LOS ANGELES COUNTY
COMMISSION ON HIV

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STANDARDS AND BEST PRACTICES COMMITTEE MEETING

TUESDAY, DECEMBER 3, 2024
10:00am-12:00pm (PST)

510 S. Vermont Avenue, 9th Floor, LA 90020
Validated Parking @ 523 Shatto Place, LA 90020

**As a building security protocol, attendees entering the building must notify parking attendant and/or security personnel that they are attending a Commission on HIV meeting.*

Agenda and meeting materials will be posted on our website at http://hiv.lacounty.gov/Meetings

Register Here to Join Virtually

https://lacountyboardofsupervisors.webex.com/weblink/register/rb72b26e7bca1809619f844b72e6bf9eb

Notice of Teleconferencing Sites

Public Comments

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

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

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

Accommodations

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

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

together.

WE CAN END HIV IN OUR COMMUNITIES ONCE & FOR ALL

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LOS ANGELES COUNTY
COMMISSION ON HIV

HYBRID MEETING GUIDELINES, ETTIQUETTE & REMINDERS

(Updated 7.15.24)

☐ This meeting is a **Brown-Act meeting** and is being recorded.
- Turn off your ringers/notifications on your smart devices so as not to disrupt the meeting.
- Your voice is important and we want to ensure that it is captured accurately on the record. Please be respectful of one another and minimize crosstalk.

☐ The **meeting packet** can be found on the Commission's website at https://hiv.lacounty.gov/meetings/ or accessed via the QR code provided. Hard copies of materials will not be provided in compliance with the County's green initiative to recycle and reduce waste.

☐ Please comply with the **Commission's Code of Conduct** located in the meeting packet.

☐ **Public Comment** for members of the public can be submitted in person, electronically @ https://www.surveymonkey.com/r/public_comments or via email at hivcomm@lachiv.org. *Please indicate your name, the corresponding agenda item, and whether you would like to state your public comment during the meeting; if so, staff will call upon you appropriately. Public comments are limited to two minutes per agenda item. All public comments will be made part of the official record.*

☐ For individuals joining in person, to mitigate any potential streaming interference for those joining virtually, we respectfully ask that you **not simultaneously log into the virtual option of this meeting via WebEx.**

☐ Committee members invoking **AB 2449 for "Just Cause" or "Emergency Circumstances**" must communicate their intentions to staff and/or co-chairs no later than the start of the meeting. Members requesting to join pursuant to AB 2449 must have their audio and video on for the entire duration of the meeting and disclose whether there is a person over the age of 18 in the room in order to be counted toward quorum and have voting privileges. For members joining virtually due to "Emergency Circumstances", a vote will be conducted by the Committee/COH for approval.

☐ Members will be required to explicitly state their agency's **Ryan White Program Part A and/or CDC prevention conflicts of interest** on the record (versus referring to list in the packet). A list of conflicts can be found in the meeting packet and are recorded on the back of members' name plates, courtesy of staff.

If you experience challenges in logging into the virtual meeting, please refer to the WebEx tutorial HERE or contact Commission staff at hivcomm@lachiv.org.

LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave., 14th Floor, Los Angeles CA 90020
MAIN: 213.738.2816 EML: hivcomm@lachiv.org WEBSITE: https://hiv.lacounty.gov

AGENDA FOR THE REGULAR MEETING OF THE LOS ANGELES COUNTY COMMISSION ON HIV

STANDARDS AND BEST PRACTICES COMMITTEE

TUESDAY, DECEMBER 3, 2024| 10:00AM – 12:00PM

510 S. Vermont Ave
Terrace Level Conference Rooms
Los Angeles, CA 90020
Validated Parking: 523 Shatto Place, Los Angeles, CA 90020

For those attending in person, as a building security protocol, attendees entering the first-floor lobby must notify security personnel that they are attending the Commission on HIV meeting to access the Terrace Conference Room (9th floor) where our meetings are held.

MEMBERS OF THE PUBLIC WHO WISH TO JOIN VIRTUALLY, REGISTER HERE:
https://lacountyboardofsupervisors.webex.com/weblink/register/rb72b26e7bca1809619f844b72e6bf9eb
To Join by Telephone: 1-213-306-3065
Password: STANDARDS Access Code: 2535 356 9264

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

AGENDA POSTED: November 26, 2024.

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

PUBLIC COMMENT: Public Comment is an opportunity for members of the public to comment on an agenda item, or any item of interest to the public, before or during the Commission's consideration of the

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

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

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

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

I. ADMINISTRATIVE MATTERS

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

II. PUBLIC COMMENT

10:10 AM – 10:15 AM

5. Opportunity for members of the public to address the Committee of items of interest that are within the jurisdiction of the Committee. For those who wish to provide public comment may do so in person, electronically by clicking here, or by emailing hivcomm@lachiv.org.

III. COMMITTEE NEW BUSINESS ITEMS

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

IV. REPORTS

7. Executive Director/Staff Report — 10:15 AM – 10:25 AM
   a. Operational and Commission—Updates
8. Co-Chair Report — 10:25 AM – 10:45 AM
   a. Review 2024 Accomplishments
   b. Draft 2025 Workplan and Meeting Schedule
   c. Service Standards Revision Tracker—Updates
   d. 2025 Committee Co-Chair Open Nominations & Elections | Reminder

9. Division on HIV and STD Programs (DHSP) Report 10:45 AM—11:15 AM

V. DISCUSSION ITEMS

10. Housing Service Standards Review 11:15 AM—11:50 AM
    a. Residential Care Facility for the Chronically Ill (RCFCI)
    b. Transitional Residential Care Facility (TRCF)

VI. NEXT STEPS 11:50 AM – 11:55 AM

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

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

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

VIII. ADJOURNMENT 12:00 PM

15. Adjournment for the meeting of December 3, 2024.

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

DRAFT

LOS ANGELES COUNTY
COMMISSION ON HIV

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HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov • *VIRTUAL WEBEX MEETING*

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

STANDARDS AND BEST PRACTICES (SBP) COMMITTEE MEETING MINUTES

November 12, 2024

COMMITTEE MEMBERS P = Present | A = Absent					
Erika Davies, *Co-Chair*	P	Felipe Findley	A	Byron Patel, RN	P
Kevin Stalter, *Co-Chair*	EA	Arlene Frames	EA	Martin Sattah, MD	A
Dahlia Ale-Ferlito	P	Lauren Gersh, LCSW	P	Russell Ybarra	P
Mikhaela Cielo, MD	P	David Hardy, MD	P		
Sandra Cuevas	A	Mark Mintline, DDS	A		
Kerry Ferguson	P	Andre Molette	LOA		
COMMISSION STAFF AND CONSULTANTS					
Cheryl Barrit; Lizette Martinez					
DHSP STAFF					
COMMUNITY MEMBERS					
Kristen Blair' Marjorie Solorzano; Jayda Arrington; Heshan Wijegunaratne; Tiana Monteilh; Katja Nelson; Rhonda Layton-Jones					

