LOS ANGELES COUNTY
COMMISSION ON HIV

AGENDA FOR THE **VIRTUAL** MEETING OF THE

STANDARDS AND BEST PRACTICES COMMITTEE

TUESDAY, DECEMBER 1, 2020, 10:00 AM – 12:00 PM

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

https://tinyurl.com/y37brcp3

or Dial

1-415-655-0001

Event Number/Access code: 145 347 2995

(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
Paul Nash, CPsychol AFBPsS FHEA	Katja Nelson, MPP	Joshua Ray (Eduardo Martinez, *alternate*)	Harold Glenn San Agustin, MD
Justin Valero, MA	Amiya Wilson		
QUORUM: 8	***Due to COVID-19, quorum requirements suspended for teleconference meetings per Governor Newsom's Executive Order N-25-20***		

AGENDA POSTED: November 25, 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
  a. Planning CHATT Webinar
  b. Committee, Caucus, Task Forces Updates

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

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

V. DISCUSSION ITEMS

8. Childcare Services Standards Updates 10:45 AM – 11:00 AM

9. Universal Standards of Care Review 11:00 AM – 11:20 AM

10. HIV Continuum Review 11:20 AM – 11:35 AM

11. Engaging Private Health Plans & Private Providers 11:35 AM – 11:45 AM

VI. NEXT STEPS 11:45 AM – 11:55 AM

12. Task/Assignments Recap

13. Agenda development for the next meeting

VI. ANNOUNCEMENTS 11:55 AM – 12:00 PM

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

VII. ADJOURNMENT 12:00 PM

15. Adjournment for the virtual meeting of December 1, 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.**

LOS ANGELES COUNTY
COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov • *VIRTUAL WEBEX MEETING*

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

STANDARDS AND BEST PRACTICES (SBP) COMMITTEE MEETING MINUTES

November 3, 2020

MEMBERS PRESENT	**MEMBERS PRESENT** ***(cont.)***	**PUBLIC**	**COMM STAFF/ CONSULTANTS**
Erika Davies, *Co-Chair*	Katja Nelson, MPP	Leopoldo Cabral	Cheryl Barrit, MPIA
Miguel Alvarez *(Alt.)*	Harold Glenn San Agustin, MD	Amy Croft	Carolyn Echols-Watson, MPA
Wendy Garland, MPH	Justin Valero, MA	Chris Elorde	Jane Nachazel
Felipe Gonzalez		Angelica Sammons	
Grissel Granados, MSW	**MEMBERS ABSENT**		**DHSP STAFF**
Thomas Green *(Alt.)*	Kevin Stalter, *Co-Chair*		None
David Lee, MSW, LCSW, MPH	Joshua Ray, RN *(Full to Martinez)*		
Eduardo Martinez *(Alt. to Ray)*	Amiya Wilson		
Paul Nash, PhD, CPsychol			

*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, *11/3/2020*
2) **Agenda**: Standards and Best Practices (SBP) Committee Meeting Agenda, *11/3/2020*
3) **Minutes**: Standards and Best Practices (SBP) Committee Meeting Minutes, *10/6/2020*
4) **Flyer**: Continuing the Commitment to End HIV, Once and For All, *11/12/2020*
5) **Flyer**: Setting the Standard: A Comprehensive Overview of Service Standards for Part A Planning Councils/Planning Bodies, *11/4/2020*
6) **Duty Statement**: Committee Co-Chair, *Approved 3/28/2017*
7) **Table**: Los Angeles County Commission on HIV Standards and Best Practices, Childcare Standards of Care Comments Log, *9/25/2020*
8) **Standards**: Ryan White Program Universal Standards of Care, *2020 Revisions Draft 10/15/2020*
9) **Graphic**: Comprehensive HIV Continuum Framework, *9/12/2019*

CALL TO ORDER-INTRODUCTIONS-CONFLICT OF INTEREST STATEMENTS: Ms. Davies called the meeting to order at 10:04 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 10/6/2020 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 comments.

IV. REPORTS

5. **EXECUTIVE DIRECTOR/STAFF REPORT**
   - Ms. Barrit provided activity updates for the Committees and other Commission bodies.
   - *Executive Committee:* The main topic at the last meeting was 11/12/2020 Annual Meeting planning with a focus on Ending the HIV Epidemic (EHE). Harold Phillips, Chief Operating Officer, EHE Initiative, will be the first speaker. Mario Pérez, MPH, Director, DHSP, will offer updates including on the home testing kit program, Take Me Home, and draft EHE Plan feedback. Naina Khanna, Executive Director, Positive Women's Network, will speak on building an inclusive, intergenerational HIV movement. Consumer Caucus Co-Chairs will facilitate a community discussion. The Caucus will not hold a separate meeting that day to encourage Annual Meeting participation. A flyer was distributed and registration opened.
   - The Committee also reviewed comments on the draft EHE Plan received, compiled, and submitted to DHSP by Ms. Barrit. Other comments were submitted directly to DHSP. The Commission continues to work closely with Julie Tolentino, MPH and DHSP staff. Like other plans, the EHE Plan is a living document adjusting to community feedback and the pandemic.
   - *Planning, Priorities and Allocations (PP&A) Committee:* One focus of the 11/17/2020 meeting will be on better integrating prevention planning into the Priority Setting and Resource Allocation (PSRA) process. A Work Group of Luckie Alexander, Miguel Martinez, and Maribel Ulloa volunteered to draft some initial recommendations.
   - *Public Policy Committee:* Richard Zaldivar, Founder and Executive Director, The Wall Las Memorias, had to postpone presenting on efforts regarding methamphetamine use to lay the groundwork for collaboration. The 11/2/2020 meeting addressed post-election policy matters and work with the Transgender Caucus to ensure implementation of the Transgender Equity Fund is consistent with community goals.
   - *Aging Task Force:* Recommendations were in their second iteration. Ms. Garland has provided additional data for Ms. Barrit to incorporate for Task Force review. The final iteration will go to PP&A and the full Commission.
   - *Operations Committee:* Recruitment work continues and two candidates were being scheduled for interviews. The training schedule and Mentorship Program were ongoing.
   - *Women's Caucus:* This Caucus has been sponsoring a four-part Lunch & Learn series on Women & HIV. The last segment will be 11/10/2020, 12:00 noon to 1:30 pm, addressing The Impact of Trauma.
   - *Standards and Best Practices (SBP) Committee:* As a reminder, Childcare Standards of Care (SOC) development has been paused while DHSP and its Part D partners facilitate focus groups which can help inform the SOC. DHSP has conducted two trainings for Medical Care Coordination (MCC) teams on implementing Emergency Financial Assistance (EFA). Ms. Barrit will represent the Commission in presenting on SOCs during the 11/4/2020, 12:00 noon to 1:30 pm, Planning CHATT. A representative of the St. Louis Transitional Grant Area will also present on their SOC development practices.

6. **CO-CHAIR REPORT**
   a. **Committee Co-Chair Nominations**
   - Ms. Davies noted it was time to open Co-Chair nominations for the next one-year term. The duty statement was in the packet. All Committee Members meet the one-year membership requirement except for Drs. Nash and San Agustin.
   - ➲ Nominees for Co-Chair elections at the next meeting were: Ms. Davies (accepted), Mr. Gonzalez (considering). Other nominations and self-nominations can be submitted until the election.

   b. **1/5/2021 Meeting**
   - ➲ Agreed to retain all regular meetings during the holidays.

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

- Ms. Garland reported DHSP has been sponsoring learning collaborative webinars for the MCC teams. A webinar the prior week focused on telephone work flow and how agencies were adapting in-person activities to the telephone. Some 100 people attended. The wrap-up webinar was scheduled for 11/18/2020, but the learning collaborative will continue in some form. The process has not only been helpful for DHSP training, but for providers sharing best practices and tips.
- DHSP was using a third-party contractor to disseminate the Take Me Home Program test kits. DHSP was receiving data. The most challenging part of the program is obtaining follow-up information and identifying most pertinent linkage to services.
- Some providers asked if they could use their rapid start date for their linkage to care date. DHSP contacted the Centers for Disease Control and Prevention (CDC) in hopes of identifying a rapid start standard, but CDC had none. Instead, DHSP has reached out to other jurisdictions participating in this prevention grant to learn what they are doing with rapid start.
- Mr. Valero noted many people returning to work after being laid off now have fewer hours and lower pay that no longer supports prior health care. He asked if DHSP had addressed possible increased need for information and services.
- ➲ Ms. Garland will follow-up on the nature and status of County Counsel's review of the Childcare SOC.
- ➲ Ms. Garland will report back on DHSP's review of the Universal SOC.
- ➲ Ms. Garland will follow-up on if DHSP was addressing people coming to Ryan White after losing their private insurance.

V. DISCUSSION ITEMS

8. CHILDCARE SERVICES STANDARDS REVIEW/UPDATES

- Ms. Davies reported, as noted earlier, this work was paused pending DHSP focus group feedback. Comments already received were in the table in the packet along with their resolution.
- ➲ Ms. Barrit will report back on focus group input and any changes to the SOC.

