LOS ANGELES COUNTY COMMISSION ON HIV
3530 Wilshire Boulevard, Suite 1140, Los Angeles, CA 90010 · TEL. (213) 738-2816 · FAX (213) 637-4748
WEBSITE: http://hiv.lacounty.gov EMAIL: hivcomm@lachiv.org

COMMISSION ON HIV MEETING

Thursday, February 8, 2018
9:00 AM - 12:30 PM

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

Los Angeles County Commission on HIV

VISION

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

MISSION

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

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

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GUIDELINES FOR CONDUCT

The Los Angeles County Commission on HIV has played an active role in shaping HIV services in this County and in the State for over a decade. The dedication to providing quality services to people with and at risk of HIV/AIDS by people who are members of this body, both past and present, is unparalleled.

In order to encourage the active participation of all members and to address the concerns of many Commissioners, consumers and other interested members of the community, it is important that meetings take place in a "safe" environment. A "safe" environment is one that recognizes differences, while striving for consensus and is characterized by consistent professional and respectful behavior. As a result, the Commission has adopted and is consistently committed to implementing the following Guidelines for Conduct for Commission, committee and associated meetings.

Similar meeting ground rules have been developed and successfully used in large group processes to tackle difficult issues. Their intent is not to discourage meaningful dialogue, but to recognize that differences and even conflict can result in highly creative solutions to problems when approached in a respectful and professional manner.

The following should be adhered to by all participants and stakeholders:

1) Be on Time for Meetings
2) Stay for the Entire Meeting
3) Show Respect to Invited Guests, Speakers and Presenters
4) Listen
5) Don't Interrupt
6) Focus on Issues, Not People
7) Don't just Disagree, Offer Alternatives
8) Give Respectful, Constructive Feedback
9) Don't Judge
10) Respect Others' Opinions
11) Keep an Open Mind to Others' Opinions
12) Allow Others to Speak
13) Respect Others' Time
14) Begin and End on Time
15) Have All the Issues on the Table and No "Hidden Agendas"
16) Minimize Side Conversations
17) Don't Monopolize the Discussion
18) Don't Repeat What Has Already Been Said
19) If Beepers or Cell Phones Must Be On, Keep Them on Silent or Vibrate

Approved (11/12/1998); Revised (2/10/2005; 9/6/2005)

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1. APPROVAL OF THE AGENDA:

A. Agenda
B. Membership Roster
C. Committee Assignments
D. Commission Member Conflict of Interest
E. Geographic Maps
F. February 2018 - May 2018 Meeting Calendars

REVISED

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

THURSDAY, FEBRUARY 8, 2018, 9:00 A.M. – 12:30 P.M.

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

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

AGENDA POSTED: February 1, 2018 (Revision Posted 2/5/18)

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

ACCOMMODATIONS: Interpretation services for the hearing impaired and translation services for languages other than English are available free of charge with at least 5 business days' notice before the meeting date. To arrange for these services, please contact Dina Jauregui at (213) 738-2816 or via email at djauregui@lachiv.org.

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

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

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

If a stakeholder is interested in joining the meeting to keep abreast of or participate in consideration of a specific agenda item, the Commission suggests that the stakeholder plan on attending the full meeting in case the agenda order is modified or timing of the items is altered. All Commission committees make every effort to place items that they are aware involve external stakeholders at the top of the agenda in order to address and resolve those issues more quickly and release visiting participants from the obligation of staying for the full meeting.

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

	Call to Order and Roll Call		9:00 A.M. – 9:03 A.M.
	I. ADMINISTRATIVE MATTERS		
1.	Approval of Agenda	**MOTION #1**	9:03 A.M. – 9:04 A.M.
2.	Approval of Meeting Minutes	**MOTION #2**	9:04 A.M. – 9:06 A.M.
3.	Consent Calendar	**MOTION #3**	9:06 A.M. – 9:07 A.M.
	II. REPORTS		
4.	Executive Director's Report A. James Stewart: Recognition of Service B. HRSA Site Visit		9:07 A.M. – 9:15 A.M.
5.	Co-Chair's Report A. At-Large Member Open Nominations B. Membership Opportunities		9:15 A.M. – 9:25 A.M.
6.	Housing Opportunities for People Living with HIV/AIDS (HOPWA) Report		9:25 A.M. – 9:30 A.M.
	III. DISCUSSION		9:30 A.M. – 10:45 A.M.
7.	**Los Angeles County HIV/AIDS Strategy: Community Engagement Opportunities for the Commission on HIV** Purpose: To continue discussion on the best role for the Commission in implementing the LACHAS; gain common understanding of the LACHAS goals and health districts. A. City of West Hollywood HIV Zero Strategic Plan B. County of Los Angeles Health Districts C. Lessons Learned | Q&A		
	IV. BREAK		10:45 A.M. – 10:55 A.M.

