LOS ANGELES COUNTY
COMMISSION ON HIV

Visit us online: http://hiv.lacounty.gov
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STANDARDS AND BEST PRACTICES COMMITTEE Virtual Meeting

Tuesday, August 4, 2020

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

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LOS ANGELES COUNTY
COMMISSION ON HIV

VIRTUAL MEETING

AGENDA FOR THE REGULAR MEETING OF THE
STANDARDS AND BEST PRACTICES COMMITTEE

TUESDAY, AUGUST 4, 2020, 10:00 AM – 12:00 PM

(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, *alternate*	Wendy Garland, MPH
Felipe Gonzalez	Grissel Granados, MSW	Thomas Green	David Lee, MSW, LCSW, MPH
Katja Nelson, MPP	Joshua Ray (Eduardo Martinez, *alternate*)	Justin Valero, MA	Amiya Wilson
Harold Glenn San Agustin, MD			
QUORUM: 7			

AGENDA POSTED: JULY 30, 2020

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 á HIVComm@lachiv.org, por lo menos setenta y dos horas antes de la junta.

SUPPORTING DOCUMENTATION can be obtained at the Commission on HIV Website at: http://hiv.lacounty.gov. The Commission Offices are located in Metroplex Wilshire, one building west of the southwest corner of Wilshire and Normandie. Validated parking is available in the parking lot behind Metroplex, just south of Wilshire, on the west side of Normandie.

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 – 10:25 AM

6. Co-Chair Report 10:25 AM – 10:35 AM

7. Division of HIV & STD Programs (DHSP) Report 10:35 AM – 10:45 AM

V. DISCUSSION ITEMS

8. Psychosocial Support Services Standards **MOTION #3** 10:45 AM – 11:20 AM

9. Childcare Services Standards Review 11:20 AM – 11:45 AM

VI. NEXT STEPS 11:45 AM – 11:55 AM

10. Task/Assignments Recap

11. Agenda development for the next meeting

VI. ANNOUNCEMENTS 11:55 AM – 12:00 PM

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

VII. ADJOURNMENT 12:00 PM

13. Adjournment for the virtual meeting of August 4, 2020

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.**
MOTION #3	**Approve the Psychosocial Support Standards of Care, as presented or revised and move the full Commission for approval.**

LOS ANGELES COUNTY
COMMISSION ON HIV

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HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov • *VIRTUAL WEBEX MEETING*

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 7, 2020

MEMBERS PRESENT	MEMBERS ABSENT	PUBLIC	COMM STAFF/ CONSULTANTS
Erika Davies, *Co-Chair*	Miguel Alvarez *(Alt.)*	Alasdair Burton	Cheryl Barrit, MPIA
Kevin Stalter, *Co-Chair*	Wendy Garland, MPH	Freddy Favela	Jane Nachazel
Felipe Gonzalez	David Lee, MSW, LCSW, MPH	Joseph Green	
Bridget Gordon	Eduardo Martinez *(Alt to Ray)*	Juan Preciado	**DHSP STAFF**
Grissel Granados, MSW	Amiya Wilson		None
Thomas Green *(Alt to Péna)*			
Katja Nelson, MPP			
Joshua Ray, RN *(Full to Martinez)*			
Harold Glenn San Agustin, MD			
Justin Valero, MA			

*Some participants may not have been captured electronically. Attendance can be corrected by emailing the Commission.

CONTENTS OF COMMITTEE PACKET

1) **Cover Page**: Standards and Best Practices (SBP) Committee Virtual Meeting, *7/7/2020*
2) **Agenda**: Standards and Best Practices (SBP) Committee Meeting Agenda, *7/7/2020*
3) **Minutes**: Standards and Best Practices (SBP) Committee Meeting Minutes, *6/2/2020*
4) **Standards**: Psychosocial Support Services Standards of Care, *DRAFT updated 6/4/2020 - includes Department of Mental Health (DMH) input; SBP discussion on 6/2/2020*
5) **Standards**: Child Care Services Standards of Care, *DRAFT FOR SBP REVIEW Updated 6/4/2020*

CALL TO ORDER-INTRODUCTIONS-CONFLICT OF INTEREST STATEMENTS

- Ms. Barrit noted the Brown Act does not require quorum for virtual meetings, but the Commission takes roll call consistent with best practices to inform both Members and the public. Quorum is required to pass motions. Ms. Barrit took the roll.
- Mr. Stalter noted quorum was achieved and called the meeting to order at 10:05 am.

I. ADMINISTRATIVE MATTERS

1. APPROVAL OF AGENDA

MOTION #1: Approve the Agenda Order, as presented ***(Passed by Consensus)***.

2. APPROVAL OF MEETING MINUTES

MOTION #2: Approve the 6/2/2020 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 comments.

III. COMMITTEE NEW BUSINESS ITEMS

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

IV. REPORTS

5. **EXECUTIVE DIRECTOR/STAFF REPORT**
    - § Ms. Barrit offered congratulations on finalizing the Emergency Financial Assistance (EFA) Standards of Care (SOC). It was presented to the 6/11/2020 Commission on HIV, approved, and forwarded to DHSP for implementation. An SBP Co-Chair cover letter highlighted next steps including the need to expedite release of funds via an administrative or contractual mechanism to fund the service. The letter also addressed the Solidarity Statement and Social Determinants of Health (SDH).
    - § Mr. Stalter was concerned that DHSP quickly initiate outreach on EFA information, especially in minority communities. Ms. Barrit noted implementation is a DHSP charge. At the same time, it would not help to advertize a service until it is available. The Commission Co-Chairs have submitted a letter to the Board of Supervisors (Board) on the importance of expediting contracts to ensure funds reach the street as quickly as possible. The letter will be in the July Commission packet.
    - § Ms. Barrit reported that the 2020 National Ryan White Conference on HIV Care and Treatment will be 8/11-14/2020. The meeting will be virtual and offered for free. The Commission meeting was being moved back one week from 8/13/2020 to 8/20/2020 to facilitate attendance by Commissioners and the public. A flyer would be in the July Commission packet and distributed by email. Psychosocial Support and Child Care Standards may be presented to the August Commission, if ready.
    - § Mr. Stalter asked if virtual meetings had increased public participation. Ms. Barrit noted every format has advantages and disadvantages. Virtual Committee meetings have met quorum and public participation has been good. Public attendance for the June Commission meeting ranged from 75 to 185. Ease of logging in when convenient may encourage attendance.
    - § Mr. Stalter suggested advocating for simpler Health Resources and Services Administration (HRSA) and California Brown Act rules pertaining to meetings since virtual meetings are serving to enhance the very important community participation.
    - § **CO-CHAIR REPORT**: Ms. Davies thanked Ms. Barrit for help with the EFA cover letter, especially the Solidarity Statement lens. Mr. Stalter also thanked her for help in coordinating with the Black African American Community (BAAC) Task Force.

7. **DIVISION OF HIV AND STD PROGRAMS (DHSP) REPORT**: Ms. Barrit reported Ms. Garland was attending AIDS 2020 Virtual, the 23rd International AIDS Conference, 7/6-10/2020, but did forward the Psychosocial Support and Child Care Standards of Care (SOC) to DHSP staff for review. Lisa Klein was also unable to attend today's SBP Committee meeting.

V. DISCUSSION ITEMS

8. **PSYCHOSOCIAL SUPPORT SERVICES STANDARDS REVIEW**
    - § Ms. Barrit reviewed the Department of Mental Health (DMH) and 6/2/2020 meeting comments that were incorporated in the packet iteration, as noted in track-changes. HRSA and Substance Abuse and Mental Health Services Administration (SAMHSA) resources on trauma-informed care were added in an appendix.
    - § Mr. Ray expressed concern about "recommendations" that are, in effect, forced. For example, he was "recommended" to join a different support group. He did not want to leave his regular group, but felt he had to do so. Mr. Gonzalez added that, while clinicians may be very good, the client should make the final decision. Per his experience, clinicians do not always write down what a client says accurately which can lead to poor recommendations.
    - § Mr. Ray suggested adding language to the effect that autonomy is retained by the client. Ms. Davies suggested rephrasing may help, e.g., not referencing the provider first. Mr. Gonzalez highlighted the need for staff to have empathy. Often they lack soft skills and treat clients like small children.
    - § Despite issues, Mr. Stalter felt proud that this effort was much broader than the norm and represented great progress.

