LOS ANGELES COUNTY
COMMISSION ON HIV

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STANDARDS AND BEST PRACTICES COMMITTEE SPECIAL MEETING

TUESDAY, JANUARY 7, 2025
1:00pm-3:00pm (PST)
****Please note change in time****

510 S. Vermont Avenue, 9th Floor, LA 90020
Validated Parking @ 523 Shatto Place, LA 90020
**As a building security protocol, attendees entering the building must notify parking attendant and/or security personnel that they are attending a Commission on HIV meeting.*
Agenda and meeting materials will be posted on our website at http://hiv.lacounty.gov/Meetings

Register Here to Join Virtually

https://lacountyboardofsupervisors.webex.com/weblink/register/r81615f80e1d260f02597dbf1b500bbfb

Notice of Teleconferencing Sites

Public Comments

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

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

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

Accommodations

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

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

together.

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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 SPECIAL MEETING OF THE LOS ANGELES COUNTY COMMISSION ON HIV

STANDARDS AND BEST PRACTICES COMMITTEE

TUESDAY, JANUARY 7, 2025 | 1:00PM – 3:00PM
Please note change in time

510 S. Vermont Ave
Terrace Level Conference Rooms
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 to access the Terrace Conference Room (9th floor) where our meetings are held.

MEMBERS OF THE PUBLIC WHO WISH TO JOIN VIRTUALLY, REGISTER HERE:
https://lacountyboardofsupervisors.webex.com/weblink/register/r81615f80e1d260f02597dbf1b500bbfb
To Join by Telephone: 1-213-306-3065
Password: STANDARDS Access Code: 2535 694 1504

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

AGENDA POSTED: January 3, 2025.

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

PUBLIC COMMENT: Public Comment is an opportunity for members of the public to comment on an

agenda item, or any item of interest to the public, before or during the Commission's consideration of the item, that is within the subject matter jurisdiction of the Commission. To submit Public Comment, you may join the virtual meeting via your smart device and post your Public Comment in the Chat box -or- email your Public Comment to hivcomm@lachiv.org -or- submit your Public Comment electronically here. All Public Comments will be made part of the official record.

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

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

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

I. ADMINISTRATIVE MATTERS

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

II. PUBLIC COMMENT

1:10 PM – 1:15 PM

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 — 1:15 PM – 1:35 PM
   a. Operational and Commission—Updates
   b. 2025 COH Workplan
   c. Mini-Training—Service Standards Development Overview
8. Co-Chair Report — 1:35 PM – 1:50 PM
   a. 2025 Committee Co-Chair Elections

b. Review 2025 Committee Meeting Calendar
c. Service Standards Revision Tracker—Updates

9. Division on HIV and STD Programs (DHSP) Report 1:50 PM—2:10 PM

V. DISCUSSION ITEMS

10. Housing Service Standards Review 2:10 PM—2:50 PM
    a. Residential Care Facility for the Chronically Ill (RCFCI)
    b. Transitional Residential Care Facility (TRCF)

VI. NEXT STEPS 2:50 PM – 2:55 PM

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

VII. ANNOUNCEMENTS 2:55 PM – 3:00 PM

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

VIII. ADJOURNMENT 3:00 PM

15. Adjournment for the meeting of January 7, 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
COMMISSION ON HIV

510 S. Vermont Ave 14th Floor • Los Angeles, CA 90020 • TEL (213) 738-2816 • FAX (213) 637-6748
HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov

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

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 9/10/24

In accordance with the Ryan White Program (RWP), conflict of interest is defined as any financial interest in, board membership, current or past employment, or contractual agreement with an organization, partnership, or any other entity, whether public or private, that receives funds from the Ryan White Part A program. These provisions also extend to direct ascendants and descendants, siblings, spouses, and domestic partners of Commission members and non-Commission Committee-only members. Based on the RWP legislation, HRSA guidance, and Commission policy, it is mandatory for Commission members to state all conflicts of interest regarding their RWP Part A/B and/or CDC HIV prevention-funded service contracts prior to discussions involving priority-setting, allocation, and other fiscal matters related to the local HIV continuum. Furthermore, Commission members must recuse themselves from voting on any specific RWP Part A service category(ies) for which their organization hold contracts.***An asterisk next to member's name denotes affiliation with a County subcontracted agency listed on the addendum.***

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
ALE-FERLITO	**Dahlia**	City of Los Angeles AIDS Coordinator	No Ryan White or prevention contracts
ALVAREZ	**Miguel**	No Affiliation	No Ryan White or prevention contracts
ARRINGTON	**Jayda**	Unaffiliated representative	No Ryan White or prevention contracts
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**	T.H.E. Clinic, Inc.	Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Transportation Services
CIELO	**Mikhaela**	Los Angeles General Hospital	No Ryan White or prevention contracts
CONOLLY	**Lilieth**	No Affiliation	No Ryan White or prevention contracts
CUEVAS	**Sandra**	Pacific AIDS Education and Training - Los Angeles	No Ryan White or prevention contracts
CUMMINGS	**Mary**	Bartz-Altadonna Community Health Center	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
DAVIES	**Erika**	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DONNELLY	**Kevin**	Unaffiliated representative	No Ryan White or prevention contracts
FERGUSON	**Kerry**	ViiV Healthcare	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
FRAMES	**Arlene**	Unaffiliated representative	No Ryan White or prevention contracts
FRANKLIN*	**Arburtha**	Translatin@ Coalition	Vulnerable Populations (Trans)
GARCIA	**Rita**	No Affiliation	No Ryan White or prevention contracts
GERSH (SBP Member)	**Lauren**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			Nutrition Support
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Residential Care Facility - Chronically Ill
			Data to Care Services
GONZALEZ	**Felipe**	Unaffiliated representative	No Ryan White or Prevention Contracts
GORDON	**Bridget**	Unaffiliated representative	No Ryan White or prevention contracts
GREEN	**Joseph**	Unaffiliated representative	No Ryan White or prevention contracts
HALFMAN	**Karl**	California Department of Public Health, Office of AIDS	Part B Grantee
HARDY	**David**	LAC-USC Rand Schrader Clinic	No Ryan White or prevention contracts
HERRERA	**Ismael "Ish"**	Unaffiliated representative	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
JONES	**Terrance**	Unaffiliated representative	No Ryan White or prevention contracts
KOCHEMS	**Lee**	Unaffiliated representative	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts
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)
			Transportation Services
			Promoting Healthcare Engagement Among Vulnerable Populations
MARTINEZ-REAL	**Leonardo**	Unaffiliated representative	No Ryan White or prevention contracts
MAULTSBY	**Leon**	Charles R. Drew University	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
MENDOZA	**Vilma**	Unaffiliated representative	No Ryan White or prevention contracts
MINTLINE (SBP Member)	**Mark**	Western University of Health Sciences (No Affiliation)	No Ryan White or prevention contracts
MOLETTE	**Andre**	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
			Data to Care Services

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MUHONEN	**Matthew**	HOPWA-City of Los Angeles	No Ryan White or prevention contracts
NASH	**Paul**	University of Southern California	Biomedical HIV Prevention
NELSON	**Katja**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			Nutrition Support
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Residential Care Facility - Chronically Ill
			Data to Care Services
OSORIO	**Ronnie**	Center For Health Justice (CHJ)	Transitional Case Management - Jails
			Promoting Healthcare Engagement Among Vulnerable Populations
PATEL	**Byron**	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
PERÉZ	**Mario**	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee
RICHARDSON	**Dechelle**	AMAAD Institute	Community Engagement/EHE
ROBINSON	**Erica**	Health Matters Clinic	No Ryan White or prevention contracts
RUSSEL	**Daryl**	Unaffiliated representative	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
SATTAH	**Martin**	Rand Schrader Clinic LA County Department of Health Services	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
SAN AGUSTIN	**Harold**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV)
			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
SAUNDERS	**Dee**	City of West Hollywood	No Ryan White or prevention contracts
SPENCER	**LaShonda**	Oasis Clinic (Charles R. Drew University/Drew CARES)	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
STALTER	**Kevin**	Unaffiliated representative	No Ryan White or prevention contracts
TALLEY	**Lambert**	Grace Center for Health & Healing (No Affiliation)	No Ryan White or prevention contracts
VALERO	**Justin**	No Affiliation	No Ryan White or prevention contracts
WEEDMAN	**Jonathan**	ViaCare Community Health	Biomedical HIV Prevention
YBARRA	**Russell**	Capitol Drugs	No Ryan White or prevention contracts

2025 COMMISSION ON HIV WORKPLAN
Ongoing 12-26-24

#	DUTY/ROLE	LEAD (S)	NOTES/TIMELINE
1	Conduct ongoing needs assessments	PP&A Shared task with DHSP	• Review, analyze and hold data presentations (Feb-August COH meetings)
2	Integrated/Comprehensive Planning Comprehensive HIV Plan Development	PP&A Shared task with DHSP	• Review CDC/HRSA guidance • Develop project timeline based on CDC/HRSA guidance • CHP Due June 2026 • Plan dedicated status-neutral and/or prevention-focused planning summit in collaboration with DHSP.
3	Priority setting	PP&A	• July-September
4	Resource allocations/reallocations	PP&A	• July-September • Receive and review expenditure data – quarterly
5	Directives	PP&A	• Complete by February 2025; secure COH approval by March 2025
6	Development of service standards	SBP Shared task with DHSP	• Housing services • Transitional case management
7	Assessment of the Efficiency of the Administrative Mechanism	Operations	• PY 33 & PY 34 AEAM recipient and subrecipient surveys will be disseminated in January/February 2025. Reports completed by April 2025
8	Planning Council Operations and Support	Operations	• Membership training • Membership recruitment and retention • Fill vacancies • Mentorship program • Bylaws and policies update

9	Complete restructuring framework and key principles and align with bylaws/ordinance updates.	Executive and Operations	• January- April 2025
10	MOU with DHSP	Co-Chairs and Executive Committee	• Complete by March 2025 (awaiting DHSP feedback)
11	Ongoing community engagement and non-member involvement of PLWH	Consumer Caucus and Operations	

Engage all caucuses, committees and subgroups in all functions.

Service Standard Development

LOS ANGELES COUNTY COMMISSION ON HIV

KEYWORDS AND ACRONYMS

BOS: Board of Supervisors
COH: Commission on HIV
SBP: Standards and Best Practices
DHSP: Division of HIV & STD Programs
RFP: Request for Proposal

HRSA: Health Resources and Services Administration
HAB: HIV/AIDS Bureau
RWHAP: Ryan White HIV/AIDS Program
PSRA: Priority Setting and Resource Allocations
PCN: Policy Clarification Notice

WHAT ARE SERVICE STANDARDS?

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

WHAT ARE SERVICE CATEGORIES?

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

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

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

HRSA/HAB GUIDANCE FOR SERVICE STANDARDS

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

COH SERVICE STANDARDS

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

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

REMINDER

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

DEVELOPING SERVICE STANDARDS

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

SERVICE STANDARD DEVELOPMENT PROCESS

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

together.

WE CAN END HIV IN OUR COMMUNITY ONCE AND FOR ALL

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

STANDARDS AND BEST PRACTICES COMMITTEE 2025 MEETING CALENDAR (Updated 1/3/25)

DATE	KEY AGENDA ITEMS/TOPICS (subject to change; for planning purposes)
Jan. 7, 2025 1pm to 3pm *TK02*	Elect co-chairs. Review 2025 COH workplan. Establish standards review schedule for 2025. Continue review of Temporary and Permanent Housing service standards
Feb. 4, 2025 10am to 12pm *TK02*	
Mar. 4, 2025 TBD	Determine meeting time: • 10am-12pm (TK02) • 1pm-3pm (14K16)
Apr. 1, 2025 1pm to 3pm *TK02*	
May 6, 2025 *TBD*	Determine meeting time: • 10am-12pm (14K16) • 1pm-3pm (TK02)
Jun. 3, 2025 1pm-3pm *TK02*	
Jul. 1, 2025 10am to 12pm *TK02*	
Aug. 5, 2025 *TBD*	
Sep. 2, 2025 *TBD*	Consider rescheduling due to Labor Day holiday on 9/1/25.
Oct. 7, 2025 *TBD*	
Nov. 4, 2025 *TBD*	Commission on HIV Annual Conference 11/13/2025
Dec. 2, 2025 *TBD*	Consider rescheduling due to World AIDS Day events. Reflect on 2025 accomplishments. Co-Nominations for 2026.

LOS ANGELES COUNTY COMMISSION ON HIV

Service Standards Revision Date Tracker as of 01/3/25 FOR PLANNING PURPOSES

#	COH Standard Title	DHSP Service	Description	Date of Last Revision	Notes
1	AIDS Drug Assistance Program (ADAP) Enrollment	AIDS Drug Assistance Program (ADAP) Enrollment	State program that provides medications that prolong quality of life and delay health deterioration to people living with HIV who cannot afford them.	n/a	ADAP contracts directly with agencies. Administered by the California Department of Public Health, Office of AIDS (CDPH/OA).
2	Benefits Specialty Services	Benefits Specialty Services (BSS)	Assistance navigating public and/or private benefits and programs (health, disability, etc.)	Last approved by COH on Sep. 8, 2022.	Upcoming solicitation—release Nov. 2024.
3	Emergency Financial Assistance	Emergency Financial Assistance (EFA)	Pay for rent, utilities (including cell phone and Wi-Fi), and food and transportation.	Last approved by COH on Jun. 11, 2020.	SBP approved on 11/12/24. EC approved on 12/12/24. For COH review/approval on 2/12/25.
4	HIV/STI Prevention Services	Prevention Services	Services used alone or in combination to prevent the transmission of HIV and STIs.	Last approved by COH on Apr. 11, 2024.	Not a program—standards apply to prevention services. Upcoming solicitation—release Aug./Sep. 2024
5	Home-Based Case Management	Home-Based Case Management	Specialized home care for homebound clients.	Last approved by COH on Sep. 9, 2022.	Active solicitation
6	Language Interpretation Services	Language Services	Translation and interpretation services for non-English speakers and deaf and.org hard of hearing individuals.	Last approved by COH in 2017.	

#	COH Standard Title	DHSP Service	Description	Date of Last Revision	Notes
7	Legal Services	Legal Services	Legal information, representation, advice, and services.	Last approved by COH on Jul. 12, 2018.	
8	Medical Care Coordination	Medical Care Coordination (MCC)	HIV care coordination through a team of health providers to improve quality of life.	Last approved by COH on Jan. 11, 2024.	Upcoming solicitation—release Nov. 2024
9	Medical Outpatient Services	Ambulatory Outpatient medical (AOM) Services	HIV medical care accessed through a medical provider.	Last approved by COH on Jan. 13, 2006.	SBP approved on 8/6/24. EC approved on 12/12/24. For COH review/approval on 2/12/25. Upcoming solicitation—release Nov. 2024
10	Medical Specialty	Medical Specialty Services	Medical care referrals for complex and specialized cases.		
11	Mental Health Services	Mental health Services	Psychiatry, psychotherapy, and counseling services.	Last approved by COH in 2017.	
12	Nutrition Support	Nutrition Support Services	Home-delivered meals, food banks, and pantry services.	Last approved by COH on Aug. 10, 2023.	Upcoming solicitation—release Oct. 2024
13	Oral Health Care	Oral Health Services (General and Specialty)	General and specialty dental care services.	Last approved by COH on Apr. 13, 2023.	

#	COH Standard Title	DHSP Service	Description	Date of Last Revision	Notes
14	Psychosocial Support	Psychosocial Support/Peer Support Services	Help people living with HIV cope with their diagnosis and any other psychosocial stressors they may be experiencing through counseling services and mental health support.	Last approved by COH on Sep. 10, 2020.	Upcoming solicitation—Release TBD
15	Substance Use Residential and Treatment Services	Substance Use Disorder Transitional Housing (SUDTH)	Housing services for clients in recovery from drug or alcohol use disorders.	Last approved by COH on Jan. 13, 2022.	
16	Temporary Housing Services	Residential Care Facility for the Chronically Ill (RCFCI)	Home-like housing that providers 24-hour care.	Last approved by COH on Feb. 8, 2018.	Currently under review Upcoming solicitation—release Nov. 2024
17	Temporary Housing Services	Transitional Residential Care Facility (TRCF)	Short-term housing that providers 24-hour assistance to clients with independent living skills.	Last approved by COH on Feb. 8, 2018	Currently under review Upcoming solicitation—release Nov. 2024
18	Transitional Case Management Services, Youth	Transitional Case Management—Youth	Client-centered, comprehensive services designed to promote access to and utilization of HIV care by identifying and linking youth living with HIV/AIDS to HIV medical and support services.	Last approved by COH on Apr. 13, 2017.	Committee decided to develop a global Transitional Case Management service standard document which will include sections for priority populations such as youth, older adults (50+), and justice-involved individuals.