V. REPORTS

8. Vaccine Preventable Disease Control Program — 10:55 A.M. – 11:00 A.M.
LA County Department of Public Health

9. Division of HIV/STD Programs (DHSP) Report — 11:00 A.M. – 11:15 A.M.
LA County Department of Public Health

10. California Office of AIDS (OA) Report — 11:15 A.M. – 11:25 A.M.

11. Standing Committee Reports**:** — 11:25 A.M. – 12:00 P.M.

A. Public Policy Committee
   1. Healthcare Access Update
   2. Federal, State and County Legislation/Policy

B. Standards and Best Practices (SBP) Committee
   1. Updated Housing Standards **MOTION #4**
   2. Prevention Standards
   3. Legal Services and Medical Care Coordination (MCC) Standards

C. Operations Committee
   1. Membership Management
   2. Community Advisory Board Outreach
   3. Assessment of Administrative Mechanism (AAM) Overview and Project Update

D. Planning, Priorities and Allocations (PP&A) Committee
   1. Ryan White Program Year 27 Expenditure Projections
   2. Minority AIDS Initiative (MAI) Plan and Directives Review

12. Caucus, Task Force and Work Group Reports — 12:00 P.M. – 12:05 P.M.

13. City/Health District Reports — 12:05 P.M. – 12:10 P.M.

14. SPA/District Reports — 12:10 P.M. – 12:12 P.M.

15. AIDS Education/Training Centers (AETCs) — 12:12 P.M. – 12:14 P.M.

VI. PUBLIC COMMENT — 12:14 P.M. – 12:20 P.M.

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

VII. COMMISSION COMMENT — 12:20 P.M. – 12:26 P.M.

17. Non-Agendized or Follow-Up

VIII. ANNOUNCEMENTS — 12:26 P.M. – 12:28 P.M.

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

IX. ADJOURNMENT AND ROLL CALL — 12:28 P.M.– 12:30 P.M.

19. Adjournment for the meeting of February 8, 2018.

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

CONSENT CALENDAR:	
MOTION #4:	Approve the Housing Standards, as presented.

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

Commission on HIV Members:			
Ricky Rosales, Co-Chair	Grissel Granados, MSW, Co-Chair	Majel Arnold, MA-HSA	Traci Bivens-Davis
Al Ballesteros, MBA	Jason Brown	Joseph Cadden, MD	Danielle Campbell, MPH
Raquel Cataldo	Deborah Owens Collins, PA, MSPAS, AAHIVS	David Cunningham (Alternate)	Michele Daniels
Kevin Donnelly	Susan Forrest (Alternate)	Aaron Fox, MPM	Marcos Garcilazo (Alternate)
Jerry D. Gates, PhD	Joseph Green	Terry Goddard II, MA	Bridget Gordon
William King, MD	Lee Kochems, MA	Bradley Land	David P. Lee, MPH, LCSW (Alternate)
Eric Paul Leue	Abad Lopez	Andrew Lopez (Alternate)	Eduardo Martinez (Alternate)
Miguel Martinez, MSW, MPH	Anthony Mills, MD	José Munoz	Katja Nelson
Derek Murray	Frankie Darling-Palacios	Raphael Péna	Mario Pérez MPH
Juan Preciado	Thomas Puckett, Jr.	Ace Robinson, MPH	Rebecca Ronquillo
Martin Sattah, MD	LaShonda Spencer, MD	Kevin Stalter	Yolanda Sumpter
Greg Wilson	Russell Ybarra		
MEMBERS:	**44**		
QUORUM:	**23**		

COMMISSION ON HIV MEMBERSHIP SLATE

APPROVED BY COH ON 07/13/2017 | **FEBRUARY 8, 2018**

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

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

= Vacant

S:\Committee - Operations\Membership\Membership Roster\2018\Membership Roster - 020818

LOS ANGELES COUNTY COMMISSION ON HIV

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COMMITTEE ASSIGNMENTS

(Updated 2/7/18)