§ Joseph Green suggested strengthening language under Evaluation, page 3, to require trauma-informed care training, assuming that is feasible. Ms. Granados reported Children's Hospital Los Angles (CHLA) does in-house training, but trauma-informed care was well enough known and practiced that training should be available even if it was not available in-house.

§ Mr. Valero wanted to ensure that the rights and responsibilities document was appended to the SOC.

§ Dr. San Agustin noted, as a provider, he found it hard to differentiate patients suitable for services under this SOC versus those suitable for services under Medical Care Coordination (MCC). Patient objectives appear to overlap except for this SOC's attention to the family. Ms. Barrit clarified that referral to MCC is based on acuity and challenges to retention in Ambulatory Outpatient Medical (AOM) care. Any Ryan White patient may access any services in whatever combination is most beneficial so one patient might benefit by counseling services under Psychosocial Support, another the range of MCC services, another might utilize both sets of services. Service needs are also expected to change over time.

§ Dr. San Agustin pondered whether to advocate for new staff for this service. He now refers newly diagnosed patients or those with special needs to MCC. Mr. Stalter replied that depends on goals, e.g., this service could fund a support group.

§ Ms. Davies called attention to the long sought new option for agencies to offer peer delivered programs. Mr. Stalter liked the option which allows agencies flexibility, e.g., he previously ran an agency at which peers met with the newly diagnosed, like a buddy program, to help with issues like stigma. Peers also engaged in outreach on dating apps like Grindr and SCRUFF.

Ü Universal SOC Parking Lot: Add need for staff empathy.

Ü Revise trauma-informed care training guideline to, "strongly recommended and required within one year of employment."

Ü Revisions to Peer Support, page 6: From, "Patients who are HIV-positive..." to "Persons (or patients) who are living with HIV..." and revise throughout, as needed; and, delete "adherent to their treatment" as criterion for selecting peers in order to avert being judgmental and/or subjective, and fully support agency selection preference.

Ü Ms. Barrit will make revisions and email to the SBP Committee for review. After revisions, the SOC will be opened for public comment 7/13-31/2020. Return to Committee for review of any comments at the 8/4/2020 meeting.

9. CHILD CARE SERVICES STANDARDS REVIEW

§ Ms. Barrit reviewed the most recent iteration incorporating 6/2/2020 Committee comments and updates to this older SOC consistent with current HRSA guidelines and regulations, e.g., Health Insurance Portability and Accountability Act (HIPAA).

§ Mr. Gonzalez questioned the restriction of services to licensed child care providers in the State of California rather than allowing informal child care. Ms. Barrit replied HRSA language does not strictly prohibit informal child care, e.g., a neighbor, but it does require payment under an invoice from a child care provider. All standards she reviewed from other jurisdictions referred to "licensed child care services," not informal child care, most likely for legal reasons. Mr. Gonzalez suggested it might help if the client was offered the option of signing a waiver of liability.

§ She expected addressing informal child care would require separate language to define and implement the service. Some agencies may provide some services, such as child watch, while others may not allow children, especially since COVID-19.

§ Ms. Davies suggested identifying a way to use available babysitting apps. It can be a barrier, especially if using public transportation, to drop off a child one place, go someplace else for a medical appointment, then return to pick up the child.

§ Joseph Green asked about HIV Connect child care references, but Ms. Barrit said it only refers to 211 for that service.

Ü Revision to Service Promotion, page 4: From, " Agencies should inform clients..." to "Agencies will inform clients..."

Ü For the 8/4/2020 meeting, Ms. Barrit will: consult with HRSA on allowable informal child care options and report back; review 211 child care options as there are no current HIV-specific services, ensure HIV providers are in the database and under multiple search functions, e.g., LGBT or women, and report back; update Child Care SOC with revisions for review.

VI. NEXT STEPS

10. TASK/ASSIGNMENTS RECAP: There were no additional items.

11. AGENDA DEVELOPMENT FOR NEXT MEETING: There were no additional items.

VII. ANNOUNCEMENTS

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

VIII.ADJOURNMENT

13. ADJOURNMENT: The meeting adjourned at 11:36 am.

LOS ANGELES COUNTY
COMMISSION ON HIV

2020 WORK PLAN – STANDARDS & BEST PRACTICES
UPDATED 7/28/2020

Purpose of Work Plan: To focus and prioritize key activities for Commission on HIV (COH) Committees and subgroups for 2019

Prioritization Criteria: Select activities that 1) represent the core functions of the COH and Committee; 2) advance the goals of the Comprehensive HIV Plan and Los Angeles County HIV/AIDS Strategy; and 3) align with COH staff and member capacities and time commitment.

TASK/ACTIVITY	DESCRIPTION/NOTES	TARGET START/ APPROVAL DATES	STATUS
Emergency Financial Assistance (EFA)	Update Standards of Care to align with PY29/multi-year allocations	November 2019/ ~~May~~ June 2020	COMPLETED
Psychosocial Support Services	Update Standards of Care to align with PY29/multi-year allocations	November 2019/ ~~June~~ Aug 2020	In progress
Childcare Services	Update Standards of Care to align with PY29/multi-year allocations	~~March~~ August 2020	In Progress
Universal Standards of Care	Update Standards annually to ensure language and key points from meeting discussions on other standards are universally captured. Include telehealth.	~~May~~ August 2020	
Update Standards according to PP&A Committee recommendations	Update workplan in accordance with PP&A priorities and allocations for the upcoming year(s).	TBD	
Develop STD service standards	STD service standards are interwoven throughout the Prevention Standards. Consider expanding by aligning with LACHAS/CHP goals, BOS STD motion and DHSP STD grant application. Resources: HIV/STD Prevention Standards; Universal HIV/STD Prevention Standards; CA and National clinical guidelines; STD prevention recommendations by highly impacted populations; DHSP STD RFP; CA Syphilis Prevention Summit 2017 materials; DHSP STD surveillance data; 2019 SBP Work Plan.	TBD	
Increase SBP membership (ideally with people who provide or supervise direct service)	Review and update recruitment and retention plan developed by Operations Committee. Present community engagement toolkit developed by staff. Review sign-in sheets for SBP meetings and identify regular non-COH member attendees as possible individuals to recruit for committee-only membership. COH Co-Chair Priority.	Ongoing	COH staff is reviewing attendance and will adjust Committee assignments if necessary

SERVICE STANDARDS

RYAN WHITE HIV/AIDS PROGRAMS

WHAT ARE SERVICE STANDARDS?

Service standards[1] outline the elements and expectations a RWHAP Service provider follows when implementing a specific service category. The purpose of service standards are to ensure that all RWHAP service providers offer the same fundamental components of the given service category across a service area. Service standards establish the minimal level of service or care that a RWHAP funded agency or provider may offer within a state, territory or jurisdiction.

Service standards must be consistent with applicable clinical and/or professional guidelines, state and local regulations and licensure requirements. The variability in state/local regulations and requirements prevents the adoption of national service standards for the RWHAP, and thus they must be set at the grantee level. Medical care service standards must be consistent with U.S. Department of Health and Human Services care and treatment guidelines as well as other clinical and professional standards. For non-clinical services, service standards may be developed using evidence-based best practices, the Part A and B National Monitoring Standards, and guidelines developed by the state and local government. As a result, service standards are essential in defining and ensuring that consistent quality care is offered to all clients.

Service standards set a benchmark by which services are monitored, and sub-grantee contracts are developed. Each funded service category must have a unique set of service standards. There may be some overlap of service standards among two or more service categories (ex. medical case management and non-medical case management may both assist with enrolling clients in insurance assistance programs).

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[1] Service Standards applies to "standards of care' in RWHAP Parts A and B manuals. Outside of RWHAP services, "standard of care" has been used to refer to acceptable levels of medical care and treatment rendered. Therefore, the term "service standards" is used to encompass services offered through RWHAP funding.

What should be addressed in Service Standards?

