LOS ANGELES COUNTY
COMMISSION ON HIV

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STANDARDS AND BEST PRACTICES COMMITTEE MEETING

TUESDAY, AUGUST 5, 2025
10:00 AM -- 12:00 PM (PST)

510 S. Vermont Avenue, 9th Floor, LA 90020
Validated Parking @ 523 Shatto Place, LA 90020

As a building security protocol, attendees entering form the 1st floor lobby must notify security personnel that they are attending the Commission on HIV meeting to access the Terrace Conference Room (9th Floor) where our meetings are held.

Agenda and meeting materials will be posted on our website
https://hiv.lacounty.gov/standards-and-best-practices-committee

Register Here to Join Virtually

https://lacountyboardofsupervisors.webex.com/weblink/register/r3bbef6cd61591770032aaa7dce275b44

Notice of Teleconferencing Sites

Public Comments

You may provide public comment in person, or alternatively, you may provide written public comment by:

- Emailing hivcomm@lachiv.org
- Submitting electronically at https://www.surveymonkey.com/r/PUBLIC_COMMENTS

** Please indicate your name, the corresponding agenda item, and whether you would like to state your public comment during the meeting. All public comments will be made part of the official record.*

Accommodations

Requests for a translator, reasonable modification, or accommodation from individuals with disabilities, consistent with the Americans with Disabilities Act, are available free of charge with at least 72 hours' notice before the meeting date by contacting the Commission office at hivcomm@lachiv.org or 213.738.2816.

Scan QR code to download an electronic copy of the meeting packet. Hard copies of materials will not be available in alignment with the County's green initiative to recycle and reduce waste. If meeting packet is not yet available, check back prior to meeting; meeting packet subject to change. Agendas will be posted 72 hours prior to meeting per Brown Act.

together.

WE CAN END HIV IN OUR COMMUNITIES ONCE & FOR ALL

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LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave., 14th Floor, Los Angeles CA 90020
MAIN: 213.738.2816 EML: hivcomm@lachiv.org WEBSITE: https://hiv.lacounty.gov

AGENDA FOR THE REGULAR MEETING OF THE LOS ANGELES COUNTY COMMISSION ON HIV

STANDARDS AND BEST PRACTICES COMMITTEE

TUESDAY, AUGUST 5, 2025 | 10:00AM – 12:00PM

510 S. Vermont Ave
Vermont Corridor 9th Floor TK02 Conference Room
Los Angeles, CA 90020
Validated Parking: 523 Shatto Place, Los Angeles, CA 90020

For those attending in person, as a building security protocol, attendees entering the first-floor lobby must notify security personnel that they are attending the Commission on HIV meeting.

MEMBERS OF THE PUBLIC WHO WISH TO JOIN VIRTUALLY, REGISTER HERE:
https://lacountyboardofsupervisors.webex.com/weblink/register/r3bbef6cd61591770032aaa7dce275b44
To Join by Telephone: 1-213-306-3065
Password: STANDARDS Access Code: 2534 890 2457

Standards and Best Practices Committee (SBP) Members:			
Erika Davies *Co-Chair*	Arlene Frames *Co-Chair*	Dahlia Ale-Ferlito	Mikhaela Cielo, MD
Sandra Cuevas	Caitlin Dolan *(Committee-only)*	Kerry Ferguson *(Alternate)*	Lauren Gersh, LCSW *(Committee-only)*
Mark Mintline, DDS *(Committee-only)*	Byron Patel, RN	Sabel Samone-Loreca *(Alt. to Arlene Frames)*	Martin Sattah, MD
Russell Ybarra			
QUORUM: 7			

AGENDA POSTED: July 30, 2025.

SUPPORTING DOCUMENTATION: Supporting documentation can be obtained via the Commission on HIV Website at: http://hiv.lacounty.gov or in person. The Commission Offices are located at 510 S. Vermont Ave., 14th Floor Los Angeles, 90020. **Validated parking is available at 523 Shatto Place, Los Angeles 90020.** **Hard copies of materials will not be made available during meetings unless otherwise determined by staff in alignment with the County's green initiative to recycle and reduce waste.*

PUBLIC COMMENT: Public Comment is an opportunity for members of the public to comment on an agenda item, or any item of interest to the public, before or during the Commission's consideration of the item, that is within the subject matter jurisdiction of the Commission. To submit Public Comment, you may join the virtual meeting via your smart device and post your Public Comment in the Chat box -or-

email your Public Comment to hivcomm@lachiv.org -or- submit your Public Comment electronically here. All Public Comments will be made part of the official record.

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.

Los 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.

I. ADMINISTRATIVE MATTERS

1.	Call to Order & Meeting Guidelines/Reminders		10:00 AM – 10:03 AM
2.	Introductions, Roll Call, & Conflict of Interest Statements		10:03 AM – 10:05 AM
3.	Approval of Agenda	**MOTION #1**	10:05 AM – 10:07 AM
4.	Approval of Meeting Minutes	**MOTION #2**	10:07 AM – 10:10 AM

II. PUBLIC COMMENT

10:10 AM – 10:15 AM

5. Opportunity for members of the public to address the Committee of items of interest that are within the jurisdiction of the Committee. For those who wish to provide public comment may do so in person, electronically by clicking here, or by emailing hivcomm@lachiv.org.

III. COMMITTEE NEW BUSINESS ITEMS

6. Opportunity for Committee 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

7. Executive Director/Staff Report — 10:15 AM – 10:25 AM
   a. Operational and Commission—Updates
8. Co-Chair Report — 10:25 AM – 10:35 AM
   a. 2025 Committee Meeting Calendar—Updates
   b. Service Standards Revision Tracker—Updates
9. Division on HIV and STD Programs (DHSP) Report — 10:35 AM—10:45 AM

V. DISCUSSION ITEMS

10. Transitional Case Management Service Standards Updates — 10:45 AM—10:55 AM

MOTION #3: Approve the Transitional Case Management service standards, as presented

or revised, and elevate to the Executive Committee.

11. Non-Medical Case Management Service Standards Review 10:55 AM—11:35 AM
12. Mental Health Service Standards Review 11:35 AM—11:45 PM

VI. NEXT STEPS 11:45 AM – 11:55 AM

12. Task/Assignments Recap
13. Agenda development for the next meeting

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

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

VIII. ADJOURNMENT 12:00 PM

15. Adjournment for the meeting of August 5, 2025.

PROPOSED MOTIONS	
MOTION #1	Approve the Agenda Order as presented or revised.
MOTION #2	Approve the Standards and Best Practices Committee minutes, as presented or revised.
MOTION #3	Approve the Transitional Case Management service standards, as presented or revised, and elevate to the Executive Committee.

LOS ANGELES COUNTY
COMMISSION ON HIV

HYBRID MEETING GUIDELINES, ETTIQUETTE & REMINDERS

(Updated 7.15.24)

☐ This meeting is a **Brown-Act meeting** and is being recorded.
- Turn off your ringers/notifications on your smart devices so as not to disrupt the meeting.
- Your voice is important and we want to ensure that it is captured accurately on the record. Please be respectful of one another and minimize crosstalk.

☐ The **meeting packet** can be found on the Commission's website at https://hiv.lacounty.gov/meetings/ or accessed via the QR code provided. Hard copies of materials will not be provided in compliance with the County's green initiative to recycle and reduce waste.

☐ Please comply with the **Commission's Code of Conduct** located in the meeting packet.

☐ **Public Comment** for members of the public can be submitted in person, electronically @ https://www.surveymonkey.com/r/public_comments or via email at hivcomm@lachiv.org. *Please indicate your name, the corresponding agenda item, and whether you would like to state your public comment during the meeting; if so, staff will call upon you appropriately. Public comments are limited to two minutes per agenda item. All public comments will be made part of the official record.*

☐ For individuals joining in person, to mitigate any potential streaming interference for those joining virtually, we respectfully ask that you **not simultaneously log into the virtual option of this meeting via WebEx.**

☐ Committee members invoking **AB 2449 for "Just Cause" or "Emergency Circumstances**" must communicate their intentions to staff and/or co-chairs no later than the start of the meeting. Members requesting to join pursuant to AB 2449 must have their audio and video on for the entire duration of the meeting and disclose whether there is a person over the age of 18 in the room in order to be counted toward quorum and have voting privileges. For members joining virtually due to "Emergency Circumstances", a vote will be conducted by the Committee/COH for approval.

☐ Members will be required to explicitly state their agency's **Ryan White Program Part A and/or CDC prevention conflicts of interest** on the record (versus referring to list in the packet). A list of conflicts can be found in the meeting packet and are recorded on the back of members' name plates, courtesy of staff.

If you experience challenges in logging into the virtual meeting, please refer to the WebEx tutorial HERE or contact Commission staff at hivcomm@lachiv.org.

LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave 14th Floor • Los Angeles, CA 90020 • TEL (213) 738-2816 • FAX (213) 637-6748
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Approved by COH 6/8/23

CODE OF CONDUCT

The Commission on HIV welcomes commissioners, guests, and the public into a space where people of all opinions and backgrounds are able to contribute. In this space, we challenge ourselves to be self-reflective and committed to an ongoing understanding of each other and the complex intersectionality of the lives we live. We create a safe environment where we celebrate differences while striving for consensus in the fights against our common enemies: HIV and STDs. We build trust in each other by having honest, respectful, and productive conversations. As a result, the Commission has adopted and is consistently committed to implementing the following guidelines for Commission, committee, and associated meetings.

All participants and stakeholders should adhere to the following:

1) **We approach all our interactions with compassion, respect, and transparency.**
2) **We respect others' time by starting and ending meetings on time, being punctual, and staying present.**
3) **We listen with intent, avoid interrupting others, and elevate each other's voices.**
4) **We encourage all to bring forth ideas for discussion, community planning, and consensus.**
5) **We focus on the issue, not the person raising the issue.**
6) **Be flexible, open-minded, and solution-focused.**
7) **We give and accept respectful and constructive feedback.**
8) **We keep all issues on the table (no "hidden agendas"), avoid monopolizing discussions and minimize side conversations.**
9) **We have no place in our deliberations for racist, sexist, homophobic, transphobic, and other discriminatory statements, and "-isms" including misogyny, ableism, and ageism.**
10) **We give ourselves permission to learn from our mistakes.**

In response to violation of the Code of Conduct which results in meeting disruption, Include provisions of SB 1100 which states in part, ". . . authorize the presiding member of the legislative body conducting a meeting or their designee to remove, or cause the removal of, an individual for disrupting the meeting . . . . Removal to be preceded by a warning to the individual by the presiding member of the legislative body or their designee that the individual's behavior is disrupting the meeting and that the individual's failure to cease their behavior may result in their removal." Complaints related to internal Commission matters such as alleged violation of the Code of Conduct or other disputes among members are addressed and resolved in adherence to Policy/Procedure #08.3302." (Commission Bylaws, Article VII, Section 4.)

DRAFT

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COMMISSION ON HIV

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

STANDARDS AND BEST PRACTICES (SBP) COMMITTEE MEETING MINUTES

JULY 1, 2025

COMMITTEE MEMBERS P = Present | A = Absent					
Erika Davies, *Co-Chair*	P	Kerry Ferguson	EA	Kevin Stalter	A
Arlene Frames, *Co-Chair*	LOA	Lauren Gersh	P	Russell Ybarra	A
Dahlia Ale-Ferlito	EA	Mark Mintline	A		
Mikhaela Cielo, MD	P	Byron Patel	EA		
Sandra Cuevas	A	Sabel Samone-Loreca	A	Danielle Campbell, MPH, *COH Co-chair*	
Caitlin Dolan	P	Martin Sattah	P	Joseph Green, *COH Co-Chair Pro-Tem*	P
COMMISSION STAFF AND CONSULTANTS					
Cheryl Barrit, Jose Rangel-Garibay, Lizette Martinez					
DHSP STAFF					
COMMUNITY MEMBERS					

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

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

CALL TO ORDER-INTRODUCTIONS-CONFLICT OF INTEREST STATEMENTS
Erika Davies, SBP committee co-chair, called the meeting to order at 10:15am and led introductions.

I. ADMINISTRATIVE MATTERS

1. APPROVAL OF AGENDA

MOTION #1: Approve the agenda order, as presented ***(No quorum; no vote held).***

2. APPROVAL OF MEETING MINUTES

MOTION #2: Approve the SBP Committee meeting minutes, as presented ***(No quorum; no vote held).***

II. PUBLIC COMMENT

3. OPPORTUNITY FOR PUBLIC TO ADDRESS COMMISSION ON ITEMS OF INTEREST WITHIN COMMISSION JURISDICTION

There were no public 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 committee new business items.

IV. REPORTS

5. **EXECUTIVE DIRECTOR/STAFF REPORT**
   - **Operational and Programmatic Updates**
     Cherly Barrit, COH Executive Director, reported that the next COH meeting will be on July 10, 2025, at the Vermont Corridor. The meeting will include discussions on the following topics: updates on the COH restructuring project; a presentation on the Division on HIV and STD Programs (DHSP) Medical Monitoring project; and a presentation on Long-Acting Injectables led by GILEAD. She added that the August and September full COH meetings are canceled. She noted that the Consumer Caucus will host a listening session on navigating the Ryan White Program (RWP) and Medi-Cal. LA Care, HealthNET, representatives and RWP Benefits Specialty service providers have all been invited to participate.

6. **CO-CHAIR REPORT**
   - **Review 2025 Committee Meeting Calendar**
     E. Davies led the committee through a review of the 2025 meeting calendar and noted that since the SBP committee did not have quorum at their June meeting, the Executive Committee opened the public comment period for the Transitional Case Management (TCM) service standards on June 26, 2025. Additionally, the next committee meeting will be on August 5, 2025, at the Vermont Corridor building. The Committee will review their meeting calendar in August to determine whether to cancel or reschedule the September 2, 2025, Committee meeting.
   - **Service Standards Revision Tracker—Updates**
     E. Davies reported that the committee will continue their review of the Patient Support Services (PSS) service standards and begin reviewing the Mental Health service standards in August. She added that the Committee will review public comments received and finalize the TCM service standards in August.

6. **DIVISION ON HIV AND STD PROGRAMS (DHSP) REPORT**
   There was no report.

V. DISCUSSION ITEMS

7. **Transitional Case Management Service Standards Review**
   The public comment period opened on June 26, 2025, and closes on July 28, 2025. The TCM service standards are posted on the COH website and can be accessed here: https://hiv.lacounty.gov/service-standards.

8. **Non-Medical Case Management (NMCM) Service Standards Review**
   E. Davies reported that instead of creating a standalone document for Patient Support Services (PSS), the Committee will develop an appendix to the existing NMCM service standards. This is in accordance with how PSS is implemented in Los Angeles County per DHSP. Committee members asked questions regarding how NMCM+PSS would differ from the existing NMCM, and what about the components of PSS that could possibly be considered "medical"?

   C. Barrit reminded the Committee that the Health Resources and Services Administration (HRSA) established 26 different service categories which include both core medical service and support services. Planning councils are responsible for developing service standards for the services funded in their jurisdiction and these services must fall within the 26 service categories. She added that during the priority setting and resource allocation process,

COH staff asked DHSP for clarification on how they are treating PSS, and they asked the COH to carve out funding allocation under NMCM. Based on the allocation, COH staff recommended to the Committee co-chairs to consider adding PSS as an addendum to NMCM. C. Barrit noted that currently, "Appendix C: Patient Support Services" includes a description of PSS, and a list of the positions covered under PSS which include Retention Outreach Specialist, Social Worker, Benefits Specialist, Housing Specialist, Substance Use Disorder Specialist, Clinical Nursing Support Specialist, and Peer Navigator. Appendix C also includes a list of the minimum qualifications for each position and job duties. All this information was taken from the PSS Request for Proposal (RFP) that DHSP released.

