LOS ANGELES COUNTY
COMMISSION ON HIV

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# STANDARDS AND BEST PRACTICES COMMITTEE MEETING

**TUESDAY, JUNE 3, 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

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- 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.*

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# together.

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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, JUNE 3, 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/rfa6b01345f62d02cbe6428efaee66c79
To Join by Telephone: 1-213-306-3065
Password: STANDARDS Access Code: 2534 388 3035

| Standards and Best Practices Committee (SBP) Members: | | | |
|---|---|---|---|
| Erika Davies *Co-Chair* | Arlene Frames *Co-Chair (LOA)* | Dahlia Ale-Ferlito | Mikhaela Cielo, MD |
| Sandra Cuevas | Caitlin Dolan (Committee-only) | Kerry Ferguson (Alternate) | Lauren Gersh, LCSW *(Committee-only)* |
| David Hardy, MD *(Alternate)* | Mark Mintline, DDS *(Committee-only)* | Byron Patel, RN | Sabel Samone-Loreca *(Alt. to Arlene Frames)* |
| Martin Sattah, MD | Kevin Stalter | Russell Ybarra | |
| QUORUM: 8 | | | |

**AGENDA POSTED:** May 28, 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.

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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 Review — 10:45 AM—11:15 AM
11. Patient Support Services (PSS) Service Standards Review — 11:15 AM—11:45 AM

**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 June 3, 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. |

LOS ANGELES COUNTY
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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.)

## Los Angeles County Commission on HIV

# REVISED 2025 TRAINING SCHEDULE

***SUBJECT TO CHANGE**

- All training topics listed below are mandatory for Commissioners and Alternates.
- All trainings are open to the public.
- Click on the training topic to register.
- Certificates of Completion will be provided.
- All trainings are virtual via Webex.
- For questions or assistance, contact: hivcomm@lachiv.org

| | |
|---|---|
| Commission on HIV Overview | February 26, 2025 @ 12pm to 1:00pm |
| Ryan White Care Act Legislative Overview and Membership Structure and Responsibilities | ~~March 26, 2025~~ @ 12pm to 1:00pm<br>April 2, 2025 |
| Priority Setting and Resource Allocations Process | April 23, 2025 @ 12pm to 1:00pm |
| Service Standards Development | May 21, 2025 @ 12pm to 1:00pm |
| Policy Priorities and Legislative Docket Development Process | June 25, 2025 @ 12pm to 1:00pm |
| Bylaws Review | July 23, 2025 @ 12pm to 1:00pm |

DRAFT

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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

MAY 6, 2025

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

**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 ***(Approved by consensus).***

### 2. APPROVAL OF MEETING MINUTES

**MOTION #2**: Approve the 04/01/25 SBP Committee meeting minutes, as presented ***(Approved by consensus).***

## II. PUBLIC COMMENT

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

**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, acknowledged upcoming changes to HIV prevention contracts and their impacts on the community. She noted that rest is a form of resistance and as leaders it is okay to rest. She shared sentiments encouraging self-care and managing emotional well-being amid ongoing challenges to HIV prevention funding.

C. Barrit reported that the Planning, Priorities, and Allocations (PP&A) Committee held an emergency meeting on May 1, 2025, to discuss another funding scenario exercise as recommended by the Division on HIV and STD Programs (DHSP) around $28 million dollars. She reminded that at the April Commission meeting, the full Commission approved a worst-case funding scenario. At the May 8, 2025, full Commission meeting, the PP&A Committee will present the $28 million funding scenario for deliberation and vote by the full body. Additionally, the PP&A Committee learned that on April 30, 2025, DHSP contractors received letters of contract cancellation because of lack of funding commitment from the Centers for Disease Control and Prevention (CDC); DHSP and the County was in no position to commit to contracts if no federal funding or guarantee of forthcoming federal funding was in place. She noted that the "skinny budget" reflects heavy cuts to the CDC budget and downsizing and reorganization of federal health agencies; there was no indication that Ryan White funding would face any cuts. The impact of the reduction in workforce and budget allocations will have on the CDC and the Health Resources and Services Administration (HRSA) remains unknown and uncertain. C. Barrit has requested guidance from HRSA Ryan White Project Officers and has been advised to proceed as normal and continue conducting legislative responsibilities as a planning council.