9. UNIVERSAL STANDARDS OF CARE REVIEW

- Ms. Barrit reviewed updates as reflected in the iteration in the packet especially regarding telehealth and confidentiality. Items in red were added while those in yellow were modified.
- Ms. Davies was glad to see the incorporation of anonymous surveys. They lend themselves to more accurate input.
- Dr. San Agustin noted most of his clients still prefer face-to-face so he was glad clients retain the right to decline telehealth. While some providers do have telehealth, many others are beginning with appointments by phone.
- ➲ Ensure provider responsiveness includes assistance in navigating confusion and/or technical difficulties with telehealth.
- ➲ Recognize that, while video telehealth is the ultimate goal, telehealth now will be on a range including the telephone.
- ➲ Include resources on best practices for telehealth over the phone as well as for video. Mr. Valero may have resources.
- ➲ Ms. Barrit will incorporate changes for final review and possible vote at next meeting.

10. HIV CONTINUUM REVIEW

- Ms. Barrit noted the Continuum helps drive service development and highlights that care continues for sustained health.
- Ms. Granados said it has been simplified over time and the focus has shifted to a healthy community by addressing Social Determinants of Health (SDH) and a healthy life whether a person is HIV+ or HIV-. Ms. Barrit added that SBP emphasized last year that people might enter or exit the Continuum at any point.
- Dr. San Agustin expressed concern that, while generally true, there may be liability in saying PLWH taking PrEP do not acquire HIV and people with sustained viral load suppression do not transmit it.
- ➲ Revise green bar title to "Diagnose and Treat" for consistency with EHE pillars.
- ➲ Move "Link to Care & Supportive Services" before "Prescribe HIV Treatment."
- ➲ Delete "& Prevention" from second green box.
- ➲ Delete examples in parentheses in "Address Risk Factors & Barriers" since other boxes do not include examples.
- ➲ Email any additional revisions to Ms. Barrit for incorporation.

11. CLIENTS' BILL OF RIGHTS REVIEW

- Ms. Barrit noted review began last year, e.g., added telephone number.
- ➲ Refer to Consumer Caucus for review and return comments to next meeting.
- ➲ Page 21, F.2.: Changes should also be updated by providers in their records.
- ➲ Email any additional revisions to Ms. Barrit for incorporation.

VI. NEXT STEPS

12. **TASK/ASSIGNMENTS RECAP**: There were no additional items.

13. **AGENDA DEVELOPMENT FOR NEXT MEETING**:

➲ Refer to Executive: Mr. Valero request to add to next year's Work Plan to interface more richly with private health care.

VII. ANNOUNCEMENTS

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

VIII.ADJOURNMENT

15. **ADJOURNMENT**: The meeting adjourned at 11:55 am.

LOS ANGELES COUNTY
COMMISSION ON HIV

DUTY STATEMENT

COMMITTEE CO-CHAIR

(APPROVED 3-28-17)

In order to provide effective direction and guidance for the Commission on HIV, Committee Co-Chairs must meet the following demands of their office, representation and leadership:

COMMITTEE LEADERSHIP:

① Serves as Co-Chair of a standing Commission Committee, and leads those monthly meetings
② Leads Committee decision-making processes, as needed
③ Meets monthly with Executive Director, or his/her designee, to prepare the Committee meeting agendas, course of action and assists Commission staff in the preparation of motions, backup materials and information for meetings, as necessary and appropriate
④ Assigns and delegates work to Subcommittees, task forces and work groups
⑤ Serves as a member of the Commission's **Executive Committee**

MEETING MANAGEMENT:

① Serves as the Presiding Officer at the Committee meetings
② In consultation with other Co-Chair and senior Commission staff member(s), leads the Committee meetings,
  - conducting business in accordance with Commission actions/interests
  - recognizing speakers, stakeholders and the public for comment at the appropriate times
  - controlling decorum during discussion and debate and at all times in the meeting;
  - imposing meeting rules, requirements and limitations
  - calling meetings to order, for recesses and adjournment in a timely fashion and according to schedule, or extending meetings as needed
  - determining consensus, objections, votes, and announcing roll call vote results
  - ensuring fluid and smooth meeting logistics and progress
  - finding resolution when other alternatives are not apparent
  - ruling on issues requiring settlement and/or conclusion

③ Ability to put aside personal advocacy interests, when needed, in deference to role as the Committee's Presiding Officer.

REPRESENTATION:

In consultation with the Executive Director, Committee Co-Chairs:

① May ONLY serve as Committee spokesperson at various events/gatherings, in the public, with public officials and to the media if approved by the Commission Co-Chairs and Executive Director
② Take action on behalf of the Committee, when necessary

③ Generates, signs and submits official documentation and communication on behalf of the Committee
③ Present Committee findings, reports and other information to the full Commission, Executive Committee, and, as appropriate, other entities
⑤ Represent the Committee to the Commission, on the Executive Committee, and to other entities
⑥ Support and promote decisions resolved and made by the Committee when representing it, regardless of personal views

KNOWLEDGE:
① CDC HIV Prevention Program, Ryan White Program (RWP), and HIV/AIDS and STI policy and information
② LA County Comprehensive HIV Plan and Comprehensive HIV Continuum
③ LA County's HIV/AIDS and STI, and other service delivery systems
④ County policies, practices and stakeholders
⑤ Ryan White Program legislation, State Brown Act, applicable conflict of interest laws
⑥ County Ordinance and practices, and Commission Bylaws
⑦ Topical and subject area of Committee's purview
⑧ **Minimum of one year active Committee membership prior to Co-Chair role**

SKILLS/ATTITUDES:
① Sensitivity to the diversity of audiences and able to address varying needs at their levels
② Life and professional background reflecting a commitment to HIV/AIDS and STI-related issues
③ Ability to demonstrate parity, inclusion and representation
④ Take-charge, "doer", action-oriented; ability to recruit involvement and interest
⑤ Unintimidated by conflict/confrontation, but striving for consensus whenever possible
⑥ Firm, decisive and fair decision-making practices

COMMITMENT AND ACCOUNTABILITY TO THE OFFICE:
① Put personal agenda aside and advocate for what's in the best interest of the Commission
② Devote adequate time and availability to the Commission and its business
③ Assure that members' and stakeholders' rights are not abridged
④ Advocate strongly and consistently on behalf of Commission's and people living with and at risk for HIV, interests
⑤ Always consider the views of others with an open mind
⑥ Actively and regularly participate in and lead ongoing, transparent decision-making processes
⑦ Respect the views of other regardless of their race, ethnicity, sexual orientation, HIV status or other factors

County of Los Angeles- Department of Public Health
Division of HIV and STD Programs

Child Care Services Consumer Listening Session
Notes/Summary

Overview

The Division of HIV and STD Programs (DHSP) in collaboration with HIV Resources Service Administration (HRSA) Part D Recipients (UCLA and Los Angeles County + USC/Maternal Child, and Adolescent/Adult Center (MCA)), the Commission on HIV (COH), and the COH Women's Task Force conducted virtual listening sessions with community consumers to further determine their need for Child Care Services while attending medical and support service appointments.

Purpose

The purpose of these listening sessions was to further determine consumer Child Care needs to inform the Commission on HIV (COH) Child Care Services Standards of Care.

Below are the notes from these listening sessions submitted on behalf of DHSP, UCLA, MCA, COH, and the COH Women's Task Force.

Method/Process

Three online Zoom sessions were held with a total of 24 cis-gender women (women). An English-only session was held on October 18, 2020 with eight (8) participants, a Spanish-only session was held on October 23, 2020 with eight (8) participants, and a bilingual (English/Spanish) session on October 25, 2020 with eight (8) participants. Demographic information was not formally collected. However, the 24 women who participated were either African American and/or Latina.

The women had children whose ages ranged from four (4) to 15 years old. There was a subset of women who no longer had dependent children but had experienced accessing Child Care Services in the past.

The sessions were facilitated through Zoom. UCLA and MCA staff were the primary recruiters for the listening session participants. Promotion of the listening sessions was done via email and social media.

The sessions were co-facilitated by staff from UCLA, MCA and DHSP.

Listening Sessions Questions

1. Is childcare a barrier to attending your medical, dental, mental health, support service appointments? Please explain and tell me some more about that.

2. Please tell me more about the child-watch services that are currently offered by your medical, dental, mental health, support service provider.

3. For those of you that have received child-watch services during one of your appointments, please tell me how happy you were with the service? Did it work for you? Did it not work for you and why?

4. Who do you usually rely on now for childcare services to attend your medical, dental, mental health appointments? Are you happy with this option and please tell us more about it?

5. Please tell us what ideally this service should look like to best serve you?

6. Is there anything else we should know about your childcare needs to help you get to your medical, dental, mental health, case management, other support services appointments?