#	COH Standard Title	DHSP Service	Description	Date of Last Revision	Notes
19	Transitional Case Management Services—Justice-Involved Individuals	Transitional Case Management	Support for incarcerated individuals transitioning from County Jails back to the community.	Last approved by COH on Dec. 8, 2022.	See notes section for item #18.
20	Transitional Case Management—Older Adults	n/a	To be developed.	n/a	See notes section for item #18.
21	Transportation	Transportation Services	Ride services to medical and social services appointments.	Last approved by COH in 2017.	SBP approved on 10/1/24. EC approved on 10/24/24. For COH review/approval on 2/12/25. Upcoming solicitation—Release Oct. 2024
22	Universal Standards and Client Rights and Responsibilities	n/a	Establish the minimum standards of care necessary to achieve optimal health among people living with HIV, regardless of where services are received in the County. These standards apply to all services.	Last approved by COH on Jan. 11, 2024.	Not a program—standards apply to all services. The Committee will review this document on a bi-annual basis or as necessary per community stakeholder, partner agency, or Commission request.

HOUSING SERVICE STANDARDS: RESIDENTIAL CARE FACILITY FOR THE CHRONICALLY ILL (RCFCI) AND TRANSITIONAL RESIDENTIAL CARE FACILITY (TRCF)

DRAFT

Last Approved by COH on 2/8/2018. For SBP Committee review as of 12/20/24.

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.

Description

Housing provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services).

Housing activities also include housing referrals services, including assessment, search placement, and housing advocacy services on behalf of the eligible client, as well as fees associated with these activities.

Program Guidance:

HRSA RWHAP recipients and subrecipients that use funds to provide Housing must have mechanisms in place to assess and document the housing status and housing service needs of new clients, and at least annually for existing clients.

HRSA RWHAP recipients and subrecipients, along with local decision-making planning bodies, are strongly encouraged to institute duration limits to housing activities. HRSA HAB recommends recipients and subrecipients align duration limits with those definitions used by other housing programs, such as those administered by the Department of Housing and Urban Development, which currently uses 24 months for transitional housing.

Housing activities cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments or rental deposits, although these may be allowable costs under the HUD Housing

RWHAP funding may be used to pay for a RWHAP client's security deposit if a RWHAP recipient or subrecipient has policies and procedures in place to ensure that the security deposit is returned to the RWHAP recipient or subrecipient and not to the RWHAP client. Opportunities for Persons with AIDS grant awards.
https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/hrsa-hab-security-deposit-program-letter.pdf

GENERAL ELIGIBILITY REQUIREMENTS

- Be diagnosed HIV or AIDS with verifiable documentation.
- Have a state-recognized identification document.
- Have an income at or below 500% of Federal Poverty Level
- Unstably housed, at-risk for homelessness, and homeless/unsheltered

RESIDENTIAL CARE FACILITY FOR THE CHRONICALLY ILL (UP TO 24 MONTHS) GENERAL REQUIREMENTS

Residential Care Facilities for the Chronically Ill (RCFCI) are licensed under the California Code of Regulations, Title 22, Division 6, Chapter 8.5 to provide services in a non-institutional, home-like environment in any building or housing arrangement which is maintained and operated to provide 24-hour care and supervision to the following PLWH: Adults 18 years age or older; emancipated minors, unable to work.

The goal of the RCFCI program is to improve the health status of PLWH who need to receive care, support, and supervision in a stable living environment to improve their health status. Clients receiving RCFCI services will have a maximum stay of 24 months. Approval will be required for extensions beyond 24 months based on the client's health status. Additional services provided can include case management services, counseling, nutrition services, and consultative services regarding housing, health benefits, financial planning, and referrals to other community or public resources.

Each RCFCI program must adhere to the following general requirements:

RCFCI GENERAL REQUIREMENTS	
STANDARD	**MEASURE**
RCFCIs are licensed to provide 24-hour care and supervision to any of the following: • Adults 18 years of age or older with living HIV/AIDS • Emancipated minors living with HIV/AIDS Family units with adults or children, or both, living with HIV/AIDS	Program review and monitoring to confirm.
RCFCIs may accept clients that meet each of the following criteria: • Have an HIV/AIDS diagnosis from a primary care physician.	Program review and monitoring to confirm.

• Be certified by a qualified a qualified health care professional to need regular or ongoing assistance with Activities of Daily Living (ADLs) • Have a Karnofsky score of 70 or less. • Have an unstable living situation. • Be a client of Los Angeles County client. • Have an income at or below 500% Federal Poverty Level • Cannot receive Ryan White services if other payor source is available for the same service	
RCFCIs may accept clients with chronic and life-threatening diagnoses requiring different levels of care, including: • Clients whose illness is intensifying and causing deterioration in their condition. • Clients whose conditions have deteriorated to a point where death is imminent. • Clients who have other medical conditions or needs, or require the use of medical equipment that the facility can provide	Program review and monitoring to confirm.
RCFCIs will not accept or retain clients who: • Require inpatient care. • Require treatment and/or observation for more than eight hours per day. • Have communicable TB or any reportable disease. • Require 24-hour intravenous therapy. • Have dangerous psychiatric conditions. • Have a Stage II or greater decubitus ulcer. • Require renal dialysis in the facility. • Require life support systems. • Do not have chronic life-threatening illness. • Have a primary diagnosis of Alzheimer's.	Program review and monitoring to confirm.

• Have a primary diagnosis of Parkinson's disease	
Maximum length of stay is 24 months with extensions bases on client's health status.	Program review and monitoring to confirm.
RCFCI will develop criteria and procedures to determine client eligibility to ensure that no other options for residential services are available.	Program review and monitoring to confirm.
Programs may charge up to 30% of the income of adult family members who are not the primary service recipient to help cover the costs of providing services not covered by the RCFCI contract. Sliding scale fee plan as follows: • For SSI/SSP recipients who are clients, the basic services will be provided and/or made available at the basic rate with no additional charge to the client. This will not preclude the acceptance by the facility of voluntary contributions from relatives on behalf of an SSI/SSP recipient. • An extra charge to client will be allowed for a private room upon the client's request (and if such room is available). If a double room is available but the client prefers a private room, it must be documented in the admission agreement and charge is limited to 10% of the board and room portion of the SSI/SSP grant. The extra charge to the client will be allowed for special food services or products beyond that specified above when the client wishes to purchase the services and agree to the extra charge in the admission agreement.	Program review and monitoring to confirm.

INTAKE

As part of the intake process, the client file will include the following information (at minimum):

RCFCI INTAKE	
STANDARD	**DOCUMENTATION**
Intake process is begun as soon as possible upon acceptance.	Intake tool is completed and in client file.
Eligibility for services is determined	Client files include: • Proof of HIV diagnosis • Proof of income • Proof of residence in Los Angeles County • Proof client is not eligible for Housing Opportunities for People with AIDS (HOPWA) or other housing services. Ryan White is the payor of last resort.
Confidentiality Policy, Consent to Receive Services and Release of Information is discussed and completed. Release of Information (must be updated annually). New forms must be added for those individuals not listed on the existing Release of Information (specification should be made about what type of information can be released)	Release of Information signed and dated by client on file and updated annually.
Client is informed of Rights and Responsibility and Grievance Procedures	Signed and dated forms in client file.

ASSESSMENT

Prior to or within 30 days of the acceptance of a client, the facility will obtain a written medical assessment of the client which enables the facility to determine if they are able to provide the necessary health-related services required by the client's medical condition. If the assessment is not completed prior to admission of the client, a Registered Nurse (RN) must provide a health assessment within 24 hours of admission to determine if any immediate health needs are present which may preclude placement.

Clients must be reassessed on a quarterly basis to monitor and document changes in health status, progress toward treatment goals, and progress towards self-sufficiency with Activities of Daily Living (ADL). Upon reaching and sustaining a Karnofsky score above 70, RCFCI clients will be expected to transition towards independent living or to another type of residential service more suitable to their needs. Assessments will include the following:

RCFCI ASSESSMENT	
STANDARD	**MEASURE**
Written medical assessments completed or supervised by a licensed physician not more than three months old are required within 30 days of acceptance.	Signed, dated medical assessment on file in client chart.
Assessments will include the following: • Need for palliative care. • Age • Health status, including HIV and STI prevention needs. • Record of medications and prescriptions • Ambulatory status • Family composition • Special housing needs • Level of independence • Level of resources available to solve problems. • ADLs • Income • Benefits assistance/Public entitlements • Substance use and need for substance use services, such as treatment, relapse prevention, and support groups. • Mental health • Personal finance skills • History of evictions • Co-morbidity factors • Physical health care, including access to tuberculosis (TB) screening and routine and preventative health and dental care. • Treatment adherence • Educational services, including assessment, GED, and school enrollment. • Linkage to potential housing out-placements should they become appropriate alternatives for current	Signed, dated assessment on file in client chart.

clients (e.g., residential treatment facilities and hospitals) • Representative payee Legal assistance on a broad range of legal and advocacy	
Clients must be reassessed on a quarterly basis to monitor and document changes in health status, progress toward treatment goals, and progress towards self-sufficiency with ADL.	Record of assessment on file in client chart.
If a RCFCI cannot meet a client's needs a referral must be made to an appropriate health facility.	Documentation of client education on file in client chart.
Upon intake, facility staff must provide client with the following: • Information about the facility and its services • Policies and procedures • Confidentiality • Safety issues • House rules and activities • Client rights and responsibilities • Grievance procedures • Risk reduction practices. • Harm reduction. • Licit and illicit drug interactions • Medical complications of substance use hepatitis. • Important health and self-care practices information about referral agencies that are supportive of people living with HIV and AIDS.	Documentation of client education on file in client chart.

INDIVIDUAL SERVICE PLAN (ISP)

The RCFCI will ensure that there is an Individual Service Plan (ISP) for each client. A service plan must be developed for all clients prior to admission based upon the initial assessment. The plan will serve as the framework for the type and duration of services provided during the client's stay in the facility and should include the plan review and reevaluation schedule. RCFCI program staff will regularly observe each client for changes in physical, mental, emotional, and social functioning. The plan will be updated every three months or more frequently as the client's condition warrants. The plan will also document mechanisms to offer or refer clients to primary medical services and case management services. The ISP should be developed with the client and will include the following:

RCFCI INDIVIDUAL SERVICE PLAN (ISP)	
STANDARD	**MEASURE**
ISP will be completed prior to admission.	Needs and services plan on file in client chart.
The plan will include, but not be limited to: • Current health status • Current mental health status • Current functional limitations and abilities • Current medications • Medical treatment/therapy • Specific services needed. • Intermittent home health care required. • Agencies or persons assigned to carry out services. • "Do not resuscitate" order, if applicable • For each un-emancipated minor, the specific legal means of ensuring continuous care and custody when the parent or guardian is hospitalized, relocated, becomes unable to meet the child's needs, or dies	Needs and services plan on file in client chart.
Plans should be updated every three months or more frequently to document changes in a client's physical, mental, emotional, and social functioning.	Updated needs and services plan on file in client chart.
Clients must be reassessed on a quarterly basis to monitor and document changes in health status, progress toward treatment goals, and progress towards self-sufficiency with ADL.	Record of reassessment on file in client chart.
If a client's needs cannot be met by facility, the facility will assist in relocating the client to appropriate level of care.	Record of relocation activities on file in client chart.
The provider will ensure that the ISP for each client is developed by the ISP team. In addition to the RN case manager, the following persons will constitute the ISP team and will be involved in the development and updating of the client's ISP: • The client and/or his/her authorized	Record of ISP team on file in client chart.

representative • The client's physician • Facility house manager • Direct care personnel • Facility administrator/designee • Social worker/placement worker • Pharmacist, if needed • For each un-emancipated minor, the child's parent or guardian and the person who will assume legal custody and control of the child upon the hospitalization, incapacitation, or death of the parent or guardian. • Others, as deemed necessary	

MONTHLY CASE CONFERENCE

A monthly case conference will include review of the ISP, including the client's health and housing status, the need for and use of medical and other support services, and progress towards discharge, as appropriate. Attendees at the monthly case conference will include the client, the registered nurse, the case manager, and direct care staff representatives. Participants can include housing coordination staff and/or representatives from other community organizations, subject to the client's approval. The client may also invite the participation of an advocate, family member or other representative. The case conference must be documented and include outcomes, participants, and any specific steps necessary to obtain services and support for the client.

RCFCI MONTHLY CASE CONFERENCE	
STANDARD	**MEASURE**
All residents, registered nurse, case manager and direct care staff representatives will participate in monthly case conferences to review health and housing status, need for medical and supportive services and progress towards discharge.	Documentation of case conference on file in client chart including outcomes, participants, and necessary steps.

SERVICE AGREEMENTS

The provider will obtain and maintain writer agreements or contracts with the following:

RCFCI MONTHLY SERVICE AGREEMENTS	
STANDARD	**MEASURE**
Programs will obtain and maintain written agreements or contracts with: • A waste disposal company	Written agreements on file at provider agency.

registered by the California Department of Toxic Substance Control and the California Department of Public Health if generating or handling bio-hazardous waste. • A licensed home health care agency and individuals or agencies that will provide the following basic services: ○ Case management services ○ Counseling regarding HIV disease and AIDS, including current information on treatment of the illness and its possible effects on the resident's physical and mental health. ○ Counseling on death, dying, and the grieving process; psychosocial support services; substance misuse counseling. ○ Nutritionist services ○ Consultation on housing, health benefits, financial planning, and availability of other community- based and public resources, if these services are not provided by provider staff or the subcontracted home health agency personnel	

MEDICATION MANAGEMENT

Administration of medication will only be performed by an appropriate skilled professional.

RCFCI MEDICATION MANAGEMENT	
STANDARD	**MEASURE**
Direct staff will assist the resident with self-administration medications if the following conditions are met:	Record of conditions on file at provider agency.

• Have knowledge of medications and possible side effects; and • On-the-job training in the facility's medication practices as specified in Section 87865 (g) 4.	
The following will apply to medications which are centrally stored: • Medications must be kept in a locked place that is not accessible to persons other than employees who are responsible for the supervision of the centrally stored medications. • Keys used for medications must not be accessible to residents. • All medications must be labeled and maintained in compliance with label instructions and state and federal laws.	Record of conditions on file at provider agency.

SUPPORT SERVICES

Support services provided must include, but are not limited to:

RCFCI SUPPORT SERVICES	
STANDARD	**MEASURE**
Programs will provide or coordinate the following (at minimum): • Provision and oversight of personal and supportive services. • Health-related services • Transmission risk assessment and prevention counseling • Social services • Recreational activities • Meals • Housekeeping and laundry • Transportation • Provision and/or coordination of all services identified in the ISP. • Assistance with taking medication. • Central storing and/or distribution of medications • Arrangement of and assistance	Program policy and procedures to confirm. Record of services and referrals on file in client chart.

with medical and dental care • Maintenance of house rules for the protection of clients • Arrangement and managing of client schedules and activities. • Maintenance and/or management of client cash resources or property.	

EMERGENCY MEDICAL TREATMENT

Clients receiving RCFCI services who require emergency medical treatment for physical illness or injury will be transported to an appropriate medical facility. The provider will have written agreement(s) with a licensed medical facility or facilities within the community for provision of emergency services as appropriate.

RCFCI EMERGENCY MEDICAL TREATMENT	
STANDARD	**MEASURE**
Clients requiring emergency medical treatment will be transported to medical facility	Program review and monitoring to confirm.
Provider will have a written agreement(s) with a licensed medical facility or facilities within the community for provision of emergency services as appropriate.	Written agreement(s) on file at provider agency.