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

EXECUTIVE COMMITTEE

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

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

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

OPERATIONS COMMITTEE

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

Number of Voting Members: **9** ***Number of Quorum***: **5**

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

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

PLANNING, PRIORITIES and ALLOCATIONS (PP&A) COMMITTEE

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

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

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

PUBLIC POLICY COMMITTEE

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

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

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

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

STANDARDS AND BEST PRACTICES (SBP) COMMITTEE

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

Number of Voting Members: **7** ***Number of Quorum***: **4**

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

CONSUMER CAUCUS

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

Open Membership

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

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

WOMEN'S CAUCUS		
3rd Wednesday of the month	Regular meeting time:	10:00am-12:00pm
Open Membership		
Bridget Gordon	**Co-Chair**	Commissioner
Yolanda Salinas	**Co-Chair**	Commissioner

TRANSGENDER TASK FORCE		
3rd Monday of the month	Regular meeting time:	10:00am-12:00pm
Open Membership		
Destin Cortez	**Co-Chair**	Community Member
Michelle Enfield	Member	Community
Susan Forrest	Member	Commissioner
Jaden Fields	Member	Community
Kimberly Kisler, PhD	Member	Community
Maria Roman	Member	Community

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COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

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

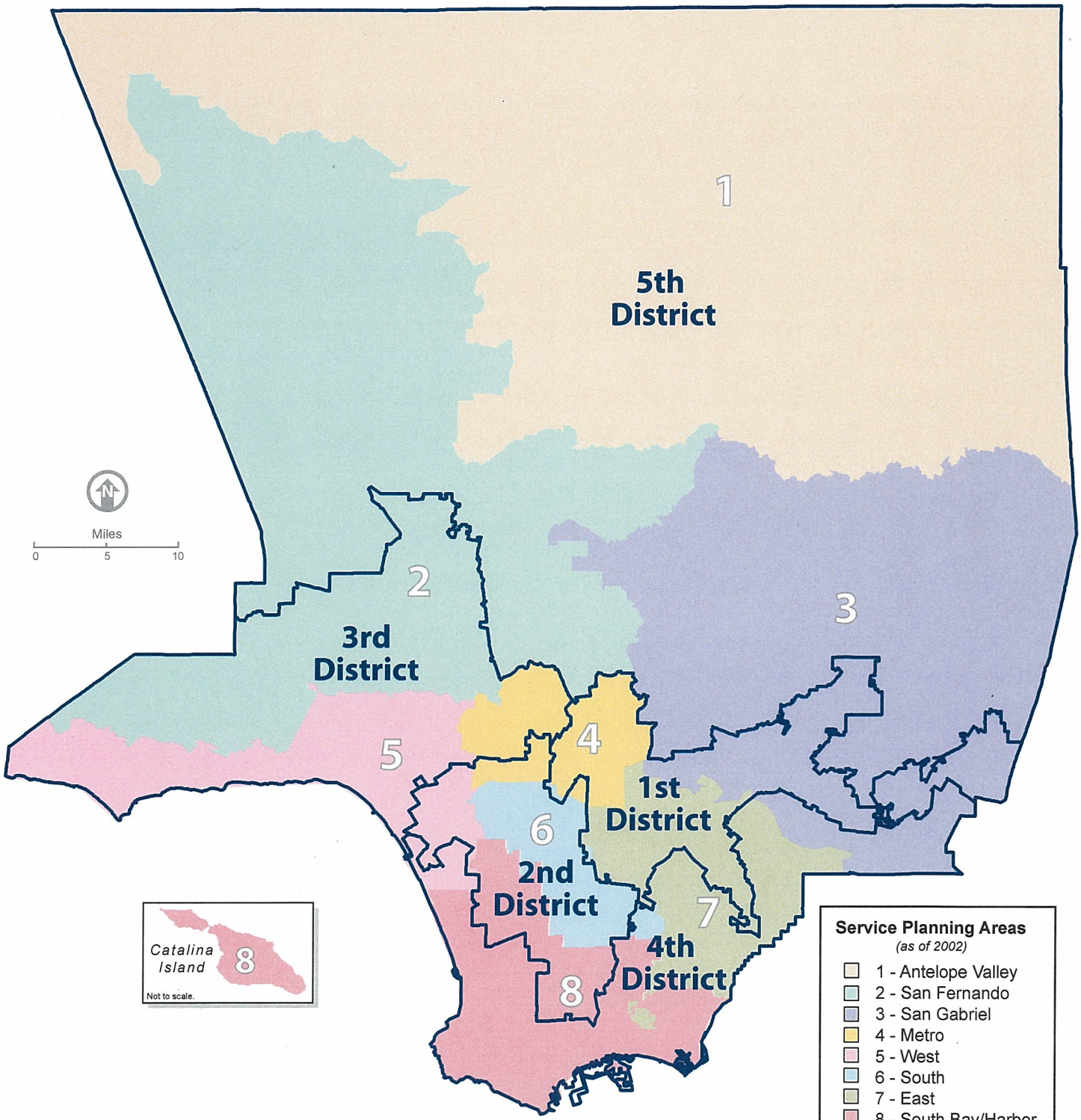
COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
ARNOLD	**Majel**	California State Office of AIDS	No Ryan White or prevention contracts
BROWN	**Jason**	Unaffiliated consumer	No Ryan White or prevention contracts
BALLESTEROS	**Al**	JWCH, INC.	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty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