E. Davies led an overview of the NMCM service standards; a copy of the document is included in the meeting packet and here. She noted the inclusion of the following blurb in the Service Components section, "In the past, DHSP has contracted TCM for youth and justice-involved populations under Non-Medical Case Management services. Additionally, in 2025 DHSP contracted Patient Support Services in conjunction with Ambulatory Outpatient Services and Medical Case Management services. For additional information, see Appendix C."

The Committee proposed the following revisions:

- Consider removing the "face-to-face" requirement under the Client Assessment and Reassessment section: "Non-Medical Case Management providers must complete an initial assessment within 30 days of intake through a collaborative, interactive, face-to-face process between the case manager and client with the client as the primary source of information." A lesson learned from the COVID-19 pandemic is the need to offer telehealth services when possible.
- Consider creating clear distinctions between the expectations for the Clinical Nursing Support Specialist and other positions covered under PSS that may not be involved in the client assessment and reassessment process described in the NMCM.
- Delete "ISPs should be completed as soon as possible given case management services should be based on the ISP" from the Individual Service Plan standard table.
- Consider changing the interval for updating a client's ISP from "every 6 months" to "once per year or as needed."
- Consider changing the frequency of client contact from "at minimum one time per year, as needed, or based on DHSP contract requirements" to "as needed or based on DHSP contract requirements."
- Consider adding a sentence in the "Staff Requirements and Qualifications" section that directs readers to Appendix C for PSS-specific staff requirements and qualifications.
- Delete "Appendix B: Case Management Models"; no longer relevant.
- Consider changing the breadth of the assessment conducted by Retention Outreach Specialists from "Comprehensive assessment" to "targeted assessment."
- Match the flexibility around educational requirements for case management supervisors, and social workers to include a combination of education, work experience, and lived experience; mirror the language used in the Benefits Specialty service standard "Staffing Requirements and Qualifications" section and add a note that directs providers to consult with DHSP for additional flexibility.

The Committee requested for DHSP staff informed in the implementation and operations of PSS be present at the August Committee meeting to help clarify the service and answer questions. COH staff will reach out to DHSP and invite their staff to attend the August Committee meeting.

VI. NEXT STEPS

9. TASK/ASSIGNMENTS RECAP:

- COH staff will compile public comments received for the Transitional Case Management service standards and prepare a summary document to share with the committee at their August 5, 2025, meeting.

- COH staff will outreach to DHSP staff and request their attendance at the August 5, 2025, committee meeting to assist the committee in their review of the Patient Support Services service standards document.
- COH staff will prepare a draft of the Mental Health service standards for the committee to review at their August 5, 2025, meeting.

11. AGENDA DEVELOPMENT FOR NEXT MEETING:

- Review public comments received for the Transitional Case Management service standards.
- Continue review of the Patient Support Service (PSS) service standards.
- Initiate review of Mental Health service standards.

VII. ANNOUNCEMENTS

12. OPPORTUNITY FOR PUBLIC AND COMMITTEE TO MAKE ANNOUNCEMENTS:

- No announcements.

VIII. ADJOURNMENT

13. ADJOURNMENT: The meeting adjourned at 11:41 am.

LOS ANGELES COUNTY
COMMISSION ON HIV

STANDARDS AND BEST PRACTICES COMMITTEE 2025 MEETING CALENDAR *(Last updated 07/30/25)*

DATE	KEY AGENDA ITEMS/TOPICS (subject to change; for planning purposes)
Jan. 7, 2025 1pm to 3pm TK02	• Hold co-chair nominations. • Review 2025 COH workplan and 2025 meeting calendar • Continue review of Temporary Housing service standards
Feb. 4, 2025 10am to 12pm TK02	• Elect co-chairs for 2025 term. • Establish standards review schedule for 2025. • Complete review of Temporary Housing service standards (RCFCI and TRCF) • Continue review of Permanent Housing service standards
Mar. 11, 2025 10am-12pm TK02	• Review public comments on "Housing Services" service standards • Initiate review of Transitional Case Management service standards
Apr. 1, 2025 10am-12pm 14th Floor	• Review Service Standards Development Tracker and determine review cycle • Continue review of Transitional Case Management service standards
May 6, 2025 10am-12pm 14th Floor	• Continue review of Transitional Case Management service standards • Preview Patient Support Services (PSS) service standards
Jun. 3, 2025 10am-12pm TK02	• Continue review of Transitional Case Management service standards • Review Patient Support Services (PSS) service standards
Jul. 1, 2025 10am-12pm TK02	• Continue review of Transitional Case Management (TCM) service standards • Review Patient Support Services (PSS) service standards
Aug. 5, 2025 10am-12pm TK02	• Finalize review of TCM service standards • Continue review of PSS service standards • Begin review of Mental Health service standards
Sep. 2, 2025 10am-12pm TK02	Consider rescheduling due to Labor Day holiday on 9/1/25.
Oct. 7, 2025 10am-12pm TK02	
Nov. 4, 2025 10am-12pm TK02	Commission on HIV Annual Conference 11/13/2025
Dec. 2, 2025 10am-12pm TK02	Consider rescheduling due to World AIDS Day events. Reflect on 2025 accomplishments. Co-Nominations for 2026.

SERVICE STANDARDS REVISION DATE TRACKER FOR PLANNING PURPOSES

Last updated: 07/30/25

KEYWORDS AND ACRONYMS	
HRSA: Health Resources and Services Administration	**COH:** Commission on HIV
RWHAP: Ryan White HIV/AIDS Program	**DHSP:** Division on HIV and STD Programs
HAB PCN 16-02: HIV/AIDS Bureau Policy Clarification Notice 16-02 RWHAP: Eligible Individuals & Allowable Uses of Funds	**SBP Committee:** Standards and Best Practices Committee
	PLWH: People Living With HIV

*** SERVICES IN BLUE ARE CURRENTLY FUNDED ***

HRSA Service Category	COH Standard Title	DHSP Service	Description	Notes
N/A	AIDS Drug Assistance Program (ADAP) Enrollment	N/A	State program that provides medications that prolong quality of life and delay health deterioration to people living with HIV who cannot afford them.	ADAP contracts directly with agencies. Administered by the California Department of Public Health, Office of AIDS.
Child Care Services	Child Care Services	Child Care Services	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 RWHAP related meetings, groups, or training sessions.	**Last approved by COH: 7/8/2021**
Early Intervention Services	Early Intervention Program (EIS) Services	Testing Services	Targeted testing to identify HIV+ individuals.	**Last approved by COH: 5/2/217**
Emergency Financial Assistance	Emergency Financial Assistance (EFA)	Emergency Financial Assistance	Pay assistance for rent, utilities, and food and transportation for PLWH experiencing emergency circumstances.	**Last approved by COH: 2/13/2025**
Food Bank/Home Delivered Meals	Nutrition Support Services	Nutrition Support Services	Home-delivered meals and food bank/pantry services programs.	**Last approved by COH: 8/10/2023**
N/A	HIV/STI Prevention Services	Prevention Services	Services used alone or in combination to prevent the transmission of HIV and STIs.	**Last approved by COH: 4/11/2024** *Not a program- Standards apply to prevention services.*

*** SERVICES IN BLUE ARE CURRENTLY FUNDED ***

LOS ANGELES COUNTY COMMISSION ON HIV

HRSA Service Category	COH Standard Title	DHSP Service	Description	Notes
Home and Community-Based Health Services	Home-Based Case Management	Home-Based Case Management	Specialized home care for homebound clients.	**Last approved by COH: 9/9/2022**
Hospice	Hospice Services	Hospice Services	Helping terminally ill clients approach death with dignity and comfort.	**Last approved by COH: 5/2/2017**
Housing	Housing Services: Permanent Supportive	Housing For Health	Supportive housing rental subsidy program of LA County Department of Health Services.	**Last approved by COH: 4/10/2025**
Housing	Housing Services: Residential Care Facility for Chronically Ill (RCFCI) and Transitional Residential Care Facility (TRCF)	Housing Services RCFCI/TRCF	RCFCI: Home-like housing that provides 24-hour care. TRCF: Short-term housing that provides 24-hour assistance to clients with independent living skills.	**Last approved by COH: 4/10/2025**
Legal Services	Legal Services	Legal Services	Legal information, representation, advice, and services.	**Last approved by COH: 7/12/2018**
Linguistic Services	Language Interpretation Services	Language Services	Interpretation (oral and written) and translation assistance to assist communication between clients and their healthcare providers.	**Last approved by COH: 5/2/2017**
Medical Case Management	Medical Care Coordination (MCC)	Medical Care Coordination	HIV care coordination through a team of health providers to improve quality of life.	**Last approved by COH: 1/11/2024**
	Treatment Education Services	Treatment Education Services	Provide ongoing education and support to ensure compliance with a client's prescribed treatment regimen and help identify and overcome barriers to adherence.	**Last approved by COH: 5/2/2017**
Medical Nutrition Therapy	Medical Nutrition Therapy Services	Medical Nutrition Therapy	Nutrition assessment and screening, and appropriate inventions and treatments to maintain and optimize nutrition	**Last approved by COH: 5/2/2017**

*** SERVICES IN BLUE ARE CURRENTLY FUNDED ***

HRSA Service Category	COH Standard Title	DHSP Service	Description	Notes
			status and self-management skills to help treat HIV disease.	
Medical Transportation	Transportation Services	Medical Transportation	Ride services to medical and social services appointments.	**Last approved by COH: 2/13/2025**
Mental Health Services	Mental Health Services	Mental Health Services	Psychiatry, psychotherapy, and counseling services.	**Last approved by COH: 5/2/2017** *SBP will begin review in August 2025.*
Non-Medical Case Management	Benefits Specialty Services (BSS)	Benefits Specialty Services	Assistance navigating public and/or private benefits and programs.	**Last approved by COH: 9/8/2022**
	Patient Support Services (PSS)	Patient Support Services	Provide interventions that target behavioral, emotional, social, or environmental factors that negatively affect health outcomes with the aim of improving an individual's health functioning and overall well-being.	New service standard currently under development. *SBP will continue review on 8/5/2025.*
	Transitional Case Management: Justice-Involved Individuals	Transitional Case Management- Jails	Support for post-release linkage and engagement in HIV care.	**Last approved by COH: 12/8/2022** Currently under review. *SBP will continue review on 8/5/2025.*
	Transitional Case Management: Youth	Transitional Case Management- Youth	Coordinates services designed to promote access to and utilization of HIV care by identifying and linking youth living with HIV/AIDS to HIV medical and supportive services.	**Last approved by COH: 12/8/2022** Currently under review. *SBP will continue review on 8/5/2025.*
	Transitional Case Management: Older Adults 50+	N/A	Coordinate transition between systems of care for older adults 50+ living with HIV/AIDS.	*SBP will continue review on 8/5/25.*
Oral Health Care	Oral Health Care Services	Oral Health Services	General and specialty dental care services.	**Last approved by COH: 4/13/2023**
Outpatient/Ambulatory Health Services	Ambulatory Outpatient Medical (AOM)	Ambulatory Outpatient Medical	HIV medical care accessed through a medical provider.	**Last approved by COH: 2/13/2025**
Outreach Services	Outreach Services	Linkage and Retention Program	Promote access to and engagement in appropriate services for people newly diagnosed or identified as	**Last approved by COH: 5/2/2017**

*** SERVICES IN BLUE ARE CURRENTLY FUNDED ***

HRSA Service Category	COH Standard Title	DHSP Service	Description	Notes
			living with HIV and those lost or returning to treatment.	
Permanency Planning	Permanency Planning	Permanency Planning	Provision of legal counsel and assistance regarding the preparation of custody options for legal dependents or minor children or PLWH including guardianship, joint custody, joint guardianship and adoption.	**Last approved by COH: 5/2/2017**
Psychosocial Support Services	Psychosocial Support Services	Psychosocial Support Services	Help PLWH cope with their diagnosis and any other psychosocial stressors they may be experiencing through counseling services and mental health support.	**Last approved by COH: 9/10/2020**
Referral for Health Care and Support Services	Referral Services	Referral	Developing referral directories and coordinating public awareness about referral directories and available referral services.	**Last approved by COH: 5/2/2017**
Substance Abuse Services (residential) Substance Abuse Outpatient Care	Substance Use Disorder and Residential Treatment Services	Substance Use Disorder Transitional Housing	Temporary residential housing that includes screening, assessment, diagnosis, and treatment of drug or alcohol use disorders.	**Last approved by COH: 1/13/2022**
N/A	Universal Standards and Client Bill of Rights and Responsibilities	N/A	Establishes the minimum standards of care necessary to achieve optimal health among PLWH, regardless of where services are received in the County. These standards apply to all services.	**Last approved by COH: 1/11/2024** *Not a program—SBP committee will review this document on a bi-annual basis or as necessary per community stakeholder, contracted agency, or COH request.*

Service Standard Development

LOS ANGELES COUNTY COMMISSION ON HIV

KEYWORDS AND ACRONYMS

BOS: Board of Supervisors
COH: Commission on HIV
SBP: Standards and Best Practices
DHSP: Division of HIV & STD Programs
RFP: Request for Proposal
HRSA: Health Resources and Services Administration
HAB: HIV/AIDS Bureau
RWHAP: Ryan White HIV/AIDS Program
PSRA: Priority Setting and Resource Allocations
PCN: Policy Clarification Notice

WHAT ARE SERVICE STANDARDS?

Service Standards establish the minimal level of service of care for consumers in Los Angeles County. Service standards outline the elements and expectations a RWHAP service provider must follow when implementing a specific Service Category **to ensure that all RWHAP service providers offer the same basic service components**.

WHAT ARE SERVICE CATEGORIES?

Service categories are the services funded by the RWHAP as part of a comprehensive service delivery system for people with HIV to improve retention in medical care and viral suppression.

Services fall under two categories: **Core Medical Services** and **Support Services**. **The COH develops service standards for 13 Core Medical Services, and 17 Support services.** As an integrated planning body for HIV prevention and care services, the COH also develops service standards for 11 Prevention Services.

A key resource the SBP Committee utilizes when developing services standards is the **HRSA/HAB PCN 16-02** which **defines and providers program guidance for each of the Core Medical and Support Services** and defines individuals who are eligible to receive these RWHAP services.

HRSA/HAB GUIDANCE FOR SERVICE STANDARDS

- Must be consistent with Health and Human Services guidelines on HIV care and treatment and the HRSA/HAB standards and performance measures and the National Monitoring Standards.
- Should NOT include HRSA/HAB performance measures or health outcomes.
- Should be developed at the local level.
- Are required for every funded service category.
- Should include input from providers, consumers, and subject matter experts.
- Be publicly accessible and consumer friendly.

COH SERVICE STANDARDS

Universal Service Standards	• General agency policies and procedures
	  ○ Intake and Eligibility
	  ○ Staff Requirements and Qualifications
	  ○ Cultural and Linguistic Competence
	  ○ Referrals and Case Closures
	• Client Bill of Rights and Responsibilities

Category-Specific Service Standards	• Include link to Universal Service Standards • Core Medical Services • Support Services
Service Standards General Structure	• Introduction • Service Overview • Service Components • Table of Standards & Documentation requirements

REMINDER

Service standards are meant to be flexible, not prescriptive, or too specific. Flexible service standards allow service providers to adjust service delivery to meet the needs of individual clients and reduce the need for frequent revisions/updates.