Dahlia Ale-Ferlito, committee member, asked if the Los Angeles County Board of Supervisors (BOS) has a mechanism for backfilling staff positions or allocating contract funds to sustain the services and programs that have received contract cancellation notices. C. Barrit reminded the committee that the COH has the legislative responsibility to plan and allocate funds but contracting and contract management falls under the purview of DHSP. She added that there are opportunities for community members and stakeholders to conduct advocacy efforts and appeal to the BOS to support funding these services and programs.

Sandra Cuevas, committee member, asked what would happen if the CDC were to release funds for the contracts DHSP has sent cancellation notices. C. Barrit noted that she did not have a copy of the letter and was not aware of the content of the letter. Caitlin Dolan, committee member, noted that the letter stated that it was a "pause" which would allow DHSP the opportunity to continue contracts once funding were available.

C. Barrit reported that at the May 8, 2025, COH meeting, the consulting group contracted to lead the COH restricting project will provide a report back on their findings from the workgroup sessions which will include a set of recommendations on the COH membership and committee structure changes. Additionally, the Housing Taskforce will also report their findings from their consultations with Ryan White housing and legal services providers to identify opportunities to scale up the use of those services to prevent the rise of homelessness amongst people living with HIV.

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 the Committee will continue their review of the Transitional Case Management (TCM) service standards and receive a preview of the Patient Support Services (PSS) service standards. She added that the June 3rd and July 1st Committee meetings will take place on the 9th floor of the Vermont Corridor building.

- **Service Standards Revision Tracker—Updates**
  E. Davies noted that the service standards revision tracker has been updated and now includes a column with the service category titles used by HRSA, DHSP, and the COH; updates are marked in red.

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

## V. DISCUSSION ITEMS

**8. Transitional Case Management Service Standards Review**
E. Davies noted that Dr. Rebecca Cohen will share their experience with the TCM jails program and recommendations for revising the TCM service standards. C. Barrit set the stage for the discussion by sharing background information the TCM jails service standards. She noted that the Committee developed service standards for TCM jails and TCM youth. TCM youth was developed for transitional age youth transitioning out of the foster care system and into the Ryan White Part A services. She added that the Committee, on recommendation from DHSP and the COH's Aging Caucus, is developing TCM Older Adults 50+ which focuses on the transition of older adults 50+ from one payor source to another such as Medi-Cal to Medi-Care. Lastly, she noted that COH staff reached out to Dr. Richard Murphy and nurse Martha Tadesse at LA General Hospital --an entity under the Department of Health Services (DHS)—to seek their expertise and input for the TCM jails service standard review. Initially, they indicated they would participate in the discussion; however, they sent notice on Friday May 2, 2025, noting that they would no longer able to participate per guidance from their leadership. C. Barrit suggested that once the TCM jails service standards document is ready for public comment, the Committing should consider sending it to Dr. Murphy and Martha Tadesse for their review and feedback.

R. Cohen shared that she is Associate Medical Director at DHSP and trained under Dr. Sattah and Dr. Cielo and completed an HIV fellowship from 2016-2020 in which she worked with the TCM jails program and the positive care team. During this time, the formation of the Correctional Health Services under DHS in its early stages, along with the development of Care Transitions department which was funded under the Whole Person Care reentry services; Whole Person Care was the predecessor to the current Medi-Cal waiver program known as CalAIM. She added that when Correctional Health Services were moved from the Sheriff's department to DHS, many systems were developed to develop the Care Transitions department including the establishment of a "Release Desk". The Release Desk would assist individuals being released from jail in the middle of the night or at an unprecedented time with providing them with resources. During this time, it was challenging for DHSP TCM providers to know all the care patients received through the DHS system and vice versa since both entities reported care and services in separate electronic health record systems. Once the TCM jails DHSP contract ended, DHSP attempted to design a way to renew the TCM jails program within the DHS system however there have not been any updates on the progress of this endeavor. Additionally, with the introduction of CalAIM, which has a re-entry component, reopened efforts by DHSP to ensure medical linkage for people living with HIV in the jails were able to receive HIV-specific TCM services as part of their release planning.