DISCHARGE PLANNING

Discharge planning should start at least 12 months prior to the end date of the client's term in the program. In all cases, a Discharge/Transfer Summary will be completed for all clients discharged from the agency. The Discharge Summary will be completed by the RN case manager or the social worker.

RCFCI DISCHARGE PLANNING	
STANDARD	**MEASURE**
Discharge planning services include, but are not limited to, RCFCIs providing discharge planning services to clients that include (at minimum): • Linkage to primary medical care, emergency assistance, supportive services, and early intervention services as appropriate • Linkage to supportive services that enhance retention in care (e.g., case	Discharge plan on file in client chart.

management, meals, nutritional support, and transportation) • Early intervention services to link HIV-positive people into care, including outreach, HIV counseling and testing and referral. • Housing such as permanent housing, independent housing, supportive housing, long-term assisted living, or other appropriate housing	
A Discharge/Transfer Summary will be completed for all clients discharged from the agency. The summary will include, but not be limited to: • Admission and discharge dates • Services provided. • Diagnosis(es) • Status upon discharge • Notification date of discharge • Reason for discharge • Transfer information, as applicable	Discharge/Transfer Summary on file in client chart.

PROGRAM RECORDS

Programs will maintain a separate, complete, and current record for each client in sufficient detail to permit an evaluation of services. These notations will be dated and include, but not limited to, type of service provided, client's response, if applicable, and signature and title of person providing the service.

RCFCI PROGRAM RECORDS	
STANDARD	**MEASURE**
Client records on file at provider agency that include (at minimum): • Client demographic data • Admission agreement • Names, addresses and telephone numbers of physician, case manager and other medical and mental health providers, if any • Names, addresses and telephone numbers of any person or agency responsible for the care of a client.	Programs will maintain sufficient records on each resident

• Medical assessment • Documentation of HIV/AIDS • Written certification that each family unit member free from active TB • Copy of current childcare contingency plan • Current ISP • Record of IST contacts • Documentation of all services provided. • Record of current medications • Physical and mental health observations and assessments	

LINKAGE TO MEDICAL CARE COORDINATION

Based on assessment and client needs, eligible individuals should be linked to Ryan White-funded Medical Care Coordination (MCC) service. MCC service providers must follow the Division on HIV and STD Programs MCC protocol. For MCC-specific service standards, click HERE.

TRANSITIONAL RESIDENTIAL CARE FACILITY (UP TO 24 MONTHS) GENERAL REQUIREMENTS

A Transitional Residential Care Facility (TRCF) provides short-term housing with ongoing supervision and assistance with independent living skills for people living with HIV who are homeless or unstably housed. TRCF are 24-hour alcohol-drug-free facilities that are secure and home-like. The goal of the TRCF program is to help clients be safely housed while they find a more permanent, stable housing situation. This service focuses on removing housing-related barriers that negatively impact a client's ability to access and/or maintain HIV care or treatment.

TRCFs must maintain a current, written, definitive plan of operation that includes (at minimum):

- Admission/discharge policies and procedures
- Admission/discharge agreements, including policies and procedures regarding drug and/or alcohol use on-site and off-site.
- Provide ample opportunity for family participate in activities in the facility.
- Include a safety plan to include precautions enacted to protect clients and staff (for those facilities that admit or specialize in care for clients who have a propensity for behaviors that result in harm to self or others)
- Adhere to basic facility safety requirements under Federal laws and State of California Health and Safety codes.

INTAKE

As part of the intake process, the client file will include the following information (at minimum):

TRCF INTAKE	
STANDARD	**DOCUMENTATION**
Intake process is begun as soon as possible upon acceptance.	Intake tool is completed and in client file.
Eligibility for services is determined	Client files include: • Proof of HIV diagnosis • Proof of income • Proof of residence in Los Angeles County • Proof client is not eligible for Housing Opportunities for People with AIDS (HOPWA) or other housing services. Ryan White is the payor of last resort.
Confidentiality Policy, Consent to Receive Services and Release of Information is discussed and completed. Release of Information (must be updated annually). New forms must be added for those individuals not listed on the existing Release of Information (specification should be made about what type of information can be released)	Release of Information signed and dated by client on file and updated annually.
Client is informed of Rights and Responsibility and Grievance Procedures	Signed and dated forms in client file.

ASSESSMENT

At minimum, each client will be assessed to identify strengths and gaps in his/ her support system to move toward permanent housing. Clients receiving TRCF services must be reassessed on a quarterly basis to monitor and document changes in health status, progress toward treatment goals, and progress towards self-sufficiency with independent living skills. TRCF clients will be expected to transition towards independent living or another type of residential service more suitable to their needs. Assessments will include the following:

TRCF ASSESSMENT	
STANDARD	**MEASURE**
Assessments will include the following: • Age	Signed, dated assessment on file in client chart.

• Health status • Family involvement • Family composition • Special housing needs • Level of independence • ADLs • Income • Public entitlements • Current engagement in medical care • Substance use • Mental health • Personal finance skills • History of evictions • Level of resources available to solve problems • Co-morbidity factors • For clients with substance use disorders, case managers must assess for eligibility and readiness for residential substance use treatment facilities. • Eligibility for Medical Care Coordination	
Clients receiving TRCF services must be reassessed on a quarterly basis to monitor and document changes in health status, progress toward treatment goals, and progress towards self-sufficiency with independent living skills.	Signed, dated assessment on file in client chart.
Staff will provide the client with information about the facility and its services, including policies and procedures, confidentiality, safety issues, house rules and activities, client rights and responsibilities, and grievance procedures.	Documentation of client education on file at provider agency.

INDIVIDUAL SERVICE PLAN (ISP)

Jointly with each cllient develop an Individualized Service Plan, complete with action steps to ensure linkage and retention in HIV medical care. Based upon the initial assessment, an Individual Service Plan (ISP) will be completed within one week of the client's admission. The ISP

will address the short-term and long-term housing needs of the client and identify resources for housing and referrals to appropriate medical and social services. Plans will also include specialized services needed to maintain the client in housing and access and adherence to primary medical care services. Documentation within the needs and services plan will include the identified goals, steps to achieve the goals, expected timeframe in which to complete the goals, and the disposition of each goal.

TRCF INDIVIDUAL SERVICE PLAN (ISP)	
STANDARD	**MEASURE**
ISP will be completed within one week of the client's admission.	ISP on file in client chart signed by client detailing all housing resources, medical, and social services referrals made.

LINKAGE TO MEDICAL CARE COORDINATION

Based on assessment and client needs, eligible individuals should be linked to Ryan White-funded Medical Care Coordination (MCC) services. MCC service providers must follow the Division of HIV and STD Programs MCC Protocol. For MCC-specific service standards, click HERE.

HOUSING SERVICE STANDARDS: EMERGENCY HOUSING ASSISTANCE

DRAFT

Last Approved by COH on 2/8/2018. For SBP Committee review as of 12/16/24.

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.

Description

Housing provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services).

Housing activities also include housing referrals services, including assessment, search placement, and housing advocacy services on behalf of the eligible client, as well as fees associated with these activities.

Program Guidance:

HRSA RWHAP recipients and subrecipients that use funds to provide Housing must have mechanisms in place to assess and document the housing status and housing service needs of new clients, and at least annually for existing clients.

HRSA RWHAP recipients and subrecipients, along with local decision-making planning bodies, are strongly encouraged to institute duration limits to housing activities. HRSA HAB recommends recipients and subrecipients align duration limits with those definitions used by other housing programs, such as those administered by the Department of Housing and Urban Development, which currently uses 24 months for transitional housing.

Housing activities cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments or rental deposits, although these may be allowable costs under the HUD Housing

RWHAP funding may be used to pay for a RWHAP client's security deposit if a RWHAP recipient or subrecipient has policies and procedures in place to ensure that the security deposit is returned to the RWHAP recipient or subrecipient and not to the RWHAP client. Opportunities for Persons with AIDS grant awards.
https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/hrsa-hab-security-deposit-program-letter.pdf

GENERAL ELIGIBILITY REQUIREMENTS

- Be diagnosed HIV or AIDS with verifiable documentation
- Have a state-recognized identification document
- Have an income at or below 500% of Federal Poverty Level
- Unstably housed, at-risk for homelessness, and homeless/unsheltered

EMERGENCY HOUSING ASSISTANCE

Emergency housing assistance may be provided through hotel/motel vouchers and placements in emergency shelters.

Short-term facilities provide temporary shelter to eligible individuals to prevent homelessness and allow an opportunity to develop an Individual Housing and Service Plan to guide beneficiary linkage to permanent housing. Hotel/motel vouchers and emergency shelters are available for a maximum of 60 days within any 6-month period. 24, CFR, Part 574.330 (a)). Agencies must provide meal vouchers and/or grocery gift cards to ensure that clients have access to food during their stay in motels/hotels or emergency shelters. Eligible clients may receive up to 3 meals per day.

CASE MANAGEMENT REQUIREMENTS

To access hotel/motel and meal vouchers, a client must be receiving case management services from a Ryan White-funded agency. Case management services will ensure that the client:

- Is engaged in care.
- Has a definitive housing plan that assesses their housing needs and assists them in obtaining longer term housing within the 60-day limit (residential substance abuse or mental health treatment program, residential care facility for the chronically ill, transitional housing or permanent housing).
- Is receiving supporting services that promote stabilization, including needs assessments, case management, mental health counseling and treatment, substance abuse counseling and treatment, benefits counseling, individual case planning, budget counseling,

assistance in locating and obtaining affordable housing and follow-up services.

- Case managers should attempt to secure other types of housing prior to exhausting a client's emergency voucher limit.
- Under extenuating circumstances, a client may receive more than 60 days of hotel/motel, emergency shelter, and meal vouchers under this program (e.g., a client is on a waiting list for a housing program with a designated move-in date that extends past the 60-day period). Such extensions are made on a case-by-case basis and must be carefully verified.

REQUIRED DOCUMENTATION

Case managers are responsible for working with the clients with to secure necessary documents such as:

- Client Intake Form - signed by both client and the case manager
- Case Management Housing Plan/Consent to Release Information - signed by client
- Rules and Regulations - reviewed by case manager and signed by both the case manager and the client
- Diagnosis Form
- Other documentation may be required by agencies in order to comply with funding agency requirements.
- Housing plan that describes specific action and target dates for securing additional services (as needed) and pathway to transitional and/or permanent housing.
- Self-attestation forms or documents already secured under other Ryan White -funded agencies may be used to avoid duplication and ease administrative burden on the client and service providers.

LINKAGE TO MEDICAL CARE COORDINATION

Based on assessment and client needs, eligible individuals should be linked to Ryan White-funded Medical Care Coordination (MCC) services. MCC service providers must follow the Division of HIV and STD Programs MCC Protocol. For MCC-specific service standards, click HERE.

HOUSING SERVICE STANDARDS: TRANSITIONAL HOUSING (Up to 24 months)

DRAFT

Last Approved by COH on 2/8/2018. For SBP Committee review as of 12/16/24.

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.

Description

Housing provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services).

Housing activities also include housing referrals services, including assessment, search placement, and housing advocacy services on behalf of the eligible client, as well as fees associated with these activities.

Program Guidance:

HRSA RWHAP recipients and subrecipients that use funds to provide Housing must have mechanisms in place to assess and document the housing status and housing service needs of new clients, and at least annually for existing clients.

HRSA RWHAP recipients and subrecipients, along with local decision-making planning bodies, are strongly encouraged to institute duration limits to housing activities. HRSA HAB recommends recipients and subrecipients align duration limits with those definitions used by other housing programs, such as those administered by the Department of Housing and Urban Development, which currently uses 24 months for transitional housing.

Housing activities cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments or rental deposits, although these may be allowable costs under the HUD Housing

RWHAP funding may be used to pay for a RWHAP client's security deposit if a RWHAP recipient or subrecipient has policies and procedures in place to ensure that the security deposit is returned to the RWHAP recipient or subrecipient and not to the RWHAP client. Opportunities for Persons with AIDS grant awards.
https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/hrsa-hab-security-deposit-program-letter.pdf

GENERAL ELIGIBILITY REQUIREMENTS

- Be diagnosed HIV or AIDS with verifiable documentation
- Have a state-recognized identification document
- Have an income at or below 500% of Federal Poverty Level
- Unstably housed, at-risk for homelessness, and homeless/unsheltered

TRANSITIONAL HOUSING (UP TO 24 MONTHS)

Transitional housing (TH) is designed to provide people living with HIV and their families who are homeless or unstably housed with the interim stability and support to successfully move to and maintain permanent housing. Transitional housing may be used to cover the costs of up to 24 months of housing with accompanying supportive services.

GENERAL REQUIREMENTS

Each transitional housing program (THP) must adhere to the following general requirements:

- Maintain a current, written, definitive plan of operation that includes (at minimum):
  - Admission/discharge policies and procedures
  - Admission/discharge agreements
  - Staffing plan, qualifications and duties
  - In-service education plan for staff
- Assist with transportation arrangements for clients who do not have independent arrangements
- Provide ample opportunity for family participation in activities in the facility
- Include a safety plan to include precautions enacted to protect clients and staff (for those facilities that admit or specialize in care for clients who have a propensity for behaviors that result in harm to self or others)
- Adhere to basic facility safety requirements under Federal laws and State of California Health and Safety Codes.

INTAKE

As part of the intake process, the client file will include the following information (at minimum):

TRANSITIONAL HOUSING INTAKE	
STANDARD	**DOCUMENTATION**
Intake process is begun as soon as possible upon acceptance.	Intake tool is completed and in client file.
Eligibility for services is determined	Client files include: • Proof of HIV diagnosis • Proof of income • Proof of residence in Los Angeles County • Proof client is not eligible for Housing Opportunities for People with AIDS (HOPWA) or other housing services. Ryan White is the payor of last resort.
Confidentiality Policy, Consent to Receive Services and Release of Information is discussed and completed. Release of Information (must be updated annually). New forms must be added for those individuals not listed on the existing Release of Information (specification should be made about what type of information can be released)	Release of Information signed and dated by client on file and updated annually.
Client is informed of Rights and Responsibility and Grievance Procedures	Signed and dated forms in client file.

ASSESSMENT

At minimum, each prospective client will be assessed to identify strengths and gaps in his/ her support system as a means to move toward permanent housing. Assessments will include the following:

TRANSITIONAL HOUSING ASSESSMENT	
STANDARD	**MEASURE**
Clients or representatives will be interviewed to complete eligibility determination, assessment and participant education.	Record of eligibility, assessment and education on file in client chart.
Assessments will include the following: • Age • Health status	Signed, dated assessment on file in client chart.

• Family involvement • Family composition • Special housing needs • Level of independence • ADLs • Income • Public entitlements • Current engagement in medical care • Substance use • Mental health • Personal finance skills • History of evictions • Level of resources available to solve problems • Co-morbidity factors • For clients with substance use disorders, case managers must assess for eligibility and readiness for residential substance use treatment facilities. • Eligibility for Medical Care Coordination	

HOUSING CASE MANAGEMENT WITH HOUSING PLAN

TRANSITIONAL HOUSING PLAN	
STANDARD	**DOCUMENTATION**
• Housing plan	• Housing plan that describes specific action and target dates for securing additional services (as needed) and pathway to stable and permanent housing. • The housing plan is reviewed with the client monthly to ensure that services and timeliness are met to achieve the ultimate goal of moving the client to stable and permanent housing. • Evidence of service referrals and completion of medical and supportive services for the client.

	• Evidence and dates of changes made to the housing plan.

OTHER REQUIRED DOCUMENTATION:

Case managers are responsible for working with the clients with to secure necessary documents such as:

- Client Intake Form - signed by both client and the case manager
- Case Management Housing Plan/Consent to Release Information - signed by client
- Rules and Regulations - reviewed by case manager and signed by both the case manager and the client
- Diagnosis Form
- Other documentation may be required by agencies in order to comply with funding agency requirements.
- Self-attestation forms or documents already secured under other Ryan White -funded agencies may be used to avoid duplication and ease administrative burden on the client and service providers.