Each categorical specific service standard should include:

- ✓ Service Category Definition
- ✓ Intake and Eligibility
- ✓ Key Services Components and Activities
- ✓ Personnel Qualifications (including licensure)
- ✓ Assessment and Service Plan*
- ✓ Transition and Discharge
- ✓ Case Closure Protocol
- ✓ Client Rights and Responsibilities
- ✓ Grievance Process
- ✓ Cultural and Linguistic Competency
- ✓ Privacy and Confidentiality (including securing records)
- ✓ Recertification Requirements*

** Where Applicable*

HOW ARE SERVICE STANDARDS DEVELOPED?

It is ultimately the responsibility of the grantee to ensure that service standards are in place for all funded service categories.

For RWHAP Part A grantees, developing service standards is a shared responsibility, typically led by the Planning Council. For Part B grantees, advisory committees and grantees are encouraged to obtain public input in the development of the service standards. Often this is done through a committee or workgroup body.

For Part A and B grantees, the development of service standards is a shared responsibility of the grantee and the planning body. Grantees and planning bodies may determine the order in which they are developed based on various criteria including: funding allocation level, service category prioritization, service utilization and changes in the national and local health service delivery systems. In addition, grantees and planning bodies should obtain input from providers, consumers and experts when developing standards to provide technical input and recommendations for service delivery, and to ensure that full consideration and diverse perspectives are included in service specific service standards. The roles and development process may vary for each jurisdiction.

For Parts A and B, service standards should, at minimum, also follow the programmatic and fiscal management requirements outlined in the Part A and B National Monitoring Standards. For Parts C and D, medical care standards should be based on the latest HHS HIV guidelines.

For Part C and D grantees, the development of service standards are done on the organizational or agency level and are often referred to as "Policies and Procedures." Each Part C and D grantee is expected to have policies and procedures in place on patient eligibility, enrollment, available services, as well as a patient grievance and discharge procedure. In addition, clinics and healthcare agencies are further guided by accrediting organizations (e.g. The Joint Commission) and regulations and guidance (e.g. Medicare Fee-For-Service Payment Regulations). All applicable standards and policies should be vetted by the legally responsible authority of the agency, usually the Board of Directors. Part C and D grantees are encouraged to refer to the most recent funding opportunity announcement for additional guidance on recommended policies and procedures.

WHY ARE SERVICE STANDARDS IMPORTANT?

Service standards are important to various stakeholders, with the goal to improve client and public health outcomes.

- ***Consumers*** - Service standards ensure the minimal expectation for consumers accessing or receiving RWHAP funded services within a state, territory or jurisdiction.
- ***Service Providers*** - Service standards define the core components of a service category to be included in the model of service delivery for each funded service category.
- ***Grantee -*** Grantees are responsible for ensuring the development, distribution, and use of the service standards. Service standards are important to ensure that services are provided to clients in a consistent manner across service providers.
- ***Quality Managers -*** Service standards are the foundation for the clinical quality management program, and provide the framework and service provision from which processes and outcomes are measured.
- ***Planning Bodies -*** Service standards assist planning bodies with understanding what activities are being provided

HOW OFTEN SHOULD SERVICE STANDARDS BE REVIEWED FOR ACCURACY AND RELEVANCE?

Service standards must be reviewed regularly and updated to reflect the most current nationally recognized guidelines in HIV care and treatment and local requirements. Therefore, planning bodies and grantees should build into their annual work plan a time to review existing standards. Service standards should be publically accessible so clients and providers can become familiar with them.

HOW ARE SERVICE STANDARDS USED?

For Parts A and B grantees, service standards should be included in Requests for Proposals when service categories are competitively bid as the service standards outline the key components of each service category, guide the implementation of each service category, and form the basis for monitoring service delivery, including site visits and chart reviews. Grantees should use service standards when conducting programmatic site visits, chart reviews, and routine monitoring of sub- recipients to determine if service providers are meeting the minimal expectations and adhering to service standards.

For Parts C and D grantees, service standards can be used in establishing definitions for services in Memorandum of Understanding or contracts. In addition, Service Standards can be used in policies and procedures to define elements for monitoring in quality improvement activities and to implement change activities for service and clinical improvement.

WHAT RESOURCES EXIST WHEN DEVELOPING SERVICE STANDARDS?

- ✓ **RWHAP National Monitoring Standards**
  The National Monitoring Standards are designed to help RWHAP Part A and B (including AIDS Drug Assistance Program) grantees meet federal requirements for program and fiscal management, monitoring, and reporting to improve program efficiency and responsiveness.
  http://hab.hrsa.gov/manageyourgrant/granteebasics.html

- ✓ **HIV/AIDS Bureau TARGET Center**
  The TARGET Center has samples of 'standards of care' established by various grantees within the RWHAP Program which may be adapted to other jurisdictions.
  https://careacttarget.org

- ✓ **U.S. Department of Health and Human Services Clinical Guidelines for the Treatment of HIV/AIDS**
  The U.S. Department of Health and Human Services (HHS) issues a series of guidelines to help clinicians treat people with HIV in the United States. Clinical guidelines outline the science and recommendations for treatment of HIV disease (e.g., antiretroviral therapy, opportunistic infection treatment and prophylaxis) as well as guidelines for conducting HIV testing and counseling. Developed by various panels of clinical experts, these are frequently updated and should be accessed directly at the AIDSInfo Web site.
  http://aidsinfo.nih.gov/guidelines

Standards & Best Practices Committee
Psychosocial Support Services Standards
Reviewer/Public Comments

Name	Comments	Recommendations for Committee Discussion
Lee Kochems, Commissioner	Thanks. I reviewed these standards. I have no significant comments. I will reread them again before the deadline. Good job standards.	
Marc Haupert Being Alive	I think the standards for Psychosocial Support are very well done. My main question of course is when might an RFP actually come out?	Contractual questions are under the purview of DHSP.
Maribel E. Ulloa Commissioner Housing + Community Investment Department	Reference to the table on page 4: ***Standard:** Staff are required to coordinate across Ryan White funded and non-funded programs, such as HOPWA to ensure clients' needs are met. ***Documentation:** Description of staff efforts of coordinating across systems in client file (e.g. referrals to housing case management services, etc.). This coordination should include establishing a two-way referral process between Psychosocial Support and non-funded programs, and participation in case conferencing, as needed.	Added in updated draft document
Rebecca Gitlin, Ph.D. Clinical Psychologist II LGBTQ+ Services Specialist Women's and Reproductive Mental Health Specialist Los Angeles County Department of Mental Health	Overall, the drafted standards look great. I reviewed them with the lens that the SOC need to be worded in a way that they can be both generalizable and customizable by individual programs receiving Ryan White funding. The standards are reasonable, achievable, and measurable, and they are overall client-centered and holistic. I do have a few suggestions for standards that can further emphasize the importance of supporting both staff and consumers from a holistic lens: · Agencies and their clients would benefit from training and integration of trauma-informed care practices. I see that Trauma-Informed Care is a suggested training for peer support staff. I might add something about trauma-	Comments accepted and integrated in the current version of the standards.

Name	Comments	Recommendations for Committee Discussion
	informed care under the Key Components section (p. 1) and/or elsewhere under Staff Requirements and Qualifications to emphasize the importance of trauma-informed care across service and provider types (i.e. all providers/staff are trained in trauma-informed care), as well as ongoing self-evaluation of trauma-informed care practices within agencies. · Ongoing support of peer support staff (under Staff Requirements and Qualifications) could be more measurable; I would specify what kind of supervision (one-on-one, group, etc.) is expected, and I would specify the frequency of supervision that is expected (e.g. weekly, biweekly, etc.). At minimum, I think biweekly supervision for peer support staff (group or one-on-one) is an appropriate requirement. I would expect that newer peer support staff might need more frequent and individualized support – there could be specified standards for supervision of peer support staff based on how long they have been working at the given agency and/or working in peer support services overall. · For agencies that include peer support staff as well as clinical or case management staff, there should be ongoing case consultation to ensure continuity of care. The SOC could specify that interdisciplinary teams will meet regularly (weekly or biweekly) to engage in case consultation and care coordination. This could help define/delineate roles between peer support and clinical staff while fostering greater collaboration.	