R. Cohen shared that the TCM jails program has been a pre-release planning program in which TCM staff met with patients in the jails and conducted an assessment and developed individual release plans with them. There was no

after-release component to the TCM program; clients would provide their contact information to TCM staff and TCM staff would attempt to follow-up with them but there was no establish after-release program. This was a limitation of the TCM program at the time. She added that the Whole Person Care program established a system of care in which staff were placed in jails and a separate network of providers were embedded in the community with the goal of linking clients to the community providers upon their release from jail. R. Cohen noted that among the jail population, most people living with HIV do great with their HIV care while they are in jail since they gain access to medications, labs and other care services that vastly improve their health. However, once released, their health tends to decline. Based on this pattern, she recommends that the TCM service standards include a pre-release component in which TCM staff can meet with clients in jails and follow-up with them during their post-release navigation. R. Cohen shared that DHS is working on including HIV positive clients in their CalAIM reentry work however these services may only be available to Medi-Cal eligible clients. She added that the Office of Diversion and Reentry collaborates with DHSP in situations where clients are facing barriers to receiving their HIV medications upon release due to issues with Medi-Cal/insurance coverage.

C. Barrit asked how many people living with HIV are in the County jail system. R. Cohen noted that historically there have been between 300 to 1,000 people living with HIV in the County jail system. She added that there is a system within the jails that designates marks on client charts noting the type of services clients will need including HIV services. DHS Correctional Health Services has denied access to TCM staff to enter jails, however, they continue to allow Public Health Investigator staff from the Department of Public Health (DHP) to enter the jails and conduct partner services. These services include conducting outreach to newly diagnosed individuals in the jails.

Andre Molette, committee member, asked how DHSP works with individuals in the K6G wing of the County jail. R. Cohen noted that the K6G floor is a space designated for those who identified as men who have sex with men, cisgender men, and trans women. She added that in comparison to the overall Ryan White client population, the jail population tends to skew to be less men who have sex with men, and more cisgender men. Additionally, compared to the overall Ryan White population, in the race and ethnicity category, there is an overrepresentation of people who are black and young.

S. Cuevas asked if the BOS efforts to close Men's Central Jail have had any impact on the Correctional Health Services programs. R. Cohen noted that it is possible these efforts have contributed to the stalling of implementing a TCM system in collaboration with DHSP. She also mentioned that the added layers of complexity involved with offering care and services to clients in the jails contribute as well. Some examples include the lack of privacy, and security factors to consider. S. Cuevas asked what services are provided in the jails. R. Cohen shared that Pre-Exposure Prophylaxis (PrEP) is available upon request by court-order or during intake and triage; there is gender-affirming care such access to hormone therapy; and DHSP has a specialized syphilis testing program at the women's jail called CRDF which is a point of care syphilis testing program.

E. Davies provided an overview of the document structure for the TCM service standards. She recommended to separate document into three documents with each focusing on one population. There will be one document for justice-involved individuals, one for youth, and one for older adults 50+. The following revisions to the TCM justice-involved individuals document were made:

- Add a bullet point emphasizing post-release services to the overview section
- Remove items on Page 28 under the comprehensive assessment section. Add: assessment of barriers to care, including gender-affirming care; legal issues and history of incarceration; and social support systems
- Consider an express IRP for individuals with short jail stays
- Develop a resource sheet that can be provided to individuals upon release containing essential information and contact details for services

- Describe the minimum attempts to contact a client and what is expected from these contacts
- Consider separating the pre and post release activities in the document
- Remove the "Case Management Supervisor Training"

**9. Patient Support Services (PSS) Service Standards Review**
The committee did not review this document. They will forward this item to the June 3, 2025, meeting.

## VI. NEXT STEPS

**10. TASK/ASSIGNMENTS RECAP**:

- COH staff will revise the draft Transitional Case Management service standards document for the committee to continue their review at their June 3, 2025, meeting.
- COH staff will prepare a draft of the Patient Support Services service standards for the committee to review at their June 3, 2025, meeting.

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

- Continue review of the Transitional Case Management service standards.
- Initiate review of Patient Support Services service standards.