DEVELOPING SERVICE STANDARDS

Service standard development is a joint responsibility shared by DHSP and the COH. There is no required format or specific process defined by HRSA HAB. **The SBP Committee leads the service standard development process for the COH.**

SERVICE STANDARD DEVELOPMENT PROCESS

SBP REVIEW	• Develop review schedule based on service rankings, DHSP RFP schedule, a consumer/provider/service concern, or in response to changes in the HIV continuum of care. • Conduct review/revision of service standards which includes seeking input from consumers, subject matter experts, and service providers. • Post revised service standards document for public comment period on COH website.
COH REVIEW	• After SBP has agreed on all revisions, SBP holds a vote to approve. • Once approved, the document is elevated to Executive Committee and COH for approval. • COH reviews the revised/updates service standards and holds vote to approve. Once approved, the document is sent to DHSP.
DISSEMINATION	• Service standards are posted on **COH website** for public viewing and to encourage use by non-RWP providers. • DHSP uses service standards when developing RFPs, contracts, and for monitoring/quality assurance activities.
CYCLE REPEATS	• Service standards undergo revisions at least every 3 years or as needed. • DHSP provides summary information to COH on the extent to which service standards are being met to assist with identifying possible need for revisions to service standards.

together.

WE CAN END HIV IN OUR COMMUNITY ONCE AND FOR ALL

For additional information about the COH, please visit our website at: http://hiv.lacounty.gov

Subscribe to the COH email list: https://tinyurl.com/y83ynuzt

LOS ANGELES COUNTY COMMISSION ON HIV | PUBLIC COMMENTS RECEIVED ON DRAFT TRANSITIONAL CASE MANAGEMENT SERVICE STADNARDS | Public comment period: June 24, 2025 – July 28, 2025

#	Date Received	Name	Comments	Standards and Best Practices Committee Decision
1	7/17/25	Rebecca Cohen	Consider separating into Outreach and In-reach. In-reach can refer to pre-release services which include promotion and initiation of services to people who are incarcerated. Outreach would be post-release services which include promotion, initiation or continuation of services to people who have been released from incarceration as well as promotion to service providers in the community. In general, I recommend more clarity about pre and post incarceration services.	
2	7/17/25	Rebecca Cohen	*"Transitional Case Management programs establish appointments (whenever possible) prior to release date."* This would fit better in the implementation section.	
3	7/17/25	Rebecca Cohen	*"Comprehensive assessment or reassessment on file in client chart to include:* • *Date* • *Signature and title of staff person* *Client strengths, needs and available resources regarding:* • *Medical/physical healthcare* • *Medication and adherence issues* • *Housing and living situation* • *Resources and referrals* • *Assessment of barriers to care including gender-affirming care* • *Legal issues/incarceration history* • *Social support system"* Consider adding mental health and substance use. Consider breaking into two bullets: • Potential barriers to care	

			• Gender-affirming care	
4	7/21/25	Sona Oksuzyan	Consider rephrasing *"Resources and referrals"* to "Benefits and resources available"	
5	7/17/25	Rebecca Cohen	*"IRP on file in client chart to include:* • *Name of client and case manager* • *Date and signature of case manager and client* • *[…]"* Client signature can be challenging in the jail setting. There are some restrictions regarding access to pens/pencils- they are often considered contraband.	
6	7/17/25	Rebecca Cohen	*"<u>Implementation, monitoring, and follow-up of IRP</u>* *Signed, dated progress notes on file that detail, at minimum, the following:* • *Description of client contacts and actions taken* • *Date and type of contact* • *Description of what occurred* • *Changes in the client's condition or circumstances* • *Progress made toward IRP goals* • *Barriers to IRPs and actions taken to resolve them* • *Linked referrals and interventions and status/results* • *Barriers to referrals and interventions* • *Time spent with, or on behalf of, client* • *Case manager's signature and title"* Consider list below to broaden beyond client contact documentation: • Date and type of action taken (client contact, advocacy, follow-up on referral, etc.) • Description of what occurred • Update on the client's condition or circumstances • Progress made toward IRP goals • Barriers to IRP goals and actions taken to resolved them • Status of referrals and interventions • Barriers to referrals and interventions and actions taken to resolve them • Time spent with, or on behalf of, client • Case manager's signature and title	

7	7/22/25	Sona Oksuzyan	*"Case managers will:* • *Provide linked referrals, advocacy* *Provide interventions and linked referrals"* It is already mentioned in the first point, repetitive.	
8	7/17/25	Rebecca Cohen	*"Case managers and other staff will participate in recertification as required by DHSP"* Not sure what certification this is in reference to.	
9	7/17/25	Rebecca Cohen	*"Appendix 1: Recommended Training Topics* *Transitional case management staff should complete ongoing training related to the provision of TCM services. Staff development and enhancement activities should include, but not be limited to:* • *HIV/AIDS Medical and Treatment Updates* • *Risk Behavior and Harm Reduction Interventions* • *Addiction and Substance Use Treatment* • *[…]"* Is this a reference to sexual health? If so, ok to call it Sexual Health and can add harm reduction to the substance use bullet point.	

LOS ANGELES COUNTY
COMMISSION ON HIV

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Public Comment Period for Draft Transitional Case Management: Justice Involved Individuals Service Standards

Posted: June 24, 2025

The Los Angeles County Commission on HIV (COH) announces an opportunity for the public to submit comments for the draft **Transitional Case Management (TCM): Justice-Involved Individuals** service standards revised by the Standards and Best Practices Committee. Comments from consumers, providers, HIV prevention and care stakeholders, and the public are welcome.

A draft of the document is posted to the COH website and can be found at: https://hiv.lacounty.gov/service-standards. Comments can be submitted via email to HIVCOMM@LACHIV.ORG.

After reading the document, consider responding to the following questions when providing public comment:

1. Are the TCM service standards reasonable and achievable for providers? Why or why not?
2. Do the TCM service standards meet consumer needs? Why or why not? Give examples of what is working/not working.
3. Is there anything missing from the TCM service standards related to HIV prevention and care?
4. Do you have any additional comments related to the TCM service standards and/or TCM services?

Public comments are due to HIVCOMM@LACHIV.ORG by Monday July 28, 2025.

TRANSITIONAL CASE MANAGEMENT SERVICES

(Draft as of 06/18/25)

Contents

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

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

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

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

Service Standards: Ryan White HIV/AIDS Programs

Introduction

Service standards outline the elements and expectations a Ryan White service provider follows when implementing a specific service category. The purpose of the service standards is to ensure that all Ryan White service providers offer the same fundamental components of the given service category across a service area. Service standards establish the minimal level of service or care that a Ryan White funded agency or provider may offer in Los Angeles County.

Service Description

Transitional Case Management (TCM) is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services for special populations living with HIV/AIDS to mitigate and eliminate barriers to HIV care services.

- Intake and assessment of available resources and needs
- Periodic reassessments of status and needs
- Development and implementation of Individual Release Plans
- Appropriate linked referrals to housing, community case management, medical/physical healthcare, mental health, dental health, and substance use disorder treatment
- Coordination of services that facilitate retention in care, achieve viral suppression, and maintain overall health and wellness
- Access to HIV and STI information, education, partner services, and behavioral and biomedical interventions such as Pre-Exposure Prophylaxis (PrEP) and Doxycycline Post-Exposure Prophylaxis (Doxy PEP) to prevent acquisition and transmission of HIV/STIs to prevent acquisition and transmission of HIV/STIs), and risk reduction
- Active, ongoing monitoring and follow-up
- Ongoing assessment of the client's needs and personal support systems

HRSA Guidance for Non-Medical Case Management

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

- Initial Assessment of service needs
- Development of a comprehensive, individualized care plan
- Continuous client monitoring to assess the efficacy of the care plan

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

Program Guidance:
Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services whereas Medical Case Management services have as their objective improving health care outcomes.

General Eligibility Requirements for Ryan White Services

- Be diagnosed with HIV or AIDS with verifiable documentation.
- Be a resident of Los Angeles County
- Have an income at or below 500% of Federal Poverty Level.
- Provide documentation to verify eligibility, including HIV diagnosis, income level, and residency.

Given the barriers with attaining documentation, contractors are expected to follow the Los Angeles County, Department of Public Health, Division of HIV and STD Programs (DHSP) guidance for using self-attestation forms for documentation eligibility for Ryan White services.

Transitional Case Management for Justice-Involved Individuals

The goal of TCM for Justice-Involved individuals is to improve HIV health outcomes among justice-involved people living with HIV/AIDS by supporting post-release linkage and engagement in HIV care. The objectives of TCM for Justice-Involved individuals include:

- Identify and address barriers to care
- Assist with health and social service system navigation
- Provide health education and risk reduction counseling
- Refer and link to culturally competent HIV medical providers
- Support reentry through community or jail-based resources

SERVICE STANDARDS

All contractors must meet the Universal Service Standards approved by the COH in addition to the following TCM service standards. The Universal Service Standards can be accessed at: https://hiv.lacounty.gov/service-standards

OUTREACH

Programs providing Transitional Case Management (TCM) for justice-involved individuals services will conduct outreach to educate potential clients, HIV and STI services providers and other supportive service organizations about the availability and benefits of transitional management services for justice-involved persons living with HIV/AIDS within the Los Angeles County Jail system. Promotion and outreach will include the provision of information sessions to incarcerated people living with HIV/AIDS that facilitate enrollment into incarcerated TCM programs. Programs will collaborate with HIV primary health care and

support services providers, as well as HIV and STI testing sites.

OUTREACH	
STANDARD	**DOCUMENTATION**
Transitional Case Management programs will conduct outreach to potential clients and providers.	Outreach plan on file at provider agency
Transitional Case Management programs will provide information sessions to incarcerated people living with HIV/AIDS.	Record of information sessions at provider agency. Copies of flyers and materials used. Record of referrals provided to clients.
Transitional Case Management programs establish appointments (whenever possible) prior to release date.	Record of appointment date.

COMPREHENSIVE ASSESSMENT

Comprehensive assessment/reassessment is completed in a cooperative, interactive, face-to-face interview process. Assessment/reassessment identifies and evaluates a client's medical, physical, psychosocial, environmental and financial strengths, needs and resources.

Comprehensive assessment is conducted to determine the:

- Client's needs for treatment and support services
- Client's current capacity to meet those needs
- Ability of the client's social support network to help meet client need(s)
- Extent to which other agencies are involved in client's care
- Areas in which the client requires assistance in securing services
- Client's medical home post-release and linkage to Medical Care Coordination (MCC) program prior to release to ensure continuity of care

COMPREHENSIVE ASSESSMENT	
STANDARD	**DOCUMENTATION**
Completed and enter comprehensive assessments into DHSP's data management system within 15 days of the initiation of services. Perform reassessments at least once per year or when a client's needs change or they have re-entered a case management program.	Comprehensive assessment or reassessment on file in client chart to include: • Date • Signature and title of staff person Client strengths, needs and available resources in: • Medical/physical healthcare • Medications and Adherence issues • Housing and living situation • Resources and referrals • Assessment of barriers to care including gender-affirming care • Lega issues/incarceration history • Social support system

INDIVIDUAL RELEASE PLAN (IRP)

An Individual Release Plan (IRP) determines the case management goals for a client and is developed in conjunction with the client and case manager within two weeks of the conclusion of the comprehensive assessment or reassessment. An IRP is a tool that enables the case manager to assist the client in systematically addressing barriers to HIV medical care by developing a concrete strategy to improve access and engagement in medical and other support services. All goals shall be determined by utilizing information gathered during assessment and subsequent reassessments.

INDIVIDUAL RELEASE PLAN	
STANDARD	**DOCUMENTATION**
Individual Release Plans (IRPs) will be developed in conjunction with the client within two weeks of completing the assessment or reassessment. IRPs will be updated on an ongoing basis.	IRP on file in client chart to include: • Name of client and case manager • Date and signature of case manager and client • Date and description of client goals and desired outcomes • Action steps to be taken by client, case manager and others • Customized services offered to client to facilitate success in meeting goals, such as referrals to peer navigators and other social or health services • Goal timeframes • Disposition of each goal as it is met, changed, or determined to be unattainable

IMPLEMENTATION, MONITORING, AND FOLLOW-UP OF IRP

Implementation, monitoring, and follow-up involved ongoing contract and interventions with (or on behalf of) the client to ensure that IRP goals are addressed, and that the client is linked to and appropriately accesses and maintains primary health care and community-based supportive services identified on the IRP. These activities ensure that referrals are completed, and services are obtained in a timely, coordinated fashion.

IMPLEMENTATION, MONITORING, AND FOLLOW-UP OF IRP	
STANDARD	**DOCUMENTATION**
Case managers will: • Provide referrals, advocacy, and interventions based on the intake, assessment, and IRP • Monitor changes in the client's condition • Update/revise the IRP • Provide interventions and linked referrals • Ensure coordination of care	Signed, dated progress notes on file that detail, at minimum, the following: • Description of client contacts and actions taken • Date and type of contact • Description of what occurred • Changes in the client's condition or circumstances • Progress made toward IRP goals

• Help clients submit applications and obtain health benefits and care • Conduct monitoring and follow-up to confirm completion of referrals and service utilization • Advocate on behalf of clients with other service providers • Empower clients to use independent living strategies • Help clients resolve barriers • Follow-up on IRP goals • Maintain/attempt contact at minimum of once every two weeks and at least one face-to-face contact monthly • Follow-up missed appointments by the end of the next business day • Collaborate with the client's community-based case manager for coordination and follow-up when appropriate • Transition clients out of TCM services at six month's post-release.	• Barriers to IRPs and actions taken to resolve them • Linked referrals and interventions and status/results • Barriers to referrals and interventions • Time spent with, or on behalf of, client • Case manager's signature and title

STAFFING REQUIREMENTS AND QUALIFICATIONS

At minimum, all TCM staff will be able to provide linguistically and culturally appropriate care to people living with HIV/AIDS and complete documentation as required by their positions. Case management staff will complete an agency-based orientation and be trained and oriented regarding client confidentiality and HIPAA regulations before providing services. See "Personnel and Cultural Linguistic Competence" section on the Universal Service Standards.

STAFFING REQUIREMENTS AND QUALIFICATIONS	
STANDARD	**DOCUMENTATION**
Case managers will have: • Knowledge of HIV/STIs and related issues • Knowledge of and sensitivity to incarceration and correctional settings and populations • Knowledge of and sensitivity to lesbian, gay, bisexual, and transgender persons • Effective Motivational Interviewing and assessment skills • Ability to appropriately interact and collaborate with others • Effective written/verbal communication skills	Resume, training certificates, interview assessment notes, reference checks, and annual performance reviews on file.

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• Ability to work independently • Effective problem-solving skills • Ability to respond appropriately in crisis situations • Effective organizational skills • Prioritize caseload • Patience • Multitasking skills Refer to "Recommended Training Topics for Transitional Case Management Staff."	
Case managers will meet one of the following educational requirement criteria: • A bachelor's degree in a Health or Human Services field and have completed a minimum of eight hours of course work on the basics of HIV/AIDS prior to providing services to clients • An associate degree plus one-year direct case management experience in health or human services • A high school diploma or GED and a minimum of three years of experience providing direct social services to patients/clients within a medical setting or in the field of HIV. Prior experience providing services to justice-involved individuals is preferred. Personal life experience is highly valued and should be considered when making hiring decisions.	Resumes on file at provider agency documenting experience. Copies of diplomas on file.
All staff will be given orientation prior to providing services.	Record of orientation in employee file at provider agency.
Case managers and other staff will participate in recertification as required by DHSP.	Documentation of training maintained in employee files to include: • Date, time, and location of function • Function type • Staff members attending • Sponsor or provider of function • Training outline, handouts, or materials • Meeting agenda and/or minutes
Case management staff will receive a minimum of four hours of client care-related supervision per month from a master's level mental health professional.	All client care-related supervision will be documented as follows, at minimum: • Date of client care-related supervision • Supervision format

DRAFT

	• Name and title of participants • Issues and concerns identified • Guidance provided and follow-up plan • Verification that guidance and plan have been implemented • Client care supervisor's name, title, and signature.
Clinical supervisor will provide general clinical guidance and follow-up plans for case management staff.	Documentation of client care related supervision for individual clients will be maintained in the client's individual file.