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

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

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

Los Angeles County Service Planning Areas by Supervisorial District



Service Planning Areas
(as of 2002)

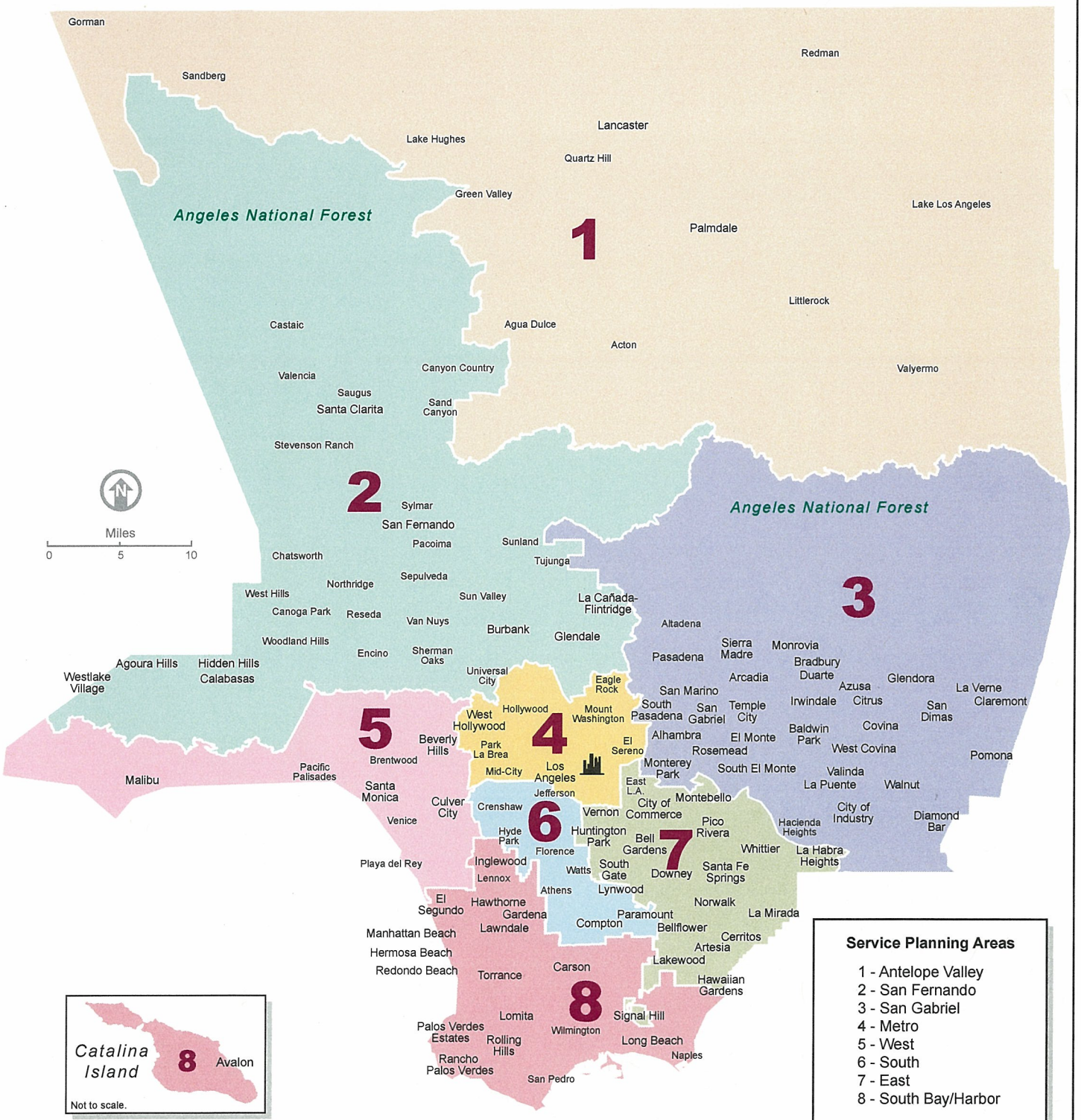
- 1 - Antelope Valley
- 2 - San Fernando
- 3 - San Gabriel
- 4 - Metro
- 5 - West
- 6 - South
- 7 - East
- 8 - South Bay/Harbor

