LOS ANGELES COUNTY
COMMISSION ON HIV

Visit us online: http://hiv.lacounty.gov
Get in touch: hivcomm@lachiv.org
Get connected to services: https://hivconnect.org/

# STANDARDS AND BEST PRACTICES COMMITTEE Virtual Meeting

**Tuesday, August 3, 2021**

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

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

http://hiv.lacounty.gov/Standards-and-Best-Practices-Committee

**REGISTER VIA WEBEX ON YOUR COMPUTER OR SMART PHONE:**

https://tinyurl.com/3df784mb

**JOIN VIA WEBEX ON YOUR PHONE:**

1-415-655-0001

Event #/Meeting Info/Access Code: 145 802 6990

*Link is for members of the public only. Commission members, please contact staff for specific log-in information if not already received.

## PUBLIC COMMENTS

**Public Comments will open at the time referenced on the meeting agenda. For those who wish to provide live public comment, you may do so by joining the WebEx meeting through your computer or smartphone and typing PUBLIC COMMENT in the Chat box**. You may also provide written public comments or materials by email to hivcomm@lachiv.org. Please include the agenda item and meeting date in your correspondence. All correspondence and materials received shall become part of the official record.

For a tutorial on joining WebEx events, please check out:
https://www.youtube.com/watch?v=iQSSJYcrgIk

**Join the Commission on HIV Email Listserv, Click Here**

**Follow the Commission on HIV at**

**Interested in becoming a Commissioner? Click here for a Member Application.**

LOS ANGELES COUNTY
COMMISSION ON HIV

AGENDA FOR THE **VIRTUAL** MEETING OF THE

# STANDARDS AND BEST PRACTICES COMMITTEE

TUESDAY, August 3, 2021, 10:00 AM – 12:00 PM

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

https://tinyurl.com/3df784mb

***or Dial***

1-415-655-0001

Event Number/Access code: 145-802-6990

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

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

*LOA: Leave of Absence

AGENDA POSTED: July 29, 2021

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

ACCOMMODATIONS: Interpretation services for the hearing impaired and translation services for languages other than English are available free of charge with at least 72 hours notice before the meeting date. To arrange for these services, please contact the Commission Office at (213) 738-2816 or via email at HIVComm@lachiv.org.

Servicios de interpretación para personas con impedimento auditivo y traducción para personas que no hablan Inglés están disponibles sin costo. Para pedir estos servicios, póngase en contacto con Oficina de la Comisión al (213) 738-2816 (teléfono), o por correo electrónico á HIVComm@lachiv.org, por lo menos setenta y dos horas antes de la junta.

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

just south of Wilshire, on the west side of Normandie.

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

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

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

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

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

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

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

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

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

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

**IV. REPORTS**

**5.** Executive Director/Staff Report 10:15 AM – 10:25 AM
- Commission and Committee Updates

**6.** Co-Chair Report 10:25 AM – 10:55 AM
- Ending the HIV Epidemic

- 2021 Workplan Review & Opportunities to Support Task Forces and Caucuses
- Committee Member Introductions/Getting to Know you

- "So, You Want to Talk About Race" by I. Oluo Reading Activity
  - Excerpts Only- from Chapters 6 or 7

**7.** Division of HIV & STD Programs (DHSP) Report 10:55 AM – 11:05 AM

## V. DISCUSSION ITEMS

**8.** Service Standards Development Training Debrief 11:05 AM – 11:25 AM
- Address questions and request feedback

**9.** Substance Use and Residential Treatment Standards Review 11:25 AM – 11:45 AM
- Review feedback and present changes
- Propose a 30-day Public Comment period

## VI. NEXT STEPS 11:45 AM – 11:55 AM

**10.** Tasks/Assignments Recap

**11.** Agenda development for the next meeting

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

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

## VIII. ADJOURNMENT 12:00 PM

**13.** Adjournment for the virtual meeting of August 3, 2021

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

LOS ANGELES COUNTY
COMMISSION ON HIV

# COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 7/29/21

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

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

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

| COMMISSION MEMBERS | | ORGANIZATION | SERVICE CATEGORIES |
|---|---|---|---|
| **GONZALEZ** | **Felipe** | Unaffiliated consumer | No Ryan White or Prevention Contracts |
| **GORDON** | **Bridget** | Unaffiliated consumer | No Ryan White or prevention contracts |
| **GRANADOS** | **Grissel** | Children's Hospital Los Angeles | Ambulatory Outpatient Medical (AOM) |
| | | | HIV Testing Storefront |
| | | | STD Screening, Diagnosis and Treatment |
| | | | Biomedical HIV Prevention |
| | | | Medical Care Coordination (MCC) |
| | | | Transitional Case Management-Youth |
| | | | Promoting Healthcare Engagement Among Vulnerable Populations |
| **GREEN** | **Joseph** | Unaffiliated consumer | No Ryan White or prevention contracts |
| **GREEN** | **Thomas** | APAIT (aka Special Services for Groups) | HIV Testing Storefront |
| | | | Mental Health |
| | | | Transportation Services |
| **HACK** | **Damontae** | Unaffiliated consumer | No Ryan White or prevention contracts |
| **HALFMAN** | **Karl** | California Department of Public Health, Office of AIDS | Part B Grantee |
| **KAMURIGI** | **Nestor** | No Affiliation | No Ryan White or prevention contracts |
| **KOCHEMS** | **Lee** | Unaffiliated consumer | No Ryan White or prevention contracts |
| **KING** | **William** | W. King Health Care Group | No Ryan White or prevention contracts |
| **LEE** | **David** | Charles R. Drew University of Medicine and Science | HIV Testing Storefront |
| | | | HIV Testing Social & Sexual Networks |
| **MARTINEZ** | **Eduardo** | AIDS Healthcare Foundation | Ambulatory Outpatient Medical (AOM) |
| | | | Benefits Specialty |
| | | | Medical Care Coordination (MCC) |
| | | | Mental Health |
| | | | Oral Healthcare Services |
| | | | STD Screening, Diagnosis and Treatment |
| | | | HIV Testing Storefront |
| | | | HIV Testing Social & Sexual Networks |
| | | | Sexual Health Express Clinics (SHEx-C) |
| | | | Transportation Services |
| | | | Medical Subspecialty |
| | | | HIV and STD Prevention Services in Long Beach |

| COMMISSION MEMBERS | | ORGANIZATION | SERVICE CATEGORIES |
|---|---|---|---|
| **MARTINEZ (PP&A Member)** | **Miguel** | Children's Hospital Los Angeles | Ambulatory Outpatient Medical (AOM) |
| | | | HIV Testing Storefront |
| | | | STD Screening, Diagnosis and Treatment |
| | | | Biomedical HIV Prevention |
| | | | Medical Care Coordination (MCC) |
| | | | Transitional Case Management - Youth |
| | | | Promoting Healthcare Engagement Among Vulnerable Populations |
| **MILLS** | **Anthony** | Southern CA Men's Medical Group | Biomedical HIV Prevention |
| | | | Ambulatory Outpatient Medical (AOM) |
| | | | Medical Care Coordination (MCC) |
| | | | Promoting Healthcare Engagement Among Vulnerable Populations |
| | | | Sexual Health Express Clinics (SHEx-C) |
| | | | Transportation Services |
| **MINTLINE (SBP Member)** | **Mark** | Western University of Health Sciences | No Ryan White or prevention contracts |
| **MORENO** | **Carlos** | Children's Hospital, Los Angeles | Ambulatory Outpatient Medical (AOM) |
| | | | HIV Testing Storefront |
| | | | STD Screening, Diagnosis and Treatment |
| | | | Biomedical HIV Prevention |
| | | | Medical Care Coordination (MCC) |
| | | | Transitional Case Management - Youth |
| | | | Promoting Healthcare Engagement Among Vulnerable Populations |
| **MURRAY** | **Derek** | City of West Hollywood | No Ryan White or prevention contracts |
| **NASH** | **Paul** | University of Southern California | Biomedical HIV Prevention |
| | | | Oral Healthcare Services |

