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

Approved by the Commission on HIV on February 8, 2018

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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	Signed, dated assessment on file in client chart.

• Mental health • Personal finance skills • History of evictions • Level of resources available to solve problems • Co-morbidity factors • For clients with substance use disorders, case managers must assess for eligibility and readiness for residential substance use treatment facilities. • Eligibility for Medical Care Coordination	

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	Release of Information signed and dated by client on file and updated annually.

Information (must be updated annually). New forms must be added for those individuals not listed on the existing Release of Information (specification should be made about what type of information can be released)	
Client is informed of Rights and Responsibility and Grievance Procedures	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	Signed, dated assessment on file in client chart.

disorders, case managers must assess for eligibility and readiness for residential substance use treatment facilities. • Eligibility for Medical Care Coordination	

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.

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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 client 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 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 resident 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 protecting the privacy and confidentiality of residents
- 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 resident crises, such as when residents 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 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.

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.	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	Documentation of resident education on file in

referral must be made to an appropriate health facility.	client chart.
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
	Written agreements on file at provider agency

benefits, financial planning, and availability of other community- based and public resources; if these services are not provided by provider staff or the subcontracted home health agency personnel	

MEDICATION MANAGEMENT

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

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

SUPPORT SERVICES

Support services 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	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 resident develop an Individualized Service Plan, complete with action steps to ensure linkage and retention to primary care provider
- Based on resident needs, intensive case management to engage with 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 residents' needs
- Services are culturally-specific and linguistically and developmentally appropriate

- Mechanisms for soliciting client input on how to improve services are established (such as resident 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 resident crises, such as when residents 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 prior to 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 • TB clearance
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	Signed, dated assessment on file in client chart.

• 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	
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 resident 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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