LOS ANGELES COUNTY COMMISSION ON HIV
3530 Wilshire Boulevard, Suite 1140, Los Angeles, CA 90010 · TEL. (213) 7382816 · FAX (213) 637-4748
Website: http://hiv.lacounty.gov Email: hivcomm@lachiv.org

COMMISSION ON HIV MEETING

Thursday, December 14, 2017
9:00 AM - 12:45 PM

St. Anne's Conference Center
Foundation Room
155 North Occidental Blvd.
Los Angeles, CA 90026

Los Angeles County Commission on HIV

VISION

A comprehensive, sustainable, accessible system of prevention and care that empowers people at risk, living with or affected by HIV to make decisions and to maximize their lifespans and quality of life.

MISSION

The Los Angeles County Commission on HIV focuses on the local HIV/AIDS epidemic and responds to the changing needs of People Living With HIV/AIDS (PLWHA) within the communities of Los Angeles County.

The Commission on HIV provides an effective continuum of care that addresses consumer needs in a sensitive prevention and care/treatment model that is culturally and linguistically competent and is inclusive of all Service Planning Areas (SPAs).

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1. APPROVAL OF THE AGENDA:

- **A. Agenda**
- **B. Membership Roster**
- **C. Committee Assignments**
- **D. Commission Member Conflict of Interest**
- **E. Geographic Maps**
- **F. December 2017 - March 2018 Meeting Calendars**

AGENDA FOR THE REGULAR MEETING OF THE
LOS ANGELES COUNTY COMMISSION ON HIV
(213) 738-2816 / FAX (213) 637-4748
hivcomm@lachiv.org http://hiv.lacounty.gov

THURSDAY, DECEMBER 14, 2017, 9:00 A.M. – 12:45 P.M.

St. Anne's Conference Center
Foundation Conference Room
155 North Occidental Boulevard, Los Angeles, CA 90026

Notice of Teleconferencing Site:
California Department of Public Health, Office of AIDS
1616 Capitol Ave, Suite 74-616
Sacramento, CA 95814

AGENDA POSTED: December 11, 2017

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 5 business days' notice before the meeting date. To arrange for these services, please contact Dina Jauregui at (213) 738-2816 or via email at djauregui@lachiv.org.

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

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

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

If a stakeholder is interested in joining the meeting to keep abreast of or participate in consideration of a specific agenda item, the Commission suggests that the stakeholder plan on attending the full meeting in case the agenda order is modified or timing of the items is altered.

All Commission committees make every effort to place items that they are aware involve external stakeholders at the top of the agenda in order to address and resolve those issues more quickly and release visiting participants from the obligation of staying for the full meeting.

External stakeholders who would like to participate in the deliberation of discussion of an a posted agenda item, but who may only be able to attend for a short time during a limited window of opportunity, may call the Commission's Executive Director in advance of the meeting to see if the scheduled agenda order can be adjusted accordingly. Commission leadership and staff will make every effort to accommodate reasonable scheduling and timing requests—from members or other stakeholders—within the limitations and requirements of other possible constraints.

	Call to Order and Roll Call		9:00 A.M. - 9:03 A.M.
	I. ADMINISTRATIVE MATTERS		
1.	Approval of Agenda	MOTION #1	9:03 A.M. - 9:04 A.M.
2.	Approval of Meeting Minutes	MOTION #2	9:04 A.M. - 9:06 A.M.
3.	Consent Calendar	MOTION #3	9:06 A.M. - 9:07 A.M.
	II. REPORTS		
4.	Executive Director's Report		9:07 A.M. - 9:15 A.M.
5.	Co-Chair's Report		9:15 A.M. - 9:25 A.M.
6.	Housing Opportunities for People Living With HIV/AIDS (HOPWA) Report		9:25 A.M. - 9:27 A.M.
	III. COLLOQUIA SERIES		**9:27 A.M. - 10:10 A.M.**
7.	**Los Angeles County Homeless Count: Data on PLWHA** JuHyun Yoo Sakota, Manager, Data and Research Los Angeles Homeless Services Authority (LAHSA)		
	V. REPORTS		
8.	Vaccine Preventable Disease Control Program Los Angeles County Department of Public Health		10:10 A.M. - 10:20 A.M.
	IV. BREAK		**10:20 A.M. – 10:30 A.M.**
9.	Division of HIV/STD Programs (DHSP) Report Department of Public Health		10:30 A.M. - 11:00 A.M.
11.	California Office of AIDS (OA) Report		11:00 A.M. - 11:15 A.M.

12. Standing Committee Reports**:** 11:15 A.M. – 11:50 P.M.

A. Planning, Priorities and Allocations (PP&A) Committee
1. Approve Ryan White (RW) Program Year (PY) 28 Paradigms and Operating Values, as presented MOTION #4

B. Standards and Best Practices (SBP) Committee
1. Approve draft Housing Services Standards, as presented for public comments MOTION #5
2. Approve draft Prevention Services Standards, as presented for public comments MOTION #6
PUBLIC COMMENT PERIOD: 12/14/17-1/12/18

C. Operations Committee
1. Membership Management:
   a. Membership Application(s):
      1. Katja Nelson: Representative, Board Office 3 MOTION #7

D. Public Policy Committee
1. 2018 Policy Priorities and Agenda Review
2. Healthcare Access
3. Federal Tax Bill

13. Caucus, Task Force and Work Group Reports 11:50 P.M. – 12:00 P.M.

14. City/Health District Reports 12:00 P.M. – 12:10 P.M.

15. SPA/District Reports 12:10 P.M. – 12:15 P.M.

16. AIDS Education/Training Centers (AETCs) 12:15 P.M. – 12:20 P.M.

VI. PUBLIC COMMENT 12:20 P.M. – 12:30 P.M.

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

VII. COMMISSION COMMENT

18. Non-Agendized or Follow-Up

VIII. ANNOUNCEMENTS 12:30 P.M. – 12:40 P.M.

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

IX. ADJOURNMENT AND ROLL CALL 12:40 P.M .- 12:45 P.M.

20. Adjournment for the meeting of December 14, 2017.

PROPOSED MOTION(s)/ACTION(s): **PROCEDURAL MOTION(S):**	
MOTION #1:	Approve the Agenda Order, as presented or revised.
MOTION #2:	Approve the Commission meeting minutes, as presented or revised.
MOTION #3:	Approve the Consent Calendar.

CONSENT CALENDAR:	
MOTION #4:	Approve Ryan White (RW) Program Year (PY) 28 Paradigms and Operating Values, as presented
MOTION #5:	Approve draft Housing Services Standards, as presented for public comments **PUBLIC COMMENT PERIOD: 12/14/17-1/12/18**
MOTION #6:	Approve draft Prevention Services Standards, as presented for public comments **PUBLIC COMMENT PERIOD: 12/14/17-1/12/18**
MOTION #7:	Approve recommendation for Katja Nelson, appointment to Board Office 3 Representative seat, as presented.

All Commission meetings will begin at their appointed times. Participants should make every effort to be prompt and ready. All agenda items are subject to action. Public comment will be invited for each item. All "action" (non-procedural) motions are included on the consent calendar and are approved when the consent calendar is approved. A motion can be "pulled" from the consent calendar if there are objections to it, or if it is to be presented or discussed later in the meeting.

Commission on HIV Members:			
Bradley Land, Co-Chair	Ricky Rosales, Co-Chair	Majel Arnold, MA-HSA	Traci Bivens-Davis
Al Ballesteros, MBA	Jason Brown	Joseph Cadden, MD	Danielle Campbell, MPH
Raquel Cataldo	Deborah Owens Collins, PA, MSPAS, AAHIVS	David Cunningham (Alternate)	Michele Daniels
Kevin Donnelly	Susan Forrest (Alternate)	Aaron Fox, MPM	Marcos Garcilazo (Alternate)
Jerry D. Gates, PhD	Joseph Green	Terry Goddard II, MA	Bridget Gordon
Grissel Granados, MSW	William King, MD	Lee Kochems, MA	David P. Lee, MPH, LCSW (Alternate)
Eric Paul Leue	Abad Lopez	Andrew Lopez (Alternate)	Eduardo Martinez (Alternate)
Miguel Martinez, MSW, MPH	Anthony Mills, MD	José Munoz	Derek Murray
Frankie Darling-Palacios	Raphael Péna	Mario Pérez MPH	Juan Preciado
Thomas Puckett, Jr.	Ace Robinson, MPH	Rebecca Ronquillo	Martin Sattah, MD
LaShonda Spencer, MD	Kevin Stalter	Yolanda Sumpter	Greg Wilson
Russell Ybarra			
MEMBERS:	**45**		
QUORUM:	**23**		

COMMISSION ON HIV MEMBERSHIP SLATE

APPROVED BY COH ON 07/13/2017

MEMBERSHIP SEAT #	MEMBERSHIP SEAT	Commissioners Seated	Committee Assignment	COMMISSIONER	AFFILIATION *(if any)*	TERM BEGINS	TERM ENDS	ALTERNATE
1	Medi-Cal representative			***Vacant***		July 1, 2017	June 30, 2019	
2	City of Pasadena representative			***Vacant***		July 1, 2016	June 30, 2018	
3	City of Long Beach representative	1	PP&A	Deborah Owens Collins, PA, MSPAS, AAHIVS	Dept. of Health and Human Services, City of Long Beach	July 1, 2017	June 30, 2019	
4	City of Los Angeles representative	1	EXC	Ricky Rosales	AIDS Coordinator's Office, City of Los Angeles	July 1, 2016	June 30, 2018	
5	City of West Hollywood representative	1	PP&A	Derek Murray	City of West Hollywood	July 1, 2017	June 30, 2019	
6	Director, DHSP	1	PP&A	Mario Pérez, MPH	DHSP, LA County Department of Public Health	July 1, 2016	June 30, 2018	
7	Part B representative	1	PP&A	Majel Arnold,MHA	CDPH Office of AIDS	July 1, 2016	June 30, 2018	
8	Part C representative	1	PP	Aaron Fox, MPM	Los Angeles Gay and Lesbian Center (LAGLC)	July 1, 2016	June 30, 2018	
9	Part D representative	1	PP&A	LaShonda Spencer, MD	LAC + USC MCA Clinic, LA County Department of Health Services	July 1, 2017	June 30, 2019	
10	Part F representative	1	PP	Jerry D. Gates, PhD	Keck School of Medicine of USC	July 1, 2016	June 30, 2018	
11	Provider representative #1	1	SBP	Joseph Cadden, MD	Rand Shrader Clinic (SPA1), LA County Department of Health Services	July 1, 2017	June 30, 2019	
12	Provider representative #2			***Vacant***		July 1, 2016	June 30, 2018	
13	Provider representative #3	1	PP&A	Miguel Martinez, MSW, MPH	Children's Hospital Los Angeles	July 1, 2017	June 30, 2019	
14	Provider representative #4	1	EXC|OPS	Raquel Cataldo	Tarzana Treatment Center	July 1, 2016	June 30, 2018	
15	Provider representative #5	1	PP	Terry Goddard, MA	Alliance for Housing and Healing	July 1, 2017	June 30, 2019	
16	Provider representative #6	1	PP&A	Anthony Mills, MD	Southern CA Men's Medical Group	July 1, 2016	June 30, 2018	
17	Provider representative #7	1	PP&A	Frankie Darling-Palacios	Los Angeles Gay and Lesbian Center (LAGLC)	July 1, 2017	June 30, 2019	
18	Provider representative #8	1	PP	Martin Sattah, MD	Rand Shrader Clinic (SPA1), LA County Department of Health Services	July 1, 2016	June 30, 2018	
19	Unaffiliated consumer, SPA 1	1	OPS	Michele Daniels	*unaffiliated consumer*	July 1, 2017	June 30, 2019	
20	Unaffiliated consumer, SPA 2	1	PP&A	Abad Lopez	*unaffiliated consumer*	July 1, 2016	June 30, 2018	
21	Unaffiliated consumer, SPA 3	1	PP&A	Jason Brown	*unaffiliated consumer*	July 1, 2017	June 30, 2019	
22	Unaffiliated consumer, SPA 4			***Vacant***		July 1, 2016	June 30, 2018	Susan Forrest
23	Unaffiliated consumer, SPA 5	1	PP&A	Yolanda Sumpter	*unaffiliated consumer*	July 1, 2017	June 30, 2019	
24	Unaffiliated consumer, SPA 6			***Vacant***		July 1, 2016	June 30, 2018	David Lee, MPH, LCSW
25	Unaffiliated consumer, SPA 7	1	PP&A	Raphael Péna	*unaffiliated consumer*	July 1, 2017	June 30, 2019	
26	Unaffiliated consumer, SPA 8			***Vacant***		July 1, 2016	June 30, 2018	
27	Unaffiliated consumer, Supervisorial District 1	1	PP	Jose Muñoz	*unaffiliated consumer*	July 1, 2017	June 30, 2019	Marcos Garcilazo
28	Unaffiliated consumer, Supervisorial District 2			***Vacant***		July 1, 2016	June 30, 2018	Andrew Lopez
29	Unaffiliated consumer, Supervisorial District 3			***Vacant***		July 1, 2017	June 30, 2019	Eduardo Martinez
30	Unaffiliated consumer, Supervisorial District 4	1	EXC|OPS	Kevin Donnelly	*unaffiliated consumer*	July 1, 2016	June 30, 2018	David Cunningham
31	Unaffiliated consumer, Supervisorial District 5	1	SBP	Thomas Puckett, Jr.	*unaffiliated consumer*	July 1, 2017	June 30, 2019	
32	Unaffiliated consumer, at-large #1	1	PP&A	Russell Ybarra	*unaffiliated consumer*	July 1, 2016	June 30, 2018	
33	Unaffiliated consumer, at-large #2	1	EXC|OPS	Joseph Green	*unaffiliated consumer*	July 1, 2017	June 30, 2019	
34	Unaffiliated consumer, at-large #3	1	OPS	Kevin Stalter	unaffiliated consumer	July 1, 2016	June 30, 2018	
35	Unaffiliated consumer, at-large #4	1	OPS	Bridget Gordon	*unaffiliated consumer*	July 1, 2017	June 30, 2019	
36	Representative, Board Office 1	1	PP&A	Al Ballesteros, MBA	JWCH Institute, Inc.	July 1, 2016	June 30, 2018	
37	Representative, Board Office 2			***Vacant***		July 1, 2017	June 30, 2019	
38	Representative, Board Office 3			***Katja Nelson (pending appointment)***		July 1, 2016	June 30, 2018	
39	Representative, Board Office 4	1	SBP	Ace Robinson, MPH	No Affiliations	July 1, 2017	June 30, 2019	
40	Representative, Board Office 5	1	EXC	Bradley Land	*unaffiliated consumer*	July 1, 2016	June 30, 2018	
41	Representative, HOPWA	1	PP&A	Rebecca Ronquillo	City of Los Angeles, HOPWA	July 1, 2017	June 30, 2019	
42	Behavioral/social scientist	1	PP	Lee Kochems	unaffiliated consumer	July 1, 2016	June 30, 2018	
43	Local health/hospital planning agency representative			***Vacant***		July 1, 2017	June 30, 2019	
44	HIV stakeholder representative #1	1	SBP	Grissel Granados, MSW	Children's Hospital Los Angeles	July 1, 2016	June 30, 2018	
45	HIV stakeholder representative #2	1	PP	Greg Wilson	In the Meantime Men's Group	July 1, 2017	June 30, 2019	
46	HIV stakeholder representative #3	1	OPS	Juan Preciado	Northeast Valley Health Corporation	July 1, 2016	June 30, 2018	
47	HIV stakeholder representative #4	1	PP	Eric Paul Leue	Free Speech Coaltion	July 1, 2017	June 30, 2019	
48	HIV stakeholder representative #5	1	OPS	Danielle Campbell, MPH	UCLA/MLKCH	July 1, 2016	June 30, 2018	
49	HIV stakeholder representative #6	1	OPS	Traci Bivens-Davis	N/A	July 1, 2017	June 30, 2019	
50	HIV stakeholder representative #7	1		William D. King, MD, JD, AAHIVS	W. King Health Care Group	July 1, 2016	June 30, 2018	
51	HIV stakeholder representative #8			***Vacant***		July 1, 2015	June 30, 2017	
	TOTAL:	**39**						

COMMITTEE ASSIGNMENT LEGEND: EXC (Executive), OPS (Operations), PP&A (Planning, Priorities & Allocations), PP (Public Policy), SBP (Standards and Best Practices)

= Vacant

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COMMITTEE ASSIGNMENTS

(Updated 12/11/17)

Committee Member Name/ Alternate	Member Category	Affiliation	Notes
* = *Primary Committee Assignment*	** = *Secondary Committee Assignment*		

EXECUTIVE COMMITTEE

Regular meeting day: 4th Thursday of the month ***Regular meeting time***: 1:00pm–3:00pm

Number of Voting Members: **14** ***Number of Quorum***: **8**

Bradley Land	**Co-Chair, Comm./Exec.***	Commissioner
Ricky Rosales	**Co-Chair, Comm./Exec.***	Commissioner
Al Ballesteros, MBA	Co-Chair, PP&A	Commissioner
Traci Bivens-Davis	Co-Chair, Operations	Commissioner
Jason Brown	Co-Chair, PP&A	Commissioner
Joseph Cadden, MD	Co-Chair, SBP	Commissioner
Raquel Cataldo	At-Large Member*	Commissioner
Kevin Donnelly	At-Large Member*	Commissioner
Aaron Fox, MPM	Co-Chair, Public Policy	Commissioner
Grissel Granados, MSW	Co-Chair, SBP	Commissioner
Joseph Green	At-Large Member*	Commissioner
Eric Paul Leue	Co-Chair, Public Policy	Commissioner
Mario Pérez, MPH	DHSP Director	Commissioner
Kevin Stalter	Co-Chair, Operations	Commissioner

OPERATIONS COMMITTEE

Regular meeting day: 4th Thursday of the month ***Regular meeting time***: 10:00am-12:00pm

Number of Voting Members: **9** ***Number of Quorum***: **6**

Traci Bivens-Davis	**Committee Co-Chair***	Commissioner
Kevin Stalter	**Committee Co-Chair***	Commissioner
Danielle Campbell, MPH	*	Commissioner
Raquel Cataldo	*	Commissioner
Michele Daniels	*	Commissioner
Kevin Donnelly	*	Commissioner
Bridget Gordon	*	Commissioner
Joseph Green	*	Commissioner
Juan Preciado	*	Commissioner

Committee Member Name	Member Category	Affiliation	Notes
* = *Primary Committee Assignment*	** = *Secondary Committee Assignment*		

PLANNING, PRIORITIES and ALLOCATIONS (PP&A) COMMITTEE

Regular meeting day: 3rd Tuesday of the month ***Regular meeting time***: 1:00pm-4:00pm

Number of Voting Members: **15** ***Number of Quorum***: **8**

Al Ballesteros, MBA	**Committee Co-Chair***	Commissioner
Jason Brown	**Committee Co-Chair***	Commissioner
Susan Forrest	*	Commissioner
Abad Lopez	*	Commissioner
Miguel Martinez, MPH, MSW	*	Commissioner
Anthony Mills, MD	*	Commissioner
Derek Murray	*	Commissioner
Deborah Owens Collins, MPA, MSPAS, AAHIVS	*	Commissioner
Frankie Darling Palacios	*	Commissioner
Raphael Péna	*	Commissioner
Rebecca Ronquillo	*	Commissioner
LaShonda Spencer, MD	*	Commissioner
Yolanda Sumpter	*	Commissioner
Russell Ybarra	*	Commissioner
TBD	DHSP staff	DHSP Staff

PUBLIC POLICY COMMITTEE

Regular meeting day: 1st Monday of the month ***Regular meeting time***: 1:00 pm-3:00pm

Number of Voting Members: **10** ***Number of Quorum***: **6**

Aaron Fox, MPM	**Committee Co-Chair***	Commissioner
Eric Paul Leue	**Committee Co-Chair***	Commissioner
Jerry Gates, PhD	*	Commissioner
Terry Goddard, MA	*	Commissioner
Lee Kochems, MA	*	Commissioner
Eduardo Martinez	*	Alternate
José Munoz	*	Commissioner
Martin Sattah, MD	*	Commissioner
Greg Wilson	*	Commissioner
Kyle Baker	DHSP staff	DHSP representative

Committee Member Name	Member Category	Affiliation	Notes
* = ***Primary Committee Assignment***	** = ***Secondary Committee Assignment***		

STANDARDS AND BEST PRACTICES (SBP) COMMITTEE

Regular meeting day: 1st Thursday of the month ***Regular meeting time***: 10:00am-12:00pm

Number of Voting Members: **6** ***Number of Quorum***: **4**

Grissel Granados, MSW	**Committee Co-Chair***	Commissioner
Joseph Cadden, MD	**Committee Co-Chair***	Commissioner
Angelica Palmeros, MSW	*	Committee member
Thomas Puckett, Jr.	*	Commissioner
Wendy Garland, MPH	DHSP staff	DHSP representative
Ace Robinson, MPH	*	Commissioner

CONSUMER CAUCUS

Regular meeting day: Following Comm. mtg. ***Regular meeting time***: 1:30pm–3:00pm

Open Membership

Joseph Green	**Co-Chair**	Commissioner
Yolanda Sumpter	**Co-Chair**	Commissioner
Raphael Péna	**Co-Chair**	Commissioner
Al Ballesteros, MBA	Member	Commissioner
Jason Brown	Member	Commissioner
Michele Daniels	Member	Commissioner
Kevin Donnelly	Member	Commissioner
Grissel Granados, MSW	Member	Commissioner
Bridget Gordon	Member	Commissioner
Lee Kochems, MA	Member	Commissioner
Brad Land	Member	Commissioner
Abad Lopez	Member	Commissioner
Eduardo Martinez	Member	Alternate
Anthony Mills, MD	Member	Commissioner
José Munoz	Member	Commissioner
Thomas Puckett	Member	Commissioner
Kevin Stalter	Member	Commissioner

WOMEN'S CAUCUS

3rd Wednesday of the month Regular meeting time: 10:00am-12:00pm

Open Membership

Bridget Gordon	**Co-Chair**	Commissioner
Yolanda Salinas	**Co-Chair**	Commissioner

Committee Member Name	Member Category	Affiliation	Notes
* = *Primary Committee Assignment*	** = *Secondary Committee Assignment*		

TRANSGENDER TASK FORCE		
Time/Date: TBD		
Open Membership		
Destin Cortez	**Co-Chair**	Community Member
Michelle Enfield	Member	Community
Susan Forrest	Member	Commissioner
Jaden Fields	Member	Community
Kimberly Kisler, PhD	Member	Community
Maria Roman	Member	Community

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COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

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

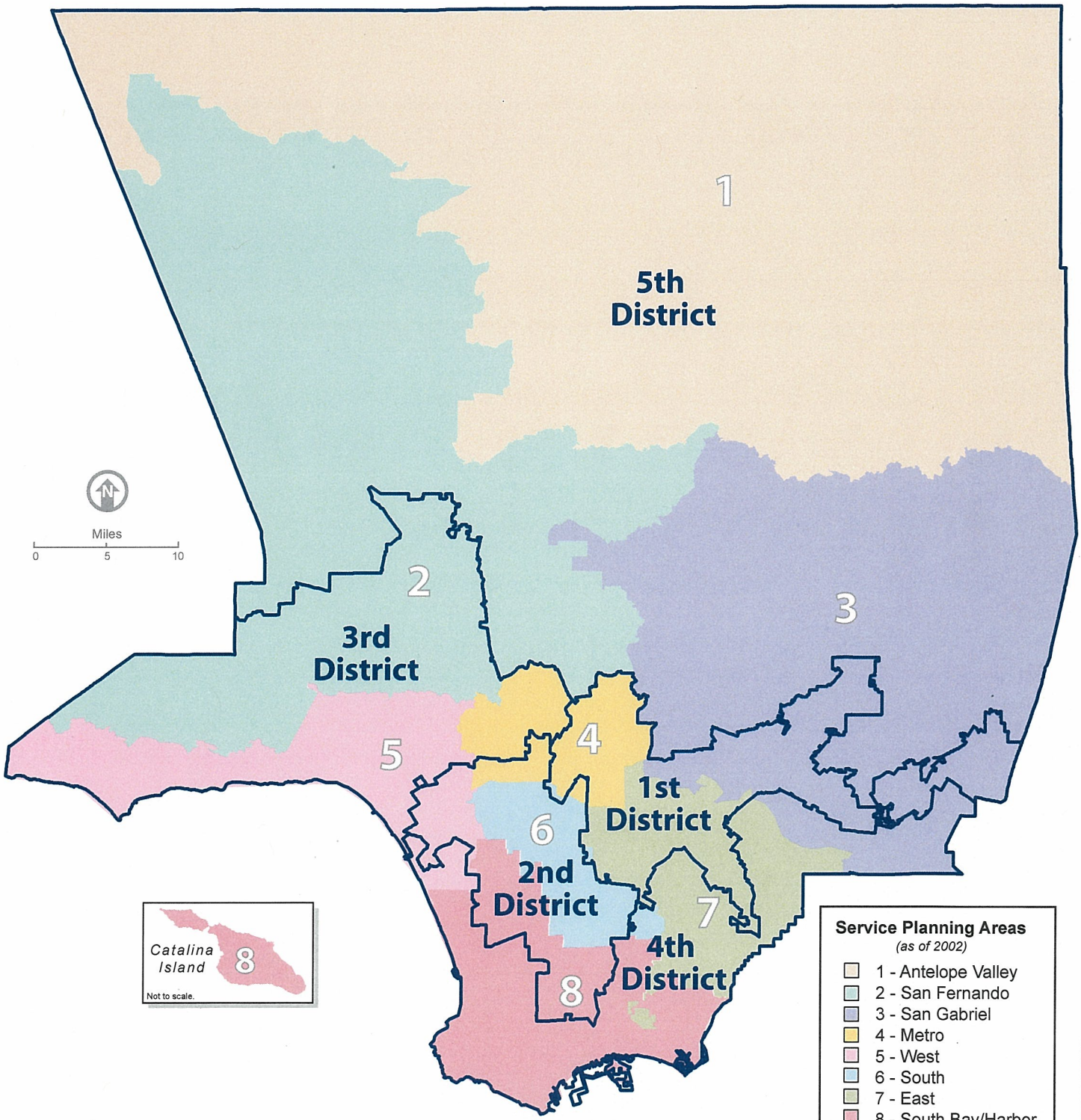
COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
ARNOLD	**Majel**	California State Office of AIDS	No Ryan White or prevention contracts
BROWN	**Jason**	Unaffiliated consumer	No Ryan White or prevention contracts
BALLESTEROS	**Al**	JWCH, INC.	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Case Management, Transitional
			Health Education/Risk Reduction (HERR)
			HIV Counseling and Testing (HCT)
			Medical Care Coordination (MCC)
			Mental Health, Psychotherapy
			Mental Health, Psychiatry
			Oral Health
			Biomedical Prevention
BIVENS-DAVIS	**Traci**	No Affiliation	No Ryan White or prevention contracts
CADEN	**Joseph**	Rand Schrader Health & Research Center	Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination
			Mental Health, Psychiatry
CAMPBELL	**Danielle**	UCLA/MLKCH	HIV/AIDS Oral Health Care (Dental) Services
			HIV/AIDS Medical Care Coordination Services
			HIV/AIDS Ambulatory Outpatient Medical Services
			HIV/AIDS Medical Care Coordination Services
			nPEP Services
CATALDO	**Raquel**	Tarzana Treatment Center	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Health Education/Risk Reduction (HERR)
			HIV Counseling and Testing (HCT)
			Medical Care Coordination (MCC)

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
			Case Management, Home-Based
			Case Management, Transitional - Jails
			Medical Transportation
			Mental Health, Psychotherapy
			Oral Health
			Substance Abuse, Residential
			Substance Abuse, Transitional
			Substance Abuse, Detox
			Biomedical Prevention
			Medical Nutrition Therapy
CUNNINGHAM	**David**	Unaffiliated consumer	No Ryan White or prevention contracts
DANIELS	**Michele**	Unaffiliated consumer	No Ryan White or prevention contracts
DARLING-PALACIOS	**Frankie**	Los Angeles Gay & Lesbian Center	Ambulatory Outpatient Medical (AOM)
			Health Education/Risk Reduction (HERR)
			HIV Counseling and Testing (HCT)
			Medical Care Coordination (MCC)
			Mental Health, Psychiatry
			Mental Health, Psychotherapy
			Non-Occupational HIV PEP
			Biomedical Prevention
			STD Screening and Treatment
DONNELLY	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
FORREST	**Susan**	Los Angeles Center for Alcohol and Drug Abuse	HIV/AIDS Health Education
			HIV/AIDS Substance Abuse
			Risk Reduction Prevention Services
			Residential Rehabilitation Services
FOX	**Aaron**	Los Angeles Gay & Lesbian Center	Ambulatory Outpatient Medical (AOM)
			Health Education/Risk Reduction (HERR)
			HIV Counseling and Testing (HCT)
			Medical Care Coordination (MCC)
			Mental Health, Psychiatry
			Mental Health, Psychotherapy
			Non-Occupational HIV PEP
			Biomedical Prevention
			STD Screening and Treatment

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
GARCILAZO	**Marcos**	UCLA Center for Behavioral and Addiction Medicine	Medical Care Coordination Services
GATES	**Jerry**	Keck School of Medicine of USC	No Ryan White or prevention contracts
GODDARD II	**Terry**	Alliance for Housing and Healing	Residential Care Facilities for the Chronically Ill (RCFCI)
GORDON	**Bridget**	Unaffiliated consumer	No Ryan White or prevention contracts
GRANADOS	**Grissel**	Children's Hospital Los Angeles	Ambulatory Outpatient Medical (AOM)
			Case Management, Transitional - Youth
			Health Education/Risk Reduction (HERR)
			HIV Counseling and Testing (HCT)
			Medical Care Coordination (MCC)
			Biomedical Prevention
GREEN	**Joseph**	Unaffiliated consumer	No Ryan White or prevention contracts
KOCHEMS	**Lee**	Unaffiliated consumer	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts
LAND	**Bradley**	Unaffiliated consumer	No Ryan White or prevention contracts
LEE	**David**	Charles R. Drew University of Medicine and Science	HIV/AIDS Benefits Specialty Services
			HIV Counseling, Testing, and Referral Prevention Services
LEUE PAUL	**Eric**	Free Speech Coalition	No Ryan White or prevention contracts
LOPEZ	**Abad**	Unaffiliated consumer	No Ryan White or prevention contracts
LOPEZ	**Andrew**	Friends Research Institute	Health Education/Risk Reduction and HIV Testing Services
MARTINEZ	**Eduardo**	AIDS Healthcare Foundation	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Medical Care Coordination (MCC)
			MH, Psychiatry
			MH, Psychotherapy
			Medical Specialty
			Oral Health
			HIV Counseling and Testing (HCT)
			STD Screening and Treatment
MARTINEZ	**Miguel**	Children’s Hospital, Los Angeles	Ambulatory Outpatient Medical (AOM)
			Case Management, Transitional - Youth
			Health Education/Risk Reduction (HERR)
			HIV Counseling and Testing (HCT)
			Medical Care Coordination (MCC)
			Biomedical Prevention
MILLS	**Anthony**	Southern CA Men’s Medical Group	Biomedical Prevention
			Medical Care Coordination (MCC)

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MUNOZ	**Jose**	Unaffiliated consumer	No Ryan White or prevention contracts
MURRAY	**Derek**	City of West Hollywood	No Ryan White or prevention contracts
OWENS COLLINS	**Deborah**	Long Beach Department of Health & Human Services	Benefits Specialty
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
PEÑA	**Raphael**	Unaffiliated consumer	No Ryan White or prevention contracts
PERÉZ	**Mario**	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee
PRECIADO	**Juan**	Northeast Valley Health Corporation	Mental Health, Psychotherapy
			Benefits Specialty
			Mental Health, Psychiatry
			Oral Health
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
PUCKETT, JR.	**Thomas**	Unaffiliated Consumer	No Ryan White or prevention contracts
ROBINSON	**Ace**	No Affiliation	No Ryan White or prevention contracts
RONQUILLO	**Rebecca**	City of Los Angeles, HOPWA	No Ryan White or prevention contracts
ROSALES	**Ricky**	City of Los Angeles AIDS Coordinator	No Ryan White or prevention contracts
SATTAH	**Martin**	Rand Schrader Clinic LA County Department of Health Services	Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Mental Health, Psychiatry
SPENCER	**LaShonda**	LAC & USC MCA Clinic	Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
STALTER	**Kevin**	The Brotherhood IMPACT Fund	No Ryan White or prevention contracts
SUMPTER	**Yolanda**	Unaffiliated consumer	No Ryan White or prevention contracts
WILSON	**Gregory**	In the Meantime Men's Group, Inc.	HIV/AIDS Health Education/Risk Reduction Prevention Services
YBARRA	**Russell**	Capitol Drugs	No Ryan White or prevention contracts

Los Angeles County Service Planning Areas by Supervisorial District



Service Planning Areas
(as of 2002)