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

Meeting agenda and materials can be found on the Commission's website at
https://hiv.lacounty.gov/standards-and-best-practices-committee/

CALL TO ORDER-INTRODUCTIONS-CONFLICT OF INTEREST STATEMENTS

The meeting was called to order at 1:35pm. Cheryl Barrit, Executive Director, noted that this is the first meeting of a COH committee since the November 5, 2024 general election and shared that the COH leadership, leadership at the Division on HIV and STD Programs (DHSP), and other local HIV stakeholders are preparing for potential changes in HIV funding/programming support from federal agencies resulting from the change in administration. She reminded attendees that it is too early to tell what these changes entail but noted that COH leadership will share information as it becomes available. Lastly, C. Barrit invited attendees to attend the Public Policy Committee on Monday November 18 from 1:30pm-3:30pm.

I. ADMINISTRATIVE MATTERS

1. APPROVAL OF AGENDA

MOTION #1: Approve the agenda order, as presented ***(✓Passed by consensus).***

2. APPROVAL OF MEETING MINUTES

MOTION #2: Approve the 10/07/24 SBP Committee meeting minutes, as presented ***(✓Passed by consensus).***

II. PUBLIC COMMENT

3. **OPPORTUNITY FOR PUBLIC TO ADDRESS COMMISSION ON ITEMS OF INTEREST WITHIN COMMISSION JURISDICTION**: There were no public comments.

III. COMMITTEE NEW BUSINESS ITEMS

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

IV. REPORTS

5. **EXECUTIVE DIRECTOR/STAFF REPORT**

- **Operational and Programmatic Updates**

C. Barrit highlighted upcoming events and activities. She noted that nominations for COH, Committee, and Caucus co-chairs are now open, and elections will be held in January. COH co-chair elections will take place at the January COH meeting on January 9th, 2025; this meeting will be held at the California Endowment. For more information, review the "Co-Chair Nominations and Elections: Frequently Asked Questions" document included in the meeting packet. This document describes the co-chair role, responsibilities, and eligibility requirements. Additional questions should be directed to COH staff.

C. Barrit reminded attendees that the COH Annual Conference will be on November 14 at the Martin Luther King Jr. Behavioral Health Center; a copy of the event flyer is included in the meeting packet. She added that presentation materials are available on the COH website. Registration for the conference is closed due to reaching capacity. The morning plenary sessions and the closing sessions will be live streamed via WebEx.

C. Barrit shared that the COH will be hosting a World AIDS Day event in the 5th Supervisorial District (The Antelope Valley) on December 3rd from 11:30am to 2:00pm at the Bartz-Altadonna Community Health Clinic Administrative Offices. The event will feature speakers, prizes, entertainment, lunch, and a report back on the community listening session held on October 18, 2024, at the JWCH clinic. A link to RSVP for the event is included on the event flyer. Additionally, the COH's Black Caucus will host a World AIDS Day event in the 2nd Supervisorial District on December 6th from 12:00pm to 2:00pm at Charles Drew University. The event will include a resource fair, and an opportunity for community members to uplift Black lives in the fight against HIV. Community organizations interested in tabling at the resource fair can register using the link on the event flyer. Lastly, the COH Consumer Caucus will host a Consumer Resource Fair event on February 13, 2025, from 12:00pm to 5:00pm at the California Endowment. The event is titled, "Love Begins with Me: Empowering Wellness, Advocacy, and Community Beyond HIV". Any community organization, agency, or individual interested in participating as a vendor or service provider, hosting a workshop, tabling, or deliver a presentation can register using the link on the event flyer. Copies of the event flyers for all the events are included in the meeting packet and available on the COH website.

6. **CO-CHAIR REPORT**

- **2024 Workplan Development and Meeting Schedule and Service Standard Revision Tracker**

Erika Davies provided an overview of the 2024 meeting calendar. She noted that the November 5 meeting lands on Election Day; the Committee decided to reschedule the November 5 meeting to November 12 contingent on the available of a conference room on that date. COH staff will follow-up with building management to request a room reservation for November 12 at the Vermont Corridor. She added that the

Committee will continue its review of the Emergency Financial Assistance (EFA) service standards, review public comments received for the Transportation Services service standards and hold a vote to approve the document.

- **2025 Committee Co-Chair Open Nominations**
  E. Davies

7. DIVISION ON HIV AND STD PROGRAMS (DHSP) REPORT
There was no report.

V. DISCUSSION ITEMS

8. Emergency Financial Assistance Service Standards Review
Jose Rangel-Garibay, Commission staff, noted that the public comments received for the Transportation Services service standards are included in the meeting packet. E. Davies provided a summary of the public comments received and noted the following:

- Application process for EFA can be stressful due to lengthy processing and fund disbursement delays.
- Processing delays due to landlord hesitancy to provide w-9 forms to Alliance for Health and Healing.
- Lack of awareness of the EFA program among Ryan White clients.
- Consider expanding eligibility for EFA to non-Ryan White clients who meet income eligibility requirements. However, the HRSA definition for the EFA service category describes the eligibility requirements and does not allow for flexibility to expand beyond Ryan White eligible clients.
- Benefits Specialty and Medical Case Management staff assist clients with applying for EFA and refer clients to other funding assistance sources to help clients meet other needs not covered by EFA or another Ryan White service category.
- Frustration with the lack of communication and transparency from Alliance for Housing and Healing regarding the status of client's EFA application. This is partially explained by the agency exhausting funds allocated for EFA within 3 months of receiving funds which led to lengthy delays in processing existing and incoming applications for EFA. Committee members recommend having Alliance for Health and Healing provide regular updates to case managers on the status of EFA funding.
- DHSP provided guidance to Alliance for Health and Healing directing them to temporarily limit the categories of items/services that clients can apply EFA for and focus on processing, approving, and funding applications for rental assistance to aid as many clients as possible. Committee members noted that while these temporary restrictions are important for the current funding situation, the service standards should not reflect these restrictions. The service standards will include the categories/items currently listed in the event funding for EFA becomes available and DHSP removes the restrictions.