Main Themes

Access to Care

- For the participants who access their medical care at MCA, childcare services were not a significant barrier for them to attend medical appointments. Before the COVID-19 pandemic and Safer at Home Orders were released, MCA offered childcare services. These same participants noted that lack of childcare was a barrier to for accessing other medical services outside of the MCA clinic, such as dental appointments, labs/x-rays. They noted that e on-site child care offered by MCA was not available for these types of appointments. The participants described that childcare services had not been as accessible as in previous years (pre-COVID). (MCA had reported that the staff assigned to provide childcare had been on medical leave.)
- Participants who were not part of the MCA, noted the lack of on-site childcare was a significant barrier to them keeping their medical appointments.
- Participants in all focus groups noted they are usually forced to bring their children with them and try to occupy them with things (such as their cell phone) during their appointments. This was also noted by MCA-clients given the interruption/lack of continuous on-site childcare at that clinic.
- Participants noted that many times they did not feel comfortable asking the doctor questions or they were not able to pay full attention to what the doctor was telling them because their children were a distraction.
    - The number of children per participant ranged from 1 to 4.
    - Traveling with children on the bus was also mentioned as a challenge to traveling to appointments as, many participants only could travel by bus.
- All participants shared that if they were not able to take their children with them and if they did not have childcare at home, they would cancel their appointment.
    - During remote schooling (as a result of the COVID-19 pandemic), some noted that they would rather cancel the appointment, so their child would not miss school.

Current Services

- All focus group participants noted they would like a childcare/child watch program to have the following components:
    - do their homework/attend school while they are in the clinic
    - Provide food for the children (and clients) given that for many, attending a doctor's appointment is an all-day endeavor
    - Ensure that childcare staff are trained to address the needs of children with special needs.
- Participants receiving their HIV medical care at MCA noted they would like to be able to access the childcare/child watch program for non-MCA medical appointments

Outside Sources of Support

- Most focus group participants reported that they did not have trusted or reliable outside support to use as an option to watch their children.

    - Some participants noted they could sometimes rely on family and friends--but not all the time. Participants with multiple children found it more difficult to rely on family and friends for childcare/watch.
    - Some noted not trusting others, including family or ex-spouses, with the care of their children because of potential harmful situations (e.g., abuse/neglect).

Components recommended in a Child Care Services program:

Staffing:

- Core training requirements to handle children with special needs for staff
- CPR-certified staff
- Staff with childcare education background
  Staffed with enough people to provide appropriate one-on-one oversight of the children

Environment

- Internet access
- Computers for the kids to use during school hours
- Age appropriate educational supplies
- Food/snacks
- Masks for the kids and PPE
- Kid-friendly space with lots of seating, visually nice and kid-friendly videos available to watch
- Open 5 days a week

Gift Cards

- Many of the participants agreed gift cards would be useful to pay others (neighbors, family members) to watch their children during their appointments. They shared that they currently pay someone between $25 or $50 per child for a few hours. For multiple children and multiple appointments, this can become expensive and unsustainable.
- Visa gift card were most preferred as they “are like cash”.

LOS ANGELES COUNTY
COMMISSION ON HIV

CHILDCARE

STANDARDS OF CARE

DRAFT—UPDATED 9/25/20

POST PUBLIC COMMENT PERIOD
PUBLIC COMMENT PERIOD:
SEPTEMBER 11-23, 2020
Email comments to HIVComm@lachiv.org

DRAFT – UPDATED 9/25/20 POST PUBLIC COMMENT PERIOD

LOS ANGELES COUNTY
COMMISSION ON HIV

CHILDCARE SERVICES
STANDARDS OF CARE

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

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

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

Service Standards: Ryan White HIV/AIDS Programs

INTRODUCTION

Standards of Care 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 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), members of the Los Angeles County Commission on HIV, Standards & Best Practices Committee, Women's Caucus, and the public-at-large.

CHILDCARE SERVICES OVERVIEW: ALLOWABLE USE OF FUNDS

HRSA allows the use of Ryan White Part A funding for childcare services for the children of clients living with HIV, provided intermittently, **only while** the client attends in person, telehealth, or other appointments and/or Ryan White HIV/AIDS Program- related meetings, groups, or training sessions. Part A funded childcare services cannot be used while the patient is at school or work. Only Ryan White Part A community advisory board meetings and Part A funded support groups are covered in these standards. The goal of childcare services is to reduce barriers for clients in accessing, maintaining and adhering to primary health care and related support services. Childcare services are to be made available for all clients using Ryan White Part A medical and support services.

Commented [BC1]: Added to clarify that childcare should not be limited to medical appointments only.

May include use of funds to support:

- A licensed childcare provider to deliver intermittent care

License-exempt or 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).

License-exempt or informal childcare should be limited and carefully monitored to assure:

- Compliance with the prohibition on direct payments to eligible individuals. Direct cash payments to clients are not permitted.
- Assurance that liability issues for the funding source are carefully weighed and addressed through the use of liability release forms designed to protect the client, provider, and the Ryan White Program

Childcare services may include recreational and social activities for the child/children, if provided in a licensed childcare setting including drop-in centers in primary care or satellite facilities. However, funds may not be used for off-premise social/recreational activities or gym membership.

SERVICE REQUIREMENTS

Depending on contractual requirements from the Division of HIV and STD Programs, provider capacity, and individual client needs, childcare providers may be licensed or license-exempt.

Licensed – means childcare providers who are licensed by the State of California and are required to maintain minimum standards related to physical size of the facility, safety features, cleanliness, staff qualifications, and staff-to-child ratios.

License-Exempt – means 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 onsite childcare or child watch 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 certificates may be considered as an option for agencies 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.

Child watch is a non-licensed service provided onsite at a service provider's site for the duration of the client's appointment only. Parents are responsible for their children during child watch hours.

All service providers receiving funds to provide childcare services are required to adhere to the following standards. To minimize barriers to accessing childcare, some of the training requirements and recommendations vary by childcare setting.

Table 1. CHILDCARE SERVICES STANDARDS OF CARE

SERVICE COMPONENT	STANDARD	DOCUMENTATION
Eligibility and Need	Eligibility for Ryan White and need for childcare service are identified at intake and assessments by agencies providing licensed and/or license-exempt childcare.	Documentation of eligibility and in the client's primary record must reflect the appointment and/or meeting/group/training session attended.
Licensed Child Care Centers and Family Child Care Homes	Licensed childcare facilities must carry a valid active license as a 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.[1]	a. Appropriate liability release forms are obtained that protect the client, provider and the Ryan White program b. Documentation that no cash payments are being made to clients or primary care givers c. Providers must develop policies, procedures and signed agreements with clients for childcare services.
License-exempt Childcare	Compliance with the prohibition on direct payments to eligible individuals. Direct cash payments to clients are not permitted. Assurance that liability issues for the funding source are carefully weighed and addressed through the use of liability release forms designed	Where license-exempt childcare arrangements are obtained, contracted agency(ies) must ensure: a. Documentation of compliance with DHSP-required mechanism for handling payments for licensed-exempt childcare arrangements

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

	to protect the client, provider, and the Ryan White Program.	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 d. Documentation that payment is for actual costs of service. e. Providers must develop policies, procedures and signed agreements with clients for child watch services.
Training: **All are required** for licensed childcare facilities *** denotes highly recommended** for license-exempt childcare	Agencies providing childcare are responsible for ensuring childcare providers are trained appropriately for their responsibilities. Childcare staff must complete the following training: • First aid/CPR* • Fire and electrical safety* • Child development* • Waste disposal procedures • Child abuse* • Domestic violence* • HIPAA and confidentiality* • HIV 101* • Infection Control* • American Disabilities Act (ADA) • Cultural Diversity Training* • HIV stigma reduction* • LGBT 101 training* • Ryan White training* • Seeing signs of sexual abuse*	Record of trainings on file at provider agency.

Commented [BC2]: Public comment received

Language	Whenever possible, childcare should be delivered in the language most familiar to the child or language preferred by the patient. If this is not possible, interpretation services must be available in cases of emergency.	Appropriate language noted in client or program file.
Confidentiality	Agencies coordinating and providing childcare services must ensure client confidentiality will be maintained at all times. HIV status shall never be disclosed to anyone.	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, external partners, and other DHSP funded Ryan White service providers.	Program flyers and emails documenting that childcare services was promoted to clients and HIV service providers.
	Agencies should attempt to disseminate information about the availability of childcare throughout all components of the continuum of HIV care, including meetings with internal agency staff and relaying information to external HIV medical and social services partners.	Offer of childcare services and/or promotional attempt are noted in client case file.
	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.

Commented [BC3]: Public comment received.

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.[2] 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.
Transportation	Clients who demonstrate a need for transportation to and from the childcare site, must be provided transportation support. Agencies must follow transportation programmatic guidance and requirements from DHSP. Childcare must be provided in a manner that is more accessible and convenient for the client.	

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[2] 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/

Appendix A: Examples of Childcare Resources

Inclusion of commercial business is for illustration purposes only and should not be interpreted as a form of endorsement.

Commented [BC4]: Added by CBarrit 9/25/20.

Childcareaware.org – works with more than 400 state and local childcare resource and referral agencies nationwide.

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

Connections For Children https://www.connectionsforchildren.org/

Crystal Stairs https://www.crystalstairs.org/

Commented [BC5]: Public comment received.

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/

https://www.maof.org/resources-for-parents/

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

YMCA of Greater Williamson County Members Responsibilities and Guidelines for Child Watch Page 11

Online or mobile app based childcare booking sites that offer gift certificates or corporate accounts:
Urbansitters.com
Nanno.com
Bambino.com
Care.com

Commented [BC6]: Public comment received.

