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STANDARDS AND BEST PRACTICES COMMITTEE

Virtual Meeting

Tuesday, November 2, 2021

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

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

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

STANDARDS AND BEST PRACTICES COMMITTEE

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

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

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or Dial

1-415-655-0001

Event Number/Access code: 2599 958 0456

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

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

AGENDA POSTED: October 29th, 2021

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, please click here.

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

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

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

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

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

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

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

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

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

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

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

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

IV. REPORTS

5. Executive Director/Staff Report 10:15 AM – 10:30 AM
- a. Commission and Committee Updates
- b. Cal AIM Updates
- c. Special Population Best Practices Template Update

6. Co-Chair Report 10:30 AM – 11:00 AM
- a. 2021 Workplan Review & Opportunities to Support Task Forces/Caucuses
- b. Committee Chair Nominations
- c. Oral Health Service Standards Review Meeting Updates
- d. "So, You Want to Talk About Race" by I. Oluo Reading Activity
  - o Brief Excerpts Only- from Chapters 14 or 15

7. Division of HIV & STD Programs (DHSP) Report 11:00 AM – 11:15 AM
- a. Benefits Specialty Summary Document

V. DISCUSSION ITEMS

8. Service Standards Development 11:15 AM – 11:45 AM
- a. Substance Use Disorder & Residential Treatment Service Standards Review
- b. Benefits Specialty Service Standard Review

VI. NEXT STEPS 11:45 AM – 11:55 AM

9. Tasks/Assignments Recap

10. Agenda development for the next meeting

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

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

VIII. ADJOURNMENT 12:00 PM

12. Adjournment for the virtual meeting of November 2, 2021.

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

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 10/21/21

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

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

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
GRANADOS	**Grissel**	Children's Hospital Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transitional Case Management-Youth
			Promoting Healthcare Engagement Among Vulnerable Populations
GREEN	**Joseph**	Unaffiliated consumer	No Ryan White or prevention contracts
GREEN	**Thomas**	APAIT (aka Special Services for Groups)	HIV Testing Storefront
			Mental Health
			Transportation Services
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
LEE	**David**	Charles R. Drew University of Medicine and Science	HIV Testing Storefront
			HIV Testing Social & Sexual Networks
MARTINEZ	**Eduardo**	AIDS Healthcare Foundation	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Medical Care Coordination (MCC)
			Mental Health
			Oral Healthcare Services
			STD Screening, Diagnosis and Treatment
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
			Medical Subspecialty
			HIV and STD Prevention Services in Long Beach

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MARTINEZ (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
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 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
PERÉZ	**Mario**	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee
PRECIADO	**Juan**	Northeast Valley Health Corporation	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Medical Care Coordination (MCC)
			Oral Healthcare Services
			Mental Health
			Biomedical HIV Prevention
			STD Screening, Diagnosis and Treatment
			Transportation Services
RAY	**Joshua**	Unaffiliated consumer	No Ryan White or prevention contracts
ROBINSON	**Mallery**	No Affiliation	No Ryan White or prevention contracts
RODRIGUEZ	**Isabella**	No Affiliation	No Ryan White or prevention contracts
ROSALES	**Ricky**	City of Los Angeles AIDS Coordinator	No Ryan White or prevention contracts
SATTAH	**Martin**	Rand Schrader Clinic LA County Department of Health Services	Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)

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
STEVENS	**Reba**	No Affiliation	No Ryan White or prevention contracts
THOMAS	**Damone**	No Affiliation	No Ryan White or prevention contracts
VALERO	**Justin**	California State University, San Bernardino	No Ryan White or prevention contracts
VEGA	**Rene**	Via Care Community Clinic	Biomedical HIV Prevention
VELAZQUEZ	**Guadalupe**	Unaffiliated consumer	No Ryan White or prevention contracts
WALKER	**Ernest**	Men's Health Foundation	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services

DRAFT

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

STANDARDS AND BEST PRACTICES (SBP) COMMITTEE MEETING MINUTES

October15, 2021

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

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

Meeting agenda and materials can be found on the Commission's website at
http://hiv.lacounty.gov/LinkClick.aspx?fileticket=FypbBq9FNMg%3d&portalid=22

CALL TO ORDER-INTRODUCTIONS-CONFLICT OF INTEREST STATEMENTS: The meeting to order at 10:00 am.

I. ADMINISTRATIVE MATTERS

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

2. **APPROVAL OF MEETING MINUTES**
   MOTION #2: Approve the 09/07/2021 Standards and Best Practices (SBP) Committee meeting minutes, as presented ***(Passed by Consensus)***.

II. PUBLIC COMMENT

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

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

4. **OPPORTUNITY FOR COMMISSIONERS TO RECOMMEND ITEMS FOR FUTURE AGENDAS, OR ITEMS REQUIRING IMMEDIATE ACTION DUE TO AN EMERGENCY, OR IF NEED FOR ACTION AROSE AFTER POSTING AGENDA**: Justin Valero recommended to reopen discussion about identifying strategies for the Commission on HIV (COH) to engage private providers and private healthcare organizations.

IV. REPORTS

5. **EXECUTIVE DIRECTOR/STAFF REPORT**
Cheryl Barrit, Executive Director (ED) reported the following.
   - C. Barrit shared that on September 16th, the Governor signed Assembly Bill 361 which extended the ability of planning bodies to continue to meet virtually. The COH will continue meeting virtually thru the remainder of 2021, including the Annual Meeting taking place on Thursday November 18th.
   - C. Barrit noted that the COH Comprehensive HIV plan update is due to the Federal Government by mid-December 2022. The COH will work with a consultant, former Commissioner AJ King, to assist with writing the COH Comprehensive HIV plan. The Planning, Priorities, and Allocations (PP&A) Committee will lead the planning efforts and the PP&A co-chairs will request feedback from the different COH groups in the coming weeks. The COH Comprehensive HIV plan is a programmatic document for Local Health Jurisdictions to help inform how programs for prevention, care, and treatment would be designed and evaluated within each County.
   - C. Barrit mentioned that at the last Executive Committee meeting, Mario Perez, the director of the Division of HIV and STD Programs (DHSP) made an appeal to have the Standards and Best Practices (SBP) Committee complete a rapid review and refinement of a specific section of the existing oral health care Standards. The inquiry originated from reports by former commissioner Dr. Fariba Younai noting the use of exclusion criteria for oral health care services by some Ryan White funded agencies. The SBP committee recommended to have a smaller group conduct a review of the Oral Health Service Standards and address the issues presented. The group will be composed of SBP committee member Dr. Mintline, co-chairs Kevin Stalter and Erika Davies, 1 or 2 agencies receiving oral health care funding, Dr. Younai, and DHSP staff member Paulina Zamudio along with other DHSP staff.
   - J. Rangel-Garibay shared updates to the Special Populations Best Practices for HIV Prevention and Care document which now includes a background information section and an outline of the framework for the best practice compilation process. The document is included in the meeting packet.
   - C. Barrit noted that this document is in response to requests from multiple committees and multiple subgroups of the COH interested in engaging in an active partnership with the SBP committee by creating best practices. She explained that the intended purpose of this exercise is to elicit a set of best practices for the key target populations that have been identified in Los Angeles County. The initial outline was presented last month, and the main feedback was to add more background and a clear standardized set of questions.
   - COH staff will assist with presenting the framework and collect information the various COH subgroups and share with the SBP committee on an ongoing basis.