## VII. ANNOUNCEMENTS

**12. OPPORTUNITY FOR PUBLIC AND COMMITTEE TO MAKE ANNOUNCEMENTS**:

- Byron Patel announced that National Nurses Week starts on May 12 which commemorates Florence Nightingale's birthday.
- Joseph Green reminded attendees of the May 8, 2025, full Commission meeting.

## VIII. ADJOURNMENT

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

LOS ANGELES COUNTY
COMMISSION ON HIV

**STANDARDS AND BEST PRACTICES COMMITTEE 2025 MEETING CALENDAR** *(Last updated 05/30/25)*

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

LOS ANGELES COUNTY COMMISSION ON HIV

# SERVICE STANDARDS REVISION DATE TRACKER FOR PLANNING PURPOSES

*Last updated: 05/19/25*

| 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.<br><br>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** *Currently under review. SBP will begin review in June 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 begin review on 6/2/2025.* |
| | 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 6/2/2025.* |
| | 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 6/2/2025.* |
| | Transitional Case Management: Older Adults 50+ | N/A | Coordinate transition between systems of care for older adults 50+ living with HIV/AIDS. | **Last approved by COH: 12/8/2022** *New service standard currently under development.* |
| 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)<br><br>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<br>  ○ Intake and Eligibility<br>  ○ Staff Requirements and Qualifications<br>  ○ Cultural and Linguistic Competence<br>  ○ Referrals and Case Closures<br>• Client Bill of Rights and Responsibilities |
| **Category-Specific Service Standards** | • Include link to Universal Service Standards<br>• Core Medical Services<br>• Support Services |
| **Service Standards General Structure** | • Introduction<br>• Service Overview<br>• Service Components<br>• 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.<br>• Conduct review/revision of service standards which includes seeking input from consumers, subject matter experts, and service providers.<br>• 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.<br>• Once approved, the document is elevated to Executive Committee and COH for approval.<br>• 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.<br>• DHSP uses service standards when developing RFPs, contracts, and for monitoring/quality assurance activities.<br>• |
| **CYCLE REPEATS** | • Revisions to service standards occur at least every 3 years or as needed.<br>• 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

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# TRANSITIONAL CASE MANAGEMENT SERVICES

*(Draft as of 05/30/25)*

**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

## 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.

## 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. This service standard covers the following special populations: Justice-involved individuals, Transitional Youth, and Older Adults 50+. TCM services include:

- 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.<br><br>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.<br><br>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:<br>• Date<br>• Signature and title of staff person<br>Client strengths, needs and available resources in:<br>• Medical/physical healthcare<br>• Medications and Adherence issues<br>• Housing and living situation<br>• Resources and referrals<br>• Assessment of barriers to care including gender-affirming care |

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| | • Lega issues/incarceration history<br>• 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:<br>• Name of client and case manager<br>• Date and signature of case manager and client<br>• Date and description of client goals and desired outcomes<br>• Action steps to be taken by client, case manager and others<br>• Customized services offered to client to facilitate success in meeting goals, such as referrals to peer navigators and other social or health services<br>• Goal timeframes<br>• 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** | |
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| **STANDARD** | **DOCUMENTATION** |
| Case managers will:<br>• Provide referrals, advocacy, and interventions based on the intake, assessment, and IRP<br>• Monitor changes in the client's condition<br>• Update/revise the IRP | Signed, dated progress notes on file that detail, at minimum, the following:<br>• Description of client contacts and actions taken<br>• Date and type of contact<br>• Description of what occurred |

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| • Provide interventions and linked referrals<br>• Ensure coordination of care<br>• Help clients submit applications and obtain health benefits and care<br>• Conduct monitoring and follow-up to confirm completion of referrals and service utilization<br>• Advocate on behalf of clients with other service providers<br>• Empower clients to use independent living strategies<br>• Help clients resolve barriers<br>• Follow-up on IRP goals<br>• Maintain/attempt contact at minimum of once every two weeks and at least one face-to-face contact monthly<br>• Follow-up missed appointments by the end of the next business day<br>• Collaborate with the client's community-based case manager for coordination and follow-up when appropriate<br>• Transition clients out of TCM services at six month's post-release. | • Changes in the client's condition or circumstances<br>• Progress made toward IRP goals<br>• Barriers to IRPs and actions taken to resolve them<br>• Linked referrals and interventions and status/results<br>• Barriers to referrals and interventions<br>• Time spent with, or on behalf of, client<br>• 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:<br>• Knowledge of HIV/STIs and related issues<br>• Knowledge of and sensitivity to incarceration and correctional settings and populations<br>• Knowledge of and sensitivity to lesbian, gay, bisexual, and transgender persons<br>• Effective Motivational Interviewing and assessment skills<br>• Ability to appropriately interact and collaborate with others | Resume, training certificates, interview assessment notes, reference checks, and annual performance reviews on file. |