LINKAGE TO MEDICAL CARE COORDINATION

Based on assessment and client needs, eligible individuals should be linked to Ryan White-funded Medical Care Coordination (MCC) services. MCC service providers must follow the Division of HIV and STD Programs MCC Protocol. For MCC-specific service standards, click HERE.

HOUSING SERVICE STANDARDS: FLEXILE HOUSING SUBSIDY POOL

DRAFT

Last Approved by COH on 2/8/2018. For SBP Committee review as of 12/16/24.

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.

Description

Housing provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services).

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https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/hrsa-hab-security-deposit-program-letter.pdf

GENERAL ELIGIBILITY REQUIREMENTS

- Be diagnosed HIV or AIDS with verifiable documentation
- Have a state-recognized identification document
- Have an income at or below 500% of Federal Poverty Level
- Unstably housed, at-risk for homelessness, and homeless/unsheltered

FLEXIBLE HOUSING SUBSIDY POOL

Ryan White funds may be used to leverage Los Angeles County's Housing for Health (HFH), Flexible Housing Subsidy Pool (FHSP) services. The Flexible Housing Subsidy Pool (FHSP) is a supportive housing rental subsidy program of the Los Angeles County Department of Health Services (DHS), along with other governmental partners and the Conrad N. Hilton foundation. The goal of the FHSP is to secure quality affordable housing for DHS patients who are homeless.

Each person is provided Intensive Case Management Services (ICMS) that ensure housing stability often starting with crisis intervention and referrals to mental and physical healthcare services. Equally important are services to ensuring housing retention, which start with building community and purpose by being present in people's lives for as long as they need the services. Services include eviction prevention, connection to disability benefits, retaining rental subsidies, assistance with life skills, job skills, and volunteer, educational and vocational opportunities.

FHSP services using Ryan White funds must adhere to HRSA and Ryan White CARE Act regulations and federal requirements. Agencies must adhere to DHS HFH service standards, the Commission on HIV Universal Standards, and the Division of HIV and STD Programs (DHSP) programmatic and time limits requirements if using Ryan White funds to enroll eligible clients in HFH FHSP Program.

LINKAGE TO MEDICAL CARE COORDINATION

Based on assessment and client needs, eligible individuals should be linked to Ryan White-funded Medical Care Coordination (MCC) services. MCC service providers must follow the Division of HIV and STD Programs MCC Protocol. For MCC-specific service standards, click HERE.

Ryan White Program Year 32
Care Utilization Data Summary

Part 3 – Housing, Emergency Financial Assistance, Nutrition Support

Oct 17, 2023
COH Planning, Priorities, and Allocations Committee

Sona Oksuzyan, PhD, MD, MPH
Division of HIV and STD Programs

HOUSING, EMERGENCY FINANCIAL ASSISTANCE AND NUTRITION SERVICES

BACKGROUND

As a Ryan White Program (RWP) Part A recipient, the Division of HIV and STD Programs (DHSP) at the Los Angeles County (LAC) Department of Public Health receives grant funds from the Health Resources and Services Administration HIV/AIDS Bureau (HRSA-HAB) to increase access to core medical and related support services for people living with HIV (PLWH)[1]. The amount of the award is based on the number of PLWH residing in LAC. DHSP receives additional funding from HRSA-HAB to reduce disparities in health outcomes among persons of color living with HIV through the Minority AIDS Initiative (MAI) and discretionary funds from the LAC Department of Public Health (net county costs [NCC]). DHSP received a total of $45.9 million from HRSA-HAB in fiscal year 2022 that included $42.1 million for Part A and $3.8 million for MAI.

HRSA-HAB and the Centers for Disease Control and Prevention (CDC) require that local HIV planning bodies develop integrated HIV prevention plans in collaboration with the health department to guide prevention and care efforts within the jurisdiction[2]. HIV surveillance and supplemental surveillance along with program service data and unmet need estimates are used to identify priority populations of focus. In LAC, the populations of focus overlap with priority populations identified in the local "Ending the HIV Epidemic" strategic plan and shown in bold[3]. These include:

1. **Latino Cisgender Men Who Have Sex with Men (MSM)**
2. **Black Cisgender MSM**
3. **Cisgender Women of Color**
4. **Transgender Persons**
5. **Youth Aged 13-29**
6. PLWH ≥ Age 50
7. **Persons Who Inject Drugs (PWID)**
8. RWP Clients Who Were Unhoused

Though not identified as priority populations in the integrated or Ending the HIV Epidemic (EHE) plans, we include RWP clients 50 years of age and older and those experiencing homelessness as an important subpopulation living with HIV with need for RWP services in LAC.

[1] Ryan White HIV/AIDS Programs Parts & Initiatives. (2022). In ryanwhite.hrsa.gov. Retrieved July 20, 2023 from https://ryanwhite.hrsa.gov/about/parts-and-initiatives
[2] Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need, CY 2022-2026.(2021). In ryanwhite.hrsa.gov. Retrieved July 20, 2023 from https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/integrated-hiv-dear-college-6-30-21.pdf
[3] Ending the HIV Epidemic Plan for Los Angeles. (2021). In lacounty.hiv. Retrieved July 19, 2023, from https://www.lacounty.hiv/wp-content/uploads/2021/04/EHE-Plan-Final-2021.pdf

Ryan White Program Service Utilization Report, Contract Year 32 (March 1, 2022-February 28, 2023)

This report series summarizes utilization of medical and support services by RWP clients in Contract Year 32 (March 1, 2022-February 28, 2023) to inform the planning and allocation activities of the LAC Commission on HIV (COH). To inform focused discussion, we will present services in the following service clusters:

1. Ambulatory Outpatient Medical (AOM) and Medical Care Coordination (MCC) services
2. Mental Health and Substance Abuse (Residential) services
3. **Housing, Emergency Financial Assistance (EFA), and Nutrition Support (NS) services**
4. General and Specialty Oral Health services
5. Case Management (CM) Services: Benefits Specialty, Transitional CM- Jails, Home-Based CM and the Linkage and Re-Engagement (LRP)

The data presented is intended to provide priority highlights of who is accessing RWP services in LAC (demographic and socio-economic characteristics, priority populations), the types of services accessed, funding sources, and how these services are delivered (in-person or telehealth). The detailed source tables are included in the appendix for reference.

Outcomes and Indicators

The following information will be used to describe service utilization and estimate expenditures. Each of the five service clusters will include:

- HIV Care Continuum Outcomes (engagement in care, retention in care (RiC) and viral suppression (VS) among priority populations:
  - Engagement in HIV care =≤1 viral load or CD4 test in the contract year
  - Retention in HIV care =≤2 viral load or CD4 tests at least 90 days apart in the contract year
  - Viral suppression =Most recent viral load test <200 copies/mL in the contract year
- RWP service utilization and expenditure indicators by service category:
  - Total service units=Number of service units paid for by DHSP in the reporting period. *Service units vary by service category and may include visits, hours, procedures, days, or sessions*
  - Service units per client=Total service units/Number of clients
  - Total Expenditure= Total dollar amount paid by DHSP in the reporting period
  - Expenditures per Client= Total Expenditure/Number of clients

DATA SOURCES

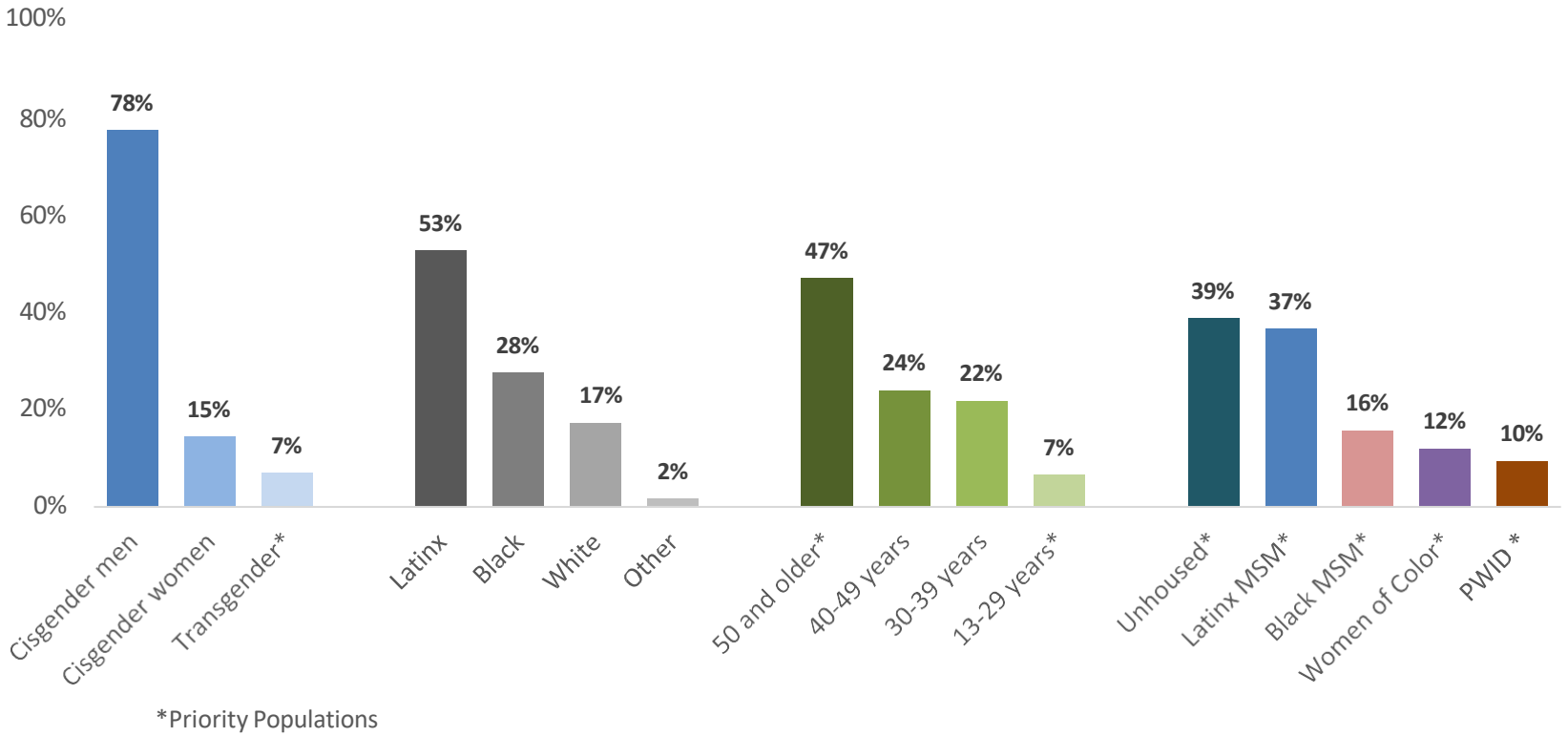
- HIV Casewatch (local RWP data reporting system)
  - Client characteristics and service utilization data reported by RWP contracted service agencies
  - Data are manually entered or submitted through electronic data transfer
- Linkage Re-engagement Program (ACCESS Database)
- eHARS (HIV surveillance data system)
- DHSP Expenditure Reports

HOUSING SERVICES

Population Served:

- In Year 32, a total of 241 clients received Housing Services in Year 32. In LAC this category includes:
  - Permanent Supportive Housing, also known as Housing for Health [H4H], that served 157 clients
  - Residential Care Facilities for Chronically Ill (RCFCI) that served 54 clients
  - Transitional Residential Care Facilities (TRCF) that served 31 clients
- Most Housing Services clients were cisgender men, Latinx, and aged 50 and older (Figure 1)
- Among the priority populations, the largest percent served were PLWH ≥ age 50, followed by unhoused people and Latinx MSM
- Unhoused status includes those clients who reported experiencing homelessness at their most recent intake during the contract year but may not necessarily reflect their housing status at the time they received the service).

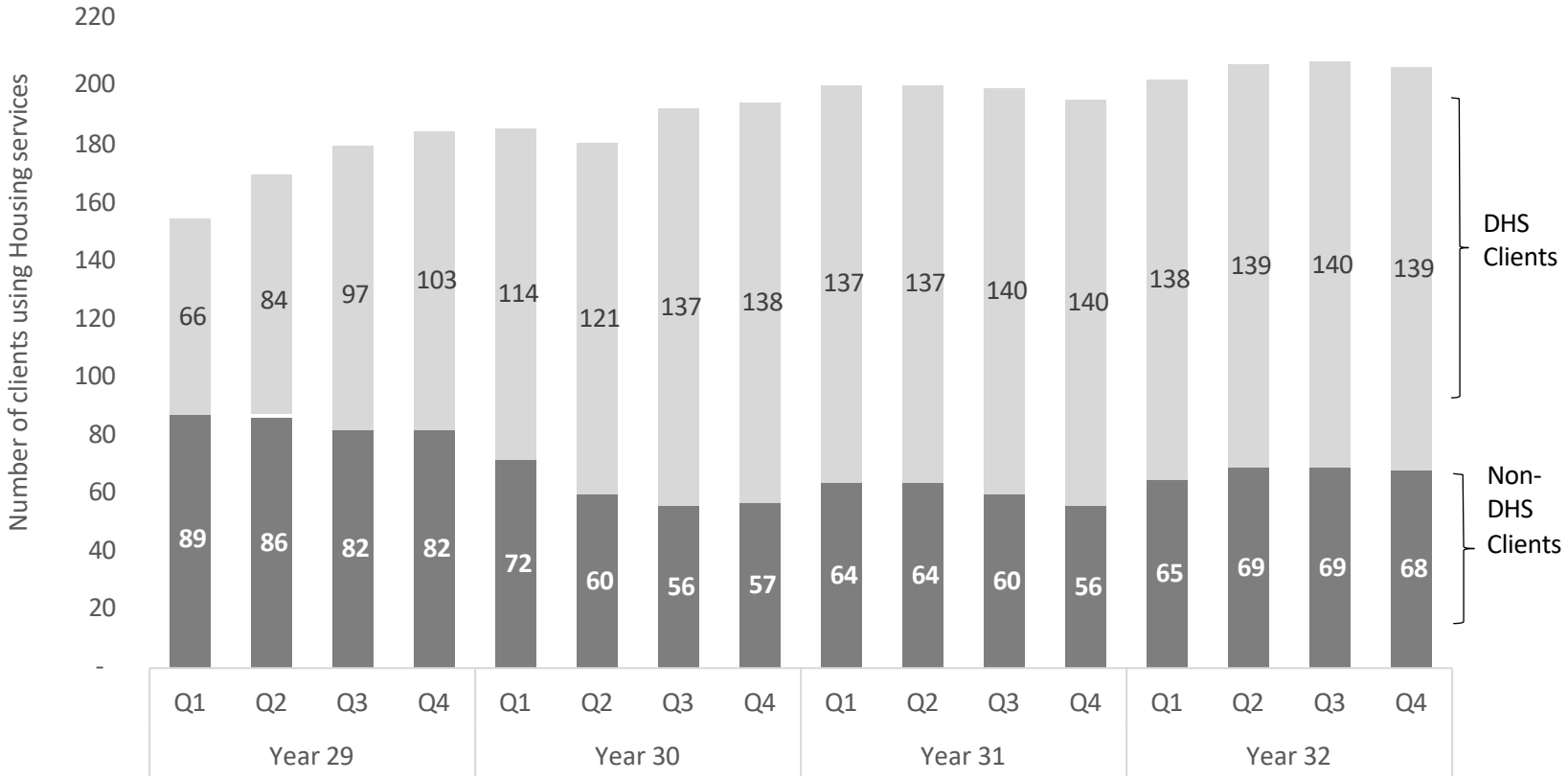
Figure 1. Key Characteristics of RWP Clients in Housing Services in LAC, Year 32



Service Utilization

Figure 2 below shows the number of RWP clients accessing Housing services from Year 29 through Year 32 by quarter. While DHS discontinued providing Ambulatory Outpatient Medical, Medical Care Coordination and Mental Health Service in Year 31, they continue to provide Housing and EFA services. The light grey part of the bar shows the number of DHS clients. The darker grey part of the bar shows the number of all other (non-DHS) clients. The total number of Housing clients increased over time including during the COVID-19 pandemic in Year 30. During this time, the number of Housing clients at DHS sites increased while the number clients served at non-DHS sites gradually decreased. All Housing services were provided in-person.

