LOS ANGELES COUNTY
COMMISSION ON HIV

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

Public Comment Period for Draft
Housing Service Standards: Residential Care Facility for the Chronically Ill and Transitional Residential Care Facility

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The Los Angeles County Commission on HIV (COH) announces an opportunity for the public to submit comments for the draft **Housing Service Standards: Residential Care Facility for the Chronically Ill (RCFCI) and Transitional Residential Care Facility (TRCF)** revised by the Standards and Best Practices Committee. Comments from consumers, providers, HIV prevention and care stakeholders, and the public are welcome. A draft of the document is posted to the COH website and can be found at: https://hiv.lacounty.gov/service-standards. Comments can be submitted via email to HIVCOMM@LACHIV.ORG. Additionally, consumers of RCFCI and/or TRCF services can request for a physical copy of the service standards be mailed to their home address. For more information, please contact COH staff at jgaribay@lachiv.org or at (213) 738-2816.

Consider responding to the following questions when providing public comment:

1. Are the service standards reasonable and achievable for providers? Why or why not?

2. Do the service standards meet consumer needs? Why or why not? Give examples of what is working/not working.

3. Is there anything missing from the service standards in any of the sections listed below?

    - General Requirements
    - Intake
    - Assessment
    - Monthly Case Conference
    - Monthly Service Agreements
    - Medication Management
    - Support Services
    - Medical Treatment
    - Discharge Planning
    - Program Records

4. Do you have any additional comments related to the service standards and/or RCFCI and/or TRCF services?

Public comments are due by March 7, 2025.

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

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.

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; 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 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 resident of Los Angeles County. • Have an income at or below 500% Federal Poverty Level	Program review and monitoring to confirm.

• 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 based 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.

INTAKE

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

RCFCI INTAKE	
STANDARD	**DOCUMENTATION**
Eligibility for services is determined	Client files include: • Proof of HIV diagnosis • Proof of income • Proof of residence in Los Angeles County
Intake process is begun after completion of eligibility screening.	Intake tool is completed and in client file.
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 including the DHSP Customer Support Program.	Signed and dated forms in client file.

ASSESSMENT

Prior to 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. **How feasible is this for providers?**

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	Signed, dated medical assessment on file in client chart.

than three months old are required within 30 days of acceptance.	
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 clients (e.g., residential treatment facilities and hospitals) • Representative payee	Signed, dated assessment on file in client chart.

• 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 or link 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 • 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 within 7 days of admission to RCFCI program. 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 within 7 days of 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	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 their authorized representative • The client's physician • Facility house manager • Direct care personnel • Facility administrator/designee • Social worker/placement worker • Pharmacist, if needed	Record of ISP team on file in client chart.

• 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 written 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 or hospice agency and individuals or agencies that can provide the following basic services:
  ○ Case management services
  ○ Counseling regarding HIV disease and AIDS, including
	Written agreements on file at provider agency.

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: • 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	Record of conditions on file at provider agency.

not be accessible to residents. • All medications must be labeled and maintained in compliance with label instructions and state and federal laws.	

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 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.	Program policy and procedures to confirm. Record of services and referrals on file in client chart.

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 or emergency room.

RCFCI EMERGENCY MEDICAL TREATMENT	
STANDARD	**MEASURE**
Clients requiring emergency medical treatment will be transported to medical facility or emergency room.	Program review and monitoring to confirm.

DISCHARGE PLANNING

Discharge planning should start as soon as the client achieves stability and readiness towards alternative forms of housing. As much as possible, early planning (at least 12 months prior to the end date of the client's term in the program) must be conducted to a ensure a smooth transition/discharge process. 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) • Ensure linkage to primary care • 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	Discharge/Transfer Summary on file in client chart.

• Notification date of discharge • Reason for discharge • Transfer information, as applicable	

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 ISP 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**
Eligibility for services is determined	Client files include: • Proof of HIV diagnosis • Proof of income • Proof of residence in Los Angeles County
Intake process is begun after completion of eligibility screening.	Intake tool is completed and in client file.
Confidentiality Policy, Consent to Receive Services and Release of Information is discussed and completed. Release of	Release of Information signed and dated by client on file and updated annually.

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)	
Client is informed of Rights and Responsibility and Grievance Procedures, including the DHSP Customer Support Program.	Signed and dated forms in client file.

ASSESSMENT

At minimum, each client will be assessed to identify strengths and gaps in their 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	Signed, dated assessment on file in client chart.

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 client develop an Individualized Service Plan (ISP), complete with action steps to ensure linkage and retention in HIV medical care. Based upon the initial assessment, 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.