LOS ANGELES COUNTY
COMMISSION ON HIV

PSYCHOSOCIAL SUPPORT STANDARDS OF CARE

Final Draft for SBP Approval
August 4, 2020
Motion 3

MOTION 3: AUGUST 4, 2020 FOR SBP COMMITTEE APPROVAL

LOS ANGELES COUNTY
COMMISSION ON HIV

PSYCHOSOCIAL SUPPORT SERVICES
STANDARDS OF CARE

INTRODUCTION

Standards of Care 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 Psychosocial Support Services Standards of Care to help people living with HIV (PLWH) cope with their diagnosis and any other psychosocial stressors they may be experiencing. 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, and members of the Los Angeles County Commission on HIV, Standards & Best Practices Committee.

All contractors must meet the Universal Standards of Care in addition to the following Psychosocial Support Services Standards of Care.[1]

PSYCHOSOCIAL SUPPORT SERVICES OVERVIEW

The purpose of psychosocial support services is to remove or lessen barriers to care and treatment through counseling services and mental health support. Psychosocial support services provide group or individual support and counseling services to assist people living with HIV in addressing behavioral and physical health concerns and provide a safe space where lived experiences and challenges can be discussed without judgement. Psychosocial support services are client-centered and may include individuals who are newly diagnosed, newly identified as living with HIV, or who require additional support to engage in and maintain HIV medical care and supportive services. The objective is to not only provide counseling and support services, but to ensure clients are linked to care and continuously supported to remain in care. According to guidance from Health Resources & Services Administration (HRSA) Psychosocial support services may include: bereavement counseling, caregiver/respite support, child abuse and neglect counseling, HIV support groups, nutrition counseling, and pastoral counseling. It is important to note that psychosocial support services do not include ongoing psychotherapy which is provided under the Mental Health Services under the Ryan White Program.[2]

KEY COMPONENTS

Psychosocial support services are associated with improved engagement in HIV care for the purpose of improving health outcomes. Agencies are expected to offer the service to individuals who are having difficulty remaining engaged in HIV care. The goal of psychosocial support services is to enhance client

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

[2] Mental Health Services Standards of Care can be accessed at http://hiv.lacounty.gov/LinkClick.aspx?fileticket=jbx4diEds1E%3d&portalid=22

self-management skills, provide counseling services to clients that aim to overcome barriers in accessing care or remaining in care.

A key component of psychosocial support services for PLWH and those affected by HIV is to provide trauma-informed care, a strength-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, emphasizes physical, psychological, and emotional safety for both providers and survivors, and creates opportunities for survivors to rebuild a sense of control and empowerment.[3] Agencies should center the provision of psychosocial support services based on trauma-informed practices. Key components include assessment, care/service plan, provision of service, outreach and retention, evaluation, and staff requirements.

ASSESSMENT & REASSESSMENT

Psychosocial Support Service providers must complete an initial assessment with the client, within 30 days of intake, through a collaborative, interactive, face-to-face process between the Case Manager and client. To ensure wrap-around services and only with client consent, assessments may also include additional information from individuals that are familiar with the client such as service providers, caregivers, and family members. Staff members must comply with established agency confidentiality policies (Refer to Universal Standards, Section 1) when soliciting information from external sources. The initial assessment may be scalable based on client need and the type of psychosocial support service offered by the agency. Accommodations may be made for clients who are unable to attend an appointment within the 30-day timeframe due to health reasons. It is the responsibility of staff at the provider agency to conduct reassessments with the client as needed and based on contract guidelines from the Division of HIV & STD Programs (DHSP).

PROVISION OF SERVICE

Staff will provide a safe, confidential space for participants to discuss topics of interest through group facilitation techniques. Meeting locations must be accessible and affordable for participants. To reduce barriers to accessing care, an agency may offer online counseling and therapy services or telepsychology through phone, webcam, email or text message appointments depending on its capacity and/or contract guidelines from the Division of HIV & STD Programs (DHSP). Psychosocial support services may also include peer navigation, peer educators, or other peer delivered services.

The goal of support group services is to provide a forum where lived experiences, challenges, and health concerns can be discussed without judgement. In addition, support groups aim to increase participant knowledge and awareness of HIV-related topics, build a trusting network among participants as well as with the facilitator, and empower participants to maintain their highest level of optimal mental, physical, and emotional health.

Topics discussed may include, but are not limited to:

- Living with HIV
- Healthy lifestyles (including substance use) and relationships
- Adherence to treatment
- Access and barriers to care
- Prevention (PrEP, PEP, treatment as prevention)
- Disclosing status

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[3] https://traumainformedoregon.org/wp-content/uploads/2016/01/What-is-Trauma-Informed-Care.pdf

- Stigma

Attendance and participation numbers will also be tracked based on reporting requirements provided by the Los Angeles County Department of Public Health, Division of HIV and STD Programs.

SERVICE PROMOTION & RETENTION

Programs providing psychosocial support services will promote psychosocial services to potential clients. Programs will collaborate with HIV service providers and HIV testing sites to identify clients and refer them appropriately.

Agencies will strive to retain clients in psychosocial support services based on individual progress documented during sessions. Agencies and staff are also responsible for offering programs and opportunities for client social connectedness, retention in the program or other relevant programs, and remaining in contact with the client after they have completed their counseling or support group sessions in the event that the client needs to be brought back in for services. For clients that miss sessions, agencies will establish follow-up procedures, such as phone calls, text messages, and/or email, to encourage client(s) to remain in support services as needed. Staff are responsible for assisting clients access other services provided by the Ryan White system whether through referrals, compiling documentation to reduce duplicative efforts, making appointments, or connecting clients to services such as transportation, childcare, etc.

EVALUATION

Based on contract guidance from the Division of HIV & STD Programs (DHSP) agencies must evaluate, at minimum on an annual basis, the services and topics covered by counseling sessions to ensure client and/or group needs are being met whether that includes solely providing counseling, linking clients to care, or retaining clients in care. Agencies are also responsible for conducting ongoing self-evaluation of trauma-informed practices within the agency to ensure services are providing a safe space, welcoming, engaging and empowering for clients. Based on evaluation results, course corrections and adaptations to curriculum should be implemented as needed.

STAFF REQUIREMENTS AND QUALIFICATIONS

It is recommended that facilitators and staff are reflective of the population and communities they are serving. For individual counseling, staff must be well qualified and/or have experience in counseling. For group counseling, support group facilitators must have excellent knowledge of the group's purpose and uphold confidentiality at all times. It is recommended that agencies provide trauma-informed care trainings to staff, especially for those that are not familiar with delivering trauma-informed care to ensure the approach is thoughtful, sensitive, and engaging for clients. For psychosocial support services intended to provide peer-delivered services, it is encouraged that staff with lived experience are hired as peer navigators, peer educators, and for other peer-delivered programs. Agencies are encouraged to hire people living with HIV as staff, however staff must not be current clients of the support group to which they are assigned.

MOTION 3: AUGUST 4, 2020 FOR SBP COMMITTEE APPROVAL

Table 1. PSYCHOSOCIAL SUPPORT SERVICES STANDARDS OF CARE

SERVICE COMPONENT	STANDARD	DOCUMENTATION
Staff Requirements and Qualifications	Staff with experience in individual and group supportive counseling. Bachelor's degree in a related field preferred and/or experienced consumer preferred.	Staff resumes on file.
	Supervisors with experience in supportive counseling and/or case management in an area of mental health, social work, counseling, psychology. Master's degree in a related field preferred and/or experienced consumer preferred. Staff providing counseling services must be provided with clinical supervision by an experienced clinical mental health professional.	Staff resumes on file.
	Staff are required to coordinate across Ryan White funded and non-funded programs, such as HOPWA, to ensure clients needs are met. Follow up with client in 30 days to track referrals related to care coordination.	Description of staff efforts of coordinating across systems in client file (e.g. referrals to housing case management services, etc.). This coordination should include establishing a two-way referral process between Psychosocial Support and non-funded programs, and participation in case conferencing, as needed. Documentation of follow up in client file.
	Agencies who provide peer support services (i.e. peer navigators, peer educators, other peer delivered programs) are responsible for ensuring peer support staff are supported throughout their roles of the program via bi-weekly meetings, at minimum, with their supervisor.	Meeting notes and signed documentation on file indicating dates of one-on-one supervision and meetings with peer support staff, type of supervision, and name of supervisor.
	Supervisors from agencies that provide peer support services are responsible for ensuring peer support staff are trained appropriately for their role and responsibilities. Peer support staff will participate in trainings to increase their capacity for fulfilling the responsibilities of their position in addition to the trainings listed in the Universal Standards of Care.	Documentation of completed trainings on file.