Figure 2. Department of Health Services (DHS) and Non-DHS Housing Clients by Quarter in LAC, RWP Years 29-32



Ryan White Program Service Utilization Report, Contract Year 32 (March 1, 2022-February 28, 2023)

Service Units and Expenditures

- Year 32 Funding Sources: **RWP Part A (5%), Part B (54%), MAI (41%)**
- Percentage of RWP Clients Accessing Housing services in Year 32: **1.6%**
- Unit of Service: **Days**

Table 1. Housing Service Utilization and Expenditures among RWP Clients in LAC, Year 32

Priority Populations	Clients	% of Clients	Total days	% of days	Days per Client	Estimated Expenditures per Client	Estimated Expenditures by Subpopulation
Total Housing clients	***241***	***100%***	***70,157***	***100%***	***291***	***$33,054***	***$7,965,955***
H4H	*157*	*65%*	*48,577*	*69%*	*309*	*$13,625*	*$3,283,615 (MAI)*
RCFCI	*54*	*22%*	*15,354*	*22%*	*284*	*$55,086*	*$418,179 (Part A) + $4,264,161 (Part B)*
TRCF	*31*	*13%*	*6,226*	*9%*	*201*		*Total $4,682,340*
PLWH ≥ age 50	114	**47%**	**34,895**	**50%**	**306**	**$34,938**	**$3,982,978**
Unhoused in the contract year	94	**39%**	**24,889**	**35%**	265	$29,660	**$2,788,084**
Latinx MSM	89	**37%**	**24,697**	**35%**	277	$31,327	**$2,788,084**
Black MSM	38	16%	11,926	17%	**314**	**$35,637**	$1,354,212
Women of Color	29	12%	9,095	13%	**314**	**$35,709**	$1,035,574
Persons who inject drugs (PWID)	23	10%	5,990	9%	260	$31,171	$716,936
Transgender Persons	17	7%	5,181	7%	305	$32,801	$557,617
Youth aged 13-29	16	7%	**4,054**	6%	**253**	$29,872	$477,957

Table 1 Highlights

- *Population Served:* The largest number and percent of HS clients were PLWH ≥ age 50 (47%), followed by clients who were unhoused in the contract year (39%) and Latinx MSM (37%).
- *Service Utilization:*
  - PLWH ≥ age 50 had received half of HS days.
  - Utilization of days per client was the highest among Black MSM and women of color (314 days/client each), followed by clients ≥ age 50 (306 days/client) compared to all clients overall and other subpopulations.
  - While days per client were the lowest among youth aged 13-29 clients (253 days/client), they also represented the smallest numbers of HS clients.

  - The percent of HS in days was slightly higher relative to their population size among clients ≥ age 50 (47% vs 50%).
  - The percent of HS in days was slightly lower relative to their population size among Latinx MSM (37% vs 35%).
- *Expenditures:*
  - Expenditure per client were highest among Black MSM and women of color, although those subpopulations did not represent the highest percentage of HS clients.
  - Expenditures per client were the lowest among clients who were unhoused in the contract year despite being the second largest subpopulation served by HS (39%).

HIV Care Continuum (HCC) Outcomes

Table 2 below shows HCC outcomes for RWP clients receiving HS in Year 32. Housing clients had slightly higher engagement in care and retention in care compared to RWP clients who did not accessing HS. There was no difference in viral suppression between HS and non-HS clients.

Table 2. HIV Care Continuum Outcomes for RWP Clients That Used and Did Not Use Housing services (HS) in LAC, Year 32

HCC Measures	HS clients		Non-HS clients	
	N=241	%	N=14,531	%
Engaged in HIV Care [a]	230	95%	13,616	94%
Retained in HIV Care[b]	187	78%	10,194	70%
Suppressed Viral Load at Recent Test[c]	199	83%	12,078	83%

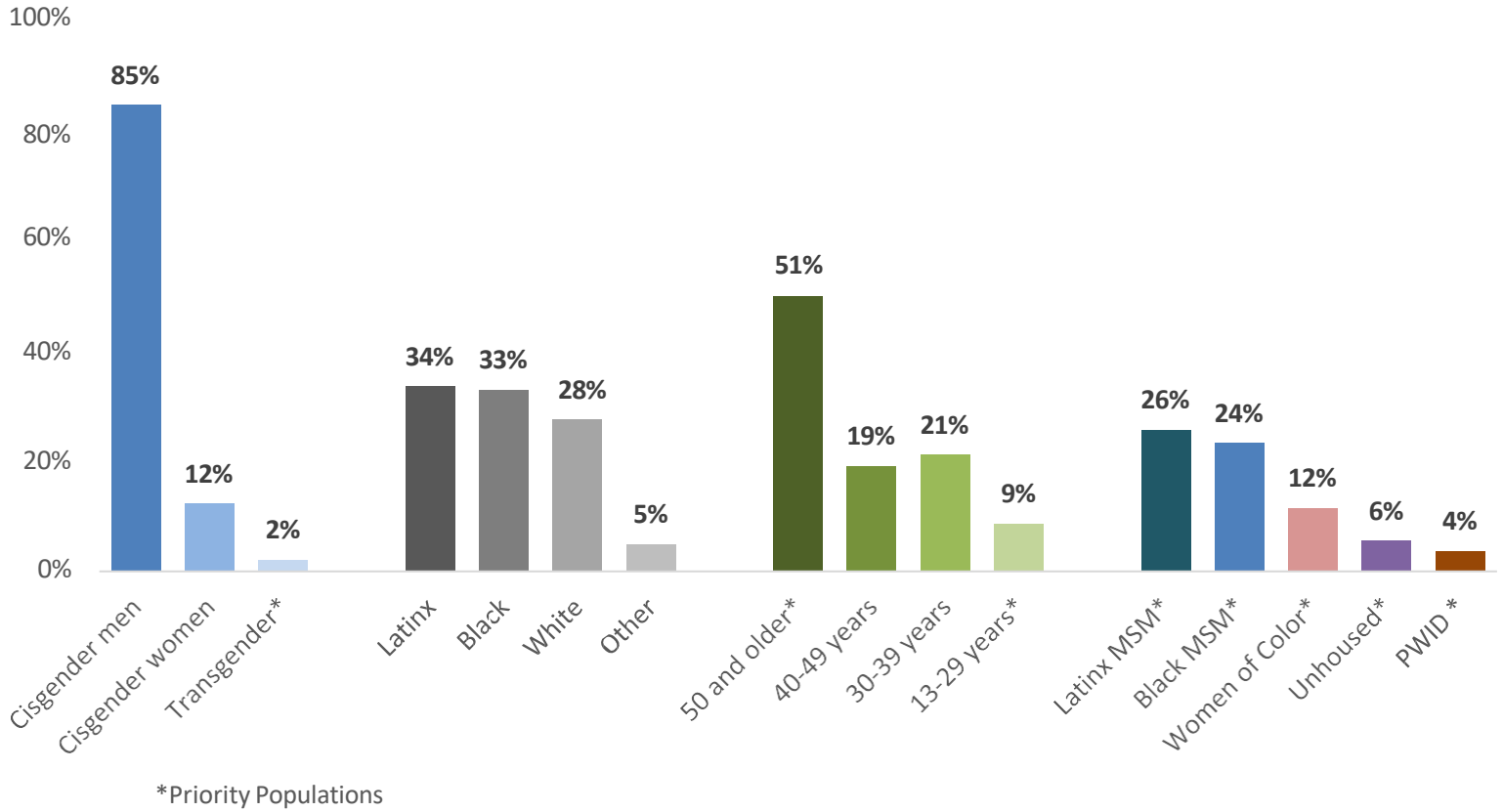
[a]Defined as having ≥1 HIV laboratory test (viral load, CD4 or genotype test) reported in the 12 months before the end of the reporting period
[b]Defined as having ≥2 HIV laboratory tests (viral load, CD4 or genotype test) reported at >90 days apart in the 12 months before the end of the reporting period
[c]Defined as viral load <200 copies/ml at most recent test reported in the 12 months before the end of the reporting period

EMERGENCY FINANCIAL ASSISTANCE (EFA) SERVICES

Population Served:

- In Year 32, a total of 378 clients received EFA that includes three types of service:
  - Food Assistance provided to 30 clients
  - Rental Assistance provided to 283 clients
  - Utility Assistance provided to 162 clients
- Most EFA clients were cisgender men, Latinx and Black, and aged 50 and older (Figure 3)
- PLWH ≥ age 50 represented the largest percent among priority populations (51%), followed by Latinx MSM (26%) and Black MSM (24%).

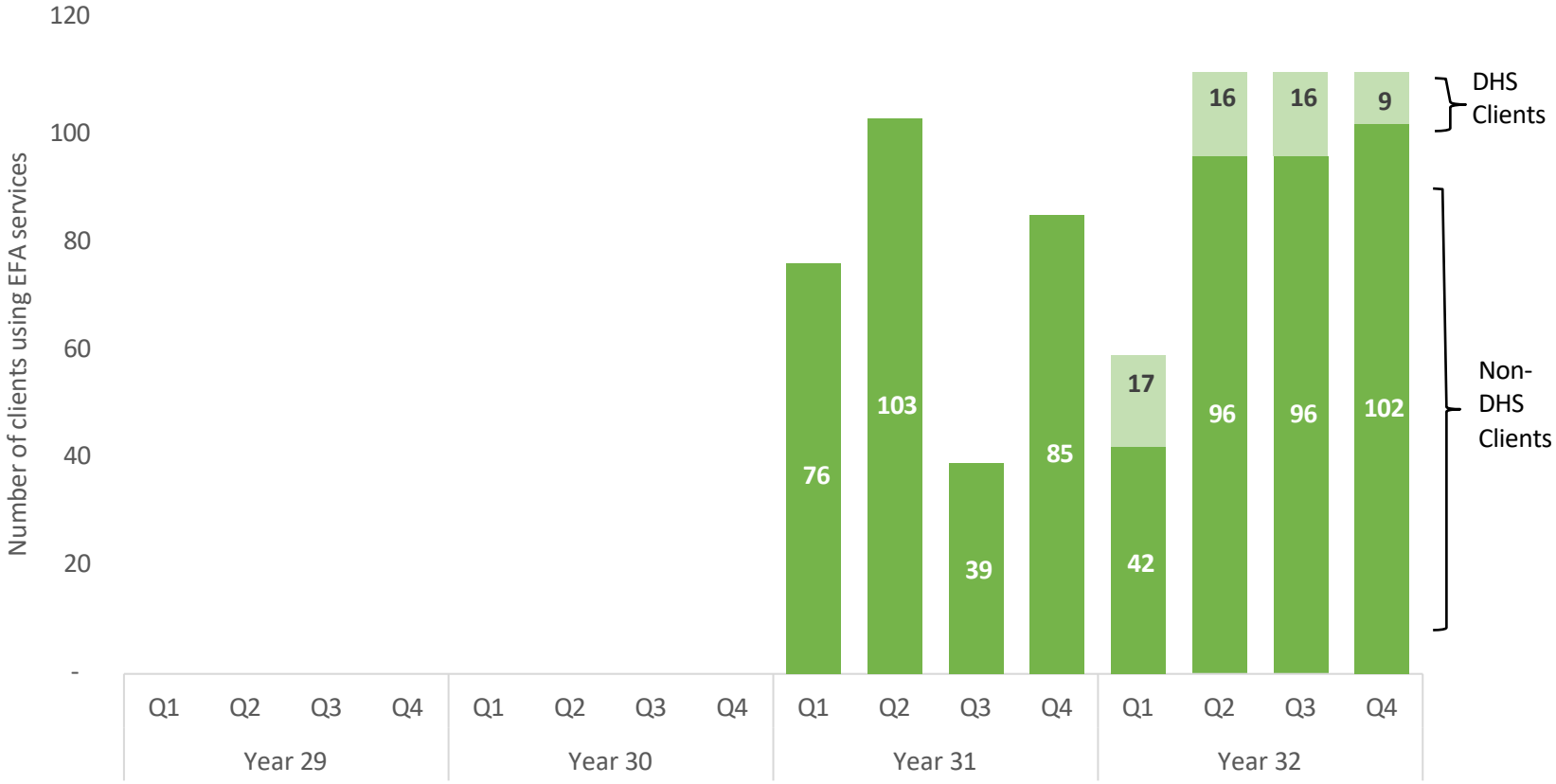
Figure 3. Demographic Characteristics and Priority Populations among EFA Clients in LAC, Year 32



Service Utilization

The figure below presents the number of clients using EFA since it launched in Year 31 at both DHS and non-DHS sites. All EFA services were delivered in-person. The light green part of the bar shows the number of DHS clients. The darker green part of the bar shows the number of all other (non-DHS) clients. The number of clients accessing EFA services increased from Year 31 to Year 32, particularly among clients accessing services at non-DHS sites.

Figure 4. Department of Health Services (DHS) and Non-DHS EFA Clients by Quarter in LAC, RWP Years 29-32



Service Units and Expenditures

- Year 32 Funding Sources: **RWP Part A (100%)**
- Percentage of RWP Clients Accessing EFA in Year 32: **3%**
- Unit of Service: **Dollars**

Table 3. EFA Service Utilization and Expenditures among RWP Clients in LAC, Year 32

Priority Populations	Clients	% of Clients	Total dollars	% of dollars	Dollars per Client	Estimated Expenditures per Client	Estimated Expenditures by Subpopulation
Total EFA clients	***378***	***100%***	***1,210,558***	***100%***	***$3,203***	***$4,607***	***$1,741,442 (Part A)***
Food	*30*	*8%*	*8,035*	*1%*	*$268*	*$385*	*$11,559*
Rental Assistance	*283*	*75%*	*1,049,839*	*87%*	*$3,710*	*$5,337*	*$1,510,241*
Utilities	*162*	*43%*	*152,684*	*13%*	*$942*	*$1,356*	*$219,643*
PLWH ≥ age 50	191	**51%**	548,067	**45%**	$2,869	$4,128	*$788,418*
Latinx MSM	98	26%	313,970	26%	$3,204	$4,609	*$451,660*
Black MSM	89	24%	293,026	24%	**$3,292**	**$4,736**	*$421,531*
Women of Color	44	**12%**	112,680	**9%**	**$2,561**	**$3,684**	*$162,095*
Youth aged 13-29	33	9%	113,597	9%	**$3,442**	**$4,952**	*$163,415*
Unhoused in the contract year	21	6%	55,570	5%	$2,646	$3,807	*$79,941*
Persons who inject drugs (PWID)	14	4%	38,819	3%	$2,773	$3,989	*$55,843*
Transgender Persons	8	2%	22,370	2%	$2,796	$4,023	*$32,180*

Table 3 Highlights

- *Population Served:* PLWH ≥ age 50 (51%) made up half of all EFA clients, followed by Latinx MSM (26%) and Black MSM (24%) in Year 32
- *Service Utilization:*
  - Service units (dollars) per client were the highest among youth aged 13-29 and Black MSM compared to total EFA clients and other subpopulations. Per client utilization was lowest among women of color and clients who were unhoused in the contract year.
  - The percent of EFA units (dollars) was lower relative to the population size of PLWH ≥ age 50, women of color, clients who were unhoused in the contract year, and PWID.
- *Expenditures:*
  - Per client expenditures were highest for youth aged 13-29 ($4,952), followed by Black MSM ($4,736).
  - Women of color had the lowest expenditures per client ($3,684).

HIV Care Continuum (HCC) Outcomes

Table 4 below compares HCC outcomes for RWP clients who did and did not access EFA in Year 32. A larger percent of clients in EFA were engaged in care, retained in care, and achieved viral suppression compared to those clients not using EFA.