6. **CO-CHAIR REPORT**
   a. **2021 Workplan Review & Opportunities to Support Task Forces and Caucuses**
      - No updates were shared.

   b. **November and December Holiday Meeting Schedule**
      - The COH Annual Meeting will take place on Thursday November 18th.
      - Committee Co-chair nominations will take place during the November meetings for all COH committees. Voting will take place during the December meeting. Reba Stevens asked a question regarding term limits for Committee Co-chairs and K. Stalter clarified that there are no term limits in place. C. Barrit added that the policy for running for Committee Co-chair position is to have served in the Committee of interested in at least 12 months.
      - The SBP Committee meetings will proceed as planned on November 2nd, December 7th, and January 4th, 2022.

   c. **Committee Member Introductions/Getting to Know You**

- SBP Committee member Dr. Mark Mintline and COH staff member Jose Rangel-Garibay introduced themselves to the group.
- J. Rangel-Garibay joined the COH in May 2021 and completed undergrad in New Orleans, LA and earned an MPH from the Tulane University School of Public Health and Tropical Medicine. During undergrad, he completed an independent research project focused on HIV prevention social marketing campaigns in Salvador, Bahia, Brazil. He worked with the American Diabetes Association where he assisted with diabetes prevention programming. He later worked at Planned Parenthood of Orange and San Bernardino Counties where he led sexual and reproductive health classes for middle and high school youth. Most recently, he was a Health Educator with the Tuberculosis Control Program at the Los Angeles County Department of Public Health. Outside of work he enjoys playing video games, teaching Zumba fitness classes, and taking a good nap.
- Mark Mintline is a dentist and oral pathologist at Western University College of Dental Medicine in Pomona, California. He completed dental school at UCLA and was student to Dr. Fariba Younai. He completed a residency in oral maxillofacial pathology at the University of Florida. Later, he was a general dentist with the Indian Health Services in Northern California. He is now an Assistant Professor at Western University. He joined the COH he recently started the Ryan White Part F program at Western University and wanted to become more involved to increase access to care for oral health services at Western University. Outside of work, he enjoys baking and spending time with his nieces on his free time.

d. "So, You Want to Talk About Race" by I. Oluo Reading Activity

- E. Davies volunteered to read an excerpt from chapter 12 referring to the topic of microaggressions.
- Reba Stevens suggested to pause for a moment after the reading and allow time for meeting attendees to share their thoughts and reactions to the reading.
- G. Granados shared that it is not always easy to speak up because there are times when she has experienced microaggressions and does not realized until later.
- R. Stevens shared her experience in recognizing the discomfort brought on from having uncomfortable conversations around microaggressions that are necessary and examining her own role in the situation.
- Ernest Walker shared his experience in distinguishing between being of member of the same race and holding similar beliefs or assuming that all members of the same race hold the same beliefs. He also stressed setting boundaries in the workplace to help navigate conversations about sensitive topics with others.
- R. Stevens highlighted the notion that people should consider the reading through perspectives beyond the examples of white on black racism expressed in the book. She also shared her gratitude for having the time to share her reflections with the group.

7. Division of HIV & STD Programs (DHSP) Report

- Lisa Klein provided an overview of the most recent data dashboards DHSP created for the services of Ambulatory Outpatient Medical (AOM) services, Medical Care Coordination (MCC), Oral Health, and Benefit Specialty Services (BSS). The dashboards were created to meet the clinical quality requirements of the Ryan White Program and are included in the meeting packet. L. Klein shared that the Clinical Quality Management (CQM) committee at DHSP is working on stratifying the data presented on the dashboards by service provider to further engage the agency in quality improvement projects as needed.
- Wendy Garland added that future dashboards will be more agency specific with the intent to identify disparities in care engagement, retention, and viral suppression outcomes. She also noted that the MCC dashboards show that there were lower outcomes for engagement, retention, and viral suppression categories compared to Ryan White overall and this is generally the case because this service is targeted to reach folks who are having difficulty engaging in care or achieving viral suppression.
- Harold San Agustin added that comparing performance measures between the homeless population and the overall Ryan White population allowed JWCH to advocate for services that were oriented towards the homeless population.

V. DISCUSSION ITEMS

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

- **a.** C. Barrit noted that the COH staff did not receive any public comment for the Substance Use Disorder and Residential Treatment Service Standards and expressed concern for approving the standards without receiving feedback from DHSP staff.
- **b.** E. Davies recommended to postpone approval of the Substance Use Disorder and Residential Treatment Services Standards of Care.

9. Benefits Specialty Service Standard Review

- **a.** J. Rangel-Garibay presented the reformatted draft of the Benefits Specialty Standards of Care for committee to review. The main changes include eliminating repetitive elements in the previous version and reformatting the document to match recently approved service standards. He noted that Table 1 included a list of the different benefit specialty services and requested for feedback from the SBP committee to refine the list. This document is included in the meeting packet.
- **b.** E. Davies suggested to display Table 1 as a single-column bulleted list instead of a two-column table for clarity and to change “food stamps” to “CalFresh”. She also suggested to include a note regarding ADAP and OAHIPP to increase consumer awareness of those services since they will be removed form the list in Table 1 given that they are not included in Benefit Specialty Services contracts.
- **c.** E. Barrit suggested for Benefits Specialty Service providers and consumers to share a list of services that are being requested are either not included on the draft list or are not necessarily medical services but help support consumers.
- **d.** H. San Agustin suggested adding a component about transportation and assistance with transportation to medical appointments, as well as include a component about linkage to care and rapid starts. He also noted that DHSP contracts do not stipulate that outreach hours count as a reimbursable unit of service and recommended to include outreach hours as a reimbursable unit of service.
- **e.** E. Davies recommended removing the “unit of service” and “number of clients” language on the basis that it sounds contractual and beyond the scope of the COH. She also suggested removing the Memorandum of Understanding (MOU) requirement under the Documentation column for the Outreach service component.
- **f.** W. Garland noted that some time ago there was an effort to develop service standards for linkage to care services, but it stalled due a lack of consensus on the components for the standalone standard.
- **g.** Claudia Martinez asked: how can clients, providers, and agencies get involved for everyone to truly understand what is needed? COH staff will follow-up with Claudia with information on ways to engage with the COH and its various committees and other opportunities to participate in the local HIV planning process.
- **h.** E. Davies suggested reviewing the Staffing Development and Enhancement Activities section to reflect the discussion around utilizing staff with lived experience to provide services.
- **i.** COH staff will address the suggestions made during the meeting and incorporate changes as need.