| COMMISSION MEMBERS | | ORGANIZATION | SERVICE CATEGORIES |
|---|---|---|---|
| **NELSON** | **Katja** | APLA Health & Wellness | Case Management, Home-Based |
| | | | Benefits Specialty |
| | | | HIV Testing Storefront |
| | | | HIV Testing Social & Sexual Networks |
| | | | STD Screening, Diagnosis and Treatment |
| | | | Sexual Health Express Clinics (SHEx-C) |
| | | | Health Education/Risk Reduction |
| | | | Health Education/Risk Reduction, Native American |
| | | | Biomedical HIV Prevention |
| | | | Oral Healthcare Services |
| | | | Ambulatory Outpatient Medical (AOM) |
| | | | Medical Care Coordination (MCC) |
| | | | HIV and STD Prevention Services in Long Beach |
| | | | Transportation Services |
| | | | Nutrition Support |
| **PERÉZ** | **Mario** | Los Angeles County, Department of Public Health, Division of HIV and STD Programs | Ryan White/CDC Grantee |
| **PRECIADO** | **Juan** | Northeast Valley Health Corporation | Ambulatory Outpatient Medical (AOM) |
| | | | Benefits Specialty |
| | | | Medical Care Coordination (MCC) |
| | | | Oral Healthcare Services |
| | | | Mental Health |
| | | | Biomedical HIV Prevention |
| | | | STD Screening, Diagnosis and Treatment |
| | | | Transportation Services |
| **RAY** | **Joshua** | Unaffiliated consumer | No Ryan White or prevention contracts |
| **ROBINSON** | **Mallery** | No Affiliation | No Ryan White or prevention contracts |
| **RODRIGUEZ** | **Isabella** | No Affiliation | No Ryan White or prevention contracts |
| **ROSALES** | **Ricky** | City of Los Angeles AIDS Coordinator | No Ryan White or prevention contracts |
| **SATTAH** | **Martin** | Rand Schrader Clinic<br>LA County Department of Health Services | Ambulatory Outpatient Medical (AOM) |
| | | | Medical Care Coordination (MCC) |
| | | | HIV Testing Storefront |
| | | | HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV) |

| COMMISSION MEMBERS | | ORGANIZATION | SERVICE CATEGORIES |
|---|---|---|---|
| **SAN AGUSTIN** | **Harold** | JWCH, INC. | STD Screening, Diagnosis and Treatment |
| | | | Health Education/Risk Reduction |
| | | | Mental Health |
| | | | Oral Healthcare Services |
| | | | Transitional Case Management |
| | | | Ambulatory Outpatient Medical (AOM) |
| | | | Benefits Specialty |
| | | | Biomedical HIV Prevention |
| | | | Medical Care Coordination (MCC) |
| | | | Transportation Services |

| COMMISSION MEMBERS | | ORGANIZATION | SERVICE CATEGORIES |
|---|---|---|---|
| **SPENCER** | **LaShonda** | Oasis Clinic (Charles R. Drew University/Drew CARES) | Ambulatory Outpatient Medical (AOM) |
| | | | HIV Testing Storefront |
| | | | HIV Testing Social & Sexual Networks |
| | | | Medical Care Coordination (MCC) |
| **SPEARS** | **Tony** | Capitol Drugs | No Ryan White or prevention contracts |
| **STALTER** | **Kevin** | Unaffiliated consumer | No Ryan White or prevention contracts |
| **STEVENS** | **Reba** | No Affiliation | No Ryan White or prevention contracts |
| **THOMAS** | **Damone** | No Affiliation | No Ryan White or prevention contracts |
| **ULLOA** | **Maribel** | HOPWA-City of Los Angeles | No Ryan White or prevention contracts |
| **VALERO** | **Justin** | California State University, San Bernardino | No Ryan White or prevention contracts |
| **VEGA** | **Rene** | Via Care Community Clinic | Biomedical HIV Prevention |
| **VELAZQUEZ** | **Guadalupe** | Unaffiliated consumer | No Ryan White or prevention contracts |
| **WALKER** | **Kayla** | No Affiliation | No Ryan White or prevention contracts |
| **WALKER** | **Ernest** | Men's Health Foundation | Biomedical HIV Prevention |
| | | | Ambulatory Outpatient Medical (AOM) |
| | | | Medical Care Coordination (MCC) |
| | | | Promoting Healthcare Engagement Among Vulnerable Populations |
| | | | Sexual Health Express Clinics (SHEx-C) |
| | | | Transportation Services |
| **WILSON** | **Amiya** | Unique Women's Coalition | No Ryan White or prevention contracts |

DRAFT

LOS ANGELES COUNTY
COMMISSION ON HIV

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

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

# STANDARDS AND BEST PRACTICES (SBP) COMMITTEE MEETING MINUTES

July 7, 2021

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

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

**Meeting agenda and materials can be found on the Commission's website at http://hiv.lacounty.gov/LinkClick.aspx?fileticket=UKHXrCRQ81I%3d&portalid=22**

**CALL TO ORDER-INTRODUCTIONS-CONFLICT OF INTEREST STATEMENTS**: The meeting to order at 10:05 am.

## I. ADMINISTRATIVE MATTERS

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

2. **APPROVAL OF MEETING MINUTES**
   **MOTION #2**: Approve the 06/04/2021 Standards and Best Practices (SBP) Committee Meeting Minutes, as presented ***(Passed by Consensus)***.

## II. PUBLIC COMMENT

3. **OPPORTUNITY FOR PUBLIC TO ADDRESS COMMISSION ON ITEMS OF INTEREST WITHIN COMMISSION JURISDICTION**: Kevin Donnelly posed a question about HIV prevention and treatment technologies such as injectables and once a month pill regimen and hoped Emily addressed the question during the training. Do we need to develop standards that outline how those technologies are being used and update how they are used in the future?

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

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

**IV. REPORTS**

**5. EXECUTIVE DIRECTOR/STAFF REPORT**

Cheryl Barrit, Executive Director (ED) reported the following.

- C. Barrit welcomed new commissioners Dr. Mikhaela Cielo who will be occupying the Part D services representative seat, Mallery Robinson, and Rene Vega. C. Barrit also welcomed and thanked Emily Gantz McKay for helping the committee navigate the service standards development process. C. Barrit shared Emily's contact information in the chat.
- C. Barrit noted that the Commission will continue to meet virtually through the end of September per Governor Newsom's extension of the executive orders allowing planning bodies to meet virtually. The Commission will resume adhering to the Brown Act rules beginning October 1st. C. Barrit reminded the Committee that the Operations Committee will review the Commission Teleconferencing policy and is working with the County lawyers to make sure the policy is updated and conforms with the expectations of the Brown Act to ensure that members of the public can still join virtually. The Commission staff will keep note of the logistics of transitioning back to in person meetings and following DPH guidelines.
- C. Barrit reported that COH staff are in the process of moving to a smaller office space on August 6th and thanked the COH staff for their efforts during this move. C. Barrit shared that the new building is located on 510 S. Vermont, it is close to the Vermont and Wilshire Metro stop, has many meeting spaces and public access areas for meetings and gatherings, and has free parking. In-person meetings will be held at the new location and more detailed information on how to access the building and how to participate in in-person meetings will be shared in October. The move will be a major cost savings for the COH. C. Barrit also announced that the COH will host an open house reception in October.

**6. CO-CHAIR REPORT**

**a.** Erika Davies echoed the welcome to the new Committee members and shared she is looking forward to engaging with everyone and learning from their experiences.

**b. Ending the HIV Epidemic**

- Kevin Stalter was not present at the meeting. The EHE update was deferred to the August meeting.

**V. DISCUSSION ITEMS**

**7. Services Standards Development Training**

**HRSA Planning CHATT (Community HIV/AIDS Technical Assistance and Training):** Below are highlights from the Service Standards training. A copy of the presentation slides is included in the meeting packet. A recording of the training recording is available upon request.

**a. Purpose of Service Standards**

To ensure all subrecipient provide the same basic service components and to establish a minimal level of service of care for consumers throughout the jurisdiction. Service standards must be available to subrecipients and consumers.

**b. Developing Service Standards**

There is no specified process, no required format, and broad guidance on required content. Developing flexible service standards allow staff to adjust service delivery to meet the needs of individual clients. Service standards must be developed at the state or local level and are required for every funded service category.

**c. Discussion**

Current COH process is to develop service standards for all services in the continuum of care, reviewed annually, and updated every 3 years or as needed.

The Service Standard review process should be done in some logical way to have the most up-to-date Service Standards for providers to implement activities. The review committee should prioritize Service categories that will be recompeted for soon and focus on having Service Standards for Service categories on current and future Request for Proposals (RFPs). Best practice is to include the Service Standards in the RFP.

An area of improvement for the Service Standard review process is for DHSP to have more transparency about how the Service Standards are being utilized beyond program auditing annual reviews. DHSP can provide summary information to the COH and the Standards and Best Practices Committee about their auditing fidnings on the extent to which Service Standards are being met and identifying possible revisions.

Another area of improvement is to review the Service Standard dissemination strategy to ensure it is accessible, understandable, and legible for providers as well as for consumers. One way to improve dissemination is to share the Service Standards more widely beyond the COH website and have them available in Spanish and other Los Angeles County threshold languages. Increasing dissemination can help let consumers know there is a minimum expectation of providers and empower consumers to advocate for themselves and increase health literacy.