Appendix 1: Recommended Training Topics

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

- HIV/AIDS Medical and Treatment Updates
- Risk Behavior and Harm Reduction Interventions
- Addiction and Substance Use Treatment
- HIV Disclosure and Partner Services
- Trauma-informed Care
- Person First Language
- Mental health and HIV/AIDS
- Legal Issues, including Jails/Corrections Services
- Alternatives to Incarceration Training
- Integrated HIV/STI prevention and care services including Hepatitis C screening and treatment
- Sexual identification, gender issues, and provision of trans-friendly services
- Stigma and discrimination and HIV/AIDS
- Health equity and social justice
- Motivational interviewing
- Knowledge of available housing, food, and other basic need support services

DRAFT

LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave. Floor 14, Los Angeles, CA 90020| (213) 738-2816 | hivcomm@lachiv.org

Public Comment Period for Draft Transitional Case Management: Youth Service Standards *Posted: June 24, 2025*

The Los Angeles County Commission on HIV (COH) announces an opportunity for the public to submit comments for the draft **Transitional Case Management (TCM): Youth** service standards revised by the Standards and Best Practices Committee. Comments from consumers, providers, HIV prevention and care stakeholders, and the public are welcome.

A draft of the document is posted to the COH website and can be found at: https://hiv.lacounty.gov/service-standards. Comments can be submitted via email to HIVCOMM@LACHIV.ORG.

After reading the document, consider responding to the following questions when providing public comment:

1. Are the TCM service standards reasonable and achievable for providers? Why or why not?
2. Do the TCM service standards meet consumer needs? Why or why not? Give examples of what is working/not working.
3. Is there anything missing from the TCM service standards related to HIV prevention and care?
4. Do you have any additional comments related to the TCM service standards and/or TCM services?

Public comments are due to HIVCOMM@LACHIV.ORG by Monday July 28, 2025.

TRANSITIONAL CASE MANAGEMENT SERVICES: YOUTH

(Draft as of 06/18/25)

Contents

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

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

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

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

Service Standards: Ryan White HIV/AIDS Programs

Introduction

Service standards outline the elements and expectations a Ryan White service provider follows when implementing a specific service category. The purpose of the service standards is to ensure that all Ryan White service providers offer the same fundamental components of the given service category across a service area. Service standards establish the minimal level of service or care that a Ryan White funded agency or provider may offer in Los Angeles County.

Service Description

Transitional Case Management (TCM) is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services for special populations living with HIV/AIDS to mitigate and eliminate barriers to HIV care services.

- Intake and assessment of available resources and needs
- Periodic reassessments of status and needs
- Appropriate linked referrals to housing, community case management, medical/physical healthcare, mental health, dental health, and substance use disorder treatment
- Coordination of services that facilitate retention in care, achieve viral suppression, and maintain overall health and wellness
- Access to HIV and STI information, education, partner services, and behavioral and biomedical interventions such as Pre-Exposure Prophylaxis (PrEP) and Doxycycline Post-Exposure Prophylaxis (Doxy PEP) to prevent acquisition and transmission of HIV/STIs to prevent acquisition and transmission of HIV/STIs), and risk reduction
- Active, ongoing monitoring and follow-up
- Ongoing assessment of the client's needs and personal support systems

HRSA Guidance for Non-Medical Case Management

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

- Initial Assessment of service needs
- Development of a comprehensive, individualized care plan
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary

- Ongoing assessment of the client's and other key family member's needs and personal support systems

Program Guidance:
Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services whereas Medical Case Management services have as their objective improving health care outcomes.

General Eligibility Requirements for Ryan White Services

- Be diagnosed with HIV or AIDS with verifiable documentation.
- Be a resident of Los Angeles County
- Have an income at or below 500% of Federal Poverty Level.
- Provide documentation to verify eligibility, including HIV diagnosis, income level, and residency.

Given the barriers with attaining documentation, contractors are expected to follow the Los Angeles County, Department of Public Health, Division of HIV and STD Programs (DHSP) guidance for using self-attestation forms for documentation eligibility for Ryan White services.

Transitional Case Management for Youth

For the purposes of these standards, "youth" is defined as adolescents and young adults aged 13-29 years old living with HIV/AIDS, including homeless, runaways, and emancipating/emancipated youth at risk for HIV/STIs. Transitional Case Management (TCM) for youth is a client-centered activity that coordinates services designed to promote access to and utilization of HIV care by identifying and linking youth living with HIV/AIDS to HIV medical and supportive services. The objectives of TCM for youth living with HIV/AIDS include:

- Locating youth not engaged in HIV care
- Identifying and addressing client barriers to care (e.g. homelessness, substance use, and emotional distress)
- Reducing homelessness
- Reducing substance use
- Improving the health status of transitional youth
- Easing a youth's transition from living on the streets or in foster care to community care
- Increasing access to education
- Increasing self-efficacy and self-sufficiency
- Facilitating access and adherence to primary health care
- Ensuring access to appropriate services and to the continuum of care
- Increasing access to HIV information and education
- Developing resources and increasing coordination between providers

DRAFT

SERVICE STANDARDS

All contractors must meet the Universal Service Standards approved by the COH in addition to the following TCM service standards. The Universal Service Standards can be accessed at: https://hiv.lacounty.gov/service-standards

OUTREACH

Outreach activities are defined as targeted activities designed to bring youth living with HIV/AIDS into HIV medical treatment services. This includes effective and culturally relevant methods to located, engage, and motivate youth living with HIV/AIDS in HIV medical services.

OUTREACH	
STANDARD	**DOCUMENTATION**
Transitional case management programs will outreach to potential clients and providers.	Outreach plan on file at provider agency.

COMPREHENSIVE ASSESSMENT AND REASSESSMENT

Comprehensive assessment and reassessment is completed in a cooperative, interactive, face-to-face interview process. Youth-friendly assessment(s) should consider the length of the questionnaire. See appendix 1 for additional information.

Assessment/reassessment identifies and evaluates a client's medical, physical, psychosocial, environmental and financial strengths, needs, and resources.

Comprehensive assessment is conducted to determine the following:

- Client's needs for engaging in HIV medical care and treatment, and supportive services
- Client's current capacity to meet those needs
- Ability of the client's social support network to help client gain access to, engage in, and maintain adherence to HIV care and treatment
- Extent to which other agencies are involved in client's care
- Areas in which the client requires assistance in securing services
- Readiness for transition to adult/mainstream case management services. Youth may remain in TCM for youth services until age 29. Appropriateness of continued transitional case management services will be assessed annually, and clients shall be transitioned into non-youth specific HIV care as appropriate but not later than age 30. Planing will be made for eventual transition to adult/non-youth specific case management at least by the client's 30th birthday.
- Eligibility for the Los Angeles County Department of Mental Health (DMH) Transition Age Youth Services, Adult Services Full-Service Partnership Program, and other DMH and Los Angeles County-funded programs to ensure continuing support while the client is in receiving TCM for youth services or once the client has completed or aged out of TCM youth services.

COMPREHENSIVE ASSESSMENT AND REASSESSMENT

STANDARD	DOCUMENTATION
Complete and enter comprehensive assessments into DHSP's data management system within 30 days of the initiation of services. Perform reassessments at least once per year or as needed.	Comprehensive assessment or reassessment on file in client chart to include: • Date • Signature and title of staff person Client strengths, needs and available resources in: • Medical/physical healthcare • Medications and Adherence issues • Mental Health • Substance use and substance use treatment • Nutrition/Food • Housing and living situation • Family and dependent care issues • Access to gender-affirming care • DCFS and other agency involvement • Transportation • Language/Literacy skills • Religious/Spiritual support • Social support system • Relationship history • Domestic violence/Intimate Partner Violence (IPV) • History of physical or emotional trauma • Financial resources • Employment and Education • Legal issues/incarceration history • Risk behaviors • HIV/STI prevention issues • Harm reduction services and support • Environmental factors • Resources and referrals • Assessment of readiness for transition to adult services.

INDVIDUAL SERVICE PLAN (ISP)

An Individual Service Plan (ISP) determines the case management goals for a client and is developed in conjunction with the client and case manager within two weeks of the completion of the comprehensive assessment or reassessment. A service plan is a tool that enables the case manager to assist the client in systematically addressing barriers to HIV medical care by developing a concrete strategy to improve access and engagement to needed medical and other support services. All goals shall be determined by utilizing information gathered during assessment and subsequent reassessments.

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INDIVIDUAL SERVICE PLAN	
STANDARD	**DOCUMENTATION**
ISPs will be developed in conjunction with the client within two weeks of completing the assessment or reassessment.	ISP on file in client chart to include: • Name of client and case manager • Date and signature of case manager and client • Date and description of client goals and desired outcomes • Action steps to be taken by client, case manager and others • Goal timeframes • Disposition of each goal as it is met, changed or determined to be unattainable

BRIEF INTERVENTIONS

Brief intervention sessions actively facilitate a client's entry into HIV medical care through the resolution of barriers to primary HIV-specific healthcare. The interventions focus on specific barriers identified through a client assessment and assist the client in successfully addressing those barriers to HIV care. Case managers must prepare clients for the transition into non-youth specific HIV medical services and a lifetime of managing HIV/AIDS. This includes empowering youth with information and skills necessary to increase their readiness to engage in non-youth specific HIV medical care.

BRIEF INTERVENTIONS	
STANDARD	**DOCUMENTATION**
Case managers will: • Provide interventions and linked referrals • Risk Reduction Counseling: Provide risk reduction/harm reduction sessions for clients that are actively engaging in behaviors that put them at risk for transmitting HIV and acquiring other STIs. • Linkage to HIV Medical Care: To assist the client with access to and engagement in primary HIV-specific health care by linking them to an HIV medical clinic • Disclosure and Partner Notification: Addressing disclosure and partner notification for clients who have not disclosed their HIV status to partner(s) or family member(s). • Help clients resolve barriers	Signed, dated progress notes on file that detail, at minimum: • Description of client contracts and actions taken • Date and type of contact • Description of what occurred • Changes in the client's condition or circumstances • Progress made toward goals • Barriers to ISPs and actions taken to resolve them • Linked referrals and interventions and status/results • Barriers to referrals and interventions/actions taken • Time spent with, or on behalf of, client • Case manager's signature and title • Detailed transition plan to adult services with specific linkage to health, medical, and social services.

IMPLEMENTATION, MONITORING, AND FOLLOW-UP OF ISP

Implementation, Monitoring, and Follow-up of Isp involve ongoing contact and interventions with (or on behalf of) the client to ensure that ISP goals are addressed, and that the client is linked to and appropriately accesses and maintains primary healthcare and community-based supportive services identified on the ISP. These activities ensure that referrals are completed, and services are obtained in a timely, coordinated fashion.

IMPLEMENTATION, MONITORING, AND FOLLOW-UP OF ISP	
STANDARD	**DOCUMENTATION**
Case managers will: • Provide referrals, advocacy, and interventions based on the intake, assessment, and ISP • Monitor changes in the client's condition • Update/revise the ISP • Provide interventions and linked referrals • Ensure coordination of care • Help clients submit applications and obtain health benefits and care • Conduct monitoring and follow-up to confirm completion of referrals and service utilization • Advocate on behalf of clients with other service providers • Empower clients to use independent living strategies • Help clients resolve barriers • Follow-up on ISP goals • Maintain/attempt contact at minimum of once every two weeks and at least one face-to-face contact monthly • Follow-up missed appointments by the end of the next business day • Collaborate with the client's community-based case manager for coordination and follow-up when appropriate • Transition clients out of TCM when appropriate • Develop a transition plan to adult services such as Medical Care Coordination (MCC), job placement, permanent supportive housing, or other appropriate services at least 6 months prior to formal date of release from TCM for youth program	Signed, dated progress notes on file that detail, at minimum, the following: • Description of client contacts and actions taken • Date and type of contact • Description of what occurred • Changes in the client's condition or circumstances • Progress made toward ISP goals • Barriers to ISPs and actions taken to resolve them • Linked referrals and interventions and status/results • Barriers to referrals and interventions • Time spent with, or on behalf of, client • Case manager's signature and title • Detailed transition plan to adult services, with specific linkage to health, medical, and social services • Documentation of expedited linkage to MCC for eligible clients

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• Upon transition case, communicate to client the availability of case manager for occasional support and role as a resource to maintain stability for client.	

STAFFING REQUIREMENTS AND QUALIFICATIONS

At minimum, all TCM staff will be able to provide linguistically and culturally appropriate care to clients and complete documentation as required by their positions. Case management staff will complete an agency-based orientation and be trained and oriented regarding client confidentiality and HIPAA regulations before providing services. See "Personnel and Cultural Linguistic Competence" section on the Universal Service Standards.

STAFFING REQUIREMENTS AND QUALIFICATIONS	
STANDARD	**DOCUMENTATION**
Case managers will have: • Knowledge of HIV/STIs and related issues • Knowledge of and sensitivity to run away, homeless or emancipating/emancipated youth • Effective Motivational Interviewing and assessment skills • Knowledge of adolescent development • Knowledge of, and sensitivity to, lesbian, gay, bisexual, and transgender persons • Ability to appropriately interact and collaborate with others • Effective written/verbal communication skills • Ability to work independently • Effective problem-solving skills • Ability to respond appropriately in crisis situations • Effective organizational skills Refer to Appendix 1 for additional information.	Resume, training certificates, interview assessment notes, reference checks, and annual performance reviews on file.
Case managers will meet one of the following educational requirement criteria: • A bachelor's degree in a Health or Human Services field and have completed a minimum of eight hours of course work on the basics of HIV/AIDS prior to providing services to clients	Resumes on file at provider agency documenting experience. Copies of diplomas on file.

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• An associate degree plus one-year direct case management experience in health or human services • A high school diploma or GED and a minimum of three years of experience providing direct social services to patients/clients within a medical setting or in the field of HIV. Prior experience providing services to run away, homeless, emancipated or emancipating youth is preferred. Personal life experience with relevant issues is highly valued and should be considered when making hiring decisions.	
All staff will be given orientation prior to providing services.	Record of orientation in employee file at provider agency.
Case management staff will complete DHSP's required case management certifications/training within three months of being hired.	Documentation of certification completion maintained in employee file.
Case managers and other staff will participate in recertification as required by DHSP.	Documentation of training maintained in employee files to include: • Date, time, and location of function • Function type • Staff members attending • Sponsor or provider of function • Training outline, handouts, or materials • Meeting agenda and/or minutes
Case management staff will receive a minimum of four hours of client care-related supervision per month from a master's level mental health professional.	All client care-related supervision will be documented as follows, at minimum: • Date of client care-related supervision • Supervision format • Name and title of participants • Issues and concerns identified • Guidance provided and follow-up plan • Verification that guidance and plan have been implemented • Client care supervisor's name, title, and signature.
Clinical supervisor will provide general clinical guidance and follow-up plans for case management staff.	Documentation of client care related supervision for individual clients will be maintained in the client's individual file.