E. Davies reminded Committee members that while the SBP Committee develops service standards which provide guidance on minimal expectations for service delivery, the Committee can only provide recommendations on the programmatic implementation of the service categories, and it is the sole responsibility of the Division on HIV and STD Programs (DHSP) to determine service implementation. These recommendations are included in the transmittal memo COH prepare when sending the approved service standards to DHSP staff. She added that this is an opportunity for the Committee to consider developing a "Best Practices" document that includes all the program implementation recommendations discussed for this service category. This is a project to consider for the 2025 workplan. After discussing the public comments, the Committee held a vote to the approve the document and elevate it to the Executive Committee.

MOTION #3: Approve the Emergency Financial Assistance services standards, as presented or revised, and elevate to the Executive Committee. ***(✓Passed; Yes: (8) D. Ale-Ferlito, M. Cielo, K. Ferguson, L. Gersh, D. Hardy, B. Patel, R. Ybarra, E. Davies; No: (0); Abstain (0).***

9. **Housing Services Standards Review**

C. Barrit provided a brief overview of the development of the Housing Services standards and described the structure of the document. The Housing Service standards was last approved by the COH in 2018. At the time, the availability of housing assistance programs was limited, and the Committee hired a consultant to assist with the development of the service standards document. The Housing Services Standards document includes guidance for a variety of different programs for temporary housing such as Hotel/motel vouchers, emergency shelters, transitional housing, and the two programs currently funded by DHSP which are Residential Care Facility for the Chronically Ill (RCFCI) and Transitional Residential Care Facility (TRCF). A separate document was developed that encompasses Permanent Housing and Permanent Supportive Housing programs; the Committee will review that document after completing review of the Temporary Housing Services document.

E. Davies led the Committee in the initial review of the Housing Service Standards document. Committee members asked aside from RCFCI and TRCF, does DHSP currently fund the other temporary housing programs. C. Barrit noted that DHSP does not currently fund those programs, but the service standards include guidance for those programs to establish the minimal service expectations should funding become allocated for those services. If the Committee decided to remove the unfunded services from the standards document, then DHSP would have the latitude to develop standards for the program and may utilize the Universal Service standards as a base and consult the SBP Committee for further guidance. E. Davies added that the "general eligibility" section at the beginning of the document needs revising. Consider the following revisions: "have a valid ID document"; "unstably housed or at risk of becoming homeless" and consider reviewing the Los Angeles City Housing guidelines for any additional revisions.

VI. NEXT STEPS

10. **TASK/ASSIGNMENTS RECAP**:
    - COH staff will elevate the Emergency Financial Assistance (EFA) service standards to the Executive Committee for approval.
    - COH staff will follow-up with DHSP staff regarding a designee for the Committee.

11. **AGENDA DEVELOPMENT FOR NEXT MEETING**:
    - Draft 2025 meeting schedule and workplan
    - Continue review of the Housing services service standards.

VII. ANNOUNCEMENTS

12. **OPPORTUNITY FOR PUBLIC AND COMMITTEE TO MAKE ANNOUNCEMENTS**:
    - There were no announcements.

VIII. ADJOURNMENT

13. **ADJOURNMENT**: The meeting adjourned at 3:39pm.

LOS ANGELES COUNTY
COMMISSION ON HIV

STANDARDS AND BEST PRACTICES COMMITTEE
2024 MEETING CALENDAR | (updated 12.01.24)

DATE	KEY AGENDA ITEMS/TOPICS (subject to change; for planning purposes)
~~**Feb. 6, 2024**~~	Meeting Cancelled due to significant weather event.
Mar. 5, 2024 10am to 12pm *Room TK08*	Review and Adopt 2024 Committee workplan and meeting calendar. Deliberate and establish standards review schedule for 2024. Review and approve HIV/STI Prevention Services standards. HIV/STI Prevention Services standards on Executive Committee agenda
Apr. 2, 2024 10am to 12pm *Room TK05*	Service standard development refresher. Review AOM service standards. HIV/STI Prevention Services standards on COH agenda
May 7, 2024 10am to 12pm *Room TK08*	Continue review of AOM service standards
Jun. 4, 2024 10am to 12pm *Room TK11*	LA LGBT Center AOM Program Presentation Initiate review of Emergency Financial Assistance (EFA) service standards
Jul. 2, 2024 10am to 12pm *Room TK11*	Continue review of AOM service standards Continue review of EFA service standards
Aug. 6, 2024 10am to 12pm *Room TK11*	Finalize review of AOM service standards Continue review of EFA service standards
Sep. 3, 2024 10am to 12pm *Room TK11*	Continue review of EFA service standards Continue review of Transportation Services standards
Oct. 1, 2024 10am to 12pm *Room TK 11*	Finalize review of EFA service standards Finalize review of Transportation Services standards
Nov. 12, 2024 1:30pm-3:30pm *Room TK 02*	Announce co-chair nominations for 2024. Review EFA public comments and vote to approve. Initiate review of Temporary and Permanent Housing service standards **REMINDER: Commission on HIV Annual Conference 11/14/2024**
Dec. 3, 2024 10am to 12pm *14th Floor*	Reflect on 2024 accomplishments. Continue review of Temporary Housing Service Standards Co-Chair Nominations Draft workplan and meeting calendar for 2025

LOS ANGELES COUNTY COMMISSION ON HIV 2024
STANDARDS AND BEST PRACTICES WORKPLAN (Updates in RED)

Co-Chairs: Erika Davies, Kevin Stalter				
Adopted on: 4/2/24				
Purpose of Work Plan: To focus and prioritize key activities for SBP Committee for 2024.				
#	**TASK/ACTIVITY**	**DESCRIPTION**	**TARGET COMPLETION DATE**	**STATUS/NOTES/OTHER COMMITTEES INVOLVED**
1	Review and refine 2024 workplan and meeting calendar.	COH staff to update 2024 workplan and meeting calendar monthly.	Ongoing, as needed	Workplan revised/updated on: 12/05/23, *02/29/24, 03/28/24, 4/30/24, 5/24/24, 6/26/24, 7/31/24, 8/28/24, 9/26/24, 11/27/24.*
2	Update Universal service standards and Consumer Bill of Rights	Annual review of the standards. Revise/update document as needed.	COMPLETE	The COH approved the document on 01/08/24. The Committee decided to move the document to a bi-annual review or as needed/requested.
3	Update the Medical Care Coordination (MCC) service standards	Committee received a public comment requesting for a review and update of the MCC services standards.	COMPLETE	The COH approved the document on 01/08/24.
4	Update Prevention Service standards	Review and revise/update document as needed.	COMPLETE	Committee forwarded the document to the Prevention Planning Workgroup for review at their 07/26/23 meeting. The PPW co-chairs presented the proposed revisions to the Prevention standards on 11/7/23. The Committee approved the standards and elevated them to the Executive Committee and full COH for approval. The COH approved the Prevention Standards on 4/11/24. Transmittal letter sent to DHSP on 5/20/24.
5	Develop global Transitional Case Management Service standards.	This standard will include sections for priority populations such as youth, older adults (50+), and justice involved individuals. The section for older adults will	TBD	The Committee decided to move the item to 2025.