American Indian Children's Council covers all SPAs

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

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

Los Angeles County
Service Planning Areas



Service Planning Areas

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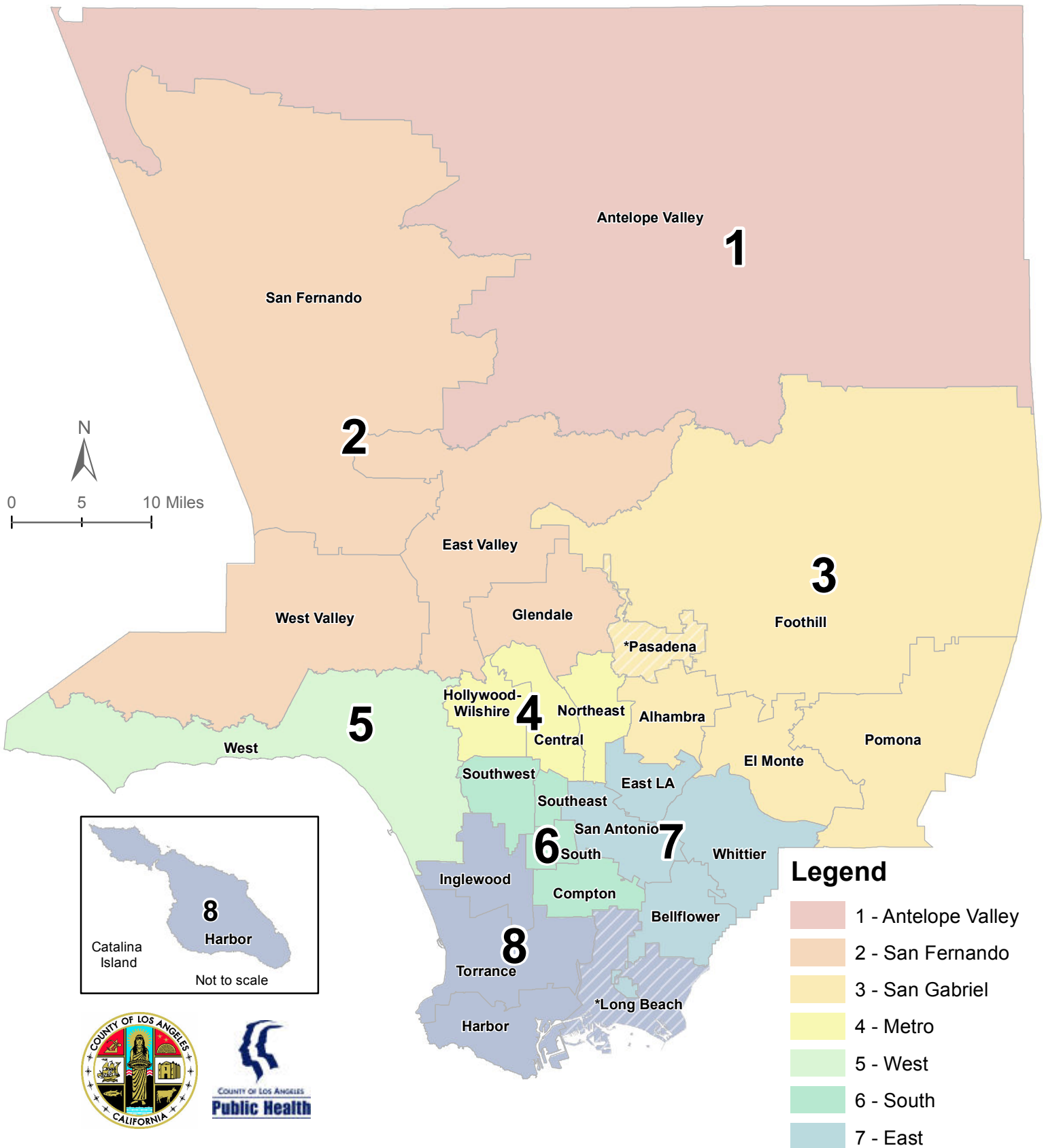
American Indian Children's Council covers all SPAs