LOS ANGELES COUNTY
COMMISSION ON HIV

RYAN WHITE PROGRAM
UNIVERSAL STANDARDS OF CARE

2020 Revisions Draft
11/16/20 Last
approved by the
Commission on
September 12, 2019

LOS ANGELES COUNTY
COMMISSION ON HIV

TABLE OF CONTENTS

Commented [BC1]: Suggestion: Delete section. Outside scope of PC, instead work with DHSP CQI Team to help shape QI efforts with strong consumer engagement and input.

IMPORTANT: Service standards must adhere to requirements and restrictions from the federal agency, Health Resources and Services Administration (HRSA). The key documents used in developing standards are as follows:
Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18)
HIV/AIDS Bureau, Division of Metropolitan HIV/AIDS Programs National Monitoring Standards for Ryan White Part A Grantees: Program – Part A
Service Standards: Ryan White HIV/AIDS Programs

INTRODUCTION

Standards of Care outline the elements and expectations a Ryan White service provider follows when implementing a specific service category. Standards of Care are available for each service category to set the minimum level of care Ryan White funded agencies should offer to clients.[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
- Prevent information technology security risks and protect patient information and records
- Inform clients of services, establish eligibility, and collect information through an intake process
- Effectively assess client needs and encourage informed and active participation
- Address client needs through coordination of care and referrals to needed services

- Ensure that the quality of service and materials given to patients during telehealth encounter is on par with in-person visits.

1. GENERAL AGENCY POLICIES

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

Agencies are encouraged to build their telehealth technology infrastructure and capacity to include videoconferencing to facilitate patient-provider connectivity and relationships.

Commented [BC2]: Attempt to include Dr. San Agustin's comments.

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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 with specific information technology safeguards for confidentiality and patient information if using telehealth service modality.
1.2 Agency ~~are~~ is responsible for informing the patient that they have the right to obtain copies of their medical and other health records maintained by the agency.	1.2 Written policy for informing the patient of their rights to receive a copy of their medical records. The policy should contain a description of the process for obtaining records, such as a verbal or written request and a reasonable timeframe for patients to receive the information.
1.3 Client determines what information of theirs can be released and with whom it can be shared. Services using telehealth modality are subject to consent by the patient.[1]	1.3 Completed *Release of Information Form* on file including: • Name of agency/individual with whom information will be shared • Information to be shared • Duration of the release consent • Client signature For agencies and information covered by the Health Insurance Portability and Accountability Act (HIPAA), form must be HIPAA disclosure authorization compliant. The form must also be compliant with the CA Medi-Cal telehealth policy.[2]

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[1] https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthFAQ.aspx

[2] https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/mednetele.pdf

1.4 Agency develops or utilizes an existing grievance procedure to ensure clients have recourse if they feel they are being treated in an unfair manner or feel they are not receiving quality services.	1.4 Written grievance procedure on file that includes, at minimum: • Client process to file a grievance • Information on the Los Angeles County Department of Public Health, Division of HIV & STD Programs (DHSP) Grievance Line 1-800-260-8787. [3] 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 or provided to the patient at the beginning of a telehealth encounter.

Commented [LK3]: Agree. LK

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

Standard	Documentation
1.5 Agency provides eligibility requirements for services available upon request. Eligibility requirements must follow guidance from Division of HIV & STD Programs (DHSP) and HRSA under Policy Clarification Notice #16-02.[4]	1.5 Written eligibility requirements on file.
1.6 All client files are stored in a secure and confidential location, and electronic client files are protected from unauthorized use. Protection of client files and information must cover use of electronic medical records, phones, text messages, email, and telehealth modalities.	1.6 Client files must be locked and/or password protected with access provided only to appropriate personnel. Agencies must establish written procedures and IT policies for message encryption and restrictions on staff access to protect client information.
1.7 Agency maintains progress notes of all communication between provider and client.	1.7 Legible progress notes maintained in individual client files that include, at minimum: • Date of communication or service • Service(s) provided • Recommended referrals linking clients to needed services (See Section 7: Referrals and Case Closure)
1.8 Agency develops or utilizes an existing crisis management policy.	1.8 Written crisis management policy on file that includes, at minimum: • Mental health crises • Dangerous behavior by clients or staff
1.9 Agency develops a policy on utilization of Universal Precaution Procedures.[4] a. Staff members are trained in universal precautions.	1.9 Written policy or procedure on file. a. Documentation of staff training in personnel file.
1.10 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.	1.10 ADA criteria on file at all sites.

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

Standard	Documentation
1.11 Agency complies with all applicable state and federal workplace and safety laws and regulations, including fire safety.	1.11 Signed confirmation of compliance with applicable regulations on file.

2. CLIENT RIGHTS AND RESPONSIBILITIES

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

2.0 CLIENT RIGHTS AND RESPONSIBILITIES	
Standard	**Documentation**
2.1 Agency ensures services are available to any individual who meets the eligibility requirements for the specific service category.	2.1 Written eligibility requirements on file. Client utilization data made available to funder.
2.2 Agency includes input from people living with HIV/AIDS in the design and evaluation of services to ensure care is client-centered.	2.2 Written documentation of how input was received to inform service planning and evaluation in regular reports. Lists may include: • Consumer Advisory Board meetings • Participation of people living with HIV in HIV program committees or other planning bodies • Needs assessments • Anonymous patient satisfaction surveys. Discreet drop off boxes should be available in various sites throughout the agency and/or anonymous electronic follow-up surveys emailed to patients after their appointment. • Focus groups

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

2.3 Agency ensures that clients receive information technology support and training on how to use telehealth services.	2.3 Written checklists and/or "how to" guides are provided to patients prior to their telehealth appointment. Materials may be emailed to patient and/or posted on the agency website. The document should contain at least the following information: • Instructions on how to use telehealth tools (i.e., phone, laptop, tablets, etc.) in plain ~~English~~ language and available ~~or a language preferred by the patient~~in the patient's preferred language. • Telephone number for technical support or trouble shooting available before, during and after the telehealth appointment.
2.4 Agency ensures that clients retain the right to accept or decline a telehealth visit. The ultimate decision on the mode of service delivery, whether in-person or telehealth, must be determined by the client first before an appointment is made.	2.4 Written procedures and telehealth acceptance or denial form completed by patients prior to the appointment.

Standard	Documentation
2.5 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 The Patient and Client Bill of Rights applies to telehealth. It is the provider's responsibility to ensure that the patient understands their rights in all service settings, including telehealth.	2.5 *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. The AIDS Education Training Center (AETC) offers a variety of training for the HIV workforce.

3.0 STAFF REQUIREMENTS AND QUALIFICATIONS	
Standard	**Documentation**

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

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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. b. Staff should have experience in or participate in trainings on: • LGBTQ+/Transgender community and • HIV Navigation Services (HNS) provided by Centers for Disease Control and Prevention (CDC). • Trauma informed care	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
3.5 Staff are required to coordinate across Ryan White funded and non-funded programs to ensure clients' needs are met.	3.5 Documentation of staff efforts of coordinating across systems for the client on file (e.g. housing case management services, etc.).

4. CULTURAL AND LINGUISTIC COMPETENCE

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

Federal and State language access laws require health care facilities that receive federal or state funding to provide competent interpretation services to limited English proficiency patients at no cost, to ensure equal and meaningful access to health care services.[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.

Commented [LK4]: Is this in reference to a client being discharged from a clinic? If so, may want to incorporate the phrase specifically (Discharge from clinic, care, etc) as providers may be more familiar with that term versus "Case Closure."

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

Commented [LK5]: As above

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~~Appendix B).

7.0 PROVIDER QUALITY MANAGEMENT PLANS

The Patient Bill of Rights note that patients have the right to “receive considerate, respectful, professional, confidential and timely care in a safe client-centered environment without bias.” Direct patient feedback and documented implementation of their suggestions for improvement are critical for increasing patient satisfaction.

7.0 PROVIDER QUALITY MANAGEMENT PLAN	
STANDARD	**DOCUMENTATION**
7.1 All providers must have written Quality Management Plans and quality improvement activities, aimed at optimal patient experience and care. Continuous quality improvement activities must address at least the following areas of patient care: • Health outcomes beyond just viral suppression and encompass overall health and wellbeing. • Timeliness and responsiveness of patient care. Providers should strive to reduce door to provider time and assess patient satisfaction of services and interactions with clinical and support staff.	7.1.a. Agency Quality Improvement Plan is reviewed and approved by DHSP. 7.1.b. Agency patient satisfaction survey results and implementation of feedback.

Commented [LK6]: What if client is being discharged (d/t behavior issues or other reasons)? This sounds as if the provider only needs to have a transition procedure if the client is leaving on their own accord. Not sure if this was the intent here. Suggest removing last bit and ending sentence after word transition.

Commented [LK7]: If referring to APPENDIX B: PEOPLE WITH HIV/AIDS BILL OF RIGHTS AND RESPONSIBILITIES then I would use that title. Also, I don’t find a section 2 on Appendix B, is this in reference to different document?

Commented [BC8]: Recommendation: Delete section. QM work is under DHP. Work with DHSP staff to help share QI efforts with strong consumer/COH involvement.