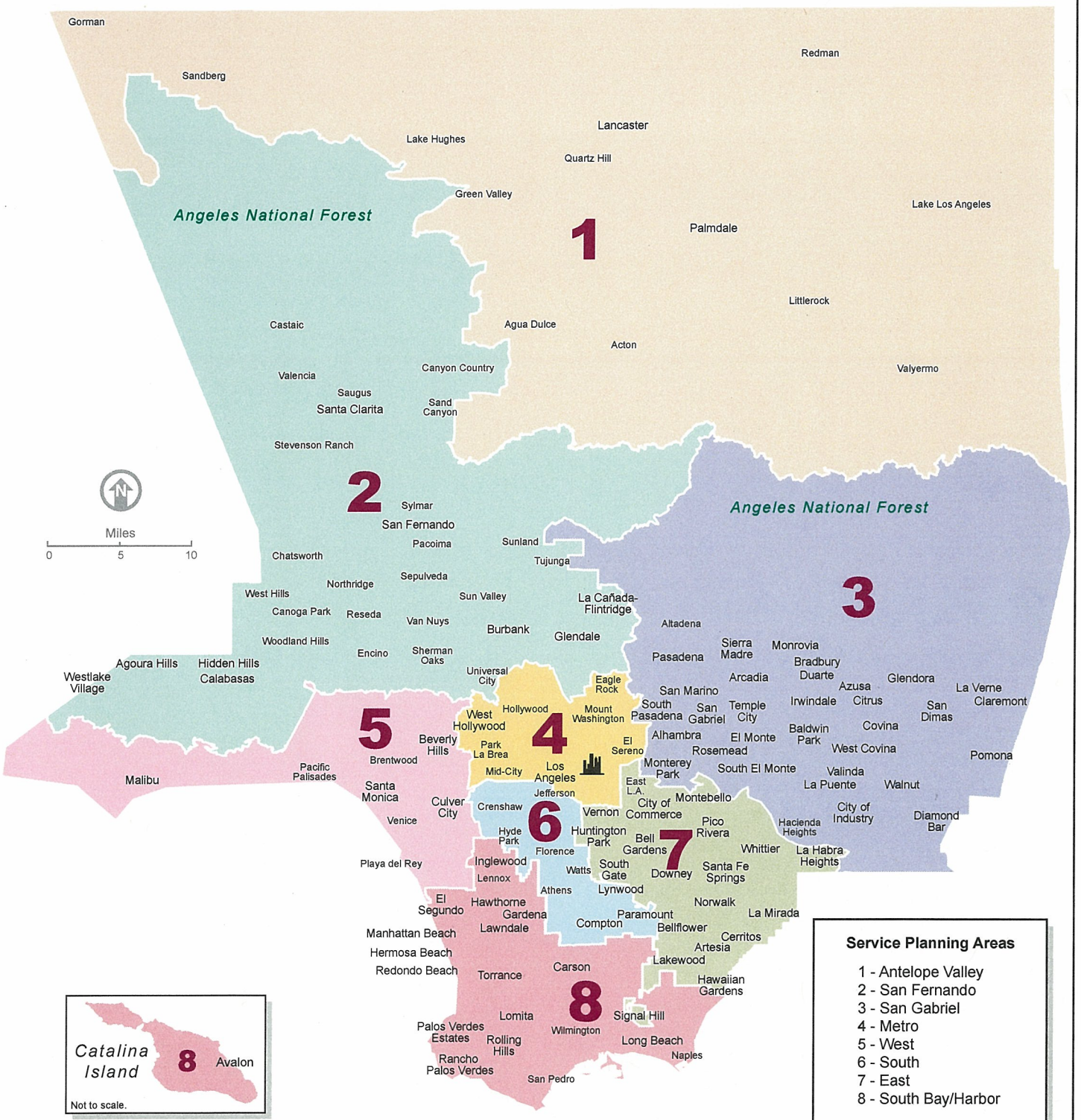
- 1 - Antelope Valley
- 2 - San Fernando
- 3 - San Gabriel
- 4 - Metro
- 5 - West
- 6 - South
- 7 - East
- 8 - South Bay/Harbor

American Indian Children's Council covers all SPAs

Los Angeles County Children's Planning Council
Improving Children's Lives

August, 2002
Los Angeles County
Children's Planning Council
Data Partnership (213) 893-0421

Los Angeles County
Service Planning Areas



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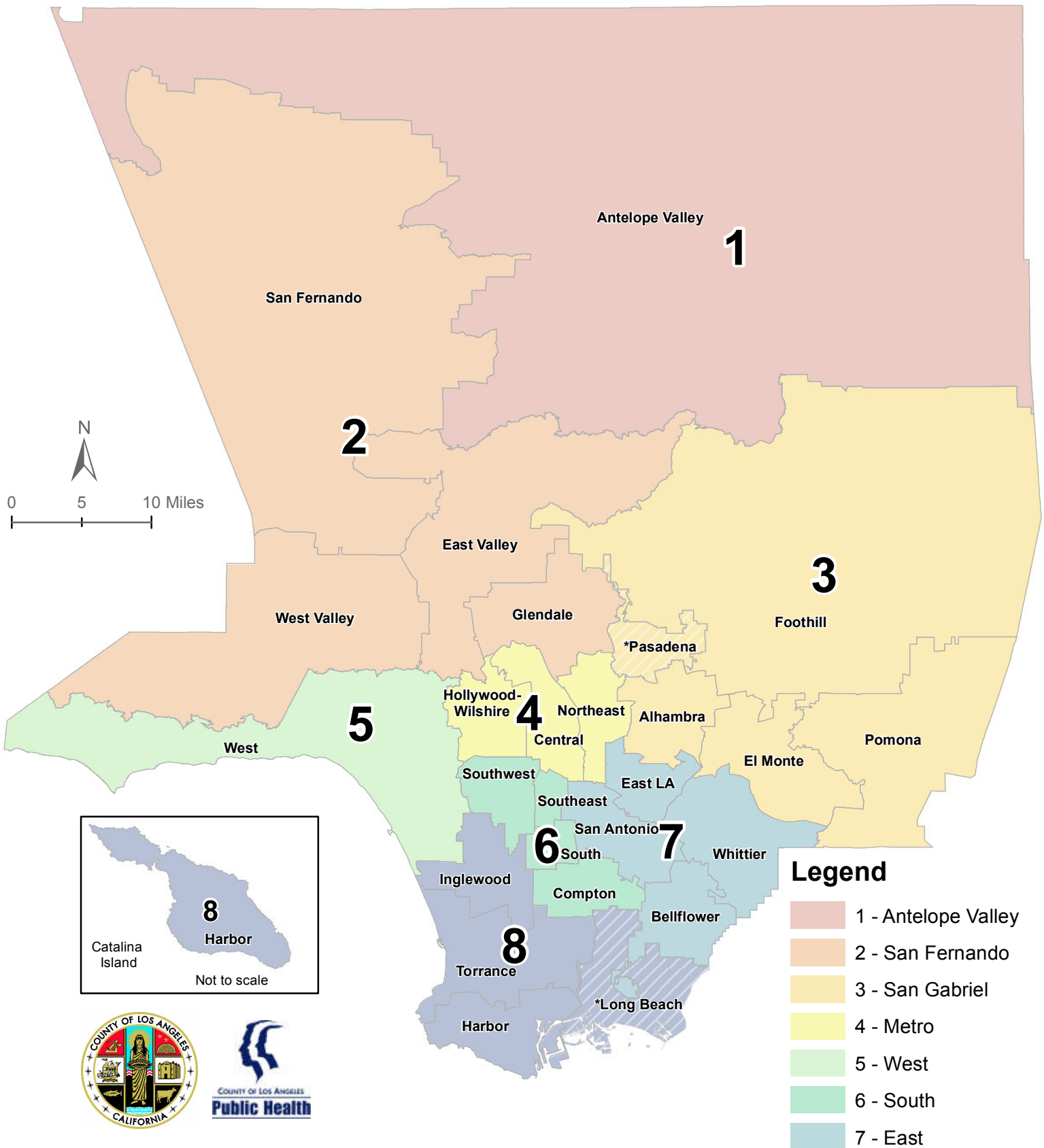
American Indian Children's Council covers all SPAs

Los Angeles County
Children's Planning Council
Improving Children's Lives

Note: City names are shown in **BLACK**.
Communities are shown in **GRAY**.

August, 2002
Los Angeles County
Children's Planning Council
Data Partnership (213) 893-0421

Los Angeles County Department of Public Health
Service Planning Areas (SPA) and Health Districts (HD) - 2012



Created by: Office of Health Assessment and Epidemiology. 07/05/2012.
Source: SPA and HD boundaries were released in 2012 based on 2010 Census TIGER/Line Shapefiles, U.S. Census Bureau, Geography Division, Geographic Products Branch.
*Long Beach and Pasadena are their own health jurisdictions.

HIV Calendar

December 2017

Sun	Mon	Tue	Wed	Thu	Fri	Sat
26 Week 48	27	28 9:30 AM - 1:00 PM Board of Supervisors (BOS)	29 9:30 AM - 11:30 AM BOS Agenda Review	30	1 World AIDS Day	2
3 Week 49	4 1:00 PM - 3:00 PM Public Policy Committee	5 9:30 AM - 1:00 PM Board of Supervisors (BOS)	6 9:30 AM - 11:30 AM BOS Agenda Review	7 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	8	9
10 Week 50	11	12 9:30 AM - 1:00 PM Board of Supervisors (BOS)	13 9:30 AM - 11:30 AM BOS Agenda Review	14 9:00 AM - 1:00 PM Commission Meeting	15	16
17 Week 51	18	19 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 3:00 PM [CANCELED] Planning, Priorities & Allocations (PP&A)	20 9:30 AM - 11:30 AM BOS Agenda Review 10:00 AM - 12:00 PM [CANCELED] Women's Caucus	21	22	23
24 Week 52	25 8:00 AM - 5:00 PM Christmas Holiday - COH Office Closed	26 9:30 AM - 1:00 PM Board of Supervisors (BOS)	27 9:30 AM - 11:30 AM BOS Agenda Review 10:00 AM - 12:00 PM [CANCELED] Housing Taskforce	28 10:00 AM - 12:00 PM Operations Committee Meeting 1:00 PM - 3:00 PM Executive Committee Meeting	29	30
31 Week 1	1 New Year's Day - Holiday (COH Office Closed) 1:00 PM - 3:00 PM [CANCELED] Public Policy Committee	2 9:30 AM - 1:00 PM Board of Supervisors (BOS)	3 9:30 AM - 11:30 AM BOS Agenda Review	4 10:00 AM - 12:00 PM [CANCELED] Standards & Best Practices (SBP)	5	6

HIV Calendar

January 2018

Sun	Mon	Tue	Wed	Thu	Fri	Sat
31 Week 1	**1** New Year's Day - Holiday (COH Office Closed) 1:00 PM - 3:00 PM [CANCELED] Public Policy Committee	**2** 9:30 AM - 1:00 PM Board of Supervisors (BOS)	**3** 9:30 AM - 11:30 AM BOS Agenda Review	**4** 10:00 AM - 12:00 PM [CANCELED] Standards & Best Practices (SBP)	**5**	**6**
7 Week 2	**8** 1:00 PM - 3:00 PM Public Policy Committee	**9** 9:30 AM - 1:00 PM Board of Supervisors (BOS)	**10** 9:30 AM - 11:30 AM BOS Agenda Review	**11** 9:00 AM - 1:00 PM Commission Meeting	**12**	**13**
14 Week 3	**15** Martin Luther King, Jr. Day - Holiday: COH Office Closed	**16** 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 3:00 PM Planning, Priorities & Allocations (PP&A)	**17** 9:30 AM - 11:30 AM BOS Agenda Review	**18**	**19**	**20**
21 Week 4	**22**	**23** 9:30 AM - 1:00 PM Board of Supervisors (BOS)	**24** 9:30 AM - 11:30 AM BOS Agenda Review 10:00 AM - 12:00 PM Housing Taskforce Meeting	**25** 10:00 AM - 12:00 PM Operations Committee Meeting 1:00 PM - 3:00 PM Executive Committee Meeting	**26**	**27**
28 Week 5	**29** 1:00 PM - 3:00 PM Data and Epidemiology Overview	**30** 9:30 AM - 1:00 PM Board of Supervisors (BOS)	**31** 9:30 AM - 11:30 AM BOS Agenda Review	1 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	2	3

HIV Calendar

February 2018

Sun	Mon	Tue	Wed	Thu	Fri	Sat
28 Week 5	29 1:00 PM - 3:00 PM Data and Epidemiology Overview	30 9:30 AM - 1:00 PM Board of Supervisors (BOS)	31 9:30 AM - 11:30 AM BOS Agenda Review	**1** 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	**2**	**3**
4 Week 6	**5** 1:00 PM - 3:00 PM Public Policy Committee	**6** 9:30 AM - 1:00 PM Board of Supervisors (BOS)	**7** 9:30 AM - 11:30 AM BOS Agenda Review	**8** 9:00 AM - 1:00 PM Commission Meeting	**9**	**10**
11 Week 7	**12**	**13** 9:30 AM - 1:00 PM Board of Supervisors (BOS)	**14** 9:30 AM - 11:30 AM BOS Agenda Review	**15** 1:00 PM - 3:00 PM Effective Communication and Active Listening	**16**	**17**
18 Week 8	**19** Holiday: COH Office Closed	**20** 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 3:00 PM Planning, Priorities & Allocations (PP&A)	**21** 9:30 AM - 11:30 AM BOS Agenda Review	**22** 10:00 AM - 12:00 PM Operations Committee Meeting 1:00 PM - 3:00 PM Executive Committee Meeting	**23**	**24**
25 Week 9	**26**	**27** 9:30 AM - 1:00 PM Board of Supervisors (BOS)	**28** 9:30 AM - 11:30 AM BOS Agenda Review 10:00 AM - 12:00 PM Housing Taskforce Meeting	1 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	2	3

HIV Calendar

March 2018

Sun	Mon	Tue	Wed	Thu	Fri	Sat
25 Week 9	26	27 9:30 AM - 1:00 PM Board of Supervisors (BOS)	28 9:30 AM - 11:30 AM BOS Agenda Review 10:00 AM - 12:00 PM Housing Taskforce Meeting	1 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	2	3
4 Week 10	5 1:00 PM - 3:00 PM Public Policy Committee	6 9:30 AM - 1:00 PM Board of Supervisors (BOS)	7 9:30 AM - 11:30 AM BOS Agenda Review	8 9:00 AM - 1:00 PM Commission Meeting	9	10
11 Week 11	12	13 9:30 AM - 1:00 PM Board of Supervisors (BOS)	14 9:30 AM - 11:30 AM BOS Agenda Review	15 1:00 PM - 3:00 PM Running and Facilitating Meetings	16	17
18 Week 12	19	20 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 3:00 PM Planning, Priorities & Allocations (PP&A)	21 9:30 AM - 11:30 AM BOS Agenda Review	22 10:00 AM - 12:00 PM Operations Committee Meeting 1:00 PM - 3:00 PM Executive Committee Meeting	23	24
25 Week 13	26 César Chávez Day - Holiday: COH Office Closed	27 9:30 AM - 1:00 PM Board of Supervisors (BOS)	28 9:30 AM - 11:30 AM BOS Agenda Review 10:00 AM - 12:00 PM Housing Taskforce Meeting	29	30	31

LOS ANGELES COUNTY COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140, Los Angeles, CA 90010 · TEL. (213) 7382816 · FAX (213) 637-4748
Website: http://hiv.lacounty.gov Email: hivcomm@lachiv.org

2. MEETING MINUTES

A. November 9, 2017 Commission Meeting Minutes

DRAFT OF MINUTES ARE REMOVED FOR WEBSITE PUBLISHING UNTIL APPROVED BY THE FULL COMMISSION MEETING ON 12/14/17.

LOS ANGELES COUNTY COMMISSION ON HIV

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7. COLLOQUIA SERIES

Los Angeles County Homeless Count: Data on PLWHA

Los Angeles County Homeless Count: Data on People Living with HIV

JuHyun Sakota is the Manager of Data and Research at Los Angeles Homeless Services Authority, the lead agency for the Los Angeles Continuum of Care. She leads a team of research and GIS analysts to design and oversee the implementation of the methodology for the annual Greater Los Angeles Homeless Count. Her expertise includes quantitative and spatial analysis on socioeconomic issues and data storytelling.

For more information, visit:

https://www.lahsa.org/homeless-count/

LAHSA

LOS ANGELES HOMELESS SERVICES AUTHORITY

LAHSA

LOS ANGELES HOMELESS SERVICES AUTHORITY

2017 Greater Los Angeles Homeless Count Results

Prepared for
LA County HIV Commission

JuHyun Sakota
Manager, Data and Research

December 14, 2017

Agenda

- Introducing LAHSA
- Introduction: Homeless Count
- Methodology: Surveys
- Data: HIV and Homelessness
- Q&A

Introducing LAHSA

- City+County Joint Powers Authority
- To support, create, and sustain solutions to homelessness in LA County by providing leadership, advocacy, planning, and management of program funding.
- Los Angeles Continuum of Care (LA CoC) lead agency

Introduction: Homeless Count

Why We Count

The Greater Los Angeles Homeless Count

- Gives a snapshot (or Point-In-Time Count) of homelessness in LA
- Answers key questions about homelessness in LA
    - How many people?
    - What are the demographics?
    - What is the distribution across the County?
    - Where are people experiencing homelessness staying?

The Point-In-Time Count is mandated by the U.S. Department of Housing and Urban Development.

Where We Count

- Los Angeles Continuum of Care (CoC)
  - 100% Census Tract Coverage (Street Count)
- Street Locations
  - Metro Lines
  - County Parks
  - Riverbeds
- Shelter Types
  - Emergency Shelters
  - Transitional Housing
  - Safe Havens
- LA CoC excludes Pasadena, Glendale, Long Beach

When We Count

- Annually
- Last 10 days of January
- Street Count, January 24—January 26, 2017 by Service Planning Area (SPA)
    - SPAs 2, 3, 7 — January 24
    - SPAs 5, 8 — January 25
    - SPAs 1, 4, 6 — January 26

Who We Count

Persons who meet HUD's definition of literal homelessness

Unsheltered

"An individual/family whose primary nighttime residence is public/private place not designed for or ordinarily used as a regular sleeping accommodation for human beings."

Sheltered

"An individual/family living in a supervised publicly or privately operated shelter designed to provide temporary living arrangement."

Emergency Shelters
Transitional Housing
Safe Havens
Emergency Hotel/Motel Voucher

24 CFR 578.3 of the Homeless Definition Final Rule

How We Count

Total Homeless Population

	Single Adult	Adult Families	Transition Age Youth (18 to 24)	Young Families	Unaccompanied Minors
Unsheltered	Street Count	Demographic Survey	Youth Count / Demographic Survey		
Sheltered		Shelter Count	Shelter Intake Survey		

Demographic Survey

Survey of persons experiencing unsheltered homelessness

Census Tract based two-stage sampling (probability/random sampling)

- January – March 2017
- 415 out of 2,160 census tracts were selected
- Survey attempts were made in 387 census tracts
- n= 4,808

Findings: Homeless Count

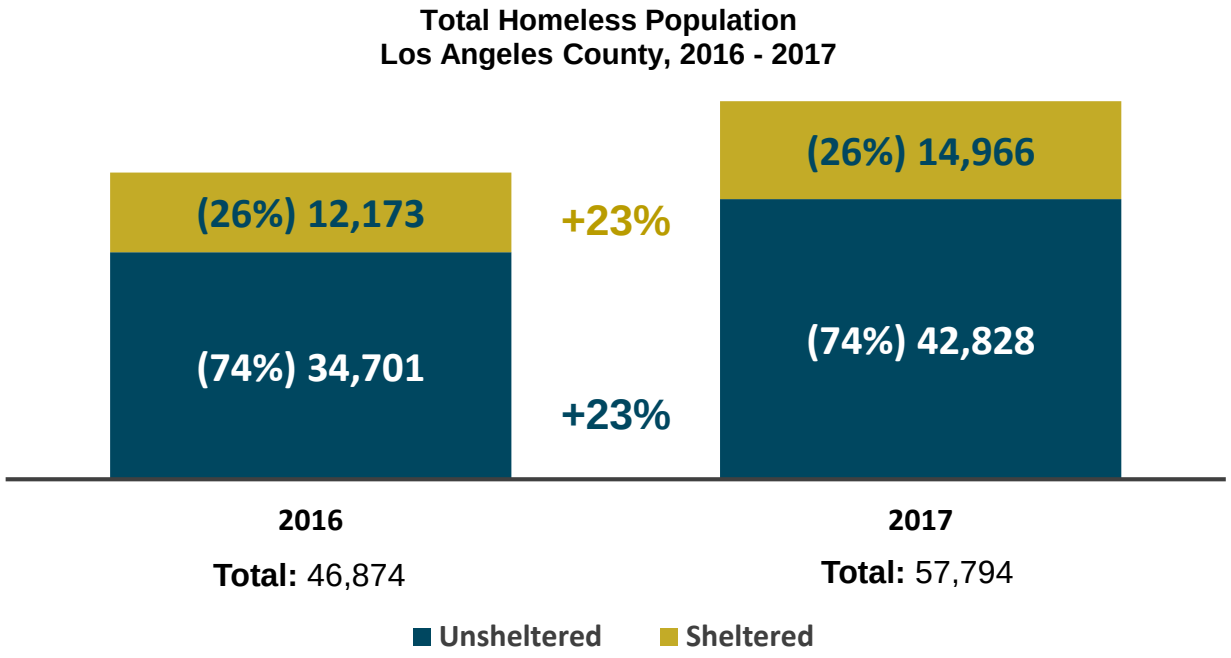
2017 Los Angeles County Results

Geography:
LA County

Population:
Total
(Sheltered and
Unsheltered)

57,794 People experiencing homelessness on a given night

23% Increase from 2016 total of 46,874



Los Angeles County also includes Glendale, Long Beach, and Pasadena CoCs

2017 Los Angeles County Findings by SPAs

Geography:
LA County

Population:
Total
(Sheltered and
Unsheltered)

Service Planning Area	2016 Total	2017 Total	% Change
1- Antelope Valley	3,038	4,559	+50%
2- San Fernando Valley	7,334	7,627	+4%
3- San Gabriel Valley	3,142	4,127	+31%
4- Metro LA	11,860	15,393	+30%
5- West LA	4,659	5,511	+18%
6- South LA	7,459	9,243	+24%
7- East LA County	3,469	5,189	+50%
8- South Bay	5,913	6,145	+4%
Totals	**46,874**	**57,794**	**+23%**

Los Angeles County also includes Glendale, Long Beach, and Pasadena CoCs

People Placed into Housing

Geography:
LA CoC

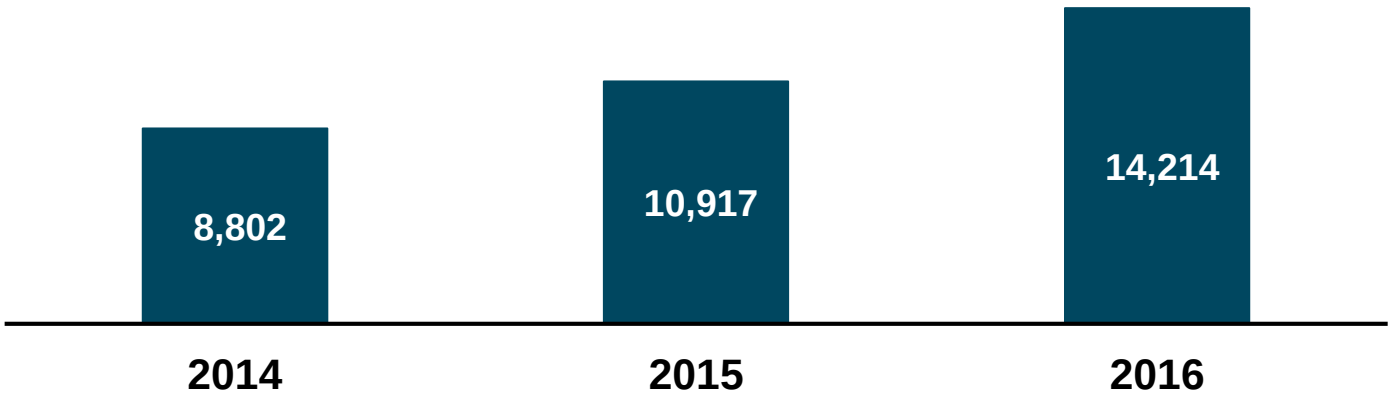
Population:
Total
(Sheltered and
Unsheltered)

14,214 People moved out of homelessness into Permanent Housing in 2016

30% Increase from 2015

61% Increase from 2014

Total Housing Placements, Los Angeles Continuum of Care, 2014 - 2016



LA CoC excludes Glendale, Pasadena, and Long Beach CoCs

Demographic Characteristics

Age

Race/Ethnicity

Gender

Sexual Orientation

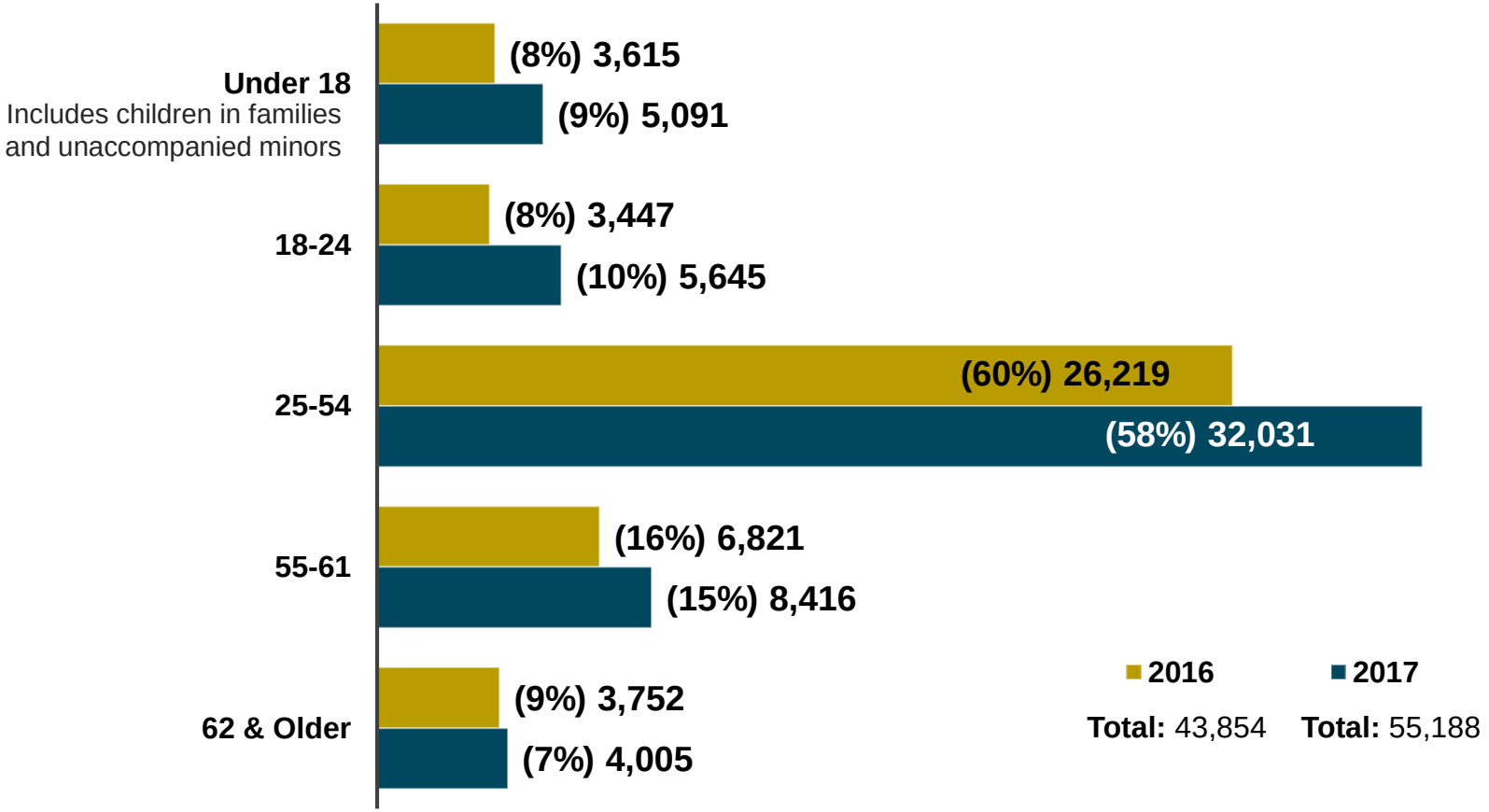
Health Conditions

Age

Geography:
LA CoC

Population:
Total
(Sheltered and
Unsheltered)

Total Homeless Population by Age
Los Angeles Continuum of Care, 2016 - 2017

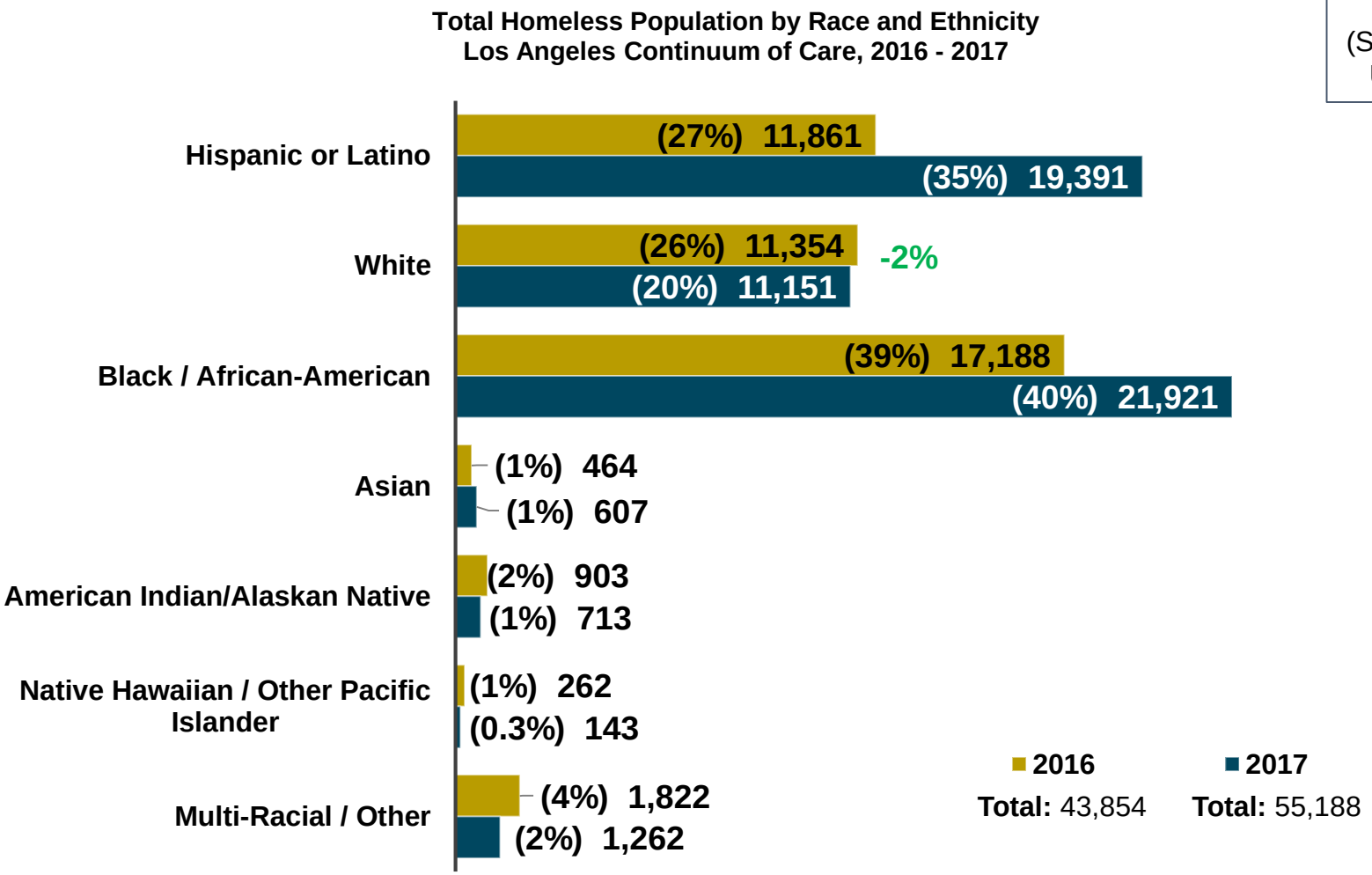


LA CoC excludes Glendale, Pasadena, and Long Beach CoCs

Race and Ethnicity

Geography:
LA CoC

Population:
Total
(Sheltered and
Unsheltered)



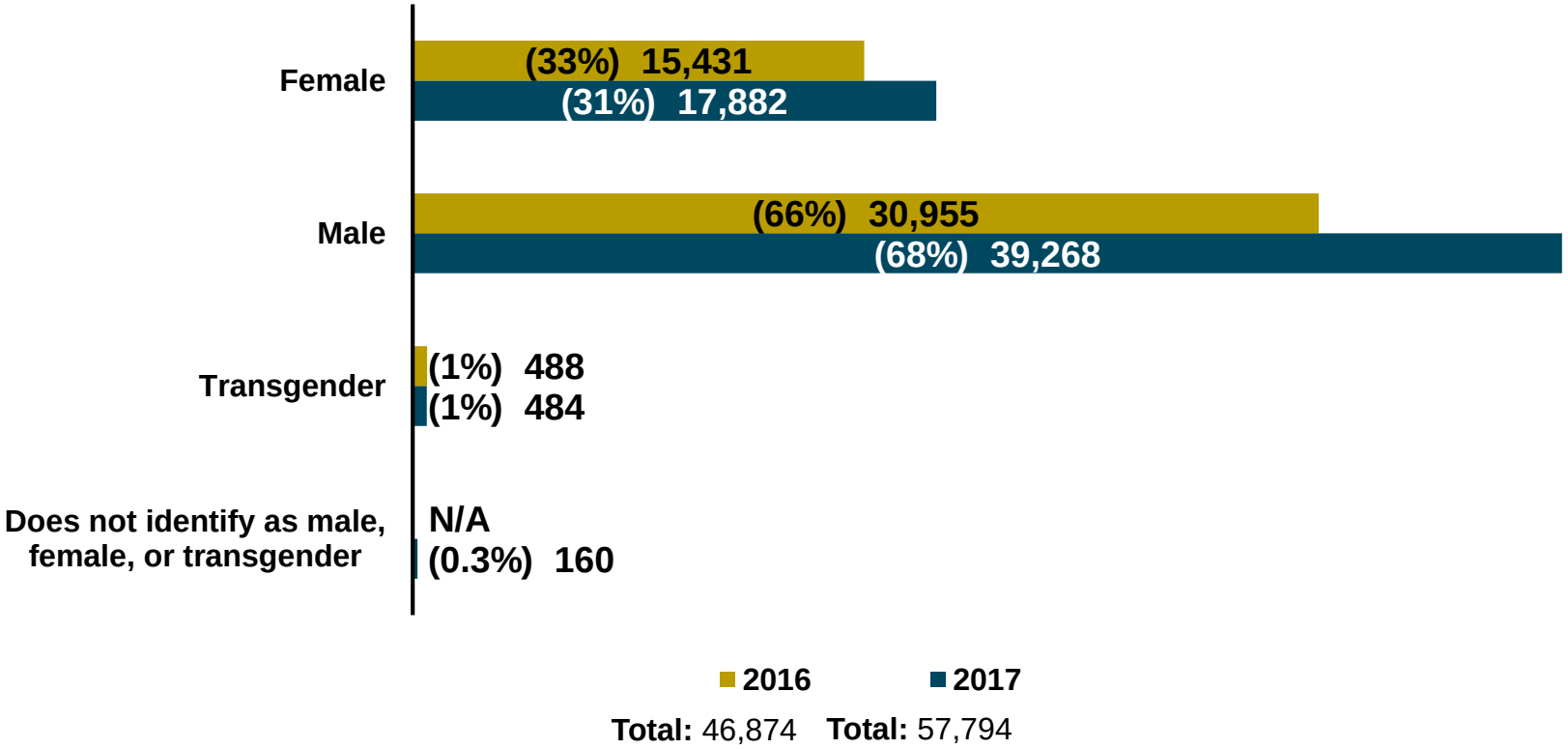
LA CoC excludes Glendale, Pasadena, and Long Beach CoCs