VI. NEXT STEPS

a. **TASK/ASSIGNMENTS RECAP**:

- COH staff will request feedback from SBP committee members on the second iteration of the Special Population Best Practices template document.
- COH staff will review the suggestions made during the meeting and incorporate changes as needed for the Benefits Specialty Standards of Care.
- COH staff will request feedback from DHSP staff for the Substance Use and Residential Treatment Standards.
- COH staff will add Committee Co-chair nominations to the agenda and include the Co-chair Duty Statements to the November meeting packet.
- COH staff will follow-up with DHSP and partners to schedule a meeting to discuss the Oral Health service standard inquiry.
- COH staff will prepare a draft change document for the Home-based case management service standard review process.

12. AGENDA DEVELOPMENT FOR NEXT MEETING:

- Nomination of Committee Co-chairs.
- Continue the Benefits Specialty Service standards of care review.
- Report back any updates on the Special Population Best Practices template document.
- Report back any updates on the Oral Health service standard inquiry.
- Initiate the Home-based case management service standard review process.

VII. ANNOUNCEMENTS

13. **OPPORTUNITY FOR PUBLIC AND COMMITTEE TO MAKE ANNOUNCEMENTS**: E. Davies mentioned that on Monday October 11, the City of Pasadena will be celebration National Coming Out Day at Memorial Park. The outdoor event will feature Drag Queen story time, guest speakers sharing their coming out stories, community drawings and outreach tables from different local LGBTQ+ serving organizations. The event will start at 6:00 pm and end at 8:00 pm.

VIII. ADJOURNMENT

14. **ADJOURNMENT**: The meeting adjourned at 11:57 am.

State of California—Health and Human Services Agency
Department of Health Care Services

RICHARD FIGUEROA
ACTING DIRECTOR

GAVIN NEWSOM
GOVERNOR

California Advancing and Innovating Medi-Cal (CalAIM)
High Level Summary

The Department of Health Care Services (DHCS) has developed a framework for the upcoming waiver renewals that encompasses broader delivery system, program and payment reform across the Medi-Cal program, called CalAIM: California Advancing and Innovating Medi-Cal. CalAIM advances several key priorities of the Administration by leveraging Medicaid as a tool to help address many of the complex challenges facing California's most vulnerable residents, such as homelessness, insufficient behavioral health care access, children with complex medical conditions, the growing number of justice-involved populations who have significant clinical needs, and the growing aging population. This proposal recognizes the opportunity to provide for non-clinical interventions focused on a whole-person care approach via Medi-Cal that target social determinants of health and reduce health disparities and inequities. Furthermore, the broader system, program, and payment reforms included in CalAIM allow the state to take a population health, person-centered approach to providing services and puts the focus on improving outcomes for all Californians. Attaining such goals will have significant impact on an individual's health and quality of life, and through iterative system transformation, ultimately reduce the per-capita cost over time. DHCS intends to work with the Administration, Legislature and our other partners on these proposals and recognizes the important need to discuss these issues and their prioritization within the state budget process. These are initial proposals whose implementation will ultimately depend on whether funding is available.

Background and Overview

Medi-Cal has significantly expanded and changed over the last ten years, most predominantly because of changes brought by the Affordable Care Act and various federal regulations as well as state-level statutory and policy changes. During this time, the DHCS has also undertaken many initiatives and embarked on innovative demonstration projects to improve the beneficiary experience. In particular, DHCS has increased the number of beneficiaries receiving the majority of their physical health care through Medi-Cal managed care plans. These plans are able to offer more complete care coordination and care management than is possible through a fee-for-service system. They can also provide a broader array of services aimed at stabilizing and supporting the lives of Medi-Cal beneficiaries.

Depending on the needs of the beneficiary, some may need to access six or more separate delivery systems (managed care, fee-for-service, mental health, substance use disorder, dental, developmental, In Home Supportive Services, etc.). As one would expect, need for care coordination increases with greater system fragmentation, greater clinical complexity, and/or decreased patient capacity for coordinating their own care. Therefore, in order to meet the behavioral, developmental, physical, and oral health needs of all members in an integrated, patient centered, whole person fashion, DHCS is seeking to integrate our delivery systems and

align funding, data reporting, quality and infrastructure to mobilize and incentivize towards common goals.

To achieve such outcome, CalAIM proposals offer the solutions to ensure the stability of Medi-Cal program and allows the critical successes of waiver demonstrations such as Whole Person Care, the Coordinated Care Initiative, public hospital system delivery transformation, and the coordination and delivery of quality care to continue and be expanded to all Medi-Cal enrollees. CalAIM seeks to build upon past successes and improve the entire continuum of care across Medi-Cal, ensuring the system more appropriately manages patients over time through a comprehensive array of health and social services spanning all levels of intensity of care, from birth to end of life. To do this, we must change the expectations for our managed care and behavioral health systems. Holding our delivery system partners accountable for a set of programmatic and administrative expectations is no longer enough. We must provide a wider array of services and supports for complex, high need patients whose health outcomes are in part driven by unmet social needs and make system changes necessary to close the gap in transitions between delivery systems, opportunities for appropriate step-down care and mitigate social determinants of health, all hindering the ability to improve health outcomes and morbidity.

Key Goals

CalAIM has three primary goals:

- Identify and manage member risk and need through Whole Person Care Approaches and addressing Social Determinants of Health;
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
- Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform.

The reforms of CalAIM are comprehensive and critical to the success of the delivery system transformation necessary to improve the quality of life for Medi-Cal members as well as long-term cost savings/avoidance that will not be possible to achieve absent these initiatives. Furthermore, these reforms are interdependent and build off one another; without one, the others are not either possible or powerful. Below is an overview of the various proposals and recommendations that make up CalAIM.

Identify and Manage Member Risk and Need through Whole Person Care Approaches and Addressing Social Determinants of Health

- Require plans to submit local population health mangement plans.
- Implement new statewide enhanced care management benefit.
- Implement in lieu of services (e.g. housing navigation/supporting services, recuperative care, respite, sobering center, etc.).
- Implement incentive payments to drive plans and providers to invest in the necessary infrastructure, build appropriate enhanced care management and in lieu of services capacity statewide.
- Evaluate participation in Institutions for Mental Disease Serious Mental Illness/Serious Emotional Disturbance Section 1115 Expenditure Waiver.
- Require screening and enrollment for Medi-Cal prior to release from county jail.

- Pilot full integration of physical health, behavioral health, and oral health under one contracted entity in a county or region.
- Develop a long-term plan for improving health outcomes and delivery of health care for foster care children and youth.