Commented [LK9]: I am not sure this statement belongs here, seems odd to discuss the BOR when table is focusing on QM Plan expectations although I do understand the link between QM Programs and improved client satisfaction.

Commented [RC10R9]: Consider referring to the PCN 15-02 here for QM program guidance and expectations.

Commented [RC12R11]: Agree with Lisa’s comments above. While a QM plan can be an important part of the QI process for an agency, I would consider a focus on documentation of QI activities instead since that is the ultimate goal for a program to actually be doing QI work, not just writing a document that says they are.

Commented [LK11]: This language is only a small part of the RWP CQM program and the following should be noted:
1. CQM Programs which includes the development of a CQM plan is ONLY required for RWP recipients and subrecipients?
2. Per HRSA’s PCN 15-02, the focus of all QI activities is improved care, improved health outcomes and Improved satisfaction.
3. To be effective, this section would need more context surrounding all CQM requirements, again only applicable to RWP recipients/subrecipients.
4. DHSP does not currently “review and approve” agency CQM plans; subrecipient CQM program monitoring has not been finalized as of yet.
5. Happy to provide additional info/language but would benefit in knowing the reason for adding this language to the standard in general.

Federal and National Resources:

HRSA's Ryan White HIV/AIDS Program Expanding HIV Care Through Telehealth CAREAction Newsletter October 2019: https://hab.hrsa.gov/sites/default/files/hab/Publications/careactionnewsletter/telehealth.pdf

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USDHHS Telehealth Discretion During Coronavirus:

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Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency

Using Telehealth to Expand Access to Essential Health Services during the COVID-19 Pandemic

-AMA Telehealth Quick Guide: https://www.ama-assn.org/practice-management/digital/ama-telehealth-quick-guide

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CMS Flexibilities for Physicians: https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf - "Under the CARES Act, CMS is waiving the requirements of section 1834(m)(1) of the ACT and 42 CFR § 410.78(a)(3) for use of interactive telecommunications systems to furnish telehealth services, to the extent they require use of video technology, for certain services. This waiver allows the use of audio-only equipment to furnish services described by the codes for audioonly telephone evaluation and management services, and behavioral health counseling and educational services."

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-CMS Flexibilities for RHCs and FQHCs: https://www.cms.gov/files/document/covid-rural-health-clinics.pdf - "Medicare telehealth services generally require an interactive audio and video telecommunications system that permits real-time communication between the practitioner and the patient. (During the PHE, some telehealth services can be furnished using audio-only technology.)"

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CMS Fact Sheet on Virtual Services: https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

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-AAFP Comprehensive Telehealth Toolkit: https://www.aafp.org/dam/AAFP/documents/practice_management/telehealth/2020-AAFP-Telehealth-Toolkit.pdf

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– ACP Telehealth Guidance & Resources: https://www.acponline.org/practice-resources/business-resources/telehealth

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-ACP Telemedicine Checklist: https://www.acponline.org/system/files/documents/practice-resources/health-information-technology/telehealth/video_visit_telemedicine_checklist_web.pdf

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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.

Standards & Best Practices Committee Members

Miguel Alvarez
Erika Davies *Co-Chair*
Wendy Garland, MPH
Felipe Gonzalez
Thomas Green
David Lee, MSW, LCSW, MPH
Katja Nelson, MPP
Joshua Ray
Harold Glenn San Agustin, MD
Kevin Stalter *Co-Chair*
Justin Valero
Amiya Wilson

8. APPENDICES

APPENDIX A: RYAN WHITE PART A SERVICE CATEGORIES

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

Core medical services include the following categories:

a. AIDS Drug Assistance Program
b. AIDS pharmaceutical assistance
c. Early intervention services
d. Health insurance premium and cost sharing assistance for low-income individuals
e. Home and community-based health services
f. Home health care
g. Hospice services
h. Medical case management, including treatment-adherence services
i. Medical nutrition therapy
j. Mental health services
k. Oral health
l. Outpatient and ambulatory medical care
m. Substance abuse outpatient care

Support services include the following categories:

n. Case Management (Non-Medical)
o. Childcare Services
p. Emergency Financial Assistance
q. Food Bank/Home Delivered Meals
r. Health Education/Risk Reduction
s. Housing Services
t. Legal Services
u. Linguistic Services
v. Medical Transportation
w. Outreach Services
x. Psychosocial Support Services
y. Referral
z. Rehabilitation
aa. Respite Care
bb. Substance Abuse Residential

cc. Treatment Adherence Counseling

APPENDIX B: PEOPLE WITH HIV/AIDS BILL OF RIGHTS AND RESPONSIBILITIES

It is the provider's responsibility to ensure that the patient understands their rights in all service settings, including telehealth.

Commented [LK13]: Understands or Is provided with written documentation of their rights? How would a provider assess and document that a patient understands? If that is the goal, then provider documentation should include that "client verbalized understanding of …" and that should somehow be part of the documentation procedure.

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

~~A. Respectful Treatment~~Respectful Treatment and Preventative Services

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~~Receive considerate, respectful, professional, confidential and timely care in a safe client-centered environment without bias~~. "Receive considerate, respectful, professional, confidential and timely care and preventative services (such as screenings and vaccinations) in a safe client-centered, trauma-informed environment without bias."

Commented [BC15]: From Octavio Vallejo

1.
2. Receive equal and unbiased care according to your age and needs in accordance with federal and State laws.

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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~~Review 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.

Commented [LK17]: This document is given to the client, who or what entity is responsible for ensuring that hospitals and healthcare providers adhere to these commitments? I recommend rewording for clarity.

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.

~~3.~~4. Have their phone calls and/or emails answered with 3 days.

~~C. Make Treatment Decisions~~ Participate in the Decision-making Treatment Process

~~1.~~5. 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.~~6. Participate actively with your provider(s) in discussions about choices and options available for your treatment.

7. Make the final decision about which ~~choice and~~treatment option is best for you after you have been given all relevant information about these choices and the clear recommendation of your provider.

Have access to patient-specific education resources and reliable information and training about patient self-management.

~~3.~~8.

~~4.~~9. Refuse any and all treatments recommended and be told of the effect that not taking the treatment may have on your health, be told of any other potential consequences of your refusal and be assured that you have the right to change your mind later.

~~5.~~10. Be informed about and afforded the opportunity to participate in any appropriate clinical research studies for which you are eligible.

~~6.~~11. Refuse to participate in research without prejudice or penalty of any sort.

~~7.~~12. Refuse any offered services or end participation in any program without bias or impact on your care.

~~8.~~13. Be informed of the procedures at the agency ~~or institution~~ for resolving misunderstandings, making complaints or filing grievances.

~~9.~~14. Receive a response to a complaint or grievance within 30 days of filing it.

~~10.~~15. 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.~~C. 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

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request with an explanation.)

~~E.~~D. 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.~~E. 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 accept~~ing~~ the consequences of failing to adhere to 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 is ~~should be~~ to speak with your provider or a designated client services representative or patient or

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treatment advocate at the agency. If this does not resolve ~~any~~ the problem in a reasonable time span, or if serious concerns or issues ~~that~~ arise ~~that you feel~~ and you would like ~~need~~ to speak ~~about~~ with someone outside the agency, you may call the number below for confidential, independent information and assistance.

Division of HIV and STD Programs Client Grievance Line~~For patient complaints/grievances call~~
~~-~~(800) 260-8787
8:00 am – 5:00 pm
Monday – Friday

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Commented [LK25]: This section seems somewhat misleading; client's should be made aware that this is the contact information for DHSP which they may not consider "independent". Overall, Appendix B has several oddly written sentences and multiple terms used to identify similar persons, concepts. (eg. Provders vs. Agency vs. institution, etc.) That said, I am not sure if the focus of this review request was for this document as well. Feel free to use or discard edits and comments as needed.

LOS ANGELES COUNTY COMMISSION ON HIV PREVENTION SERVICES STANDARDS

LOS ANGELES COUNTY
COMMISSION ON HIV

Approved the Commission on HIV 06/14/18

Cultural humility: All HIV prevention organizations should strive to deliver culturally responsive services. Culturally responsive services are those that are respectful of, and relevant to, the beliefs, practices, culture and linguistic needs of diverse consumer/client populations and communities.[1] Cultural responsiveness describes the capacity to respond to the issues of diverse communities. It thus requires knowledge and capacity at different levels of intervention: structural, community, organizational, and individual. Culturally-responsive services acknowledge that power imbalances exist between groups of people and cultures based on historical and institutional oppression and privilege; that we are not simply "different" from one another. Culturally responsive agencies also create a physical environment that is welcoming, warm, and that communicates a sense of safety for clients.