		focus on healthcare navigation between the Ryan White Care system, Medi-Cal, and Medi-Care.		
6	Update the Emergency Financial Assistance service standards	Committee received a request to consider reviewing the EFA service standards.	January 2025	The Committee completed their review on 11/12/24. The document will be elevated to the Executive Committee for review and approval at their 12/12/24 meeting.
7	Update Ambulatory Outpatient Medical Services standards	Upcoming solicitation to release in Nov. 2024	August 2024	The Committee approved the service standards on 8/6/24 and elevated to the Exec/COH approval on 12/12/24.
8	Update Transportation Services standards	Upcoming solicitation to release in Oct. 2024.	January 2025	The Committee completed their review on 10/1/24. The Executive Committee approved the document on 10/24/24. The document will be elevated to the full COH for review and approval at their 1/9/25 meeting.
9	Update Temporary and Permanent Housing Services standards	Upcoming solicitation to release in Nov. 2024.	Early 2025	The Committee will continue their review on 12/3/24.

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510 S. Vermont Ave., 14th Floor, Los Angeles CA 90020
MAIN: 213.738.2816 EML: hivcomm@lachiv.org WEBSITE: https://hiv.lacounty.gov

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

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

Am I Eligible? (*Per COH Bylaws, Policies #08.1102 and #08.1104)*

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

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

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

Committee Co-Chairs (Nominations will open by Dec with elections in Jan 2025)

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

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

Caucus Co-Chairs (Nominations will open by Dec, with elections in Jan 2025)

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

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

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

What Are the Co-Chair Roles & Responsibilities?

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

How Should I Prepare?

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

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

LOS ANGELES COUNTY
COMMISSION ON HIV

STANDARDS AND BEST PRACTICES COMMITTEE 2025 MEETING CALENDAR (Updated 10/25/24)

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

HOUSING SERVICE STANDARDS: TEMPORARY HOUSING SERVICES

Approved by COH on 2/8/2018. For SBP Committee review as of 12/02/24.

Covers: Hotel/Motel and Meal vouchers, Emergency Shelter Programs, Transitional Housing, Income-based Rental Assistance, Residential Care Facility for the Chronically Ill (RCFCI), and Transitional Residential Care Facility (TRCF).

INTRODUCTION

Services standards for the Ryan White HIV/AIDS Part A Program outline the elements and provide guidance on the expectations a service provider should follow when implementing a specific service category. The purpose of service standards is to ensure that all Ryan White service providers offer the same fundamental components of the given service category across a service area. The standards set the minimum level of care a Ryan White funded agency or provider should offer to clients, however, providers are encouraged to exceed these standards.

The Los Angeles County Commission on HIV developed the Housing Service Standards: Temporary Housing Services to ensure people living with HIV (PLWH) can apply for housing assistance/support programs to maintain housing stability. The development of the Standards includes guidance from service providers, consumers, the Los Angeles County Department of Public Health - Division of HIV and STD Programs (DHSP), as well as members of the Los Angeles County Commission on HIV, Standards & Best Practices (SBP) Committee.

OVERVIEW

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.

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.

All contractors must meet the Universal Standards of Care in addition to the following Emergency Financial Assistance Standards of Care.[1]

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

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 may access hotel/motel and meal vouchers through case management services from a designated referral agency.

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 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.
- 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.
Documentation of client need and eligibility for MCC services.	Linkage to MCC services documented in client chart.

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 Emergency Shelter 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 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.

Based on assessment and client needs, eligible individuals should be linked to MCC services.

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)

TRANSITIONAL HOUSING (UP T0 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	Release of Information signed and dated by client on file and updated annually.

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:

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

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.

Based on assessment and client needs, eligible individuals should be linked to MCC services.

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

INCOME-BASED RENTAL SUBSIDIES (UP TO 24 MONTHS)

Income-based rental based subsidies provide 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 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:

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 residential substance use treatment facilities. • Eligibility for Medical Care Coordination	Signed, dated assessment on file 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.

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.

Based on assessment and client needs, eligible individuals should be linked to MCC services.

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

RESIDENTIAL CARE FACILITY 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 goal of the RCFCI is to improve the health status of people living 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 if 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://www.cdss.ca.gov/ord/entres/getinfo/pdf/rcfciman1.pdf

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.	Program review and monitoring to confirm.

• 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	
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 follows:	Program review and monitoring to confirm.

• 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 referral must be made to an appropriate health facility.	Documentation of resident education on file in 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 meet the child's needs, or dies	Needs and services plan on file in client chart.
Plans should be updated every three months or more frequently to document changes in a 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. • Others, as deemed necessary	Record of ISP team on file in client chart.

MONTHLY CASE CONFERENCE

A monthly case conference will include review of the ISP, including the 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 are not provided by provider staff or the subcontracted home health agency personnel
	Written agreements on file at provider agency

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 childcare contingency plan • Current ISP • Record of IST contacts • Documentation of all services provided. • Record of current medications • Physical and mental health observations and assessments	Programs will maintain sufficient records on each resident

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 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 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.	Signed, dated assessment on file in client chart.

• 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	
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.