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| • Effective written/verbal communication skills<br>• Ability to work independently<br>• Effective problem-solving skills<br>• Ability to respond appropriately in crisis situations<br>• Effective organizational skills<br>• Prioritize caseload<br>• Patience<br>• Multitasking skills<br><br>Refer to "Recommended Training Topics for Transitional Case Management Staff." | |
| Case managers will meet one of the following educational requirement criteria:<br>• 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<br>• An associate degree plus one-year direct case management experience in health or human services<br>• 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.<br><br>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:<br>• Date, time, and location of function<br>• Function type<br>• Staff members attending<br>• Sponsor or provider of function<br>• Training outline, handouts, or materials<br>• Meeting agenda and/or minutes |
| Case management staff will receive a minimum of four hours of client care-related supervision per | All client care-related supervision will be documented as follows, at minimum: |

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| month from a master's level mental health professional. | • Date of client care-related supervision<br>• Supervision format<br>• Name and title of participants<br>• Issues and concerns identified<br>• Guidance provided and follow-up plan<br>• Verification that guidance and plan have been implemented<br>• 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. |

## 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

LOS ANGELES COUNTY COMMISSION ON HIV

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# TRANSITIONAL CASE MANAGEMENT SERVICES: YOUTH

*(Draft as of 05/30/25)*

**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

## 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.

## 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

Providers of TCM for Youth living with HIV/AIDS services are expected to follow 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.

## 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. 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).

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 aged 30. Planing will be made for eventual transition to adult/non-youth specific case management at leas 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** | |
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| **STANDARD** | **DOCUMENTATION** |
| Completed and enter comprehensive assessments into DHSP's data management system within 30 days of the initiation of services.<br><br>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:<br>• Date<br>• Signature and title of staff person<br>Client strengths, needs and available resources in:<br>• Medical/physical healthcare<br>• Medications and Adherence issues<br>• Mental Health<br>• Substance use and substance use treatment<br>• Nutrition/Food<br>• Housing and living situation<br>• Family and dependent care issues<br>• Access to gender-affirming care<br>• DCFS and other agency involvement<br>• Transportation<br>• Language/Literacy skills<br>• Religious/Spiritual support<br>• Social support system<br>• Relationship history<br>• Domestic violence/Intimate Partner Violence (IPV)<br>• History of physical or emotional trauma<br>• Financial resources<br>• Employment and Education<br>• Legal issues/incarceration history<br>• Risk behaviors<br>• HIV/STI prevention issues<br>• Harm reduction services and support<br>• Environmental factors<br>• Resources and referrals<br>• 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.

| INDIVIDUAL SERVICE PLAN | |
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| **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:<br>• Name of client and case manager<br>• Date and signature of case manager and client<br>• Date and description of client goals and desired outcomes<br>• Action steps to be taken by client, case manager and others<br>• Goal timeframes<br>• 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 | |
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| **STANDARD** | **DOCUMENTATION** |
| Case managers will:<br>• Provide interventions and linked referrals<br>• 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.<br>• 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<br>• Disclosure and Partner Notification: Addressing disclosure and partner notification for clients who have not | Signed, dated progress notes on file that detail, at minimum:<br>• Description of client contracts and actions taken<br>• Date and type of contact<br>• Description of what occurred<br>• Changes in the client's condition or circumstances<br>• Progress made toward goals<br>• Barriers to ISPs and actions taken to resolve them<br>• Linked referrals and interventions and status/results |