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

To practice cultural humility is to maintain a willingness to suspend what you know, or what you think you know, about a person based on generalizations about their culture. Whereas cultural *competency* implies that one can function with a thorough knowledge of the mores and beliefs of another culture, cultural *humility* acknowledges that it is impossible to be adequately knowledgeable about cultures other than one's own. What you learn about your clients' culture stems from being open to what they themselves have determined is their personal expression of their culture.[2] Tenets of cultural humility include:

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

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

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

Another resource to consider:

Cultural Competemility: A Paradigm Shift in the Cultural Competence versus Cultural Humility Debate – Part I

https://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-24-2019/No1-Jan-2019/Articles-Previous-Topics/Cultural-Competemility-A-Paradigm-Shift.html

LOS ANGELES COUNTY
COMMISSION ON HIV

RYAN WHITE PROGRAM
UNIVERSAL STANDARDS OF CARE

2020 Revisions Draft
~~(10/15/20)~~ 11/16/20
Last approved by by
Commission on
~~Approved~~ September
12, 2019

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TABLE OF CONTENTS

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IMPORTANT: Service standards must adhere to requirements and restrictions from the federal agency, Health Resources and Services Administration (HRSA). The key documents used in developing standards are as follows:
Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18)
HIV/AIDS Bureau, Division of Metropolitan HIV/AIDS Programs National Monitoring Standards for Ryan White Part A Grantees: Program – Part A
Service Standards: Ryan White HIV/AIDS Programs

INTRODUCTION

Standards of Care outline the elements and expectations a Ryan White service provider follows when implementing a specific service category. Standards of Care are available for each service category to set the minimum level of care Ryan White funded agencies should offer to clients.[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
- Prevent information technology security risks and protect patient information and records
- Inform clients of services, establish eligibility, and collect information through an intake process
- Effectively assess client needs and encourage informed and active participation
- Address client needs through coordination of care and referrals to needed services

- Ensure that the quality of service and materials given to patients during telehealth encounter is on par with in-person visits.
- ~~Ensure RWP service providers have mechanisms in place to~~

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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.

Agencies are encouraged to build their telehealth technology infrastructure and capacity to include videoconferencing to facilitate patient-provider connectivity and relationships.

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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 with specific information technology safeguards for confidentiality and patient information if using telehealth service modality.
1.2 Agency ~~are~~ is responsible for informing the patient that they have the right to obtain copies of their medical and other health records maintained by the agency.	1.2 Written policy for informing the patient of their rights to receive a copy of their medical records. The policy should contain a description of the process for obtaining records, such as a verbal or written request and a reasonable timeframe for patients to receive the information.
1.3 Client determines what information of theirs can be released and with whom it can be shared. Services using telehealth modality are subject to consent by the patient.[1]	1.3 Completed *Release of Information Form* on file including: • Name of agency/individual with whom information will be shared • Information to be shared • Duration of the release consent • Client signature For agencies and information covered by the Health Insurance Portability and Accountability Act (HIPAA), form must be HIPAA disclosure authorization compliant. The form must also be compliant with the CA Medi-Cal telehealth policy.[2]

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[1] https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthFAQ.aspx

[2] https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/mednetele.pdf

1.4 Agency develops or utilizes an existing grievance procedure to ensure clients have recourse if they feel they are being treated in an unfair manner or feel they are not receiving quality services.	1.4 Written grievance procedure on file that includes, at minimum: • Client process to file a grievance • Information on the Los Angeles County Department of Public Health, Division of HIV & STD Programs (DHSP) Grievance Line 1-800-260-8787. [3] 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 or provided to the patient at the beginning of a telehealth encounter.

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

Standard	Documentation
1.5 Agency provides eligibility requirements for services available upon request. Eligibility requirements must follow guidance from Division of HIV & STD Programs (DHSP) and HRSA under Policy Clarification Notice #16-02.[4]	1.5 Written eligibility requirements on file.
1.6 All client files are stored in a secure and confidential location, and electronic client files are protected from unauthorized use. Protection of client files and information must cover use of electronic medical records, phones, text messages, email, and telehealth modalities.	1.6 Client files must be locked and/or password protected with access provided only to appropriate personnel. Agencies must establish written procedures and IT policies for message encryption and restrictions on staff access to protect client information.
1.7 Agency maintains progress notes of all communication between provider and client.	1.7 Legible progress notes maintained in individual client files that include, at minimum: • Date of communication or service • Service(s) provided • Recommended referrals linking clients to needed services (See Section 7: Referrals and Case Closure)
1.8 Agency develops or utilizes an existing crisis management policy.	1.8 Written crisis management policy on file that includes, at minimum: • Mental health crises • Dangerous behavior by clients or staff
1.9 Agency develops a policy on utilization of Universal Precaution Procedures.[4] a. Staff members are trained in universal precautions.	1.9 Written policy or procedure on file. a. Documentation of staff training in personnel file.
1.10 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.	1.10 ADA criteria on file at all sites.

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[4] 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
1.11 Agency complies with all applicable state and federal workplace and safety laws and regulations, including fire safety.	1.11 Signed confirmation of compliance with applicable regulations on file.

2. CLIENT RIGHTS AND RESPONSIBILITIES

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

2.0 CLIENT RIGHTS AND RESPONSIBILITIES	
Standard	**Documentation**
2.1 Agency ensures services are available to any individual who meets the eligibility requirements for the specific service category.	2.1 Written eligibility requirements on file. Client utilization data made available to funder.
2.2 Agency includes input from people living with HIV/AIDS in the design and evaluation of services to ensure care is client-centered.	2.2 Written documentation of how input was received to inform service planning and evaluation in regular reports. Lists may include: • Consumer Advisory Board meetings • Participation of people living with HIV in HIV program committees or other planning bodies • Needs assessments • Anonymous patient satisfaction surveys. Discreet drop off boxes should be available in various sites throughout the agency and/or anonymous electronic follow-up surveys emailed to patients after their appointment. • Focus groups

2.3 Agency ensures that clients receive information technology support and training on how to use telehealth services.	2.3 Written checklists and/or "how to" guides are provided to patients prior to their telehealth appointment. Materials may be emailed to patient and/or posted on the agency website. The document should contain at least the following information: • Instructions on how to use telehealth tools (i.e., phone, laptop, tablets, etc.) in plain ~~English~~ language and available ~~or a language preferred by the patient~~in the patient's preferred language. • Telephone number for technical support or trouble shooting available before, during and after the telehealth appointment.
2.4 Agency ensures that clients retain the right to accept or decline a telehealth visit. The ultimate decision on the mode of service delivery, whether in-person or telehealth, must be determined by the client first before an appointment is made.	2.4 Written procedures and telehealth acceptance or denial form completed by patients prior to the appointment.

Standard	Documentation
2.5 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 The Patient and Client Bill of Rights applies to telehealth. It is the provider's responsibility to ensure that the patient understands their rights in all service settings, including telehealth.	2.5 *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. The AIDS Education Training Center (AETC) offers a variety of training for the HIV workforce.

3.0 STAFF REQUIREMENTS AND QUALIFICATIONS	
Standard	Documentation

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

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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. b. Staff should have experience in or participate in trainings on: • LGBTQ+/Transgender community and • HIV Navigation Services (HNS) provided by Centers for Disease Control and Prevention (CDC). • Trauma informed care	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
3.5 Staff are required to coordinate across Ryan White funded and non-funded programs to ensure clients' needs are met.	3.5 Documentation of staff efforts of coordinating across systems for the client on file (e.g. housing case management services, etc.).

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

Federal and State language access laws require health care facilities that receive federal or state funding to provide competent interpretation services to limited English proficiency patients at no cost, to ensure equal and meaningful access to health care services.[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.)

---

[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.

Commented [LK7]: Is this in reference to a client being discharged from a clinic? If so, may want to incorporate the phrase specifically (Discharge from clinic, care, etc) as providers may be more familiar with that term versus "Case Closure."

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

Commented [LK8]: As above

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~~Appendix B).

Commented [LK9]: What if client is being discharged (d/t behavior issues or other reasons)? This sounds as if the provider only needs to have a transition procedure if the client is leaving on their own accord. Not sure if this was the intent here. Suggest removing last bit and ending sentence after word transition.

Commented [LK10]: If referring to APPENDIX B: PEOPLE WITH HIV/AIDS BILL OF RIGHTS AND RESPONSIBILITIES then I would use that title. Also, I don't find a section 2 on Appendix B, is this in reference to different document?

7.0 PROVIDER QUALITY MANAGEMENT PLANS

Commented [BC11]: Recommendation: Delete section. QM work is under DHP. Work with DHSP staff to help share QI efforts with strong consumer/COH involvement.

The Patient Bill of Rights note that patients have the right to "receive considerate, respectful, professional, confidential and timely care in a safe client-centered environment without bias." Direct patient feedback and documented implementation of their suggestions for improvement are critical for increasing patient satisfaction.

Commented [LK12]: I am not sure this statement belongs here, seems odd to discuss the BOR when table is focusing on QM Plan expectations although I do understand the link between QM Programs and improved client satisfaction.

Commented [RC13R12]: Consider referring to the PCN 15-02 here for QM program guidance and expectations.

7.0 PROVIDER QUALITY MANAGEMENT PLAN	
STANDARD	DOCUMENTATION
7.1 All providers must have written Quality Management Plans and quality improvement activities, aimed at optimal patient experience and care. Continuous quality improvement activities must address at least the following areas of patient care: • Health outcomes beyond just viral suppression and encompass overall health and wellbeing. • Timeliness and responsiveness of patient care. Providers should strive to reduce door to provider time and assess patient satisfaction of services and interactions with clinical and support staff.	7.1.a. Agency Quality Improvement Plan is reviewed and approved by DHSP. 7.1.b. Agency patient satisfaction survey results and implementation of feedback.