**VI. NEXT STEPS**

a. **TASK/ASSIGNMENTS RECAP**:

- E. Davies requested to carve out some time in the August meeting agenda to debrief the training.
- Resume Getting to Know You activity.
- Resume reading activity with an excerpt from either Chapter 6 or 7 of the *So, You Want to Talk About Race* book.
- Review feedback and present changes to Substance Use and Residential Treatment Standards review and propose a 30-day public comment period

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

- Debrief on the Service Standards training at the August meeting

**VII. ANNOUNCEMENTS**

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

**VIII. ADJOURNMENT**

**14. ADJOURNMENT**: The meeting adjourned at 12:00 pm.

# STANDARDS AND BEST PRACTICES COMMITTEE 2021 WORK PLAN
## Updated 4/14/21 (Revisions in RED)

| | | |
|---|---|---|
| **Co-Chairs: Erika Davies & Kevin Stalter** | | |
| **Approval Date: 3/1/21** | **Revision Dates: 3/10/21, 4/14/21** | |
| **Purpose of Work Plan**: To focus and prioritize key activities for COH Committees and subgroups for 2021.<br>**Prioritization Criteria:** Select activities that 1) represent the core functions of the COH; 2) advance the goals of the local Ending the HIV Epidemic (EHE) Plan; and 3) align with COH staff and member capacities and time commitment; 4) ongoing COVID public health emergency response and recovery priorities. | | |
| **#** | **TASK/ACTIVITY** | **TARGET COMPLETION DATE** |
| 1 | Review BAAC and ATF charge and implement recommendations best aligned with the purpose and capacity of the Commission<br>• Work with the BAAC TF to explore feasibility of designating a member to attend SBP meetings.<br>• Seek input from the Aging Task Force (ATF) on service standards. Benefits Specialty and Home-Based Case Management services were cited as examples. | Start Jan/Ongoing |
| ~~2~~ | ~~Complete Universal service standards.~~ COMPLETED | ~~March Executive Committee April- COH~~ |
| 3 | Complete Childcare service standards. ~~Waiting for DHSP on provider survey results/summary.~~ Survey results presented on 4/6/21 | May |
| 4 | Provide feedback on and monitor implementation of the local Ending the HIV Epidemic (EHE) plan:<br>• Develop strategies on how to engage with private health plans and providers in collaboration with DHSP | ~~On hold~~ Ongoing |
| 5 | Update Substance use outpatient and residential treatment service standards | July |
| 6 | Update Benefits Specialty service standards | August |
| 7 | Update Home-based Case Management service standards | September |

LOS ANGELES COUNTY COMMISSION ON HIV

**SERVICE STANDARDS REVISION DATE TRACKER as of 3/16/2021**

| | Standard Title | DHSP Program(s) | Date of Last Standard Revision | Program Currently Funded | Contract Expiration Date | Notes |
|---|---|---|---|---|---|---|
| **1** | AIDS Drug Assistance Program (ADAP) Enrollment | | 2009 | | | ADAP contracts directly with agencies |
| Non-Medical Case Management | | | | | | |
| **2** | Benefits Specialty | Benefits Specialty Services | 2009 | X | February 28, 2022 | |
| **3** | Case Management, Transitional – Youth | Transitional Case Management-Youth | 4/13/2017 | | March 31, 2020 | Last funded two providers for this service through March 31, 2020 |
| **4** | Case Management, Transitional – Incarcerated/Post Release | Transitional Case Management-Jails | 4/13/2017 | X | February 28, 2022 | |
| **5** | Non-Medical Case Management | Linkage Case Management | 12/12/2019 | | March 31, 2017 | No longer funded. |
| **6** | Childcare | | 2009; currently being updated; latest draft revision date 12/14/2020 | | | Last funded in 2009. |
| **7** | Emergency Financial Assistance Program (EFA) | EFA | 6/11/2020 | X | February 28, 2022 | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **8** | Home-Based Case Management | Home-Based Case Management | 2009 | X | June 30, 2021 | Contracts to be renewed for an additional 12 months in June 2021. |
| **9** | Hospice | | 2009 | | | |
| **10** | Housing, Temporary:<br>• Hotel/motel and meal vouchers,<br>• Emergency shelter programs,<br>• Transitional housing,<br>• Income-based Rental Assistance,<br>• Residential Care Facility for the Chronically Ill, and<br>• Transitional Residential Care Facility | • Transitional Residential Care facilities (TRCF)<br>• Residential Care facilities for the Chronically Ill (RCFCI)<br>• Substance Use Transitional Housing (SUTH) | 2/8/2018 | X | February 28, 2022 | |
| **11** | Housing, Permanent Supportive | Permanent Supportive Housing | 2/8/2018 | | N/A | No contracts in permanent housing only temporary and worked with other entities for permanent housing (eg. DHS Housing for Health MOU). |
| **12** | Language Interpretation | | 2009 | | February 28, 2021 | Contract expired 2-28-21, no response from provider need to solicit for new services again. |
| **13** | Legal | Legal Services | 7/12/2018 | X | August 24, 2024 | New provider started December 2020 |
| **14** | Medical Care Coordination | Medical Care Coordination | 2/14/2019 | X | February 28, 2022 | New contracts started 3-1-19 |
| **15** | Mental Health, Psychiatry, and Psychotherapy | Mental Health | 2009 | X | February 28, 2022 | New FFS model started 8-1-17 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **16** | Nutrition Support | • Food Bank<br>• Home Delivery | 2009 | X | February 28, 2022 | |
| **17** | Oral Health<br>• Practice Guidelines for Treatment of HIV Patients in General Dentistry | • General Oral Health<br>• Specialty Oral Health | 2009<br>2015 | X | February 28, 2022 | |
| **18** | Outreach | | 2009 | | N/A | Never funded as a stand-alone contract. but has been part of Health Education/Risk Reduction. Linkage and Re-engagement Program (LRP) and partner services were supported as HRSA Part A Outreach Services. No contract for LRP and partner services because these activities are conducted by DHSP staff. |
| **19** | Peer Support | | 2009; integrated in Psychosocial Support 9/10/2020 | | October 15, 2009 | No longer funded. Terminated due to state cuts back in 2009. |
| **20** | Permanency Planning | | 2009 | | February 28, 2010 | No longer funded. It can be addressed by either BSS or Legal. Merged under legal contract in 2010. |
| **21** | Prevention Services:<br>• Assessment;<br>• HIV/STD Testing and Retesting;<br>• Linkage to HIV Medical Care and Biomedical Prevention; | | 6/14/2018 | | HERR; 06/30/2021<br><br>VP: 12/31/2022<br><br>HIV Testing: 12/31 2022 | "Take Me Home" online self HIV testing kits distributed through MOU with NASTAD.<br><br>Self HIV tests kits also pending distribution through HIV/STD Testing contracts and with non-traditional community partners through MOUs. |

| | | | | | | |
|---|---|---|---|---|---|---|
| | • Referral and Linkages to Non-biomedical Prevention;<br>• Retention and Adherence to Medical Care, ART; and<br>• Other Prevention Services | | | | STD screening and Treatment: 12/31/2022<br><br>BIomedical: 6/30/2021 | Currently evaluating extension of Biomedical contracts |
| **22** | Psychosocial Support | | 9/10/2020 | | August 31, 2017 | No longer funded |
| **23** | Referral Services | | 2009 | | N/A | Not funded as a standalone service, included under various modalities |
| **24** | Residential Care and Housing | | 2009; integrated in Temporary and Permanent Supportive Housing 2/8/2018 | | (See #9 and 10) | |
| **25** | Skilled Nursing Facilities | | 2009 | | February 28, 2010 | No longer funded replaced with RCFCI and TRCF- see under #24 |
| **26** | Substance Use and Residential Treatment | | 4/13/2017 | | February 28, 2019 | No longer funded. Funded by SAPC |
| **27** | Transportation | | 2009 | X | February 28, 2023 | New contracts began 6-1-20 and 9-1-20 |
| **28** | Treatment Education | | 2009 | | October 15, 2009 | No longer funded. Terminated due to state cuts. Activities incorporated into other programs (e.g. U=U social marketing) |
| **29** | Universal Standards | | 9/12/2019; currently being updated; latest draft | | N/A | Not a program – standards that apply to all services |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | revision date 12/16/2020 released for public comments | | | |

# Service Standards

## Standards and Best Practices Committee
## Los Angeles County Commission on HIV
## July 6, 2021, 10 am – 12 noon

**Emily Gantz McKay**
**Through the JSI Planning CHATT Project**

# HRSA HAB Guidance on Service Standards

- **Purpose:**
  - Ensure that all subrecipients provide the **same basic service components**
  - Establish **a minimal level of service or care** for consumers throughout the jurisdiction
- **For the recipient:** *"Set a benchmark by which services are monitored, and sub-grantee contracts are developed"**
- **For CQM:** *"Set the foundation for the clinical quality management program, and provide the framework and service provision from which processes and outcomes are measured"**

