacting costs (reductions in ED use and self reported unstable housing and hunger when compared to themselves at baseline and at 6 Month follow up) were found under the Transitional Care Coordination intervention including a reduction in emergency department use and homeless shelter stays[13, 14]

Resources

OVERVIEW OF PRIOR SPNS INITIATIVES

- Enhancing Linkages to HIV Primary Care and Services in Jail Settings
  www.hab.hrsa.gov/abouthab/special/carejail.html
- Enhancing Linkages: Opening Doors for Jail Inmates. *What's Going on @ SPNS*:
  www.hab.hrsa.gov/abouthab/files/cyberspns_enhancing_linkages_may_2008.pdf
- HRSA Consultation Meeting. Enhancing Linkages to HIV Primary Care in Jail Settings:
  www.hab.hrsa.gov/abouthab/files/enhancinglinkages.pdf
- HRSA/CDC *Opening Doors: Corrections Demonstration Project for People Living with HIV/AIDS:*
  www.hab.hrsa.gov/abouthab/files/openingdoors.pdf

CREATING A JAIL LINKAGE PROGRAM: TOOLS FROM THE INTEGRATING HIV INNOVATIVE PRACTICES PROGRAM

- Training Manual:
  https://careacttarget.org/library/creating-jail-linkage-program-training-manual-0
- Curriculum: https://careacttarget.org/library/creating-jail-linkage-program-curriculum-manual
- Pocket Guide: https://careacttarget.org/library/best-practices-hiv-interventions-jails-pocket-guide
- Webinar series: https://careacttarget.org/library/hiv-and-jails-public-health-opportunity

EVALUATION RESOURCES

- Enhancing Linkages to HIV Primary Care and Services in Jail Settings implementation guide and evaluation instruments www.enhancelink.org

PEER-REVIEWED ARTICLES PROVIDING BACKGROUND INFORMATION ON WORKING IN JAILS AND LINKING INMATES TO CARE

- Adherence to HIV Treatment and Care among Previously Homeless Jail Detainees.
  www.ncbi.nlm.nih.gov/pmc/articles/PMC3325326/
- Contribution of Substance Use Disorders on HIV Treatment Outcomes and Antiretroviral Medication Adherence Among HIV-Infected Persons Entering Jail.
  www.ncbi.nlm.nih.gov/pmc/articles/PMC3818019/

- Correlates of Retention in HIV Care after Release from Jail: Results from a Multi-site Study. www.ncbi.nlm.nih.gov/pmc/articles/PMC3714328/
- An Exploration of Community Reentry Needs and Services for Prisoners: A Focus on Care to Limit Return to High Risk Behavior. www.ncbi.nlm.nih.gov/pubmed/21663540
- Gender Disparities in HIV Treatment Outcomes Following Release From Jail: Results From a Multicenter Study. www.ncbi.nlm.nih.gov/pmc/articles/PMC3953795/
- Gender Differences in Baseline Health, Needs at Release, and Predictors of Care Engagement Among HIV-positive Clients Leaving Jail. www.ncbi.nlm.nih.gov/pmc/articles/PMC3758427/
- Health outcomes for HIV-infected persons released from the New York City jail system with a transitional care-coordination plan. www.ncbi.nlm.nih.gov/pubmed/25521890
- Jail: Time for Testing. Yale University School of Medicine www.enhancelink.org/EnhanceLink/documents/Jail%20-%20Time%20for%20Testing.pdf
- Linking HIV-positive Jail Inmates to Treatment, Care, and Social Services After Release: Results from a Qualitative Assessment of the COMPASS Program. www.ncbi.nlm.nih.gov/pmc/articles/PMC3005089/
- Post-Release Substance Abuse Outcomes among HIV-infected Jail Detainees: Results from a Multisite Study. www.ncbi.nlm.nih.gov/pmc/articles/PMC3600070/
- Rapid HIV Testing in Rapidly Released Detainees: Next Steps. http://journals.lww.com/stdjournal/Fulltext/2009/02001/Rapid_HIV_Testing_In_Rapidly_Released_Detainees_.9.aspx#
- Transitional Care Coordination in New York City Jails: Facilitating Linkages to Care for People with HIV Returning Home from Rikers Island. www.ncbi.nlm.nih.gov/pubmed/23128979
- Understanding the Revolving Door: Individual and Structural-level Predictors of Recidivism Among Individuals with HIV Leaving Jail. www.ncbi.nlm.nih.gov/pmc/articles/PMC4049299/

SOURCES

[1]Jordan AO. Linkages and Care Engagement: From NYC Jail to Community Provider. New York State Department of Health AIDS Institute, End of AIDS and the Criminal Justice System. September 16, 2015 [webinar]. Available at: www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/webinar_series/cjs/linkages_and_care.pdf.