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Appendix 1: Recommended Training Topics and Additional Resources

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

- Integrated HIV/STI prevention and care services
- The role of substances in HIV and STI prevention and progression
- Substance use harm reduction models and strategies
- Sexual identification, gender issues, and provision of trans-friendly services
- Cultural competence
- Correctional issues
- Youth development issues
- Risk reduction and partner notification
- Current medical treatment and updates
- Mental health issues for people living with HIV
- Confidentiality and disclosure
- Behavior change strategies
- Stigma and discrimination
- Community resources including public/private benefits
- Grief and loss

Providers for TCM: Youth services should refer to the "Best Practices for Youth-Friendly Clinical Services," developed by Advocates for Youth, a national organization that advocates for policies and champions programs that recognize young people's rights to honest sexual health information.

Providers are highly encouraged to use or adapt youth-friendly assessment tools such as the HEADSS assessment for adolescents (Home and Environment; Education and Employment; Activities; Drugs; Sexuality; Suicide; Depression).

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Public Comment Period for Draft Transitional Case Management: Older Adults 50+ Service Standards

Posted: June 24, 2025

The Los Angeles County Commission on HIV (COH) announces an opportunity for the public to submit comments for the draft **Transitional Case Management (TCM): Older Adults 50+** service standards revised by the Standards and Best Practices Committee. Comments from consumers, providers, HIV prevention and care stakeholders, and the public are welcome.

A draft of the document is posted to the COH website and can be found at: https://hiv.lacounty.gov/service-standards. Comments can be submitted via email to HIVCOMM@LACHIV.ORG.

After reading the document, consider responding to the following questions when providing public comment:

1. Are the TCM service standards reasonable and achievable for providers? Why or why not?
2. Do the TCM service standards meet consumer needs? Why or why not? Give examples of what is working/not working.
3. Is there anything missing from the TCM service standards related to HIV prevention and care?
4. Do you have any additional comments related to the TCM service standards and/or TCM services?

Public comments are due to HIVCOMM@LACHIV.ORG by Monday July 28, 2025.

TRANSITIONAL CASE MANAGEMENT SERVICES: OLDER ADULTS 50+

(Draft as of 06/18/25)

Contents

IMPORTANT: The service standards for Transitional Case Management: Older Adults 50+ Services adhere to requirements and restrictions from the federal agency, Health Resources and Services Administration (HRSA). The key documents used in developing standards are as follows:

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

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

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

Service Standards: Ryan White HIV/AIDS Programs

Purpose

Service standards outline the elements and expectations a Ryan White service provider follows when implementing a specific service category. The purpose of the service standards is to ensure that all Ryan White service providers offer the same fundamental components of the given service category across a service area. Service standards establish the minimal level of service or care that a Ryan White funded agency or provider may offer in Los Angeles County.

Service Description

Transitional Case Management (TCM) is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services for special populations living with HIV/AIDS to mitigate and eliminate barriers to HIV care services.

- Intake and assessment of available resources and needs
- Periodic reassessments of status and needs
- Appropriate linked referrals to housing, community case management, medical/physical healthcare, mental health, dental health, and substance use disorder treatment
- Coordination of services that facilitate retention in care, achieve viral suppression, and maintain overall health and wellness
- Access to HIV and STI information, education, partner services, and behavioral and biomedical interventions such as Pre-Exposure Prophylaxis (PrEP) and Doxycycline Post-Exposure Prophylaxis (Doxy PEP) to prevent acquisition and transmission of HIV/STIs to prevent acquisition and transmission of HIV/STIs), and risk reduction
- Active, ongoing monitoring and follow-up
- Ongoing assessment of the client's needs and personal support systems

HRSA Guidance for Non-Medical Case Management

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

- Initial Assessment of service needs
- Development of a comprehensive, individualized care plan
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family member's needs and personal support systems

Program Guidance:
Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services whereas Medical Case Management services have as their objective improving health care outcomes.

General Eligibility Requirements for Ryan White Services

- Be diagnosed with HIV or AIDS with verifiable documentation.
- Be a resident of Los Angeles County
- Have an income at or below 500% of Federal Poverty Level.
- Provide documentation to verify eligibility, including HIV diagnosis, income level, and residency.

Given the barriers with attaining documentation, contractors are expected to follow the Los Angeles County, Department of Public Health, Division of HIV and STD Programs (DHSP) guidance for using self-attestation forms for documentation eligibility for Ryan White services.

Transitional Case Management for Older Adults 50+

PURPOSE
Coordinate transition between systems of care for older adults 50+ living with HIV/AIDS.

SERVICE COMPONENTS

Comprehensive Assessment: identifies and reevaluates a client's medical, physical, psychosocial, environmental and other health and social service needs. To ensure optimal transitional care plans for older adults living with HIV who may be eligible for other payor sources outside of or in tandem with Ryan White-funded services, comprehensive assessments and screenings should be performed when the client approaches their 50th birthday.

Assessments may include: (assessments conducted under other RW medical services such as AOM or MCC may be used as a base to avoid duplicative assessments and burden on the client and provider).

1. Comprehensive benefits analysis and financial security
2. Clients 55 years and older should be assessed for eligibility for Program of All-Inclusive Care for the Elderly (PACE)
3. Mental health
4. Hearing
5. Neurocognitive disorders/cognitive function
6. Functional status
7. Frailty/falls and gait
8. Social support and levels of interactions, including access to care giving support and related services.
9. Vision
10. Dental
11. Hearing
12. Osteoporosis/bone density
13. Cancers
14. Muscle loss and atrophy
15. Nutritional needs
16. Housing status
17. Immunizations
18. Polypharmacy/drug interactions
19. HIV-specific routine tests
20. Cardiovascular disease
21. Smoking-related complications
22. Renal disease
23. Coinfections
24. Hormone deficiency

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25. Peripherical neuropathology
26. Sexual health
27. Advance care planning
28. Occupational and physical therapy

**these assessments and screenings are derived from the Aging Task Force Recommendations.*

Care Planning

Once the comprehensive assessment is completed, a standing care plan should be developed in collaboration with the client that the patient may use to communicate their care needs to providers who may be operating under different healthcare systems. Care plans should at a minimum include the client's health goals, medication adherence and continuity, eligibility for services, and an HIV care provider contact to assist with communicating care needs during periods of transitions into another health system (such as Medi-Cal, Medicare), or non-HIV specialist providers.

Resource Navigation

Resource navigation seeks to assist clients with understanding and accessing information about resources available to them and their caregivers. At a minimum, case managers should:

1. Work with the client and show them what benefits they may be eligible for using Benefitscheckup.org.
2. Connect them to a Benefits Specialty Services (BSS) to access and enroll in public and/or private health and disability programs.
3. Educate and assist client in navigating enrollment and application processes.

Follow-up Support: Ongoing contact and intervention with (or on behalf of) the client to ensure that care plan goals and resource needs are addressed, and that the client is linked to and appropriately accesses and maintains primary health care and community-based supportive services identifies on the care plan.

TCM Older Adults Service Components	
STANDARD	**DOCUMENTATION**
Comprehensive Assessment and Screening	Recommended assessment and screenings are completed around the client's 50th birthday.
Care Planning	Results of the assessments/screenings are used to develop a care plan that at minimum contains the client's health goals, medication adherence and continuity, eligibility for services, and an HIV care provider contact to assist with communicating care needs during periods of transitions into another health system (such as Medi-Cal, Medicare), or non-HIV specialist providers.

Resource Navigation	Documentation of joint effort with client to identify programs they may be eligible for via Benefitscheckup.org, BSS, and assistance with enrollment/application process.
Follow-up Support	Documentation of contact with and offers of support for clients regarding the status of their care plan and enrollment in other services at 3-month intervals up to a year.

Recommended Training Topics for Transitional Case Management Staff

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

- HIV/AIDS Medical and Treatment Updates
- Risk Behavior and Harm Reduction Interventions
- Addiction and Substance Use Treatment
- HIV Disclosure and Partner Services
- Trauma-informed Care
- Person First Language
- Mental health and HIV/AIDS
- Legal Issues, including Jails/Corrections Services
- Alternatives to Incarceration Training
- Integrated HIV/STI prevention and care services including Hepatitis C screening and treatment
- Sexual identification, gender issues, and provision of trans-friendly services
- Stigma and discrimination and HIV/AIDS
- Health equity and social justice
- Motivational interviewing
- Knowledge of available housing, food, and other basic need support services

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NON-MEDICAL CASE MANAGEMENT

(Last approved by COH on 12/12/19; Draft as of 06/17/25)

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

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

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

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

Service Standards: Ryan White HIV/AIDS Programs

Contents

Introduction

Service standards outline the elements and expectations a Ryan White service provider follows when implementing a specific service category. The purpose of the service standards is to ensure that all Ryan White service providers offer the same fundamental components of the given service category across a service area. Service standards establish the minimal level of service or care that a Ryan White funded agency or provider may offer in Los Angeles County. The development of the service standards includes guidance from service providers, consumers, and members of the Los Angeles County Commission (COH) on HIV, Standards and Best Practices Committee.

General Eligibility Requirements for Ryan White Services

- Be diagnosed with HIV or AIDS with verifiable documentation.
- Be a resident of Los Angeles County
- Have an income at or below 500% of Federal Poverty Level.
- Provide documentation to verify eligibility, including HIV diagnosis, income level, and residency.

Given the barriers with attaining documentation, contractors are expected to follow the Los Angeles County, Department of Public Health, Division of HIV and STD Programs (DHSP) guidance for using self-attestation forms for documentation eligibility for Ryan White services.

Non-Medical Case Management Service Description

Case management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet client's health and social services needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes.[1]

Non-Medical Case Management consists of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. NMCM may also include assisting clients to obtain access to other public and private programs for which they may be eligible.

Non-Medical Case Management services include all types of case management models such as intensive case management, strengths-based case management, and referral case management; see Appendix A for additional information on case management models. An agency may offer a specific type

[1] Introduction to the Case Management Body of Knowledge. Commission for Case Manager Certification (CCMC). https://www.cmbodyofknowledge.com/content/introduction-case-management-body-knowledge

of case management model depending on its capacity and/or the contract from the Division on HIV and STD Programs (DHSP). Depending on the type of case management offered, NMCM may also involve assisting the client's support network, key family members, and other individuals that play a direct role in the client's health and well-being.

Service components include:

- Initial assessment of service needs
- Development of a comprehensive, Individual Service Plan
- Timely and coordinated access to needed health and support services and continuity of care
- Client specific advocacy and review of utilization of services
- Continuous client monitoring to assess Individual Service Plan progress
- Revisiting the Individual Service Plan and adjusting as necessary
- Ongoing assessment of client needs and, if appropriate based on the case management offered, other key individuals in the client's support network

In the past, the DHSP has contracted Transitional Case Management for Youth and Justice-Involved populations under NMCM services. Additionally, in 2025, DHSP contracted Patient Support Services (PSS) in conjunction with Ambulatory Outpatient Medical (AOM) and Medical Case Management (MCC) services. See Appendix C for additional information on PSS.

Non-Medical Case Management coordinates services for people living with HIV to improve health outcomes and facilitate client self-sufficiency. Case managers at provider agencies are responsible for educating clients on available HIV non-medical support services as well as serving as liaisons in improving access to services. Case managers are responsible for understanding HIV care systems and wrap-around services, advocating for clients, and accessing and monitoring client progress on an ongoing basis. Case managers identify client service needs in all non-medical areas and facilitate client access to appropriate resources such as health care, financial assistance, HIV education, mental health, substance use prevention, harm reduction and treatment, and other supportive services. Non-Medical Case Management services should be client-focused, increase client empowerment, self-advocacy and medical self-management, as well as enhance their overall health status.

Non-Medical Case Management Service Standards

All contractors must meet the Universal Service Standards approved by the COH in addition to the following TCM service standards. The Universal Service Standards can be accessed at: https://hiv.lacounty.gov/service-standards

Client Assessment and Reassessment

Non-Medical Case Management providers must complete an initial assessment within 30 days of intake through a collaborative, interactive, face-to-face process between the case manager and client with the client as the primary source of information. With client consent, assessments may also include additional information from other sources such as service providers, caregivers, and family members to support client well-being and process. Case management staff must comply with established agency confidentiality policies when soliciting information from external sources. It is the responsibility of case management staff at the provider agency to conduct reassessments with the client as needed and based on contract guidelines from the DHSP. If a client's income, housing status, or insurance status has changed since assessment or the most recent reassessment, agencies must ensure that the data on the Client Information Form is updated accordingly.

The client assessment identifies and evaluates the medical, non-medical, physical, environmental, and financial strengths, needs, and resources. The assessments determines:

- Client needs for treatment and support services
- Client capacity to meet those needs
- Ability of the client social support network to help meet client needs
- Extent to which other agencies are involved in client care
- Areas in which the client requires assistance in securing services

Assessment and reassessment topics may include, at minimum:

- Client strengths and resources
- Medical Care
- Mental health counseling/therapy
- Substance use, harm reduction, and treatment
- Nutrition/food
- Housing or housing related expenses
- Family and dependent care
- Transportation
- Linguistic services
- Social support system
- Community or family violence
- Financial resources
- Employment and education
- Legal needs
- Knowledge and beliefs about HIV
- Agencies that service client and household

Case managers will identify medical and non-medical service providers and make appointments as early as possible during the initial intake process for clients that are not connected to primary medical care. Services provided to the client and actions take on behalf of the client must be documented in progress notes and in the Individual Services Plan, which is developed based on the information gathered in the assessment and reassessments.

CLIENT ASSESSMENT AND REASSESSMENT

STANDARD	DOCUMENTATION
Assessments will be completed within 30 days of initiation of services and at minimum should assess whether the client is in care. Accommodations may be made for clients who are unable to attend an appointment within the 30-day timeframe due to health reasons.	Completed assessment in client chart signed and dated by case manager.
Staff will conduct reassessments with the client as needed and in accordance with DHSP contract guidelines.	Completed reassessment in client chart signed and dated by case manager.

Individual Support Plan (ISP)

An Individual Service Plan (ISP) is a tool that enables the case manager to assist the client in systematically addressing barriers to HIV medical care by developing an action plan to improve access and engagement in medical and other support services. ISPs include short-term and long-term client goals determined by utilizing information gathered during assessment and subsequent reassessments. The ISP should include specific service needs, referrals to be made, clear timeframes, and a plan to follow-up.

ISPs are developed in conjunction with the client and case manager within two weeks of the conclusion of the comprehensive assessment or reassessment. It is the responsibility of case managers to review and revise ISPs as needed and based on client need. As part of the ISP, case managers must ensure the coordination of the various services the client is receiving. Coordination of services requires identifying other staff or service provides with whom the client may be working. As appropriate and with client consent, case management staff act as liaisons among clients, caregivers, and other service providers to obtain and share information that supports optimal care and service provision. If a program is unable to provide a specific service, it must be able to make immediate and effective referrals. Case management staff is responsible for facilitating the scheduling of appointments, transportation, and the transfer of related information.

ISPs will, at minimum, include the following:

- Client and case manager names
- Client and case manager signatures and date on the initial ISP and on subsequent, revised ISPs
- Description of client goals and desired outcomes
- Timeline for when goals are expected to be met
- Action steps to be taken by client and/or case manager to accomplish goals
- Status of each goal as client progresses

INDIVIDUAL SERVICE PLAN (ISP)	
STANDARD	**DOCUMENTATION**
ISPs will be developed collaboratively between the client and case manager within two weeks of completing the assessment or reassessment and, at minimum, should include: • Description of client goals and desired outcomes • Action steps to be taken and individuals responsible for the activity • Anticipated time for each action step and goal • Status of each goal as it is met, changed or determined to be unattainable ISPs should be completed as soon as possible given case management services should be based on the ISP.	Completed ISP in client chart, dated and signed by client and case manager.
Staff will update the ISP every six months, or as needed based on client progress or DHSP contract requirements, with client outcomes or ISP revisions based on changes in access to care and services.	Updated ISP in client chart, dated and signed by client and case manager.