* *Source:* "Service Standards: Guidance for Ryan White HIV/AIDS Program Grantees/Planning Bodies," 2014

# Guidance, cont.

- 2014 Guidance* says:
  - Recipient is "*responsible for the development, distribution, & use of service standards"*
  - For Part A programs, *"developing service standards is a shared responsibility, typically led by the Planning Council*
- **Medical care standards** must be consistent with HHS/Public Health Service (PHS) *"care and treatment guidelines and other clinical and professional standards"*
- **Non-clinical/support services** may use *"evidence-based best practices, National Monitoring Standards, and/or guidelines developed by state or local government"*

# Guidance, cont.

- Not directly addressed in the legislation or in the *Part A Manual*
- Because *"national service standards are not feasible due to differences in state and local requirements,"* they must be developed at the state and/or local level
- Required for every funded service category
- Service standards should:
  - Reflect *"the programmatic and fiscal management requirements outlined in the Part A and B National Monitoring Standards"*
  - Include *"input from providers, consumers and experts"*
  - Be *"publicly accessible"*

# Recent Guidance from HRSA HAB

- Jurisdictions should not include HRSA HAB performance measures or health outcomes in their service standards
  - Recipients include service standards in their RFPs
  - Potential subrecipients indicate in the application their ability to meet the standards
  - Selected subrecipients have performance measures in their contracts
  - Recipient monitoring addresses whether these measures, which are based on the service standards, are being met
- Outcomes are essential to measure the impact of services delivered
- If completely compliant subrecipients are not meeting client outcome measures such as adherence or viral suppression, this suggests that service standards may need review and refinement

# Value of Flexible Service Standards

- Permit staff to adjust service delivery to meet the needs of individual clients
- Allow adaptations needed for culturally and linguistically appropriate services – since “one size does not fit all” clients
- Encourage continuing service refinements by providers
- Support innovative approaches and pilot projects to improve services and outcomes – without delays for revising standards
- Avoid excluding qualified service providers
- Reduce the need for frequent revisions to Service Standards

# Developing Service Standards

- No specified process
- No required format – but structure can improve clarity
- Broad guidance on required content
- Differing views/approaches on:
  - Level of detail – and how “prescriptive” standards should be
- HRSA concern with avoiding confusion between:
  - Quality Assurance – done through recipient monitoring, based partly on service standards, and
  - Clinical Quality Management (CQM) – activities aimed at improving patient care, health outcomes, and patient satisfaction

# HRSA Guidance on Developing or Updating Service Standards

- Agree annually on service categories to review/update based on:
  - Including all service categories that are currently funded or have been allocated funds for the next program year
  - Prioritizing reviews based on a service category's allocation level or local priority or the recipient's RFP schedule
- Agree on an outline to be used for all service category-specific service standards
- Review each set of standards at least every 3 years
- Obtain technical input from providers, consumers, and other experts, including RWHAP-funded and other providers
- Be prepared to review/revise service standards to respond to environmental or continuum of care changes [like those due to COVID-19]

# Commission Approach to Developing, Reviewing, and Refining Service Standards (2010 Procedures)

1. **Develop:** For all services in the continuum of care
   - ***Questions:*** Is priority given to funded service categories? What other factors are considered?
2. **Review:** Every 4 years
   - ***Question:*** Is this still your schedule (6 funded categories have Service Standards last updated in 2009)?
   - ***Question:*** Should reviews include categories that are not funded and are unlikely to be funded?
3. **Update:** Before regularly scheduled review, due to:
   - Changes in the continuum of care
   - Changes to the service category nationally, statewide, or locally
   - Problems with service implementation requiring action
   - Incorporation of best practices

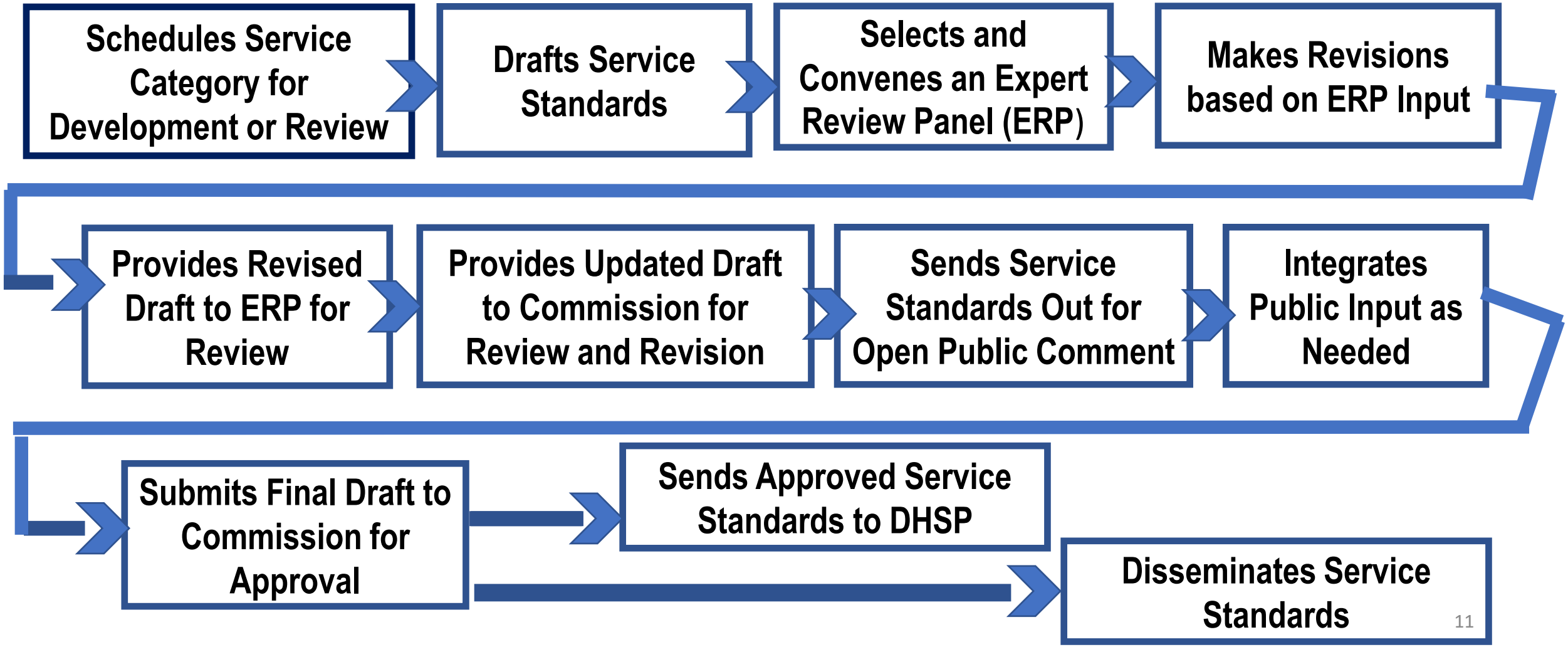
# Discussion

The committee is updating its schedule for Service Standards review and updating, since you will have time to deal with 3 additional service categories this program year. Here are your options:

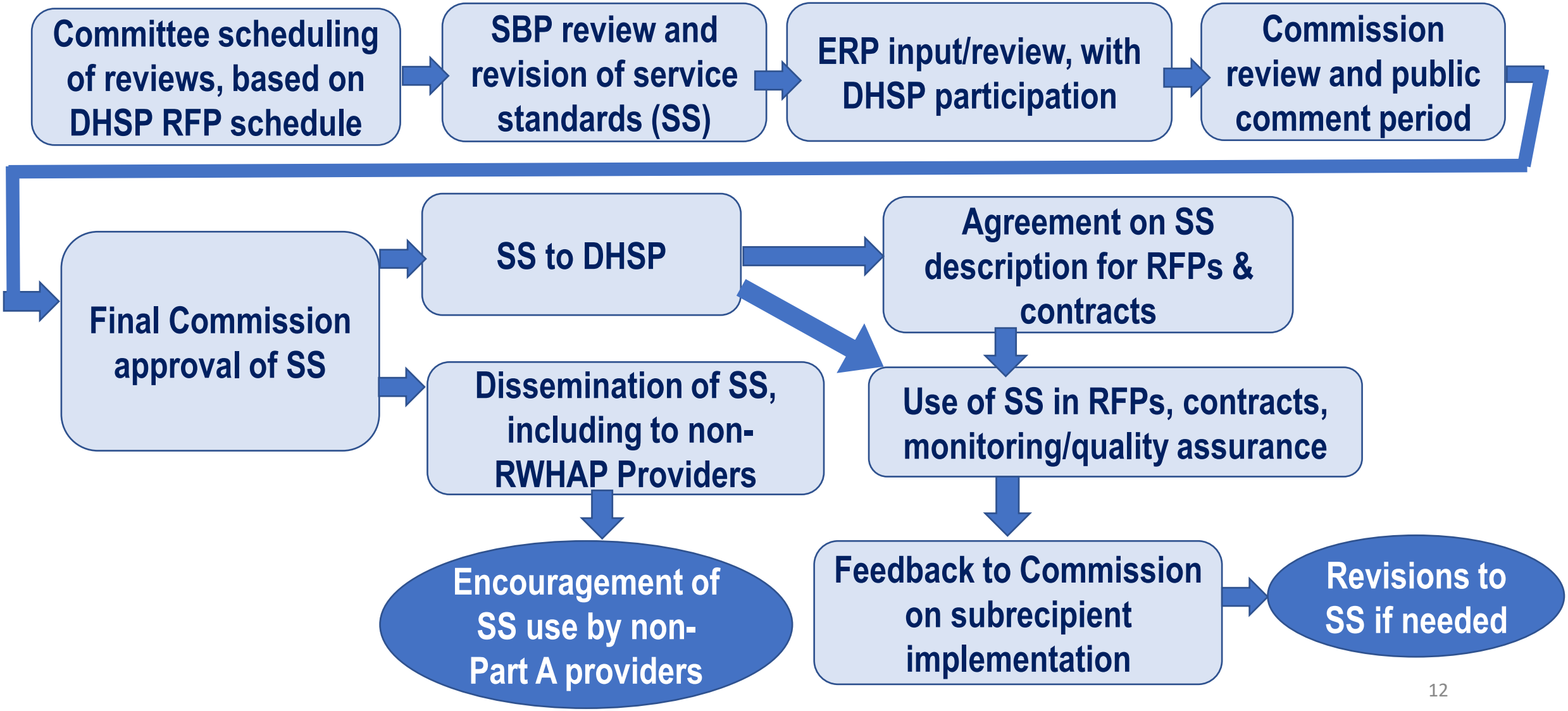
- The PC recently approved a directive and substantially increased the allocation for one service category that had its Service Standards updated 5 years ago, because the EMA will be supporting a new service model to improve retention and viral suppression for young Latino MSM; the new model is not really permissible under the current Service Standards.
- DHSP plans to recompete two service categories this year that both DHSP and the Commission feel need Service Standards reviews based on needs assessment and quality assurance data.
- You have 4 funded service categories that have not been updated for 10 years or more, though 2 of them have very small allocations.

*What should be added to your "to do" list? How should you decide?*

# Established SBP Committee Process for Development or Review/Updating of Service Standards



# Suggested Annual Service Standards Cycle



# Roles for the Recipient

- Ultimate responsibility for ensuring service standards are developed, updated as needed, and used
- Use of service standards in:
  - Subrecipient RFPs
  - Subrecipient contracts
  - Monitoring/quality assurance
- Providing summary information to the Planning Council on the extent to which service standards are being met (based on monitoring)
- Identifying possible need for revisions to service standards, because:
  - Subrecipients are following them but medical outcomes are not good
  - Subrecipients are finding it very difficult to meet some standards
  - Service standards are discouraging flexibility needed for service innovations or appropriate care for diverse populations

# Provider Familiarity with Service Standards

- Many clinicians/service staff have multiple roles:
  - Work full-time for a Part A provider, but services to some clients are paid for by MediCal or other third parties
  - Work part-time for a Part A provider, so used to meeting Part A service standards
  - Worked for a Part A provider in the past, so familiar with service standards
- Unknowns regarding non-Part A clients or roles:
  - Extent to which they apply these standards
  - Extent to which they teach colleagues to use these standards

# Encouraging Non-Part A Providers to Adopt/Follow Service Standards

**Incentives:**

- Good preparation if provider may apply for Part A funding in the future
- Way to ensure service quality
- Help in providing services appropriate for people with HIV – especially if people with HIV are not a provider's only clients
- Awareness through invitation to serve on an expert panel that helps develop or update service standards

**Disincentives:**

- Takes effort to learn about these standards if not providing Part A services
- Requires staff training
- May cost more

# Discussion

1. What actions might the Committee take to encourage non-RWHAP-funded providers to learn about and follow Part A Service Standards?
2. Who – within or outside the Commission -- might help to make this happen?
3. What other information might you need to develop a sound plan of action?

# Trends/Approaches to Consider

1. **Make standards as short and concise as possible**
   - Use charts where practical, to increase clarity
   - Put common information into universal standards only, not both places
   - Use plain language
   - Develop standards that tell clients what the service is and what they can expect if they receive it
   - Limit reference to HRSA HAB National Monitoring Standards, Guidances, and Policy Clarification Notices (PCNs) like PCN #16-02,
2. **Limit sound/best practice content – have standards specify requirements**
   - Consider providing best/sound practices separately
   - If used, clearly label such content as optional

# Trends, cont.

3. **Closely link Universal and category-specific service standards** by putting into the category-specific standards:
   - A statement that they must be used together with the Universal Standards
   - A list of topics covered in Universal Standards
   - An indication that the category-specific standards address these topics only where there are special or additional requirements

***For example:*** If the service category has a different income limit from other services or additional eligibility requirements, include only that information – do not repeat other information from the universal standards

# Trends, cont.

4. **Put topics like the following into Universal Standards**:
   - Access to Services
   - Client Rights & Responsibilities
   - Grievance Process
   - Training, Licensing, & Supervision [General Expectations]
   - Cultural & Linguistic Competency
   - Agency Policies & Procedures
   - Privacy and Confidentiality (including securing records)
   - Program Safety
   - Intake and Eligibility
   - Transition and Discharge

5. **Put the following into service-specific standards:**
   - Service Category Definition
   - Key Service Components and Activities
   - Service-specific Personnel Qualifications (including licensure, education, training, and recertification)
   - Assessment and Treatment/Service Plan [Where applicable]
   - Case Closure Protocol [Specific to service category]

# Questions/Discussion

- Questions?
- Discussion?
- What if any follow up to this training is needed?


**Standards of Care Review**
**Guiding Questions**

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

2. Are the standards reasonable and achievable for providers?

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

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

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

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

7. Are the references still relevant?

LOS ANGELES COUNTY
COMMISSION ON HIV

# Standards & Best Practices Committee
# Standards of Care

- Service standards are written for service providers to follow
- Service standards establish the minimal level of service or care that a Ryan White funded agency or provider may offer
- Service standards are essential in defining and ensuring consistent quality care is offered to all clients
- Service standards serve as a benchmark by which services are monitored and contracts are developed
- Service standards define the main components/activities of a service category
- Service standards do not include guidance on clinical or agency operations

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

**Comment Log for the Substance Use Disorder Outpatient care and Residential Services Standards of Care As of 7/28/2021**

| **Document location:** S:\Committee - Standards & Best Practices\Substance Abuse 2017\SUD_SoC_2021Draft.docx | | |
|---|---|---|
| **Date** | **Comment/Details** | **Action/Next Steps** |
| 6/9/21 | ***Felipe Gonzalez:*** *I was wondering if there could be included linkage or referrals to job placement for substance use outpatients that desire to work since this population is highly discriminated on employment due to their usage of substance* | |
| 6/14/21 | ***Paul Nash:*** *Just a couple typos I picked up. I have used trach changes so you can see and decided if you leave or change.*<br><br>**I. Location:** Page 3, Table 2, Column 2<br>"Agencies must maintain ~~and~~ complete thorough documentation of services provided to client"<br><br>**II. Location:** Page 7, Table 2, Column 2, Row 7<br>"Link clients and partners to appropriate community-based behavioral health services/systems including, but not limited to, primary HIV care and antiretroviral treatment (ART), HIV pre-exposure prophylaxis (PrEP), viral hepatitis B and C, primary health care, and other recovery support services."<br><br>**III. Location:** Page 9, Paragraph 2<br>"Collateral Services are session between significant persons in the life of the patient (i.e., personal, not official or professional relationship with patient) and SUD counselors or Licensed Practitioner of the Healing Arts (LPHA) are used to obtain useful information regarding the patient to support the patient's recovery. The focus of Collateral Services is on better addressing the treatment needs of the patient."<br><br>**IV. Location:** Page 9, Paragraph 4<br>"Discharged services or discharge planning is the process of preparing the patient for referral into another level of care, post-treatment return, or re-entry into the community, and/or the linkage of the individual to essential community treatment, housing and human services. Discharge planning should identify a description of the patient's triggers, a plan to avoid relapse for each o these triggers and an overall support plan."<br><br>**V. Location:** Page 10, Paragraph 2<br>"Individual counseling session are designed to support direct communication and dialogue between the staff and patient and focus on psychosocial issues related to substance use and goals outlined in the patient's individualized treatment plan." | |