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

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

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

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



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

HIV Calendar

February 2018

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

HIV Calendar

March 2018

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

HIV Calendar

April 2018

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1 Week 14	**2** 1:00 PM - 3:00 PM Public Policy Committee	**3** 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 3:00 PM CHP | Goals & Objectives Workgroup	**4** 9:30 AM - 11:30 AM BOS Agenda Review	**5** 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	**6**	**7**
8 Week 15	**9**	**10** 9:30 AM - 1:00 PM Board of Supervisors (BOS)	**11** 9:30 AM - 11:30 AM BOS Agenda Review	**12** 9:00 AM - 1:00 PM Commission Meeting	**13**	**14**
15 Week 16	**16**	**17** 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 3:00 PM Planning, Priorities & Allocations (PP&A)	**18** 9:30 AM - 11:30 AM BOS Agenda Review	**19** 1:00 PM - 3:00 PM Planning Council Refresher & Committee Spotlight	**20**	**21**
22 Week 17	**23**	**24** 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 3:00 PM STD & HIV 101	**25** 9:30 AM - 11:30 AM BOS Agenda Review 10:00 AM - 12:00 PM Housing Taskforce Meeting	**26** 10:00 AM - 12:00 PM Operations Committee Meeting 1:00 PM - 3:00 PM Executive Committee Meeting	**27**	**28**
29 Week 18	**30**	1 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 3:00 PM CHP | Goals & Objectives Workgroup	2 9:30 AM - 11:30 AM BOS Agenda Review	3 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	4	5

HIV Calendar

May 2018

Sun	Mon	Tue	Wed	Thu	Fri	Sat
29 Week 18	30	**1** 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 3:00 PM CHP | Goals & Objectives Workgroup	**2** 9:30 AM - 11:30 AM BOS Agenda Review	**3** 10:00 AM - 12:00 PM Standards & Best Practices (SBP)	**4**	**5**
6 Week 19	**7** 1:00 PM - 3:00 PM Public Policy Committee	**8** 9:30 AM - 1:00 PM Board of Supervisors (BOS)	**9** 9:30 AM - 11:30 AM BOS Agenda Review	**10** 9:00 AM - 1:00 PM Commission Meeting	**11**	**12**
13 Week 20	**14**	**15** 9:30 AM - 1:00 PM Board of Supervisors (BOS) 1:00 PM - 3:00 PM Planning, Priorities & Allocations (PP&A)	**16** 9:30 AM - 11:30 AM BOS Agenda Review	**17**	**18**	**19**
20 Week 21	**21**	**22** 9:30 AM - 1:00 PM Board of Supervisors (BOS)	**23** 9:30 AM - 11:30 AM BOS Agenda Review	**24** 10:00 AM - 12:00 PM Operations Committee Meeting 1:00 PM - 3:00 PM Executive Committee Meeting	**25**	**26**
27 Week 22	**28**	**29** 9:30 AM - 1:00 PM Board of Supervisors (BOS)	**30** 9:30 AM - 11:30 AM BOS Agenda Review	**31**	1	2

LOS ANGELES COUNTY COMMISSION ON HIV
3530 Wilshire Boulevard, Suite 1140, Los Angeles, CA 90010 · TEL. (213) 738-2816 · FAX (213) 637-4748
WEBSITE: http://hiv.lacounty.gov EMAIL: hivcomm@lachiv.org

2. APPROVAL OF THE MEETING MINUTES:

A. January 11, 2018 Meeting Minutes

DRAFT OF MINUTES ARE REMOVED FOR WEBSITE PUBLISHING UNTIL APPROVED BY THE FULL COMMISSION MEETING ON 02/08/2018.

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5. CO-CHAIRS' REPORT:

A. At-Large Member Duty Statement

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DUTY STATEMENT

UNAFFILIATED CONSUMER, AT-LARGE MEMBER

(APPROVED 3-28-17)

In order to be an effective, active member of the Commission on HIV, an individual must meet the following demands of Commission membership and constituency representation:

RESPONSIBILITY/ACCOUNTABILITY:

General:

① Knowledge of the particular HIV/AIDS community, constituency and/or body that you are representing;
② A commitment to continually and consistently inform those bodies you represent of Commission and Commission-related activities and information.
③ Provide a data-driven perspective of consumers on matters before the Commission regardless of your personal viewpoint.
④ Cast your vote in a manner that is best for Los Angeles County regardless of your personal opinion.