Commented [BC1]: Comment from Maribel Ulloa

Commented [BC2]: Comment from Maribel Ulloa

MOTION 3: AUGUST 4, 2020 FOR SBP COMMITTEE APPROVAL

SERVICE COMPONENT	STANDARD	DOCUMENTATION
	Trainings may include, but are not limited to: · Motivational interviewing · Trauma informed care (strongly recommended within 1 year of employment) · Mental health overview · HIV/AIDS service providers and resources available to clients	
Client Assessment and Reassessment	Assessments will be completed within 30 days of the initiation of services and at minimum should assess whether the client is in care. Accommodations may be made for clients who are unable to attend an appointment within the 30-day timeframe due to health reasons.	Completed assessment in client chart signed and dated by Case Manager.
	Staff will conduct reassessments with the client as needed and in accordance with DHSP contract guidelines.	Completed reassessment in client chart signed and dated by Case Manager.
Individual Service Plan	Individual Service Plans will be developed collaboratively with the client within two weeks of completing the assessment or reassessment and, at minimum, should include: · Description of client goals and desired outcomes · Action steps to be taken and individuals responsible for the activity · Anticipated time for each action step and goal · Status of each goal as it is met, changed or determined to be unattainable	Completed plan in client chart, dated and signed by client and Case Manager.
	Staff will update Individual Service Plans every six months, or as needed based on client progress or DHSP contract requirements, with client outcomes and/or revisions based on changes in access to care and services.	Updated plan in client chart, dated and signed by client and Case Manager.
Group Session Service Plans	Group Session Service Plans will be developed by staff, based on best practices	Completed plan submitted to DHSP for prior approval.

SERVICE COMPONENT	STANDARD	DOCUMENTATION
	and evidence-based curriculum and, at minimum, should include: · Overall vision and mission of the group · Membership details (e.g. recruitment, maximum number of members) · Support group leadership · Potential group goals determined by participants	Documentation of meeting dates, group session topics, and sign-in sheets on file.
Individual Counseling*	One-to-one supportive counseling to address goals in Individual Service Plan	Progress notes in client file.
Group Counseling*	Groups must have at least 3 participants. At least 1 participant must be enrolled in the program. Group session topics and curriculum must be prepared in advance and evidence-based	Sign-in sheet, date, and handouts on file Group progress notes on file. Topics and curriculum approved for use by Division of HIV & STD Programs.
Family Counseling*	Supportive counseling that includes client's family members, friends, or anyone else who matters to the client to address goals described in the Individual Service Plan	Client must be present during family counseling session, documented by sign-in sheets and progress notes on file.
Pastoral Counseling*	One-to-one counseling for clients seeking spiritual guidance, provided by pastoral care program, center, or a service provided by a licensed provider (e.g. home care or hospice provider)	Progress notes in client file.
Biomedical Counseling*	Counseling and education to be included in individual, group, and family counseling sessions to increase knowledge on prevention of HIV transmission. Topics include: · Undetectable = Untransmittable · PrEP, PEP · Treatment as prevention	Progress notes in client file.
Peer Support	Agencies may include peer navigation, peer educators, or other peer delivered programs. People living with HIV are trained to serve as "peers" for patients who are either ART-experienced or ART-naïve and need	Lists of peer services on file. Sign-in sheets with dates, handouts provided, on file. Progress notes in client file.

SERVICE COMPONENT	STANDARD	DOCUMENTATION
	additional support.[4] Those who serve as peers provide medication-related social support through group meetings and weekly individual telephone calls. Individual or group meetings are led by peers, who are supervised by agency or clinic program staff. The group meetings are designed to give patients an opportunity to engage face-to-face with their assigned peer, meet other peers and patients who are taking ART and share experiences with the group.	
Case Conferencing	For agencies that include peer support staff as well as clinical or case management staff, there should be ongoing case consultation to ensure continuity of care. Teams will meet regularly (weekly or biweekly) to engage in case consultation and care coordination to help define/delineate roles between peer support and clinical staff while fostering greater collaboration.	Meeting notes on file indicating meeting dates, names of meeting participants, summary of topics discussed and next steps. Documentation signed by supervisor or case manager.
Service Promotion & Retention	Staff will promote services to potential clients and HIV service providers.	Individual progress documented in client files.
Evaluation	Agency annually evaluates the services and topics covered to ensure they meet client need. Evaluations may occur via customer satisfaction surveys, focus groups, etc.	Completed results on file and shared with DHSP upon request. Documentation of shared results with staff and program adaptations implemented as a result of the evaluation results.
	Agency tracks and evaluates clients that are linked to or retained in care as a result of participating in psychosocial support services.	Clients linked to care documented in client file. Evaluation reports including summaries with client cases linked or retained to care on file and shared with DHSP upon request.
	Agency tracks linked referrals for clients as a result of participating in psychosocial support services.	Linked referrals documented in client file. Evaluation reports including summaries with clients linked to referrals on file and shared with DHSP upon request.
Case Closure	Agencies must adhere to the case closure protocol from the Universal Standards of Care. For Psychosocial Support Services, a	Justification for case closure documented in client file.

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[4] https://www.cdc.gov/hiv/effective-interventions/treat/peer-support/index.html

SERVICE COMPONENT	STANDARD	DOCUMENTATION
	client case may also be closed after completion of a curriculum-based support group or the completion of individual counseling sessions based on the Individual Service Plan.[5] Although a client case may be closed, agencies are encouraged to create programs and opportunities that allow clients to access services or engage with previous case managers or staff as needed.	

*Counseling services are not to replace or to be used in place of psychotherapy services. Psychotherapy services are provided under the Ryan White Mental Health service category.

Appendix A: Examples of Psychosocial Service Standards Resources

I. Health Resources Services Administration (HRSA), HIV AIDS Bureau (HAB)

- The Use of Peer Workers in Special Projects of National Significance Initiatives, 1993 – 2009 March 2010 https://hab.hrsa.gov/sites/default/files/hab/About/RyanWhite/spns_useofpeersreport.pdf
- The Power of Peers on Engagement and Retention in Care among People of Color https://hab.hrsa.gov/sites/default/files/hab/About/Parts/cyperspnsoctober2013.pdf
- HRSA Key Populations https://targethiv.org/library/topics/key-populations

II. Trauma-Informed Care

- Trauma-informed Care at AIDS Service Organizations https://targethiv.org/library/trauma-informed-care-aids-service-organizations

- NASTAD A Health Systems Approach to Trauma Informed Care https://www.targethiv.org/sites/default/files/supporting-files/NASTAD-Trauma-Informed-Care-2017.pdf

- Trauma-Informed Approach: Improving Care for People Living with HIV Curriculum Trainer's Manual https://www.nasmhpd.org/sites/default/files/NCTIC_TIA_TrainersManual_HIV%20Final2.pdf

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

- Trauma-Informed Care Implementation Resource Center
  https://www.traumainformedcare.chcs.org/

- SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach
  https://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884

- Trauma-Informed Care in Behavioral Health Services
  https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816

- Resource Guide to Trauma-Informed Human Services
  https://www.acf.hhs.gov/trauma-toolkit

DRAFT FOR SBP REVIEW Updated 07/15/20

LOS ANGELES COUNTY
COMMISSION ON HIV

CHILDCARE SERVICES
STANDARDS OF CARE

INTRODUCTION

Standards of Care 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.

Commented [BC1]: From Joshua Ray:
Is there a way to note individualized needs or patient specific needs?