[2]Flanigan TP, Zaller N, Beckwith CG, et al. Testing for HIV, sexually transmitted infections, and viral hepatitis in jails: still a missed opportunity for public health and HIV prevention. *JAIDS (Suppl)*. 2010;55(2): S78–83.

[3]Emory University Rollins School of Public Health. Enhancing linkages to HIV primary care and services in jail settings initiative: linkage to social support services. *Policy Brief*. Spring 2010. Available at: https://careacttarget.org/sites/default/files/file-upload/resources/EnhanceLinkPolicyBriefs.pdf.

[4]Teixeira PA, Jordan AO, Zaller N, et al. Health outcomes for HIV-infected persons released from the New York City jail system with a transitional care-coordination plan. *Am J Public Health*. 2015 Feb;105(2):351–7.

[5]Jordan AO, Cohen LR, Harriman G, et al. Transitional Care Coordination in New York City Jails: Facilitating Linkages to Care for People with HIV Returning Home from Rikers Island. *JAIDS (Suppl)*. 2013;(2); S212–219.

[6]Jordan AO, Cohen LR, Harriman G, et al. Transitional Care Coordination in New York City Jails: Facilitating Linkages to Care for People with HIV Returning Home from Rikers Island. *JAIDS (Suppl)*. 2013;(2); S212–219.

[7]Rapp RC, Ciomcia R, Zaller N, et al. The role of jails in engaging PLWHA in care: from jail to community. *AIDS Behav.* 2013 Oct; 17(0 2): S89–S99.

[8]Draine J, Ahuja D, Altice FL, et al. Strategies to enhance linkages between care for HIV/AIDS in jail and community settings. *AIDS Care*. 2011;23(3):366–77.

[9]Walmsley R. *World Prison Population List*, 2009 (8th ed.), United Kingdom Home Office Research. Available at: www.apcca.org/uploads/8th_Edition_2009.pdf

[10]Warren J, Belb A, Horowitz J, et al. *One in 100: Behind Bars in America 2008*. Washington, DC: The Pew Charitable Trusts, Public Safety Performance Project. 2008.

[11]HRSA, HAB. Enhancing linkages: opening doors for jail inmates. *What's Going on @ SPNS*. May 2008. Available at: hab.hrsa.gov/abouthab/files/cyberspns_enhancing_linkages_may_2008.pdf.

[12]Zack B, Hane L At the Nexus of Correctional Health and Public Health: Policies and Practice, American Public Health Association Annual Meeting. 2015 [Presentation]

[13]Zack B, Hane L At the Nexus of Correctional Health and Public Health: Policies and Practice, American Public Health Association Annual Meeting. 2015 [Presentation]

[14]Draine J, Ahuja D, Altice FL, et al. Strategies to enhance linkages between care for HIV/AIDS in jail and community settings. *AIDS Care*. 2011;23(3):366–77.

[15]Spaulding AC, Perez SD, Seals RM, et al. Diversity of release patterns for jail detainees: implications for public health interventions. *Am J of Public Health (Suppl).* 2010; 1010(1): S347–52.

[16]Draine J, Ahuja D, Altice FL, et al. Strategies to enhance linkages between care for HIV/AIDS in jail and community settings. *AIDS Care*. 2011; 23(3):366–77.

[17]Drug Policy Alliance. *The Drug War, Mass Incarceration and Race.* June 2015. Available at: www.drugpolicy.org/sites/default/files/DPA_Fact_Sheet_Drug_War_Mass_Incarceration_and_Race_June2015.pdf

[18]Muhammad KG. The Condemnation of Blackness: Race, Crime, and the Making of Modern Urban America. Cambridge, MA: Harvard; 2011.

[19]Kushel MB, Hahn JA, Evans JL, et al. Revolving doors: imprisonment among the homeless and marginally housed populations. *Am J Public Health*. 2005;95: 1747–52.

[20]Centers for Disease Control and Prevention. *HIV Testing Implementation Guidance for Correctional Settings*. January 2009: 1–38. Available at: www.cdc.gov/hiv/pdf/risk_correctional_settings_guidelines.pdf.

[21]Harcourt, BE. From the Asylum to the Prison: Rethinking the Incarceration Revolution. Texas Law Review. 2006; 84:175. Available at: www.law.uchicago.edu/files/file/harcourt_institutionalization_final.pdf.

[22]Metzl JM. *The Protest Psychosis: How Schizophrenia Became a Black Disease*. Boston, MA: Beacon Press; 2010.