Client Monitoring

Implementation, monitoring, and follow-up involve ongoing contact and interventions with, or on behalf of, the client to achieve the goals on the ISP. Case management staff are responsible for evaluating whether services provided to the client are consistent with the ISP, and whether there are any changes in the client's status that require a reassessment or updating the ISP. Client monitoring ensures that referrals are completed and needed services are obtained.

CLIENT MONITORING	
STANDARD	**DOCUMENTATION**
Case managers will ensure clients are accessing needed services and will identify and resolve any barriers clients may have in following through the ISP. Responsibilities include, at minimum: • Monitor changes in the client's condition • Update/revise the ISP based on progress • Provide interventions and follow-up to confirm completion of referrals	Signed, dated progress notes on file that detail, at minimum: • Changes in the client's condition or circumstances • Progress made toward ISP goals • Barriers to ISPs and actions taken to resolve them

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• Ensure coordination of care among client, caregiver(s), and service providers • Advocate on behalf of clients with other service providers • Empower clients to use independent living strategies • Help clients resolve barriers to completing referrals, accessing or adhering to services • Follow-up on ISP goals • Maintain client contact at minimum one time per year, as needed, or based on DHSP contract requirements • Follow-up missed appointments by the end of the next business day	• Linked referrals and interventions and status/results of same • Barriers to referrals and interventions, actions taken • Time spent • Case manager's signature and title

Staff Requirements and Qualifications

Case management staff will have the knowledge, skills, and ability to fulfill their role including striving to maintain and improve professional knowledge related to their responsibilities, basing all services on assessment, evaluation, or diagnosis of clients, and providing clients with a clear description of services, timelines, and possible outcomes at the initiation of services. Staff are responsible for educating clients on the importance of adhering and staying engaged in care.

Case managers should have experience in or participate in trainings on:

- HIV/AIDS and related issues
- Effective interviewing and assessment skills
- Appropriately interacting and collaborating with others
- Effective written and verbal communication skills
- Working independently
- Effective problem-solving skills
- Responding appropriately in crisis situations

STAFF REQUIREMENTS AND QUALIFICATIONS	
STANDARD	**DOCUMENTATION**
Case managers with experience in clinical and/or case management in an area of social services. Bachelor's degree in a related field preferred and/or experienced consumers preferred.	Staff resumes on file.

Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a multicultural environment.	
Case management supervisors with experience in clinical and/or case management in area of mental health, social work, counseling, nursing with specialized mental health training, psychology. Master's degree in a related field preferred and/or experienced consumer preferred. Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a multicultural environment.	Staff resumes on file.

Appendix A: HRSA Guidance for Non-Medical Case Management

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

- Initial Assessment of service needs
- Development of a comprehensive, individualized care plan
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family member's needs and personal support systems

Program Guidance:
Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services whereas Medical Case Management services have as their objective improving health care outcomes.

Appendix B: Case Management Models

Referral (Brokerage) Case Management
This is the first formally articulated approach to case management. Focuses on assessing needs, referring to services, and coordinating and monitoring on-going treatment. The case manager coordinates services provided by a variety of agencies and professionals.

Strengths-based Case Management
Developed in response to concerns that services and systems focus mainly on limitations and impairments vs. strengths and capabilities, this model focuses on individual strengths, the helping relationship as essential, contact in the community, and a focus on growth, change and consumer choice. Case managers provide direct services.

Intensive Case Management
Developed to meet the needs of high service users, focuses on low staff to client ratios, outreach, services brought to the client, and practical assistance in a variety of areas. May include outreach and counseling services, including skill-building, family consultations and crisis intervention. Caseloads are not normally shared.

Retrieved from https://www.homelesshub.ca/resource/step-step-comprehensive-approach-case-management

Appendix C: Patient Support Services (PSS) Service Description

Patient Support Services (PSS) are conducted by a multi-disciplinary team comprised of specialists who conduct client-centered interventions that target behavioral, emotional, social, or environmental factors that negatively affect health outcomes for Ryan White Program (RWP) eligible clients with the aim of improving an individual's overall well-being and achieve or maintain viral suppression. PSS will deliver interventions directly to RWP eligible clients, link and actively enroll them with support services, and provide care coordination, when needed.

Agencies contracted to provide PSS services must determine the type and number of support specialists form the list below to make up PSS teams that address the unique needs of its clinic in support of clients' complex medical issues and social challenges.

Retention Outreach Specialist (ROS)

- Ensures that PLWH remain engaged in their care and have access to necessary resources and support.
- Integrates with other HIV clinic team members to effectively identify, locate, and re-engage clients who have lapsed in their HIV care.

- Provides comprehensive assessment, outreach, linkage, and re-engagement services, focusing on clients who are considered "out of care," facilitating their return to consistent and effective HIV treatment and support services.
- Conducts field outreach operations to efficiently locate and assist clients who have disengaged from HIV care.
- Acts as the liaison between HIV counseling and testing sites and the medical clinic to ensure that new clients are enrolled in medical care seamlessly and in a timely fashion.
- Provides crisis interventions, offering immediate support in challenging situations.
- Provides services to clients not yet enrolled in PSS, MCC Services, or clinic-based programs and can outreach clients who have not yet enrolled into any services with Contractor.
- Collaborates with the HIV clinic team members, documents client interactions, and contributes to program evaluation.
- Demonstrates cultural and linguistic competency to effectively communicate with and support a diverse range of clients.
- Participates in case conferences as needed.

Must meet the following minimum qualifications:

- Must have a High School Diploma or successful completion of GED.
- Ability and interest in doing field-based work when necessary to locate or assist clients.
- Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a multicultural environment.

PSS Social Worker (SW)

- Determines client resources and needs regarding mental health services, substance use counseling and treatment, as well as housing and transportation issues to make appropriate referrals and linkages.
- Holds counselling and psychotherapy sessions for individuals, couples, and families.
- Provides support services utilizing housing-first, harm reduction, and trauma-informed care principles.
- Utilizes a sex positive framework including provision of patient education about U=U.
- Collaborates with the HIV clinic team, documents interactions, and contributes to program evaluation.
- Maintains knowledge of local, State, and federal services available.

- Addresses clients' socioeconomic needs, and as part of the PSS team, assists with client monitoring, referrals, and linkages to services, as well as following up with clients and tracking outcomes.
- Acts as the liaison between HIV counseling and testing sites and the medical clinic to ensure that new clients are enrolled in medical care seamlessly and in a timely fashion.
- Performs home visits and other field outreach on a case by-case basis.
- Provides urgent services to clients not yet enrolled in PSS.
- Participates in case conferences as needed.
- Conducts a comprehensive assessment of the SDH using a cooperative and interactive face-to-face interview process. The assessment must be initiated within five working days of client contact and be appropriate for age, gender, cultural, and linguistic factors.
    - The assessment will provide information about each client's social, emotional, behavioral, mental, spiritual, and environmental status, family and support systems, client's coping strategies, strengths and weaknesses, and adjustment to illness.
    - SW will document the following details of the assessment in each client's chart:
        - Date of assessment;
        - Title of staff persons completing the assessment; and
        - Completed assessment form.
- Develops a PSS Intervention Plan SW will, in consultation with each client, develop a comprehensive multi-disciplinary intervention plan (IP). PSS IPs should include information obtained from the SDH assessment. The behavioral, psychological, developmental, and physiological strengths and limitations of the client must be considered by the SW when developing the IP. IPs must be completed within five days and must include, but not be limited to the following elements:
- Identified Problems/Needs: One or more brief statements describing the primary concern(s) and purpose for the client's enrollment into PSS as identified in the SDH assessment.
- Services and Interventions: A brief description of PSS interventions the client is receiving, or will receive, to address primary concern(s), describe desired outcomes and identify all respective PSS Specialist(s) assisting the client.
- Disposition: A brief statement indicating the disposition of the client’s concerns as they are met, changed, or determined to be unattainable.
- IPs will be signed and dated by the client and respective SW assisting the client.
- IPs must be revised and updated, at a minimum, every six months.

Meets the following minimum qualifications:

- Master's degree in social work, Counseling, Psychology, or related field from an accredited social work program. On a case-by-case basis and with consultation and approval from DHSP, agencies may consider candidates with bachelor's degree in social work, counseling, psychology, or related field and 2 years of related work experience.
- Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a multicultural environment.

Benefits Specialist

- Conducts client-centered activities and assessments that facilitate access to public benefits and programs. Focuses on assisting each client's entry into and movement through care service systems.
- Stays up to date on new and modified benefits, entitlements, and incentive programs available for PLWH.
- Ensures clients are receiving all benefits and entitlements for which they are eligible.
- Educates clients about available benefits and provides assistance with the benefits application process.
- Helps prepare for and facilitates relevant benefit appeals.
- Collaborates with the HIV clinic team, documents interactions, and contributes to program evaluation.
- Develops and maintains expert knowledge of local, State, and federal services and resources including specialized programs available to PLWH.
- Participates in case conferences as needed.

Meets the following minimum qualifications:

- High school diploma (or GED equivalent).
- Has at least one year of paid or volunteer experience making eligibility determinations and assisting clients in accessing public benefits or public assistance programs.
- Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a multicultural environment.

Housing Specialist

- Develops and maintains expert knowledge of, and contacts at, local housing programs and resources including specialized programs available to PLWH.
- Conducts housing assessments and creates individualized housing plans.

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- Assists clients with applications to housing support services such as emergency finance assistance, referral and linkage to legal services (for issues such as tenant's rights and evictions), and navigation to housing opportunities for persons with AIDS programs.
- Conducts home or field visits as needed.
- Develops a housing procurement, financial, and self-sufficiency case management plan with clients as part of client housing plans.
- Offers crisis intervention and facilitates urgent referrals to housing services.
- Collaborates with the HIV clinic team, documents interactions, and contributes to program evaluation.
- Attends meetings and trainings to improve skills and knowledge of best practices in permanent supportive housing and related issues.
    - Participates in case conferences as needed.

Meets the following minimum qualifications:

- Bachelor's degree or a minimum of two years' experience in social services, case management, or other related work.
- Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a multicultural environment.

Substance Use Disorder (SUD) Specialist

- Conducts SUD assessments and devises personalized SUD plan with clients as part of the client's individualized care plan.
- Provides one-on-one counseling to prevent and/or support clients through recurrence by assisting and recognizing causal factors of substance use and developing coping behaviors.
- Connects clients to harm reduction resources, medications for addiction treatment, cognitive behavioral therapy, and other SUD treatment services available to reduce substance use, or to prevent or cope with recurrence.
- Collaborates with other HIV clinic team members to align substance use treatment goals with overall care, documents interactions, and contributes to program evaluation.
- Conducts individual and group counseling sessions using evidence-based interventions to address personalized goals and develop needed skill sets to minimize relapse and maintain sobriety.
- Oversees or leads day-to-day operations of contingency management programs or other evidence-based interventions.
- Provides education on harm reduction strategies and additional key resources to clients.
- Participates in case conferences as needed.

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Meets the following minimum qualifications:

- Certified as a Substance Use Counselor.
- Has at least one year of experience in an SUD program with experience providing counseling to individuals, families, and groups.
- Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a multicultural environment.

Clinical Nursing Support Specialist

- Provides enhanced clinical nursing support, performed by a registered nurse to facilitate:
    - Administration and supervision of client injectable medications and vaccinations;
    - Tracking of clients receiving long-acting injectable, multi-dose injectable treatments, or multi-dose vaccine series; monitors clients for side effects; makes appointments for subsequent nursing visits to ensure timely receipt of injections; and
    - Coordinates care activities among care providers for patients receiving long-acting injectable medications, vaccinations, and other injectable medications to ensure appropriate delivery of HIV healthcare services.
- Participates in case conferences as needed.
- Collaborates with the HIV clinic team, conducts health assessments as needed, documents interactions, and contributes to program evaluation.

Peer Navigator

- Provides client-centered group or individual psycho-social support services to assist PLWH by providing a safe space where lived experiences and challenges can be discussed without judgement. Topics to be discussed include but are not limited to:
    - Living with HIV;
    - Healthy lifestyles (including substance use) and relationships;
    - Adherence to treatment;
    - Access and barriers to care;
    - Prevention (PrEP, PEP, DoxyPEP, treatment as prevention);
    - Disclosing status; and
    - Stigma.
- Supports individuals who may be newly diagnosed, newly identified as living with HIV, or who may require additional support to engage in and maintain HIV medical care and support services to ensure that clients are linked to care and continuously supported to remain in care.

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- Conducts individual and group interventions to address personalized goals and develop needed skill sets for healthy living, ensure medication adherence and support a positive outlook for individuals living with HIV.
- Collaborates with other HIV clinic team members to align treatment goals with overall care, documents interactions, and contributes to program evaluation.
- Oversees incentives, contingency management programs, and/or other evidence-based interventions.
- Provides education on HIV clinic services available and additional key resources to clients.
- Participates in case conferences as needed.

Meets the following minimum qualifications:

- Is reflective of the population and community being served.
- Has lived experience.
- Must NOT be a current client of Contractor's clinic.
- Ability to work effectively with people of diverse races, ethnicities, nationalities, sexual orientations, gender identities, gender expression, socio-economic backgrounds, religions, ages, English-speaking abilities, immigration status, and physical abilities in a multicultural environment.

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LOS ANGELES COUNTY COMMISSION ON HIV

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MENTAL HEALTH SERVICES

(Draft as of 07/18/25)

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

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

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

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

Service Standards: Ryan White HIV/AIDS Programs

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Introduction

Service standards outline the elements and expectations a Ryan White HIV/AIDS Program (RWHAP) provider follows when implementing a specific service category. The purposed of service standards is to ensure that all RWHAP providers offer the same fundamental components of the given service category across a service area. Service standards establish the minimal level of service or care that a RWHAP-funded agency or provider may offer in Los Angeles County.

Service Description

Mental health treatment for PLWH attempts to improve and sustain a client's quality of life. Counseling and psychotherapy have been shown to be helpful in alleviating or decreasing psychological symptoms that can accompany a diagnosis of HIV. Psychiatric treatment for PLWH attempts to stabilize mental health conditions while improving and sustaining quality of life. Evidence based psychiatric treatment approaches and psychotherapeutic medications have proven effective in alleviating or decreasing psychological symptoms and illnesses that may accompany a diagnosis of HIV. Often, PLWH have psychological illnesses that pre-date their infection, but have been exacerbated by the stress of living with a chronic illness.

Mental health services include:

- Mental health assessment
- Treatment planning
- Treatment provision
    - Individual counseling/psychotherapy
    - Family counseling/psychotherapy
    - Group counseling/psychotherapy
    - Psychiatric medication assessment, prescription and monitoring
    - Drop-in psychotherapy groups
    - Crisis intervention

General Eligibility Requirements for Ryan White Services

- Be diagnosed with HIV or AIDS with verifiable documentation.
- Be a resident of Los Angeles County
- Have an income at or below 500% of Federal Poverty Level.
- Provide documentation to verify eligibility, including HIV diagnosis, income level, and residency.

Given the barriers with attaining documentation, contractors are expected to follow the Los Angeles County, Department of Public Health, Division of HIV and STD Programs (DHSP) guidance for using self-attestation forms for documentation eligibility for Ryan White services.