Commented [RC15R14]: Agree with Lisa's comments above. While a QM plan can be an important part of the QI process for an agency, I would consider a focus on documentation of QI activities instead since that is the ultimate goal for a program to actually be doing QI work, not just writing a document that says they are.

Commented [LK14]: This language is only a small part of the RWP CQM program and the following should be noted:
1. CQM Programs which includes the development of a CQM plan is ONLY required for RWP recipients and subrecipients?
2. Per HRSA's PCN 15-02, the focus of all QI activities is improved care, improved health outcomes and Improved satisfaction.
3. To be effective, this section would need more context surrounding all CQM requirements, again only applicable to RWP recipients/subrecipients.
4. DHSP does not currently "review and approve" agency CQM plans; subrecipient CQM program monitoring has not been finalized as of yet.
5. Happy to provide additional info/language but would benefit in knowing the reason for adding this language to the standard in general.

Federal and National Resources:

HRSA's Ryan White HIV/AIDS Program Expanding HIV Care Through Telehealth CAREAction Newsletter October 2019:
https://hab.hrsa.gov/sites/default/files/hab/Publications/careactionnewsletter/telehealth.pdf

USDHHS Telehealth Discretion During Coronavirus:

Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency

Describes the landscape of telehealth services and provide considerations for healthcare systems, practices, and providers using telehealth services to provide virtual care during and beyond the COVID-19 pandemic. Using Telehealth to Expand Access to Essential Health Services during the COVID-19 Pandemic

- AMA Telehealth Quick Guide: https://www.ama-assn.org/practice-management/digital/ama-telehealth-quick-guide
- CMS Flexibilities for Physicians: https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf - "Under the CARES Act, CMS is waiving the requirements of section 1834(m)(1) of the ACT and 42 CFR § 410.78(a)(3) for use of interactive telecommunications systems to furnish telehealth services, to the extent they require use of video technology, for certain services. This waiver allows the use of audio-only equipment to furnish services described by the codes for audioonly telephone evaluation and management services, and behavioral health counseling and educational services."
- CMS Flexibilities for RHCs and FQHCs: https://www.cms.gov/files/document/covid-rural-health-clinics.pdf - "Medicare telehealth services generally require an interactive audio and video telecommunications system that permits real-time communication between the practitioner and the patient. (During the PHE, some telehealth services can be furnished using audio-only technology.)"
- CMS Fact Sheet on Virtual Services: https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet
- AAFP Comprehensive Telehealth Toolkit: https://www.aafp.org/dam/AAFP/documents/practice_management/telehealth/2020-AAFP-Telehealth-Toolkit.pdf
- ACP Telehealth Guidance & Resources: https://www.acponline.org/practice-resources/business-resources/telehealth
- ACP Telemedicine Checklist: https://www.acponline.org/system/files/documents/practice-resources/health-information-technology/telehealth/video_visit_telemedicine_checklist_web.pdf

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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.

Standards & Best Practices Committee Members

Miguel Alvarez
Erika Davies *Co-Chair*
Wendy Garland, MPH
Felipe Gonzalez

Thomas Green
David Lee, MSW, LCSW, MPH
Katja Nelson, MPP
Joshua Ray
Harold Glenn San Agustin, MD
Kevin Stalter *Co-Chair*
Justin Valero
Amiya Wilson

8. APPENDICES

APPENDIX A: RYAN WHITE PART A SERVICE CATEGORIES

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

Core medical services include the following categories:

a. AIDS Drug Assistance Program
b. AIDS pharmaceutical assistance
c. Early intervention services
d. Health insurance premium and cost sharing assistance for low-income individuals
e. Home and community-based health services
f. Home health care
g. Hospice services
h. Medical case management, including treatment-adherence services
i. Medical nutrition therapy
j. Mental health services
k. Oral health
l. Outpatient and ambulatory medical care
m. Substance abuse outpatient care

Support services include the following categories:

n. Case Management (Non-Medical)
o. Childcare Services
p. Emergency Financial Assistance
q. Food Bank/Home Delivered Meals
r. Health Education/Risk Reduction
s. Housing Services
t. Legal Services
u. Linguistic Services
v. Medical Transportation
w. Outreach Services
x. Psychosocial Support Services
y. Referral
z. Rehabilitation
aa. Respite Care
bb. Substance Abuse Residential

cc. Treatment Adherence Counseling

APPENDIX B: PEOPLE WITH HIV/AIDS BILL OF RIGHTS AND RESPONSIBILITIES

It is the provider's responsibility to ensure that the patient understands their rights in all service settings, including telehealth.

Commented [LK16]: Understands or Is provided with written documentation of their rights? How would a provider assess and document that a patient understands? If that is the goal, then provider documentation should include that "client verbalized understanding of …" and that should somehow be part of the documentation procedure.

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

~~A. Respectful Treatment~~Respectful Treatment and Preventative Services

Commented [BC17]: From Octavio Vallejo

~~Receive considerate, respectful, professional, confidential and timely care in a safe client-centered environment without bias~~. "Receive considerate, respectful, professional, confidential and timely care and preventative services (such as screenings and vaccinations) in a safe client-centered, trauma-informed environment without bias."

Commented [BC18]: From Octavio Vallejo

1.
2. Receive equal and unbiased care according to your age and needs in accordance with federal and State laws.

Commented [BC19]: From Octavio Vallejo

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~~Review 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.

Commented [LK20]: This document is given to the client, who or what entity is responsible for ensuring that hospitals and healthcare providers adhere to these commitments? I recommend rewording for clarity.

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.

~~3.~~4. Have their phone calls and/or emails answered with 3 days.

~~C. Make Treatment Decisions~~ Participate in the Decision-making Treatment Process

~~1.~~5. 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.~~6. Participate actively with your provider(s) in discussions about choices and options available for your treatment.

7. Make the final decision about which ~~choice and~~ treatment option is best for you after you have been given all relevant information about these choices and the clear recommendation of your provider.

Have access to patient-specific education resources and reliable information and training about patient self-management.

~~3.~~8.

~~4.~~9. Refuse any and all treatments recommended and be told of the effect that not taking the treatment may have on your health, be told of any other potential consequences of your refusal and be assured that you have the right to change your mind later.

~~5.~~10. Be informed about and afforded the opportunity to participate in any appropriate clinical research studies for which you are eligible.

~~6.~~11. Refuse to participate in research without prejudice or penalty of any sort.

~~7.~~12. Refuse any offered services or end participation in any program without bias or impact on your care.

~~8.~~13. Be informed of the procedures at the agency ~~or institution~~ for resolving misunderstandings, making complaints or filing grievances.

~~9.~~14. Receive a response to a complaint or grievance within 30 days of filing it.

~~10.~~15. 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.~~C. 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

Commented [BC21]: Attempt to capture F. Gonzalez's feedback.

Commented [BC22]: From Octavio Vallejo

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Commented [BC23]: From Octavio Vallejo

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Commented [LK24]: DHSP's grievance policy allows an agency 30 days to respond to grievance investigation requests, therefore, the client does not normally receive a resolution letter until 30+ days. The client does receive an acknowledgement of receipt from DHSP within 10 days.

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Commented [LK25]: Confidentiality extends beyond HIV counseling and testing services. Again, not sure of the original intent.

Commented [LK26R25]:

request with an explanation.)

~~E.~~D. 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.~~E. 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 accept~~ing~~ the consequences of failing to adhere to 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.

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Commented [LK27]: Recommend rewording.

For More Help or Information

Your first step in getting more information ~~or~~ involving any complaints or grievances is ~~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~~ the problem in a reasonable time span, or if serious concerns or issues ~~that~~ arise ~~that you feel~~ and you would like ~~need~~ to speak ~~about~~ with someone outside the agency, you may call the number below for confidential, independent information and assistance.