Gender

Geography:
LA County

Population:
Total
(Sheltered and
Unsheltered)

Total Homeless Population by Gender
Los Angeles County, 2016 - 2017

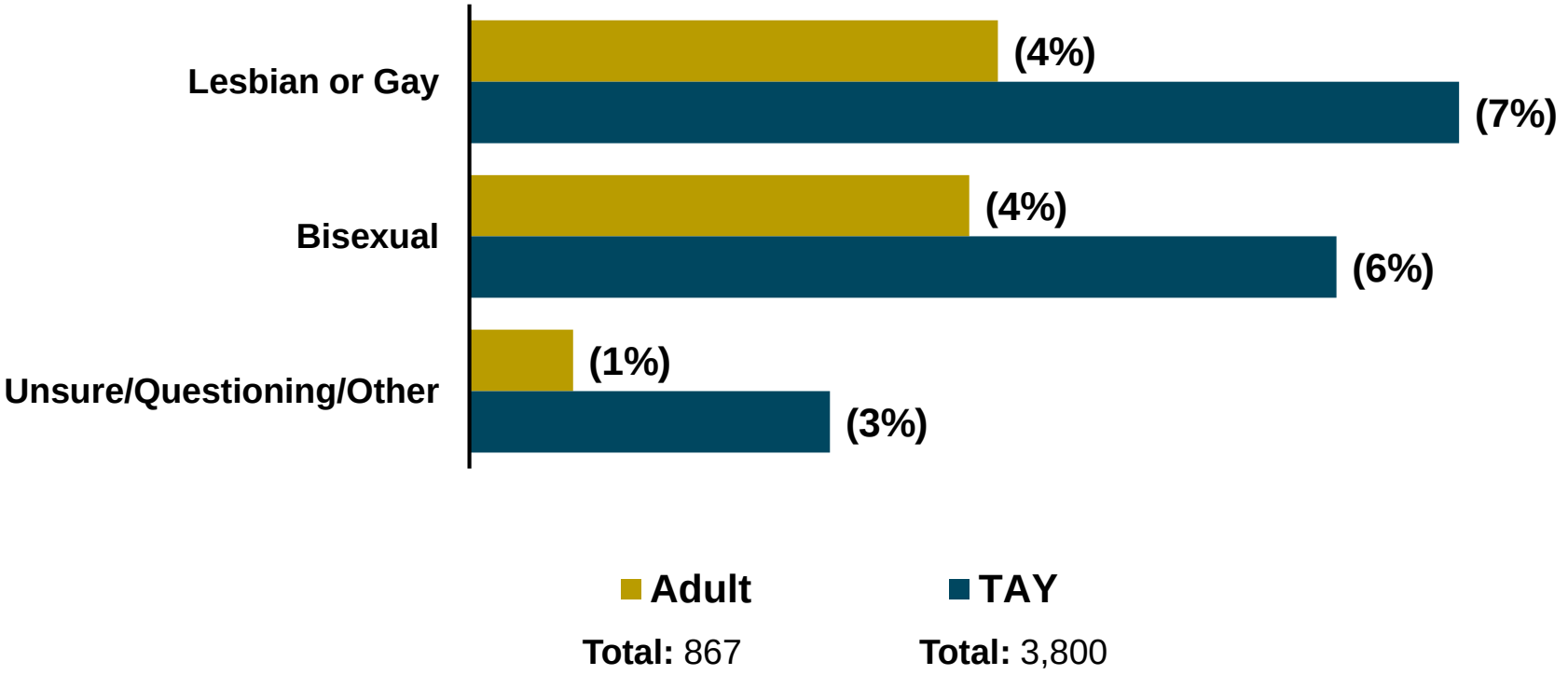


"Does not identify as male, female, or transgender" category was introduced to the Demographic Survey for the first time in 2017
Los Angeles County includes Glendale, Pasadena, and Long Beach CoCs

Sexual Orientation

Geography:
LA CoC

Population:
Total (Sheltered and Unsheltered) 18+

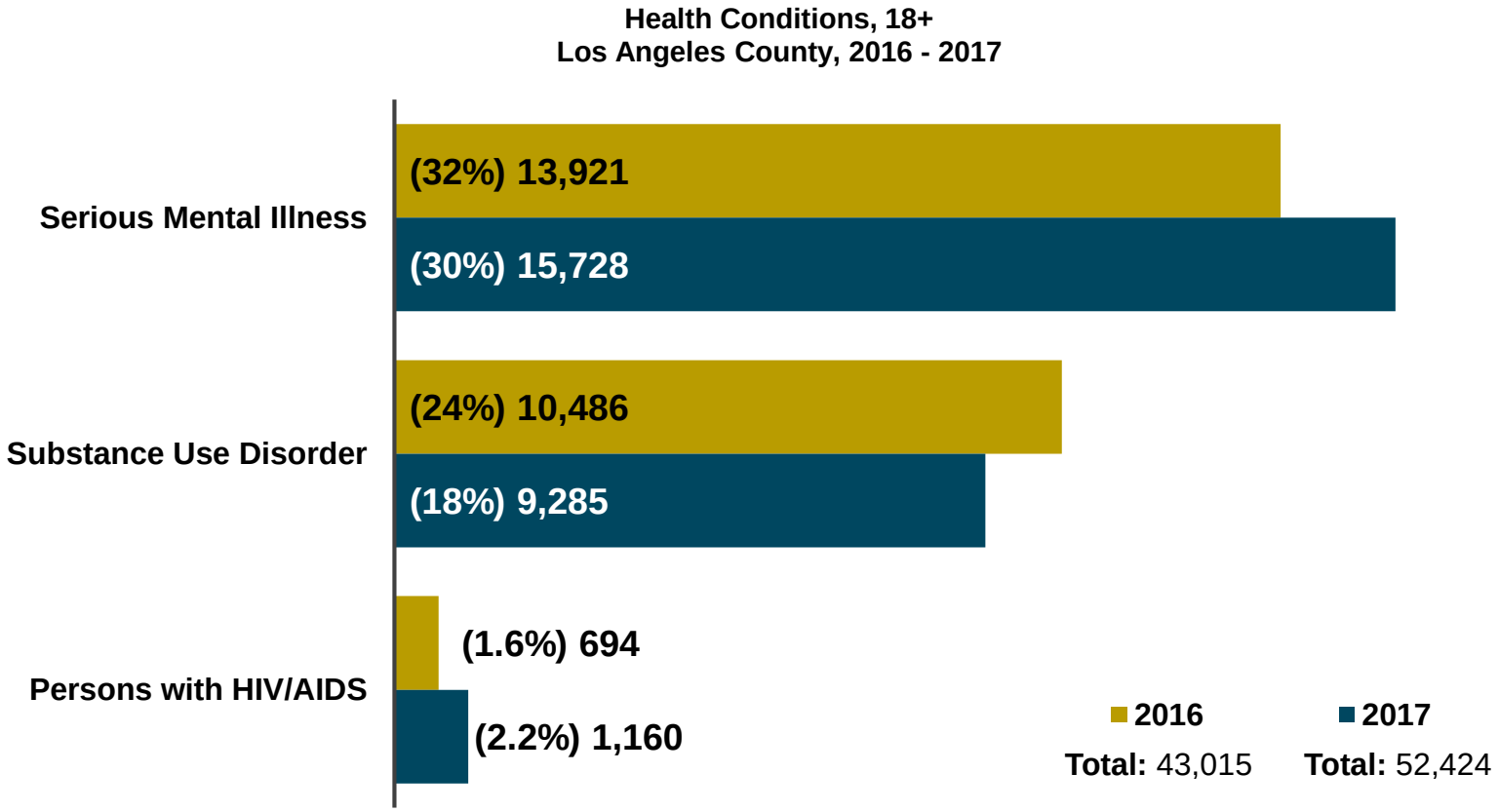


LA CoC excludes Glendale, Pasadena, and Long Beach CoCs

Health Conditions

Geography:
LA County

Population:
Total (Sheltered and Unsheltered) 18+



Question asked using response card
Totals for each condition include persons 18 years and older only
Los Angeles County includes Glendale, Pasadena, and Long Beach CoCs

Health Conditions

36. Do you have, have you ever had, or has a healthcare provider ever told you that you have any of the following health conditions? *Please use the response card.*

- ❑ Problematic alcohol use
- ❑ Problematic drug use
- ❑ Serious and long continuing mental illness (e.g, depression, bipolar disorder, or schizophrenia)
- ❑ Physical disability
- ❑ Physical illness (chronic or ongoing)
- ❑ HIV / AIDS-related illness
- ❑ Severe depression (chronic or ongoing)
- ❑ Post-Traumatic Stress Disorder (PTSD)
- ❑ Traumatic Brain Injury (TBI)
- ❑ Developmental disability
- ❑ None of the above
- ❑ Declined
- ❑ Don't know

Data: HIV and Homelessness

Results from Demographic Survey

2 out of 100 persons ages 18 and over experiencing homelessness in LA have HIV/AIDS (self-reported). (Incidence rate of HIV/AIDS in the County: 24.3 per 100,000 persons)

Significant increases in persons who have HIV/AIDS in SPAs 4, 7, and 8 from 2016 to 2017.

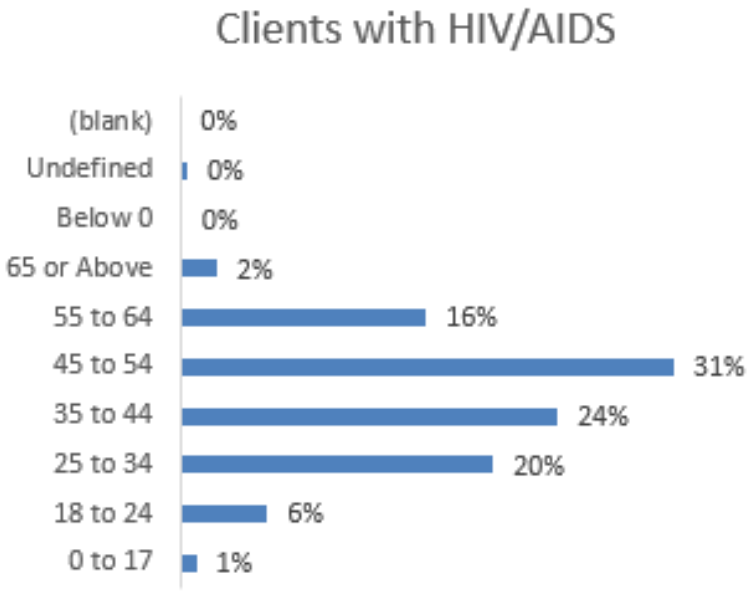
Service Planning Area	2016	2017	% Change
1- Antelope Valley	20 (1%)	32 (1%)	+60%
2- San Fernando Valley	157 (2%)	126 (2%)	-20%
3- San Gabriel Valley	22 (1%)	60 (2%)	+173%
4- Metro LA*	284 (3%)	641 (4%)	+126%
5- West LA	14 (0.3%)	49 (1%)	+250%
6- South LA	102 (1%)	114 (1%)	+12%
7- East LA County*	49 (2%)	24 (1%)	-51%
8- South Bay*	61 (2%)	111 (3%)	+82%
Totals	**694 (2%)**	**1,160 (3%)**	**+67%**

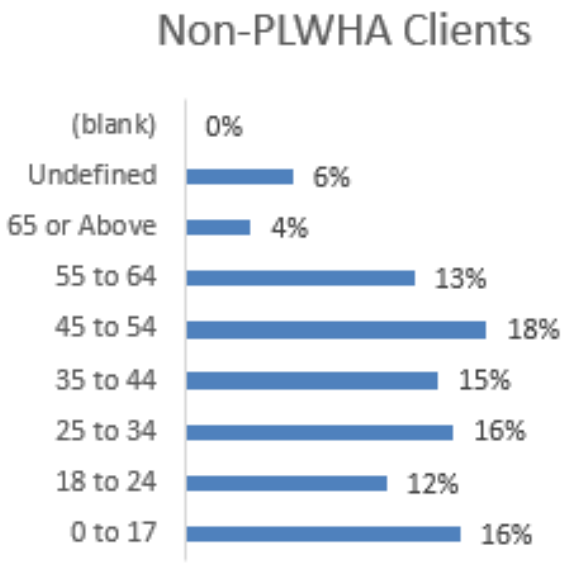
Los Angeles County includes Glendale, Pasadena, and Long Beach CoCs

* Statistically significant change in population of people with HIV/AIDS

Annualized Picture (People on HMIS)

- About 2% of clients on HMIS live with HIV/AIDS. (2,573 out of 122,112)
- 76% are male (v. 54% among non-PLWHA clients)
- 55% are ages between 35 and 54 (v. 33% among non-PLWHA clients)





HMIS Client Data from Los Angeles Homeless Services Authority. (Data period: 12/1/2016 to 11/30/2017)

Shelter Programs for PLWHA

Transitional Housing (205 Beds)

SPA 2

- Tarzana Treatment Center – HIV Transitional Housing Program

SPA 4

- Alliance for Housing and Healing – Serra Project
- JWCH Institute, Inc. – HOPWA
- Project New Hope – Residential Care Facilities for the Chronically Ill
- SRO Housing Corporation - HOPWA
- The Salvation Army – Bethesda House at Algeria

SPA 7

- Whittier Area First Day Coalition – Homelessness Program

Data from Housing Inventory Count (2017), Los Angeles Homeless Services Authority

Shelter Programs for PLWHA

Emergency Shelter (90 Beds)

SPA 4

- First Presbyterian Church of Hollywood – Hollywood Winter Refuge
- JWCH Institute, Inc. – HOPWA
- SRO Housing Corporation - HOPWA

Data from Housing Inventory Count (2017), Los Angeles Homeless Services Authority

Housing Programs for PLWHA

Permanent Supportive Housing (612 Beds)

SPA 1: Affordable Living for the Aging – Lancaster Shared Housing

SPA 3: Alliance for Housing and Healing – CHOISS

SPA 4

- Hollywood Community Housing Corporation – Allesandro, Argyle Court, and Hollywood Bungalow Apartments
- Project New Hope – Hoover and Nyumba Apartments
- Skid Row Housing Trust – Lincoln and Dewey Hotel
- SRO Housing Corporation – Eugene Hotel and Rivers Apartments

SPA 5: Alliance for Housing and Healing - CHOISS

SPA 6: Project New Hope – Lockwood, Hoover, and Nyumba Apartments

SPA 7: Alliance for Housing and Healing – CHOISS Program

SPA 8: Project New Hope – Tripp House

Data from Housing Inventory Count (2017), Los Angeles Homeless Services Authority

Housing Programs for PLWHA

Other Permanent Housing (35 Beds)

SPA 4: SRO Housing Corporation - Rivers Apartment

Data from Housing Inventory Count (2017), Los Angeles Homeless Services Authority

Resources

2017 Homeless Count

http://www.lahsa.org/homeless-count/

- Fact Sheets
- Interactive Data Visualizations
- Data Summary Tables
- GIS Maps with Jurisdictions
- Count Methodology Report
- Special Data Reports
- Other Technical Notes

2018 Homeless Count

Theycountwillyou.org

- Background/Information
- Promotional Materials
- Volunteer Sign Up

The homeless count, no matter where they live.

Become a volunteer at:
theycountwillyou.org

Contact

- **Data Requests**

datasupport@lahsa.org

- **Questions on Homeless Count Methodology**

jsakota@lahsa.org

11. CALIFORNIA OFFICE OF AIDS (OA) REPORT

California Department of Public Health (CDPH), Office of AIDS
Monthly Report
December 2017

Office of AIDS Division/Cross Branch Issues

- CDPH has signed on to the Undetectable Equals Untransmittable (U=U) campaign. Considerable scientific evidence verifies that anyone who is HIV positive, taking daily antiretroviral therapy, and has achieved an undetectable viral load in their blood for at least 6 months effectively poses no risk of transmitting the virus to their sexual partners. This "treatment as prevention" approach is a key component of California's Getting to Zero Plan, informs all of CDPH, Office of AIDS (OA) programmatic work, and reduces stigma against people living with HIV.

- CDPH, OA is partnering with the CDPH Immunization Branch to help disseminate a Provider Alert to remind providers to immunize both HIV negative and HIV positive men who have sex with men (MSM) against hepatitis A infection, and offer HIV testing to MSM not known to be positive. The Provider Alert is located on the CDPH website at www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/Immunization/Advisory-MSMHAV.pdf, which also contains links to patient resources regarding viral hepatitis and vaccinations for MSM. Please help OA disseminate these resources throughout the state.

Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention and Care Plan

- On November 8, 2017, at the "HIV Testing in Jails: Tools for Planning, Implementation, and Sustaining" Conference, Diem Tran and Kevin Sitter presented on how the Plan addresses people living with HIV who are incarcerated and the critical need for effective navigation to care and services when a HIV-positive inmate is released. In addition, effective linkage to care models were included in the presentation.

Ryan White (RW) Part B: AIDS Drug Assistance Program (ADAP)

- **Pre-Exposure Prophylaxis Assistance Program (PrEP-AP)**
  CDPH, OA has started developing trainings for enrollment workers to assist in navigating the PrEP portion of the ADAP Enrollment System (AES); which will include Snip-It videos, an ELearning module, and job aids. OA is also developing

a separate training that focuses on policy and enrolling clients in the PrEP Assistance Program during phase I implementation for uninsured clients. Job aids will also be provided to assist uninsured and insured clients and enrollment workers in filling out the online application for the Gilead Patient Assistance Program. CDPH, OA expects to release a training schedule a month before implementation and will conduct live webinar sessions.

- **Access, Adherence, and Navigation Program**
  CDPH, OA is holding regular status meetings with enrollment sites selected to participate in the Access, Adherence, and Navigation Program to answer questions and provide program updates such as contracting and training updates.

- **ADAP Enrollment System (AES)**
  The AES is being developed in stages, with releases of features and improvements to support eligibility management, system navigation, data exchange, reporting, quality assurance, and data security. ADAP continues to coordinate each release with training and outreach to ensure enrollment workers and other users are aware of changes and can correctly use any new features.

  On November 7, CDPH, OA sent enrollment workers an email regarding the new functionality available in the AES:
    - Ability to create and submit work items via the Workload Management Module

  Attached to the email was the “Workload Management for EWs; Release 9, Nov 8” job aid.

  On November 21, CDPH, OA sent enrollment workers an email regarding the new functionalities available in the AES effective November 22:
    - Viral load validation on the Clinical tab for when a value <200 is entered into the Viral Load field. For values <200, enrollment workers will be prompted to select the “Undetectable Viral Load” box.
    - A status of “Pending” will now be shown on the Client Profile screen for work items that are under review by ADAP staff.
    - Ability to view medication payment information (i.e., date of service, day supply, refills remaining) on the Pharmacy Benefits Manager (PBM) page.

  Attached to the email was the “Workload Management for EWs; Release 10, Nov 22” job aid, “Navigating the AES for ADAP, EWs; Release 10, Nov 22” job aid, and the “IBM-MBM-PBM Display” job aid.

- **Covered California Open Enrollment, Off-Exchange Plan Open Enrollment and Medicare Part D Open Enrollment**
  On October 2, letters were sent to Medicare Part Premium Payment Program clients regarding the Medicare Part D open enrollment period, which is October 15, 2017, to December 7, 2017.

  The Covered California open enrollment period is November 1, 2017, to January 31, 2018. ADAP staff and enrollment workers were provided with Management Memoranda regarding the Covered California open enrollment period, off-exchange plan open enrollment periods, and Office of AIDS Health Insurance Premium Payment (OA-HIPP) program requirements. The Management Memoranda contained information regarding changes for Covered California consumers and resources to help assist clients in choosing a health insurance plan. CDPH, OA is mailing letters in English and Spanish regarding the Covered California open enrollment period to existing clients that are enrolled in Covered California and ADAP clients that do not have health coverage.

RW Part B: HIV Care Program

OA awarded an additional $280,932 in RW Part B Minority AIDS Initiative (MAI) funds for fiscal year (FY) 2017 to the following six MAI contractors: Community Medical Center (Fresno), Riverside County, Sacramento County, San Bernardino County, San Mateo County, and Ventura County. These funds are for MAI outreach and treatment education services and only for the RW Part B MAI FY 2017. The funds were made available to all 18 MAI contractors. The six contractors that received the funds were those that submitted requests for additional funds for allowable activities.

AIDS Medi-Cal Waiver Program (MCWP)

On November 16, 2017, the Medi-Cal Subscription Service released Bulletin 518, which announced the implementation of the increased reimbursement rates for eleven of sixteen MCWP service categories. The increased rates were activated in the California Medicaid Management Information System on November 27, 2017, and are retroactive to July 1, 2017.

- Medi-Cal Subscription Service Bulletin 518 is available on the Medi-Cal website at: http://files.medi-cal.ca.gov/pubsdoco/bulletins/artfull/aid201711.asp

- To subscribe to Medi-Cal Subscription Service Bulletins, visit the Medi-Cal website at http://files.medi-cal.ca.gov/pubsdoco/mcss/mcss.asp

HIV Prevention

On December 1, 2017, the Orange County Needle Exchange Program (OCNEP) submitted a request for renewal of certification to CDPH. OCNEP was the first syringe exchange program (SEP) authorized under Health & Safety Code 121349, which allows CDPH to authorize SEPs. After consultation with the local health officer and law enforcement leadership, CDPH will issue a final response to the request for renewal by January 12, 2018.

Surveillance, Research, and Evaluation

In November 2017, the Prevention Research and Evaluation section:

1. Presented "Moving Beyond Performance Measurement: The Importance of Context in Designing California Department of Public Health's (CDPH) Evaluation Plan for Project PrIDE" as part of a Centers for Disease Control and Prevention-sponsored panel presentation at the American Evaluation Association conference in Washington D.C.; and

2. Co-presented a workshop titled "Designing Transgender and Gender Non-Binary Inclusive Surveys and Forms" alongside staff from the Center of Excellence for Transgender Health at the National Transgender Health Summit in Oakland, CA.

For questions regarding this report, please contact: michael.foster@cdph.ca.gov.

LOS ANGELES COUNTY COMMISSION ON HIV

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12. (A) PLANNING, PRIORITIES AND ALLOCATIONS (PP&A) COMMITTEE

1. Approve Ryan White (RW) Program Year (PY) 28 Paradigms and Operating Values (Motion #4)

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Planning, Priorities and Allocations (PP&A) Committee
Paradigms and Operating Values for PY 28
Priority and Allocation Setting

Paradigms	Operating Values
Beliefs that define the boundaries in which the body operates	Understanding what is most important to the body then incorporating it into the decision-making process.
➢ **Equity:** relatively equal portions with attention paid to those disproportionately impacted (e.g. funding allocations with directive for special circumstances)	➢ **Efficiency:** accomplishing the desired operational outcomes with the least use of resources
➢ **Compassion:** response to suffering of others that motivates a desire to help	➢ **Quality:** the highest level of competence in the decision-making process
	➢ **Advocacy:** addressing the asymmetrical power relationships of stakeholders in the process
	➢ **Access:** assuring access to the process for all stakeholders and/or constituencies

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12. (B) STANDARDS AND BEST PRACTICES COMMITTEE REPORT

1. **Proposed Housing Services Standards (Motion #5)**
2. **Proposed Prevention Services Standards (Motion #6)**

Standards and Best Practices (SBP) Committee Report

December 14, 2017

LOS ANGELES COUNTY COMMISSION ON HIV

Updates

- Approve for public comment:
- Housing Services Standards
- Prevention Standards

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Purpose of Standards

- SBP Committee is charged with developing standards of care for the organization and delivery of HIV care, treatment and prevention services.
- Used in monitoring contractors and in determining service quality, as part of its clinical quality management function (HRSA Part A Manual, 2013).
- **Minimum standards intended to meet the needs of clients. Providers may exceed standards.**

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Housing SoC Update Process

- SBP Committee review, development and refinement
- Subject matter expert reviewers
- Sought guidance from housing consultant and DHS Housing for Health program
- Multiple reviews from Housing Task Force, SBP, PP&A, and DHSP partners
- Ensure Ryan White funds are used as last resort

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COMMISSION ON HIV

Housing Standards Process Highlights

- Analyzed Housing For Health Intensive Case Management Services requirements and related RFPs
- Analyzed HOPWA RFPs and assessed where funding may be leveraged
- Analyzed LAHSA RFPs, Coordinated Entry System (CES), and HUD requirements
- Conducted housing site visits to better understand housing systems

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Prevention Standards Project

- Commitment to duty of the COH as an integrated prevention and care planning body.
- Use the Comprehensive HIV Continuum as key document that guides the development and review of all standards
- Ongoing effort aimed at continuous quality improvement

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Process Overview

- Convened Expert Review Panels and community review meetings
- Multiple reviews from SBP Committee and DHSP partners
- First round of public comments held in June 2017
- Analyzed CDC Funding Opportunity Announcement (FOA) PS18-1802: Integrated Human Immunodeficiency Virus (HIV) Surveillance and Prevention Programs for Health Departments
- Alignment with LAC HIV/AIDS Strategy for 2020 and Beyond

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Project Team and Knowledge Partners

- SBP Committee
- COH Staff
- Collaborative Research, LLC
- DHSP Colleagues

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Summary and Next Steps

- Provide comments on proposed Housing and Prevention Services standards
  - COH website
  - Public comment period 12/14/17-1/12/18hivcomm@lachiv.org
  - Attend SBP meetings

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Thank you

Questions & Answers

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DRAFT/UPDATED 12.7.17
For public comment
Email comments to: hivcomm@lachiv.org
Public comment period: 12/14/17-1/12/18

LOS ANGELES COUNTY COMMISSION ON HIV HOUSING SERVICE STANDARDS

Temporary Housing Services

Covers:

Hotel/motel and meal vouchers, Emergency shelter programs, Transitional housing, Income-based Rental Assistance, Residential Care Facility for the Chronically Ill, and Transitional Residential Care Facility

TABLE OF CONTENTS

PURPOSE AND GENERAL ELIBILITY REQUIREMENTS

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 are 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. Evidence shows that housing assistance improves HIV health outcomes at each stage of the HIV Care Continuum. Housing supports increase stability and connection to care for PLWHA experiencing homelessness or unstable housing, and are consistently linked to improved HIV treatment access, continuous care, better health outcomes, and reduced risk of ongoing HIV transmission (https://www.hudexchange.info/resources/documents/The-Connection-Between-Housing-and-Improved-Outcomes-Along-the-HIV-Care-Continuum.pdf)

GENERAL ELIGIBILITY REQUIREMENTS

- Be diagnosed HIV or AIDS with verifiable documentation
- Have a state-recognized identification document
- Be homeless and residing or moving to Los Angeles County
- Have proof of income, if applicable
- Be working with an authorized referral agency and possess a designated housing plan
- Have an income at or below 500% of Federal Poverty Level
- Households that are currently homeless or unstably housed
- Since Ryan White HIV/AIDS Program funds must be considered funds of last resort, providers must develop criteria and procedures to determine client eligibility and to ensure that no other options for residential services are available. Providers must document client eligibility, and must further demonstrate that third party reimbursement (e.g., Medi-Cal) is being actively pursued, where applicable.

1A. HOTEL/MOTEL AND MEAL VOUCHERS (Maximum of 60 days per year)

The primary goal of the hotel/motel and meal voucher program is to prevent people living with HIV from sleeping in places not meant for human habitation when appropriate emergency shelter is unavailable. Clients are may access hotel/motel and meal vouchers through case management services from a designated referral agency. Examples of designated referral agencies include Division of HIV and STD Programs contracted service providers, organizations under the Los Angeles Continuum of Care system, agencies within the City of Los Angeles Housing and Community Investment Department network, and the County of Los Angeles Countywide Housing Assistance Program.

GENERAL REQUIREMENTS

Hotel/motel and meal vouchers are available for a maximum of 60 days per year. To access hotel/motel and meal vouchers, a client must be receiving case management services from a designated referral agency. Eligible clients may receive up to 3 meals per day. Hotel/motel accommodations must be a private room with a bathroom.

Case management services will ensure that the client:

- Is engaged in care
- Has a definitive housing plan that assesses his/her 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 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

The following documents are required to complete the initial hotel/motel and meal voucher process:

- 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
- Identification for all adults over 18 included on the voucher
- Other documentation may be required by agencies in order to comply with funding agency requirements.

When a request to extend hotel/motel and meal vouchers is received, the following documentation must accompany the request

- Updated Case Management Plan - including the follow-up with previous and continuing housing plans

INTENSIVE CASE MANAGEMENT (ICM)

Based on the assessment of client needs and strengths, intensive case management services may be provided to the client. ICM services should follow requirements from Los Angeles County Department of Health Services Supportive Housing Services contractors (RFQS for Supportive Housing Services, April 2017). A detailed description of ICM services is found in Attachment A.

ICMS form the core of the services for people who are homeless, at risk of homelessness, formerly homeless and who have complex health and/or behavioral health conditions; are high utilizers of public services and other vulnerable populations including individuals with criminal justice histories and individuals who are exiting institutions such as hospitals, residential treatment programs, and custody facilities.

ICMS can be provided in a variety of settings including interim housing, rapid rehousing, permanent supportive housing, field based locations, community based locations, health and behavioral health facilities, sobering centers, recuperative care centers, criminal justice and custody facilities, and other settings as needed to end homelessness and support the community reintegration of persons leaving institutions.

HOTEL/MOTEL/MEAL VOUCHER INTENSIVE CASE MANAGEMENT (ICM)	
STANDARD	**MEASURE**
Documentation of client need for ICM through assessments and patient medical and social needs history.	ICM services documented in client chart.

LINKAGE TO MEDICAL CARE COORDINATION

The Medical Care Coordination (MCC) model uses a multi-disciplinary team of a Patient Care Manager, Medical Care Manager and a Case Worker, who work together to facilitate behavioral interventions and coordinate support services to promote improved health outcomes for PLWHA. MCC team members are co-located at the patient's medical home and deliver patient-centered

activities that focus on addressing health status, engagement and retention in care, adherence to HIV medications, and HIV risk reduction. Based on assessment and client needs, eligible individuals should be linked to MCC services. MCC service providers must follow the Division of HIV and STD Programs MCC Protocol (http://ph.lacounty.gov/dhsp/Contractors/MCC/MCCprotocolMay2015.pdf)

MOTEL/HOTEL/MEAL VOUCHER LINKAGE TO MEDICAL CARE COORDINATION	
STANDARD	**MEASURE**
Documentation of client need and eligibility for MCC services.	Linkage to MCC services documented in client chart.

1B: EMERGENCY SHELTER (Up to 90 days per year)

Emergency shelters are defined as any facility, the primary purpose of which is to provide a temporary shelter for the people living with HIV who are homeless or unstably housed, and which does not require occupants to sign leases or occupancy agreements. Clients who qualify for emergency shelter may access this service for up to 90 days per contract year. Emergency shelters may be offered to eligible clients experiencing a housing crisis and have no place to go.

GENERAL REQUIREMENTS

Each ES 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 (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.
- Since Ryan White HIV/AIDS Program funds must be considered funds of last resort, providers must develop criteria and procedures to determine client eligibility and to ensure that no other options for residential services are available. Providers must document client eligibility, and must further demonstrate that third party reimbursement (e.g., Medi-Cal) is being actively pursued, where applicable.

EMERGENGY SHELTER INTAKE	
STANDARD	**MEASURE**
Intake process is begun as soon as possible upon admission.	Intake tool is completed and in client file.
Eligibility for services is determined.	Client's file includes: • Proof of HIV diagnosis • Proof of income • Proof of Los Angeles County residence
Confidentiality Policy, Consent to Receive Services and Release of Information is discussed and completed.	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.

EMERGENCY SHELTER ASSESSMENT	
STANDARD	**MEASURE**
As soon as possible after admission a client or representative will be interviewed to complete eligibility determination, assessment and client education.	Record of eligibility, assessment and education on file in client chart.
Assessments will include the following: • Age • Health status • Family involvement • Family composition • Special housing needs • Level of independence • Active daily living • Income • Public entitlements • Current engagement in medical care • Substance abuse • Mental health • Personal finance skills • History of evictions • Level of resources available to solve problems • Co-morbidity factors • Eligibility for Medical Care Coordination services	Signed, dated assessment on file in client chart.

INDIVIDUAL SERVICE PLAN (ISP)

Based upon the initial assessment, an ISP that identifies resources for housing and referrals to appropriate medical and social services will be completed for each participant within one week of admission. ISPs will include a housing plan that addresses the short-term and long-term housing needs of the client. Plans also will serve to identify specialized services needed to maintain the client in housing and access and adherence to primary medical care services.

EMERGENCY SHELTER INDIVIDUAL SERVICE PLAN	
STANDARD	**MEASURE**
An ISP will be completed within seven days of acceptance into services.	ISP on file in client chart signed by client detailing housing resources and referrals made.

LINKAGE TO MEDICAL CARE COORDINATION

The Medical Care Coordination (MCC) model uses a multi-disciplinary team of a Patient Care Manager, Medical Care Manager and a Case Worker, who work together to facilitate behavioral interventions and coordinate support services to promote improved health outcomes for PLWHA. MCC team members are co-located at the patient's medical home and deliver patient-centered activities that focus on addressing health status, engagement and retention in care, adherence to HIV medications, and HIV risk reduction. Based on assessment and client needs, eligible individuals should be linked to MCC services. MCC service providers must follow the Division of HIV and STD Programs MCC Protocol (http://ph.lacounty.gov/dhsp/Contractors/MCC/MCCprotocolMay2015.pdf)

EMERGENCY SHELTER LINKAGE TO MEDICAL CARE COORDINATION	
STANDARD	**MEASURE**
Documentation of client need and eligibility for MCC services.	Linkage to MCC services documented in client chart.