Ryan White Program Year 32
Care Utilization Data Summary

Part 3 – Housing, Emergency Financial Assistance, Nutrition Support

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

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

HOUSING, EMERGENCY FINANCIAL ASSISTANCE AND NUTRITION SERVICES

BACKGROUND

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

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

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

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

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

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

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

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

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

Outcomes and Indicators

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

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

DATA SOURCES

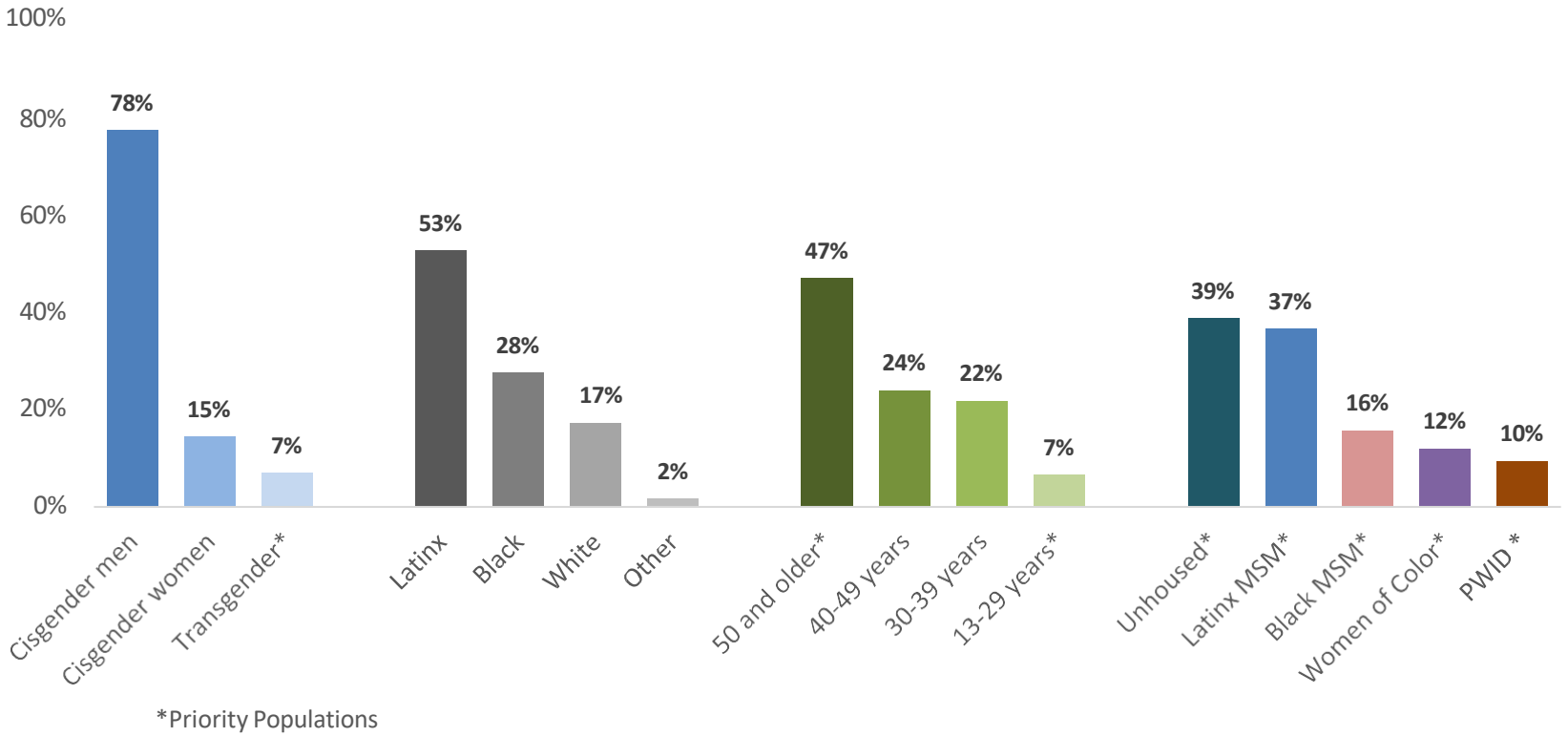
- HIV Casewatch (local RWP data reporting system)
  - Client characteristics and service utilization data reported by RWP contracted service agencies
  - Data are manually entered or submitted through electronic data transfer
- Linkage Re-engagement Program (ACCESS Database)
- eHARS (HIV surveillance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

HOUSING SERVICES

Population Served:

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

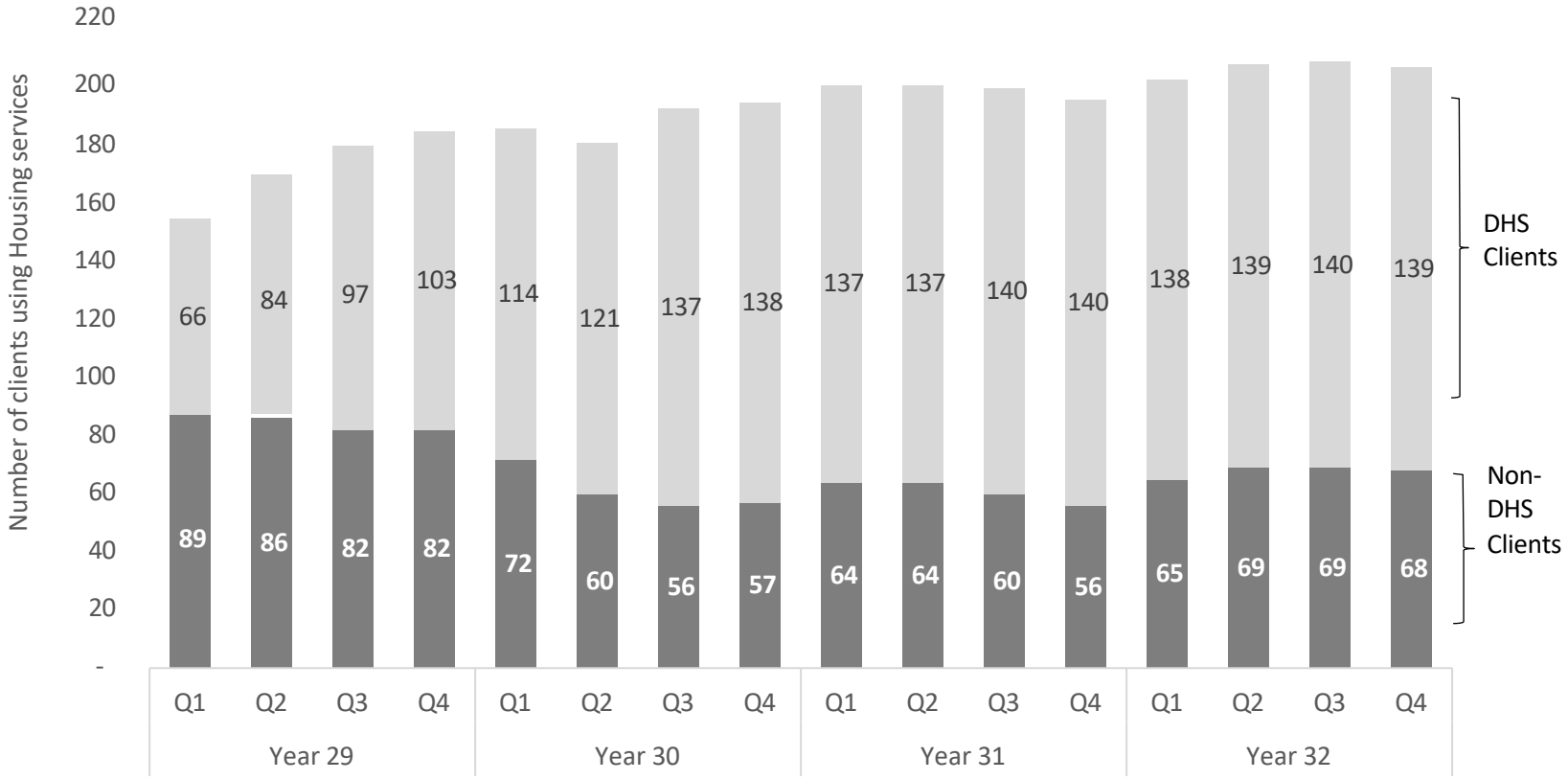
Figure 1. Key Characteristics of RWP Clients in Housing Services in LAC, Year 32