Table 4. HIV Care Continuum Outcomes for RWP Clients That Used and Did Not Use EFA Services in LAC, Year 32

HCC Measures	EFA clients		Non-EFA clients	
	N=378	Percent	N=14,394	Percent
Engaged in HIV Care[a]	368	97%	13,478	94%
Retained in HIV Care[b]	297	79%	10,084	70%
Suppressed Viral Load at Recent Test [c]	333	88%	11,944	83%

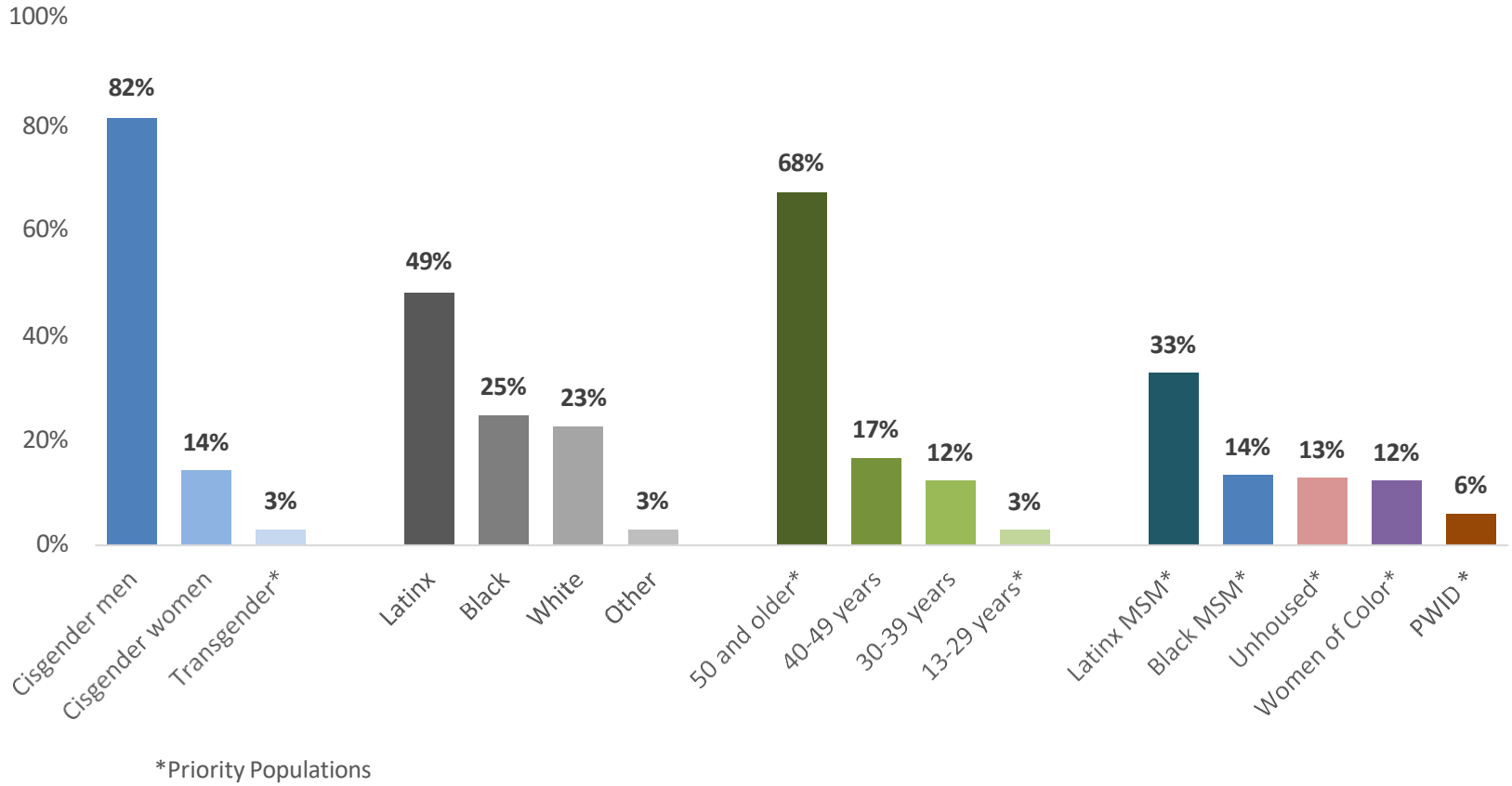
[a]Defined as having ≥1 HIV laboratory test (viral load, CD4 or genotype test) reported in the 12 months before the end of the reporting period
[b]Defined as having ≥2 HIV laboratory tests (viral load, CD4 or genotype test) reported at >90 days apart in the 12 months before the end of the reporting period
[c]Defined as viral load <200 copies/ml at most recent test reported in the 12 months before the end of the reporting period

NUTRITION SUPPORT SERVICES

Population Served:

- In Year 32, a total of 2,117 clients received Nutrition Support (NS) services that include:
  - A total of 541 who received Delivered Meals
  - A total of 1,724 who accessed the Food Bank
- Most NS clients were cisgender men, Latinx and Black, and PLWH ≥ age 50 (Figure 5).
- PLWH ≥ age 50 represented the largest percent among priority populations (68%), followed by Latinx MSM (33%).

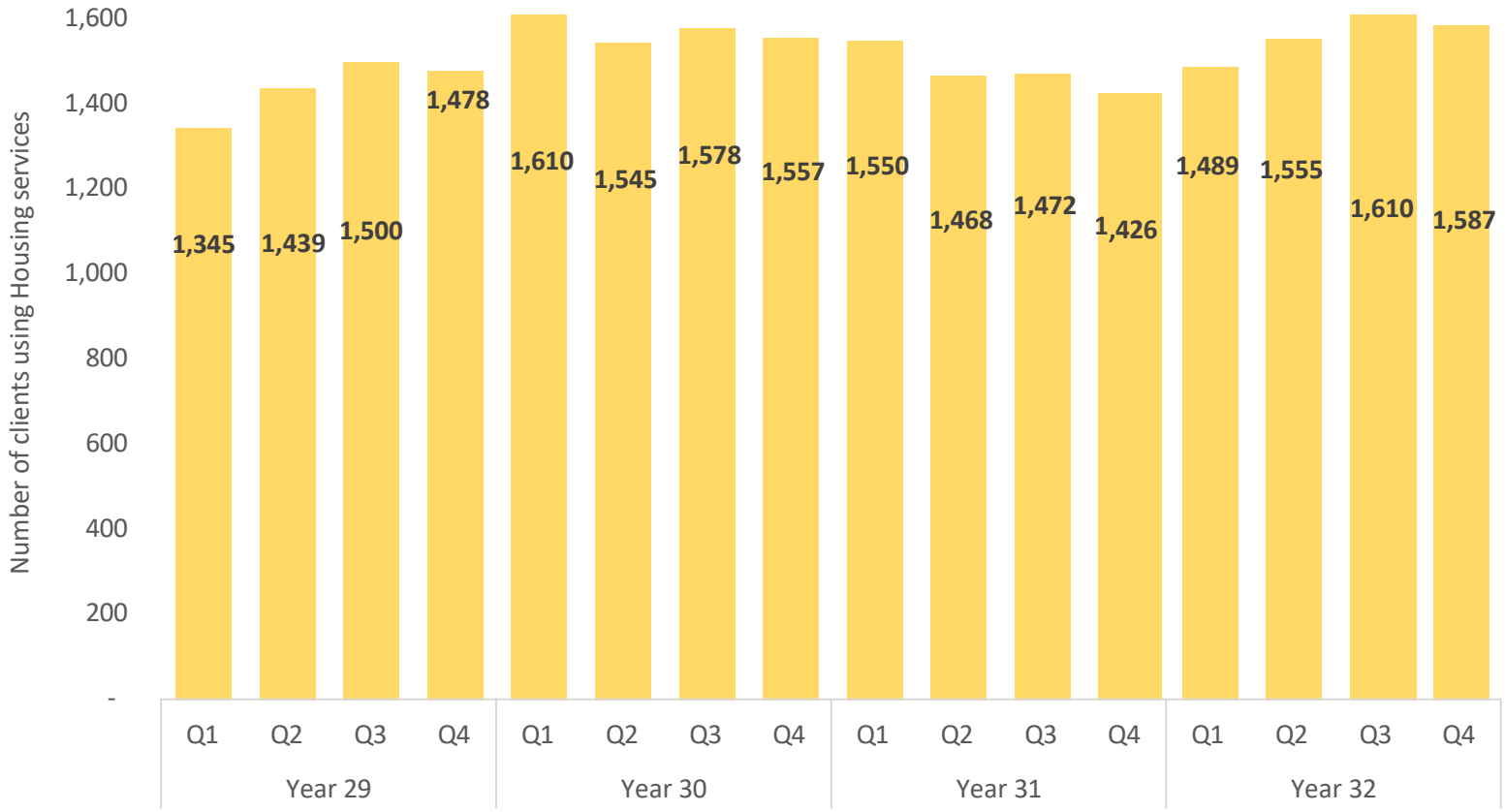
Figure 5. Demographic Characteristics and Priority Populations among Nutrition Service Clients in LAC, Year 32



Service Utilization

All NS services must be accessed in-person. As shown below in Figure 6, the number of NS clients has increased from Year 29 to Year 32.

Figure 6. RWP Clients Accessing Nutrition Services (NS) by Quarter in LAC, RWP Years 29-32



Service Units and Expenditures

- Year 32 Funding Sources: **RWP Part A (100%)**
- Percentage of RWP Clients Accessing NS services in Year 32: **14%**
- Unit of Service: **Meals** and **Bags of groceries**

Table 5. Nutrition Service Utilization and Expenditures among RWP Clients in LAC, Year 32

Priority Populations	Clients	% of Clients	Total Units	% of Total Units	Units per Client	Estimated Expenditures per Client	Estimated Expenditures by Subpopulation
*Total Nutrition Support clients**	***2,117***	***100%***	***450,679***	***100%***	***213***	***$1,767***	***$3,740,480***
Delivered Meals	*541*	*26%*	*286,984*	*64%*	*530 meals*	*$4,403*	*$2,381,868*
Food Bank	*1,724*	*81%*	*163,695*	*36%*	*95 bags*	*$788*	*$1,358,612*
PLWH ≥ age 50	1,436	**68%**	358,676	**80%**	**250**	***$2,073***	*$2,976,887*
Latinx MSM	701	33%	140,577	31%	201	*$1,664*	*$1,166,741*
Black MSM	286	14%	52,063	12%	182	*$1,511*	*$432,105*
Unhoused in the contract year	273	**13%**	30,582	**7%**	112	***$930***	*$253,820*
Women of Color	262	12%	58,014	13%	221	*$1,838*	*$481,496*
Persons who inject drugs (PWID)	128	6%	29,379	7%	**230**	***$1,905***	*$243,836*
Transgender Persons	73	3%	13,265	3%	182	*$1,508*	*$110,095*
Youth aged 13-29	62	**3%**	3,222	**1%**	**52**	***$431***	*$26,741*

*Clients used an average of 1.5 meals per day and 1.8 bags of groceries per week in Year 32.

Table 5 Highlights

- *Population Served:* PLWH ≥ age 50 (68%) made up most of NS clients, followed by Latinx MSM (33%) in Year 32.
- *Service Utilization:*
  - Meals/bags per client were the highest among PLWH ≥ age 50 and PWID compared to total NS clients and other subpopulations.
  - Meals/grocery bags per client were lowest among youth aged 13-29.
  - Clients ≥ age 50 represented 68% of clients but used 80% of total NS units demonstrating higher utilization than other subpopulations.
  - Clients who were unhoused in the contract year represented 13% of NS clients but only used 7% of total NS units, suggesting lower access to need.
- *Expenditures:*
  - PLWH ≥ age 50 had the highest expenditures per client, followed by PWID, and is consistent with their higher per client utilization.
  - Youth aged 13-29 represented the smallest number of NS client and had the lowest expenditures per client ($431). Per client expenditures were also low among clients who were unhoused in the contract year ($930) as service units were low relative to population size.

HIV Care Continuum (HCC) Outcomes

Table 6 below compares HCC outcomes for RWP clients who did and did not use NS services in Year 32. A larger percent of clients in NS services were engaged in care, retained in care, and achieved viral suppression compared to those clients not using NS services.

Table 6. HIV Care Continuum Outcomes for RWP Clients That Used and Did Not Use Nutrition Support Services in LAC, Year 32

HCC Measures	NS clients		Non-NS clients	
	N=2,117	Percent	N=12,655	Percent
Engaged in HIV Care[a]	2,018	95%	11,828	93%
Retained in HIV Care[b]	1,681	79%	8,700	69%
Suppressed Viral Load at Recent Test [c]	1,793	85%	10,484	83%

[a]Defined as having ≥1 HIV laboratory test (viral load, CD4 or genotype test) reported in the 12 months before the end of the reporting period
[b]Defined as having ≥2 HIV laboratory tests (viral load, CD4 or genotype test) reported at >90 days apart in the 12 months before the end of the reporting period
[c]Defined as viral load <200 copies/ml at most recent test reported in the 12 months before the end of the reporting period

Overlap of Services Provided

RWP service categories may not mutually exclusive; there can be overlap in clients accessing these services during the contract year. To explore the degree of overlap across HS, EFA and NS services in Year 32, we constructed the cross tabulation shown below in Table 7. The data should be read across from left to right. We can see among EFA clients, approximately 28% also accessed NS but very few accessed HS. Among those clients in HS, nearly one-third (32%) also accessed NS but few accessed EFA. Finally, among NS clients we see the least overlap with few accessing EFA or HS.

Table 7. Cross tabulation of RWP Clients Received Emergency Financial Assistance, Housing and Nutrition Support Services in LAC, Year 32

Count (%)	Emergency Financial Assistance	Housing Services	Nutrition Support
Emergency Financial Assistance	*378*	4 (1%)	105 (28%)
Housing Services	4 (2%)	*241*	76 (32%)
Nutrition Support	105 (5%)	76 (4%)	*2,117*

SUMMARY OF FINDINGS

Service use and expenditures vary by service category and by priority populations. This variation may be influenced by the priority population size, underlying characteristics within each priority and priority population such as health status, income, housing status or neighborhood of residence, service need or service access and others. The main findings are summarized in Table 8.