**Comment Log for the Substance Use Disorder Outpatient care and Residential Services Standards of Care As of 7/28/2021**

| | | |
|---|---|---|
| 7/5/21 | ***Reba Stevens:*** *Please forgive me for sending input at the last minute but, as a recovered alcoholic and other drugs abuser, I couldn't rush this important opportunity, I needed to be thorough in providing input/suggestions on this matter.*<br><br>**I. Location:** Title Page, Title<br>"Standards of Care for Substance Abuse Disorder Outpatient Care and Residential Services"<br>• *Note: substance abuse is very different from substance use, (a term used within this document) - Some examples are eating, drinking or prescription drug abuse, people can use drugs, alcohol, eating and prescriptions without abusing these substances. A person can drink, nothing is wrong with drinking but if you CANNOT stop drinking it is a problem. So, if the doctor says, "you must stop drinking or you will lose your liver", and you can stop drinking and do stop, this is an example of a heavy user, although a heavy user can also be classified as an abuser. On the other hand, if your doctor says, "you must stop drinking or you will lose your liver" and you are unable to stop drinking, this is an example of a substance abuser or an addict. This does not only apply to alcohol and other drugs it often also applies to addictive activities or behaviors.*<br>• *Note: When and at what point will the underlying issues/trauma be addressed for the abuser.*<br>• *Note: The suggestions below need to be cross checked with the three Ryan White standards and the HRSA Definitions and Program Guidance listed below.*<br><br>**II. Location:** Page 1, Title<br>"Substance ~~Use~~ Abuse Disorder Services"<br><br>**III. Location:** Page 1, Paragraph 1, 2 and 3<br>"Standards or Care for Ryan White HIV/AIDS Part A Program, HRSA's Ryan White HIV/AIDS Program (RWHAP), the federal program that funds local and state agencies to deliver HIV care for people with HIV who are uninsured or underinsured, outline the elements and expectations a service provider should follow when implementing a specific service category. The standards are writer to ~~for~~ providers for guidance on what services may be offered when developing their Ryan White Part A programs. The standards set the minimum level of care Ryan White funded agencies offer to clients, however, providers are encouraged to exceed these standards"<br>• *This part is excellent, "providers are courage to exceed these standards."*<br><br>The Los Angeles County Commission on HIV developed the Substance Abuse Disorder ~~Use~~ Outpatient Care and Residential Service standards to establish the minimum services necessary to support clients through treatment and | |

counseling services for drug or alcohol abuse ~~use~~ disorders and promote engagement in medical care and treatment adherence to achieve viral load suppression.

The development of the standards includes guidance from service providers, people living with HIV who are recovered from substance abuse disorders??, the Los Angeles County Department of Public Health, Division of HIV and STD Programs (DHSP), members of the Los Angeles County Commission on HIV, Standards & Best Practices Committee, caucuses, the Commission on Alcohol and Other Drugs?? and the public-at-large.

**The Health Resources and Services Administration (HRSA) Definitions and Program Guidance**

| **Substance Abuse ~~Use~~ Outpatient Care** | **Substance Abuse ~~Use~~ Residential Services** |
|---|---|
| Per HRSA Policy Guidance, Substance Use Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol abuse ~~use~~ disorders. Activities under Substance Use Outpatient Care service category include:<br>• Screening<br>• Assessment<br>• Diagnosis, and/or treatment of substance use disorder, including:<br>  ○ Pretreatment/recovery readiness programs<br>  ○ Harm reduction? define this – abstinence? (Use a little bit or regulate the use?)<br>  ○ Behavioral health counseling associated with substance abuse ~~use~~ disorder.<br>  ○ Outpatient drug-free treatment and counseling<br>  ○ Medication-assisted therapy (MAT)<br>  ○ Neuro-psychiatric pharmaceuticals | Per HRSA Policy Guidance, Substance Use Residential Services is the provision of services for the treatment of drug or alcohol abuse ~~use~~ disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder. This service includes:<br>• Pretreatment/recovery readiness programs<br>• Harm reduction? define.<br>• Behavioral health counseling associated with substance use disorder (at what point and how much mental health services do people diagnosed with HIV/AIDS immediately and continuously receive and/or have access to any mental health services)<br>• Medication-assisted therapy (MAT)<br>• Neuro-psychiatric pharmaceuticals<br>• Relapse prevention<br>• Detoxification, if offered in a separate licensed residential setting (including a separately licensed detoxification facility within the walls of an inpatient medical |

| | | | | | |
|---|---|---|---|---|---|
| | | ○ Relapse prevention<br><br>**Program Guidance:** Acupuncture therapy may be allowable under this service category only when, as part of a substance use disorder treatment program funded under the HRSA RWHAP, it is included in a documented plan. Syringe access services are allowable, to the extent that they comport with current appropriations law and applicable Health and Human Services (HHS) guidance, including HRSA- or HIV/AIDS Bureau (HAB)-specific guidance. | or psychiatric hospital)<br><br>**Program Guidance:** Substance Abuse ~~Use~~ Residential Services is permitted only when the client has received a written referral from the clinical provider as part of a substance use disorder treatment program funded under the HRSA Ryan white HIV/AIDS Program (RWHAP). Acupuncture therapy may be an allowable cost under this service category only when it is included in a documented plan as part of a substance use disorder treatment program funded under the HRSA RWHAP. HRSA RWHAP funds may not be used for inpatient detoxification in a hospital setting, unless the detoxification hospital setting facility has a separate license. (This doesn't seem fair, especially with the limited availability of licensed treatment facilities especially in Los Angeles County)<br><br>Substance Abuse ~~Use~~ Residential Services seek to provide interim housing with supportive services for up to one (1) year exclusively designated and targeted for homeless or unstably housed persons living with HIV/AIDS in various stages of recovery from substance use disorder. The purpose of the service is to facilitate continued recovery from **substance abuse** and movement toward more traditional, permanent housing through assessment of the individual's needs, counseling, and case management.<br>**For both outpatient and residential services it is crucial to address mental, emotional issues and** | | |

| | | | | |
|---|---|---|---|---|
| | | **trauma that are the root cause of the substance abuse – or could an HIV or AIDS diagnosis be a cause for substance abuse.** | | |

| Service Components | Standard |
|---|---|
| **1a. Activities**<br>Based on client needs and assessment, providers must provide the following service activities:<br>• Intake<br>• Individual counseling (what is this and is mental health attached to this? Along with using the lens of trauma)<br>• Group counseling (what is this and is mental health attached to this? Through the lens of trauma)<br>• Patient education (is phych/social edu, trauma information and useful tools for living or daily life functioning included)<br>• Family therapy<br>• Safeguard medications<br>• Medication services<br>• Collateral services | Agencies must maintain complete and thorough documentation of services provided to client. |

| | | | | |
|---|---|---|---|---|
| | are?<br>• Crisis intervention services<br>• Treatment planning<br>• Discharge services<br>What other resources are included in treatment planning and discharge services – is there a "whatever it takes" approach? Are there referrals and/adequate follow up? Is "Discharge services" a plan? | | | |
| | **1b. Agency Licensing and Policies** | **Outpatient Services:** Agency is licensed and accredited by appropriate state and local agency to provide substance abuse disorder ~~use~~ outpatient care services. (Does the person need a clinical diagnosis for treatment?)<br><br>**Residential Services:** Agencies must operate as a licensed adult residential facility, a transitional housing facility or a congregate living facility. (What about youth? Where are they included in this? Note that older adults tend to special needs and should not be excluded from services) | | |
| | **Location:** Page 5 | | | |

Why is Psychosocial not included here? **Psychosocial**" **means** "pertaining to the influence of social factors on an individual's mind or behavior, and to the interrelation of behavioral and social factors" (Oxford English Dictionary, 2012). ... Individual psychological and social aspects are related to individual's social conditions, mental and emotional health.

Why are "Social Determinants of Health" not included here? About Social Determinants of Health (SDOH) (cdc.gov)

What are the "Highest Standards & Best Practices" in the field of "Substance Abuse Disorder Inpatient Care and Outpatient care?

How are these standards wholistic? What does effective treatment look like, root cause of addiction… If you do not know what the problem is, then there is no solution.

Are the twelve steps out of bounds for this?