Service Utilization

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

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



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

Service Units and Expenditures

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

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

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

Table 1 Highlights

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

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

HIV Care Continuum (HCC) Outcomes

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

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

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

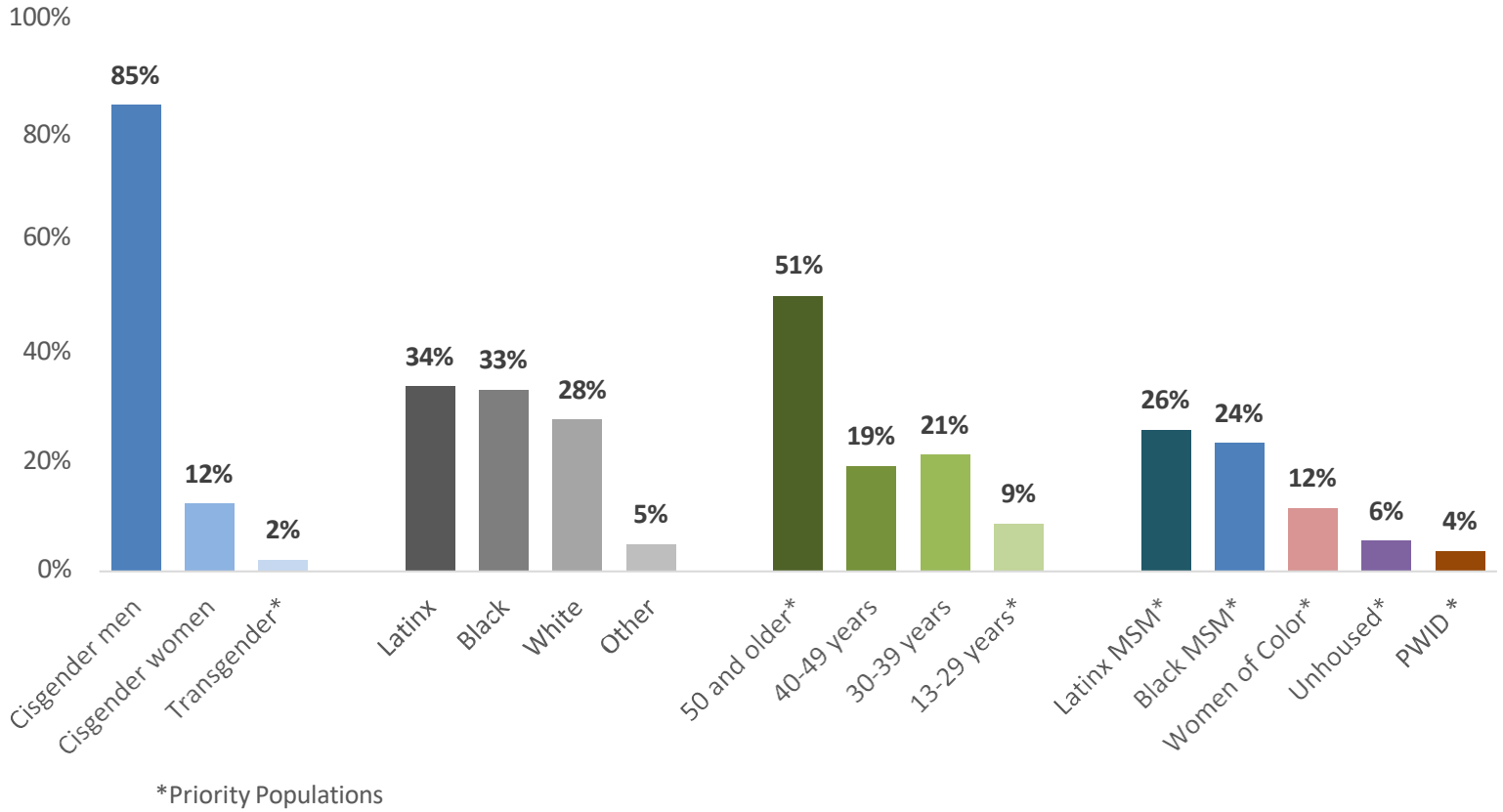
[a]Defined as having ≥1 HIV laboratory test (viral load, CD4 or genotype test) reported in the 12 months before the end of the reporting period
[b]Defined as having ≥2 HIV laboratory tests (viral load, CD4 or genotype test) reported at >90 days apart in the 12 months before the end of the reporting period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

EMERGENCY FINANCIAL ASSISTANCE (EFA) SERVICES

Population Served:

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

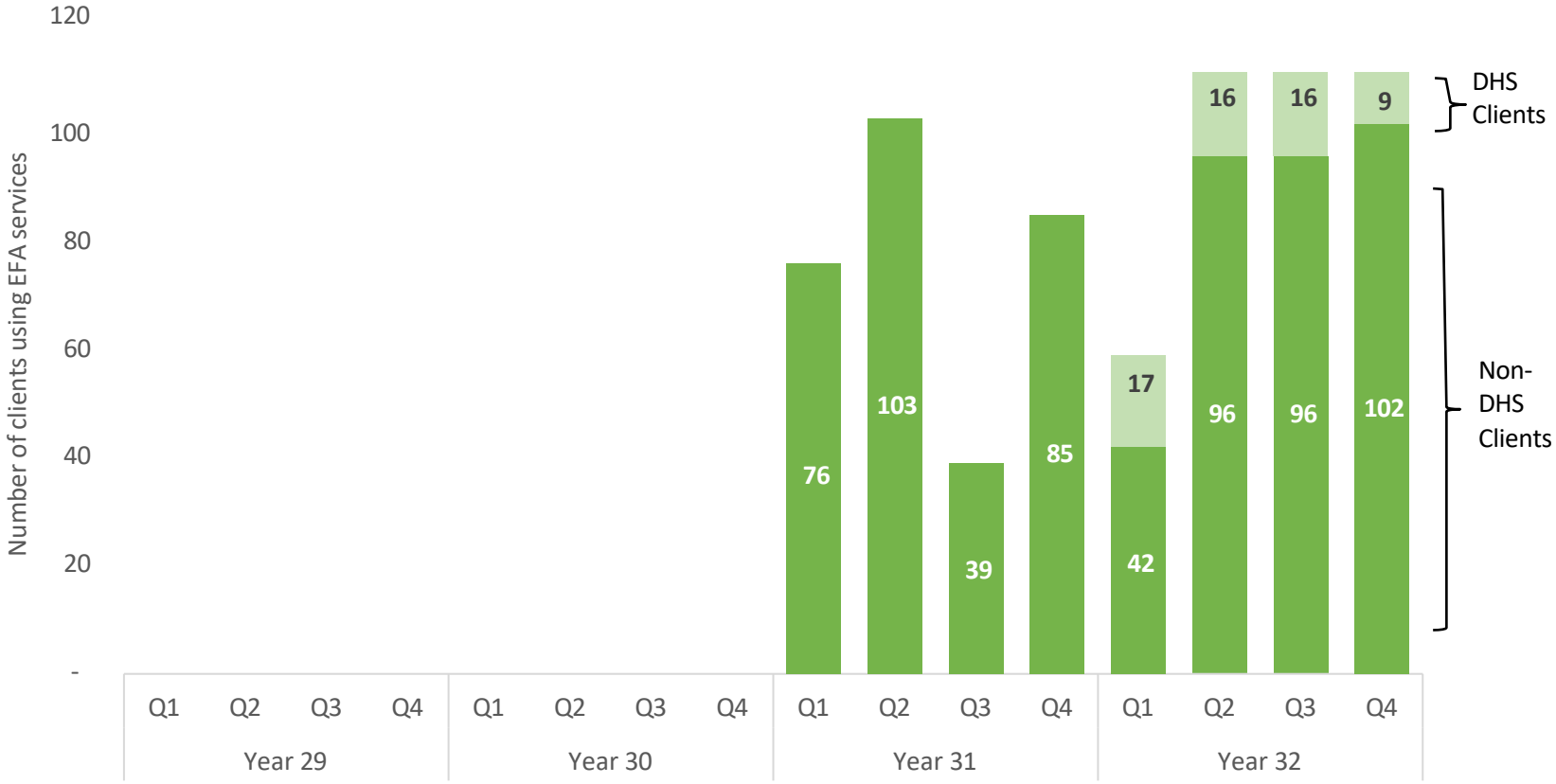
Figure 3. Demographic Characteristics and Priority Populations among EFA Clients in LAC, Year 32



Service Utilization

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

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



Service Units and Expenditures

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

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

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

Table 3 Highlights

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

HIV Care Continuum (HCC) Outcomes

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

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

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

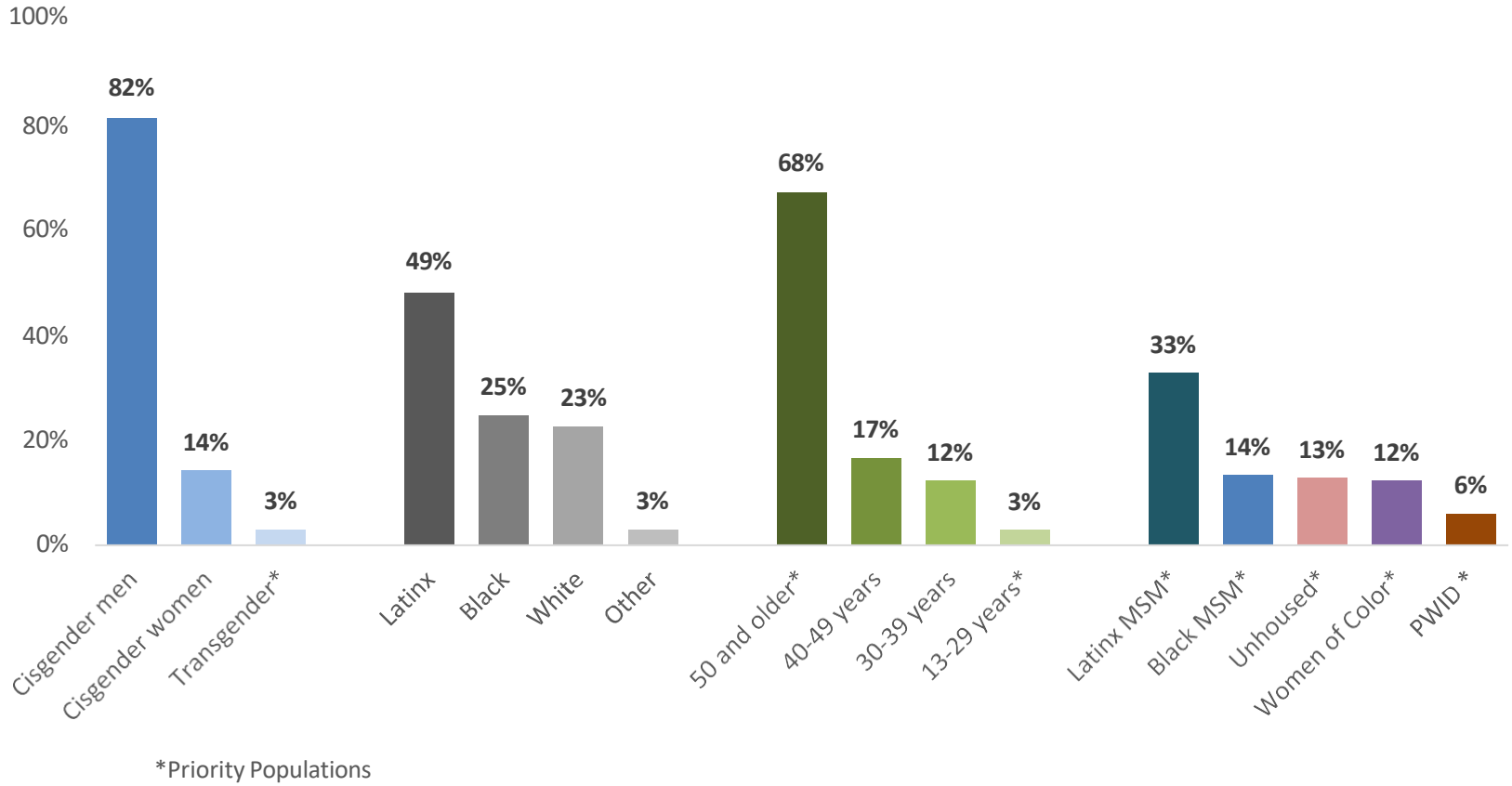
[a]Defined as having ≥1 HIV laboratory test (viral load, CD4 or genotype test) reported in the 12 months before the end of the reporting period
[b]Defined as having ≥2 HIV laboratory tests (viral load, CD4 or genotype test) reported at >90 days apart in the 12 months before the end of the reporting period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