Moving Medi-Cal to a More Consistent and Seamless System by Reducing Complexity and Increasing Flexibility

Managed Care

- Standardize managed care enrollment statewide
- Standardize managed care benefits statewide
- Transition to statewide managed long term services and supports
- Require Medi-Cal managed care plans be National Committee for Quality Assurance accredited
- Implement annual Medi-Cal health plan open enrollment
- Implement regional rates for Medi-Cal managed care plans

Behavioral Health

- Behavioral health payment reform
- Revisions to behavioral health inpatient and outpatient medical necessity criteria for children and adults
- Administrative behavioral health integration statewide
- Regional contracting
- Substance use disorder managed care program renewal and policy improvements

Dental

- New benefit: Caries Risk Assessment Bundle and Silver Diamine Fluoride for young children
- Pay for Performance for adult and children preventive services and continuity of care through a Dental Home

County Based Services

- Enhance oversight and monitoring of Medi-Cal Eligibility
- Enhance oversight and monitoring of California Children's Services and the Child Health and Disability Prevention program
- Improving beneficiary contract and demographic information

For detailed descriptions of the CalAIM proposals please refer to the full CalAIM document located on CalAIM page of the DHCS website.

Advancing Key Priorities

CalAIM aligns with and advances several key priorities of the Administration. At its core, CalAIM recognizes the impact of Medi-Cal on the lives of its beneficiaries well beyond just accessing health services in traditional delivery settings. CalAIM establishes a foundation where investments and programs within Medicaid can easily integrate, complement and catalyze the Administration's plan to impact the State's homelessness crisis, support reforms of our justice systems for youth and adults who have significant health issues, build a platform for vastly more

integrated systems of care and move toward a level of standardization and streamlined administration required as we explore single payer principles through the Healthy California for All Commission. Furthermore, CalAIM will advance a number of existing Medi-Cal efforts such as Whole Person Care and the Health Homes Program, the prescription drug Executive Order, improving screenings for kids, proliferating the use of value-based payments across our system, including in behavioral health and long-term care. CalAIM will also support the ongoing need to increase oversight and monitoring of all county-based services including specialty mental health and substance use disorder services, Medi-Cal eligibility, and other key children's programs currently administered by our county partners.

Below is an overview of the impact CalAIM could have on certain populations, if enacted and funded as proposed:

Health for All: In addition to focusing on preventive and wellness services, CalAIM will identify patients with high and emerging risk/need and improve the entire continuum of care across Medi-Cal, ensuring the system more appropriately manages patients over time, through a comprehensive array of health and social services spanning all levels of intensity of care, from birth and early childhood to end of life.

High Utilizers (top 5%): It is well documented that the highest utilizers represent a majority of the costs in Medi-Cal. CalAIM proposes enhanced care management and in lieu of services benefits (such as housing transitions, respite and sobering centers) that address the clinical and non-clinical needs of high-cost Medi-Cal beneficiaries, through a collaborative and interdisciplinary whole person care approach to providing intensive and comprehensive care management services to improve health and mitigate social determinants of health.

Behavioral Health: CalAIM's behavioral health proposals would initiate a fundamental shift in how Californians (adults and children) will access specialty mental health and substance use disorder services. It aligns the financing structure of behavioral health with that of physical health, which provides financial flexibility to innovate, and enter into value-based payment arrangements that improve quality and access to care. Similarly, the reforms in CalAIM simplify administration of, eligibility for, and access to integrated behavioral health care.

Vulnerable Children: CalAIM would provide access to enhanced care management for medically complex children to ensure they get their physical, behavioral, developmental and oral health needs met. It aims to identify innovative solutions for providing low-barrier, comprehensive care for children and youth in foster care and furthers the efforts already underway to improve preventive services for children including identifying the complex impacts of trauma, toxic stress and adverse childhood experiences by, among other things, a reexamination of the existing behavioral health medical necessity definition.

Homelessness and Housing: The addition of in lieu of services would build capacity to clinically linked housing continuum via in lieu of services for our homeless population, including housing transitions/navigation services, housing deposits, housing tenancy and sustaining services, short-term post hospitalization housing, recuperative care for inpatient transitions and day habilitation programs.

Justice Involved: The Medi-Cal pre-release application mandate, enhanced care management and in lieu of services would provide the opportunity to better coordinate medical, behavioral

health and non-clinical social services for justice-involved individuals prior to and upon release from county jails. These efforts will support scaling of diversion and reentry efforts aimed at keeping some of the most acute and vulnerable individuals with serious medical or behavioral health conditions out of jail/prison and in their communities, further aligning with other state hospital efforts to better support care for felons incompetent to stand trial and other forensic state-responsible populations.

Aging Population: In lieu of services would allow the state to build infrastructure over time to provide Managed Long-Term Services and Supports (MLTSS) statewide by 2026. MLTSS will provide appropriate services and infrastructure for home and community-based services to meet the needs of aging beneficiaries and individuals at risk of institutionalization and should be a critical component on the State's Master Plan on Aging.

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

INTRODUCTION

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

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

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

PURPOSE

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

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

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FRAMEWORK FOR DEVELOPING BEST PRACTICES

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

Table 2. Outline for Developing Best Practices Guidance Document

Step One: Brainstorm Key Issues

This step serves to identify key issues --not already addressed in Service Standards and the Universal Standards of Care-- that the group wants to include in the Best Practice Guidance document. Discuss and identify barriers, challenges, areas of improvement, unmet needs, inequities, and disparities in systems and services that prevent members of the designated population from:

- Accessing HIV care and prevention services
- Enrolling and engaging in HIV care and prevention services
- Realizing individual/population target health outcomes

Generate a list of the key issues identified during the brainstorm session. Please review the current Service Standards and Universal Standards of Care to ensure the key issues identified are not already addressed by either document.

Step Two: Research and Identify Best Practices

This step serves to generate an inventory of existing materials and articles containing HIV care and prevention guidelines from various jurisdictions that serve the designated population. Assign items to different group members based on their background/expertise, preferences and/or interests and have them research and collect information on the item.

Consider the following guiding questions and format for organizing the information collected:

I. **Title of Best Practice**
   Concise and reflective of the practice being documented.

II. **Description**
   Provide context and justification for the practice and address the following:
   a. What is the problem being addressed?
   b. Which population(s) is/are being affected?
   c. How is the problem impacting the population?
   d. What were the objectives being achieved?

III. Implementation of the Practice
   a. Where was the Best Practice implemented?

IV. Results of the Practice
   a. What are the outcomes of the Best Practice?

V. Lessons Learned
   a. Does the Best Practice influence something relevant for the population? What is it?
   b. How effective is the Best Practice in achieving its goal/objectives?

VI. Conclusion
   a. Why is that intervention considered a Best Practice?

Step Three: Select Best Practice and Draft Guidance Document

This step serves to develop a draft of the Best Practices guidance document. Group members review the Best Practices identified in Step Two and provide their insight and feedback. The group should invite community members and providers with experience providing health and social services to the

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designated population as well as consumers of services that are members of the designated population to participate in the discussion. Once deliberations are complete, the group will select the Best Practices to include in the guidance document and use the format in Step Four.

Step Four: Format for Guidance Document

Use the following format to organize the Best Practices identified in Step Three:

I. **Introduction**
   a. What is the problem being addressed?
   b. Which population is being affected?
   c. How is the problem impacting the population?
   d. What are the objectives of this guidance document?

II. **Methodology**
   a. Describe the process the group employed to develop this document.

III. **Key Issues Identified**
   a. Describe the key issues the group identified during the brainstorm session.

IV. **Best Practices Identified**
   a. Describe the Best Practices the group identified. For this section use the same format outlined in Step Two.