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Mental Health Service Components

HIV/AIDS mental health services are short-term or sustained therapeutic interventions provided by mental health professionals who specialize in HIV (see Appendix B for a description of mental health professionals) for clients experiencing acute and/or ongoing psychological distress. This document describes the following service components for Mental Health Services: Mental health Assessment, Treatment Plans, Treatment Provision, Documentation, Informed Medication Consent, Crisis Intervention,

MENTAL HEALTH ASSESSMENT

Mental health assessment is completed during a collaborative face-to-face interview in which the client's biopsychosocial history and current presentation are valuated to determine diagnosis and treatment plan. Reassessments are indicated when there is significant change in the client's status, or when the client re-enters treatment. To reduce client assessment burden, mental health providers should utilize existing assessments such as those performed by Medical Care Coordination (MCC) teams, as a tool to inform treatment plan development. While it is generally the case that a client receiving mental health services will be registered and enrolled in a MCC program, circumstances may arise under which a client must be seen immediately to mitigate a crisis that requires stabilization. Once stabilized, clients should be referred to a MCC program within three working days. Persons receiving crisis intervention or drop-in psychotherapy groups require a brief assessment of the presenting issues that supports the mental health treatment modality chosen.

MENTAL HEALTH SERVICES: MENTAL HEALTH ASSESSMENT	
STANDARD	MEASURE
Mental health assessments will be completed within two visits, but in no longer than 30 days.	Completed assessment, in client file to include (at minimum): • Detailed mental health presenting problem • Psychiatric or mental health treatment history • Mental status exam • Complete DSM five axis diagnosis
Clients seen in crisis who are not currently enrolled in a Medical Care Coordination (MCC) program will be referred to one within three working days of stabilization.	Record of linked referral on file in client chart.
"Expanded" assessment (for clients without a medical care coordination assessment on file) should be completed within two visits, but in no longer than 30 days.	Completed assessment, signed and dated in client file to include (at minimum): • Statement of client's presenting problem • Psychiatric of mental health treatment history • Substance abuse history • Family, relationships and support systems • Cultural influences • Education and employment history • Legal history • General and HIV-related medical history • Medication adherence

	• HIV risk behavior, disclosure practices and harm reduction • Mental status exam • Complete DSM five axis diagnosis If assessment is not completed in 30 days, reason for delay to be documented in progress note.
Reassessment is ongoing and driven by client need, when a client's status has changed significantly or when the client has left and re-entered treatment, but at a minimum of once every 12 months.	Progress notes or new assessment demonstrating reassessment in client file.
Assessments and reassessments completed by unlicensed providers will by cosigned by licensed clinical supervisors; if completed by unlicensed psychiatric provider, assessment will be cosigned by a medical doctor board-eligible in psychiatry.	Co-signature on file in client record.

TREATMET PLANS

Treatment plans are developed in collaboration with the client and outline the course of treatment and are required for clients receiving all mental health services, excluding drop-in psychotherapy groups and crisis intervention services. A treatment plan begins with a statement of problems to be addressed in treatment and follows with goals, objectives, timeframes, interventions to meet these goals, and referrals. Mental health assessment and treatment plans should be developed concurrently; however, treatment plans must be finalized within two weeks of the completion of the mental health assessment. Treatment plans must be developed by the same mental health provider that conducts the mental health assessment. Treatment plans will be reviewing and revised at a minimum of every 12 months.

MENTAL HEALTH SERVICES: TREATMENT PLANS	
STANDARD	MEASURE
Mental health assessments and treatment plans are developed concurrently and collaboratively with the client. Treatment plans must be finalized within two weeks of the completion of the mental health assessment and developed by the same mental health provider that conducts the mental health assessment.	Completed, signed treatment plan on file in client chart to include: • Statement of problem(s), symptom(s) or behavior(s) to be addressed in treatment • Goals and objectives • Interventions and modalities proposed • Frequency and expected duration of services • Referrals (e.g. day treatment programs, substance use treatment, etc.)
Review and revised treatment plan not less than once every twelve months.	Documentation of treatment plan revision in client chart.
Assessments and reassessments completed by unlicensed providers will be cosigned by licensed clinical supervisor; those completed by an	Co-signature in client record.

unlicensed psychiatric providers will be cosigned by a medical doctor board-eligible in psychiatry.	

TREATMENT PROVISION

Treatment provision consists of ongoing contact and clinical interventions with (or on behalf) of the client necessary to achieve treatment plan goals. All modalities and interventions in mental health treatment will be guided by the needs expressed in the treatment plan. Practitioners shall be knowledgeable about outcome research and utilize clinically proven treatment for their client's presenting problems. Treatment provision should be documented through progress notes and include the date and signature of the mental health provider. If the provider is unlicensed, progress notes will be cosigned by the licensed clinical supervisor. For unlicensed psychiatric providers, progress notes will be cosigned by a medical doctor board-eligible in psychiatry. See **Appendix C** for Descriptions of Treatment Modalities.

MENTAL HEALTH SERVICES: TREATMENT PROVISION	
STANDARD	MEASURE
Interventions and modalities will be determined by treatment plan.	Treatment plan signed and dated by mental health provider and client in client file.
Practitioners will use outcome research and published standards of care, as appropriate and available, to guide their treatment.	Progress note signed and dated by mental health provider detailing interventions in client file.
Treatment, as appropriate, will include counseling about (at minimum): • Prevention and transmission risk behaviors, including root causes and underlying issues related to increased HIV transmission behaviors • Substance use • Treatment adherence • Development of social support systems • Community resources • Maximizing social and adaptive functioning • The role of spirituality and religion in a client's life • Disability, death, and ying • Exploration of future goals	Progress note, signed and dated by mental health provider detailing counseling sessions in client file.
Progress notes for individual, family and conjoint treatment will document progress through treatment provision.	Signed, dated progress note in client chart to include: • Date, type of contact, time spent • Interventions/referrals provided • Progress toward Treatment Plan goals • Newly identified issues • Client response
Progress notes for group psychotherapy will document progress through treatment provision.	Signed, dated progress note in client chart to include: • Date, time, and length of group • Record of attendance

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	• Issues discussed and interventions provided
Progress notes for psychiatric services will document progress through treatment provision.	Signed, dated progress note in client chart to include: • Date, type of contact, time spent • Treatment Plan including current medical and psychotropic medication and dosages • Progress towards psychiatric Treatment Plan goals • Interventions and client's response to interventions • Referrals provided • Results of interventions and referrals • Documentation of provider's addressing existing and newly identified goals
Progress notes completed by unlicensed providers will be cosigned by licensed clinical supervisor. Notes completed by an unlicensed psychiatric provider will be cosigned by a medical doctor board-eligible in psychiatry.	Co-signature on file in client record.

INFORMED MEDICATION CONSENT

Informed Medication consent is required of every patient receiving psychotropic medications.

MENTAL HEALTH SERVICES: INFORMED MEDICATION CONSENT	
STANDARD	MEASURE
An informed Medication Consent will be completed for all patients receiving psychotropic medications.	Completed, signed, and dated Informed Medication Consent on file in client chart indicating the patient has been told about and understands: • Medication benefits • Risks • Common side effects • Side effect management • Timetable for expected benefit
A new Informed Medication Consent will be completed whenever a new medication is prescribed.	New Informed Medication Consent on file in client chart.
Informed Medication Consents completed by unlicensed providers will be cosigned by medical doctor board-eligible in psychiatry.	Co-signature on file in client record.

CRISIS INTERVENTION

Crisis intervention is an unplanned service provided to an individual, couple or family experiencing biopsychosocial distress. These services focus on reversing and stabilizing crisis-related deterioration of

functioning. Crisis intervention can be provided face-to-face or by telephone. It is imperative that client safety is assessed and addressed under these crisis situations. Crisis intervention services may occur as often as necessary to ensure client safety and maintenance of baseline functioning.

MENTAL HEALTH SERVICES: CRISIS INTERVENTION	
STANDARD	MEASURE
Crisis intervention services will be offered to clients experiencing psychological distress.	Progress notes to detail reasons for crisis intervention services.
Client safety will be continuously assessed and addressed when providing crisis intervention services.	Progress notes to detail safety assessment.
Progress notes will document crisis intervention services.	Signed, dated progress notes in client chart to include: • Date, time of day, and time spent with or on behalf of the client • Summary of crisis event • Interventions and referrals provided • Results of interventions and referrals • Follow-up plan
Progress notes completed by unlicensed providers will be cosigned by licensed clinical supervisor	Co-signature on file in client record.

TRIAGE/REFERRAL/COORDINATION

In certain cases, clients will require a higher level of mental health intervention than a given agency is able to provide. Mental health providers are responsible for referring these clients to additional mental health services including neuropsychological testing, day treatment programs and in-patient hospitalization. Referrals to other services including case management, treatment advocacy, peer support, medical treatment and dental treatment will also be made as indicated. Regular contact with client's primary care clinic and other providers will ensure integration of services and better client care.

MENTAL HEALTH SERVICES: TRIAGE/REFERRAL/COORDINATION	
STANDARD	MEASURE
As needed, providers will refer clients to full range of mental health services including: • Neuropsychological testing • Day treatment programs • In-patient hospitalization	Signed, dated progress notes to document referrals in client chart.
As needed, providers will refer to other services including case management, treatment advocacy, peer support, medical treatment, and dental treatment.	Signed, dated progress notes to document referrals in client chart.
Providers will attempt to make contact with a client's primary care clinic at minimum once a year, or as clinically indicated, to coordinate and	Documentation of contact with primary medical clinics and providers to be placed in progress notes.

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integrate care. Contact with other providers will occur as clinically indicated.	

CASE CONFERENCES

Programs will conduct monthly interdisciplinary discussions of selected patients to assist in problem-solving related to a patient's progress toward mental health treatment plan goals and to ensure that professional guidance and high-quality mental health treatment services are being provided. All members of the treatment team available, including case managers, treatment advocates, medical personnel, etc., are encouraged to attend. Documentation of case conferences shall be maintained within each client record in a case conference log.

MENTAL HEALTH SERVICES: CASE CONFERENCES	
STANDARD	MEASURE
Interdisciplinary case conferences will be held for each active client at least once every six months.	Case conference documentation, signed by the supervisor, on file in client chart to include: • Date, name of participants, and name of client • Issues and concerns • Follow-up plan • Clinical guidance provided • Verification that guidance has been implemented

CLIENT RETENTION AND CASE CLOSURE

Provider agencies will strive to retain clients in mental health treatment. A broken appointment policy and procedure to ensure continuity of service and retention of clients is required. Follow-up can include telephone calls, written correspondence and/or direct contact, and efforts to maintain a client's participation in care.

Case closure is a systematic process for discharging clients from mental health services. The process includes the completion of a Case Closure Summary (CCS) to be maintained in the client record. Case closure will be initiated if the patient does not receive mental health services or is unable to be contacted within a one-year period.

MENTAL HEALTH SERVICES: CLIENT RETENTION AND CASE CLOSURE	
STANDARD	MEASURE
Programs will develop a broken appointment policy to ensure continuity of service and retention of clients.	Written policy on file at provider agency.
Programs will provide regular follow-up procedures to encourage and help maintain a client in mental health treatment.	Documentation of attempts to contact in progress notes. Follow-up may include: • Telephone calls • Written correspondence • Direct contact

Programs will develop case closure criteria and procedures.	Case closure criteria and procedures on file at provider agency. Cases may be closed when the patient: • Successfully attains psychiatric treatment goals • Relocates out of the service area • Becomes eligible for benefits or other third-party payer (e.g. Medi-Cal, private medical insurance, etc.) • Has had no direct program contact in a one-year period • Is ineligible for the service • No longer needs the service • Discontinues the service • Is incarcerated long term • Utilizes the service improperly or has not complied with the client services agreement • Had died
Regular follow-up will be provided to clients who have dropped out of treatment without notice.	Documentation of attempts to contact in progress notes.
A Case Closure Summary will be completed for each client who has terminated treatment.	Signed, and dated Case Closure Summary on file in client chart to include: • Course of treatment • Discharge diagnosis • Referrals made • Reason for termination
Case Closure Summaries completed by unlicensed providers will be cosigned by licensed clinical supervisor. For unlicensed psychiatric providers, the Case Closure Summary must be cosigned by a medical doctor board-eligible in psychiatry.	Co-signature on file in client chart.

STAFFING REQUIREMENTS AND QUALIFICATIONS

Providers of mental health services will be, at minimum, master's or doctoral level graduate students in counseling, marriage and family therapy, nursing (with specialized mental health training), psychiatry, psychology, or social work.

HIV/AIDS psychiatric treatment services are provided by medical doctors board-eligible in psychiatry. A psychiatrist may work in collaboration with a psychiatric resident, or RN/NP. While state law governs prescription of medication, it is recommended that physicians licensed as such by the state of California shall prescribe all prescriptions for psychotropic medications. If an NP is utilized to provide medications, he or she must do so according to standardized protocol and under the supervision of a psychiatrist (Please see Service/Organizational Licensure Category).

All staff hired by provider agencies will possess the ability to provide developmentally and culturally appropriate care to clients living with and affected by HIV. All clinical staff will have previous experience or training utilizing appropriate treatment modalities in practice.

All hired staff will participate in orientation and training before beginning treatment provision. Licensed providers are encouraged to seek consultation to address clinical, psychosocial, developmental, and programmatic issues, as needed. If providers are unlicensed, they must be clinically supervised in accordance with the requirements of the licensing board of their respective professions. Graduate-level interns must be supervised according to the requirement of their respective programs and to the degree that ensure appropriate practice.

Practitioners should have training and experience with HIV/AIDS related issues and concerns. At a minimum, providers will participate in eight hours of continuing education or contouring medical education (CME) on the topics of HIV and mental health issues every two years.

Practitioners providing mental health services to people living with HIV should possess knowledge about the following (at minimum):

- HIV disease process and current medical treatments
- Medication interactions (for psychiatrists)
- Psychosocial issues related to HIV/AIDS
- Cultural issues related to communities affected by HIV/AIDS
- Mental disorders related to HIV and other medical conditions
- Mental disorders that can be induced by prescription drug use
- Adherence to medication regimes
- Diagnosis and assessment of HIV-related mental health issues
- HIV/AIDS legal and ethical issues
- Knowledge of human sexuality, gender and sexual orientation issues
- Substance use theory, treatment, and practice

Finally, practitioners and staff must be aware of and able to practice under the legal and ethical obligations as set forth by California state law and their respective professional organizations.

Psychiatrists shall comply with existing laws regarding confidentiality, informed consent and client's rights, and shall conform to the standards and guidelines of the American medical Association and the American Psychiatric Association regarding ethical conduct, including:

- **Duty to treat:** Practitioners have an ethical obligation not to refuse treatment because of fear or lack of knowledge about HIV
- **Confidentiality:** Maintenance of confidentiality is a primary legal and ethical responsibility of the psychiatric practitioner.
- **Duty to warn:** Serious threats of violence against a reasonability identifiable victim must be reported. However, at present, in California, a person living with HIV engaging in behaviors that may put others at risk for HIV infection is not a circumstance that warrants breaking of confidentiality. Physicians, however, may notify identified partners who may have been infected, while other mental health providers are not permitted to do so.

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Mental health services providers are advised to seek legal advice when they are unsure about issues and the level/ethical ramifications of their actions.