PROGRAM RECORDS

Programs will maintain records on each participant in sufficient detail to permit monitoring and evaluation of services to include (at minimum):

EMERGENCY SHELTER PROGRAM RECORDS	
STANDARD	**MEASURE**
Programs will maintain sufficient records on each participant.	• Documentation of participant's HIV status • Housing status prior to admission • Signed, written program participant's rights agreement • Participant data, including dates of admission and discharge and emergency notification information • Documentation of evaluations performed and referrals made for HIV medical care and supportive services • Name of case management agency in which participant is enrolled or to which participant has been referred • Documentation of program participation • Written certification from authorized health care professional that the participant is free from active TB (must be obtained prior to admission for those programs that do not provide single occupancy rooms)

1C: 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.
- Since Ryan White HIV/AIDS Program funds must be considered funds of last resort, providers must develop criteria and procedures to determine client eligibility and to ensure that no other options for residential services are available. Providers must document client eligibility, and must further demonstrate that third party reimbursement (e.g., Medi-Cal) is being actively pursued, where applicable.

INTAKE

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

TRANSITIONAL HOUSING INTAKE	
STANDARD	**MEASURE**
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 • Family involvement • Family composition • Special housing needs • Level of independence • ADLs • Income • Public entitlements • Current engagement in medical care • Substance use • Mental health	Signed, dated assessment on file in client chart.

• 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	

INTENSIVE CASE MANAGEMENT (ICM)

Based on the assessment of client needs and strengths, intensive case management services may be provided to the client. ICM services should follow requirements from Los Angeles County Department of Health Services Supportive Housing Services contractors (RFQS for Supportive Housing Services, April 2017). A detailed description of ICM services is found in Attachment A.

ICMS form the core of the services for people who are homeless, at risk of homelessness, formerly homeless and who have complex health and/or behavioral health conditions; are high utilizers of public services and other vulnerable populations including individuals with criminal justice histories and individuals who are exiting institutions such as hospitals, residential treatment programs, and custody facilities.

ICMS can be provided in a variety of settings including interim housing, rapid rehousing, permanent supportive housing, field based locations, community based locations, health and behavioral health facilities, sobering centers, recuperative care centers, criminal justice and custody facilities, and other settings as needed to end homelessness and support the community reintegration of persons leaving institutions.

TRANSITIONAL HOUSING INTENSIVE CASE MANAGEMENT (ICM)	
STANDARD	**MEASURE**
Documentation of client need for ICM through assessments and patient medical and social needs history.	ICM services documented in client chart.

LINKAGE TO MEDICAL CARE COORDINATION

The Medical Care Coordination (MCC) model uses a multi-disciplinary team of a Patient Care Manager, Medical Care Manager and a Case Worker, who work together to facilitate behavioral interventions and coordinate support services to promote improved health outcomes for PLWHA. MCC team members are co-located at the patient's medical home and deliver patient-centered activities that focus on addressing health status, engagement and retention in care, adherence to HIV medications, and HIV risk reduction. Based on assessment and client needs, eligible individuals should be linked to MCC services. MCC service providers must follow the Division of HIV and STD Programs MCC Protocol (http://ph.lacounty.gov/dhsp/Contractors/MCC/MCCprotocolMay2015.pdf)

TRANSITIONAL HOUSING LINKAGE TO MEDICAL CARE COORDINATION	
STANDARD	**MEASURE**
Documentation of client need and eligibility for MCC services.	Linkage to MCC services documented in client chart.

PROGRAM RECORDS

Programs will maintain records on each participant in sufficient detail to permit monitoring and evaluation of services to include (at minimum):

TRANSITIONAL HOUSING PROGRAM RECORDS	
STANDARD	**MEASURE**
Programs will maintain sufficient records on each participant.	Client records on file at provider agency that include (at minimum): • Documentation of eligibility in a Ryan White supported housing program • Documentation of participant's HIV status • Documentation of participant's HIV medical care history • Housing status prior to admission • Written certification from an authorized health care professional that participant is free from active TB • Signed, written program and housing rights agreement • Participant data, including dates of admission and discharge and emergency notification information • Documentation of case management services provided, including assessment

	of needs, assistance with goal development and housing plan and weekly progress toward accomplishment of goals/plan • Name of case management agency in which participant is enrolled or to which participant has been referred • Documentation of provision of or referral to drug or alcohol abuse counseling • Documentation of program participation

1D: INCOME-BASED RENTAL SUBSIDIES (Up to 24 months)

Income-based rental based subsidies provides short-term housing assistance to HIV-positive clients through partial rent subsidies. General requirements for income-based rental subsidies include:

- Income at or below 500% of the Federal Poverty Level. Resident must contribute 30 percent of income toward housing costs (HUD guidelines).
- Individuals must:
  - be HIV positive
  - be temporarily or unstably housing or at-risk of becoming temporarily or unstably housed
  - not be receiving HOPWA rental assistance, Housing Choice Voucher program (formerly known as Section 8), or other housing assistance
- Since Ryan White HIV/AIDS Program funds must be considered funds of last resort, providers must develop criteria and procedures to determine client eligibility and to ensure that no other options for residential services are available. Providers must document client eligibility, and must further demonstrate that third party reimbursement (e.g., Medi-Cal) is being actively pursued, where applicable.

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

INCOME-BASED RENTAL SUBSIDIES INTAKE	
STANDARD	**MEASURE**
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 currently receiving Housing for People Living with AIDS (HOPWA) rental assistance, Housing Choice Voucher Program, or other housing assistance
Confidentiality Policy, Consent to Receive Services and Release of Information is discussed and completed. Release of Information (must be updated annually). New	Release of Information signed and dated by client on file and updated annually.

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	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:

INCOME-BASED RENTAL SUBSIDIES 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 • Family involvement • Family composition • Special housing needs • Level of independence • ADLs • Income • Public entitlements • Current engagement in HIV 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	Signed, dated assessment on file in client chart.

residential substance use treatment facilities. • Eligibility for Medical Care Coordination	

INTENSIVE CASE MANAGEMENT (ICM)

Based on the assessment of client needs and strengths, intensive case management services may be provided to the client. ICM services should follow requirements from Los Angeles County Department of Health Services Supportive Housing Services contractors (RFQS for Supportive Housing Services, April 2017). A detailed description of ICM services is found in Attachment A.

ICMS form the core of the services for people who are homeless, at risk of homelessness, formerly homeless and who have complex health and/or behavioral health conditions; are high utilizers of public services and other vulnerable populations including individuals with criminal justice histories and individuals who are exiting institutions such as hospitals, residential treatment programs, and custody facilities.

ICMS can be provided in a variety of settings including interim housing, rapid rehousing, permanent supportive housing, field based locations, community based locations, health and behavioral health facilities, sobering centers, recuperative care centers, criminal justice and custody facilities, and other settings as needed to end homelessness and support the community reintegration of persons leaving institutions.

INCOME-BASED RENTAL SUBSIDIES INTENSIVE CASE MANAGEMENT (ICM)	
STANDARD	**MEASURE**
Documentation of client need for ICM through assessments and patient medical and social needs history.	ICM services documented in client chart.

LINKAGE TO MEDICAL CARE COORDINATION

The Medical Care Coordination (MCC) model uses a multi-disciplinary team of a Patient Care Manager, Medical Care Manager and a Case Worker, who work together to facilitate behavioral interventions and coordinate support services to promote improved health outcomes for PLWHA. MCC team members are co-located at the patient's medical home and deliver patient-centered activities that focus on addressing health status, engagement and retention in care, adherence to HIV medications, and HIV risk reduction. Based on assessment and client needs, eligible individuals should be linked to MCC services. MCC service providers must follow the Division of HIV and STD Programs MCC Protocol (http://ph.lacounty.gov/dhsp/Contractors/MCC/MCCprotocolMay2015.pdf)

INCOME-BASED RENTAL SUBSIDIES LINKAGE TO MEDICAL CARE COORDINATION	
STANDARD	**MEASURE**
Documentation of client need and eligibility for MCC services.	Linkage to MCC services documented in client chart.

PROGRAM RECORDS

Programs will maintain records on each participant in sufficient detail to permit monitoring and evaluation of services to include (at minimum):

INCOME-BASED RENTAL SUBSIDIES PROGRAM RECORDS	
STANDARD	**MEASURE**
Programs will maintain sufficient records on each participant.	Client records on file at provider agency that include (at minimum): • Documentation of participant's HIV status • Housing status prior to admission • Written certification from an authorized health care professional that participant is free from active TB • Signed, written program and housing rights agreement • Participant data, including dates of admission and discharge and emergency notification information • Documentation of case management services provided, including assessment of needs, assistance with goal development and housing plan and weekly progress toward accomplishment of goals/plan • Name of case management agency in which participant is enrolled or to which participant has been referred • Documentation of provision of or referral to drug or alcohol abuse counseling • Documentation of program participation

1E: RESIDENTIAL CARE FACILTY FOR THE CHRONICALLY ILL (RCFCI) (Up to 24 months*)

*May be extended based on client's needs and approval from the Division of HIV and STD Programs, Department of Public Health

RESIDENTIAL CARE FOR THE CHRONICALLY ILL (RCFCI):
An RCFCI must be licensed by the Community Care Licensing Division of the California Department of Social Services unless it is exempt from licensure, as specified in regulation.

RCFCI PROGRAM GOALS
The goals of RCFCI services for PLWHA are to:

- Remove housing-related barriers that negatively impact clients' ability to access and/or maintain HIV medical care or treatment
- Provide end-stage care to appropriate clients
- Maintain HIV medical care and treatment
- Assist people living with HIV to remain housed and
- Increase access to other needed medical and social services

RCFCI SERVICE COMPONENTS
RCFCI service providers are expected to comply with the Universal Standards of Care, as well as these additional standards.

Depending on the needs of the client, service providers are required to provide these **Minimum Services** to residents, either directly or through formal agreements or referrals with other agencies:

- Jointly with each tenant develop an Individualized Service Plan, complete with action steps to ensure linkage and retention to primary care provider
- Based on client needs, intensive case management to engage with each resident and work toward achieving Individualized Service Plan goals
- Linkage to Medical Care Coordination services
- Referrals to needed services

RCFCI GENERAL REQUIREMENTS
The overriding goal of the RCFCI is to improve the health status of people with HIV/AIDS who need to receive care, support and supervision in a stable living environment to improve their health status before transitioning to self-sufficiency.

RCFCIs are licensed under the California Code of Regulations, Title 22, Division 6, Chapter 8.5 to provide services in a non-institutional, homelike environment in any building or housing arrangement which is maintained and operated to provide 24-hour care and supervision. The capacity of a RCFCI may not exceed 50 beds.

Residents receiving RCFCI services will have a maximum stay of 24 months. Approval will be required for monthly extensions beyond 24 months based on the resident's health status. A resident's bed may be held by a provider for no more than eight one-night "bed-holds" per resident per quarter in medical emergencies or for therapeutic reasons, as long as this is clearly documented in the resident's chart and/or treatment plan. RCFCI providers will develop criteria and procedures to determine resident eligibility to ensure that no other options for residential services are available. RCFCI providers must document resident eligibility and must further demonstrate that third-party reimbursement (e.g., medical) is being actively pursued, where applicable.

Detailed information about Title 22 licensing requirements for RCFCI can be found at:

https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=IB67E7870D4BE11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)

Service providers must ensure:

- Service provision is flexible and responsive to clients' needs
- Services are culturally-specific and linguistically and developmentally appropriate
- Mechanisms for soliciting client input on how to improve services are established (such as tenant advisory boards, ongoing customer service surveys)
- The development and ongoing revision of customized housing transition plans to meet the unique social and health needs of each individual. Ryan White funds may be used to extend housing services for at least 6 months (beyond the HRSA recommended guideline of 24 months) to facilitate successful linkage to care and ensure that clients remain virally suppressed.

All service providers are required to have written policies and procedures to train staff on policies and procedures covering these topics:

- Policies and procedures for drug and/or alcohol use on-site and off-site, including steps to deal with relapsing residents to ensure their ability to remain in the housing
- Policies and procedures for payment of rent by residents during periods of hospitalizations
- Policies and procedures for protecting the privacy and confidentiality of residents
- Policies and procedures for assisting applicants and residents in making reasonable accommodation requests, both of property management and outside entities, such as housing authorities, to ensure that persons with disabilities have access to and can maintain housing
- Policies and procedures for ensuring safety and security of staff and residents, including instances of violence and the sale and use of controlled and/or illegal drugs/substances
- Policies and procedures for all staff to be initially and periodically trained in the appropriate and immediate response to tenant crises, such as when tenants

become a danger to themselves or others
- Policies and procedures for all staff to be initially and periodically trained in handling relapse, substance misuse on-site, and harm reduction
- Grievance procedures

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 • Be certified by a qualified a qualified health care professional to need regular or ongoing assistance with ADL • Have a Karnofsky score of 70 or less • Have an unstable living situation • Be a resident of Los Angeles County resident • 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	Program review and monitoring to confirm.

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 monthly extensions bases on resident's health status.	Program review and monitoring to confirm.
RCFCI will develop criteria and procedures to determine resident 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	Program review and monitoring to confirm.

follows: • For SSI/SSP recipients who are residents, the basic services will be provided and/or made available at the basic rate with no additional charge to the resident. 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 resident will be allowed for a private room upon the resident's request (and if such room is available). If a double room is available but the resident 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 resident will be allowed for special food services or products beyond that specified above when the resident wishes to purchase the services and agree to the extra charge in the admission agreement.	

ASSESSMENT

Prior to or within 30 days of the acceptance of a resident, the facility will obtain a written medical assessment of the resident which enables the facility to determine if they are able to provide the necessary health-related services required by the resident's medical condition. Such assessment will be performed by, or under the supervision of, a licensed physician and should not be more than three months old when obtained. If the assessment is not completed prior to admission of the resident, an RN must provide a health assessment within 24 hours of admission to determine if any immediate health needs are present which may preclude placement.

Areas for assessment include need for palliative care, age, health status, including HIV and STD prevention needs, record of medications and prescriptions, ambulatory status, family composition, special housing needs, level of independence/level and resources available to solve problems, and co-morbidity factors.

The medical assessment will provide a record of any infectious or contagious disease which would preclude care of the person. A chest X-ray which was obtained not more than three months prior to placement or a Mantoux tuberculin skin test recorded in a millimeter which was performed not more than three months prior to placement. A person who has had a previous

positive reaction should not be required to obtain a Mantoux tuberculin skin test, but will be required to obtain chest X-ray results and a physician's statement that he/ she does not have communicable TB.

If the facility provides services for residents with mental illness, a written intake assessment is completed by a licensed mental health professional prior to acceptance of the resident. This assessment may be provided by a student intern if the work is supervised by a licensed mental health professional. Facility administrators may use placement agencies, including, but not limited to, County clinics for referrals and assessments.

Residents receiving DHSP-funded RCFCI 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 ADL. Upon reaching and sustaining a Karnofsky score above 70, RCFCI residents will be expected transition towards independent living or another type of residential service more suitable to his/her needs.

If it is determined that the person requires immediate health care, and needs cannot be met by the RCFCI, the provider will ensure that the person is referred to the appropriate health facility and that the medical assessment is performed.

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. If not completed prior to client admission, an RN must provide a health assessment within 24 hours of admission to determine if any immediate health needs are present that may preclude placement. The medical assessment will provide a record of any infectious or contagious disease precluding care. If a facility provides services for residents with mental illness, a written intake assessment is completed by a licensed mental health professional prior to acceptance of the resident. This assessment may be provided by a student intern if work is supervised by a licensed mental health professional.	Signed, dated medical assessment on file in client chart.

Assessments will include the following: • Need for palliative care • Age • Health status, including HIV and STD 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 residents (e.g., residential treatment facilities and hospitals) • Representative payee Legal assistance on a broad range of legal and advocacy	Signed, dated assessment on file in client chart.
Residents 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	Documentation of resident education on file in client chart.

health facility.	
Upon intake, facility staff must provide resident with the following: • Information about the facility and its services • Policies and procedures • Confidentiality • Safety issues • House rules and activities • Resident 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 resident education on file in client chart.

INDIVIDUAL SERVICE PLAN (ISP)

The RCFCI will ensure that there is an ISP for each resident. A service plan must be developed for all residents prior to admission based upon the initial assessment. This plan will serve as the framework for the type and duration of services provided during the resident's stay in the facility and should include the plan review and reevaluation schedule. The program staff will regularly observe each resident for changes in physical, mental, emotional and social functioning. The plan will also document mechanisms to offer or refer residents with HIV/AIDS to primary medical services and case management services. The provider will ensure that there will be an RN case manager who is responsible for the coordination and/or the provisions of the services specified in the ISP.

The ISP should be developed with the resident and will include the resident's background, medical and mental/emotional functioning and the facility's plans for providing services to meet the individual needs identified above. If the resident has a restricted health condition, the ISP must include the restricted health condition plan.

All health services components of the plan will be developed and monitored in coordination with the provider of service and will reflect the elements of the resident's plan of treatment developed by the ISP team. The plan will be updated every three months or more frequently as the resident's condition warrants.

Services identified in the ISP should be provided directly or the facility should link the resident with outside resources. The facility will provide necessary personal assistance and care, as indicated in the ISP, with ADL including, but not limited to, dressing, eating and bathing.

While the plan will be updated as frequently as necessary to ensure its accuracy and to document significant occurrences that result in changes in the resident's physical, mental and/or social functioning, residents receiving DHSP-funded RCFCI 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 ADL. Upon reaching and sustaining a Karnofsky score above 70, RCFCI residents will be expected transition towards independent living or another type of residential service more suitable to his/her needs.

If modifications to the plan identify an individual resident service need which is not being met by the facility, the facility must secure consultation to determine if the facility can meet the resident service need. If it is determined that the resident's needs cannot be met, the facility should assist with relocation of the resident into an appropriate level of care.

RCFCI INDIVIDUAL SERVICE PLAN (ISP)	
STANDARD	**MEASURE**
ISP will be completed prior to admission.	Needs and services plan on file in
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	Needs and services plan on file in client chart.
Plans should be updated every three months or more frequently to document changes in a resident's physical, mental, emotional and social functioning.	Updated needs and services plan on file in client chart.

Residents 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 resident's needs cannot be met by facility, the facility will assist in relocating the resident to appropriate level of care.	Record of relocation activities on file in client chart.
The provider will ensure that the ISP for each resident 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 resident's ISP: • The resident and/or his/her authorized representative • The resident'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	Record of ISP team on file in client chart.

MONTHLY CASE CONFERENCE

A monthly case conference will include review of the ISP, including the resident'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 resident, 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 resident's approval. The resident 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 resident.

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:

RCFCI 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 these services
	Written agreements on file at provider agency

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.
Residents who are physically and mentally able to be responsible for their own medications will be permitted to do so under the following circumstances: All members of the ISP team are in agreement. The resident's ISP includes a statement that the resident is capable of administration of medication. The program provides the resident with a locked container in which to store the medication. There is more than one key to the container. One key will be given to the	Record of conditions on file at provider agency.

resident and the other is kept by direct staff. The program will consider all residents in the facility when making a decision regarding self-administered medications.	
There will be a written agreement between the program and the resident that he/she will self-administer the medication. The agreement will state who will be responsible for reordering medications. A copy of the agreement will be kept in the resident's file.	Written agreement on file in client chart.
Direct care staff will notify the physician and the RN case manager of any change in the resident's capacity to self- administer medications.	Notification of any change on file in client chart.
The appropriately skilled professional will not pre-pour medication that has not been prepackaged more than 12 hours prior to being taken by the resident.	Program review and monitoring to confirm.

SUPPORT SERVICES

Support services that are to be provided or coordinated 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 residents • Arrangement and managing of resident schedules and activities • Maintenance and/or management of resident cash resources or property.	Program policy and procedures to confirm. Record of services and referrals on file in client chart.

EMERGENCY MEDICAL TREATMENT

Residents 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 a written agreement(s) with a licensed medical facility(ies) within the community for provision of emergency services as appropriate.

RCFCI EMERGENCY MEDICAL TREATMENT	
STANDARD	**MEASURE**
Residents requiring emergency medical treatment will be transported to medical facility at provider's expense. The cost of such transportation as well as the cost of emergency medical care will not be a charge to nor reimbursable under RCFCI services.	Program review and monitoring to confirm.
The provider will have a written agreement(s) with a licensed medical facility(ies) 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 residents 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 residents 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 resident in sufficient detail to permit an evaluation of services. These notations will be dated and include, but not limited to, type of service provided, resident'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): • Resident 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 resident • Medical assessment • Documentation of HIV/AIDS • Written certification that each family unit member free from active TB • Copy of current child care 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

1F: TRANSITIONAL RESIDENTIAL CARE FACILITY (TRCF) (Up to 24 months*)

*May be extended based on client's needs and approval from the Division of HIV and STD Programs

TRCF PROGRAM GOALS

The goals of TRCF services for PLWHA are to:

- Remove housing-related barriers that negatively impact clients' ability to access and/or maintain HIV medical care or treatment
- Assistance with Independent Living Skills (ILS) in preparation for living more independently
- Maintain HIV medical care and treatment
- Assist people living with HIV to remain housed and
- Increase access to employment, mental health and substance abuse service

TRCF SERVICE COMPONENTS

TRCF service providers are expected to comply with the Universal Standards of Care, as well as these additional standards.

Depending on the needs of the client, service providers are required to provide these **Minimum Services** to residents, either directly or through formal agreements with other agencies:

- Jointly with each tenant develop an Individualized Service Plan, complete with action steps to ensure linkage and retention to primary care provider
- Based on client needs, intensive case management to engage with each resident and work toward achieving Individualized Service Plan goals
- Linkage to Medical Care Coordination services
- Referrals to needed services

TRCF GENERAL REQUIREMENTS

TRCFs provide interim housing with ongoing supervision and assistance with independent living skills (ILS) for homeless individuals living with HIV/AIDS in a non-institutional, homelike environment. The purpose of TRCFs is to facilitate movement towards a more traditional and permanent living situation through assessment of a person's needs, counseling, case management and other supportive services.

Service providers must ensure:

- Service provision is flexible and responsive to clients' needs
- Services are culturally-specific and linguistically and developmentally appropriate
- Mechanisms for soliciting client input on how to improve services are established

(such as tenant advisory boards, ongoing customer service surveys)

- The development and ongoing revision of customized housing transition plans to meet the unique social and health needs of each individual. Ryan White funds may be used to extend housing services for at least 6 months (beyond the HRSA recommended guideline of 24 months) to facilitate successful linkage to care and ensure that clients remain virally suppressed.

All service providers are required to have written policies and procedures to train staff on policies and procedures covering these topics:

- Policies and procedures for drug and/or alcohol use on-site and off-site, including steps to deal with relapsing residents to ensure their ability to remain in the housing
- Policies and procedures for payment of rent by residents during periods of hospitalizations
- Policies and procedures for protecting the privacy and confidentiality of residents
- Policies and procedures for assisting applicants and residents in making reasonable accommodation requests, both of property management and outside entities, such as housing authorities, to ensure that persons with disabilities have access to and can maintain housing
- Policies and procedures for ensuring safety and security of staff and residents, including instances of violence and the sale and use of controlled and/or illegal drugs/substances
- Policies and procedures for all staff to be initially and periodically trained in the appropriate and immediate response to tenant crises, such as when tenants become a danger to themselves or others
- Policies and procedures for all staff to be initially and periodically trained in handling relapse, substance misuse on-site, and harm reduction
- Grievance procedures

Eligibility Requirements:

- Be 18 years of age or older
- Have an HIV/AIDS diagnosis from a primary care physician
- Have a Karnofsky score of 70 or higher
- Have an income at or below 500% Federal Poverty Level
- Be actively engaged / receiving medical care
- Be certified by their medical care providers to be taking prescription medications independently
- Be homeless or at risk of becoming homeless

Since Ryan White HIV/AIDS Program funds must be considered funds of last resort, providers

must develop criteria and procedures to determine client eligibility and to ensure that no other options for residential services are available. Providers must document client eligibility, and must further demonstrate that third party reimbursement (e.g., Medi-Cal) is being actively pursued, where applicable.

Providers may charge up to 30% of residents' income to cover program costs not covered by the contracting agency. The provider will comply with provisions of Section 2605 (e) of Title 26 (CARE Act) which is entitled "Requirements Regarding Imposition of Charges for Services." Providers will be responsible for developing and implementing a resident fee system. The provider will pursue funding from public assistance and entitlement programs for which each County responsible resident may be eligible.

INTAKE

The intake determines eligibility and includes demographic data, emergency contact information and eligibility documentation. Upon acceptance of a client into a TRCF, the person responsible for admissions must interview the prospective client and his/ her authorized representative, including the assigned case manager, if any, as soon as reasonably possible. Required forms must conform with State and local guidelines.

TRCF INTAKE	
STANDARD	**MEASURE**
Prospective client interviewed upon acceptance in TRCF.	Intake tool is completed and in client file.
Eligibility for services is determined.	Client's file includes: • Proof of HIV diagnosis • Proof of income • Proof of Los Angeles County residence
Consent to Receive Services and Release of Information is discussed and completed.	Release of Information signed and dated by client on file and updated annually.
Client is informed of Confidentiality Policy, Consent to Receive Services, Rights and Responsibility and Grievance Procedures.	Signed and dated forms in client file.

ASSESSMENT

At a minimum, each client will be assessed to identify strengths and gaps in his/her support system as a means to move towards permanent housing.

Residents 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 (ILS). TRCF residents will be expected to transition towards independent living or another type of residential service more suitable to his/her needs.

TRCF ASSESSMENT	
STANDARD	**MEASURE**
Clients will be assessed to identify strengths and gaps in his/her support system as a means to move towards permanent housing. Assessments will include the following: • Age • Health status • Family involvement • Family composition • Special housing needs • Level of independence • ADLs • Income • Benefits assistance/Public entitlements • Substance use and need for substance use services, such as treatment, relapse prevention, and support groups • Mental health needs • Personal finance skills • History of evictions • Level of resources available to solve problems • 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 residents (e.g., residential treatment facilities and hospitals)	Signed, dated assessment on file in client chart.

• Representative payee Legal assistance on a broad range of legal and advocacy	
Residents 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 ILS.	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 tenant 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	
STANDARD	**MEASURE**
Needs and services plan will be completed within one week of the client's admission.	Needs and services plan on file in client chart signed by client detailing a housing resources and medical and social service referrals made.

LINKAGE TO MEDICAL CARE COORDINATION

The Medical Care Coordination (MCC) model uses a multi-disciplinary team of a Patient Care Manager, Medical Care Manager and a Case Worker, who work together to facilitate behavioral interventions and coordinate support services to promote improved health outcomes for PLWHA. MCC team members are co-located at the patient's medical home and deliver patient-centered activities that focus on addressing health status, engagement and retention in care, adherence to HIV medications, and HIV risk reduction. Based on assessment and client needs, eligible individuals should be linked to MCC services. MCC service providers must follow the Division of HIV and STD

Programs MCC Protocol
(http://ph.lacounty.gov/dhsp/Contractors/MCC/MCCprotocolMay2015.pdf)

LINKAGE TO MEDICAL CARE COORDINATION	
STANDARD	**MEASURE**
Documentation of client need and eligibility for MCC services.	Linkage to MCC services documented in client chart.

ATTACHMENT A: INTENSIVE CASE MANAGEMENT SERVICES (ICMS)

Source: Request for Statement of Qualifications (RFQS) for Supportive Housing Services, April 2017

ICMS form the core of the services for people who are homeless, at risk of homelessness, formerly homeless and who have complex health and/or behavioral health conditions; are high utilizers of public services and other vulnerable populations including individuals with criminal justice histories and individuals who are exiting institutions such as hospitals, residential treatment programs, and custody facilities.

ICMS can be provided in a variety of settings including interim housing, rapid rehousing, permanent supportive housing, field based locations, community based locations, health and behavioral health facilities, sobering centers, recuperative care centers, criminal justice and custody facilities, and other settings as needed to end homelessness and support the community reintegration of persons leaving institutions.

The ICMS provider must be able to assemble a team of case managers capable of providing services to all clients who have signed an authorization to participate in the specific ICMS project. Frequency and intensity of services should be tailored to the need of each client which will change over time depending on the client's needs. The ICMS team should employ a "whatever it takes approach" to assist a client in their transition from homelessness to housing stability. The ICMS provider must be able to hire and support case managers who can seamlessly deliver and/or develop linkages to assist clients with accessing a range of services that might include a mental health intervention if a client is in crisis or transportation and assistance with completing forms for a client who needs to go to the Department of Motor Vehicles (DMV) for a California ID. At the core of the service delivery model is the trust that the case manager develops with the client to assist the individual in their journey toward improved health and well-being.

The ICMS staffing model shall include a project manager and intensive case managers. The intensive case manager caseload is typically one (1) intensive case manager to 15-40 clients. Actual caseload varies by project and will be specified in executed Work Orders. All intensive case managers must have experience working with clients with mental illness, chronic health issues, and substance use disorders. Intensive case managers are typically bachelor degree-level social workers or social workers with advanced degrees. Project managers are usually licensed social workers or other licensed clinicians.

ICMS includes, but is not limited to, the following:

- Ongoing outreach and engagement to the client population including field and community based locations, health and behavioral health facilities, interim and bridge housing settings, criminal justice and custody facilities, and other locations as needed to engage the target population.
- Assisting clients with rental application including paperwork required by Housing Authorities and the Section 8 program.

- Assistance with mental health and life skills services and referrals.
- Establishment of a case management plan based on their authorization including but not limited to establishing future goals, improvement of behaviors associated with drug use, reduction in frequency and quantity of drug and alcohol use, coping with mental health disorders, coping with chronic medical problems, improvement of interpersonal relationships.
- Help accessing public benefits and educational opportunities as appropriate.
- Assistance with budgeting and money management.
- Assistance with substance use disorder services and referrals with a focus on harm reduction.
- Referrals to primary medical care, mental health services, and other community services as needed.
- Assistance in obtaining clothing and food.
- Group programming ranging from life-skills groups to community activities.
- Eviction prevention counseling and advocacy.
- Assistance with educational, vocational, and employment services as appropriate for each client.
- Assistance with domestic violence and safety planning services and referrals.
- Transportation assistance.
- Assisting clients with maintaining medication regimen.
- Housing location services including assisting clients with locating affordable permanent housing, establishing relationships with landlords/agencies willing to provide affordable permanent housing to DHS clients, and providing assistance with negotiating rental agreements. (Note: The need for housing location services will vary by project. Housing location experience is not a minimum qualification.)
- Administer move-in assistance funds to assist clients with timely security deposits, household goods and furnishings, utility deposits, etc.
- Assistance with temporary housing until client moves into supportive housing unit.
- Assistance with monitoring any legal issues and making appropriate referrals while addressing any barriers to accessing and maintaining housing and services (e.g., Personal finance skills, criminal records, pending warrants, etc.).
- Collaboration with Property Related Tenant Services (PRTS) and property owner to ensure clients provide authorization to receive the support they need to remain housed and stable, including attending and/or convening periodic meetings with partners to problem-solve around client, building, and community issues.
- Provision of on-going training to ICMS staff to ensure services are appropriate and to promote continuous quality improvement.
- Maintenance of program and client records and legally permissible data systems as may be required.
- Submit reports and invoices as requested and in a timely manner and provide all required supporting documentation.
- Comply and deliver services in accordance with contract deliverables and objectives.

ATTACHMENT B: RECOMMENDED TRAINING TOPICS FOR STAFF

Housing resources and assisting clients navigate housing options. Staff are encouraged to use chirpla.org for local housing resources, networking and training opportunities.

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

ADMINISTRATIVE AND SUPPORT STAFF
An administrative employee has primary responsibility for the facility. The provider will operate continuously with at least a house manager and the necessary staff for the delivery of required services.

TB CONTROL
The provider will adhere to "Tuberculosis Exposure Control Plan for Residential Facilities" as provided by the Los Angeles County Department of Public Health Tuberculosis Control Program.

ANNUAL TB SCREENING FOR STAFF
Prior to employment or service provision and annually thereafter, the provider will obtain and maintain documentation of TB screening for each employee, volunteer and consultant providing services. Such TB screening will consist of a tuberculin skin test (Mantoux test) and/or written certification by a physician that the person is free from active TB based on a chest X-ray. The provider will adhere to guidelines for staff tuberculosis screening provided by the Los Angeles County Department of Public Health Tuberculosis Control Program.

ATTACHMENT C: DEFINITIONS AND DESCRIPTIONS

Activities of daily living (ADL) mean various chores that must be completed by or for a person on a daily basis to meet his/her personal needs. Such chores will include but not be limited to housework, meal preparation, laundry of clothes/linens and other washable items, taking medication, money management, transportation for personal or medical appointments, communicating with others either through telephone or in writing, dressing, eating, toileting, bathing, grooming and ambulation.

Activity program leader means a person who meets one of the following: a) has two years of experience in a social or recreational program within the past five years, one year of which was full time in a resident activities program in a health care setting; b) be an occupational therapist, art therapist, music therapist, dance therapist, recreation therapist, or occupational therapist assistant; or c) have satisfactorily completed at least 36 hours of training in a course designed specifically for this position and approved by the State Department of Public Health and will receive regular consultation from an occupational therapist, occupational therapist, or recreation therapist who has at least one year of experience in a health care setting.

Attending physician means the physician responsible for the treatment of the resident.

Care and supervision means the ongoing assistance with activities of daily living, not to include the endangerment of a resident's physical health, mental health, safety, or welfare.

Certified nursing assistant or **home health aide** means a person who is certified as such by the California State Department of Public Health.
Congregate housing is the practice through which a provider develops or leases an entire building with several units for the purpose of housing people living with HIV at affordable costs.

Direct care staff means those individuals who are employed by the facility and provide direct care services to the residents including, but not limited to, assistance with ADL.

HIV/AIDS emergency shelter provides temporary housing for homeless persons living with HIV disease who require immediate living quarters.

Homeless individuals are PLWHA who lack a fixed, regular and adequate residence; lack the financial resources to acquire shelter; or reside in 1) a shelter to provide temporary, emergency accommodation; 2) an institution that provides temporary residence or care for individuals; or 3) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

Hospice nurse means a registered nurse (RN) who has acute care experience and training and experience in the delivery of nursing care to the terminally ill who have accepted the

hospice concept.
Housing specialist assists clients with housing searches and placement and works with other community based organizations to work collaboratively to meet the clients' needs.