V. **Conclusion**
   a. Describe how the Best Practices included in the document address the Key Issues identified

Step Five: Submit Best Practice Guidance Document to Standards and Best Practices Committee

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STANDARDS AND BEST PRACTICES COMMITTEE 2021 WORK PLAN
Updated 10/29/21 (Revisions in RED)

Co-Chairs: Erika Davies & Kevin Stalter	
Approval Date: 3/1/21	**Revision Dates: 3/10/21, 4/14/21, 9/2/21, 9/30/21, 10/29/21**
Purpose of Work Plan: To focus and prioritize key activities for COH Committees and subgroups for 2021. **Prioritization Criteria:** Select activities that 1) represent the core functions of the COH; 2) advance the goals of the local Ending the HIV Epidemic (EHE) Plan; and 3) align with COH staff and member capacities and time commitment; 4) ongoing COVID public health emergency response and recovery priorities.	

#	TASK/ACTIVITY	TARGET COMPLETION DATE
1	Review BAAC and ATF charge and implement recommendations best aligned with the purpose and capacity of the Commission • Work with the BAAC TF to explore feasibility of designating a member to attend SBP meetings. • Seek input from the Aging Task Force (ATF) on service standards. Benefits Specialty and Home-Based Case Management services were cited as examples. Committee will provide guiding questions for COH Task Forces, Caucuses, and Workgroups to develop best practices/guidelines for their respective groups. COH will share updates to Special Populations Best Practices Development document.	Start Jan/Ongoing
~~2~~	~~Complete Universal service standards.~~ COMPLETED	~~March-Executive Committee April- COH~~
3	Complete Childcare service standards. ~~Waiting for DHSP on provider survey results/summary.~~ Survey results presented on 4/6/21 COMPLETED	~~May~~
4	Provide feedback on and monitor implementation of the local Ending the HIV Epidemic (EHE) plan: • Develop strategies on how to engage with private health plans and providers in collaboration with DHSP	~~On hold~~ Ongoing
5	Update Substance use outpatient and residential treatment service standards. SUD service standards posted for a 30-public comment period starting 8/23 and ending on 9/22. Review comments receiving during Public Comment period. Committee will place a temporary hold on approving the SUD service standards pending further review of the implications of the upcoming implementation of CalAIM.	~~July~~ On Hold
6	Update Benefits Specialty service standards. Continue review process on 11/2/2021.	~~August~~ November
7	Update Home-based Case Management service standards. Committee will begin review process during December meeting.	~~September~~ December

Meeting Summary

<table>
<tr><td>Meeting Name:</td><td colspan="3">Dental Standards/Exclusion Criteria Concerns</td></tr>
<tr><td>Date of Meeting:</td><td>October 28th, 2021</td><td>Time:</td><td>10:00 am -11:00 am PST</td></tr>
<tr><td>Minutes Prepared by:</td><td>Jose Rangel-Garibay (COH staff)</td><td>Location:</td><td>WebEx Teleconference</td></tr>
<tr><td colspan="4">Meeting Objective</td></tr>
<tr><td colspan="4">Initial conversation to help the Standards and Best Practices (SBP) Committee gather information and determine the need to review and update the Oral Health standards in response to an appeal from the Director of the Division on HIV and STD Programs (DHSP).</td></tr>
<tr><td colspan="4">Attendees</td></tr>
<tr><td colspan="4">Commission on HIV (COH) SBP committee members: Erika Davies, Kevin Stalter, Dr. Mark Mintline
DHSP representatives: Mario Perez, Paulina Zamudio, Dr. Michael Green, Pamela Ogata
Community Stakeholders: Dr. Fariba Younai
COH Staff: Cheryl Barrit, Jose Rangel-Garibay</td></tr>
<tr><td colspan="4">Agenda and Notes, Decisions, Issues</td></tr>
<tr><td>Topic</td><td colspan="3">Discussion</td></tr>
<tr><td>Introductions</td><td colspan="3">Meeting attendees briefly introduced themselves and shared their affiliations.</td></tr>
<tr><td>Description of Appeal</td><td colspan="3">DHSP Director Mario Perez made an appeal to the SBP committee requesting a review of the Oral Health service standards to address reports of specialty dental providers implementing exclusion criteria for dental implants. He noted the lack of explicit exclusion criteria language regarding dental implants in the current Oral Health service standards has led certain providers to interpret the standards at their discretion and adopt exclusion criteria for dental implants. One example of these criteria is that some providers are limiting the number of implants a consumer can receive within a 12-month period.</td></tr>
<tr><td>Background</td><td colspan="3">Kevin Stalter shared his lived experience with the process of receiving dental implants through a Ryan White Funded provider.

Dr. Fariba Younai emphasized the delicate balance between patient autonomy and clinician judgment in the decision-making process for determining if a patient is a good candidate for a dental implant. She noted individual oral hygiene behaviors are a determining factor in dental implant success and patients with history of previous or current drug use, smoking, or Diabetes with a Hemoglobin A1C greater than 7% are typically not considered good candidates for dental implants. She added that in her practice, providers evaluate dental implant candidates on a case-by-case basis.

She shared that the current oral standards were based on the practice guidelines developed by the Oral Health Advisory Group of the Pacific AIDS Education and Training Center which was revised in 2015.</td></tr>
<tr><td>Decisions</td><td colspan="3">M. Perez proposed a two-step approach to addressing the issue. Step one involves conducting an immediate review of the Oral Health service standards and developing guidance for specialty dental providers related to dental implants. Step two is</td></tr>
</table>

	leading an overall review of the Oral Health service standards and updating the service standards as needed. M. Perez also suggested creating a workplan and agenda for future meetings to promote efficiency and achieve timely resolution of the issues identified.
	Cheryl Barrit and Jose Rangel-Garibay will develop a workplan that outlines the next steps for this project and schedule for future meetings.
Next steps:	• Gather contact information for specialty dental providers and other specialty dental subject matter experts to schedule a series of meetings -Group to provide to COH staff by November 8th, 2021. • Convene the identified expert panel and collect feedback and develop an addendum for the current Oral Health standards explicitly stipulating service standards for dental implants/address provider practices—Group to schedule expert panel meeting for mid to late January. • COH staff will develop a workplan and timeline for the review process – due to the group by November 8th, 2021. • COH staff will add an item to the SBP Committee November 2, 2021 meeting agenda to share updates with the committee

RYAN WHITE BENEFIT SPECIALTY SERVICES (BSS)

Ryan White Program Years 29-30

Background

HIV/AIDS Benefits Specialty Services (BSS) were funded by Los Angeles County (LAC) Division of HIV and STD programs (DHSP) on March 1, 2016 to address gaps in patient access to public benefits and programs supported by funding streams other than the Ryan White Program (RWP).