MENTAL HEALTH SERVICES: STAFFING REQUIREMENTS AND QUALIFICATIONS	
STANDARD	MEASURE
Provider will ensure that all staff providing psychiatric treatment services will be licensed, supervised by a medical doctor board-eligible in psychiatry, accruing house toward licensure or a registered graduate student enrolled in counseling, social work, psychology or marriage and family therapy program.	Documentation of licensure/professional/student status on file.
It is recommended that physicians licensed as such by the state of California shall prescribe psychotropic medications.	Documentation of licensure on file.
New staff will completed orientation/training prior to providing services.	Documentation of training file.
Mental health staff are training and knowledgeable regarding HIV/AIDS and the affected community.	Training documentation on file maintained in each personnel record which includes: • Date, time, and location of the function • Function type • Name of the agency and staff members attending the function • Name of the sponsor or provider • Training outline, meeting agenda and/or minutes
Programs will provide and/or allow access to ongoing staff training and development of staff including medical, psychiatric and mental health HIV-related issues.	Training documentation on file maintained in each personnel record which includes: • Date, time, and location of the function • Function type • Name of the agency and staff members attending the function • Name of sponsor or provider • Training outline, meeting agenda, and/or minutes
Licensed staff are encouraged to seek consultation as needed.	Documentation of consultation on file.
Treatment providers will practice according to California state law and the ethical codes of their respective professional organizations.	Chart review will ensure legally and ethically appropriate practice.
Psychiatric treatment providers will possess skill, experience and licensing qualifications appropriate to provision of psychiatric treatment services.	Resume and current license on file.
Unlicensed professional psychiatric and mental health professionals will receive supervision in accordance with sate licensing requirements. The	Documentation of supervision on file.

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Division on HIV and STD Programs (DHSP) will be notified immediately in writing if a clinical supervisor is not available.	
Mental health service staff will complete documentation required by program.	Administrative supervisor will review documentation periodically.

ADMINSTRATIVE SUPERVISION

Programs will conduct client record reviews to assess that all required mental health documentation is completed properly in a timely manner and secured within the client records.

MENTAL HEALTH SERVICES: ADMINISTRATIVE SUPERVISION	
STANDARD	MEASURE
Programs shall conduct record reviews to ensure appropriate documentation.	Client record review, signed and dated by reviewed on file to include: • Checklist of required documentation • Written documentation identifying steps to be taken to rectify missing or incomplete documentation • Date of resolution for omissions

UTILIZING INTERNS, ASSOCIATES, AND TRAINEES

A significant portion of mental health services are provided by interns, associates and trained (IATs). While this process expands capacity by developing a well-trained workforce and provides increased access through cost effective services, extra care must be taken to ensure that high quality, ethical counseling and psychotherapy services are maintained. See **Appendix D** for additional information on Utilizing Interns, Associates, and Trainees (IATs).

MENTAL HEALTH SERVICES: UTILIZING INTERNS, ASSOCIATES, AND TRAINEES	
STANDARD	MEASURE
Programs using IATs will provide an orientation and training program of no less than 24 hours to be completed before IATs begin providing services.	Documentation of training/orientation on file at provider agency.
IATs will be assigned cases appropriate to experience and scope of practice and that can likely be resolved over the course of the IAT's internship.	Record of case assignment on file at provider agency.
Programs will provide IATs with clinical supervision in accordance with all applicable rules and standards.	Record of clinical supervision on file at provider agency.
IATs will inform clients of their status as an intern and the name of the supervisor covering the case.	Internship notification form, signed by the client and the therapist on file in client chart.
Termination/transition/transfer will be addressed at the beginning of assessment, treatment inception and six weeks prior to termination.	Signed, dated progress notes confirming termination/transition/transfer on file in client chart.

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At termination the IAT and client will discuss accomplishments, challenges, and treatment recommendations.	Signed, dated progress notes detailing this discussion on file in client chart.
Clients requiring services beyond the IAT's internship will be referred immediately to another clinician.	Singed, dated, Client Transfer Form (CTF) in client chart.
All clients place don a waiting list will be offered the following options: • Telephone contact • Transition group • Crisis counseling	Signed, dated CTF that details the transfer plan on file in client chart.

Appendix A: Health Resources and Services Administration (HRSA) Guidance

Description:
Mental Health Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized withing the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

Program Guidance:
Mental Health Services are allowed only for PLWH who are eligible to receive HRSA RWHAP services.

Appendix B: Mental Health Service Providers

Providers of mental health services include licensed practitioners and unlicensed practitioners who practice under the supervision of a licensed mental health professional and as mandated by their respective licensing bodies. HIV/AIDS mental health psychiatric treatment services are provided by medical doctors (MDs) board-eligible in psychiatry. A psychiatrist may collaborate with a psychiatric resident or registered nurse/nurse practitioner (RN/NP) under the supervision of a medical doctor board-eligible in psychiatry. All prescriptions shall be prescribed solely by physician licensed by the state of California.

Licensed Practitioners:

- **Licensed Clinical Social Workers (LCSW):** LCSWs possess a mater's degree in social work (MSW). LCSWs are required to accrue 3,200 hours of supervised professional experience to qualify for licensing. The Board o Behavioral Science Examiners regulates the provision of mental health services by LCSWs.
- **Licensed Marriage and Family Therapists (LMFT):** LMFTs possess a master's degree in counseling. LMFTs are required to accrue 3,000 hours of supervised counseling or psychotherapy experience to qualify for licensing. The Board of Behavioral Science Examiners regulates the provision of mental health services by LMFTs.
- **Nurse Specialists and Practitioners:** Registered nurses (RNs) who hold a master's degree as a nurse practitioner (NP) in mental health or a psychiatric nurse specialist (PNS) are permitted to diagnose and treat mental disorders. NPs may prescribe medications in accordance with

standardized procedures or protocols, developed and approved by the supervising psychiatrist, NP and facility administrator. Additionally, the NP must furnish and order medications under a psychiatrist's supervision.

To qualify for prescribing medications, NPs must complete:

- At least six months of psychiatrist-supervised experience in the ordering of medications or devices
- A course in pharmacology covering the medications to be furnished or ordered

RNs who hold a bachelor's degree are permitted to provide psychoeducational services but are not allowed to diagnose or treat mental disorders independently. Nurses and NPs are regulated by the California State Board of Nursing.

- **Psychiatrists:** Psychiatrists are physicians (medical doctors or MDs) who have completed an internship and psychiatric residency (most are three years in length). They are licensed by the state medical board, which regulates their provision of services, to practice independently. They are certified or eligible for certification by the American Board of Psychiatry. They have ultimate clinical authority but function collaboratively with multidisciplinary teams, which may include psychiatric residents or NPs. They initiate all orders for medications.

  They provide HIV/AIDS mental health treatment services as follows:

  - Examination and evaluation of individual patients
  - Diagnosis of psychiatric disorders
  - Medication treatment planning and management
  - Medical psychotherapy
  - Supervision of allied health professionals through a defined protocol
  - Participation and leadership in interdisciplinary case conferences including signing off on diagnoses and treatment plans
- **Psychologists:** Psychologists possess a doctoral degree in psychology or education (PhD, PsyD, EdD). Psychologists are required to accrue 3,000 hours of supervised professional experience to qualify for licensing. The Board of Psychology regulates the provision of mental health services by psychologists.

Unlicensed Practitioners:

- **Marriage family therapist (MFT) interns; psychological assistants, post-doctoral fellows and trainees; and social work associates:** Interns, assistants, fellows, and associates are accumulating supervised experience as part of their preparation for licensing or certification. They have completed graduate work in counseling, psychology or social work. These providers required direct supervision by a licensed mental health practitioner as mandated by their respective licensing bodies.

Marriage family therapist (MFT) trainees and social work interns: Trainees and interns are in the process of obtaining their master's degrees and completing the necessary practicum or field work in a site approved by their academic institutions. Trainees and interns require direct supervision by a licensed mental health practitioner at the approved site as mandated by their respective licensing bodies.

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Appendix C: Description of Treatment Modalities

Ongoing psychiatric sessions: Mental health treatment should include counseling regarding knowledge of modes of transmission, prevention, risk and harm reduction strategies (as well as root causes and underlying issues related to increased HIV transmission behaviors). Substance use, treatment adherence, development of social support systems and community resources as indicated by the client's circumstance are important areas to be explored. Focus should also be placed on maximizing social and adaptive functioning. The role of and –when present in a client's life—spirituality and religion should be understood and utilized as a strength when present. If clients being to deteriorate physically, emotional distress can be relieved by helping them prepare for disability, even death. For the client whose health has improved, exploration of future goals including returning to school or work is indicated. When a signed release has been completed, sources of support and care can be recommended to significant others and family members.

The provision of specific types of psychotherapy (behavioral, cognitive, post-modern, psychodynamic) is guided by the individual client's need and based on published practice guidelines and research. For those clients on psychotropic medications, side effects of these agents should be assessed at each visit, along with the provision of education regarding such medications, within the scope of the provider's practice. As indicated, these clients will be referred to the prescribing physician for further information.

Individual counseling/psychotherapy: Individual counseling or psychotherapy may be either short- or long-term in duration, depending on the needs outlined in the treatment plan. Short-term or brief therapy lasts up to 12 sessions and can be most useful when client goals are specific and circumscribed. Longer-term therapy providers a means to explore more complex issues that may interfered with a client's quality of life. Even in the case of longer-term therapy, specific, short-term, mutually defined goals are recommended to focus treatment and measure progress.

Family counseling/psychotherapy: A family may be defined as either the family of origin or a chosen family (Bor, Miller & Goldman, 1993). The impact of HIV on the family system can be enormous. The overall goal of family counseling/psychotherapy is to help families improve their functioning, given the complications of living with HIV. Interventions with the family system can be especially effective in helping children and caregivers with behavioral problems and symptoms.

Couples counseling/psychotherapy: This modality is most appropriate where the presenting problem is dissatisfaction or conflict within a relationship that impacts a person living with HIV. In cases of domestic violence, couples counseling should not begin until the provider determines the appropriateness of this modality based upon the progress both parties have made in individual or group treatment and the fact that current violence is no longer a risk. If these criteria are not met, members of such couples should be referred for individual or group treatment.

Group psychotherapy treatment: Group treatment can provide opportunities for increased social support vital to those isolated by HIV.

While groups may be led by a single leader, significant benefits arise when utilizing two co-facilitators:

- Fewer group cancellations due to facilitator absence
- Increased change that important individual and group issues will be explored
- Members can witness different skills and styles of the therapists

- Increased opportunity to work through transference relationships

Group treatment can be provided in a variety of formats:

- **Closed psychotherapy groups** typically require a process for joining and terminating. Closed groups usually have a set number of group members (between six and ten). This format providers an opportunity to build group cohesion and for members to take part in active interpersonal learning. These groups can be time limited or ongoing, issue specific or more general in content.
- **Open psychotherapy groups** do not require ongoing participation form clients. The group membership shifts from session to sessions, often requiring group leaders to be more structured and active in their approach. These groups can be especially useful to clients requiring immediate support, but unsure about making a commitment to ongoing treatment.

Drop-in groups can also be offered as a mental health service, as long as at least one of the leaders of the group is a mental health provider as defined in this standard.

- **Drop-in groups** do not have an ongoing membership. Instead of a psychotherapeutic focus, these groups focus on such functions as providing topic-specific education, social support and emotional encouragement. As such, they do not require inclusion in a client's treatment plan, nor is a full mental health assessment required to access this service.

Psychiatric evaluations, medication monitoring and follow-up: Psychiatrists shall use clinical presentation, evidence-based practice guidelines and specific treatment goals to guide the evaluation, prescription and monitoring of appropriate medication.

For medication monitoring and follow-up, visit frequency should be at a minimum:

- Once every two weeks in the acute phase
- Once every month in the sub-acute phase
- Once every three months in the maintenance phase

For those patients on psychotropic medication, side effects of these agents shall be assessed at each visit, along with the provision of education regarding their medications. In addition, these patients should regularly be counseled about the importance of adherence to psychotropic medications.

The American Psychiatric Association (2001) suggests the following general pharmacologic treatment guidelines, especially for those patients with symptomatic HIV disease:

- Use lower starting doses and titrate more slowly
- Provide the least complicated dosing schedules possible
- Concentrate on drug side effect profiles to avoid unnecessary adverse effects
- Be aware of drug metabolism/clearance pathways to minimize drug-drug interactions and possible organ damage

In general, refills shall not be written beyond three months of the last psychiatric visit. However, exception can be made in special circumstances or when the stability of the client warrants less frequent monitoring. Such exceptions shall be documented in client progress notes.

Psychiatrists must coordinate the provision of psychiatric care with primary care medical clinics and other related providers. Regular contact with a patient's primary care clinic and related providers will ensure integration of services and maintain care continuity.

Appendix D: Utilizing Interns, Associates, and Trainees (IATs)

Programs utilizing IATs will give thoughtful attention to:

- **Training:** Programs utilizing IATs will provide an orientation and training program of no less than 24 hours of instruction focusing on the specifics of providing HIV mental health services. This orientation/training will be completed before IATs begin providing services.
- **Case assignment:** IATs will only be assigned cases that are appropriate to their experience and scope of practice. Additionally, IAT should not be assigned cases that require an intervention that is longer term than the IAT's internship. Such cases should be referred to staff clinicians or referred out.
- **Supervision:** Programs will provide IATs with clinical supervision in accordance with all applicable rules and standards. Supervisors, or other appropriate mental health staff will always be available to IAT that they are providing direct services to clients.

IATs will explicitly inform their clients of their intern status at the beginning of treatment. A document that acknowledges IAT status and details the case supervisor's name will be signed by the client and IAT and placed in the client record. The issue of termination/transition/transfer (due to a therapist's IAT status) will be addressed at the beginning of the assessment, at treatment inception and revisited six weeks prior to IAT termination.

IATs will consult with the clinical supervisor prior to the termination/transition intervention with a client. As part of the termination process, the IAT and client will discuss the client's treatment accomplishments, challenges, preference for future treatment and treatment recommendation. As is true throughout the treatment process, the clinical supervisor will provide oversight for the termination/transition process and cosign the IAT documentation.

While every effort should be made to ensure that IATs will not provider services for clients whose Treatment Plans extend past the internship term, it is recognized that in some cases, clients require unanticipated additional and/or ongoing treatment to meet the stated goals of their treatment plans. In such cases, special care must be given to the transfer of these clients.

Programs will endeavor to transfer IAT clients immediately to another clinician or outside program.

If a client must be placed on a waiting list for transfer to another clinician or IAT, programs will provide the following options for ongoing monitoring and crisis care:

- **Telephone contact:** Existing mental health staff or IAT will attempt contact at least twice a month to every client on the transfer waiting list to monitor current mental status and asses for emergent crises.
- **Transition group:** All clients on a transfer waiting list will be offered the opportunity to attend a transition group or another existing support group to monitor current mental status and assess for emergent crises.

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- **Crisis counseling:** Utilizing both monitoring mechanisms noted above, all clients on a transfer waiting list will be informed of the availability of crisis counseling designated for them on an as needed basis.

Program will complete a Client Transfer Form (CTF) detailing the transfer plan for each IAT transfer.

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NAVIGATING SERVICES IN TIMES OF UNCERTAINTIES

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VALIDATED PARKING: 523 SHATTO PL, LA 90020

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(800) 260-8787

Why should I call?

The Customer Support Line can assist you with accessing HIV or STD services and addressing concerns about the quality of services you have received.

Will I be denied services for reporting a problem?

No. You will not be denied services. Your name and personal information can be kept confidential.

Can I call anonymously?

Yes.

Can I contact you through other ways?

Yes.

By Email:
dhspsupport@ph.lacounty.gov

On the web:
http://publichealth.lacounty.gov/dhsp/QuestionServices.htm

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

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Línea de Atención al Cliente

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¿Se me negarán los servicios por informar de un problema?

No. No se le negarán los servicios. Su nombre e información personal pueden mantenerse confidenciales.

¿Puedo llamar de forma anónima?

Si.

¿Puedo ponerme en contacto con usted a través de otras formas?

Si.

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dhspsupport@ph.lacounty.gov

En el sitio web:
http://publichealth.lacounty.gov/dhsp/QuestionServices.htm

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