The Los Angeles County Commission on HIV developed the Childcare Services Standards of Care to establish the minimum standards of care necessary to ensure people living with HIV (PLWH) are able to receive quality childcare 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), and members of the Los Angeles County Commission on HIV, Standards & Best Practices Committee.

Commented [BC2]: To match HRSA language.

All contractors must meet the Universal Standards of Care in addition to the following Childcare Services Standards of Care.[1]

CHILDCARE SERVICES OVERVIEW

Childcare services are provided to children living in the household of people living with HIV (PLWH) for the purpose of enabling those clients to attend medical visits, related appointments, and/or Ryan White related meetings, groups, or training sessions. The goal of childcare services is to reduce barriers for clients in accessing, maintaining and adhering to primary health care and related support services.

The Health Resources Services Administration (HRSA) allows the following use of funds: a licensed or registered childcare provider to deliver intermittent care of informal childcare provided by a neighbor, family member or other person (with the understanding that existing federal restrictions prohibit giving cash to clients or primary caregivers to pay for these services. The use of these funds under this service category should be limited and carefully monitored. Direct cash payments to clients are not permitted.

SERVICE REQUIREMENTS

All service providers receiving funds to provide childcare services are required to adhere to the following standards:

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

Table 1. CHILDCARE SERVICES STANDARDS OF CARE

SERVICE COMPONENT	STANDARD	DOCUMENTATION
	Depending on agency capacity, DHSP guidance, and individual client needs, licensed and/or license-exempt childcare services may be provided on an intermittent basis to the children living in the household of PLWH who are Ryan White eligible clients for the purpose of enabling clients to attend medical visits, related appointments, and/or Ryan White HIV/AIDS Program (RWHAP) related meetings, groups, or training sessions.	Documentation in the client's primary record must reflect the appointment and/or meeting/group/training session attended.
Licensed Facilities (i.e., childcare centers, family childcare homes)	Agencies must be a licensed childcare provider in the State of California. Services must be delivered according to California State and local childcare licensing requirements which can be found on the California Department of Social Services, Community Care Licensing Division website.[2]	A copy of valid California childcare license or proper certification.
Licensed-exempt Childcare	License-exempt childcare includes: 1) individuals who care for the children of a relative, or who care for the children of one other family in addition to their own children; 2) agencies that offer limited childcare to their clients. These programs usually require that the parent or guardian remain on the premises and that they remove their children within a specified amount of time; and 3) online childcare booking service. Online or mobile app based childcare services that offer gift cards may be considered as an option for agencies	Where license-exempt childcare arrangements are obtained, subrecipient must ensure**:** a. Documentation of compliance with DHSP-required mechanism for handling payments for licenses-exempt childcare arrangements b. Appropriate liability release forms are obtained that protect the client, provider and the Ryan White program c. Documentation that no cash payments are being made to clients or primary care givers

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[2] https://cdss.ca.gov/inforesources/child-care-licensing

	and clients. Agencies that opt to provide childcare through online or mobile app based childcare services are responsible for reading, understanding, explaining to the clients, and accepting the terms of service specified in the company website.	d. Documentation that payment is for actual costs of service.
Training	Agencies are responsible for ensuring childcare providers are trained appropriately for their responsibilities. In addition to trainings listed in the Universal Standards of Care, childcare staff should participate in trainings such as: - First aid/CPR - Fire and electrical safety - Child development - Waste disposal procedures - Child abuse - Domestic violence - Needs of children in families impacted by HIV	Record of trainings on file at provider agency.
Language	Whenever possible, childcare should be delivered in the language most familiar to the child. If this is not possible, interpretation services must be available in cases of emergency.	Appropriate language noted in client program file.
Confidentiality	Client confidentiality will be maintained at all times. HIV status will never be disclosed without written permission from a client.	Record of HIPAA and confidentiality before the start of service provision.
Service Promotion	Agencies coordinating childcare services with licensed and license-exempt providers are expected to promote the availability of childcare to potential clients as well as external partners. Agencies should attempt to disseminate information about the availability of childcare throughout all components of the continuum of HIV	Program flyers and emails documenting that childcare services was promoted to clients and HIV service providers. Offer of childcare services is noted in client case file.

Commented [BC3]: From: Joshua Ray: Can there be a meet and greet first?

	care, including meetings with internal agency staff and relaying information to external HIV medical and social services partners.	
	Agencies should inform clients of the details of the childcare services, including: • How far in advance the service must be scheduled • Whether the childcare is in-home or at the service site	Description of information shared with potential clients and partners and method of communication on file.
Referrals	Programs coordinating childcare services will provide referrals and information about other available resources to adults living with HIV who have the primary responsibility for the care of children. Special consideration should be given to helping clients find longer term or additional childcare options and resources.[3] Whenever appropriate, program staff will provide linked referrals demonstrating that clients, once referred, have accessed services.	Documentation of referral efforts will be maintained on file by coordinating agency.
	Staff are required to coordinate across Ryan White funded and non-funded programs to ensure clients' needs are met.	Description of staff efforts of coordinating across systems in client file (e.g. referrals to housing case management services, etc.).
	Follow up with client in 30 days to track referrals related to care coordination.	Documentation of follow up in client file.

Commented [TJ4]: Added per Felipe's comment

Appendix A: Examples of Childcare Resources

Trustline.org - TrustLine is a database of nannies and baby-sitters that have cleared criminal background checks in California. It's the only authorized screening program of in-home

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[3] Los Angeles County Department of Public Health, Office for the Advancement of or Early Care and Education: https://childcare.lacounty.gov/resources-for-families-and-communities/

caregivers in the state with access to fingerprint records at the California Department of Justice and the FBI.

Childcareaware.org - works with more than 400 state and local Childcare Resource and Referral agencies nationwide.

Online or mobile app based childcare booking sites that offer gift cards:
Urbansitters.com
Nanno.com
Bambino.com

Child Care Alliance Los Angeles offers voucher-based services for low income families.
https://www.ccala.net/

LOS ANGELES COUNTY
COMMISSION ON HIV

RYAN WHITE PROGRAM
UNIVERSAL STANDARDS OF CARE

Commission Approved
September 12, 2019

LOS ANGELES COUNTY
COMMISSION ON HIV

TABLE OF CONTENTS

INTRODUCTION

Standards of Care outline the elements and expectations a Ryan White service provider follows when implementing a specific service category. Standards of Care are available for each service category to set the minimum level of care Ryan White funded agencies should offer to clients.[1] The Standards are intended to help Ryan White Part A funded agencies meet the needs of their clients. Providers are encouraged to exceed these standards.

The Los Angeles County Commission on HIV developed the Universal Standards of Care to reflect current guidelines from federal and national agencies on HIV care and treatment, and to establish the minimum standards of care necessary to achieve optimal health among people living with HIV (PLWH), regardless of where services are received in the County. The development of the Standards includes guidance from service providers, consumers and members of the Los Angeles County Commission on HIV, Standards and Best Practices Committee.

UNIVERSAL STANDARDS OVERVIEW

The objectives of the Universal Standards are to ensure agencies:

- Provide services that are accessible and non-discriminatory to all people living with HIV in Los Angeles County with a focus on highly impacted populations
- Educate staff and clients on the importance of receiving care, treatment as prevention, and how people who are completely, durably suppressed will not sexually transmit HIV.
- Protect client rights and ensure quality of care
- Provide client-centered, age appropriate, culturally and linguistically competent care
- Provide high quality services through experienced and trained staff
- Meet federal, state, and county requirements regarding safety, sanitation, access, and public health.
- Guarantee client confidentiality, protect client autonomy, and ensure a fair process of addressing grievances
- Inform clients of services, establish eligibility, and collect information through an intake process
- Effectively assess client needs and encourage informed and active participation
- Address client needs through coordination of care and referrals to needed services

1. GENERAL AGENCY POLICIES

All agencies offering Ryan White services must have written policies that address client confidentiality, release of information, client grievance procedures, and eligibility. Agency policies and procedures facilitates service delivery as well as ensures safety and well-being of clients and staff.