Division of HIV and STD Programs Client Grievance Line~~For patient complaints/grievances call~~
~~-~~(800) 260-8787
8:00 am – 5:00 pm
Monday – Friday

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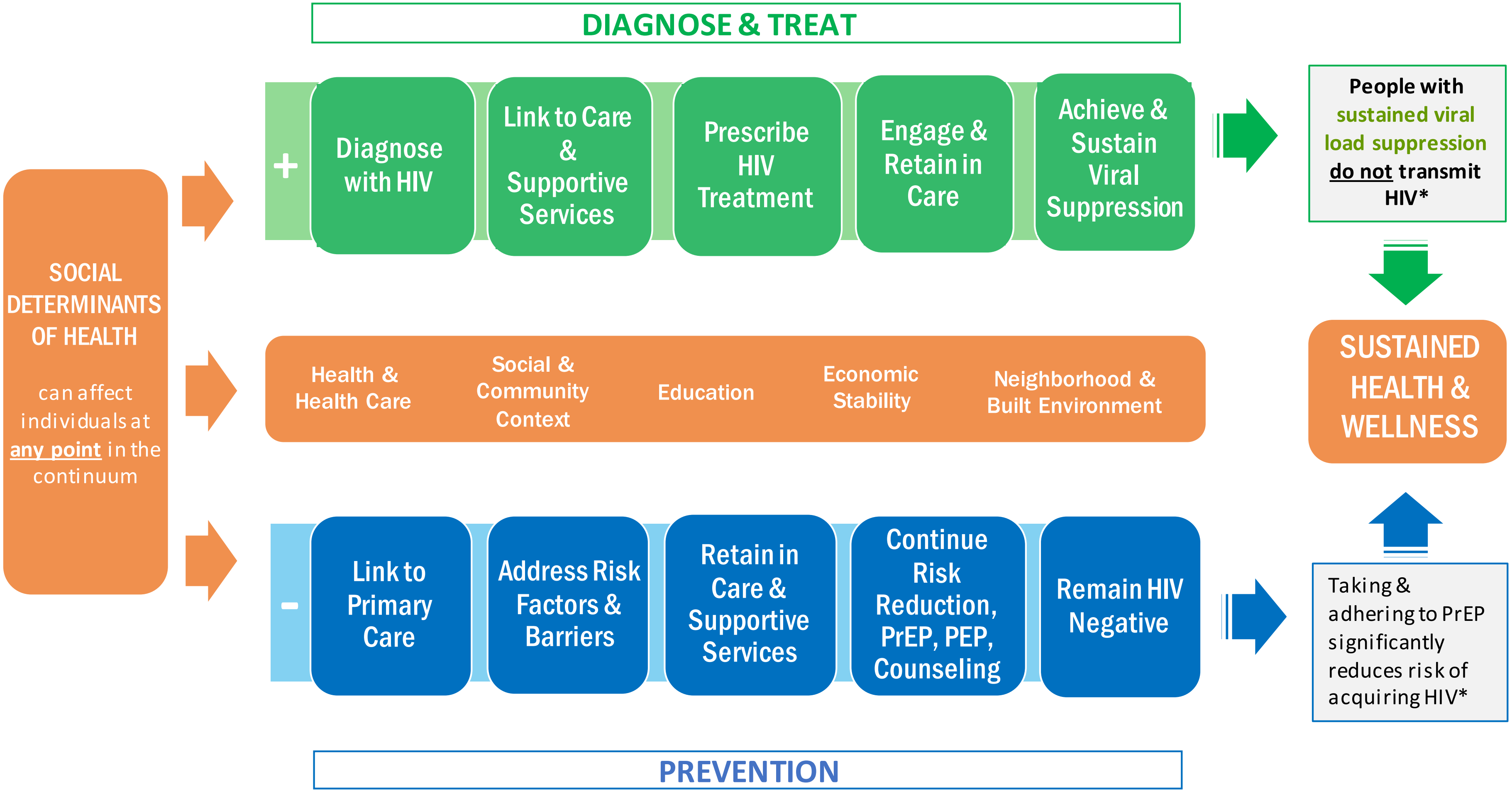
Commented [LK28]: This section seems somewhat misleading; client's should be made aware that this is the contact information for DHSP which they may not consider "independent". Overall, Appendix B has several oddly written sentences and multiple terms used to identify similar persons, concepts. (eg. Provders vs. Agency vs. institution, etc.) That said, I am not sure if the focus of this review request was for this document as well. Feel free to use or discard edits and comments as needed.

LOS ANGELES COUNTY
COMMISSION ON HIV

Comprehensive HIV Continuum Framework

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



DIAGNOSE & TREAT

+

- Diagnose with HIV
- Link to Care & Supportive Services
- Prescribe HIV Treatment
- Engage & Retain in Care
- Achieve & Sustain Viral Suppression

People with sustained viral load suppression do not transmit HIV*

SOCIAL DETERMINANTS OF HEALTH

can affect individuals at **any point** in the continuum

- Health & Health Care
- Social & Community Context
- Education
- Economic Stability
- Neighborhood & Built Environment

SUSTAINED HEALTH & WELLNESS

-

- Link to Primary Care
- Address Risk Factors & Barriers
- Retain in Care & Supportive Services
- Continue Risk Reduction, PrEP, PEP, Counseling
- Remain HIV Negative

Taking & adhering to PrEP significantly reduces risk of acquiring HIV*

PREVENTION

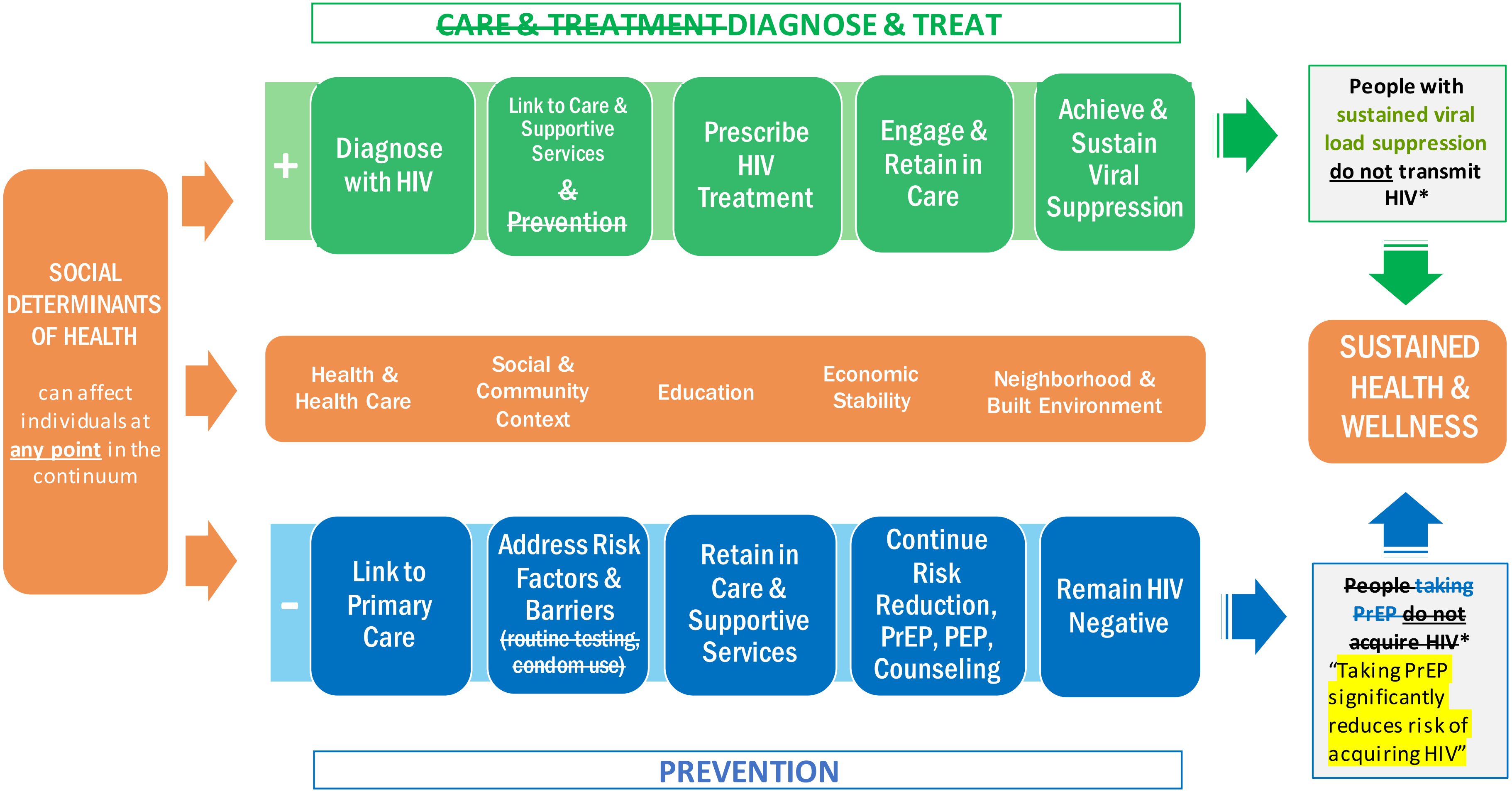
Revised 9/10/19
Commission approved 9/12/19

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

LOS ANGELES COUNTY
COMMISSION ON HIV

Comprehensive HIV Continuum Framework

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



~~CARE & TREATMENT~~ DIAGNOSE & TREAT

\+

- Diagnose with HIV
- Link to Care & Supportive Services ~~& Prevention~~
- Prescribe HIV Treatment
- Engage & Retain in Care
- Achieve & Sustain Viral Suppression

People with sustained viral load suppression <u>do not</u> transmit HIV*

SOCIAL DETERMINANTS OF HEALTH

can affect individuals at **<u>any point</u>** in the continuum

- Health & Health Care
- Social & Community Context
- Education
- Economic Stability
- Neighborhood & Built Environment

SUSTAINED HEALTH & WELLNESS

\-

- Link to Primary Care
- Address Risk Factors & Barriers ~~(routine testing, condom use)~~
- Retain in Care & Supportive Services
- Continue Risk Reduction, PrEP, PEP, Counseling
- Remain HIV Negative

~~People taking PrEP do not acquire HIV~~*
“Taking PrEP significantly reduces risk of acquiring HIV”

PREVENTION

Revised 9/10/19
Commission approved 9/12/19

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