Licensed vocational nurse (LVN) means a person licensed as such by the California of Vocational Nurse and Psychiatric Technician Examiners.

Medical professional means an individual licensed or certified in California to perform the necessary medical procedures within the scope of his/her practice. This includes, but is limited to, medical doctor (MD), RN and LVN.

Nutritionist means a person who has a Master's degree in food and nutrition, dietetics, or public health nutrition.

Occupational therapist means a person who is a graduate of an occupational therapy curriculum accredited jointly by the Council on Medical Education of the American Medical Association and the American Occupational Therapy Association, and is registered by the American Occupational Therapy Association.

Permanent supportive housing is affordable permanent housing with supportive services that assist people living with HIV and their families to adjust to new living arrangements, maintain independent living and coordinate overall housing and service needs. Supportive services include service coordination, mental health counseling and treatment and substance abuse counseling and treatment. Permanent supportive housing can be provided either in a congregate housing facility or through scattered site master leasing.

Pharmacist means a person licensed as such by the California Board of Pharmacy.
Physical therapist means a person licensed as such by the Physical Therapy Examining Committee of the California Board of Medical Quality Assurance.

Physician means a person licensed as a physician and surgeon by the California Board of Medical Quality Assurance or by the California Board of Osteopathic Examiners.

Registered nurse (RN) means a person licensed as such in the State California by the Board of Registered Nursing.

Residential care facilities for the chronically ill (RCFCI) is any housing arrangement maintained, licensed, and operated to provide care and supervision to adults, emancipated minors or family units living with HIV. An RCFCI may not exceed 50 beds. This service is limited to 24 months.

Respiratory therapist means a person with a California State respiratory Care Practitioner's Certificated issued by the Respiratory Care Examining Committee, and has: a one year's experience at the level of a Respiratory Therapy Technician; b) an associate degree in respiratory therapy from an accredited college; or c) a certificate of completion from an approved two-year training program in respiratory therapy.

Scattered site master leasing is the practice through which an organization leases rental units throughout the county that are then sub-leased at affordable costs to people living with HIV.

Social worker means a person who has a Master of Social Work degree from a school of social work accredited or approved by the Council on Social Work Education and has one year of social work experience in a health care setting.

Social worker assistance means a person with a baccalaureate degree in the social sciences or related fields from an accredited college or university and has had a least one year of social work experience in a health care setting.

Speech pathologist means a person licensed as such by the California Board of Medical Quality Assurance.

SSI/SSP means Supplemental Security Income / State Supplemental Program which is a federal/state program that provides financial assistance to the aged, blind and/or disabled residents of California.

Transitional housing is housing for up to twenty-four months for homeless persons living with HIV and their families. The purpose of this service is to facilitate movement towards more traditional and permanent housing through self-sufficiency activities such as counseling, case management and other supportive services.

ATTACHMENT D: Housing Services Definitions (Source: Health Resources Services Administration (HRSA) HIV/AIDS Branch (HAB) Policy Clarification Notice (PCN) 16-02))

Housing Services: provide transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment. Housing services include housing referral services and transitional, short-term, or emergency housing assistance.

Transitional, short-term, or emergency housing provides temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Housing services must also include the development of an individual housing plan, updated annually, to guide the client's linkage to permanent housing. Housing services also can include housing referral services: assessment, search, placement, and advocacy services; as well as fees associated with these services.

Eligible housing can include either housing that:

- Provides some type of core medical or support services (such as residential substance use disorder services or mental health services, residential foster care, or assisted living residential services); or
- Does not provide direct core medical or support services, but is essential for a client or family to gain or maintain access to and compliance with HIV-related outpatient/ambulatory medical services and treatment. The necessity of housing services for the purposes of medical care must be documented.

Resources used:

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- https://www.huduser.gov/portal/datasets/il/il2017/2017IlCalc.odn
- https://www.huduser.gov/portal/datasets/il/il2017/2017summary.odn
- https://www.hudexchange.info/resources/documents/HPRP_FinancialAssistance.pdf
- https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_care_hhp.aspx
- https://aspe.hhs.gov/poverty-guidelines

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DRAFT/UPDATED 12.7.17
For public comment
Email comments to: hivcomm@lachiv.org
Public comment period: 12/14/17-1/12/18

LOS ANGELES COUNTY COMMISSION ON HIV HOUSING SERVICE STANDARDS

Permanent Supportive Housing Services

TABLE OF CONTENTS

PURPOSE: Service standards outline the elements and expectations a Ryan White service provider follows when implementing a specific service category. The purpose of the service standards are 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.

Evidence shows that housing assistance improves HIV health outcomes at each stage of the HIV Care Continuum. Housing supports increase stability and connection to care for people living with HIV/AIDS (PLWHA) experiencing homelessness or unstable housing, and are consistently linked to improved HIV treatment access, continuous care, better health outcomes, and reduced risk of ongoing HIV transmission. (https://www.hudexchange.info/resources/documents/The-Connection-Between-Housing-and-Improved-Outcomes-Along-the-HIV-Care-Continuum.pdf)

While there are time limitations for using Ryan White Care Act funding for shousing services, other resources may be leveraged to identify and secure permanent supportive housing for PLWHA. With several local initiatives aimed at combatting homelessness in Los Angeles County, opportunity exists for complementing Ryan White funded housing services with more longer term, permanent supportive housing under programs such as Housing for Health, Measure H and HHH.

PERMANENT SUPPORTIVE HOUSING PROGRAMS (PSHPS)

PSHP services include permanent housing with supportive services that assist people living with HIV and their families to adjust to new living arrangements, maintain independent living and coordinate overall housing and service needs. Supportive services include service coordination, mental health counseling and treatment and substance abuse counseling and treatment. While programs cannot, in most cases, coerce tenants to use supportive services, they will make every attempt to encourage and engage tenants to do so. Permanent supportive housing can be provided either in a congregate setting or through scattered-site master leasing.

GENERAL REQUIREMENTS

Programs providing permanent housing with supportive services will comply with program requirements of the funding entity. Programs that provide rental subsidies will do so in accordance with guidelines approved by the subsidizing entity.

All PSHPs will be culturally and linguistically appropriate to the target population. In addition, HIV permanent housing services will respect the inherent dignity of clients and will be client-centered, aiming to foster client self-determination, and aid in attaining self- sufficiency.

SERVICE COMPONENTS REQUIREMENTS FOR PERMANENT SUPPORTIVE HOUSING PROGRAMS

Depending on the needs of the clients, service providers are required to provide these

Minimum Services to residents, either directly or through referrals to other agencies:

- Jointly with each tenant develop an Intensive Case Management Plan, complete with action steps to ensure linkage and retention to primary care provider
- Mental health care, such as assessment, crisis counseling, individual and group therapy, and support groups
- Substance use services, such as treatment, relapse prevention, and support groups
- Physical health care, including access to tuberculosis (TB) screening and routine and preventative health and dental care
- Medication management
- HIV treatment and adherence
- Educational services, including assessment, GED, and school enrollment
- Employment services, such as job skills training, job readiness, job placement, and job retention services
- Linkage to potential housing out-placements should they become appropriate alternatives for current residents (e.g., residential treatment facilities and hospitals)
- Life skills training, such as household maintenance, nutrition, cooking, and laundry, personal finance
- Benefits assistance
- Legal assistance on a broad range of legal and advocacy issues
- Peer advocacy
- Transportation assistance
- Social, recreational activities, and community volunteer service
- Linkage to Medical Care Coordination services
- Three balanced meals per day
- Ongoing assistance with activity of daily living
- If applicable, child care, as needed
- Referrals to needed services

ASSESSMENT

An assessment serves as the basis for developing a needs and services plan and to ensure the quality of services provided. Initial assessments must be completed within 30 days of a client's admission to a permanent supportive housing program. Reassessments will be offered to residents at least twice a year. Assessments are developed collaboratively and signed by both the resident and staff member completing the assessment.

Assessment information should include (at minimum):

ASSESSMENT	
STANDARD	**MEASURE**
Assessments will be completed within 30 days of client admission.	Assessment, signed by client and staff on file in client chart that includes: • HIV medical treatment • History of trauma • Substance use and history • ADL needs • Spiritual/religious needs • Social support system • Legal issues • Family issues • Financial/insurance status • Nutritional needs • Harm reduction practices • Mental health treatment history • History of housing experiences • Case management history and needs • Needs and current services
Reassessments will be offered to residents at least twice a year.	Reassessments on file in client chart.

EDUCATION

Tenant education is a continuous process. To ensure the relevance of the information provided, tenants should be given ongoing opportunities to have input into the education planning process. Upon intake, tenants should be offered information about the facility, policies and procedures and services to include (at minimum):

- 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 abuse
- Hepatitis
- Health and self-care practices
- Referral information

- Pet-owner responsibilities
- Neighbor relations
- TB

EDUCATION	
STANDARD	**MEASURE**
Tenants will be educated about facility, policies and procedures and services.	Education contacts recorded in client chart.

INTENSIVE CASE MANAGEMENT (ICM)

Based on the assessment of client needs and strengths, intensive case management services may be provided to the client. ICM services should follow requirements from Los Angeles County Department of Health Services Supportive Housing Services contractors (RFQS for Supportive Housing Services, April 2017). A detailed description of ICM services is found in Attachment A.

ICMS form the core of the services for people who are homeless, at risk of homelessness, formerly homeless and who have complex health and/or behavioral health conditions; are high utilizers of public services and other vulnerable populations including individuals with criminal justice histories and individuals who are exiting institutions such as hospitals, residential treatment programs, and custody facilities.

ICMS can be provided in a variety of settings including interim housing, rapid rehousing, permanent supportive housing, field based locations, community based locations, health and behavioral health facilities, sobering centers, recuperative care centers, criminal justice and custody facilities, and other settings as needed to end homelessness and support the community reintegration of persons leaving institutions.

INTENSIVE CASE MANAGEMENT (ICM)	
STANDARD	**MEASURE**
Documentation of client need for ICM through assessments and patient medical and social needs history.	ICM services documented in client chart.

LINKAGE TO MEDICAL CARE COORDINATION

The Medical Care Coordination (MCC) model uses a multi-disciplinary team of a Patient Care Manager, Medical Care Manager and a Case Worker, who work together to facilitate behavioral interventions and coordinate support services to promote improved health outcomes for PLWHA. MCC team members are co-located at the patient's medical home and deliver patient-centered activities that focus on addressing health status, engagement and retention in care, adherence to HIV medications, and HIV risk reduction. Based on assessment and client needs, eligible individuals

should be linked to MCC services. MCC service providers must follow the Division of HIV and STD Programs MCC Protocol (http://ph.lacounty.gov/dhsp/Contractors/MCC/MCCprotocolMay2015.pdf)

TRANSITIONAL HOUSING LINKAGE TO MEDICAL CARE COORDINATION	
STANDARD	**MEASURE**
Documentation of client need and eligibility for MCC services.	Linkage to MCC services documented in client chart.

ATTACHMENT A: INTENSIVE CASE MANAGEMENT SERVICES (ICMS)
Source: Request for Statement of Qualifications (RFQS) for Supportive Housing Services, April 2017

ICMS form the core of the services for people who are homeless, at risk of homelessness, formerly homeless and who have complex health and/or behavioral health conditions; are high utilizers of public services and other vulnerable populations including individuals with criminal justice histories and individuals who are exiting institutions such as hospitals, residential treatment programs, and custody facilities.

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The ICMS staffing model shall include a project manager and intensive case managers. The intensive case manager caseload is typically one (1) intensive case manager to 15-40 clients. Actual caseload varies by project and will be specified in executed Work Orders. All intensive case managers must have experience working with clients with mental illness, chronic health issues, and substance use disorders. Intensive case managers are typically bachelor degree-level social workers or social workers with advanced degrees. Project managers are usually licensed social workers or other licensed clinicians.

ICMS includes, but is not limited to, the following:

- Ongoing outreach and engagement to the client population including field and community based locations, health and behavioral health facilities, interim and bridge housing settings, criminal justice and custody facilities, and other locations as needed to engage the target population.
- Assisting clients with rental application including paperwork required by Housing Authorities and the Section 8 program.

- Assistance with mental health and life skills services and referrals.
- Establishment of a case management plan based on their authorization including but not limited to establishing future goals, improvement of behaviors associated with drug use, reduction in frequency and quantity of drug and alcohol use, coping with mental health disorders, coping with chronic medical problems, improvement of interpersonal relationships.
- Help accessing public benefits and educational opportunities as appropriate.
- Assistance with budgeting and money management.
- Assistance with substance use disorder services and referrals with a focus on harm reduction.
- Referrals to primary medical care, mental health services, and other community services as needed.
- Assistance in obtaining clothing and food.
- Group programming ranging from life-skills groups to community activities.
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- Housing location services including assisting clients with locating affordable permanent housing, establishing relationships with landlords/agencies willing to provide affordable permanent housing to DHS clients, and providing assistance with negotiating rental agreements. (Note: The need for housing location services will vary by project. Housing location experience is not a minimum qualification.)
- Administer move-in assistance funds to assist clients with timely security deposits, household goods and furnishings, utility deposits, etc.
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- Provision of on-going training to ICMS staff to ensure services are appropriate and to promote continuous quality improvement.
- Maintenance of program and client records and legally permissible data systems as may be required.
- Submit reports and invoices as requested and in a timely manner and provide all required supporting documentation.
- Comply and deliver services in accordance with contract deliverables and objectives.

ATTACHMENT B: DEFINITIONS AND DESCRIPTIONS

Activities of daily living (ADL) mean various chores that must be completed by or for a person on a daily basis to meet his/her personal needs. Such chores will include but not be limited to housework, meal preparation, laundry of clothes/linens and other washable items, taking medication, money management, transportation for personal or medical appointments, communicating with others either through telephone or in writing, dressing, eating, toileting, bathing, grooming and ambulation.

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Attending physician means the physician responsible for the treatment of the resident.

Care and supervision means the ongoing assistance with activities of daily living, not to include the endangerment of a resident's physical health, mental health, safety, or welfare.

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Residential care facilities for the chronically ill (RCFCI) is any housing arrangement maintained, licensed, and operated to provide care and supervision to adults, emancipated minors or family units living with HIV. An RCFCI may not exceed 50 beds. This service is limited to 24 months.

Respiratory therapist means a person with a California State respiratory Care Practitioner's Certificated issued by the Respiratory Care Examining Committee, and has: a one year's experience at the level of a Respiratory Therapy Technician; b) an associate degree in respiratory

therapy from an accredited college; or c) a certificate of completion from an approved two-year training program in respiratory therapy.

Scattered site master leasing is the practice through which an organization leases rental units throughout the county that are then sub-leased at affordable costs to people living with HIV.

Social worker means a person who has a Master of Social Work degree from a school of social work accredited or approved by the Council on Social Work Education and has one year of social work experience in a health care setting.

Social worker assistance means a person with a baccalaureate degree in the social sciences or related fields from an accredited college or university and has had a least one year of social work experience in a health care setting.

Speech pathologist means a person licensed as such by the California Board of Medical Quality Assurance.

SSI/SSP means Supplemental Security Income / State Supplemental Program which is a federal/state program that provides financial assistance to the aged, blind and/or disabled residents of California.

Transitional housing is housing for up to twenty-four months for homeless persons living with HIV and their families. The purpose of this service is to facilitate movement towards more traditional and permanent housing through self-sufficiency activities such as counseling, case management and other supportive services.

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I. TEMPORARY HOUSING SERVICES						
Service Name	**Description**	**Duration**	**Intensive Case Management (ICM)**	**Individual Service Plan (ISP)**	**Linkage to MCC**	**Other Service Requirements/Notes**
1A. Hotel/motel and meal voucher	The primary goal of the hotel/motel and meal voucher program is to prevent people living with HIV from sleeping in places not meant for human habitation when appropriate emergency shelter is unavailable.	Clients who qualify for hotel/motel and meal vouchers may access this service for no more than 60 days per contract year and in increments of no more than seven days at a time.*	**X**		**X**	• To access hotel/motel and meal vouchers, a client must be receiving case management services from a designated referral agency. • ICM and Linkage to MCC include housing plan and referrals to medical and social services.
1B: Emergency Shelter	Emergency shelters are defined as any facility, the primary purpose of which is to provide a temporary shelter for the people living with HIV who are homeless or unstably housed, and which does not require occupants to sign leases or occupancy agreements. Clients who qualify for emergency shelter may access this service for up to 90 days per contract year. Emergency shelters may be offered to eligible clients experiencing a housing crisis and have no place to go.	Up to 90 days per contract year.		**X**	**X**	• Intake, Assessment, Program Records • ISP and Linkage to MCC include housing plan and referrals to medical and social services.
1C: Transitional Housing	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.	Up to 24 months	**X**		**X**	• Intake, Assessment, Program Records • ICM, and Linkage to MCC include housing plan and referrals to medical and social services.

Service Name	Description	Duration	Intensive Case Management (ICM)	Individual Service Plan (ISP)	Linkage to MCC	Other Service Requirements/Notes
1D: Income-based Rental subsidies	Provides short-term housing assistance to people living with HIV through partial rent subsidies. Income must be at or below 500% of FPL. Resident must contribute 30 percent of income toward housing costs. (HUD guidelines). Individuals must (1) be HIV positive, (2) be temporarily or unstably housing or at-risk of becoming temporarily or unstably housed, and (3) not be receiving HOPWA rental assistance, Housing Choice Voucher program (formerly known as Section 8), or other housing assistance.	24 months	**X**		**X**	• Intake, Assessment, Program Records • ICM and Linkage to MCC include housing plan and referrals to medical and social services.
1E: RCFCI (licensed transitional)	The overriding goal of the RCFCI is to improve the health status of people with HIV/AIDS who need to receive care, support and supervision in a stable living environment to improve their health status before transitioning to self-sufficiency.	Up to 24 mos*		**x**	**x**	• Intake, Assessment, Monthly Case Conference, Service Agreements, Medication Management, Support Services, Emergency Medical Treatment, Discharge Planning, Program Records • ISP and Linkage to MCC include housing plan and referrals to medical and social services
1F: TRCF (unlicensed; transitional)	TRCFs provide interim housing with ongoing supervision and assistance with independent living skills (ILS) for homeless individuals living with HIV/AIDS in a non-institutional, homelike environment. The purpose of TRCFs is to facilitate movement towards a more traditional and permanent living situation through assessment of a person's needs, counseling, case management and other supportive services.	Up to 24 mos*		**X**	**X**	• Intake, Assessment, Discharge Planning, Program Records • ISP, ICM, and Linkage to MCC include housing plan and referrals to medical and social services.

II. PERMANENT HOUSING						
Service Name	**Description**	**Duration**	**Intensive Case Management (ICM)**	**Individual Service Plan (ISP)**	**Linkage to MCC**	**Other Service Requirements/Notes**
2A:Permanent Supportive Housing**	PSHP services include permanent housing with supportive services that assist people living with HIV and their families to adjust to new living arrangements, maintain independent living and coordinate overall housing and service needs. Supportive services include service coordination, mental health counseling and treatment and substance abuse counseling and treatment. While programs cannot, in most cases, coerce tenants to use supportive services, they will make every attempt to encourage and engage tenants to do so. Permanent supportive housing can be provided either in a congregate setting or through scattered-site master leasing.	Upon approval of agreement with DHS and other appropriate partners, may use RW funds for up to 24 months, then transition to other funding source (i.e., Measure H/HHH)	**X**		**X**	Assessment and Education

***May be extended based on client's needs and approval from DHSP**
****ICM must be offered once engaged in the PSH pipeline. Clients may refuse services offered.**
https://www.huduser.gov/portal/datasets/il/il2017/2017IICalc.odn
https://www.huduser.gov/portal/datasets/il/il2017/2017summary.odn
https://www.hudexchange.info/resources/documents/HPRP_FinancialAssistance.pdf
https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_care_hhp.aspx

MOTION #6

DRAFT/UPDATED 12.7.17
For public comment
Email comments to: hivcomm@lachiv.org
Public comment period: 12/14/17-1/12/18

LOS ANGELES COUNTY COMMISSION ON HIV PREVENTION SERVICES STANDARDS

Table of Contents

BACKGROUND

PURPOSE: HIV Prevention Service Standards outline the essential elements of service delivery a provider agency must adhere to when implementing HIV prevention services. The purpose of the service standards is to ensure consistent high-quality service delivery throughout Los Angeles County. Service standards establish the minimal level of service delivery. Providers are encouraged to exceed this minimal level if able to, given their capacity and scope.

A multitude of factors at the structural-, environmental-, interpersonal-, and individual-level impact the risk of HIV infection. Therefore, a multitude of services (e.g. housing, employment, social marketing, counseling, condom distribution, etc.) may also serve to prevent the acquisition of HIV. Because it is not feasible to create standards for every potential prevention service, the HIV Prevention Service Standards described in this document focus on ensuring that every individual at risk of acquiring or transmitting HIV infection is successfully connected to and retained in the prevention service(s) that are appropriate for them at any given point in time.

Additionally, because there are many different types of organizations that may provide prevention services, it should be understood that not every category of prevention standards described herein will be applicable to all agencies. For example, an agency that provides HIV/STD testing only, will not necessarily be expected to provide adherence services for clients who are accessing PrEP.

A NEW ERA OF HIV PREVENTION: The overall approach to HIV prevention has shifted drastically in recent years, due largely to major improvements in HIV medication, or antiretroviral therapy (ART). ART, when taken regularly, not only improves the health outcomes of people living with HIV, it also significantly lowers the risk of transmitting HIV to others by reducing the amount of the HIV virus in the body. According to the Centers for Disease Control and Prevention, "When ART results in viral suppression, defined as less than 200 copies/ml or undetectable levels, it prevents sexual HIV transmission."[1]

Treatment advancements have also ushered in a new era of HIV prophylaxis for HIV-negative individuals, specifically HIV pre-exposure prophylaxis (PrEP), and HIV post-exposure prophylaxis (PEP). PrEP is a daily pill taken by individuals who are HIV-negative before they are potentially exposed to HIV. PrEP, when taken consistently, is a highly effective prevention intervention - reducing the risk of HIV infection by up to 92%. PEP is a 28-day course of an antiretroviral regimen taken within 72 hours of a high risk HIV exposure to prevent HIV sero-conversion.

Given these scientific breakthroughs, the central tenets of today's HIV prevention efforts focus on biomedical prevention interventions, including the viral suppression of HIV-positive

[1] https://www.cdc.gov/hiv/library/dcl/dcl/092717.html

individuals and widespread access to PrEP, particularly for populations that are disproportionately impacted by HIV disease.

DEFINITION OF HIV PREVENTION SERVICES: HIV Prevention Services are those services used alone or in combination to prevent the transmission of HIV. *Biomedical* HIV prevention refers to HIV prevention methods that use antiretroviral treatment (ART) to decrease the risk of HIV transmission by reducing the viral load of people living with HIV (PLWH) and/or by reducing the susceptibility of HIV infection among HIV-negative individuals (via PrEP and PEP).

GOALS OF HIV PREVENTION EFFORTS IN LOS ANGELES COUNTY: Aligned with the Los Angeles County Comprehensive HIV Plan (2017-2021)[2] and the National HIV/AIDS Strategy (NHAS)[3], the overarching goals of HIV prevention efforts in Los Angeles County are to:

1. Reduce new HIV infections, and
2. Reduce HIV-related disparities and health inequities.

Furthermore, these service standards support the Los Angeles County HIV/AIDS Strategy for 2020 and Beyond goals:

1. Reduce annual HIV infections to 500 by 2020
2. Increase the proportion of persons living with HIV who are diagnosed to at least 90% by 2022
3. Increase the proportion of diagnosed people living with HIV who are virally suppressed to 90% by 2022

METHOD/HIGH IMPACT PREVENTION: In order to achieve our goals, we must implement a *High-Impact Prevention*[4] approach that utilizes combinations of scientifically proven, cost-effective, and scalable interventions targeted to the populations most disproportionately impacted by HIV in Los Angeles County, as indicated by those populations with the highest HIV incidence rates and the lowest rates of viral suppression. The Los Angeles County Comprehensive HIV Plan (2017-2021), based on the most recent surveillance data, identifies the following populations that experience the highest HIV incidence rates in Los Angeles County:

- Men who have Sex with Men (MSM)
- Black/African American MSM, Transwomen, and Cisgender Women
- Transwomen
- Young Men (18-29) who have Sex with Men (YMSM)
- Persons living in the Metro, South, and South Bay Service Planning Areas (SPAs)

[2] Los Angeles County Commission on HIV and the Los Angeles County Department of Public Health Division of HIV and STD Programs. Los Angeles County Comprehensive HIV Plan (2017-2021), September 2016.
[3] The National HIV/AIDS Strategy for the United States: Updated to 2020. https://www.aids.gov/federal-resources/national-hiv-aids-strategy/nhas-update.pdf
[4] High-Impact HIV Prevention: CDC's Approach to Reducing HIV Infections in the United States. https://www.cdc.gov/hiv/policies/hip/hip.html

Among people living with HIV, the following populations have the lowest rates of viral suppression in Los Angeles County:

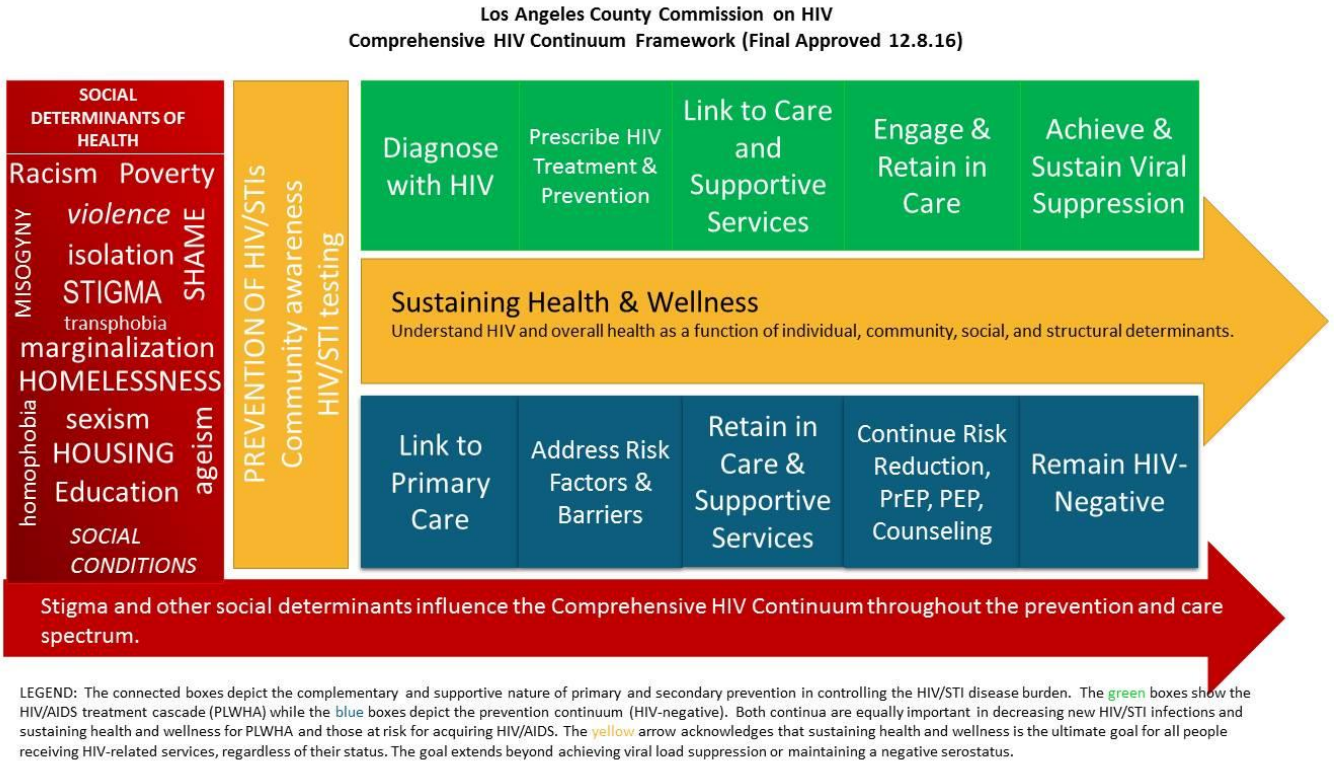
- Persons who inject drugs (PWID)
- Youth (18-29 years)
- Cisgender women
- Transgender persons
- Blacks/African Americans
- American Indians/Alaska Natives

In addition, there are many other populations and sub-populations highly impacted by HIV, including, but not limited to:

- Latino MSM
- Asian/Pacific Islander MSM
- Latina Cisgender women
- People between the ages of 13-17
- People over the age of 50
- Incarcerated populations
- Stimulant users
- Commercial Sex Workers
- Sex and needle-sharing partners of individuals who are HIV-positive

FOUNDATION FOR DEVELOPMENT OF STANDARDS: The Los Angeles County Commission on HIV's *Comprehensive HIV Continuum Framework,* depicted in Figure 1, below, was used to guide the development of the HIV Prevention Service Standards. The *Comprehensive HIV Continuum* is an aspirational framework that builds upon the social ecological model to underscore the importance of addressing HIV care and prevention across several dimensions. The connected boxes depict the complementary and supportive nature of primary and secondary prevention in controlling the HIV/STD disease burden. The green boxes depict the HIV Care Continuum (focused on people living with HIV), while the blue boxes depict the HIV Prevention Continuum (focused on HIV-negative individuals).

Figure 1: The Los Angeles County Commission on HIV *Comprehensive HIV Continuum Framework*



LEGEND: The connected boxes depict the complementary and supportive nature of primary and secondary prevention in controlling the HIV/STI disease burden. The green boxes show the HIV/AIDS treatment cascade (PLWHA) while the blue boxes depict the prevention continuum (HIV-negative). Both continua are equally important in decreasing new HIV/STI infections and sustaining health and wellness for PLWHA and those at risk for acquiring HIV/AIDS. The yellow arrow acknowledges that sustaining health and wellness is the ultimate goal for all people receiving HIV-related services, regardless of their status. The goal extends beyond achieving viral load suppression or maintaining a negative serostatus.

Standards Development Process: The development of the HIV Prevention Service Standards included the input and feedback of service providers, consumers, members of the Standards and Best Practices Committee (SBP), and the Los Angeles County Department of Public Health, Division of HIV and STD Programs. In addition, four Expert Review Panels (ERPs) composed of subject matter experts were convened to provide extensive critique on proposed standards. Moreover, two community meetings were convened to further vet the proposed standards. All comments were thoroughly reviewed by the SBP Committee resulting in recommended revisions.

In order to guide the development of the HIV Prevention Service Standards, SBP Committee members, ERPs, and community stakeholders considered the following questions:

1. Are the standards up-to-date and consistent with national standards of high quality HIV and STD[5] prevention services?

[5] For the purposes of this document, we chose to use the term STD (Sexually Transmitted Disease), rather than STI (Sexually Transmitted Infection). Factors that we weighted in making this decision included: perceived stigma; literal meaning of *disease* versus *infection*; and alignment with county, state, and national departmental names. See Dr. H. Hunter Handsfield's article, "Sexually Transmitted Diseases, Infections, and

2. Are the standards reasonable and achievable for providers?
3. Will the services meet consumer needs?
4. Are proposed standards client-centered?
5. What are the important outcomes we expect for people receiving these services? How can we measure whether or not the service is working for them?

Disorders: What's in a Name?" (http://www.ncsddc.org/blog/sexually-transmitted-diseases-infections-and-disorders-what's-name).

UNIVERSAL STANDARDS

UNIVERSAL HIV PREVENTION SERVICE STANDARDS: In order to achieve the goals of reducing new HIV infections and HIV-related disparities, HIV prevention services in Los Angeles County must include the following universal standards:

Whole Person Care: Preventing HIV is typically one priority among many in the lives of people accessing our services. Therefore, HIV prevention services are most effective when they are delivered with the *whole person* in mind. Whenever possible, programs and services should attend to clients' overall physical health, mental health, and spiritual health, as guided by each individual client.

Address the social determinants of health: Social determinants of health are the economic and social conditions that influence the health of individuals and communities.[6] Social determinants shape the contexts that either increases or decreases an individual's risk of exposure to HIV. Because HIV disparities are inextricably linked to social determinants, interventions or services that focus on social determinants (e.g. housing, education, employment, healthcare, etc.) are necessary to reduce these disparities. The implementation of such structural interventions typically requires a great deal of time and effort on behalf of multiple stakeholders, given that social determinants are deeply entrenched and institutionalized in our society. For this reason, many HIV prevention agencies may not have the capacity to implement structural or social level interventions. However, HIV prevention services should minimally reflect an understanding of the role of social determinants in their design (e.g. consider a client's competing priorities related to housing and employment). HIV prevention agencies, no matter how small, should strive to complement traditional HIV prevention services), with services that help to address social determinants (e.g. resume writing workshops).

Strength-Based: A strength-based approach to service design and provision seeks to understand and develop clients' strengths and capabilities that can lead to improved health and quality of life. Services that focus solely on individuals' deficits, needs, problems, or pathologies tend to focus only on what a client needs to "fix" about themselves, thus emphasizing negative behaviors rather than emphasizing resiliency and protective factors. Furthermore, when we emphasize what a client is lacking, a dependency is created on the provider and a process of disempowerment occurs. A strength-based approach focuses on individuals' strengths, resources and the ability to recover from adversity; thus allowing a client to focus on opportunities and solutions rather than problems and hopelessness. A strength-based approach results in different questions being asked (see Assessment section

[6] World Health Organization, Commission on Social Determinants of Health. Geneva: WHO; 2008. Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health

below) and facilitates an openness and exploration on behalf of the provider-client relationship.

Sex-Positive: When services are delivered from a "sex-positive" framework or attitude, they are free from judgment about clients' sexual behaviors, including the behavior itself (as long as it is consensual); the number and type of sexual partners; and the frequency of sexual behaviors. A sex-positive attitude also serves to destigmatize sex, and may also serve to destigmatize being gay, being transgender, living with, or being at risk for HIV, etc. Being sex-positive does not mean that you ignore behaviors or circumstances that may increase someone's risk of acquiring HIV or STDs. On the contrary, when clients know that they will not be shamed or judged for the behaviors they engage in, they then will be more likely to disclose important facts and likely will be receptive to information from providers that helps them reduce their risk and/or build upon protective factors.