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| disclosed their HIV status to partner(s) or family member(s).<br>• Help clients resolve barriers | • Barriers to referrals and interventions/actions taken<br>• Time spent with, or on behalf of, client<br>• Case manager's signature and title<br>• 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** | |
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| **STANDARD** | **DOCUMENTATION** |
| Case managers will:<br>• Provide referrals, advocacy, and interventions based on the intake, assessment, and ISP<br>• Monitor changes in the client's condition<br>• Update/revise the ISP<br>• Provide interventions and linked referrals<br>• Ensure coordination of care<br>• Help clients submit applications and obtain health benefits and care<br>• Conduct monitoring and follow-up to confirm completion of referrals and service utilization<br>• Advocate on behalf of clients with other service providers<br>• Empower clients to use independent living strategies<br>• Help clients resolve barriers<br>• Follow-up on ISP goals<br>• Maintain/attempt contact at minimum of once every two weeks and at least one face-to-face contact monthly<br>• Follow-up missed appointments by the end of the next business day<br>• Collaborate with the client's community-based case manager for coordination and follow-up when appropriate | Signed, dated progress notes on file that detail, at minimum, the following:<br>• Description of client contacts and actions taken<br>• Date and type of contact<br>• Description of what occurred<br>• Changes in the client's condition or circumstances<br>• Progress made toward ISP goals<br>• Barriers to ISPs and actions taken to resolve them<br>• Linked referrals and interventions and status/results<br>• Barriers to referrals and interventions<br>• Time spent with, or on behalf of, client<br>• Case manager's signature and title<br>• Detailed transition plan to adult services, with specific linkage to health, medical, and social services<br>• Documentation of expedited linkage to MCC for eligible clients |

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| • Transition clients out of TCM when appropriate<br>• 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<br>• 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** | |
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| **STANDARD** | **DOCUMENTATION** |
| Case managers will have:<br>• Knowledge of HIV/STIs and related issues<br>• Knowledge of and sensitivity to run away, homeless or emancipating/emancipated youth<br>• Effective Motivational Interviewing and assessment skills<br>• Knowledge of adolescent development<br>• Knowledge of, and sensitivity to, lesbian, gay, bisexual, and transgender persons<br>• Ability to appropriately interact and collaborate with others<br>• Effective written/verbal communication skills<br>• Ability to work independently<br>• Effective problem-solving skills<br>• Ability to respond appropriately in crisis situations<br>• Effective organizational skills | Resume, training certificates, interview assessment notes, reference checks, and annual performance reviews on file. |

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| Refer to "Recommended Training Topics for TCM Youth Staff." | |
| Case managers will meet one of the following educational requirement criteria:<br>• 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<br>• An associate degree plus one-year direct case management experience in health or human services<br>• 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.<br><br>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. | Resumes on file at provider agency documenting experience. Copies of diplomas on file. |
| All staff will be given orientation prior to providing services. | Record of orientation in employee file at provider agency. |
| Case management staff will complete DHSP's required case management certifications/training within three months of being hired. Case management supervisors will complete DHSP's required supervisors certification/training within six 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:<br>• Date, time, and location of function<br>• Function type<br>• Staff members attending<br>• Sponsor or provider of function<br>• Training outline, handouts, or materials<br>• 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:<br>• Date of client care-related supervision<br>• Supervision format<br>• Name and title of participants<br>• Issues and concerns identified |

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| | • Guidance provided and follow-up plan<br>• Verification that guidance and plan have been implemented<br>• 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. |

## 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:

- 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

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# TRANSITIONAL CASE MANAGEMENT SERVICES: OLDER ADULTS 50+

*(Draft as of 05/30/25)*

**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

## Contents

## 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 50$^{th}$ 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
25. Peripherical neuropathology
26. Sexual health
27. Advance care planning
28. Occupational and physical therapy

**these assessments an 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 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** | |
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| **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, |

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| | medication adherence and continuity, eligibility for services, and an HIV care provider contact to assist with communicating care needs during periods of transitions 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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# PATIENT SUPPORT SERVICES

*(Draft as of 05/30/25)*

**IMPORTANT:** The service standards for Non-Medical Case Management: Patient Support 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

## Table of Contents

## Introduction

Service standards outline the elements and expectations a Ryan White HIV/AIDS (RWHAP) provider follows when implementing a specific service category. The purpose 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

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.

## HRSA Program Guidance

*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.