BSS focus on assisting an entry of people living with HIV (PLWDH) into and movement through care service systems outside of the RWP-funded service delivery network and education of clients about public and private benefits and entitlement programs with provision of assistance in accessing and securing these benefits. It is the primary responsibility of the Benefits Specialists to ensure that their clients are receiving all the benefits and entitlements for which they are eligible.

DHSP currently includes BSS as a subcategory of RWP Non-Medical Case Management (NMCM) Services. Twelve community-based clinics are currently contracted for BSS and to provide the key services as follow:

- Benefit screening
- Benefit assessment
- Benefit enrollment
- Benefit management
- Application and paperwork assistance
- Appeals counseling and facilitation
- Assistance and management of benefits issues for clients who are enrolled in health and disability programs

The current BSS contracts started in RWP Year 29 (March 1, 2019 for two agencies and April 1, 2019 for 10 agencies) and continue through RWP Year 31 (March 31, 2022).

Overview of Benefit Specialty Services

<u>Contractor and staff requirements</u>

1. BSS are unlicensed (no licensed staff is required). All BSS are be provided in accordance with Commission on HIV (COH) guidelines and procedures, and LAC DPH/DHSP laws and regulations.
2. Benefits specialists should have: 1) a bachelor's degree in an area of human services and/or certification in self-insurance liability; 2) a high school diploma (or equivalent) and at least one year's experience working as an HIV case manager or HIV policy advocate; or, 3) at least three years' experience working within a related health services field.
3. All benefits specialists shall successfully complete certification in RWP/Health Insurance Premium Payment Program (HIPP) and recommended certification in AIDS Drug Assistance Program (ADAP) within six months of being hired, as well as any requisite training (as appropriate).
4. Annual performance targets number of clients to be served, number of service hours and number of informational sessions.

Service Description:

To assist clients directly or through referral in obtaining the following:

Category	Services
Health Care	• AIDS Drug Assistance Program (ADAP) • Patient Assistance Programs (Pharmaceutical Companies)
Insurance	• CARE/Health Insurance Premium Payment (HIPP) • Healthy Families Program • Medicaid/Medi-Cal; Medi-Cal/HIPP • Medicare • Medicare Buy-In Program • Private Insurance
Food and Nutrition	• CalFresh (formerly known as Food Stamps) • DHSP-funded nutrition programs (food banks or home delivery services)
Disability	• Social Security Disability Insurance (SSDI) • State Disability Insurance • In-Home Supportive Services (IHSS)
Unemployment/Financial Assistance	• Unemployment Insurance (UI) • Worker's Compensation • Ability to Pay Program (ATP) • Supplemental Security Income (SSI) • State Supplementary Payments (SSP) • Cal-WORKS (TANF) • General Relief/General Relief Opportunities to Work (GROW)
Housing	• Section 8 and other housing programs
Other	• Women, Infants and Children (WIC) • Entitlement programs • Other public/private benefits programs • DHSP-funded transportation services (starting in Year 30)

Service Population: persons living with diagnosed HIV in Los Angeles County who are:

1. Uninsured or underinsured (current health plan does not cover services)
2. Have an income at or below 500% Federal Poverty Level

Key Service Activities

1. *Benefits Screening (Initial Intake)* of service needs is required during the first contact for all potential clients and should include the following information (at minimum):
   - Written documentation of HIV status
   - Proof of Los Angeles County residency or Affidavit of Homelessness
   - Verification of financial eligibility for services
   - Date of intake
   - Client name, home address, mailing address and telephone number
   - Emergency and/or next of kin contact name, home address and telephone number

2. *Benefit assessment* is completed in a cooperative, interactive, face-to-face or telehealth interview process and are conducted to:
    - Determine a client's need for public benefits advocacy
    - Educate a client about available benefits and entitlements
    - Identify appropriate benefits and entitlements with the client
    - Preliminarily assess a client's eligibility for benefits and entitlements
    - Provide necessary referrals, forms, and instructions, as indicated
    - Identify any benefits-related barriers the client is experiencing
    - Determine whether the client has already sought legal recourse related to services for which he or she is seeking benefits

3. *Individualized benefit service plan (BSP)* is developed in conjunction with the client to determine the benefits and entitlements for which the client will be referred to apply or the plan that the specialist will develop to help the client resolve his or her current benefits issue(s). Re-evaluation of the care plan should be performed at least every 6 months with adaptations as necessary with ongoing assessment of the client's and other key family members' needs and personal support systems.

4. *Application assistance*
   Clients with significant functional barriers should be given an appointment within two weeks of assessment to assist in the completion of relevant applications or recertifications. Other clients should also be offered individual application assistance if they express a need for this service. This ensures that the applications are complete, and that the client has clear instructions about the next steps required to finalize the application process (e.g., setting appointments at benefits offices, mailing instructions, and other).

5. *Benefit management* refers to the benefit counseling needs that many clients have once they are enrolled in various health and disability benefits programs. Clients may require benefits management assistance for various reasons, including health or lifestyle changes, program recertification or reenrollment, treatment/service denials, return-to-work issues, legislative or budget related changes to benefits. Referrals to legal, county departments, community-based organizations, other agencies for services and resources to address client immediate and long-term needs should be provided as needed. In addition, clients should attend at least one BSS workshop at the agency they are enrolled.

6. *Appeals counseling and facilitation*
   Clients denied a benefit or medical service should be offered individual appeals counseling and facilitation services where clients will be educated and advised on methods to address appeals, and, when indicated, accompany them to the appeal in a facilitative role (not as a legal representative). When a specialist deems that further legal assistance is required to successfully negotiate an appeal, clients will be referred to a legal service provider.

7. *Progress notes and documentation* are maintained on file, signed, and dated with details on every service provided, every contact and attempt of contact, correspondence, referrals, time spent.

Reimbursement Structure: Cost reimbursement

Service unit definition: Hours of service

Service tracking measures:

1. Number of unduplicated clients
2. Number of service hours delivered

Limits on service utilization: None.

Contractor Reporting Requirements

1. Narrative Reports
   - Monthly reports (written and summary CaseWatch reports)
     - Includes informational sessions
   - Semi-annual reports (six-month summary submitted January-June and July-December)
   - Annual report (written report for calendar year)
2. Client-level Data (reported through HIV CaseWatch)
   - Screening (eligibility) data
   - Demographic data
   - Service utilization data
     - Benefits screening
     - Benefit assessment
     - Benefit enrollment
     - Benefit management
     - Application and paperwork assistance
     - Appeals counseling and facilitation
     - Assistance and management of benefits issues for clients who are enrolled in health and disability programs
   - Core medical and support services outcomes, and
   - Service linkages/referrals to other service providers

BSS Service Utilization Summary for Year 29-30

Data are presented below for RWP years 29 (March 1, 2019-February 28, 2020) and 30 (March 1, 2020-February 28, 2021) to describe which clients are using BSS and the services being provided. In addition, comparison of these two years of data can be used to assess any impact of COVID-19 on BSS service utilization.

A total of 3,894 clients utilized the BSS program From Year 29 to Year 30, the number of clients utilizing BSS services increased from 3,894 to 4,542. Similarly, the total number of service hours provided increased from 14,024 in Year 29 to 16,353 in Year 30. In contrast, the average number of services hours per client was 3.6 hours per client and did not change from Year 29 to Year 30.