Cultural humility: All HIV prevention organizations should strive to deliver culturally responsive services. Culturally responsive services are those that are respectful of, and relevant to, the beliefs, practices, culture and linguistic needs of diverse consumer/client populations and communities.[7] Cultural responsiveness describes the capacity to respond to the issues of diverse communities. It thus requires knowledge and capacity at different levels of intervention: structural, community, organizational, and individual. Culturally-responsive services acknowledge that power imbalances exist between groups of people and cultures based on historical and institutional oppression and privilege; that we are not simply "different" from one another. Culturally responsive agencies also create a physical environment that is welcoming, warm, and that communicates a sense of safety for clients.

To practice cultural humility is to maintain a willingness to suspend what you know, or what you think you know, about a person based on generalizations about their culture. Whereas cultural *competency* implies that one can function with a thorough knowledge of the mores and beliefs of another culture, cultural *humility* acknowledges that it is impossible to be adequately knowledgeable about cultures other than one's own. What you learn about your clients' culture stems from being open to what they themselves have determined is their personal expression of their culture.[8] Tenets of cultural humility include:

1) Lifelong learning & critical self-reflection
2) Recognizing and challenging power imbalances for respectful partnerships, and
3) Institutional accountability

Data driven and outcome-based: Data-driven and outcome-based program planning

[7] Adapted from: Curry-Stevens, A., Reyes, M.-E. & Coalition of Communities of Color (2014). *Protocol for culturally responsive organizations.* Portland, OR: Center to Advance Racial Equity, Portland State University.
[8] Adapted from: "Cultural Humility: People, Principles and Practices," https://www.youtube.com/watch?v=_Mbu8bvKb_U

ensures that programs and services address specific needs in the community and lead to specific outcomes in mind, and including an evaluation component which enables you to capture data. More specifically, data-driven and outcome-based programs and services:

- are designed based on quality data and with specific HIV-related outcomes in mind
- are responsive and relevant to the communities we serve
- are developed in response to specific drivers or causes of HIV-related problems in our communities
- are aligned with local and national HIV prevention goals
- require the collection and utilization of process and outcome data in order to continuously improve
- show meaningful results that demonstrate the value of our services
- contribute to the body of knowledge in the HIV field

Elicit community feedback: Responsive services are services that are designed and/or delivered with continuous feedback from the populations served. Feedback should help to ensure that the services are culturally appropriate, effective in preventing HIV, respectful of clients, strength-based, sex-positive and destigmatizing, and easily accessed. Feedback methods may include client satisfaction surveys, focus groups, secret shoppers, and other means to continuously assess quality of services.

CORE PREVENTION COMPONENTS

Summary of Core Prevention Service Components: The HIV Prevention Service Standards detailed in this document seek to ensure the provision of a core set of integrated HIV prevention services aimed at preventing the acquisition and transmission of HIV and STDs. The Core Prevention Service Components are: Assessment, HIV/STD Testing and Retesting, Linkage to HIV Medical Care and Biomedical Prevention Services, Referral and Linkage to Non-Biomedical Prevention Services, and Retention and Adherence to HIV Medical Care and Prevention Services. These categories, in addition to their corresponding data indicators, documentation needs, and population-based outcomes, are outlined in Table 1.

Table 1: Summary of Core Prevention Service Components

Core Prevention Service Components	Data Indicators	Documentation Needs	Population-Based Outcomes
1. Assessment	• Number of clients/patients who complete assessments • Number of participants screened for: connection to a medical home; primary care engagement; insurance coverage; HIV status; STDs; immunizations; pregnancy; mental health; substance abuse; experiences of trauma and violence; housing and employment status; and sexual and needle-sharing behaviors that may increase their risk of HIV acquisition or transmission	• Completed assessments indicating specific areas or topics assessed and type of assessments used	• Decrease the number of new HIV infections • Decrease the number of STDs • Increase the number of persons with known HIV status • Increase the number of persons treated for STDs • Increase the number of newly diagnosed clients that have their first HIV medical visit within 14 days of their HIV test.
2. HIV/STD Testing and Retesting	• Number of persons tested/screened for HIV and STDs • Number of persons tested/screened for HIV and STDs who have never tested/screened before • Number of persons who test positive for an STD who are treated or referred to treatment	• Documentation of HIV/STD testing in client files and data management system • Documentation of type and frequency of outreach and recruitment methods • Documentation of clients treated for STDs or referred to treatment	

	• Percentage of high-risk[9] negative clients having documentation of HIV/STD testing every 3 months • Type and number of outreach and recruitment methods		

Core Prevention Service Components	Data Indicators	Documentation Needs	Population-Based Outcomes
3. Linkage to HIV Medical Care and Biomedical Prevention Services	**HIV-positive individuals:** • Number of HIV-positive clients linked to HIV medical care within 14 days of receiving a HIV-positive test result • Number of HIV-positive clients lost to care who re-engage in HIV medical care within 30 days of interaction with provider **HIV-negative individuals:** • Number of high-risk HIV-negative clients receiving education on PrEP • Number of high-risk[10] HIV-negative clients who are interested in PrEP • Number of high-risk HIV-negative clients	• Documentation of linkage to HIV medical care • Documentation of re-engagement in HIV medical care • Documentation of PrEP and PEP education • Documentation of client interest in learning more about PrEP (i.e. responded affirmatively to the question, "Would you like to learn more about PrEP or PEP?") • Documentation of linkage to a PrEP Navigator (may be internal or external linkage)	• Increase the number of out-of-care previously diagnosed clients that are re-engaged in HIV medical care within 30 days of their identification. • Increase the number of HIV positive clients that have at least 2 medical visits per year at least 3 months apart. • Increase the number of HIV-positive persons that are virally suppressed (<200

[9] "High risk" is defined as someone who has an HIV positive sex partner; a history of bacterial STD diagnosed in the past 12 months;
a history of multiple sex partners of unknown HIV status; or other risk factors that increase HIV risk, including transactional sex (such as sex for money, drugs, housing); or someone who reports sharing injection equipment such as those used to inject drugs or hormones.

[10]

	interested in PrEP that are linked to a PrEP Navigator. • Number of high-risk HIV-negative clients who received a PrEP prescription • Number of high-risk HIV-negative clients receiving education on PEP • Number of high-risk HIV-negative clients who received PEP within 72 hours of exposure		copies/ml)
	• Number of high-risk HIV-negative clients who accessed PEP and transitioned to PrEP	• If available, documentation of PrEP or PEP prescription (may be client self-report) • Documentation of former PEP clients who currently access PrEP • Documentation of PrEP and PEP clients who are referred to medication adherence services	• Increase the number of HIV negative clients that are given accurate PrEP and PEP information • Increase the number of high-risk HIV negative individuals accessing HIV pre-exposure prophylaxis (PrEP) and HIV post- exposure prophylaxis (PEP), as needed

Core Prevention Service Components	Data Indicators	Documentation Needs	Population-Based Outcomes

4. Referral and Linkage to Non-Biomedical Prevention Services	• Number of high-risk HIV-negative and HIV-positive clients that are referred to needed non-biomedical prevention services, as indicated via the assessment process. This may include referrals to:
	  • behavioral interventions
	  • risk-reduction education
	  • syringe exchange
	  • housing services
	  • mental health services
	  • substance abuse services
	  • food pantries
	  • employment services
	  • health insurance navigation
	• Number of high-risk HIV-negative clients who have not accessed primary care in over one year linked to primary care medical visit within 90 days of assessment.[11]
	• Number of external and internal[12] condoms distributed free of charge
		• Documentation of referrals in client files and data management system
		• Documentation of linkage to primary care (may be client self-report)
		• Documentation of condom availability or distribution
			Same as above

[11] Assuming that primary care is available to the client, which may not always be the case (i.e. for undocumented individuals, individuals who speak a language other than English, transgender individuals, etc., affordable and accessible primary care may not always be available).

[12] "External" and "internal" condoms are also known as "male" and "female" condoms, respectively, but are not referred to as such in this document since their use is not necessarily aligned with one's gender identity.

Core Prevention Service Components	Data Indicators	Documentation Needs	Population-Based Outcomes (from CHP)
5. Retention and Adherence to HIV Medical Care, ART, and Other Prevention Services	• Number of HIV-positive clients who receive HIV medical care at least 2 times per year, at least 3 months apart • Number of HIV-positive clients who adhere to their HIV medications • Number of HIV-positive clients who remained engaged in prevention service as needed • Number of PrEP and PEP clients referred to medication adherence interventions or support services. • Number of PrEP and PEP clients who access medication adherence interventions or support services. • Number of HIV-negative clients who remained engaged in prevention service as needed • Number of PrEP clients who adhere to PrEP medication per adherence plan determined with PrEP provider • Number of PEP clients who adhere to PEP for 28-day course	• Documentation of provision of service(s) • Documentation of client engagement in service(s) • Documentation of adherence to ART, PrEP or PEP medication • Documentation of PrEP and PEP clients who access medication adherence services	Same as above

ASSESSMENT

Client assessments are often the first in-depth interaction a client has with a provider agency, and thus can foster a lasting positive relationship built on trust and respect, if conducted correctly. Conversely, an assessment that a client perceives to be judgmental or disrespectful in any way can impede the client's willingness or ability to secure necessary prevention services.

Standards for Assessment:

Assessments should be conducted by trained personnel.
The training should include basic client-centered counseling techniques (e.g. how to communicate in a non-judgmental manner, the use of appropriate body language, etc.), and should also include elements that are specific/relevant to the type of assessment(s) conducted. For example, providers should be trained in how to utilize specific mental health and/or substance abuse screening tools (e.g. Patient Health Questionnaire (PHQ-2)), if the assessment utilizes such tools.

The assessment process should include the following activities and or elements (not necessarily in this order):

1. Explain the purpose of the assessment and obtain verbal consent to continue
2. Conduct the assessment in private, with no other clients, and preferably no other staff members able to hear the conversation
3. Gather relevant information to determine the client's needs, risks, and strengths, when appropriate
4. Inform the client of the services available (internally and externally) and what the client can expect if they were to enroll
5. Establish the client's eligibility for services, including HIV status, if relevant, and other criteria
6. Inform the client of any documentation requirements for the assessment (e.g. income verification for insurance purposes)
7. Collect required county, state, federal client data for reporting purposes
8. Collect basic client information to facilitate client identification and client follow-up
9. Begin to establish a trusting client relationship.

Assessments should be a cooperative and interactive endeavor between the staff and the client, and should be conducted in a strength-based manner.

The assessment should highlight clients' skills, competencies and resilience in addition to their challenges and needs. Included below are some examples of strength-based questions[13] that may be asked during an assessment, or over the course of multiple assessments, as appropriate:

[13] Adapted from "50 First Strength-Based Questions" (http://www.changedlivesnewjourneys.com/50-first-strength-based-questions).

1. What is working well (either in general, or with respect to a certain subject, e.g. adherence, overall health, etc.)?
2. Can you think of things you have done in the past that have helped with ___?
3. What small thing could you do that would make ____ better?
4. Tell me about what a good day looks like for you? What makes it a good day?
5. On a scale of 1 to 10 how would you say ___ is? What might make that score a little better?
6. What are you most proud of in your life?
7. What inspires you?
8. What do you like doing? What makes this enjoyable?
9. What do you find comes easily to you?
10. What do you want to achieve in your life?
11. When things are going well in your life – tell me what is happening?
12. What are the things in your life that help you keep strong?
13. What do you value about yourself?
14. What would other people who know you say you are good at doing?
15. You are resilient. What do you think helps you bounce back?
16. What is one thing you could do to have better health, and feeling of wellbeing?
17. How have you faced/overcome the challenges you have had?
18. How have people around you helped you overcome challenges?
19. What are three things that have helped you overcome obstacles?
20. If you had the opportunity, what would you like to teach others?
21. Without being modest, what do you value about yourself, what are your greatest strengths?
22. How could/do your strengths help you to be a part of your community?
23. Who is in your life?
24. Who is important in your life?
25. How would you describe the strengths, skills, and resources you have in your life?
26. What could you ask others to do, that would help create a better situation for you?
27. What are the positive factors in your life at present?
28. What are three (or five or ten) things that are going well in your life right now?
29. What gives you energy?
30. What is the most rewarding part of your life?
31. Tell me about a time when you responded to a challenge in a way that made you feel really on top of things?
32. How have you been able to develop your skills?
33. How have you been able to meet your needs?
34. What kind of supports have you used that have been helpful to you? How did the supports improve things for you?
35. Tell me about any creative, different solutions you have tried. How did this work out?

Clients should be the primary source of information during an assessment.

However, if appropriate and with client consent, assessments may include additional information from case manager(s), medical or psychosocial providers, caregivers, family members, and other sources of information.

Assessments should be conducted in a client-centered manner that accommodates clients who are unable or otherwise hesitant to attend the appointment at the provider agency.

Diverse methods of interaction (e.g., text-based, via social apps, in-person) should be supported, given that confidentiality policies are adhered to.

Assessments that are conducted should align with the client's reason(s) for accessing services and point of entry. For example, a client who is interested in accessing HIV/STD testing, PEP, or PrEP should not have to endure a lengthy assessment before accessing these services. Clients should be able to access services as expeditiously as possible. However, in some situations, or at a different point in time, a longer assessment may be appropriate.

Whenever possible, collect demographic information in a manner that is affirming of various identities and of intersecting identities.

For example, allow clients to identify their race or ethnicity using whatever categories best fit for them. When asking questions related to gender identify, consider using the two-step question that captures a transgender person's current gender identity as well as their assigned sex at birth: 1. What is your current gender identity? 2. What sex were you assigned at birth (on your original birth certificate)? Also, ask all clients what pronoun(s) to use to address them (he, she, they).

If appropriate, assess for barriers to accessing services and remaining engaged in services.

If barriers are identified, assist the client in identifying potential solutions.

Specific topics or areas should be assessed only if the provider can offer support, resources, referrals, and/or services in response.

For example, if questions are asked pertaining to a client's history of trauma, the provider should be prepared to handle a client's potential range of emotions. Given that providers/agencies have resources, referrals, and/or services at hand, consider including the following topics in client assessments:

- Connection to spirituality
- Intimate partner violence
- Trauma
- Sex-trafficking

The assessment process should utilize a health promotion approach.
This includes using information collected during the assessment/ screening to identify appropriate messages that promote health-seeking behavior and minimize risk-behaviors or circumstances. The intention is to offer information, and suggest services and interventions that are tailored to the specific person (and their partners, if relevant) and to highlight current health promoting behaviors and overall strengths of the client. Health promotion includes provision of information or resources related to:

- overall health (may include overall physical health, nutrition, oral health, spiritual health, and emotional health)
- behavioral interventions (e.g., brief or intensive risk reduction strategies that encourage safer sex and use of sterile drug-injection equipment, substance use treatment)
- biomedical interventions (e.g., PrEP, STD services, special reproductive and pregnancy services)
- clarifying concepts and misinformation about HIV transmission, acquisition, or prevention methods
- specialized counseling and support to members of HIV-serodiscordant relationships
- a variety of condoms (e.g. external, internal[14], non-latex, etc.) and lubrication options
- new, sterile syringes through syringe services programs, pharmacists, physicians, or other legal methods to persons who lack consistent access to sterile drug-injection equipment

The assessment process should include assessing for medical and social factors that impact HIV acquisition and transmission.
Individuals at high risk for HIV acquisition or transmission can experience significant personal, social, and structural challenges, such as poverty, mental illness, substance use, unstable housing, and lack of regular medical care. Assessments should include questions pertaining to these medical and social factors that influence HIV acquisition or transmission.

[14] "External" and "internal" condoms are also known as "male" and "female" condoms, respectively, but are not referred to as such in this document since their use is not necessarily aligned with one's gender identity.

HIV/STD TESTING AND RETESTING

HIV and STD testing often serve as the first point of entry in the HIV Care and Prevention Continua and for many, the key opportunity to facilitate linkage to a comprehensive array of services. Individuals at high risk for HIV should be tested every 3-6 months, regularly assessed for risks and needs, and linked or re-linked to other HIV prevention services, depending on their needs.

Agencies should implement a streamlined model of HIV testing that includes delivering key information, conducting the HIV test, completing brief risk screening, providing test results, providing referrals and/or ensuring linkages to services tailored to the client's status and specific needs.

Standards that apply to HIV/STD testing include[15]:

- HIV/STD testing must be voluntary and free from coercion. Patients/clients must not be tested without their knowledge.
- Opt-out HIV screening (notifying the patient/client that an HIV test will be performed, unless the patient/client declines) is recommended in all settings.
- Specific signed consent for HIV testing should not be required.
- Use of antigen and antibody (Ag/Ab) combination tests is encouraged unless persons are unlikely to receive their HIV test results.
- Preliminary positive screening tests for HIV infection must be followed by additional testing to definitively establish the diagnosis.
- Providers should be alert to the possibility of acute HIV infection and perform an (Ag/Ab) immunoassay or HIV RNA in conjunction with an antibody test. Persons suspected of recently acquired HIV infection should be referred immediately to an HIV clinical-care provider.
- Agencies should adhere to local and state public health policies and laws to ensure they deliver high-quality HIV testing services that are culturally competent and linguistically appropriate.
- HIV testing should be simple, accessible, and straightforward. Minimize client barriers and focus on delivering HIV test results and on supporting clients to access follow-up HIV care, treatment, and prevention services as indicated.
- To reach populations at high risk for HIV infection, sites should employ strategic targeting and recruitment efforts, establish program goals and monitor service delivery to ensure targeted testing is achieving program goals.
- To provide the most accurate results to clients, sites should use HIV testing technologies that are the most sensitive, cost-effective, and feasible for use at their

[15] Adapted from *Implementing HIV Testing in Nonclinical Settings: A Guide for HIV Testing Providers*. https://www.cdc.gov/hiv/pdf/testing/cdc_hiv_implementing_hiv_testing_in_nonclinical_settings.pdf

agency. Establishing relationships with facilities offering laboratory-based HIV testing is important for referring clients who may have acute HIV infection.

- Sites should consider offering HIV testing services for couples or partnered relationships to (a) attract high-risk clients who are not otherwise testing and (b) identify HIV-discordant couples and previously undiagnosed HIV-positive clients.
- Diagnostic HIV testing and opt-out HIV screening should be a part of routine care in all health-care settings while also preserving the client's option to decline HIV testing and ensuring a provider-client relationship conducive to optimal clinical and preventive care.
- Inform clients at high-risk for HIV/STDs about 1) methods to reduce the risk of HIV/STD acquisition; 2) STDs that can facilitate HIV acquisition; 3) the benefits of screening for STDs (that are often asymptomatic) and STD treatment
- Assess these risk factors for HIV/STD transmission:
  - Sexual, alcohol, and drug-use triggers (boredom, depression, incarceration, sexual violence, sex work, abuse) and behaviors that may lead to HIV/STD transmission
  - Recent sex and/or needle-sharing partners who were treated for HIV/STDs, and/or other behaviors they may have that contribute to possible HIV acquisition
  - Past and recent HIV/STD diagnosis, screening, and symptoms
  - Survival sex work
  - Sense of self-worth
- Lack of basic health information and/or information pertaining to HIV/STD risk
- Offer external and internal condoms, and lubrication options
- Personnel from every HIV and STD testing site should be knowledgeable about the HIV and STD burden in their health district. Report cases of HIV/STDs according to jurisdiction requirements and inform clients diagnosed with HIV and/or STDs that case reporting may prompt the health department to offer voluntary, confidential partner services

HIV and STD Testing services must follow these guidelines, adapted from the CDC:[16]

1. All adults and adolescents ages 13 and older should be tested at least once for HIV.
2. Annual chlamydia screening of all sexually active cisgender women younger than 25 years, as well as older cisgender women with risk factors such as a sex partner who has a sexually transmitted infection
3. Annual gonorrhea screening for all sexually active cisgender women younger than 25 years, as well as older cisgender women with risk factors such as a sex partner who has a sexually transmitted infection.
4. Syphilis, HIV, hepatitis B, chlamydia and gonorrhea screening for all pregnant women, starting early in pregnancy, with repeat testing as needed, to protect the health of mothers and their infants.

[16] Access this link for more information:
http://publichealth.lacounty.gov/dhsp/Providers/LAC_ONLY_STDScreeningRecs-5-2017.pdf

5. Screening at least once a year for syphilis, chlamydia, gonorrhea, and hepatitis C for all sexually active gay, bisexual, and other men who have sex with men (MSM), as well as sexual active transgender women who have sex with men. MSM or transgender women who have sex with men, who have unprotected sex should be screened more frequently for STDs (e.g., at 3-to-6 month intervals).
6. Sexually active gay and bisexual men and sexually active transgender women who have sex with men may benefit from more frequent HIV testing (i.e., every 3 to 6 months).
7. Anyone who has unprotected sex or shares injection drug equipment should get tested for HIV at least once a year.

In populations for whom no recommendations exist, screening should be based on risk factors, local epidemiology and prevalence of specific STDs in the service area. The Los Angeles County Department of Public Health, Division of HIV and STD Programs' (DHSP) mapping project[17] depicts STD and HIV burden by health district throughout Los Angeles County. This project ranks geographical areas (health districts) in order of highest to lowest HIV and STD burden by analyzing several important driving factors including number of infections, number of people infected, the population size, geographic size, and results from hot spot analyses.

[17] http://publichealth.lacounty.gov/dhsp/Mapping.htm

LINKAGE TO HIV MEDICAL CARE AND BIOMEDICAL PREVENTION SERVICES

Once HIV status is determined and the needs of clients are identified via the assessment and/or screening process, they should be connected to appropriate services to address those needs in the most expeditious manner possible.

For both recently diagnosed and previously diagnosed HIV-positive clients, linkage to/re-engagement in HIV medical care is a critical component of the HIV Care Continuum. Likewise, for high-risk HIV-negative individuals who have recently been tested for HIV and STDs, linkage to biomedical interventions (i.e. PrEP and PEP) is a priority.

Standards for linking newly-diagnosed persons to HIV medical care and re-engaging previously diagnosed HIV-positive persons who have fallen out of care to HIV medical care include:

- Develop written protocols to ensure linkage to HIV care within 14 days after diagnosis, or re-engagement in care within 30 days after identification (for those out of care)
- Inform persons about the benefits of starting HIV care and antiretroviral treatment (ART) early (even when feeling well)
- Assess possible facilitators and barriers to linkage and retention and provide or make referrals for other medical and social services that may improve linkage and retention
- Help persons enroll in health insurance or medical assistance programs that provide HIV care or cover costs of care
- Collaborate with other health care providers, case managers, navigation assistants, nonclinical community-based organizations, and health department personnel to provide services that promote prompt linkage to and retention in care
- Track outcomes of linkage and retention services and provide follow-up assistance to persons who have not started HIV medical care within 14 days after diagnosis, or within 30 days for those out of care
- Train staff to comply with laws, policies, and procedures to protect patient confidentiality when exchanging personal, health, or financial information used for linkage and reengagement services
- Provide staff training and tools to increase competence in serving patients with differing health literacy levels
- Train clinical providers about the most recent U.S. Department of Health and Human Services guidelines that advise offering ART to all persons (regardless of CD4 cell count) for health benefits and preventing HIV transmission.
- Help schedule the first HIV medical visit, seeking same-day or priority appointments when possible, especially for newly diagnosed persons

- Provide transportation assistance to the first visit, when possible
- Verify attendance at first visit by contacting the person or the HIV health care provide
- If the first visit was not completed, provide additional linkage assistance until visit is completed or no longer required
- If providing HIV medical care, offer convenient scheduling whenever possible (e.g., same-day or priority appointments, extended hours)

Identify and utilize specific strategies designed to overcome barriers to successful linkage. Such strategies may include:

- Co-locating HIV testing and HIV medical care services
- Multiple case management sessions
- Motivational counseling
- Reminders for follow-up visits
- Help enrolling in health insurance or medical assistance programs
- Transportation services to the health care facility
- Providing or linking to other medical or social services (e.g., substance abuse treatment, mental health services, child care)
- Maintaining relationship between patient and a consistent care team

Standards for linking HIV-negative persons to biomedical prevention interventions include:

- If agencies do not provide PrEP services, they must develop written protocols/MOUs with agencies/clinics that do provide PrEP, outlining the referral and linkage process
- Inform clients about the benefits of biomedical interventions to prevent the acquisition of HIV
- Ask all high-risk HIV-negative clients if they are interested in learning more about PrEP or PEP
- Connect all high-risk HIV-negative clients to a PrEP Navigator (in-house or external) within 24 hours (or 2 business days)
- Provide immediate, active, and, if necessary, repeated, linkage services to clients with an expressed interest in PrEP, and the immediate need for PEP
- Counsel and refer individuals exposed to HIV within a 72 hour time range for evaluation to a PEP program
  as appropriate.
- Provide follow-up assistance to clients who are not able to link to a PrEP Navigator
- If an agency provides PrEP, assess the client's readiness to engage in PrEP services and barriers and facilitators to starting services
- Help schedule appointments to see a PrEP Navigator or PrEP provider (in-house or external)
- Offer convenient scheduling whenever possible (e.g., same-day or priority appointments, extended hours)
- Maintain a client-friendly environment that welcomes and respects new clients
- Provide reminder (and accompaniment, if possible) for first appointment, using the client's preferred contact method(s)

- Offer support to encourage attendance (e.g., directions, transportation resources, such as Metro tokens or ride shares)
- Identify and utilize specific strategies designed to overcome barriers to successful linkage. Such strategies may include:
    - Co-locating HIV testing and biomedical interventions
    - Client accompaniment to access services
    - Multiple case management sessions
    - Motivational counseling
    - Providing trauma-informed care
    - Providing crisis intervention counseling
    - PrEP navigation
- Offer guidance and assistance on how to obtain financial assistance for PrEP through private- or public-sector sources
- Assist with health insurance and other benefits, including linkage to health insurance navigators, case management and client navigation, and intervention-specific programs (e.g. PrEP medication and co-pay assistance programs)

REFERRALS AND LINKAGES TO NON-BIOMEDICAL PREVENTION SERVICES

Although numerous HIV prevention related services exist throughout Los Angeles County, clients in need of services may not be willing or able to access them. For example, an undocumented transgender woman may want to access regular primary care, but may not feel comfortable doing so if she fears transphobia or legal implications. For this reason, while the ultimate goal is *linkage* to a needed service, oftentimes *referrals* are all an agency can be held accountable for.

Standards related to referring clients to non-biomedical services focus on *active referrals* rather than *passive referrals*. The latter defined as telling a client about a service and or giving them a phone number and leaving it up to them to initiate contact. Conversely, active referrals address barriers to accessing services by helping the client make contact with a service provider or agency. This may include scheduling the appointment with the client and/or accompanying them to their first appointment.

Based on information obtained via the assessment process, clients may be in need of any number of prevention services; specialty services that address medical needs (e.g. primary care); and/or social needs (e.g. needs related to housing, employment etc.). Whenever possible, agencies should strive to provide specialty services onsite. If this is not feasible, providers need to ensure that clients are referred to external specialty services. How these services are prioritized depends upon the need of each particular client.

The standards for actively referring clients to non-biomedical prevention services include:

- Developing written protocols/MOUs with other HIV/STD prevention and primary care providers and social service agencies to ensure linkage to appropriate prevention services
- Assisting clients with enrolling in health insurance by referring them to a benefits counselor
- Actively referring clients who are not accessing regular care to a medical home or primary care provider
- Assessing possible facilitators and barriers to accessing services
- Tracking outcomes of referral services (i.e. track linkages) and providing follow-up assistance to clients who have not been linked to prevention services
- Helping schedule the first prevention-related service appointment
- Linking all newly diagnosed individuals with HIV, syphilis or gonorrhea to the LAC DHSP Partner Counseling and Referral Services.
- Actively referring to mental health services, substance use services, behavioral interventions and other psychosocial and ancillary services (e.g. housing, employment, nutritional and social support)
- Providing transportation assistance to the first visit, when possible
- Offering convenient scheduling whenever possible (e.g., same-day or priority appointments, extended hours)
- Maintaining a client-friendly environment that welcomes and respects new clients

- Providing reminders for first appointment, using the client's preferred contact method
- Offering support to encourage attendance (e.g., directions, transportation resources, such as Metro tokens or ride shares)
- Identifying and utilizing specific strategies designed to overcome barriers to successful linkage. Such strategies may include:
    - Co-locating HIV testing and prevention services
    - Multiple case management sessions
    - Motivational counseling
    - Trauma-informed care
    - Crisis intervention counseling
    - Navigation assistance
- Maintaining a relationship with a consistent prevention team
- Offering assistance with health insurance and other benefits, including active referrals to health insurance navigators
- Make available online directories of providers, agencies, telemedicine agencies, and professional advice hotlines that offer specialty services. Ensure that these resources are gay- and trans-affirming and otherwise culturally appropriate.
- Develop and participate in provider networks that offer specialty services for persons with HIV, especially persons who are uninsured or underinsured or who live in underserved areas
- Develop written protocols, memoranda of understanding, contracts, or other agreements that define financial arrangements, staff and agency responsibilities for providing linkages, making referrals, and the tracking of referral completion and satisfaction
- Establish policies and procedures to safeguard the confidentiality of personal and health information exchanged during the linkage/referral process
- Train staff and any specialty service providers in the following topics:
- Staff roles and responsibilities within the agency
- Issues such as sex trafficking, substance use, etc. that can provide a better understanding of their clients' needs
- Identifying specialty service providers who serve the community
- Tailoring of services to personal characteristics (e.g., language, location, and insurance status)
- Inter- and intra-agency referral procedures
- Maintaining confidentiality of collected personal information
- Advocating for persons who need specialty services
- Minor consent for HIV/STD testing (consent from youth aged 13 and older)
- Engage case managers, navigation assistants, or other staff to provide service coordination for persons living with or at risk for HIV who have complex needs
- Routinely provide print or audiovisual materials that describe specialty services provided onsite or through referrals
- Monitor the quality of referrals for specialty services to inform quality improvement strategies (e.g., proportion of referred persons who obtained specialty services), client satisfaction, and barriers and facilitators
- Routinely assess agency staff regarding knowledge and comfort to offer the prevention services the agency is providing
- Include services related to economic empowerment and job-readiness

RETENTION AND ADHERENCE TO HIV MEDICAL CARE, ART, AND HIV PREVENTION SERVICES

Retention to HIV medical care is described as at least 2 medical care visits per year, at least 3 months apart. Adherence to ART is described as the extent to which a person takes ART according to the medication instructions. Sustained high adherence is essential to suppress viral load in HIV positive individuals and, in turn, improve health outcomes and prevent HIV transmission. Adherence to ART is also critical to maximize the benefit of PrEP and PEP among HIV-negative individuals. Additionally, a key component of the Comprehensive HIV Continuum is retention and adherence to prevention services to facilitate ongoing access to the full array of services, including behavioral interventions, psycho-social services, etc.

Standards related to retention and adherence to HIV medical care and ART include:

- Develop protocols to update patient contact information at each visit (e.g., residence, phone number(s), payment method)
- Develop procedures to routinely assess factors that enable or hinder attending visits
- Establish procedures to identify patients at risk for lapses in care and services that support their continued care
- Establish methods to monitor timing and completion of each patient's scheduled medical visits
- Schedule follow-up HIV medical care visits
- Provide reminders for all visits, using the person's preferred method of contact
- Reinforce the benefits of regular HIV care for improving health and preventing HIV transmission to others during in-person encounters or outreach by phone, email, or other methods
- Periodically assess facilitators and barriers to retention and motivate the person to overcome the barriers
- Verify if the person attended follow-up visits, even when the patient was seen in another clinical setting
- Participate in multidisciplinary teams with health educators, service linkage facilitators, community health workers, case managers, nurses, pharmacists, and physicians to assess and support adherence to antiretroviral treatment
- Provide adherence support tailored to each person's regimen and characteristics, according to provider role, authority, and setting
- Provide or refer to medication adherence interventions
- Offer advice on how to obtain sustained coverage or subsidies for ART through private- or public-sector sources

Standards related to retention and adherence to prevention services, including biomedical prevention services, include:

- Inform clients about the benefits of sustained adherence to PrEP and PEP
- Reinforce the benefits of prevention services

- Regularly assess facilitators and barriers to retention, and supporting clients to overcome identified barriers
- Regularly assess clients' need for prevention services: *Have their needs changed? Do they no longer need services? Do they need different services?*
- Provide adherence support tailored to each client's needs and characteristics, and/or connect clients to medication adherence interventions
- Work with client to develop a plan for stopping PrEP, when appropriate (e.g. temporarily, long-term, or quitting use) and transitioning to other prevention options, including addressing relationship issues and health issues that increase HIV/STD risk
- Provide or make referrals for services to address factors that may impair adherence (e.g., comorbidity, financial, psychosocial, and structural issues)
- Offer advice on how to maintain financial assistance for PrEP through private- or public-sector sources
- Advise clients to take PrEP medications as prescribed; provide information about the regimen, and check for understanding in the following areas:
    - Details of the regimen, including dosing method and schedule, dietary restrictions, and what to do when drinking alcohol or when missing doses
    - Consequences of missing doses
    - Potential side effects
    - Potential interactions with other prescription, nonprescription, and recreational drugs, alcohol, and dietary supplements that may impair PrEP medication effectiveness or cause toxicity that could impair adherence
    - Advising the client that PrEP does not protect them from other STDs and pregnancy
- Routinely assess the client's questions, concerns, or challenges regarding PrEP use to identify potential problems
- Assess self-reported adherence at each visit using a nonjudgmental manner
- Assess and manage side effects at each visit
- Consider assessing PrEP prescription refills or pill counts, if feasible, when needed to supplement routine assessment of self-reported adherence
- Address misinformation, misconceptions, negative beliefs, or other concerns about PrEP regimen or adherence
- Acknowledge the challenges of maintaining high adherence over a time and offer long-term adherence support, especially when health coverage, insurance, or other life circumstances change
- Promote disclosure of challenges to adherence, and when disclosures occur, address them in a nonjudgmental manner
- Apply motivational interviewing techniques during routine adherence assessments. These include:
    - asking about the methods clients have successfully used or could use to increase adherence
    - asking about recent challenges to adherence and how they could be overcome

- Offer advice, tools, and training tailored to individual strengths, challenges, and circumstances to support adherence. Examples of advice include:
    - linking taking PrEP to daily events, such as meals or brushing teeth
    - using pill boxes, dose-reminder alarms, or diaries as reminders
    - carrying extra pills when away from home
    - actions to take if pill supply is depleted or nearly depleted
    - avoiding treatment interruptions when changing routines (e.g., travel, erratic housing, or legal detention)
- Encourage persons to seek adherence support from family members, partners, or friends, if appropriate
- Provide or refer to medication adherence interventions

Subject Expert Reviewers and Standards and Best Practices (SBP) Committee Members*

NAME	AFFILIATION
Stacy Alford	Children's Hospital Los Angeles
Alonso Bautista, MA, MFT	Alta Med Health Services
Joseph Cadden, MD	Los Angeles County Commission on HIV Standards and Best Practices Committee
Danielle Campbell, MPH	UCLA
Jim Chud	Public
Peter Cruz	Asian Pacific AIDS Intervention
Trevor A. Daniels, PsyD	Community Psychologist
Jamie Deville, MD	UCLA-Care Families Program (HIV+ Adolescents and Families)
Tom Donahoe, MBA	Pacific AIDS Education and Training Center
Matthew Emons, MD, MBA	Los Angeles County Commission on HIV Standards and Best Practices Committee
John Carlos Fabian	Center for Health Justice
Dahlia Ferlito	AIDS Coordinator Office, Los Angeles
Nourbese Flint, MA	Black Women for Wellness
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Nina Harawa, PhD	UCLA
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Kathleen Jacobson, MD	Los Angeles AIDS Education and Training Center
Marcus Jordan	Community Member
William King, MD, JD	W. King Health Care Group – Los Angeles
Kim Kisler, PhD	Friends Research Institute
Roxanne Lewis	JWCH Institute
Miguel Martinez, MSW, MPH	Children's Hospital Los Angeles
riKu Matsuda	Los Angeles County Department of Community and Senior Services
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Terry Smith, MPA	APLA Health
Martha Tadesse, MSN, MPH, MPA, CCHP, RN	Los Angeles County Sheriff's Department
Octavio Vallejo, MD, MPH	Los Angeles County Commission on HIV Standards and Best Practices Committee
Alberto Vasquez	Bienestar – Hollywood Center
Arlene Vasquez	Southern California Alcohol & Drug Program, Inc.
Greg Wilson	Los Angeles County Commission on HIV Standards and Best Practices Committee
Joseph Wing, LMFT	Los Angeles County Department of Mental Health
Paulina Zamudio	Los Angeles County Division of HIV and STD Programs

Key Resources Used to Help Inform the Development of the Prevention Service Standards

- Centers for Disease Control and Prevention, Health Resources and Services Administration, National Institutes of Health, American Academy of HIV Medicine, Association of Nurses in AIDS Care, International Association of Providers of AIDS Care, National Minority AIDS Council, and Urban Coalition for HIV/AIDS Prevention Services. Recommendations for HIV Prevention with Adults and Adolescents with HIV in the United States, 2014: Summary for Health Departments and HIV Planning Groups. 2014. http://stacks.cdc.gov/view/cdc/26065.