NUTRITION SUPPORT SERVICES

Population Served:

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

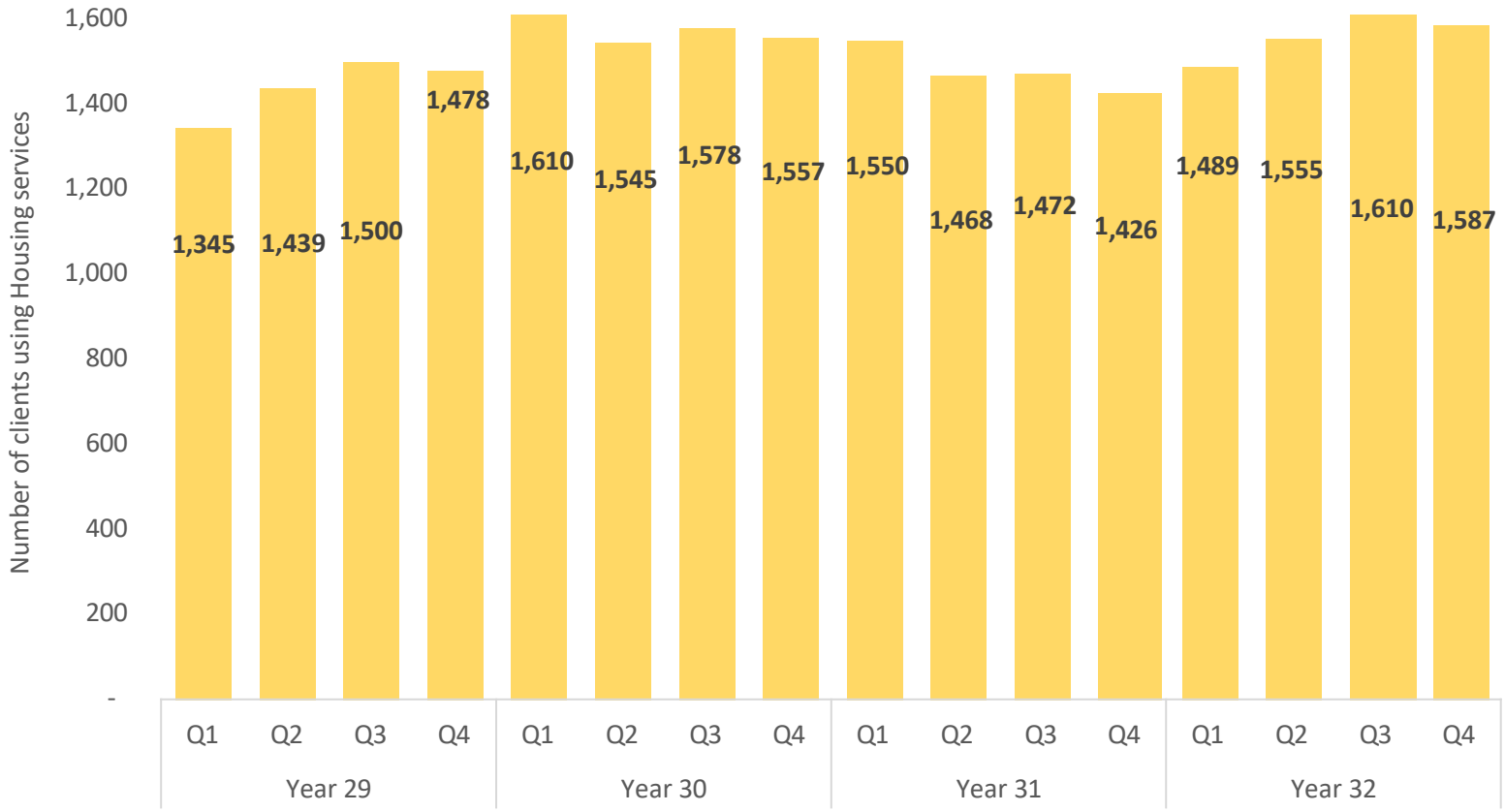
Figure 5. Demographic Characteristics and Priority Populations among Nutrition Service Clients in LAC, Year 32



Service Utilization

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

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



Service Units and Expenditures

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

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

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

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

Table 5 Highlights

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

HIV Care Continuum (HCC) Outcomes

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

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

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

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

Overlap of Services Provided

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

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

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

SUMMARY OF FINDINGS

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

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

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

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

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

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

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

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- HIV/STD Surveillance

Ryan White Program Agencies, Providers and Clients

Thank you

****UPDATED****

SAVE THE DATE

Los Angeles County Commission on HIV Black Caucus

OUR STORIES, OUR STRENGTH: ELEVATING BLACK LIVES ON WORLD AIDS DAY

WORLD AIDS DAY

DEC 6 — 2024

Join the **Los Angeles County Commission on HIV Black Caucus** for a community-wide event commemorating **World AIDS Day** at Charles Drew University.

The program begins at 10:00AM. Resource Fair will be held 12:00PM-2:00PM

Let's come together to honor our stories, build strength, and uplift Black lives in the fight against HIV.

To nominate a community member for the Changemaker Award, click **HERE**.
If interested in tabling at the Resource Fair, click **HERE**

HOLLY J. MITCHELL
LOS ANGELES COUNTY SUPERVISOR ◆ 2ND DISTRICT

LOS ANGELES COUNTY COMMISSION ON HIV

CDU

Drew CARES
Charles R. Drew University of Medicine and Science

SAVE THE DATE

CONSUMER RESOURCE FAIR 2025

LOVE BEGINS WITH ME

Empowering Wellness, Advocacy, and Community Beyond HIV

Thursday, February 13, 2025
12:00PM - 5:00PM
The California Endowment

Join us for the 2025 Consumer Resource Fair, a holistic event focused on supporting the whole person beyond HIV.

Interested in participating as a vendor or service provider, hosting a workshop, tabling, or giving a presentation?
CLICK HERE TO SIGN-UP

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