Table 8. Summary of Findings for RWP Service Utilization in LAC, Year 32

	RWP	Housing Service (Permanent Supportive Housing (H4H), RCFCI, TRCF)	Emergency Financial Assistance (Food, Rental Assistance, Utilities)	Nutrition Support (Delivered Meals, Food Bank)
Main population served	• Latinx and Black race/ethnicity • Cisgender male • PLWH ≥ age 50 • MSM	• Latinx race/ethnicity • Cisgender male • PLWH ≥ age 50 • MSM	• Latinx race/ethnicity • Cisgender male • PLWH ≥ age 50 • MSM	• Latinx race/ethnicity • Cisgender male • PLWH age 30-39 • MSM
Utilization over time	• Total number of clients decreased in Year 32 due to AOM, MCC, and MH services stopping at DHS sites • However, number of clients at remaining agencies was steady	• Service still provided by DHS • Increase in total clients, largely from DHS sites	• Service still provided at DHS • Increase in total clients from Year 31 to 32 primarily from non-DHS sites	• Steady decrease in number of clients since Year 29
Service units per client	N/A (units vary)	• Days	• Dollars	• Meals • Bags of grocery
Total expenditures	$45.9 million	• $7,965,955 (Part A, B, MAI) • $33,054 per client	• 1,741,442 (part A) • $4,607 per client	• 3,740,480 (Part A) • $ 1,767 per client
HCC outcomes	• HCC outcomes were higher among RWP clients compared to PLWH in LAC	• Engagement and RiC were higher among HS clients compared to non-HS clients but no difference in VS	• HCC outcomes were higher among EFA clients compared to clients not accessing EFA	• HCC outcomes were higher among NS clients compared to clients not accessing NS

Ryan White Program Service Utilization Report, Contract Year 32 (March 1, 2022-February 28, 2023)

	RWP	Housing Services	EFA	Nutrition Support
Latinx MSM	• Largest RWP population (52%) • Largest percentage of uninsured clients	• Third largest priority population (37%) and accounted for about 35% of services provided • Expenditure per client slightly lower than the overall average	• Second largest priority population (26%) and accounted for 26% of services provided • Expenditure per client similar to the overall average	• Second largest priority population (33%) and accounted for 31% of NS provided • Expenditure and average units per client were lower than overall average for all NS clients
Black MSM	• About 4% of RWP clients • Over 2/3 living ≤ FPL	• Represented 16% of HS clients and 17% of services provided • Highest number of days per client and second highest per client expenditures	• Represented 24% of EFA clients and of services provided • Second highest number per client service units (dollars) and expenditures	• Represented 14% t of NS clients and 12% of services provided • Per client number of meals, bags and expenditures were lower than those overall averages
Youth 13-29 years old	• 12% of RWP clients • The lowest percentage of RiC among priority populations	• Smallest population by number and percent of clients (7%) • Lowest per client number of days and expenditures	• Represented 9% of EFA clients and services provided • Highest utilizers of EFA services, by service units and expenditures per client	• Smallest percent of clients (3%) & services provided (1%) • The lowest per client number of meal/bags and expenditures
Women of color	• 8% of RWP clients • The highest percentage of engagement in care and the second highest percentage of RiC among priority populations	• Represented 12% t of HS clients and 13% of services provided • Highest per client number of days and expenditures	• Represented 12% of EFA clients and 9% of services provided • Lowest per client service units (dollars) and expenditures	• Represented 12% of NS clients and 13% NS services provided • Third highest per client number of meals/bags and expenditures
PLWD ≥ age 50	• Over a third of RWP clients • The highest percentage of RiC and VS and the 2nd highest percentage of engagement among priority populations • The highest percentage of people living ≤ FPL and PWID • Second highest percentage of uninsured and unhoused	• Highest utilizers of HS, by percent of clients (47%) and services provided (50%) • Second highest per client use by service days. • Third highest overall expenditures among priority populations	• Highest utilizers of EFA services by the highest percentage of EFA clients (51%) and services provided (45%)	• Highest utilizers of NS services percentage of clients and services provided • Highest per client number of meals/bags and expenditures

Ryan White Program Service Utilization Report, Contract Year 32 (March 1, 2022-February 28, 2023)

	RWP	Housing Services	EFA	Nutrition Support
Transgender clients	• 4% of all RWP clients • Highest percentage of clients unhoused in the contract period • Second largest percentage of people living ≤ FPL	• Represented a small number and percent of HS clients and services provided (7%) • Days per client slightly higher than overall average • Per client expenditure slightly lower than overall average	• Smallest percent of EFA clients and services provided • Per client service units (dollars) expenditures were lower than the overall average however based on small numbers	• Represented small percent of NS clients (3%) and services provided (3%) • Average meals/bags provided and expenditures per client were lower than overall averages
Unhoused in the contract year	• 18% of all RWP clients • Largest percent of clients living ≤ FPL and PWID	• Second highest utilizers by HS percent of clients and services provided • Lowest per client expenditures by only third lowest per client number of days.	• Represented 6% of EFA clients and 5% of services provided • Second lowest per client units (dollars) provided and expenditures	• Represented 13% of NS clients but received only 7% of provided • Second lowest average number of meals/bags and expenditures per client
PWID	• 5% of RWP clients • Second highest percent of clients unhoused in past 12m	• Represented 10% percent of clients and 9% of services provided • Second lowest per client days and expenditures compared to overall averages	• Represented a small number and percent of EFA clients and services provided • Average amount of dollars and expenditures were considerably lower than respective averages for all EFA clients • Third lowest per client service units (dollars) and expenditures	• Represented 6% of NS clients and 7% of services provided • Second highest average number of meals/bags and expenditures per client among priority populations

Acknowledgements

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- Planning, Development and Research (Michael Green, PhD)
- Program Monitoring and Evaluation (Wendy Garland, MPH , Janet Cuanas, MPP)
- HIV/STD Surveillance

Ryan White Program Agencies, Providers and Clients

Thank you

From: Savvoy Toney <stoney@projectnewhope.org>
Sent: Saturday, January 4, 2025 3:05 PM
To: Barrit, Cheryl <CBarrit@lachiv.org>
Cc: Brigitte Tweddell <btweddell@projectnewhope.org>
Subject: Re: Subject Matter Expert Review Panel Invitation-- Housing Services Standards

Happy New Year Cheryl,

I have some thoughts on the attachments relating to RCFCI and TRCF:

RCFCI:
It mentions that the ISP is done prior to admit, it is required to be done within 7 days of admission, not prior, and typically the client is involved in the creation of the plan (similar to how it reads for TRCF)

TRCF:
Add TRCF General Requirements Section
ISP section should be updated to reflect details of what the plan includes, similar to how it is written for RCFCI
TRCF also has monthly case conference
Add discharge planning, similar to RCFCI
Add program records

Overall, I think additional information would be useful in the TRCF section, I would be happy to assist with this area but I will need a bit more time to do so if you would like me to add specific input.

We appreciate the opportunity to give feedback.

Warm regards,

Savvoy Toney

Associate Director of Residential Facilities

Project New Hope

HOUSING SERVICE STANDARDS: RESIDENTIAL CARE FACILITY FOR THE CHRONICALLY ILL (RCFCI) AND TRANSITIONAL RESIDENTIAL CARE FACILITY (TRCF)

DRAFT

Last Approved by COH on 2/8/2018. For SBP Committee review as of 12/20/24.

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.

Description

Housing provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services).

Housing activities also include housing referrals services, including assessment, search placement, and housing advocacy services on behalf of the eligible client, as well as fees associated with these activities.

Program Guidance:

HRSA RWHAP recipients and subrecipients that use funds to provide Housing must have mechanisms in place to assess and document the housing status and housing service needs of new clients, and at least annually for existing clients.

HRSA RWHAP recipients and subrecipients, along with local decision-making planning bodies, are strongly encouraged to institute duration limits to housing activities. HRSA HAB recommends recipients and subrecipients align duration limits with those definitions used by other housing programs, such as those administered by the Department of Housing and Urban Development, which currently uses 24 months for transitional housing.

Housing activities cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments or rental deposits, although these may be allowable costs under the HUD Housing

RWHAP funding may be used to pay for a RWHAP client's security deposit if a RWHAP recipient or subrecipient has policies and procedures in place to ensure that the security deposit is returned to the RWHAP recipient or subrecipient and not to the RWHAP client. Opportunities for Persons with AIDS grant awards.
https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/hrsa-hab-security-deposit-program-letter.pdf

GENERAL ELIGIBILITY REQUIREMENTS

- Be diagnosed HIV or AIDS with verifiable documentation.
- Have a state-recognized identification document.
- Have an income at or below 500% of Federal Poverty Level
- Unstably housed, at-risk for homelessness, and homeless/unsheltered

RESIDENTIAL CARE FACILITY FOR THE CHRONICALLY ILL (UP TO 24 MONTHS) GENERAL REQUIREMENTS

Residential Care Facilities for the Chronically Ill (RCFCI) are licensed under the California Code of Regulations, Title 22, Division 6, Chapter 8.5 to provide services in a non-institutional, home-like environment in any building or housing arrangement which is maintained and operated to provide 24-hour care and supervision to the following PLWH: Adults 18 years age or older; emancipated minors, unable to work.

The goal of the RCFCI program is to improve the health status of PLWH who need to receive care, support, and supervision in a stable living environment to improve their health status. Clients receiving RCFCI services will have a maximum stay of 24 months. Approval will be required for extensions beyond 24 months based on the client's health status. Additional services provided can include case management services, counseling, nutrition services, and consultative services regarding housing, health benefits, financial planning, and referrals to other community or public resources.

Each RCFCI program must adhere to the following general requirements:

RCFCI GENERAL REQUIREMENTS	
STANDARD	**MEASURE**
RCFCIs are licensed to provide 24-hour care and supervision to any of the following: • Adults 18 years of age or older with living HIV/AIDS •	Program review and monitoring to confirm.
RCFCIs may accept clients that meet each of the following criteria: • Have an HIV/AIDS diagnosis from a primary care physician. • Be certified by a qualified a qualified health care professional to need	Program review and monitoring to confirm.

regular or ongoing assistance with Activities of Daily Living (ADLs) • Have a Karnofsky score of 70 or less. • Have an unstable living situation. • Be a client of Los Angeles County client. • Have an income at or below 500% Federal Poverty Level • Cannot receive Ryan White services if other payor source is available for the same service	
RCFCIs may accept clients with chronic and life-threatening diagnoses requiring different levels of care, including: • Clients whose illness is intensifying and causing deterioration in their condition. • Clients whose conditions have deteriorated to a point where death is imminent. • Clients who have other medical conditions or needs, or require the use of medical equipment that the facility can provide	Program review and monitoring to confirm.
RCFCIs will not accept or retain clients who: • Require inpatient care. • Require treatment and/or observation for more than eight hours per day. • Have communicable TB or any reportable disease. • Require 24-hour intravenous therapy. • Have dangerous psychiatric conditions. • Have a Stage II or greater decubitus ulcer. • Require renal dialysis in the facility. • Require life support systems. • Do not have chronic life-threatening illness. • Have a primary diagnosis of Alzheimer's. • Have a primary diagnosis of Parkinson's disease	Program review and monitoring to confirm.

Maximum length of stay is 24 months with extensions bases on client's health status.	Program review and monitoring to confirm.
RCFCI will develop criteria and procedures to determine client eligibility to ensure that no other options for residential services are available.	Program review and monitoring to confirm.
	Program review and monitoring to confirm.

INTAKE

As part of the intake process, the client file will include the following information (at minimum):

RCFCI INTAKE	
STANDARD	**DOCUMENTATION**
Intake process is begun as soon as possible upon acceptance.	Intake tool is completed and in client file.
Eligibility for services is determined	Client files include: • Proof of HIV diagnosis • Proof of income • Proof of residence in Los Angeles County • Proof client is not eligible for Housing Opportunities for People with AIDS (HOPWA) or other housing services. Ryan White is the payor of last resort.
Confidentiality Policy, Consent to Receive Services and Release of Information is discussed and completed. Release of Information (must be updated annually). New forms must be added for those individuals not listed on the existing Release of Information (specification should be made about what type of information can be released)	Release of Information signed and dated by client on file and updated annually.
Client is informed of Rights and Responsibility and Grievance Procedures	Signed and dated forms in client file.

ASSESSMENT

Prior to or within 30 days of the acceptance of a client, the facility will obtain a written medical assessment of the client which enables the facility to determine if they are able to provide the necessary health-related services required by the client's medical condition. If the assessment is not completed prior to admission of the client, a Registered Nurse (RN) must provide a health assessment within 24 hours of admission to determine if any immediate health needs are present which may preclude placement.

Clients must be reassessed on a quarterly basis to monitor and document changes in health status, progress toward treatment goals, and progress towards self-sufficiency with Activities of Daily Living (ADL). Upon reaching and sustaining a Karnofsky score above 70, RCFCI clients will be expected to transition towards independent living or to another type of residential service more suitable to their needs. Assessments will include the following:

RCFCI ASSESSMENT	
STANDARD	**MEASURE**
Written medical assessments completed or supervised by a licensed physician not more than three months old are required within 30 days of acceptance.	Signed, dated medical assessment on file in client chart.
Assessments will include the following: • Need for palliative care. • Age • Health status, including HIV and STI prevention needs. • Record of medications and prescriptions • Ambulatory status • Family composition • Special housing needs • Level of independence • Level of resources available to solve problems. • ADLs • Income • Benefits assistance/Public entitlements • Substance use and need for substance use services, such as treatment, relapse prevention, and support groups. • Mental health • Personal finance skills • History of evictions	Signed, dated assessment on file in client chart.

• Co-morbidity factors • Physical health care, including access to tuberculosis (TB) screening and routine and preventative health and dental care. • Treatment adherence • Educational services, including assessment, GED, and school enrollment. • Linkage to potential housing out-placements should they become appropriate alternatives for current clients (e.g., residential treatment facilities and hospitals) • Representative payee Legal assistance on a broad range of legal and advocacy	
Clients must be reassessed on a quarterly basis to monitor and document changes in health status, progress toward treatment goals, and progress towards self-sufficiency with ADL.	Record of assessment on file in client chart.
If a RCFCI cannot meet a client's needs a referral must be made to an appropriate health facility.	Documentation of client education on file in client chart.
Upon intake, facility staff must provide client with the following: • Information about the facility and its services • Policies and procedures • Confidentiality • Safety issues • House rules and activities • Client rights and responsibilities • Grievance procedures • Risk reduction practices. • Harm reduction. • Licit and illicit drug interactions • Medical complications of substance use hepatitis. • Important health and self-care practices information about referral agencies that are supportive of people	Documentation of client education on file in client chart.

living with HIV and AIDS.	

INDIVIDUAL SERVICE PLAN (ISP)

The RCFCI will ensure that there is an Individual Service Plan (ISP) for each client. A service plan must be developed for all clients prior to admission based upon the initial assessment. The plan will serve as the framework for the type and duration of services provided during the client's stay in the facility and should include the plan review and reevaluation schedule. RCFCI program staff will regularly observe each client for changes in physical, mental, emotional, and social functioning. The plan will be updated every three months or more frequently as the client's condition warrants. The plan will also document mechanisms to offer or refer clients to primary medical services and case management services. The ISP should be developed with the client and will include the following:

RCFCI INDIVIDUAL SERVICE PLAN (ISP)	
STANDARD	**MEASURE**
ISP will be completed prior to admission.	Needs and services plan on file in client chart.
The plan will include, but not be limited to: • Current health status • Current mental health status • Current functional limitations and abilities • Current medications • Medical treatment/therapy • Specific services needed. • Intermittent home health care required. • Agencies or persons assigned to carry out services. • "Do not resuscitate" order, if applicable • For each un-emancipated minor, the specific legal means of ensuring continuous care and custody when the parent or guardian is hospitalized, relocated, becomes unable to meet the child's needs, or dies	Needs and services plan on file in client chart.
Plans should be updated every three months or more frequently to document changes in a client's physical, mental, emotional, and social functioning.	Updated needs and services plan on file in client chart.
Clients must be reassessed on a quarterly basis to monitor and document changes in	Record of reassessment on file in client chart.

health status, progress toward treatment goals, and progress towards self-sufficiency with ADL.	
If a client's needs cannot be met by facility, the facility will assist in relocating the client to appropriate level of care.	Record of relocation activities on file in client chart.
The provider will ensure that the ISP for each client is developed by the ISP team. In addition to the RN case manager, the following persons will constitute the ISP team and will be involved in the development and updating of the client's ISP: • The client and/or his/her authorized representative • The client's physician • Facility house manager • Direct care personnel • Facility administrator/designee • Social worker/placement worker • Pharmacist, if needed • For each un-emancipated minor, the child's parent or guardian and the person who will assume legal custody and control of the child upon the hospitalization, incapacitation, or death of the parent or guardian. • Others, as deemed necessary	Record of ISP team on file in client chart.

MONTHLY CASE CONFERENCE

A monthly case conference will include review of the ISP, including the client's health and housing status, the need for and use of medical and other support services, and progress towards discharge, as appropriate. Attendees at the monthly case conference will include the client, the registered nurse, the case manager, and direct care staff representatives. Participants can include housing coordination staff and/or representatives from other community organizations, subject to the client's approval. The client may also invite the participation of an advocate, family member or other representative. The case conference must be documented and include outcomes, participants, and any specific steps necessary to obtain services and support for the client.

RCFCI MONTHLY CASE CONFERENCE	
STANDARD	**MEASURE**
All residents, registered nurse, case manager	Documentation of case conference on file in

and direct care staff representatives will participate in monthly case conferences to review health and housing status, need for medical and supportive services and progress towards discharge.	client chart including outcomes, participants, and necessary steps.

SERVICE AGREEMENTS

The provider will obtain and maintain writer agreements or contracts with the following:

RCFCI MONTHLY SERVICE AGREEMENTS	
STANDARD	**MEASURE**
Programs will obtain and maintain written agreements or contracts with: • A waste disposal company registered by the California Department of Toxic Substance Control and the California Department of Public Health if generating or handling bio-hazardous waste. • A licensed home health care agency and individuals or agencies that will provide the following basic services: ○ Case management services ○ Counseling regarding HIV disease and AIDS, including current information on treatment of the illness and its possible effects on the resident's physical and mental health. ○ Counseling on death, dying, and the grieving process; psychosocial support services; substance misuse counseling. ○ Nutritionist services ○ Consultation on housing, health benefits, financial planning, and availability of other community- based and public resources, if	Written agreements on file at provider agency.

	these services are not provided by provider staff or the subcontracted home health agency personnel	

MEDICATION MANAGEMENT

Administration of medication will only be performed by an appropriate skilled professional.