## Eligibility and Documentation Requirements for RWHAP Services in LA County

- 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.

## PSS Staffing Requirements and Qualifications

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.

| **Staffing Requirements and Qualifications** | |
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| **Retention Outreach Specialist (ROS)**<br>○ Ensures that PLWH remain engaged in their care and have access to necessary resources and support.<br>○ Integrates with other HIV clinic team members to effectively identify, locate, and re-engage clients who have lapsed in their HIV care.<br>○ 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.<br>○ Conducts field outreach operations to efficiently locate and assist clients who have disengaged from HIV care.<br>○ 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.<br>○ Provides crisis interventions, offering immediate support in challenging situations.<br>○ 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.<br>○ Collaborates with the HIV clinic team members, documents client interactions, and contributes to program evaluation.<br>○ Demonstrates cultural and linguistic competency to effectively communicate with and support a diverse range of clients. | Staff resumes on file.<br><br>Must meet the following minimum qualifications:<br>▪ Must have a High School Diploma or successful completion of GED.<br>▪ Ability and interest in doing field-based work when necessary to locate or assist clients.<br>▪ 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.<br>▪ Valid Class C California Driver's License, proof of vehicle insurance, and reliable transportation for travel to a variety of sites throughout LAC. |

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| ○ Participates in case conferences as needed.<br>○ Demonstrates compassion and commitment to making a significant impact in the lives of those affected by HIV. | |
| **PSS Social Worker (SW)**<br>○ 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.<br>○ Holds counselling and psychotherapy sessions for individuals, couples, and families.<br>○ Provides support services utilizing housing-first, harm reduction, and trauma-informed care principles.<br>○ Utilizes a sex positive framework including provision of patient education about U=U.<br>○ Collaborates with the HIV clinic team, documents interactions, and contributes to program evaluation.<br>○ Maintains knowledge of local, State, and federal services available.<br>○ 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.<br>○ 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.<br>○ Performs home visits and other field outreach on a case by-case basis.<br>○ Provides urgent services to clients not yet enrolled in PSS.<br>○ Participates in case conferences as needed.<br>○ 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.<br>▪ The assessment will provide information about each client's social, emotional, | Staff resumes on file.<br><br>Meets the following minimum qualifications:<br>▪ Master's degree in social work, Counseling, Psychology, or related field from an accredited social work program.<br>▪ 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.<br>▪ Valid Class C California Driver's License, proof of vehicle insurance, and reliable transportation for travel to a variety of sites throughout LAC. |

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| behavioral, mental, spiritual, and environmental status, family and support systems, client's coping strategies, strengths and weaknesses, and adjustment to illness.<br>▪ SW will document the following details of the assessment in each client's chart:<br>• Date of assessment;<br>• Title of staff persons completing the assessment; and<br>• Completed assessment form.<br>○ 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:<br>▪ 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.<br>▪ 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.<br>▪ Disposition: A brief statement indicating the disposition of the client's concerns as they are met, changed, or determined to be unattainable.<br>▪ IPs will be signed and dated by the client and respective SW assisting the client.<br>▪ IPs must be revised and updated, at a minimum, every six months. | |
| **Benefits Specialist**<br>○ Conducts client-centered activities and assessments that facilitate access to public benefits and programs. Focuses on assisting | Staff resumes on file.<br><br>Meets the following minimum qualifications:<br>▪ High school diploma (or GED equivalent). |