***** Please include definitions for all services and specific terms, these must up front in the beginning of the document.

| Service Components | Standard | Documentation |
|---|---|---|
| **1c. Client Assessment and Reassessment** | Assessments will be completed at the initiation of services and at minimum should assess whether the client is in care (what care does the refer to?). Reassessments must be completed every 6 months. | Completed assessment in client chart signed and dated by Case Manager. |
| | Appropriate medical evaluation must be performed prior to initiating residential treatment services, including physical examinations when deemed necessary. This should always be necessary. | Medical record of complete physical examinations and complete medical evaluation by a licensed medical provider. |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | Use the Medical Care Coordination (MCC) Assessment tool to determine acuity level and eligibility for MCC services. What biases are built into this assessment? Are these MCC services readily available to the population? | Documentation of use MCC assessment tool as deemed appropriate by staff. ? is the staff competent? Who is the staff? It could be janitor or receptionist, they are staff. | | |
| | | | Screen and assess clients for the presence of co-occurring mental disorders and use the information obtained from the screening and assessment to develop appropriate treatment approaches for the persons identified as having co-occurring disorders. What are the appropriate treatment approaches for those with co-occurring disorders? For example, mental health and substance abuse are co-occurring disorders. Would HIV/AIDS be considered a co-occurring disorder? | Documentation of assessment in client file. | | |
| | | **1d. Staff Competencies** | Staff members are licensed or certified, as necessary, to provide substance abuse ~~use~~ outpatient care and residential services and have experience and skills appropriate to the specified substance needed by the client. Bachelor's degree in a related field preferred and/or lived experience preferred. | Current license and résumé on file. | | |
| | | | Providers are responsible to provide culturally competent services. Services must be embedded in the | Agencies must have in place policies, procedures and practices that are consistent | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | organizational structure and upheld in day-to-day operations. | with the principles outlined in the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS). | | |
| | | | Use a trauma-informed approach following SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach This link does not work. (http://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-aTrauma-Informed-Approach/SMA14-4884). Concerned that this approach has become a buzz word, this must be well defined and used in each aspect of inpatient or outpatient treatment. See TIP 57 Trauma-Informed Care in Behavioral Health Services (samhsa.gov) | Training documentation in personnel and program files. | | |
| | | **1e. Integrated Behavioral and Medical Care** | All Ryan White funded substance use outpatient care and residential services must provide integrated services of behavioral health treatment and HIV medical care. An integrated behavioral health and HIV medical care program addresses alcohol, marijuana, cocaine, heroin, injection drug use (IDU), and prescription drug misuse; mental disorder treatment and HIV/viral hepatitis services, including HIV and hepatitis B and C testing; and use | A comprehensive written program service delivery protocol outlining how staff will deliver all service components based on Los Angeles County, SAMHSA, and ASAM guidelines. | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | evidence-based interventions defined by the Substance Use and Mental Health Services Administration (SAMHSA). Where is this actually happening and is it available for those who need it. | | | |
| | | | Agencies must have procedures for linkage/integration of Medication-Assisted Treatment (MAT) for patients to ensure adequate access to core components of substance use disorder (SUD) treatment. | Established protocols for MAT following prescribing standards from ASAM and SAMHSA. | | |
| | | | Agencies must use Evidence-Based Practices such as Motivational Interviewing and Cognitive Behavioral Therapy, relapse prevention, trauma-informed treatment, and psychoeducation. What is the validity of "Evidence Based Practices" – the issues here is… that it takes an enormous amount of money to qualify as an "Evidence Based Practices", which leave out many modes of treatment that are just as or more effective like the twelve step program, mentorship, sponsorship, connectivity etc. | Written evidence-based program protocol. | | |
| | | | Case management will assist patients in navigating and accessing mental health, physical health, and social service delivery systems. | Case notes must show that the initiating provider provided case management services and communicated with both the "patient" and the next provider along the | | |

| | | | | | |
|---|---|---|---|---|---|
| | | | Are there enough case managers to give actual care, this should be called "care management" people who truly have time to care for the individual. So, the begs the quest what is an acceptable patient to ~~case~~ care manager ratio | continuum of care to ensure smooth transitions between levels of care. If the client is referred to a different agency, case notes must show that the client has been successfully admitted for services with the new treating provider. Consistency in communication & transparency are important. | |
| | | **Location:** Page 11<br>**APPENDIX A: DEFINITIONS**<br>Source: Substance Use Disorder Treatment Services Provider Manual, Version 5.0, Last Updated July 2020. Los Angeles County Department of Public Health, Substance Abuse Prevention and Control.<br><br>Again, these definitions should be up front rather than on the last page. | | | |


# STANDARDS OF CARE FOR SUBSTANCE USE OUTPATIENT CARE AND RESIDENTIAL SERVICES

Last Approved by the Commission on HIV on 4/13/2017
Draft Revisions as of 6/3/21

Draft Revisions as of 6/3/21

# SUBSTANCE USE SERVICES
# STANDARDS OF CARE

IMPORTANT: The service standards for Substance Use Outpatient Care and Residential 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:
Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18)

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

Service Standards: Ryan White HIV/AIDS Programs

## INTRODUCTION

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

The Los Angeles County Commission on HIV developed the Substance Use Outpatient Care and Residential Service standards to establish the minimum services necessary to support clients through treatment and counseling services for drug or alcohol use disorders and promote engagement in medical care and treatment adherence to achieve viral load suppression.

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

### HRSA Definitions and Program Guidance

| Substance Use Outpatient Care | Substance Use Residential Services |
|---|---|
| Per HRSA Policy Guidance, Substance Use Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Activities under Substance Use Outpatient Care service category include:<br>• Screening | Per HRSA Policy Guidance, Substance Use Residential Services is the provision of services for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder. This |

| | |
|---|---|
| • Assessment<br>• Diagnosis, and/or treatment of substance use disorder, including:<br>  ○ Pretreatment/recovery readiness programs<br>  ○ Harm reduction<br>  ○ Behavioral health counseling associated with substance use disorder<br>  ○ Outpatient drug-free treatment and counseling<br>  ○ Medication-assisted therapy (MAT)<br>  ○ Neuro-psychiatric pharmaceuticals<br>  ○ Relapse prevention<br><br>**Program Guidance:** Acupuncture therapy may be allowable under this service category only when, as part of a substance use disorder treatment program funded under the HRSA RWHAP, it is included in a documented plan. Syringe access services are allowable, to the extent that they comport with current appropriations law and applicable HHS guidance, including HRSA- or HIV/AIDS Bureau (HAB)-specific guidance. | service includes:<br>• Pretreatment/recovery readiness programs<br>• Harm reduction<br>• Behavioral health counseling associated with substance use disorder<br>• Medication-assisted therapy (MAT)<br>• Neuro-psychiatric pharmaceuticals<br>• Relapse prevention<br>• Detoxification, if offered in a separate licensed residential setting (including a separately licensed detoxification facility within the walls of an inpatient medical or psychiatric hospital)<br><br>**Program Guidance:** Substance Use Residential Services is permitted only when the client has received a written referral from the clinical provider as part of a substance use disorder treatment program funded under the HRSA Ryan white HIV/AIDS Program (RWHAP). Acupuncture therapy may be an allowable cost under this service category only when it is included in a documented plan as part of a substance use disorder treatment program funded under the HRSA RWHAP. HRSA RWHAP funds may not be used for inpatient detoxification in a hospital setting, unless the detoxification facility has a separate license.<br><br>Substance Use Residential Services seek to provide interim housing with supportive services for up to one (1) year exclusively designated and targeted for homeless or unstably housed persons living with HIV/AIDS in various stages of recovery from substance use disorder. The purpose of the service is to facilitate continued recovery from substance abuse and movement toward more traditional, permanent housing through assessment of the individual's needs, |

| | |
|---|---|
| | counseling, and case management. |

***All contractors must meet the Universal Standards of Care in addition to the following Substance Use Outpatient Care and Residential Services service standards***.[1]

| Service Components | Standard | Documentation |
|---|---|---|
| **1a. Activities**<br>Based on client needs and assessment, providers must provide the following service activities:<br>• Intake<br>• Individual counseling<br>• Group counseling<br>• Patient education<br>• Family therapy<br>• Safeguard medications<br>• Medication services<br>• Collateral services<br>• Crisis intervention services<br>• Treatment planning<br>• Discharge services | Agencies must maintain complete and thorough documentation of services provided to client. | Agencies maintain documentation based on Los Angeles County, Substance Abuse and Mental Health Services Administration (SAMHSA), and American Society of Addiction Medicine (ASAM) guidelines.<br><br>Progress notes are thorough, dated, and verified by a licensed supervisor. |
| **1b. Agency Licensing and Policies** | **Outpatient Services:** Agency is licensed and accredited by appropriate state and local agency to provide substance use outpatient care services.<br><br>**Residential Services:** Agencies must operate as a licensed adult residential facility, a transitional housing facility or a congregate living facility. | Current license(s) on file. |