- Healthy People 2020 Evidence-Based Resources
https://www.healthypeople.gov/2020/tools-resources/Evidence-Based-Resources

- Federal Response: HIV Prevention
https://www.hiv.gov/federal-response/federal-activities-agencies/hiv-prevention-activities

- Funding Opportunity Announcement (FOA) PS18-1802: Integrated Human Immunodeficiency Virus (HIV) Surveillance and Prevention Programs for Health Departments
https://www.cdc.gov/hiv/funding/announcements/ps18-1802/index.html

- Department of Public Health, Division of HIV and STD Programs, Request for Statement of Qualifications for Biomedical HIV Prevention Services. July 2015.

- Promising Practices Database. Thinkhealthla.org

LOS ANGELES COUNTY COMMISSION ON HIV

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12. (C) OPERATIONS COMMITTEE REPORT

1. Membership Management

Membership Application: Katja Nelson (Motion #7)

APPLICATION REMOVED FOR WEBSITE PUBLISHING DUE TO CONFIDENTIALITY.

COH MEMBERS ARE PROVIDED WITH A COPY OF MS. NELSON'S APPLICATION FOR REVIEW & INSTRUCTED TO RETURN THE APPLICATION AT THE 12/14/17 COMMISSION MEETING.

Los Angeles County Commission on HIV (COH)
2018 Training Schedule for Interested Applicants and Commissioners

WORKSHOP LOCATION AND TIME: All workshops will be held at the COH office, located at 3530 Wilshire Blvd., Suite 1140, Los Angeles, CA 90010 FROM 1 PM TO 3 PM. Please RSVP to confirm your attendance to DJauregui@lachiv.org.

Data and Epidemiology Overview: January 29
Participants will review reports used in priority setting and resource allocations decision-making process, needs assessments and the Comprehensive HIV Plan.

Effective Communication and Active Listening: February 15
Participants will assess their personal communication styles and learn strategies on how to communication with others.

Running and Facilitating Meetings: March 15
Participants will learn tips for leading and participating in COH meetings. Participants will learn the "6 Thinking Hats" strategy for encouraging different perspectives and active participation.

Planning Council Refresher & Committee Spotlight: April 19
Get a refresher on Planning Council responsibilities and key policies and procedures. This workshop will discuss the functions of the COH's standing committees and how they inter-relate with each other.

These trainings are **highly recommended.** The Ryan White HIV/AIDS Program Part A Manual stipulates the provision of a thorough orientation to new and returning planning council members and ongoing formal training to attain skills necessary to perform their duties.

LOS ANGELES COUNTY COMMISSION ON HIV

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12. (D) PUBLIC POLICY COMMITTEE REPORT

1. 2018 Policy Priorities and Agenda Review

LOS ANGELES COUNTY COMMISSION ON HIV

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The Public Policy (PP) Committee acts in accordance with the role of the Commission on HIV, as dictated by Los Angeles County Code 3.29.090. Consistent with Commission Bylaws Article VI, Section 2, no Ryan White resources are used to support PP Committee activities.

2018~~7~~ POLICY PRIORITIES

(~~Adopted 4-27-17~~Draft 12/7/17)

POLICY PRIORITIES

The Public Policy Committee recommends the following policy priorities for the Commission on HIV to focus on in 2018~~7~~ (*in no particular order*):

- Preserve access to and continuity of care for PLWHA and communities at highest risk for the acquisition and transmission of HIV disease.
  - Preserve federal funding for Medicaid, Medicare, and for HIV/AIDS programs
  - Preserve health insurance coverage for individuals with pre-existing conditions, including HIV and STD programs.

- Protect HIV service access and availability in California's annual budgeting process.

- Maintain and preserve the Ryan White Program (RWP) at current or increased funding levels and, where appropriate and strategically viable, support stronger compatibility and greater effectiveness between the RWP, Medicaid, Medicare, and other health systems.

- Advance and enhance routine HIV testing, expanded linkage to care, and other improvements to the local, state, and national HIV service delivery systems that optimize health outcomes in the HIV Continuum and advance HIV services in LA County consistent with the National HIV AIDS Strategy goals, LA County HIV/AIDS Strategy, and LA County Comprehensive HIV Plan.

- Support policies that use data, without risking personal privacy and health, to improve health outcomes and eliminate health disparities among PLWHA and communities highly impacted by HIV/STIs

- Enhance Federal accountability for deliverables from a heightened and coordinated federal response, particularly in the context of local planning and responsiveness to the NHAS.

- Support proposals and increased funding for the provision of and access to: prevention, care and treatment services; and bio-medical interventions (such as PreP and PEP) for people at risk for acquiring HIV and people living with HIV/AIDS; and comprehensive HIV/STI counseling, testing, education, outreach, research and social marketing programs.

- Support proposals that seek to reduce stigma and address social determinants of health such as ~~homelessness, violence, poverty, and lack of education~~ poverty, education, violence, substance abuse, and transportation in order to improve health outcomes for people living with HIV/AIDS and special populations at highest risk for contracting HIV.

- Preserve and/or support systems, strategies and proposals that seek to expand affordable housing, as well as priortize housing opportunities for people living with, affected by, or at risk of contracting, HIV/AIDS.

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- Support proposals that eliminate discrimination against or the criminalization of people living with, or at risk of, HIV/AIDS.

- Support proposals that reduce the cost of HIV/AIDS and STI drugs.

- Support proposals that expand the inclusion of HIV biomedical interventions in basic health benefits packages.

- Preserve full funding and accessibility to the AIDS Drug Assistance Program (ADAP).

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18. ANNOUNCEMENTS

Integration Advisory Board – Final Report to the Board of Supervisors

Integration Advisory Board

Kenneth Hahn Hall of Administration
500 West Temple Street, Room B-50
Los Angeles, CA 90012
213-974-1431

November 15, 2017

TO: Supervisor, Mark Ridley-Thomas, Chairman
Supervisor, Hilda L. Solis
Supervisor, Sheila Kuehl
Supervisor, Kathryn Barger
Supervisor, Janice Hahn

FROM: Al Ballesteros, Co-Chair
Bridget Gordon, Co-Chair
on behalf of the Integration Advisory Board

SUBJECT: FINAL REPORT TO THE BOARD OF SUPERVISORS

The Integration Advisory Board (IAB) was established on August 11, 2015 for a two-year period and was charged with assessing the impact (positive or negative) of the Los Angeles County Health Agency (Health Agency) on the ongoing Departmental activities, operations and on achieving Los Angeles County's (County) health-related priorities. The IAB includes people with lived-experience (consumers), subject matter expert representatives from numerous County health commissions, residents and representatives from organized labor.

Health Agency Mission

The mission of the Health Agency is to improve the health and wellness of County residents through provision of integrated, comprehensive, culturally appropriate services, programs, and policies that promote healthy people living in healthy communities. This will be achieved through the aligned efforts of the Departments of Health Services, Mental Health, and Public Health (Departments) and in partnership with its clients and their families and communities, County residents, organized labor, faith-based organizations, community providers and agencies, health plans, academia, and other stakeholders.

Executive Summary

The IAB feels that leadership and staff of the Health Agency and its three Departments have much to be proud of. Several new integration projects have started, are beginning or planned that will foster integration. Overall, it is our consensus that the formation of the Health Agency has been positive in the County and with respect to ongoing departmental activities and operations. The IAB believes the Health Agency should continue forward with an even greater sense of urgency and clarity to bring the benefits of integration to full fruition. It is time to move from "bright spots" and "innovative pilot" projects to full breadth and scale. In this final report, we call out several of these successes as we call attention to three specific priority areas. We also attach a summary for each strategic priority and reference subcommittee reports which the IAB has approved as appendices specific to the eight strategic priority areas.

Neighborhood conditions, resources and opportunities influence health behaviors and outcomes. The Health Agency has an important role to play in bringing health to residents, particularly where resources are systematically scarce and there is importance in bringing health to residents, to homes and to neighborhoods. It is also critical to seek the root causes for poor health and work to solve these. The IAB heard numerous testimonies and presentations and received various reports from staff about Health Agency services being evaluated, changed, implemented and/or expanded through the eight strategic priorities. As we received these reports, the issues of the social determinants of health repeatedly came to the forefront; and it became clear that in order to be successful, the Health Agency and its Departments needed to address more deeply these social determinants while integrating operations and implementing strategic priorities. Homelessness, substance misuse, the sexually transmitted infection (STI) epidemic and the spread of human immunodeficiency virus (HIV) ,chronic and preventable illnesses like diabetes and heart disease, obesity and untreated mental illness, to name a few are all exacerbated by social determinants at the root of these conditions.

The IAB concludes that these issues--the resources, opportunities, and conditions available to people where they live, work, study and play--are now widely discussed among the leadership of the Health Agency, the IAB and with various commissions. The Agency Director, Mitchell Katz, M.D., as well as department directors Jonathan E. Sherin, M.D., Ph.D., and Barbara Ferrer, Ph.D., M.P.H., appear to fully embrace the necessity to tackle these social determinants within the context of the integration activities and yet all acknowledged that there is much more to be done to systematically take aim at the determinants of health. The IAB believes this is the "right track."

While the IAB understands that many of these fundamental shapers of health may seem to lie outside of the "mandate" or scope of the Health Agency, the IAB observes that these issues must be systematically considered and addressed by programs and/or policy within and across the Health Agency in order to foster improved health for County residents. These issues include poverty, racism, housing stability, homophobia, xenophobia, access to clean outdoor spaces, access to proper food and nutrition, and access to proper education and employment opportunities. In describing the Center for Health Equity, a new Health Agency initiative, leadership described an intention to ask new questions that could better reveal the causes and context surrounding inequitable health outcomes. In our view, endeavors like the Health Equity Center represent critical modes of inter-departmental collaboration aimed at improving outcomes and seeking the root causes; we think this effort is critical and should be well supported.

With that said, the IAB is concerned that the path forward for the Health Agency and integration need to continue, especially in light of the announced departure of the Health Agency director, Dr. Katz. **As its first recommendation, the IAB asks that the Board of Supervisors (BOS) seek new leadership for the Health Agency with a demonstrated track record of engaging with and unifying diverse partners to address the determinants of health and increase access to health and well-being, while advancing population health that aligns with BOS priorities. It is critical that the vision of integration and service delivery systems be viewed through the lens of social determinants for the next leaders of both the Department of Health Services (DHS) and the Health Agency to succeed in significantly improving health outcomes in Los Angeles County.**

As its second recommendation, the IAB asserts that it is critical that the BOS consider the funding necessary to support leadership and operation of the Health Agency. The operational framework which was approved by the BOS along with the eight strategic priorities, *articulated that that departmental budgets would remain separate and that no additional funds would be used to create the Health Agency*. Therefore, the Health Agency would remain unfunded. However, with the departure of Dr. Mitch Katz, who held both the Director of Health Services and Director of Health Agency positions, the IAB notes that the BOS is at a critical juncture with respect to both staffing up the Health Agency and maintaining its commitment to County residents, which indicated that the budgets of the three departments would remain independent. Ultimately integrating processes and avoiding duplicate administrative processes will create cost savings, simplifying bureaucracy and increasing easy access to services and care are included must be included in this effort. We feel this is a near-term issue that needs to be addressed in a fairly transparent and inclusive manner.

General Findings

While the IAB did receive regular reports from the eight strategic priority workgroups, there were gaps in information. This created some challenges in our ability to fully evaluate the work and somewhat hindered our ability to comprehensively assess impact towards completing the outlined metrics of each strategic workgroup. It was the general impression of the IAB that the Strategic Priority workgroups are/were missing input from the community, the first line "hands on" workforce, residents seeking and/or utilizing County services and from people with lived experience. The IAB believes this has created blind spots and gaps in the work both for the IAB and for the workgroups themselves. The IAB believes that the deliverables of the workgroups could be expedited and produce scalable "user friendly" results with community participants at the table working together.

In general, the IAB concludes that leadership and staff of the Health Agency and its three component Departments are making progress to improve health services, and change policies and practices related to the eight strategic priorities. Several exciting and new projects are underway, will begin soon or are planned that will foster integration with the goal of improving processes and outcomes. The IAB concludes that the Health Agency needs to move forward with a greater sense of urgency and clarity to bring integration and the benefits of integrating the Departments into full fruition. It is time to move from "bright spots" and small "innovative pilot" projects to breadth and scale on par with the size and scope of Los Angeles County. The Health Agency should further build on its concept of integration as a platform to catalyze new ways of doing business across the Health Agency. Here we emphasize the importance of: 1) focusing on populations of greatest need, specifically addressing racial equity and improving the health status of African Americans and Latinos; 2) implementing a robust process for increased community participation; and, 3) developing a common framework for integration and utilizing/communicating the shared framework as the basis for implementing common tools, standards and metrics, where appropriate.

The impact of the integration philosophy is starting to appear. The appointment of directors of the Department of Mental Health (DMH) and Department of Public Health (DPH) was an important benchmark. Still early in their tenure, this new leadership shows the ability to collaborate in concrete ways with the launch of joint projects including the Peer Resource Center located at 560 South Vermont, Los Angeles, and in launching the Health Equity Center in October 2017. Collaborative planning of Housing for Health efforts focused on vulnerable homeless populations also shows promise and must lead the way in providing wrap-around supportive services to actually meet the needs and possibly exceed expectations in delivering residents back into the realm of health, well-being and full employment whenever possible. In addition, there is a noticeable sense of hope experienced by residents (and IAB members appointed as "consumers") and department employees who are familiar with the work of the Health Agency's new leadership.

The IAB notes some areas for focused attention and expansion. These "bright spots" can be scaled and refined through continued attention from the Health Agency:

- "Parks after Dark" Program
- eConsult across all departments to access specialty care
- Whole Person Care Waiver Implementation
- Recuperative Care Expansions
- The activities of the Housing for Health Department of Services
- The Misdemeanor Incompetent to Stand Trial Community-Based Restoration (MIST-CBR) Program and the Office of Diversion and Re-Entry Housing Program
- Street-Based Engagement for the Health Agency driven collaborative known as C3
- The Sobering Center in Skid Row as a means of Emergency Response Diversion

The IAB feels these programs can be more effective and must be scaled-up so more residents have access to them.

Culture Change

"Be Kind and Be Fair." Members of the IAB fully support the implementation of "Just Culture" within the Health Agency. Creating a culture of fairness, open communication and human kindness is essential for delivering medical mental health, prevention services and social services. The philosophy of "Just culture" applied to making improvements in policies and practices that influence health for Los Angeles County's approximately 10 million residents is critical, particularly for the most vulnerable and overlooked populations. All County employees and all workers throughout the County deserve a working environment that is open to hearing what is really going on without the fear of retribution and a workplace that provides opportunities to address the root causes of issues. The IAB has heard some unfortunate accounts describing the internal state of the three Departments and more accounts from residents having difficulty accessing services and describing outright trauma while "receiving" services. The IAB would suggest further exploration of these concerns within the three Departments and the Health Agency. We believe "Just Culture" could have a positive affect and is one approach among others that could improve processes, increase access to consistent and high-quality healthcare for County residents.

History and Context

Equal accesses to education, employment opportunities, preventative health services, health and medical services, proper housing and environments which are conducive to health and well-being have not been equal across Los Angeles County. Our collective ability to have discussions about race and the impact of racial discrimination in creating disparities in certain populations is important when considering the overall health of Los Angeles County residents and the impact of the Health Agency's activities.
Data presented in the *County of Los Angeles Department of Public Health Community Health Assessment 2015*, *Health Indicators for Women In Los Angeles County – Highlighting Disparities by Ethnicity and Poverty Level (A Publication of the Los Angeles County Department of Public Health Office of Women's Health and Office of Health Assessment & Epidemiology –January 2017)*, and *Los Angeles County Department of Public Health – January 2017 Key Indicators of Health by Service Planning Area*, summarize health determinants and outcomes across Los Angeles County and indicate that better health is related to wealth and poor health is related to poverty and often impacted by issues of racism. We find that our communities and the systems that support them are organized to provide easy access to healthcare and other life sustaining resources for some residents and, while at the same time may deprive resources from other residents.

As is documented, the homeless population is disproportionately comprised of a substantial number of African American men, women and families and a growing number of poor and marginalized Latinos. The IAB calls for system transformation that supports health and wellbeing for residents who are the most vulnerable in our communities. We encourage the integration activities of the Los Angeles County Department of Health Services-Housing for Health be fully supported and activated by the Health Agency and the BOS so that it quickly expands cross-sector collaboration for access to comprehensive health and mental health care, housing, employment, nutritious foods and supportive social/emotional programs for all stages of life.

Three Major Themes Emerged from Our Work

This section of the IAB report prioritizes key areas for urgent, focused and sustained attention from the Health Agency and the BOS. While there are eight strategic priority areas for which specific recommendations and comments are listed later in the attachments, the IAB has identified three consistent themes which have cut across each priority area for focused attention.

Priority #1: Racial Equity as a key to Health Equity

Utilize a cross departmental, agency-wide approach to improving health outcomes for the African American population in the County.

Los Angeles County's African American population disproportionately represents negative health outcomes and experience positive health outcomes at lower rates. This is tied to less access to heathy, safe environments, institutions and resources. African American residents have greater exposure to risk factors within communities and negative institutional interactions in the form of over policing and mass incarceration.

Latino populations, including recent immigrants and those living in poverty who are continually uninsured, also experience poor health outcomes. This is evidenced by high rates of diabetes and other chronic illness rooted in poor access to healthy food choices and low access to safe spaces to exercise or reduce stress for both African Americans and Latino residents. We heard on multiple occasions about the importance racial equity. To this end, it is important that Department and Health Agency staff continues to participate in trainings, capacity building and facilitated dialogue to understand the history and address persistent racial inequities, implicit/explicit bias and identify actions (policies, procedures, programs and resource allocation) to narrow the gaps—not just in services, but in outcomes.

Better Data

The various County Departments and specific agencies are missing baseline data for African American and Native American populations to track changes over time. This is not *only* a matter of sharing data across the Departments; it is a tool to measure progress. We received presentations about the Department's electronic health records systems and the completion of a system of sharing "necessary" information that is still a ways off. With the current uncertainties in the healthcare climate and the data security issues in the news, we encourage forward thinking in developing systems that support healthcare for all residents in the 21st century rather than continuing the cost in productivity, time and money required for patching outdated systems. It is critical that each department, unit and county residents be at the table to advocate for its needs in what is ultimately produced.

Additional IAB recommendations include:

- Engaging and employing people with lived experiences.
- Training and capacity building for all staff regarding culturally relevant and appropriate engagement.
- Supporting and funding the Health Equity Center

- Allocating resources from Measures (A, M and H) and the Whole Person Care Waiver to the Health Agency to fund local organizations reflective of and skilled in addressing racial inequities and to implement strategies that reduce the racial inequities that create disparate health outcomes. Specially target resources to agencies which reach the African American and Latino communities in SPAs showing greater health disparities including South Los Angeles, San Gabriel and San Fernando Valleys. Among the metrics that may be considered are:
  - Measuring the number of staff and community members of all racial and ethnic backgrounds participating in shared racial equity trainings.
  - Addressing psychological trauma experienced across all demographics from cultural abuses, violence and living under the assault of hatred. Exposure to trauma is an indicator of poor health.
  - Providing human development/early childhood development along with parenting training and guidance for all County employees and residents to prevent and mitigate childhood trauma – refer to the Adverse Childhood Experience Study, the findings apply to all children and most adults living in Los Angeles County.

Priority #2: <u>Community Engagement and Public Input</u>

Utilize cross-departmental, agency-wide approaches to embedding resident and community engagement as a standard practice in priority setting, solutions development, data collection and monitoring and oversight.

The perspective and context people with lived experience bring to the table is critical in expediting the design and implementation of programs and processes intended to improve health and equity conditions in Los Angeles County. Create a standard operating practice of including and engaging residents.

The IAB received many questions on how and if community engagement was being done and in what form. We found that the communities where not always involved. The IAB believes communities know what they need, and if asked, – they will tell you. Employ the community to solve problems. It is expeditious and cost effective for people who are intimately familiar with their own experiences, familiar with some of the causes of their conditions and their daily life challenges to play a central role in resolving the problems they face. The Health Agency could have a powerful impact on the health of County residents by:

- Developing a robust process for soliciting on-going public input, including youth, community residents and people with “lived experience” with relevant systems, issues and concerns;
- Developing some agency-wide metrics/benchmarks to measure the process for community engagement;

- Creating and implementing training to involve the public internally and members of the public, including involving various County health commissions and boards -- a pipeline for new energy in the form of robust resident engagement; and measuring the impact of such trainings;
- Building capacity and skill sets of staff to appropriately engage in processes for soliciting public input and using the input to inform action – consider utilizing skilled facilitators for convening new boards or workgroups for efficiency and improved results
- Highlighting ”best practices” nationwide where public engagement is working well and producing impactful results on the outcomes of interest and sharing that with employees across the agency; and
- Implementing a “board and commissions” training to build a more robust pipeline for diverse, resident participation in the boards and commissions relevant to the Health Agency.

Priority #3: A Common Framework for Integration

Develop, implement and communicate a simple framework across the three Departments for what integration means. The IAB believes that integration goes beyond specific partnerships and project-based collaborations to a shared vision that must start with prevention and includes intervention using high quality, affordable and coordinated services that are culturally appropriate and located within communities. Then, build relationships and communicate.

Throughout our two years, the IAB heard different examples of partnership, pilot projects and collaborations across the three Departments. We *did not hear* a consistent understanding of the value and purpose of integration. From the IAB’s perspective, bringing the practice of coordination and integration to scale across the County and elevating a common understanding of integration is paramount. Start by increasing resources and opportunities for residents to achieve optimal well-being. The goal is going beyond isolated examples of working together to achieving coordination at a breadth, scale and depth consistent with the size of the County and pockets of need. A significant increase in communication internally and externally will have an impact.

To address this priority area, the Health Agency could:

- Use the Health Agency Vision statement as a starting point for developing a measurement tool determining whether specific projects or programs address the whole continuum, from integrated approaches to primary prevention all the way to coordinated services;

- Conduct training, for all staff, on the purpose of integration and include residents whenever possible, **learning together is a high impact activity**. Build knowledge and skills for prevention and how non-clinical aspects of public health link to clinical approaches;
- Find concrete ways to standardize and streamline tools across the three Departments such as: Privacy and Confidentiality, Patient/Client/Resident Satisfaction (or input) tools, collection of Race/Ethnicity Data;
- Create and Implement Standards for linguistic, culture and gender, emphasizing African American as one of the many important cultures in Los Angeles County;
- Consider evidence-based practices applied across the three Departments, such as trauma reduction and awareness, substance abuse and tobacco control and cessation policies;
- Provide a continuum of services to medically fragile residents (homeless, formerly incarcerated, victims of trauma, recent immigrants, people grappling with mental health and substance abuse) that is connected consistently and intentionally to "upstream" efforts designed to transform conditions (e.g., employment and financing opportunities), resources (e.g., training and education support) and environments (e.g., affordable food and fewer liquor stores) at the neighborhood level; and
- Develop common language. For example each Department has a different operating definition of "vulnerable, transition aged youth."

Continuation of the IAB or like Commission/Board

The IAB requests that the BOS conduct a sunset review of the IAB's work, purpose and achievements. We believe this review should assess the IAB's usefulness to the BOS, to the Health Agency and the residents of Los Angeles County, particularly in light of the IAB's unique purview looking at the Health Agency across its three Departments. The IAB recommends its continuation in a re-constituted form as a board or commission to work in an advisory position to the BOS on the activities of the Health Agency. As we've noted in earlier reports, the IAB brings together stakeholders, subject matter experts and people with "lived experience" from different disciplines to advise Health Agency activities. The IAB allows for cross-sectional health planning, recommendations on how various aspects of health interact with one another, broader discussion on the various social determinates, and policy which affect the health system and residents. With the need to secure new leadership for both the Health Agency and the Department of Health Services, the IAB can be a significant resource to the BOS.

In Conclusion

We appreciate the BOS for establishing the Integration Advisory Board. We were honored to commit our time and energy in service to the Health Agency efforts to improve the health and well-being for the residents of the County. We also stand ready to provide any clarification on the contents of this report, approved attachments, subcommittee reports and other appendices or our previous reports to the BOS. We hope all of our work serves the BOS as it guides the Health Agency leadership forward.

If there is anything the IAB can do to further clarify any information put forth in this report, please do not hesitate to reach us by contacting Commission Services at 213-974-1431 or via email at commserv@bos.lacounty.gov.

AB/BG:ma

Attachment

c: Chief Deputies
Chief Executive Officer
Executive Officer, Board of Supervisors
County Counsel
Health Agency

ATTACHMENT

Attachment

Eight Strategic Priorities

This section is dedicated to the three HIV positive women who were unable to stay in care and died in our county hospital over the last 12 months. One woman's last breath was 'no one in my family must know I have HIV'.

We have many opportunities to transform health access and well-being for residents of Los Angeles County (County). The Los Angeles County Health Agency (Health Agency) Eight Strategic Priorities and their associated Workgroups provided the Integration Advisory Board (IAB) with a snapshot of the challenging state of affairs for many of our residents and the work being done within the three departments of Health Services (DHS), Mental Health (DMH) and Public Health (DPH) to address the needs of our county's residents, including children in crisis and the crises of over 58,000 human beings who are homeless. Addressing the Strategic Priorities is a huge task. The very good news is the marked increase in awareness the IAB witnessed in the Health Agency from the first year to the second year. The IAB expects the increasing awareness to continue translating into proactive new ways of doing business and delivering whole healthcare and life affirming social services to County residents.

First, we must acknowledge that health and well-being has become out of reach for many residents over the course of many decades for many reasons. Some residents cannot afford high co-pays or find that their health insurance is out of step with their health needs, many find that providers are too frustrated administratively to build the necessary relationships required to provide effective health care – this is not a County issue, it is a national issue. Our current system of care was built on the needs and rules set by insurance organizations or "payors of care" not necessarily based on the needs of people who seek health care. We live among many working people in the County who have health insurance but cannot afford the time away from work or the cost of the copay for medical or mental health services, this causes delays accessing care and often makes medical care unattainable until emergency care is required. This must change, <u>we must dig deeper</u>. Our systems of health care must be preventative, high quality and accessible for all residents. Health insurance is not health care.

When adjusted for the cost of living, more than 27% of County residents live below the Federal poverty line, with a population of approximately 10.4 million that makes 2.8 million people within our County who cannot afford healthy food, shelter or healthcare. This begs the question, why don't we in the County join the rest of the developed world and offer universal health care? We are smart people, why can't we figure out how to use the $7 billion allocated to healthcare annually to assure that every one of our 10.4 million residents receives healthcare?

The summary of the strategic priorities that follows is supported by IAB subcommittee feedback and points within each priority that IAB members felt were important to recognize. We must acknowledge the work of the IAB Subcommittee on Implementation of the Expanded Substance Use Disorder Benefit, the work of the Subcommittee and its report was fully vetted and approved by the IAB, the report was submitted to the County's workgroup to provide recommendations. We learned here that substance abuse is often the consequence of unmet needs, trauma, childhood abuse, violence and sexual abuse among other things; is often passed from generation to generation – substance abuse in all forms is an effort to numb pain and the hopelessness of daily life. We learned that continuing to ignore the root causes of substance abuse and the intergenerational damage it creates will continue costing our County exponentially both financially and in human suffering.

Who we heard from:

A first grade teacher from Inglewood Unified School District struggled to get help for a bright student who was missing school because he and his four young siblings had head lice. The student's mother was in crisis; social services could not touch the children and did not provide support. The teacher finally found a church to treat the head lice; however in the course of this effort, the teacher lost the trust of the young student and his mother.

A grief stricken father who was seeking mental health services after losing his young adult daughter to cancer. This grieving African American man did not receive services, instead he was detained and shackled on the floor of a "waiting area" for hours with other men who were in crisis.

An IAB member told of her experience sitting near an African American man listening to music while waiting for health services; the music was soft and playing low. The man was approached by security and told to turn off his music. When he did not, the man was arrested.

A father whose child was born in the County hospital stated, "My thought about access, is that people are aware; they just don't want it for whatever reason. Dangers real and imagined, effectiveness real and imagined, usefulness real and imagined. The perception is bad because the system is pretty bad. Here's what goes through my mind, starting with a categorization of what I see happening now, and their connections: Homeless people, Incarcerated, Addicts/Alcoholics - I truly believe that these categories, in the big picture, are one category; they can be mixed n' matched. One of these often begets the other and cycles are created. The current system often creates conditions that result in problems being magnified for the individual, with the exception of 12-step programs which, while not for everyone, can have profoundly positive effects. But going back to my original point, and your original question, I think it hinges on perception. On all sides. Best case scenario is that this healthcare joke results in a backlash so huge that we get single payer."

A man living with HIV stated, “The way HIV positive people get dropped in this system is sickening. I went six months without hearing from my doctor. After I called for services, and by the time I got contacted from my doctor, I didn’t have medical anymore – then trying to get my medical back was a mess! LA County can and should do better.” Women seeking support from a “women’s re-integration” program in an effort to get on their feet and in some cases get their children back. The women reported difficulty; the sessions were cancelled and some court-ordered programs the re-integration claimed to offer were unavailable.

Strategic Priority 1: Consumer Access to and Experience with Clinical Services
Barriers getting in the door include bureaucracy, the complexity with enrolling in care and the requirements to “re-enroll” in care annually. Gaps in enrollment cause gaps in medical care, including insurance carrier changes when workers move between jobs or lose their jobs. Additional barriers are navigating the complicated healthcare system (especially during an illness), proximity to medical offices from work, home or schools, parking availability and transportation to and from appointments. Hours required to use public transportation is a challenge as well.

Once in the door, the length of wait time for people seeking care is often hours. One IAB member explained that current scheduling systems are in part responsible for long wait times.

Many residents and County healthcare workers don’t know what services are available to them, so access is denied.

Unconscious bias from medical providers, support staff, health workers and administrators is nationally known as a cause for disparities in treatment and health outcomes between White patients and Black and Latino patients. Education of providers, support staff, health workers and consumers would help as long as the training reduces harm and reduces “racial resentment” toward people of color.
See more on unconscious bias and poor health outcomes TEDx - Carmona Phyllis Jones MD https://www.youtube.com/watch?v=GNhcY6fTyBM

The healthcare cliff, a more detailed presentation to the University of Washington Department of Medicine – Carmona Phyllis Jones MD
https://www.youtube.com/watch?v=E-exB7xcPnQ

For the Health Agency, the important thing is 1) expanding services and 2) meeting people where they stand. It is important to understand that for many services are far from meeting needs because residents have been unable to access care as is evident in the County homeless crisis and the County health assessments. Resources must be focused in the areas of most need and focus on building long-term relationships with residents - there are a number of professions that must be enrolled in meeting people where they are, nurse practitioners, physician assistants, midwives, physical therapists and occupational therapists add a variety of skill sets to reach more County residents. Really sick people are being sent all over the County for care and services. Social Services must have advocates/navigators that complete one universal screening one

time so that sick people are getting housing, transportation, case management, mental health care, nutrition, needs for child care, after school programs and family counseling. One assessment must assure the needs of a sick person are met. Behavioral therapists must be deployed to homes on a regular basis – sick people are suffering with inhumane treatment, services are being delivered with "blatant disregard for human value."