[23]Zellman H. Philadelphia FIGHT Institute for Community Justice. Establishing the need for an intervention program. 2012. [Unpublished]

[24]Flanigan TP, Zaller N, Beckwith CG, et al. Testing for HIV, sexually transmitted infections, and viral hepatitis in jails: still a missed opportunity for public health and HIV prevention. *JAIDS (Suppl)*. 2010;55(2): S78–83.

[25]Flanigan TP, Zaller N, Beckwith CG, et al. Testing for HIV, sexually transmitted infections, and viral hepatitis in jails: still a missed opportunity for public health and HIV prevention. *JAIDS (Suppl).* 2010;55(2): S78–83.

[26]Draine J, Ahuja D, Altice FL, et al. Strategies to enhance linkages between care for HIV/AIDS in jail and community settings. *AIDS Care.* 2011; 23(3):366–77.

[27]Teixeira PA, Jordan AO, Zaller N, et al. Health outcomes for HIV-infected persons released from the New York City jail system with a transitional care-coordination plan. *Am J Public Health*. 2015 Feb; 105(2): 351–7.

[28]Spaulding AC, Perez SD, Seals RM, et al. Diversity of release patterns for jail detainees: implications for public health interventions. *Am J Public Health (Suppl)*. 2010; 1010(1): S347–52.

[29]Emory University Rollins School of Public Health. Enhancing linkages to HIV primary care and services in jail settings initiative: linkage to social support services. *Policy Brief.* Spring 2010. Available at: careacttarget.org/sites/default/files/file-upload/resources/EnhanceLinkPolicyBriefs.pdf.

[30]Centers for Disease Control and Prevention. HIV Testing Implementation Guidance for Correctional Settings. January 2009: 1–38. Available at: www.cdc.gov/hiv/pdf/risk_correctional_settings_guidelines.pdf.

[31]deVoux A, Spaulding AC, Beckwith C, et al. Early identification of HIV: empirical support for jail-based screening. *PLos One.* 2012;7(5):1–7.

[32]deVoux A, Spaulding AC, Beckwith C, et al. Early identification of HIV: empirical support for jail-based screening. *PLos One.* 2012;7(5):1–7.

[33]Spaulding AC, Seals RM, Page MJ, et al. HIV/AIDS among inmates of, and releasees from, U.S. correctional facilities, 2006: declining share of epidemic but persistent public health opportunity. *PLos One*. 2009;4(11):1–8.

[34]Emory University Rollins School of Public Health. Enhancing linkages to HIV primary care and services in jail settings initiative: linkage to social support services. *Policy Brief*. Spring 2010. Available at: careacttarget.org/sites/default/files/file-upload/resources/EnhanceLinkPolicyBriefs.pdf.

[35]Teixeira PA, Jordan AO, Zaller N, et al. Health outcomes for HIV-infected persons released from the New York City jail system with a transitional care-coordination plan. *Am J Public Health*. 2015 Feb; 105(2): 351–7.

[36]International Advisory Panel on HIV Care Continuum Optimization. IAPAC Guidelines for Optimizing the HIV Care Continuum for Adults and Adolescents. *J Int Assoc Provid AIDS Care*. 2015;1–32.

[37]Wohl DA, Scheyett A, Golin CE, et al. Intensive case management before and after prison release is no more effective than comprehensive pre-release discharge planning in linking HIV-infected prisoners to care: a randomized trial. *AIDS Behav*. 2011 Feb;15(2):356–64.

[38]deVoux A, Spaulding AC, Beckwith C, et al. Early identification of HIV: empirical support for jail-based screening. *PLos One.* 2012;7(5):1–7.

[39]Glanz K, Rimer BK, Viswanath K. *Health Behavior and Health Education: Theory, Research and Practice* (4th Edition). San Francisco, CA: Jossey-Bass; 2008. P. 26.

[40]Prochaska JO, Velicer, WF. The Transtheoretical Model of Health Behavior Change. *Am J Health Promot.* September/October 1997;12(1); 38–48.

[41]Nunn A, Cornwall A, Fu J, et al. Linking HIV-positive jail inmates to treatment, care, and social services after release: results from a qualitative assessment of the COMPASS Program. *J Urban Health.* 2010;87(6): 954–68.

[42]Spaulding AC, Pinkerton SC, Superak H, et al. Cost analysis of enhancing linkages to HIV care following jail: a cost-effective intervention. *AIDS Behav (Suppl).* 2013;(2); S220–6.

[43]Spaulding AC, Pinkerton SC, Superak H, et al. Cost analysis of enhancing linkages to HIV care following jail: a cost-effective intervention. *AIDS Behav (Suppl)*. 2013;(2); S220–6.