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[1] Appendix A: List of Ryan White Part A Service Categories

1.0 GENERAL AGENCY POLICIES	
Standard	**Documentation**
1.1 Agency develops or utilizes an existing client confidentiality policy in accordance with state and federal laws to assure protection of client HIV status, behavioral risk factors, and/or use of services.	1.1 Written client confidentiality policy on file.
1.2 Client determines what information of theirs can be released and with whom it can be shared.	1.2 Completed *Release of Information Form* on file including: • Name of agency/individual with whom information will be shared • Information to be shared • Duration of the release consent • Client signature For agencies and information covered by the Health Insurance Portability and Accountability Act (HIPAA), form must be HIPAA disclosure authorization compliant.
1.3 Agency develops or utilizes an existing grievance procedure to ensure clients have recourse if they feel they are being treated in an unfair manner or feel they are not receiving quality services.	1.3 Written grievance procedure on file that includes, at minimum: • Client process to file a grievance • Information on the Los Angeles County Department of Public Health, Division of HIV & STD Programs (DHSP) Grievance Line 1-800-260-8787. [2] Additional ways to file grievances can be found at http://publichealth.lacounty.gov/dhsp/QuestionServices.htm DHSP Grievance Line is posted in a visible location on site.

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[2] http://publichealth.lacounty.gov/dhsp/QuestionServices.htm

Standard	Documentation
1.4 Agency provides eligibility requirements for services available upon request. Eligibility requirements must follow guidance from Division of HIV & STD Programs (DHSP) and HRSA under Policy Clarification Notice #16-02.[3]	1.4 Written eligibility requirements on file.
1.5 All client files are stored in a secure and confidential location, and electronic client files are protected from unauthorized use.	1.5 Client files must be locked and/or password protected with access provided only to appropriate personnel.
1.6 Agency maintains progress notes of all communication between provider and client.	1.6 Legible progress notes maintained in individual client files that include, at minimum: • Date of communication or service • Service(s) provided • Recommended referrals linking clients to needed services (See Section 7: Referrals and Case Closure)
1.7 Agency develops or utilizes an existing crisis management policy.	1.7 Written crisis management policy on file that includes, at minimum: • Mental health crises • Dangerous behavior by clients or staff
1.8 Agency develops a policy on utilization of Universal Precaution Procedures.[4] a. Staff members are trained in universal precautions.	1.8 Written policy or procedure on file. a. Documentation of staff training in personnel file.
1.9 Agency ensures compliance with Americans with Disabilities Act (ADA) criteria for programmatic accessibility (e.g. building and design accessibility, parking, etc.). For agencies with multiple sites, all sites must be in compliance.	1.9 ADA criteria on file at all sites.

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[3] https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

[4] https://www.cdc.gov/niosh/topics/bbp/universal.html

Standard	Documentation
1.10 Agency complies with all applicable state and federal workplace and safety laws and regulations, including fire safety.	1.10 Signed confirmation of compliance with applicable regulations on file.

2. CLIENT RIGHTS AND RESPONSIBILITIES

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

2.0 CLIENT RIGHTS AND RESPONSIBILITIES	
Standard	**Documentation**
2.1 Agency ensures services are available to any individual who meets the eligibility requirements for the specific service category.	2.1 Written eligibility requirements on file. Client utilization data made available to funder.
2.2 Agency includes input from people living with HIV/AIDS in the design and evaluation of services to ensure care is client-centered.	2.2 Written documentation of how input was received to inform service planning and evaluation in regular reports. Lists may include: • Consumer Advisory Board meetings • Participation of people living with HIV in HIV program committees or other planning bodies • Needs assessments • Satisfaction surveys • Focus groups

Standard	Documentation
2.3 Agency provides each client a copy of the *Patient & Client Bill of Rights*[5] document that informs them of the following: • Confidentiality policy • Expectations and responsibilities of the client when seeking services • Client right to file a grievance • Client right to receive no-cost interpreter services • Client right to access their file (if psychotherapy notes cannot be released per clinician guidance, agency should provide a summary to client within 30 days) • Reasons for which a client may be discharged from services and the process that occurs during involuntary discharge	2.3 *Patient & Client Bill of Rights* document is signed by client and kept on file.

3. STAFF REQUIREMENTS AND QUALIFICATIONS

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

3.0 STAFF REQUIREMENTS AND QUALIFICATIONS	
Standard	Documentation
3.1 Staff members meet the minimum qualifications for their job position and have the knowledge, skills, and ability to effectively fulfill their role and the communities served.	3.1 Staff resumes on file.

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[5] Appendix B: Patient & Client Bill of Rights

Standard	Documentation
3.2 If a position requires licensed staff, staff must be licensed to provide services.	3.2 Copy of current license on file.
3.3 Staff will participate in trainings appropriate to their job description and program a. Required education on how a client achieving and maintaining an undetectable viral load for a minimum of six months will not sexually transmit HIV.	3.3 Documentation of completed trainings on file
3.4 New staff will participate in trainings to increase capacity for fulfilling the responsibilities of their position. a. Required completion of an agency-based orientation within 6 weeks of hire b. Training within 3 months of being hired appropriate to the job description. c. Additional trainings appropriate to the job description and Ryan White service category.	3.4 Documentation of completed trainings on file

4. CULTURAL AND LINGUISTIC COMPETENCE

Ryan White funded agencies must provide services that are culturally and linguistically competent based on the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. As noted in the CLAS Standards, ensuring culturally and linguistically appropriate services advances health equity, improves quality, and helps eliminate health care disparities by establishing a blueprint for health and health care organizations. For the purpose of these standards, culture is defined as the integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics.[6] The standards below are adapted directly from the National CLAS Standards.

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[6] National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice. Office of Minority Health, US Department of Health and Human Services. April 2013. https://www.thinkculturalhealth.hhs.gov/clas/standards

Agencies should also strive towards acknowledging implicit bias, how it plays a role in service delivery, and how it can be addressed and countered. Agencies must provide services that align with strategies to reduce implicit bias by the Institute for Healthcare Improvement.[7] For the purpose of the standards, implicit bias refers to the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner. These biases, which encompass both favorable and unfavorable assessments, are activated involuntarily and without an individual's awareness or intentional control. Residing deep in the subconscious, these biases are different from known biases that individuals may choose to conceal for the purposes of social and/or political correctness.[8]

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

Federal and State language access laws require health care facilities that receive federal or state funding to provide competent interpretation services to limited English proficiency patients at no cost, to ensure equal and meaningful access to health care services.[9] Interpretation refers to verbal communication where speech is translated from a speaker to a receiver in a language that the receiver can understand. Translation refers to the conversion of written material from one language to another.

4.0 CULTURAL AND LINGUISTIC COMPETENCE	
Standard	**Documentation**
4.1 Recruit, promote, and support a culturally and linguistically diverse workforce that are responsive to the population served.	4.1 Documentation of how staff demographics reflect the demographics of clients served on file (e.g. race, gender identity, age, sexual orientation, etc.)

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[7] http://www.ihi.org/communities/blogs/how-to-reduce-implicit-bias

[8] http://kirwaninstitute.osu.edu/research/understanding-implicit-bias/

[9] Title VI of the Civil Rights Act of 1964 and California's 1973 Dymally-Alatorre Bilingual Services Act

Standard	Documentation
4.2 Agency develops or utilizes existing culturally and linguistically appropriate policies and practices. a. Agency educates and trains workforce on culturally and linguistically appropriate practices on an ongoing basis.	4.2 Written policy and practices on file a. Documentation of completed trainings on file.
4.3 Provide resources onsite to facilitate communication for individuals who experience impairment due to a challenging medical condition or status (e.g. augmentative and alternative communication resources or auxiliary aids and services)	4.3 Resources on file b. Checklist of resources onsite that are available for client use. c. Type of accommodations provided documented in client file.
4.4 Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.	4.4 *Signed Patient & Client Bill of Rights* document on file that includes notice of right to obtain no-cost interpreter services.
4.5 Ensure the competence of individuals providing language assistance a. Use of untrained individuals and/or minors as interpreters should be avoided b. Ensure quality of language skills of self-reported bilingual staff who use their non-English language skills during client encounters	4.5 Staff resumes and language certifications, if available, on file.
4.6 Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area in clinic points of entry (e.g. registration desks, front desks, reception, waiting rooms, etc.) and areas where work with client is performed (e.g. clinic rooms, meeting rooms, etc.)	4.6 Materials and signage in a visible location and/or on file for reference.