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

| Service Components | Standard | Documentation |
|---|---|---|
| **1c. Client Assessment and Reassessment** | Assessments will be completed at the initiation of services and at minimum should assess whether the client is in care. Reassessments must be completed every 6 months. | Completed assessment in client chart signed and dated by Case Manager. |
| | Appropriate medical evaluation must be performed prior to initiating residential treatment services, including physical examinations when deemed necessary. | Medical record of physical examinations and medical evaluation by a licensed medical provider. |
| | Use the Medical Care Coordination (MCC) Assessment tool to determine acuity level and eligibility for MCC services. | Documentation of use MCC assessment tool as deemed appropriate by staff. |
| | Screen and assess clients for the presence of co-occurring mental disorders and use the information obtained from the screening and assessment to develop appropriate treatment approaches for the persons identified as having co-occurring disorders. | Documentation of assessment in client file. |
| **1d. Staff Competencies** | Staff members are licensed or certified, as necessary, to provide substance use outpatient care and residential services and have experience and skills appropriate to the specified substance needed by the client. Bachelor's degree in a related field preferred and/or lived experience preferred. | Current license and résumé on file. |
| | Providers are responsible to provide culturally competent services. Services must be embedded in the organizational structure and upheld in day-to-day operations. | Agencies must have in place policies, procedures and practices that are consistent with the principles outlined in the National Standards for Culturally and Linguistically |

| | | |
|---|---|---|
| | | Appropriate Services in Health Care (CLAS). |
| | Use a trauma-informed approach following SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach (http://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-aTrauma-Informed-Approach/SMA14-4884). | Training documentation in personnel and program files. |
| **1e. Integrated Behavioral and Medical Care** | All Ryan White funded substance use outpatient care and residential services must provide integrated services of behavioral health treatment and HIV medical care. An integrated behavioral health and HIV medical care program addresses alcohol, marijuana, cocaine, heroin, injection drug use (IDU), and prescription drug misuse; mental disorder treatment and HIV/viral hepatitis services, including HIV and hepatitis B and C testing; and use evidence-based interventions defined by the Substance Use and Mental Health Services Administration (SAMHSA). | A comprehensive written program service delivery protocol outlining how staff will deliver all service components based on Los Angeles County, SAMHSA, and ASAM guidelines. |
| | Agencies must have procedures for linkage/integration of Medication-Assisted Treatment (MAT) for patients to ensure adequate access to core components of substance use disorder (SUD) treatment. | Established protocols for MAT following prescribing standards from ASAM and SAMHSA. |
| | Agencies must use Evidence-Based Practices such as Motivational Interviewing and Cognitive Behavioral Therapy, relapse prevention, trauma-informed treatment, and psychoeducation. | Written evidence-based program protocol. |

| | | |
|---|---|---|
| | Case management will assist patients in navigating and accessing mental health, physical health, and social service delivery systems. | Case notes must show that the initiating provider provided case management services and communicated with the next provider along the continuum of care to ensure smooth transitions between levels of care. If the client is referred to a different agency, case notes must show that the client has been successfully admitted for services with the new treating provider. |
| | Providers must deliver recovery support services to clients to sustain engagement and long-term retention in recovery, and re-engagement in SUD treatment and other services and supports as needed. | Written recovery support services protocol.<br><br>MOUs with agencies for ensuring coordination of care. |
| | All clients who are considered to be at risk for viral hepatitis (B and C), as specified by the United States Preventive Services Task Force (USPSTF) recommendations for hepatitis B and hepatitis C screening, must be tested for viral hepatitis (B and C) in accordance with state and local requirements, either onsite or through referral. | Documentation of hepatitis screening and treatment described in client file. |
| **1f. Individual Treatment Plan** | Individual Treatment Plans (ITPs) will be developed collaboratively between the client and Case Manager within 7 calendar days (or as soon as possible) of completing the assessment or reassessment and, at minimum, should include:<br>• Description of client goals and desired outcomes | Completed ITP in client chart, dated and signed by client and Case Manager. |

| | | |
|---|---|---|
| | • Action steps to be taken and individuals responsible for the activity<br>• Anticipated time for each action step and goal<br>• Status of each goal as it is met, changed or determined to be unattainable | |
| **1g. Linkage and Referral** | Link clients and partners to appropriate community-based behavioral health services/systems including primary HIV care and antiretroviral treatment (ART), HIV pre-exposure prophylaxis (PrEP), viral hepatitis B and C, primary health care, and other recovery support services. | Documentation of linkage and referrals, follow-up care and treatment for in client case files. |
| | Ensure that patients who need trauma-related services have access to these services through case management and referral to certified trauma providers. | Documentation of linkage and referrals in client case files. |
| **1h. Discharge Planning** | Client Discharge Plan should be developed for every client, regardless of reason for discharge. At minimum, the Discharge Plan should include:<br>• Reason for client discharge from services (i.e., treatment goals achieved, client requested termination of services, client left facility, client deceased, etc.)<br>• Referrals to ongoing outpatient substance use treatment service<br>• Identification of housing options and address at which client is expected to reside | Client record documentation contains signed and dated Discharge Plan with required Elements. |

| | | |
|---|---|---|
| | • Identification of medical care provider from whom client is expected to receive treatment<br>• Identification of case manager/care coordinator from whom client is expected to receive services<br>• Source of client's HIV medications upon discharge | |
| | Client Discharge Plan should be provided to client. | Client record signed and dated progress notes reflect provision of Discharge Plan to client. |

## APPENDIX A: DEFINITIONS

Source: Substance Use Disorder Treatment Services Provider Manual, Version 5.0, Last Updated July 2020. Los Angeles County Department of Public Health, Substance Abuse Prevention and Control.

### Collateral Services

Collateral Services are sessions between significant persons in the life of the patient (i.e., personal, not official or professional relationship with patient) and SUD counselors or Licenses Practitioner of the Healing Arts (LPHA) are used to obtain useful information regarding the patient to support the patient's recovery. The focus of Collateral Services is on better addressing the treatment needs of the patient.

### Crisis Intervention Services

Crisis Intervention services include direct communication and dialogue between the staff and patient and are conducted when: 1) A threat to the physical and/or emotional health and well-being of the patient arises that is perceived as intolerable and beyond the patient's immediately available resources and coping mechanisms; or 2) An unforeseen event or circumstance occurs that results in or presents an imminent threat of serious relapse. These sessions are immediate and short-term encounters that focus on (1) stabilization and immediate management of the crisis, often by strengthening coping mechanisms and (2) alleviating a patient's biopsychosocial functioning and well-being after a crisis.

### Discharge Services

Discharge services or discharge planning is the process of preparing the patient for referral into another level of care, post-treatment return, or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services. Discharge planning should identify a description of the patient's triggers, a plan to avoid relapse for each of these triggers and an overall support plan.

### Family Therapy

Family therapy is a form of psychotherapy that involves both patients and their family members and uses specific techniques and evidence-based approaches (e.g. family systems theory, structural therapy, etc.) to improve the psychosocial impact of substance use and the dynamics of a social/family unit.

### Field-based Services (FBS)

Field-based Services (FBS) are a method of mobile service delivery for SUD outpatient services case, management, and recovery support services (RSS) for patients with established medical necessity. FBS provide an opportunity for SUD network providers to address patient challenges to accessing traditional treatment settings, such as physical limitations, employment conflicts, transportation limitations, or restrictive housing requirements (e.g., registered sex offenders).

**Group Counseling**
Group counseling sessions are designed to support discussion among patients, with guidance from the facilitator to support understanding and encourage participation, on psychosocial issues related to substance use.

**Individual Counseling**
Individual Counseling sessions are designed to support direct communication and dialogue between the staff and patient and focus on psychosocial issues related to substance use and goals outlined in the patient's individualized Treatment Plan.

**Intake**
Intake involves completing a series of administrative processes that are designed to ensure/verify eligibility, discuss program offerings, consent forms and other relevant documents. The intake process is a critical first step in establishing trust between the provider and the client and sets the stage for supporting the client in their treatment process.

**Medication-assisted Treatment/Therapy (MAT)**
Medication-assisted treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. Medications used in MAT are approved by the Food and Drug Administration (FDA) and MAT programs are clinically driven and tailored to meet each patient's needs.

**Medication Services and Safeguarding Medications**
Medication services and safeguarding medications include the prescription, administration, or supervised self-administration (in residential settings) of medication related to SUD treatment services or other necessary medications. Medication services may also include assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services and/or order laboratory testing within their scope of practice or licensure.

**Patient Education**
Patient education sessions are designed to enable the facilitator to teach participants and encourage discussion among patients on research-based educational topics such as addiction, treatment, recovery, and associated health consequences with the goal of minimizing the harms of SUDs, lowering the risk of overdose and dependence, and minimizing adverse consequences related to substance use.

**Treatment Plan/Planning**
A treatment plan is an electronic or paper document that describes the patient's individualized diagnosis, strengths, needs, long-range goals, short-term goals, treatment and supportive interventions, and treatment providers.