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| each client's entry into and movement through care service systems.<br>○ Stays up to date on new and modified benefits, entitlements, and incentive programs available for PLWH.<br>○ Ensures clients are receiving all benefits and entitlements for which they are eligible.<br>○ Educates clients about available benefits and provides assistance with the benefits application process.<br>○ Helps prepare for and facilitates relevant benefit appeals.<br>○ Collaborates with the HIV clinic team, documents interactions, and contributes to program evaluation.<br>○ Develops and maintains expert knowledge of local, State, and federal services and resources including specialized programs available to PLWH.<br>○ Participates in case conferences as needed. | ▪ Has at least one year of paid or volunteer experience making eligibility determinations and assisting clients in accessing public benefits or public assistance programs.<br>▪ 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.<br>▪ Valid Class C California Driver's License, proof of vehicle insurance, and reliable transportation for travel to a variety of sites throughout LAC. |
| **Housing Specialist**<br>○ Develops and maintains expert knowledge of, and contacts at, local housing programs and resources including specialized programs available to PLWH.<br>○ Conducts housing assessments and creates individualized housing plans.<br>○ 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.<br>○ Conducts home or field visits as needed.<br>○ Develops a housing procurement, financial, and self-sufficiency case management plan with clients as part of client housing plans.<br>○ Offers crisis intervention and facilitates urgent referrals to housing services.<br>○ Collaborates with the HIV clinic team, documents interactions, and contributes to program evaluation.<br>○ Attends meetings and trainings to improve skills and knowledge of best practices in permanent supportive housing and related issues. | Staff resumes on file.<br><br>Meets the following minimum qualifications:<br>▪ Bachelor's degree or a minimum of two years' experience in social services, case management, or other related work.<br>▪ 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.<br>▪ Valid Class C California Driver's License, proof of vehicle insurance, and reliable transportation for travel to a variety of sites throughout LAC. |

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| ○ Participates in case conferences as needed. | |
| **Substance Use Disorder (SUD) Specialist**<br>○ Conducts SUD assessments and devises personalized SUD plan with clients as part of the client's individualized care plan.<br>○ 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.<br>○ 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.<br>○ Collaborates with other HIV clinic team members to align substance use treatment goals with overall care, documents interactions, and contributes to program evaluation.<br>○ 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.<br>○ Oversees or leads day-to-day operations of contingency management programs or other evidence-based interventions.<br>○ Provides education on harm reduction strategies and additional key resources to clients.<br>○ Participates in case conferences as needed. | Staff resumes on file.<br><br>Meets the following minimum qualifications:<br>▪ Certified as a Substance Use Counselor.<br>▪ Has at least one year of experience in an SUD program with experience providing counseling to individuals, families, and groups.<br>▪ 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.<br>▪ Valid Class C California Driver's License, proof of vehicle insurance, and reliable transportation for travel to a variety of sites throughout LAC. |
| **Clinical Nursing Support Specialist**<br>○ Provides enhanced clinical nursing support, performed by a registered nurse to facilitate: | Staff resumes on file. |

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| ▪ Administration and supervision of client injectable medications and vaccinations;<br>▪ 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<br>▪ 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.<br>○ Participates in case conferences as needed.<br>○ Collaborates with the HIV clinic team, conducts health assessments as needed, documents interactions, and contributes to program evaluation. | |
| **Peer Navigator**<br>○ 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:<br>▪ Living with HIV;<br>▪ Healthy lifestyles (including substance use) and relationships;<br>▪ Adherence to treatment;<br>▪ Access and barriers to care; | Staff resumes on file.<br><br>Meets the following minimum qualifications:<br>▪ Is reflective of the population and community being served.<br>▪ Has lived experience.<br>▪ Must NOT be a current client of Contractor's clinic.<br>▪ 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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| ▪ Prevention (PrEP, PEP, DoxyPEP, treatment as prevention);<br>▪ Disclosing status; and<br>▪ Stigma.<br>○ 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.<br>○ 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.<br>○ Collaborates with other HIV clinic team members to align treatment goals with overall care, documents interactions, and contributes to program evaluation.<br>○ Oversees incentives, contingency management programs, and/or other evidence-based interventions.<br>○ Provides education on HIV clinic services available and additional key resources to clients.<br>○ Participates in case conferences as needed. | ▪ Valid Class C California Driver's License, proof of vehicle insurance, and reliable transportation for travel to a variety of sites throughout LAC. |

# We're Listening

*share your concerns with us.*

## HIV + STD Services Customer Support Line

## (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

# Estamos Escuchando

*Comparta sus inquietudes con nosotros.*

**Servicios de VIH + ETS**
**Línea de Atención al Cliente**

**(800) 260-8787**

## ¿Por qué debería llamar?

La Línea de Atención al Cliente puede ayudarlo a acceder a los servicios de VIH o ETS y abordar las inquietudes sobre la calidad de los servicios que ha recibido.

## ¿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.

**Por correo electronico:**
dhspsupport@ph.lacounty.gov

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

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