Police presence in waiting areas - In 2017, communities of color across the country continue to suffer injustices, regrettably for many people of color, police presence means "your life is in danger." Over the course of decades, witnessing countless displays of unrestrained and fatal violence against a sole person of color at the hands of law enforcement officers – caught on camera - continue traumatizing communities of color and County residents. To date, this trauma is ignored and unaddressed, people of color are expected to "get over it and move on" – this is an impossible expectation in response to injustice and the loss of life. Therefore, seeking healthcare services in medical waiting rooms where law enforcement personnel are permitted to congregate in groups for long periods of time is a problem, their very presence signals to black and brown people "you are not safe here." We acknowledge that the experience for some County employees and some residents may be the exact opposite; we understand that there is a feeling of safety and protection in the presence of police – we request that the Health Agency ask law enforcement to refrain from gathering in groups of two or more in waiting areas while residents wait for appointments.

Accountability – The Agency must monitor the results from all agencies that receive County dollars to provide services with simple measurable deliverables such as "client outcome." Complicated audits should be avoided. Monitor the contracts fairly. If an organization underbids and is unable to deliver services, the contract should not be awarded. The least expensive bid is not necessarily the best. Policies that support low ball bidding should be eliminated. Contract awardees must be capable of reaching the most vulnerable people and able to get resources where they are needed most. Some things to consider: what are the expected measurable outcomes; what are the processes used to validate activity. Do the people within the agency have "lived experience;" do they look like the people they are charged to engage with and do they live near the location where services are provided? We want providers to know and understand the communities where they are receiving money to provide services.

Team up and work together - so that residents remain in reliable and supportive care, have health goals and guidance they can work on between visits or by using e-consult sessions for residents who have access to technology. This is important for the most vulnerable populations. These populations include Latinas, African-American and Asian women who experience barriers accessing care. African American women in the County experience higher levels of poverty, violence, discrimination, homelessness and trauma; this is an opportunity to develop gender specific and culturally appropriate services.

Access to care and crisis prevention - People who are homeless or almost homeless are in “survival mode.” Most have no access to care and may require mobile medical, mental health care, trauma care services and other supportive services. Using a simple diagram of Maslow’s Hierarchy of needs, it’s easy to understand what is missing in the lives of County residents in crisis - the theory suggests that the most basic human needs such as food, water, shelter, warmth and sex must be met, when these needs are not met, people fail to thrive. In the County, a person must prove homelessness to meet a “criteria for receiving services” before any help is provided. This process and the policy can be traumatizing particularly when help is denied or dispensed ineffectively as “one size fits all”. For example, a person who earns “too much money” in a low-paying job yet spends 68% of their income on housing is denied services, while the standards used to deny services do not account for cost of living and housing expenses, nor does the criteria account for individual circumstances – for many, denial of service is a slippery slope into homelessness. We heard about single women who were homeless and turned away from services because they did not have a child. Sending a resident away without providing sustained supportive services is not acceptable; the cost of extracting a person or family out of homelessness is likely more expensive than preventing homelessness. The County can no longer accept offering minimal, inadequate services with the expectation that residents will “self-resolve” when social determinates are unequal.

Waivers

Waivers to increase access to health care and supportive services for more County residents - There are currently thresholds for providing services that were established on “average” Federal and State levels – living in California is much more expensive than average state. The County must consider requesting thresholds be suspended for at least five years so more County residents can “regain their footing” on health, gain access to care and supportive services. This action will assure help for the working people who are impoverished due to the high cost of living in the County.

Waivers for employment to increase income opportunities for more County residents - consider waiving education thresholds and move toward hiring using equivalences when possible within the county - The workforce must be balanced, embracing all residents, their experiences and backgrounds – residents seeking services need to find an accepting reflection of themselves.

The experiences of many people privileged with access to higher education can be very different from the experiences of populations who are systemically and institutionally denied access to high-quality education, gainful employment, medical care and housing.

For example, a single mother of three children who has completed high school and has successfully navigated her children to graduation and into college has significant equivalent skills and experience to offer an organization. She may have utilized the public health system to raise those children. She has personally navigated at least two complex systems, healthcare for her family and the educational system for her children with successful outcomes. Honor the experience she has access to, pay her what that experience is worth. Understand that few people delivering, designing or administering health services possess the lived experience of actually accessing and utilizing public services.

Ombudsman or Integrated Conflict Resolution Center – so that consumers have a way to resolve conflicts in services and County employees can address persistent conflicts within Departments. Conflicts often reflect systemic issues, here is an opportunity to identify, embrace and resolve conflict through mediation, communication and produce systemic process changes that support consumers and employees. This would also improve management skills, organizational communication, team & leadership development and system design. Outcomes can include training and coaching in conflict resolution to residents within communities, DMH, DPH and DHS employees.

This is also an opportunity to "make things right" and avoid the cost of litigation, improve moral, build trust and customer satisfaction.

Implement Peer counseling – across the County in neighborhoods based on the following studies: 1. The Healthy Activity Program (HAP), a lay counsellor-delivered brief psychological treatment for severe depression, in primary care in India: a randomized controlled trial. Prof Vikram Patel, FMedSci
http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)31589-6/fulltext#

RFQ/RFP Process – the current process taking 18 to 24 months delays critical and necessary services to residents. Revise the process so services and resources are provided within months rather than years.

Information Systems:
The Cerner product of ORCHID was required to be searchable according to the Request for Proposal. State required statistics and patient data for mandatory reporting (e.g. Trauma Center and California Perinatal Quality Care Collaborative); however, these data still must be hand derived from ORCHID. At each of the acute care hospitals, the data for these programs must be gathered by hand and are assigned to high level Registered Nurses. This expensive collection of data removes nurses from the bedside. There are aftermarket programs available to collect this data.

Suggestions from the people who use ORCHID must be heard as to the functionality of these Cerner products. Suggestions on the "search ability" needs of the providers must dealt with. In this age, a provider should be able to query the number of patients with a specific disease or medication. This must be addressed beyond the life of the IAB.

The results for the "Happy or Not" kiosks have not been released. The kiosk has been implemented in only one clinical site, the Roybal Clinic. These kiosks have not been implemented at an Acute Care Facility. After "Happy or Not" then what? Seems that more information is needed to discern why and how a person seeking services was 'happy' or address the specific issue(s) around "not happy" so the process or problem can be corrected.

Retooling out dated software systems is inefficient and costly. The County requires an information system that supports and interfaces the needs of the entire enterprise. The current system as it's being augmented is cumbersome, costly and time consuming. Concern about maintaining privacy – the firewall for those who are or were incarcerated.

Security concerns about privacy for consumer personal and medical information, per the Experian data breach. Is the County data adequately protected?

The tight time schedule of two years did not allow for follow up visits from the heads of the Health Agency's Strategic Priority Committees on the progress of their efforts. The Chief Information Officer did update the IAB on the LANDS efforts with Gartner Consulting Group, but no time table was given for completion of this contracted project. Having electronic health records that can interface with each other and maintain the security required by both mental health and substance abuse programs is key to having integrated health services. The ability to bypass these firewall issues have been resolved by other large health agencies, why can't the County?

Strategic Priority 2: Housing and Supportive Services for Homeless Consumers

See the Subcommittee reports in the appendix.

Homelessness is a health issue. Concerned about HEP A outbreak is creating more barriers for providing housing and services to Homeless people. With this along with the potential of other outbreaks, how can you provide adequate services for people who are not housed?

Concerned that supportive services are not being provided, seeing resources going into build bureaucracies. Find root causes and fund solutions to the root cause, move away from building bureaucracies.

Homeless people first need someone who will connect with them, without judgement, fear or the attitude of "doing them a favor." Outreach is critical, what does outreach look like? It is so important for people with lived experience opening with his/her life experience to another homeless person, there to guide another to a better space.

People in temporary housing facilities are not receiving services with the "housing first" model; this model is a disadvantage because it does not provide supportive services, counseling or education. For example, Testimonial of Love shelter is not providing adequate services to meet people where there are. If you are allowing people to come in drunk but do not have on site support services to provide options and alternatives substance use by introducing groups… why are there no independent living education services so people can learn how to live. Requirement for working on site is important and helps people learn -If you're getting up for cleaning but you are not participating in the cleaning you are doing a disservice – why not help people participate in helping themselves. What about paperwork, job training, - while you can't force people to participate, you can provide guidance to introduce people to other options. It's about helping people thrive in their lives and get beyond the pain, fear and trauma of homelessness – this is how to end homelessness.
It's imperative that each of the 88 cities elected officials are on board for building permanent supportive housing. That is the only way many will get housed.

Who is looking into building "tiny homes"?

Concerns: Shelters are not being inspected and are not responding to reports of bedbugs by residents who live in the shelters.

What are the results to date on expanding Street-Based Engagement for the Health Agency driven collaborative known as C3 (County+City+Community)? How many homeless people have been reached to date?

Strategic Priority 3: Overcrowding of Emergency Departments by Individuals in Psychiatric Crisis

There is good progress in this effort for adults, again the breath and scale must increase.

Pediatric and transitional age youth are not getting the resources they need to avert psychiatric crisis. There has been an increase over the past four years in this age group. Once children are in crisis the beds and necessary resources are not available to accommodate this age group.

An IAB member found that Pediatric Patients with acute psychiatric conditions are crowding Community and DHS Emergency Departments. Access to psychiatric inpatient beds for these children are difficult for ER providers to find. Also, Emergency Providers do not have child psychiatry specialists to consult for these children. Approximately 45% of these patients are less than 13 years of age. In researching this problem, DMH is not aware of the lack of beds for these age groups or the need. This issue needs to be coordinated between DMH, pediatric and emergency providers.

Strategic Priority 4: Access to Culturally and Linguistically Competent Programs and Services

The Work Group provided detailed information on language. Very little explanation on the meaning of cultural competence was presented. We are a highly diverse community and the three departments must go beyond language and begin to understand and respect cultural differences.

Attention is required for addressing race, gender, ethnicity, identity and culture. One of the first steps is understanding the history of the many and diverse people living in the County. We recommend first addressing, an accurate history of African Americans beginning with how people of African descent were transported to the Americas as free labor, deprived of basic human rights and used for centuries to build the wealth many in United States enjoy. It is also important to address the recent history and experience of African American people in the County. There is often a harshness and lack of understanding of or compassion for people seeking services from the county particularly for African American residents seeking services.

Finally, women in the County have been neglected and are more likely to need multiple services from organizations within the Health Agency. We recommend immediately addressing the needs of women across the County by providing gender and culturally sensitive services and support to women of every race primarily those most impacted in the 2017 Indicators of Health for Women in Los Angeles County. We on the IAB agree that no additional studies should be necessary to address the needs of women. By simply asking a woman what she needs and adequately addressing those needs with more than a referral, by providing actual support for medical care, mental health care, trauma care, parenting guidance, family support services whether she has children or not is a start that will garner major impact in stabilizing a women to take the next steps forward.

Strategic Priority 5: Diversion of Corrections-Involved Individuals to Community-Based Programs and Services

The Misdemeanor Incompetent to Stand Trial Community Based Restoration (MIST-CBR) Program and the ODR Housing Program are a strong start. Scaling these efforts are important. The IAB commends the MIST-CBR team, serving 416 people for Intensive Case Management Services within six months is a good beginning.
DMH has expanded co-response teams, which will pair a mental health clinician with law enforcement personnel to respond to emergency calls involving individuals with mental illness or critical incidents. This is another good start for diversion, more expanded co-response teams are needed. How often will mental health clinicians be dispatched?

Members of the IABs subcommittee on Diversion of Corrections-Involved Individuals was diligent in attending all meeting that were open to the public and completed additional research on the topic. This subcommittee learned much more about the negative effects of incarceration in County jails and for detention involved youth. Paying for one year in prison or jail is approximately six times more costly than providing one year of high quality education to a young person. It is important to find humane alternative opportunities for reform and growth, incarcerating fellow human beings is damaging for families, our communities and the people we choose to lock up.
The committee strong recommends looking at decarceration. See Smart Decarceration: Guiding Concepts for an Era of Criminal Justice Transformation.pdf
We are seeing studies showing that young African American girls are increasingly sent to prisons, this is problematic on several levels, and here diversion must be implemented. Women with children and young girls sent to jails speaks poorly of our communities, the justice system and policies – we know that jails and prisons cost more and cause more damage than providing supportive services, education, employment and mental health services.

We recommend keeping police off of and away from school campuses as a protective mechanism – other protective mechanisms must be put in place so that children and youth have little to no interaction with police especially where African American and Latino populations are concerned. The IAB requests that schools and communities provide children and young people with a chance to 'make things right' before involving the criminal justice system. There are always other issues that must be addressed and mitigated before any resident is tossed into the criminal injustice system.
Demilitarize police and require police to live in the communities they serve so they live among us and know who they are "policing". If they are not able to "live among us" they are not fit to serve us in a humane and compassionate manor and should not be hired.

"Just Culture" in neighborhoods and the addition of culturally appropriate "protective mechanisms" in communities of color that include comprehensive training of residents in conflict resolution, mediation and negotiation, de-escalation and community development. We must understand the community, its history, and its residents - provide a point of access to services and care for community members who are in medical or emotional crisis. What protective mechanisms can be implemented to reduce and transform policing? Policing reduction – what is possible?

Eliminate the womb (cradle) to prison pipeline and create a "cradle to career" pipeline. Schools, foster care and the norms of discriminatory policing are the path that many residents in the County are delivered into the "criminal justice" system. By bringing health, education and the required guidance into the neighborhoods so that residents thrive with access to all of Maslow Expanded Hierarchy of Needs for families and communities that are most impacted by the corrections industry and hyper militarized policing practices.

See ‘Mass incarceration and children’s outcomes_ Criminal justice policy is education policy _ Economic Policy Institute.pdf’

Coordinated release for small populations related to need – for example people living with HIV, imprisonment and poverty drives this STI. See HIV and Incarceration Brief in the appendix.

Strategic Priority 6: Implementation of the Expanded Substance Use Disorder Benefit

See the full report in Appendix ( )

Launch of the new substance use disorder benefits occurred on July 1, 2017. Members of the IAB Subcommittee focused on bringing forward the risks residents are exposed to relating to substance abuse and the service provisions that reflect the needs of county residents.
One member of this subcommittee describes substance abuse as:
A “living problem” not a drinking/drug/smoking problem. People don’t know how to recover from trauma. People don’t know how to live where there is no means to live. Much is systemic and traumatizing. The Adverse Childhood Experiences (ACE) Study shows how trauma in childhood impacts health. There is too much pain and hurt from trauma, the substance abuse comes from unaddressed trauma. Folks abuse ‘not to feel the pain’. Service providers must begin to build relationships with communities and community members. Providers must ask the questions “What else is going on?”; “What happened?”

Help people understand what is/has happened to them, address the root cause, help communities understand what is depression is… much of their experience is not their fault and you can’t just put a pill on the experience that has brought them to the point of substance abuse. Think about the old fashioned occupational therapist who help people do the day-to-day activities that "occupy" their time, sustain them, and enable people to contribute to the wider community, providing meaningful benefit to the health of people.”

We in Los Angeles County need a re-introduction to basics, principles, values and well-being. Self-awareness and education, mindfulness, personal growth and life-long learning. The importance of building a strong social and emotional foundation is paramount. Re-introduce residents and communities to relaxation, continually offer residents training to develop the skills to clear and relax versus escaping through self-medication. Provide support in problem resolution. If these things are introduced and presented correctly to community members it’s easy for residents to take on and integrate into their life.

The committee prefaces its recommendations in the context of the following information:

Addiction and Substance Abuse Disorders are the leading cost of death and disability in the County.
SUDs impact 70% of the population in Los Angeles County who have a loved one who suffers from the disease of addiction.

Los Angeles County's DUI injuries represent about one quarter of all DUI injuries in the state of California during 2007 to 2011 costing over $10 billion annually in LA County for Alcohol Abuse *(this dollar amount does not include other forms of addiction)*

Substance abuse is the leading cause of incarceration, in the last four years, per capita prison costs have jumped from $49,000 to $64,000 annually
Every dollar spent on SUD treatment ultimately saves the County at least 7-12 dollars in other areas.

The subcommittee operated on the principle emphasis on reducing artificial and bureaucratic limits on treatment that is in accordance with evidence-based practices. The Sub-committee's recommendations are as follows:

Planning and budget strategies must reflect addiction treatment as a priority; the current health budget only directs about 5% of resources to what is the leading cause of death and disability.
The County must seek to have the evidence-based practice of Treatment on Demand (TOD) as a goal.
Use of Harm Reduction strategies (including Tobacco Harm Reduction) must be included in all planning.

Co-Occurring Disorders. In accordance with evidence-based practices, clients needing both mental health and substance use disorders treatment should be provided with programs that integrate concurrent treatments.

When making referrals for addiction treatment all County-contracted employees must use only the best interest of the patient as the basis of referral. (This must include possible referrals to treatment by non-contracted providers, providers outside the county, etc.) Referrals to sober living must only be made to homes that are members of a sober living coalition or who are certified by a recognized certifying body.

In budgeting and contracting with providers the County must include funding for addiction treatment providers that allows and requires the hiring of qualified licensed mental health professionals who are familiar with Co-Occurring Disorders.

When hiring certified addiction counselors the County must hire only counselors who meet national standards of education for addiction counselors.

Due to the unique requirements of the Code of Federal Regulations, Section 42, part B (CFR 42) all County agencies must provide special training for staff who are in any way part of the addiction treatment process and the mental health system. (HIPAA training alone is inadequate.)

Outpatient treatment services must be geographically available and accessible to residents of LAC.

Treatment services must be culturally and linguistically competent.
Treatment services must include aftercare and long-term support rather than episodic short term interventions.

Treatment must be made available for all expressions of the disease of addiction, such as gambling, shopping, sex, etc.

Funding must be structured so as to allow and require treatment for the entire family. This must include making available certified family intervention counselors who can help the 70% of the population of Los Angeles County who have a loved one who suffers from the disease of addiction and/or mental health challenges who is not in treatment.

Addiction treatment and mental health services must be provided with <u>full</u> parity with other medical services with the needs of the patient as the priority; no artificial or bureaucratic limits. In accordance with evidence-based practices as stated by the National Institute for Drug Abuse (NIDA) addiction treatment centers must be able to assess and directly admit patients without pre-authorization, gatekeeping, or unnecessary bureaucratic delays.

<u>All</u> Substance Abuse Disorders (SUDs) services, including prevention, treatment, tobacco, DUI programs, needle-exchanges, etc. should be under a single department or agency in order to best enhance quality provision of services.

The Drug Court system and the new diversion programs must be available to all who suffer with the disease of addiction, with treatment in lieu of incarceration as the primary goal. Increased training must be provided for all involved in the criminal justice system. This would be clinically sound and cost-effective for the taxpayers, in that treatment is must less costly than incarceration.

The County must include all evidence-based smoking cessation modalities, including non-abstinence-based harm reduction strategies supported by current research.
As smoking is considered a substance use disorder, all tobacco control and smoking prevention & cessation services and resources must fall under Substance Abuse Prevention and Control and not categorized as simply a public health issue. Like other Substance Use Disorder services, treatment must be provided by licensed or certified counselors in accordance with State regulations.

Families who struggle with addiction are terribly underserved in the current system. This problem must be directly addressed and a mechanism for informing all healthcare providers & citizens of available counseling and resources targeted specifically at:
Mothers in residential care who have young children.

Children and concerned others who must deal with addiction in a loved one.
Contracted providers must be required to provide treatment for family members.
The BOS must ensure that County contracts reflect a living wage for licensed and certified staff, and that there is a mechanism for adequate & prompt reimbursements for providers.

Data and analysis must be provided to ensure cultural diversity and competence in treatment providers.

Strategic Priority 7: Vulnerable Children and Transitional Age Youth
The IAB was pleased to hear representatives from each department report that things have started to change this year (August 2017) due primarily to monthly meetings implemented by new leadership.

We are concerned with the checks and balances of "vulnerability", the definitions that vary across the three department may leave some vulnerable children trapped and without services. We suggest adding health services and more mental health / behavioral health services into school systems.

The definition of "vulnerable youth" is inconsistent across the three departments.

Definitions of vulnerable: DHS – any child within DCFS

Definitions of vulnerable: DMH – a special diagnosis with medical necessity

Definitions of vulnerable: DPH – low income, medical, health & disability or foster care

The IAB believes that we **must transform and provide prevention and protective mechanisms so NO child in the county is vulnerable to abuse of any sort.**
We were presented with a scenario where a health inspector discovered a young child in a motel room who admitted to being sexually exploited. Health Inspectors are "boots on the ground" - Who should environmental health call EH regarding sex trafficking in the Western Corridor and 69th street, the Figueroa corridor for sexually exploited children - Hot spots in urban communities like King & Western were noted by the health inspectors.

We suggest health inspector training to identify and report service needs so that resources and support services are allocated to residents where and when they are needed.

We have also been informed that daycare centers are not being inspected across the county, is there a reason for this?

In August 2017, there were only 81 - Commercial Sexually Exploited Children (CSEC) in services within Los Angeles County. We are a county of more than 10 million with an epidemic of STIs, how can we reach more who are sexually exploited and sexually abused? This seems like a very low number.

Foster care – 24K children in outside placement, 11K children in the referral process, we asked the demographics and racial breakdown of the children and have not received a referral response from DCFS to date. Working on "no show" rates for this population however, DCFS referrals are slow and Transitional Age Youth (TAY) are dependent on primary care givers to bring them to appointments.

There are 34K children in "out of home care" currently.
It was noted that issues pertaining to Maternal-Child Health were very under-represented in the Strategic Priorities.

Currently there are no HUB's in supervisory district 3 and 4, for youth these locations provide medical, forensic and mental health services to address the 'whole person'.
Foster Kids aging out – these are still vulnerable children with even fewer resources, how are needs being met?

What protective mechanisms are available for children and youth? Need creative and innovative interventions.
Children who are adopted are denied all services. Why?

Need countywide support for parents and families who are experiencing crisis.
The county has higher rates of employed women living in poverty and 49% of single mother families with children under the age of 5 live in poverty. This must be corrected, children living in poverty is unacceptable in a "first world country". What happens to children beyond age 5? How do we support children and their care givers so that they can focus on building strong young adults?

The IAB hopes Los Angeles County will consider providing unfettered access to children and parents for supportive guidance, preventative health and behavioral services.

Strategic Priority 8: Chronic Disease and Injury Prevention
The LA County Health Agency's eighth strategic priority focuses on chronic disease and injury prevention with the goal of aligning and integrating population health with personal health strategies by creating healthy community environments and strengthening linkages between community resources and clinical services. The six leading causes of death are all chronic diseases and they are:

1) Heart disease
2) Stroke
3) Lung Cancer
4) COPD
5) Alzheimer's Disease
6) Diabetes

Chronic diseases, overall, account for 75% of all health care costs. Yet, these chronic diseases are largely preventable through actions taken to address tobacco use, physical activity and diet. Importantly, it is well understood that land use patterns and economic factors in the places where LA County residents live, work and play influence their exposure to harmful and unhealthy substances, and reduce exposure to opportunities, resources and institutions that support the healthy and safe behaviors proven to prevent chronic disease and injury.

Health, quality of life, and the prevalence of chronic conditions is not equally spread throughout the County of Los Angeles. Some Service Planning Areas (geographic divisions of Los Angeles County to assist in assessing and delivering services throughout the county) have higher rates of specific chronic conditions, as shown in the table below. For example, Antelope Valley has higher rates of Arthritis, South has higher rates of both Diabetes and Hypertension.

Chronic conditions among population ages 50+ (by percentage)

	Arthritis	Diabetes	Hypertension	Serious psychological distress during past year
Antelope Valley	45.7	17.3	44.6	7.0*
San Fernando	36.9	14.9	40.6	5.6
San Gabriel	40.5	16.4	53.3	5.8
Metro	34.8	21.6	52.4	12.3
West	33.9	8.2	42	3.5*
South	38.6	26.3	58.8	9
East	40.7	21.5	53.6	4.4
South Bay	38.9	19.8	52.3	5.9

*unstable estimates. Source: Los Angeles Healthy Aging Report, 2015. USC Social Work – USC Edward R. Roybal Institute on Aging.

The communities in Los Angeles that are economically vulnerable, such as South Los Angeles, experience higher rates of Emergency Department admissions for heart conditions, falls and hip fractures.[1]

Injuries, which include causes of death like homicides, suicides, motor vehicle crashes, drowning, and accidental poisoning are responsible for premature death and disability among LA County residents. Unintentional drug overdose is the 4th leading cause of premature death among women in LA County (LA County DPH, Office of Health Assessment and Epidemiology, 2013). Homicide takes 24,905 years of premature death (LA County, 2012, Office of Health Assessment). Here again, we know that injury deaths are not evenly distributed across the County with issues such as access to / availability of firearms, road design and maintenance, and other factors associated with injury "hot spots". African American males, aged 15-24 are disproportionately involved in homicides and high rates of homicide are also concentrated geographically in areas such as Westmont West Athens, Watts Willowbrook, Florence Firestone. A complex constellation of factors have been implicated in these persistently high rates of homicide and related violence including high rates of incarceration (and cycles of incarceration), lack of access to and availability of quality jobs, under-resourced schools, high densities of alcohol outlets, lack of places for safe youth engagement and institutional and societal discrimination that presents barriers to full access to and inclusion into processes and institutions that are protective against injury.

Investments in chronic disease prevention have been demonstrated to be successful in preventing chronic diseases and the behaviors closely associated with chronic illness, improving quality of life for those living with chronic diseases and extending years of productive life for those living with chronic conditions. Investments in comprehensive injury prevention efforts also have demonstrated success, including for example those to increase seat belt use, prevent drowning, increase helmet use and reduce multiple forms of violence.

The Health Agency—working across the three departments--is well positioned to narrow gaps in chronic disease and injury incidence and prevalence. Doing so will improve health and quality of life, avoid 'inappropriate' use of institutional care, improve self-care, increase 'appropriate' use of primary care, and reduce readmissions for costly care in costly settings. Achieving these benefits requires a comprehensive and multi-faceted approach. We recommend that the Health Agency and it's three departments engage in the following activities:

1) **Invest new and align existing resources** toward proven efforts aimed at improving community conditions and building institutional capacity to address inequities in chronic disease and injury
    a. Strengthen the portfolio of investments that address socioeconomic conditions and the contexts where people live, work, and go to school because that's where the potential to improve population health is greatest.

[1] Los Angeles Healthy Aging Report, 2015. USC Social Work – USC Edward R. Roybal Institute on Aging.

    b. Focus investments in population-level strategies where outcomes are worst, and disproportionately negative for people of color and low income people.
2) **Partner with community-based organizations, particularly those working alongside communities of color and low income communities.**
    a. to address a continuum of community priorities ranging from high quality physical, mental and behavioral health care all the way to advocating for high quality affordable housing, safe parks and open space, safe streets and sidewalks and healthy affordable fresh foods, especially in the most under-resourced communities where rates of injury and chronic disease have been persistently high and inequitable.
    b. invest in expanding resident empowerment with evidence-based programs that help establish skills and knowledge in achieving life style changes that achieve better health outcomes in self-management of chronic conditions and other risks such as falls.
3) **Develop institutional fluency and competency** to engage in sustained efforts to eliminate chronic disease and injury inequities.
    a. Recognize that defaulting to individually-focused interventions is a common reflex both for institutions that are reimbursed for units of services and because it's typically easier to hand out brochures and information than it is to engage in the work to transform institutions, structures and community contexts.
    b. Note that social determinants of health like safe, affordable housing for people or all ages, safe, well designed streets and sidewalks, safe and clean parks and open space, clean environments which provide clean air, water and safe soil, and healthy food retail are all fundamental population-level interventions to prevent chronic disease and injury and that the Health Agency can have a catalytic role in ensuring these needs are met for all LA County residents.
4) **Build, strengthen and support community capacity** to lead and engage in efforts to eliminate inequities in chronic conditions and injuries, including the capacity of people with lived experiences, (e.g., survivors of violence, people living with chronic conditions) who can help people navigate services but also link to community-based organizing and advocacy organizations that provide social connections, personal empowerment and civic engagement opportunities—all things linked to better health outcomes as well.

Over the course of our two years working together as the IAB, we observed some significant, yet under-tapped opportunities to integrate comprehensive chronic disease and injury prevention efforts across County departments and across the eight strategic priorities. Chronic diseases and injuries are very often co-morbid conditions with the other 7 strategic priorities. Listed above are several concrete strategies that would simultaneously bolster chronic disease and injury prevention and should be embedded within the county workgroups and whole person care implementation.

ADDITIONAL RECOMMENDATIONS

- Clean Air, Clean Water, Clean Food
  The health of county residents requires clean air, clean water and clean food. We ask that budgets and resources align for a clean economy without the use, processing and production of fossil fuels within the county. The results of irresponsible handling and management of toxic chemicals have negatively impacted the health, safety and wellbeing of county residents particularly those living near sites where toxic chemicals and gasses are emitted into the air and land. The health payoff of a clean economy is massive, the switch promotes new jobs, improved health outcomes, physical activity and will have the biggest impact when implemented in the most vulnerable communities first.
- Innovate – Health and environment are intertwined, while much chronic illness and preventable diseases are linked directly to poor air quality, chemical pollution, chemical spills and byproducts of the fossil fuel production.
- Promote nutrition, access to healthy food sources particularly schools and in communities of color. There are few grocery stores in South Los Angeles – Funding Food Co-operatives that employ and engage people in the neighborhoods are preferable to large grocery chains that have refused to serve low income areas.
- Urban farming to build neighborhoods and communities. The U.S. Department of Agriculture (USDA) defines food insecurity as not having consistent, dependable access to enough food for active, healthy living (1). Approximately one in five U.S. children live in food-insecure households (2). Food-insecure children are more likely to experience a host of health issues, including developmental, cognitive, behavioral, and mental health problems (3). Among pregnant women, food insecurity is associated with physical and mental health problems, as well as birth complications (3). Children and communities of color are disproportionately affected by food insecurity.
- Job creation and collaboration with corporations that produce green products. Infrastructure improvements like a smart energy grid across the county. Sustainable economy and renewable energy to improve population health and reduce greenhouse gas and pollution.
- Utilize the health integration process to further to protect health and lives by planning and practicing comprehensive preparation for disaster across Los Angeles County so that every resident is prepared, knows their disaster plan and is able to put it into practice.
  Around the world, the month of September 2017 we have seen earthquakes, hurricanes and flooding kill hundreds of people. Los Angeles County sits along several fault lines, is a coastal county with 10.4 million residents. Many parts of the county experienced triple digit heat, as we head into the winter months we should be planning for rain and leaving no one in the streets.
  The county could use disaster preparation and disaster planning by collaborating with city fire departments, DPH and Neighborhood Councils to:
  1) to get homeless people off of the streets before winter
  2) strengthen and map service delivery needs in the most vulnerable communities using census tracks

3) plan and practice what vulnerable neighborhood must do to survive when a disaster hits – every block should have a captain, every neighborhood should have a plan, every household should have a plan.

An opportunity to map out needs of the most vulnerable in the county. Also an opportunity to strengthen service delivery, inventory unmet needs and allocate services in the neighborhoods most in need. An opportunity to find and service homeless residents and help all resident be prepared for emergencies.
Cuba sets the example in disaster preparation at a low cost.
https://www.un.org/press/en/2004/iha943.doc.htm
http://en.granma.cu/cuba/2016-05-04/the-key-to-disaster-preparedness

- County Commission composition – The IAB recommends that at least 1/3rd of commissioners be residents who currently use services or have recently (within 2 years) utilized services. Charged with assuring accountability for public services, county commissions are often populated with residents who have never utilized county services. The residents who experience services must also sit on commissions to balance the perspective. There is need for building the skills and capacity of residents who access services. Residents who use services must be represented on commissions. We support and encourage understanding of what it really means to utilize services in Los Angeles County and support professional curiosity and humility from sitting commissions regarding the actual needs and experiences of people who currently access or attempt to access services in Los Angeles County.

Methodology

The Integration Advisory Board relied on monthly meeting and presentations from Strategic Priority Work Groups, Directors from Health Services, Mental Health and Public Health, researchers, community members, IAB Subcommittee meetings and public comment from IAB meetings. IAB member attended public meetings including county commission meetings, Health Agency Town Hall meetings, and forums relating to health and public health.

The Integration Advisory Board reviewed numerous documents produced during the formation of the Health Agency and the proposed integration of the three departments. We referred to Los Angeles County reports for measuring the health, well-being and living conditions of residents. In addition, members conducted independent research to understand causes of health disparities and unmet needs within the county. We listened and looked for both context and results.
The IAB includes county residents who utilize Health Agency services, organized labor who are also department employees, community providers and members representing County commissions.

APPENDIX

1. HIV and Incarceration Brief
   http://file.lacounty.gov/SDSInter/bos/supdocs/HIVandIncarcerationBrief.pdf
2. Office of Diversion and Reentry Status Report Dated 07-13-17
   http://file.lacounty.gov/SDSInter/bos/supdocs/OfficeofDiversionandReentryStatusReport071317.pdf
3. IAB Subcommittee on Homelessness Report 1 (Authored by Member Jeff)
   http://file.lacounty.gov/bos/supdocs/102335.pdf
   (IAB received and filed report at the March 23, 2017 IAB Meeting)
4. IAB Subcommittee on Homelessness Report 2 (Authored by Member Jeff)
   http://file.lacounty.gov/SDSInter/bos/supdocs/110004.pdf
   (IAB received and filed the report at the January 25, 2017 IAB meeting)
5. IAB Subcommittee on Homelessness Report 3 (Authored by General Jeff)
   http://file.lacounty.gov/SDSInter/bos/supdocs/IABSubcommitteeonHomeessness-3rd.pdf
   (IAB received and filed the report at the October 25, 2017 IAB meeting)
6. IAB Subcommittee on Consumer Access and Experience with Clinical Services (Authored by Member Todd)
   http://file.lacounty.gov/bos/supdocs/102333.pdf
   (IAB received and filed this report at the March 23, 2016 IAB Meeting)
7. IAB Subcommittee on Implementation of the Expanded Substance Use Disorders (Authored by the Subcommittee)
   http://file.lacounty.gov/SDSInter/bos/supdocs/ImplementationoftheExpandedSubstanceUseDisorderBenefits.pdf
   (IAB approved the recommendations of the Subcommittee at the July 26, 2017 meeting) Note: Member Kelly voted No; Members Champommier and McKenna abstained; Members: Co-Chair Al Ballesteros, Manal J. Aboelata, Hildy Aguinaldo, Traci Bivens-Davis, Herman DeBose, Victor Marrero, Claude Martinez, Enrique Peralta and Pat Stewart-Nolen were absent)

END OF COMMISSION PACKET