5. INTAKE AND ELIGIBILITY

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

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

6. REFERRALS AND CASE CLOSURE

A client case may be closed through a systematic process that includes case closure justification and a transition plan to other services or other provider agencies, if applicable. Agencies should maintain a list of resources available for the client for referral purposes. If the client does not agree with the reason for case closure, they should follow the grievance policy at the provider agency and/or be referred to the Department of Public Health, Division of HIV and STD Programs Grievance Line.

6.0 REFERRALS AND CASE CLOSURE	
Standard	**Documentation**
6.1. Agency will maintain a comprehensive list of providers for full spectrum HIV-related and other service referrals a. Staff will provide referrals to link clients to services based on assessments and reassessments	6.1 Identified resources for referrals at provider agency (e.g. lists on file, access to websites) a. Written documentation of recommended referrals in client file
6.2 If needed, staff will engage additional providers for specific support services (e.g. behavioral health, substance abuse, housing)	6.2 Agency establishes partnerships with agencies for referrals as needed. Memoranda of Understanding (MOU) on file.
6.3 For clients with missed appointments or pending case closure, staff will attempt to contact client. a. Cases may be closed if the client: • Relocates out of the service area • Is no longer eligible for the service • Discontinues the service • No longer needs the service • Puts the agency, service provider, or other clients at risk • Uses the service improperly or has not complied with the services agreement • Is deceased • Has had no direct agency contact, after repeated attempts, for a period of 12 months.	6.3 Attempts to contact client and mode of communication documented in file. a. Justification for case closure documented in client file

Standard	Documentation
6.4 Agency has a transition procedure in place that is implemented for clients leaving services to ensure a smooth transition for clients who no longer want or need services.	6.4 Completed transition summary in file, signed by client and supervisor (if possible). Summary should include reason for discharge; and a plan for transition to other services, if applicable, with confirmation of communication between referring and referral agencies, or between client and agency.
6.5 Agency develops or utilizes existing due process policy for involuntary discharge of clients from services; policy includes a series of verbal and written warnings before final notice and discharge.	6.5 Due process policy on file as part of transition, discharge, and case closure policy described in the *Patient & Client Bill of Rights* document. (Refer to Section 2).

ACKNOWLEDGEMENTS

The Los Angeles County Commission on HIV would like to thank the following people for their contributions to the development of the Universal Standards of Care.

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7. APPENDICES

APPENDIX A

RYAN WHITE PART A SERVICE CATEGORIES

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

Core medical services include the following categories:

- AIDS Drug Assistance Program
- AIDS pharmaceutical assistance
- Early intervention services
- Health insurance premium and cost sharing assistance for low-income individuals
- Home and community-based health services
- Home health care
- Hospice services
- Medical case management, including treatment-adherence services
- Medical nutrition therapy
- Mental health services
- Oral health
- Outpatient and ambulatory medical care
- Substance abuse outpatient care

Support services include the following categories:

- Case Management (Non-Medical)
- Childcare Services
- Emergency Financial Assistance
- Food Bank/Home Delivered Meals
- Health Education/Risk Reduction
- Housing Services
- Legal Services
- Linguistic Services
- Medical Transportation
- Outreach Services
- Psychosocial Support Services
- Referral
- Rehabilitation
- Respite Care
- Substance Abuse Residential
- Treatment Adherence Counseling

APPENDIX B

PEOPLE WITH HIV/AIDS BILL OF RIGHTS AND RESPONSIBILITIES

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

A. Respectful Treatment

1. Receive considerate, respectful, professional, confidential and timely care in a safe client-centered environment without bias.
2. Receive equal and unbiased care in accordance with federal and State laws.
3. Receive information about the qualifications of your providers, particularly about their experience managing and treating HIV/AIDS or related services.
4. Be informed of the names and work phone numbers of the physicians, nurses and other staff members responsible for your care.
5. Receive safe accommodations for protection of personal property while receiving care services.
6. Receive services that are culturally and linguistically appropriate, including having a full explanation of all services and treatment options provided clearly in your own language and dialect.
7. Look at your medical records and receive copies of them upon your request (reasonable agency policies including reasonable fee for photocopying may apply).
8. When special needs arise, extended visiting hours by family, partner, or friends during inpatient treatment, recognizing that there may be limits imposed for valid reasons by the hospital, hospice or other inpatient institution.

B. Competent, High-Quality Care

1. Have your care provided by competent, qualified professionals who follow HIV treatment standards as set forth by the Federal Public Health Service Guidelines, the Centers for Disease Control and Prevention (CDC), the California Department of Health Services, and the County of Los Angeles.
2. Have access to these professionals at convenient times and locations.
3. Receive appropriate referrals to other medical, mental health or other care services.

C. Make Treatment Decisions

1. Receive complete and up-to-date information in words you understand about your diagnosis, treatment options, medications (including common side effects and complications) and prognosis that can reasonably be expected.

2. Participate actively with your provider(s) in discussions about choices and options available for your treatment.
3. Make the final decision about which choice and option is best for you after you have been given all relevant information about these choices and the clear recommendation of your provider.
4. Refuse any and all treatments recommended and be told of the effect not taking the treatment may have on your health, be told of any other potential consequences of your refusal and be assured that you have the right to change your mind later.
5. Be informed about and afforded the opportunity to participate in any appropriate clinical research studies for which you are eligible.
6. Refuse to participate in research without prejudice or penalty of any sort.
7. Refuse any offered services or end participation in any program without bias or impact on your care.
8. Be informed of the procedures at the agency or institution for resolving misunderstandings, making complaints or filing grievances.
9. Receive a response to a complaint or grievance within 30 days of filing it.
10. Be informed of independent ombudsman or advocacy services outside the agency to help you resolve problems or grievances (see number at bottom of this form), including how to access a federal complaint center within the Center for Medicare and Medicaid Services (CMS).

D. Confidentiality and Privacy

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

E. Billing Information and Assistance

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

F. Patient/Client Responsibilities

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

1. Participate in the development and implementation of your individual treatment or service plan to the extent that you are able.
2. Provide your providers, to the best of your knowledge, accurate and complete information about your current and past health and illness, medications and other treatment and services you are receiving, since all of these may affect your care. Communicate promptly in the future any changes or new developments.
3. Communicate to your provider whenever you do not understand information you are given.
4. Follow the treatment plan you have agreed to and/or accepting the consequences of failing the recommended course of treatment or of using other treatments.
5. Keep your appointments and commitments at this agency or inform the agency promptly if you cannot do so.
6. Keep your provider or main contact informed about how to reach you confidentially by phone, mail or other means.
7. Follow the agency's rules and regulations concerning patient/client care and conduct.
8. Be considerate of your providers and fellow clients/patients and treat them with the respect you yourself expect.
9. Refrain from the use of profanity or abusive or hostile language; threats, violence or intimidations; carrying weapons of any sort; theft or vandalism; intoxication or use of illegal drugs; sexual harassment and misconduct.
10. Maintain the confidentiality of everyone else receiving care or services at the agency by never mentioning to anyone who you see here or casually speaking to other clients not already known to you if you see them elsewhere.

For More Help or Information

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

For patient complaints/grievances call (800) 260-8787
8:00 am – 5:00 pm
Monday – Friday

Universal Standards Updates
As of PPC meeting 12/3/19

From Non-Medical Case Management Standards:

1. Under Staff Requirement and Qualifications

Given there are case management services funded outside of the Ryan White Part A program, staff are responsible for ensuring clients' needs are met through collaboration and coordination across Ryan White funded and non-funded programs.
**Consider adding Case Conferences section back to Universal Standards*

Standards Table:

Staff are required to coordinate across Ryan White funded and non-funded programs to ensure clients needs are met.	Documentation of staff efforts of coordinating across systems for the client on file (e.g. housing case management services, etc.).

2. Trainings

Case Managers and Case Manager Supervisors should have experience in or participate in trainings on:

- LGBTQ+/Transgender community
- HIV Navigation Services (HNS) provided by CDC (currently taken by MCC teams)