Key client characteristics are presented below in Table 2. The largest groups of clients for each characteristic are indicated with red font. While there were few differences in socio-demographic client characteristics from Year 29 to Year 30 however decreases were seen for engagement and retention in medical care indicators likely reflecting reduced medical care access and use during COVID-19.

Table 2. Comparison of key characteristics between RWP clients receiving BSS in RWP Years 29 and 30, Los Angeles County, CA

Characteristic	Year 29 (03/01/2019-02/28/2020)	Year 30 (03/01/2020-2/28/2021)
Race/Ethnicity		
White	18%	19%
Latinx	61%	58%
Black	15%	18%
Asian	4%	4%
Another race/ethnicity*	<1%	<1%
Gender Identity		
Cisgender Men	88%	89%
Cisgender Women	10%	10%
Transgender Women	2%	2%
Age Group		
13-17 years	<0.1%	<0.1%
18-29 years	11%	11%
30-39 years	21%	22%
40-49 years	23%	22%
50-59 years	30%	29%
60 and older	16%	17%
English is Primary Language	64%	68%
Income by Federal Poverty Level (FPL)		
At/below FPL	51%	53%
101-500% FPL	49%	47%
Above 500% FPL	<0.5%	<0.5%
Uninsured	38%	33%
Experiencing Homelessness	9%	6%
History of Incarceration	14%	12%
Received ≥1 RWP-Supported Medical Visit in the Reporting Year	45%	34%
Engaged in HIV Care in the Reporting Year	98%	95%
Retained in HIV Care in the Reporting Year	84%	72%
Suppressed Viral Load at Last Test in the Reporting Year	88%	87%

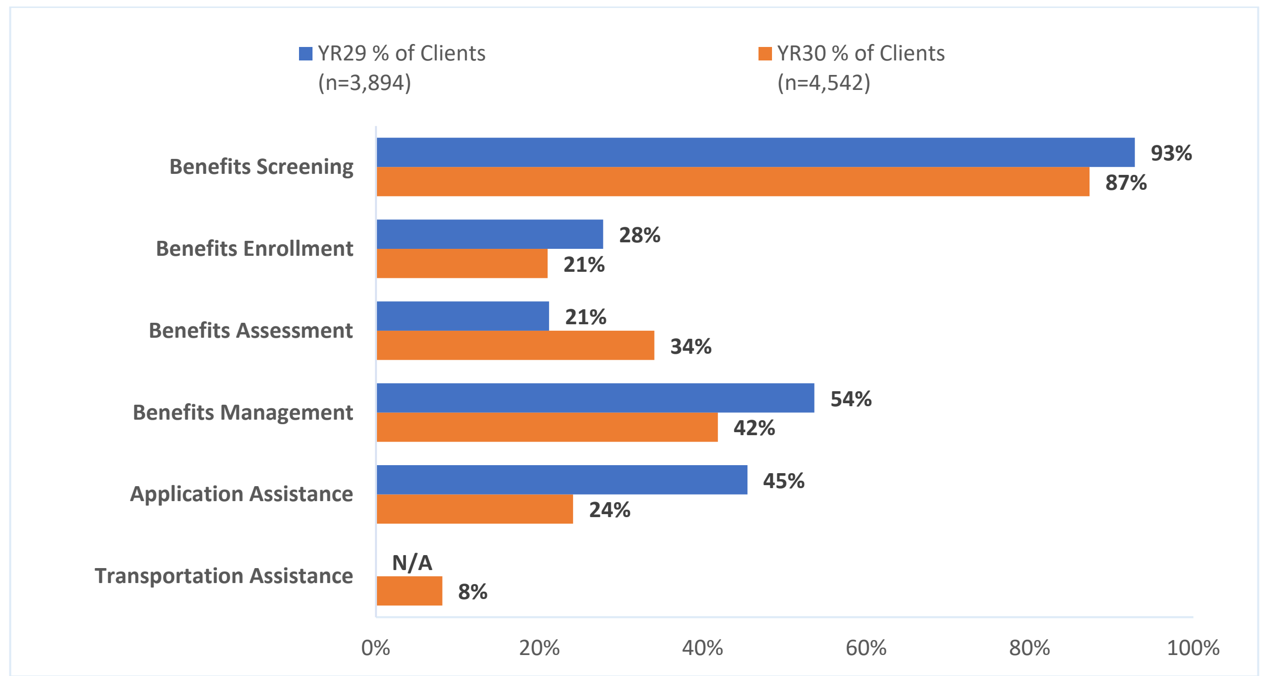
*Includes Native Hawaiian/Pacific Islanders and Native Americas/Alaska Natives.

**Percentages may not total 100% due to rounding.

In addition to hours of service, specific service activities for BSS were reported for Years 29 and 30. Figure 1 below presents the percent of clients who received each type of activity each year. Year 29 is represented by the blue bars and Year 30 by the orange bars. There was a notable decrease in the proportion of clients who received benefit screening, and especially benefit management and application assistance from Year

29 to Year 30, for which the most likely explanation is COVID-19 restrictions. Transportation services were added in Year 30 and therefore not reflected in Year 29. Appeals facilitation was provided to less than 1% of clients in each year and not included on Figure 1.

Figure 1: Benefit Specialty Service Activities Reported by Contracted Agencies, Years 29-30



In Year 30, telehealth modalities were added to BSS to increase service access during the COVID-19 pandemic. Approximately 20% of total BSS provided in Year 30 were delivered via telehealth.

Benefit Specialty Services Description per HRSA PCN #16-02:

Benefit Specialty Services (BSS) are not specifically defined as a RWP service by HRSA but are included by COH and DHSP to be a Non-Medical Case Management (NMCM) service. The description of NMCM services per the HRSA PCN#16-02 is presented below.

Non-Medical Case Management Services Description:
Non-Medical Case Management Services (NMCM) provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. The services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans. This service category includes several methods of communication including face-to-face, phone contact, and any other forms of communication deemed appropriate by the RWHAP Part recipient. Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan

- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems

Program Guidance:

NMCM have as their objective providing guidance and assistance in improving access to needed services whereas Medical Case Management services have as their objective improving health care outcomes.

Acknowledgements

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Standards & Best Practices Committee
Standards of Care

- Service standards are written for service providers to follow

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

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

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

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

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

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

Standards of Care Review
Guiding Questions

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

2. Are the standards reasonable and achievable for providers?

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

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

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

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

7. Are the references still relevant?

BENEFITS SPECIALTY

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11/2/2021

Benefits Specialty
SERVICE STANDARDS

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

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

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

Service Standards: Ryan White HIV/AIDS Programs

INTRODUCTION

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

The Los Angeles County Commission on HIV developed the Benefits Specialty standards to establish the minimum standards of care necessary to ensure people living with HIV (PLWH) can receive quality Benefits Specialty services when attending core medical and/or support services appointments and meetings.