RCFCI MEDICATION MANAGEMENT	
STANDARD	**MEASURE**
Direct staff will assist the resident with self-administration medications if the following conditions are met: • Have knowledge of medications and possible side effects; and • On-the-job training in the facility's medication practices as specified in Section 87865 (g) 4.	Record of conditions on file at provider agency.
The following will apply to medications which are centrally stored: • Medications must be kept in a locked place that is not accessible to persons other than employees who are responsible for the supervision of the centrally stored medications. • Keys used for medications must not be accessible to residents. • All medications must be labeled and maintained in compliance with label instructions and state and federal laws.	Record of conditions on file at provider agency.

SUPPORT SERVICES

Support services provided must include, but are not limited to:

RCFCI SUPPORT SERVICES	
STANDARD	**MEASURE**
Programs will provide or coordinate the following (at minimum): • Provision and oversight of personal and supportive services. • Health-related services • Transmission risk assessment	Program policy and procedures to confirm. Record of services and referrals on file in client chart.

and prevention counseling • Social services • Recreational activities • Meals • Housekeeping and laundry • Transportation • Provision and/or coordination of all services identified in the ISP. • Assistance with taking medication. • Central storing and/or distribution of medications • Arrangement of and assistance with medical and dental care • Maintenance of house rules for the protection of clients • Arrangement and managing of client schedules and activities. • Maintenance and/or management of client cash resources or property.	

EMERGENCY MEDICAL TREATMENT

Clients receiving RCFCI services who require emergency medical treatment for physical illness or injury will be transported to an appropriate medical facility. The provider will have written agreement(s) with a licensed medical facility or facilities within the community for provision of emergency services as appropriate.

RCFCI EMERGENCY MEDICAL TREATMENT	
STANDARD	**MEASURE**
Clients requiring emergency medical treatment will be transported to medical facility	Program review and monitoring to confirm.
Provider will have a written agreement(s) with a licensed medical facility or facilities within the community for provision of emergency services as appropriate.	Written agreement(s) on file at provider agency.

DISCHARGE PLANNING

Discharge planning should start at least 12 months prior to the end date of the client's term in the program. In all cases, a Discharge/Transfer Summary will be completed for all clients discharged from the agency. The Discharge Summary will be completed by the RN case manager or the social worker.

RCFCI DISCHARGE PLANNING	
STANDARD	**MEASURE**
Discharge planning services include, but are not limited to, RCFCIs providing discharge planning services to clients that include (at minimum): • Linkage to primary medical care, emergency assistance, supportive services, and early intervention services as appropriate • Linkage to supportive services that enhance retention in care (e.g., case management, meals, nutritional support, and transportation) • Early intervention services to link HIV-positive people into care, including outreach, HIV counseling and testing and referral. • Housing such as permanent housing, independent housing, supportive housing, long-term assisted living, or other appropriate housing	Discharge plan on file in client chart.
A Discharge/Transfer Summary will be completed for all clients discharged from the agency. The summary will include, but not be limited to: • Admission and discharge dates • Services provided. • Diagnosis(es) • Status upon discharge • Notification date of discharge • Reason for discharge • Transfer information, as applicable	Discharge/Transfer Summary on file in client chart.

PROGRAM RECORDS

Programs will maintain a separate, complete, and current record for each client in sufficient detail to permit an evaluation of services. These notations will be dated and include, but not limited to, type of service provided, client's response, if applicable, and signature and title of person providing the service.

RCFCI PROGRAM RECORDS	
STANDARD	**MEASURE**

Client records on file at provider agency that include (at minimum): • Client demographic data • Admission agreement • Names, addresses and telephone numbers of physician, case manager and other medical and mental health providers, if any • Names, addresses and telephone numbers of any person or agency responsible for the care of a client. • Medical assessment • Documentation of HIV/AIDS • Written certification that each family unit member free from active TB • Copy of current childcare contingency plan • Current ISP • Record of IST contacts • Documentation of all services provided. • Record of current medications • Physical and mental health observations and assessments	Programs will maintain sufficient records on each resident

LINKAGE TO MEDICAL CARE COORDINATION

Based on assessment and client needs, eligible individuals should be linked to Ryan White-funded Medical Care Coordination (MCC) service. MCC service providers must follow the Division on HIV and STD Programs MCC protocol. For MCC-specific service standards, click HERE.

TRANSITIONAL RESIDENTIAL CARE FACILITY (UP TO 24 MONTHS) GENERAL REQUIREMENTS

A Transitional Residential Care Facility (TRCF) provides short-term housing with ongoing supervision and assistance with independent living skills for people living with HIV who are homeless or unstably housed. TRCF are 24-hour alcohol-drug-free facilities that are secure and home-like. The goal of the TRCF program is to help clients be safely housed while they find a more permanent, stable housing situation. This service focuses on removing housing-related barriers that negatively impact a client's ability to access and/or maintain HIV care or treatment.

TRCFs must maintain a current, written, definitive plan of operation that includes (at minimum):

- Admission/discharge policies and procedures
- Admission/discharge agreements, including policies and procedures regarding drug and/or alcohol use on-site and off-site.
- Provide ample opportunity for family participate in activities in the facility.
- Include a safety plan to include precautions enacted to protect clients and staff (for those facilities that admit or specialize in care for clients who have a propensity for behaviors that result in harm to self or others)
- Adhere to basic facility safety requirements under Federal laws and State of California Health and Safety codes.

INTAKE

As part of the intake process, the client file will include the following information (at minimum):

TRCF INTAKE	
STANDARD	**DOCUMENTATION**
Intake process is begun as soon as possible upon acceptance.	Intake tool is completed and in client file.
Eligibility for services is determined	Client files include: • Proof of HIV diagnosis • Proof of income • Proof of residence in Los Angeles County • Proof client is not eligible for Housing Opportunities for People with AIDS (HOPWA) or other housing services. Ryan White is the payor of last resort.
Confidentiality Policy, Consent to Receive Services and Release of Information is discussed and completed. Release of Information (must be updated annually). New forms must be added for those individuals not listed on the existing Release of Information (specification should be made about what type of information can be released)	Release of Information signed and dated by client on file and updated annually.
Client is informed of Rights and Responsibility and Grievance Procedures	Signed and dated forms in client file.

ASSESSMENT

At minimum, each client will be assessed to identify strengths and gaps in his/ her support system to move toward permanent housing. Clients receiving TRCF services must be reassessed on a quarterly basis to monitor and document changes in health status, progress toward treatment goals, and progress towards self-sufficiency with independent living skills. TRCF clients will be expected to transition towards independent living or another type of residential service more suitable to their needs. Assessments will include the following:

TRCF ASSESSMENT	
STANDARD	**MEASURE**
Assessments will include the following: • Age • Health status • Family involvement • Family composition • Special housing needs • Level of independence • ADLs • Income • Public entitlements • Current engagement in medical care • Substance use • Mental health • Personal finance skills • History of evictions • Level of resources available to solve problems • Co-morbidity factors • For clients with substance use disorders, case managers must assess for eligibility and readiness for residential substance use treatment facilities. • Eligibility for Medical Care Coordination	Signed, dated assessment on file in client chart.
Clients receiving TRCF services must be reassessed on a quarterly basis to monitor and document changes in health status, progress toward treatment goals, and progress towards self-sufficiency with	Signed, dated assessment on file in client chart.

independent living skills.	
Staff will provide the client with information about the facility and its services, including policies and procedures, confidentiality, safety issues, house rules and activities, client rights and responsibilities, and grievance procedures.	Documentation of client education on file at provider agency.

INDIVIDUAL SERVICE PLAN (ISP)

Jointly with each cllient develop an Individualized Service Plan, complete with action steps to ensure linkage and retention in HIV medical care. Based upon the initial assessment, an Individual Service Plan (ISP) will be completed within one week of the client's admission. The ISP will address the short-term and long-term housing needs of the client and identify resources for housing and referrals to appropriate medical and social services. Plans will also include specialized services needed to maintain the client in housing and access and adherence to primary medical care services. Documentation within the needs and services plan will include the identified goals, steps to achieve the goals, expected timeframe in which to complete the goals, and the disposition of each goal.

TRCF INDIVIDUAL SERVICE PLAN (ISP)	
STANDARD	**MEASURE**
ISP will be completed within one week of the client's admission.	ISP on file in client chart signed by client detailing all housing resources, medical, and social services referrals made.

LINKAGE TO MEDICAL CARE COORDINATION

Based on assessment and client needs, eligible individuals should be linked to Ryan White-funded Medical Care Coordination (MCC) services. MCC service providers must follow the Division of HIV and STD Programs MCC Protocol. For MCC-specific service standards, click HERE.

HRSA
Health Resources & Services Administration
HIV/AIDS Bureau
5600 Fishers Lane
Rockville, MD 20857

December 20, 2024

Dear Ryan White HIV/AIDS Program Colleagues,

As many of you know, earlier this year the Health Resources and Services Administration's (HRSAs) HIV/AIDS Bureau (HAB) introduced **Ryan White Program 2030 (RWP 2030),** a renewed vision for the Ryan White HIV/AIDS Program (RWHAP). Building on 35 years of success and innovation, RWP 2030 integrates lessons learned from the RWHAP and the Ending the HIV Epidemic in the U.S. (EHE) initiative. This framework is designed to sustain high-quality care and treatment for people currently receiving services through the RWHAP **while expanding efforts to identify and engage individuals with HIV who are undiagnosed or out-of-care[1].**

Achieving this goal will require a comprehensive, collaborative approach that builds upon existing successes and resources while fostering innovation[2]. At its core, RWP 2030 reflects our shared commitment to improving health outcomes for people with HIV. This vision calls on the HIV community to establish and strengthen partnerships, prioritize community engagement, and utilize focused interventions to end the HIV epidemic.

Since 2010, viral suppression among people receiving HIV medical care through the RWHAP has increased significantly, from 69.5% to 90.6% in 2023. Thanks to advancements in treatment, HIV is now a manageable chronic condition for individuals who remain engaged in care, allowing them to live long, healthy lives while preventing transmission to others. Despite this progress, we recognize that approximately 40% of people with HIV in the U.S. are either undiagnosed or not receiving regular care, contributing to most new HIV infections. Addressing these gaps is essential to achieving our goal of ending the epidemic.

Through EHE, we have seen the power of targeted investments and innovative strategies. In 2022, EHE-funded providers served over 22,000 individuals who were new to care and re-engaged more than 19,000 individuals who were out of care. Remarkably, 79.2% of individuals new to care achieved viral suppression, underscoring the effectiveness of our collective efforts. These successes highlight the importance of combining strategic investments with community-driven planning to achieve high-impact outcomes.

Ryan White Program 2030 emphasizes the importance of sustaining care for those already engaged in the RWHAP, while expanding our reach to ensure timely diagnosis and sustained treatment for underserved communities. This will require collaboration across sectors, innovation in care delivery, and a commitment to addressing barriers to care. We must also engage individuals with lived experience and non-traditional partners to inform program planning[3] and care models that are responsive to the needs of diverse communities.

[1] Legal authority: §§ 2602(b)(4), 2617(b), 2664(a), and 2671(c) of the Public Health Service (PHS) Act.
[2] Legal authority: §§ 2603(b)(2)(B), 2620, 2654(c), and 2691 of the PHS Act.
[3] Legal authority: § 2681 of the PHS Act.

Ryan White HIV/AIDS Program recipients play a critical role in advancing the goals of RWP 2030 and are responsible for employing sound planning and decision-making processes to determine which HIV related services are prioritized and how much to fund them. As part of these responsibilities, RWHAP recipients must continue to base service priorities and resource allocation decisions on the size, demographics, and needs of people with or affected by HIV. RWP 2030 specifically entails a renewed focus on reaching those who are undiagnosed or out of care. This may necessitate a re-evaluation of existing resource allocations to ensure outreach, engagement, and support efforts are effectively scaled to meet the needs of these especially high-need populations while still addressing the needs of individuals who are currently receiving care through the RWHAP.

We encourage you to begin engaging your partners in discussions about this vision and its implications for your work. Over the next several months, HRSA HAB will work to develop additional guidance and tools to support your efforts in implementing RWP 2030. The RWHAP Best Practices Compilation contains effective innovative interventions and best practices on outreach, linkage to and engagement in care. TargetHIV also contains a number of trainings, resources, and reference guides to support recipients and subrecipients in providing care to people with HIV. HAB is also planning a series of listening sessions in 2025 to ensure that RWP 2030 is informed by diverse perspectives and to better understand the challenges and barriers to implementing this vision.

We are confident that, with your continued partnership, we can realize the goals of RWP 2030 and bring us closer to ending the HIV epidemic. If you have questions, please contact your HRSA HAB Project Officer.

Thank you for your unwavering dedication to improving the lives of people with HIV.

Sincerely,

/Laura W. Cheever/

Laura Cheever, MD, ScM
Associate Administrator, HIV/AIDS Bureau
Health Resources and Services Administration

Get Ready for Co-Chair Open Nominations & Elections: Your Questions Answered!

Greetings! It's that time of year again—election season is upon us, not just for general elections, but also for our Commission, Committee and Caucus Co-Chairs. The nomination and election process for COH, Committee, and Caucus Co-Chairs is underway. Below is a quick FAQ to help you prepare and make an informed decision about becoming a Co-Chair.

Am I Eligible?

Per COH Bylaws, Policies #08.1102 and #08.1104

Commission Co-Chairs (Nominations remain open until the January 9, 2025, COH meeting)

(2) Commission Co-Chairs have two-year staggered terms – one co-chair seat is up for election which will serve the Jan 2025-Dec 2026 term.

- Only voting Commissioners can serve as Commission Co-Chairs.
- Candidates must have at least one year of service on the Commission to ensure leadership diversity and representation.
- At least one Co-Chair must be HIV-positive, and at least one must be a person of color. It is also preferred that at least one Co-Chair is female.

Committee Co-Chairs (Nominations will open by December, with elections in January 2025)

(2) Committee Co-Chairs serve one-year terms – all co-chair seats are up for election which will serve the Jan-Dec 2025 term.

- The Commission does not impose specific requirements, though one year of experience on the Committee is strongly encouraged.
- Nominees must be primary members of the Committee, not serving in alternate or secondary roles.
- Only Commissioners can serve as Co-Chairs.

Caucus Co-Chairs (Nominations will open by December, with elections in January 2025)

Caucuses typically have two Co-Chairs serving one-year terms, except the Consumer Caucus, which has three seats, including a prevention representative. All co-chair seats are up for election which will serve the Jan-Dec 2025 term.

- One Co-Chair must be a Commissioner to ensure that the Caucus activities are aligned with the COH's scope, goals and objectives
- Note: Caucuses are not subject to Brown Act requirements but work with COH consent to set their own leadership structure, guidelines, membership, and activities.

All Co-Chair candidates will be asked to provide a brief statement before the election.

What Are the Co-Chair Roles & Responsibilities?

- Lead COH/committee/caucus activities and meetings.

- Set agendas for meetings in collaboration with staff.
- Develop work plans with the Executive Director and staff.
- Facilitate meetings, guiding discussion and ensuring effective workflow.
- Summarize discussions and assist in developing work products.
- Act on behalf of the group and communicate with stakeholders.

How Should I Prepare?

- Honestly assess your accessibility, bandwidth, and time to ensure you are able to show up fully and prepared. *Co-Chair roles require at least 10-12 commitment hours per month.*
- Review the COH Co-Chair training slides to understand the role's expectations
- Familiarize yourself with the:
    - Ryan White Program Part A Planning Council Primer,
    - COH bylaws,
    - COH Co-Chair Duty Statement (if applicable),
    - Committee Co-Chair Duty Statement (if applicable)
    - Required Commissioner trainings.

Ready to take on a leadership role? Nominate yourself or a colleague and help guide our collective work toward meaningful community impact! If you have questions, please reach out to your respective staff lead.

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

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