The development of the standards includes guidance from service providers, people living with HIV, the Los Angeles County Department of Public Health, Division of HIV and STD Program (DHSP), members of the Los Angeles County Commission on HIV, Standards & Best Practices Committee, and the public-at-large.

BENEFITS SPECIALTY SERVICES (BSS): OVERVIEW

Benefits Specialty Services are client-centered activities that facilitate a client's access to public/private maintenance of health, social services, and disability benefits and programs. Benefits Specialty Services work to maximize public funding by helping clients identify all available health, social services, and disability benefits supported by funding streams other than the Ryan White Part A funds.

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These services are designed to assist a client navigate care and social services systems outside of the service delivery network funded by the Ryan White Program, educate people living with HIV about public and private benefit programs, and aid in accessing and securing these benefits.

Benefits Specialty Services are unlicensed. All HIV Benefits Specialty Services will be provided in accordance with Commission on HIV guidelines and procedures, and local laws and regulations and will respect the inherent dignity of each person living with HIV they serve. In addition, BSS contractors must adhere to contractual requirements stipulated by DHSP. Specialists will explore possible options for their clients the following benefits (at minimum):

BENEFIT SPECIALTY SERVICES LIST

- AIDS Drug Assistance Program (ADAP)
- Ability to Pay Programs (ATP)
- Cal-WORKS
- State Office of AIDS Health Insurance Premium Payment Program (OA-HIPP)
- CalFreshGeneral Relief/General Relief Opportunities to Grow (GROW)
- In-Home Supportive Services (IHSS)
- Covered California/Health Insurance Marketplace
- Managed Care Systems
- Medicaid/Medi-Cal/MyHelath LA
- Medicare
- Medical Savings Programs
- Pharmaceutical Patient Assistance Programs (PAPs)
- Private Insurance
- Social Security Programs
- Social Security Disability Insurance (SSDI)
- Supplemental Security Income (SDI)
- Social Security Retirement
- State Disability Insurance (SDI)
- Temporary Aid to Needy Families (TANF)
- Unemployment Insurance (UI)
- Veteran's Administration Benefits (VA)
- Women, Infants, and Children (WIC)
- Rent and Mortgage Relief programs
- Childcare
- Other public/private benefit programs

All service providers receiving funds to provide Benefits specialty services are required to adhere to the following standards[1].

[1] Universal Standards of Care can be accessed at http://hiv.lacounty.gov/Projects

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Table 1. BENEFITS SPECIALTY SERVICE REQUIREMENTS

SERVICE COMPONENT	STANDARD	DOCUMENTATION
Outreach	Benefits specialty programs will outreach to potential clients/families and providers.	Outreach plan on file at provider agency.
	Benefits specialty programs will collaborate with primary health care and supportive services providers.	Memoranda of Understanding on file at the provider agency.
Intake	The intake process will begin during first contact with client.	Intake tool in client file to include (at minimum): • Documentation of HIV status • Proof of LA County residency or Affidavit of Homelessness • Verification of financial eligibility • Date of intake • Client name, home address, mailing address and telephone number • Emergency and/or next of kin contact name, home address and telephone number
	Confidentiality policy and Release of Information will be discussed and completed.	Release of Information signed and dated by client on file and updated annually.
	Consent for Services will be completed.	Signed and dated Consent in client file.
	Client will be informed of Rights and Responsibility and Grievance Procedures.	Signed and dated forms in client file.
	When indicated, the client will provide Disclosure of Duty Statement.	Signed and date Disclosure of Duty Statement in client file.
	Client will be informed of limitations of benefits specialty services through Disclaimer form.	Signed and date Disclaimer in client file.

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Benefits Assessment	Benefits assessments will be completed during first appointment.	Benefits assessment in client chart on file to include: • Date of assessment • Signature and title of staff person • Completed Assessment/Information form • Functional barriers • Notation of relevant benefits and entitlements and record of forms provided • Benefits service plans
Benefits Management	Benefits management services will be provided to clients who are enrolled in benefits programs and require advocacy to maintain their benefits.	Benefits assessment on file in client chart to include: • Date • Signature and title of staff person • Notation of relevant benefits and presenting issues(s) • Benefits service plan to address identifies benefits issue(s)
Benefits Service Plan (BSPs)	BSPs will be developed in conjunction with the client at the completion of the benefits assessment.	BSP on file in client chart that includes: • Name, date and signature of client and case manager • Benefits/entitlements for which to be applied • Functional barriers status and next steps • Disposition for each benefit/entitlement and/or referral
Appeals Counseling and Facilitation	As necessary, specialists will assist clients with appeals counseling and facilitation. Cases that require further legal assistance will be referred to Ryan White Program-funded or other legal service provider.	Signed, date progress notes on file that detail (at minimum): • Brief description of counseling provided • Time spent with, or on behalf of, the client • Legal referrals (as indicated)

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	Specialists will attempt to follow up missed appointments within one business day.	Progress notes on file in client chart detailing follow-up attempt.
Client Retention	Programs will develop a broken appointment policy to ensure continuity of service and retention of clients.	Written policy on file at provider agency.
	Programs will provider regular follow-up procedures to encourage and help maintain a client in benefits specialist services.	Documentation of attempts to contact tin signed, date progress notes. Follow-up may include: • Telephone calls • Written correspondence • Direct contact
	Programs will develop and implement a client contact policy and procedure for homeless clients and those with no contact information.	Contact policy on file at provider agency. Program review and monitoring to conform.
Case Closure	Clients will be formally notified of pending case closure.	Contact attempts and notification about case closure on file in client chart.
	Benefits cases may be closed when the client: • Successfully completes benefits and entitlement applications • Seeks legal representation for benefits • Relocates out of the service area • Has had no direct program contact tin the past six months • Is ineligible for the service • No longer needs the service • Discontinues the service • Is incarcerated long term • Uses the service improperly of has not complied with the client services agreement • Has died	Case closure summary on file in client chart to include: • Date and signature of benefits specialist • Date of case closure • Status of the BSP • Reasons for case closure

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Staffing Development and Enhancement Activities	Benefits specialty programs will hire staff that have the ability to provide linguistically and culturally appropriate care to clients infected with and affected by HIV.	Resume on file at provider agency to confirm.
	All staff will be given orientation prior to providing services.	Record of orientation in employee file at provider agency.
	Benefits specialists will complete DHSP's certification training within three months of being hired and become ADAP and Ryan White/OA-HIPP certified in six months.	Documentation of Certification completion maintained in employee file.
	Staff will complete benefits specialty recertification training annually and will seek other training opportunities as available.	Documentation of training maintained in employee files to include: • Date, time, and location of training • Title of training • Staff members attending • Training provider • Training outline • Meeting agenda and/or minutes
	Benefits specialists will practice according to generally accepted ethical standards.	Program review and monitoring to confirm.
	Benefits specialists will receive a minimum of four hours of supervision per month.	Record of supervision on file at provider agency.

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Appendix A: Definitions and Descriptions

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

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

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

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

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

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

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

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

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