Specific:

① Must be diagnosed with HIV/AIDS, a Ryan White Program service consumer, and not be affiliated (on the board, employed by, consulting with) with a Ryan White Program (RWP) Part A-funded agency
② Although assigned to a primary Committee, participates in other Committees, Caucuses, Task Forces, Work Groups and activities as necessary to provide a voice and representation of an Unaffiliated Consumer to fill critical roles in the Commission.
③ Advocate on behalf of people living with and at risk of HIV/AIDS and the organizations serving them.

PARTICIPATION:

General:

① Willingness to fill a full two-year Commission term.
② Each year of the two-year term, the Commissioner is expected to attend and participate in, at a minimum, these activities:
- Commission orientation and assorted trainings throughout the year;
- Board of Supervisors Executive Office orientation;
- Monthly Commission meetings;
- Assigned monthly Committee meetings;
- One priority- and-allocation setting meeting;

- Commission annual meeting;
- Assorted voluntary workgroups, task forces and special meetings as required due to Committee assignment and for other Commission business.

③ A commitment to devote a minimum of ten hours per month to Commission/Committee attendance, preparation and other work as required by your membership on the body.

④ A pledge to:

- respect the view of other regardless of their race, ethnicity, sexual orientation, HIV status or other factors;
- abide by Robert's Rules of Order, the Ralph M. Brown Act, and the Commission's Code of Conduct;
- consider the view of others with an open mind;
- actively and regularly participate in the ongoing decision-making process; and
- support and promote decisions resolved and made by the Commission when representing the Commission.
- adhere to the Commission's Attendance Policy #08.3204

Specific:

① Help coordinate consumer participation in the Commission's needs assessment, service effectiveness and priority- and allocation-setting activities.

② Help identify consumers who can lend expertise and provide critical feedback to Commission activities, such as standards development, assessment, evaluation and planning activities.

③ Provide input and feedback regarding HIV/AIDS and STI prevention and care, needs and barriers, and provider challenges and best practices

④ Offers consumer perspective and feedback to policy, planning and other Commission-driven initiatives.

⑤ Represents consumer initiatives, ideas or topics or interest to the Commission and its committees and workgroups.

KNOWLEDGE:

General:

① A commitment to constantly develop, build and enhance knowledge about the following topics:

- General information about HIV/AIDS and STIs and its impact on the local community;
- LA County Comprehensive HIV Plan and Comprehensive HIV Continuum
- Commission's annual priority and allocation process; and
- CDC HIV Prevention and RWP information and other information related to funding and service support.

Specific:

① Comprehension of other consumers' interest, needs and challenges
② Ability to strategize with others in assessing the needs of the HIV/AIDS and STI community and how to best serve those needs through provider innovation

SKILLS/ATTRIBUTES:

① Sensitivity to the diversity of audiences and able to address varying needs at their levels
② Life and professional background reflecting a commitment to HIV/AIDS and STI-related issues
③ Ability to demonstrate parity, inclusion and representation
④ Multi-tasker, take-charge, "doer", action-oriented
⑤ Unintimidated by conflict/confrontation, but striving for consensus whenever possible
⑥ Capacity to attend to the Commission's business and operational side, as well as the policy and advocacy side
⑦ Strong focus on mentoring, leadership development and guidance
⑧ Firm, decisive and fair decision-making practices
⑨ Attuned to and understanding personal and others' potential conflicts of interest

COMMITMENT AND ACCOUNTABILITY TO THE OFFICE:

① Put personal agenda aside and advocate for what's in the best interest of the Commission
② Devote adequate time and availability to the Commission and its business
③ Assure that members' and stakeholders' rights are not abridged
④ Advocate strongly and consistently on behalf of Commission's and people living with and at risk for HIV, interests
⑤ Always consider the views of others with an open mind
⑥ Actively and regularly participate in and lead ongoing, transparent decision-making processes
⑦ Respect the views of other regardless of their race, ethnicity, sexual orientation, HIV status or other factors

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7. LOS ANGELES COUNTY HIV/AIDS STRATEGY: COMMUNITY ENGAGEMENT OPPORTUNITIES FOR THE COMMISSION ON HIV:

A. City of West Hollywood HIV Zero Strategic Plan

B. County of Los Angeles Health Districts

HIV Zero Initiative:

West Hollywood's Role in LA County's Strategy for 2020 and Beyond

Presented to: **Los Angeles County Commission on HIV**

February 8, 2018

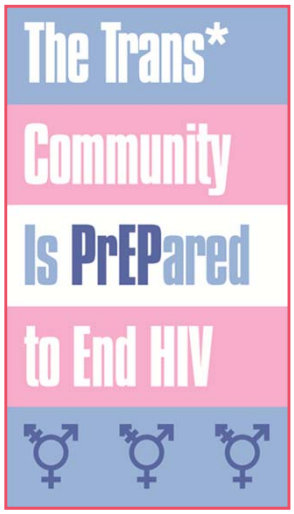
Aaron Celious, Ph.D.
Director, Research & Strategy
Maroon Society

Derek Murray
Social Services Program Administrator
City of West Hollywood

BACKGROUND

- West Hollywood and HIV history
- Funding commitment and social service contracts
- HIV Zero Strategic Plan

TIMELINE



3

METHODS

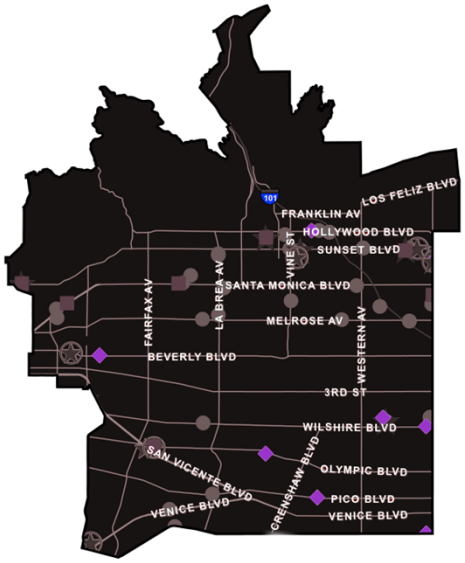
4

Hollywood-Wilshire Health District

Health District has Highest Rate of HIV in the County

City of West Hollywood has Highest Rate of HIV in the Health District

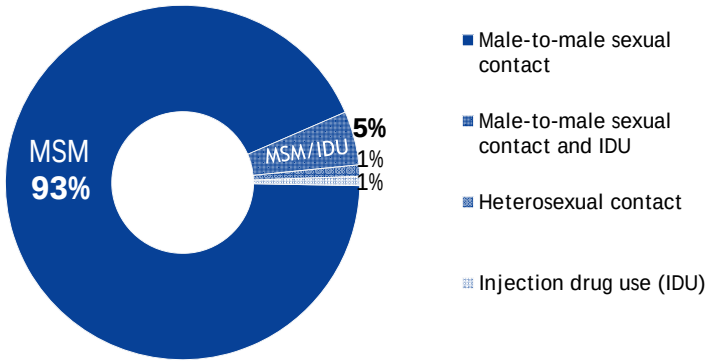
21% of PLWH in Health District live in West Hollywood



5

Transmission Modes

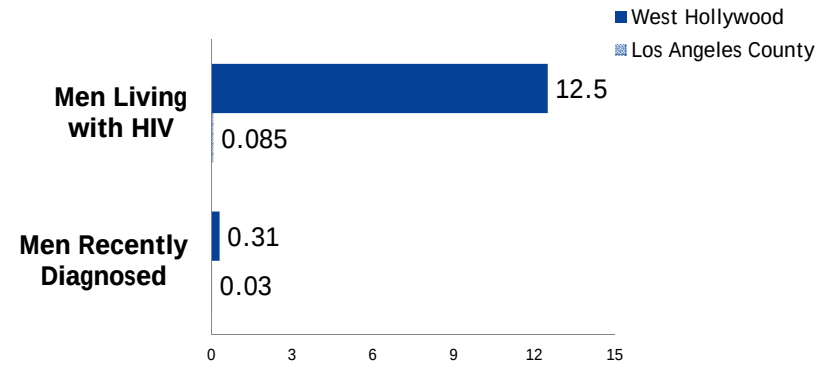
Persons living with HIV infection by transmission category, 2016 (N=2,481)



6

HIV Surveillance

Men Living with HIV & Recently Diagnosed (per 100), West Hollywood vs. Los Angeles County, 2016*

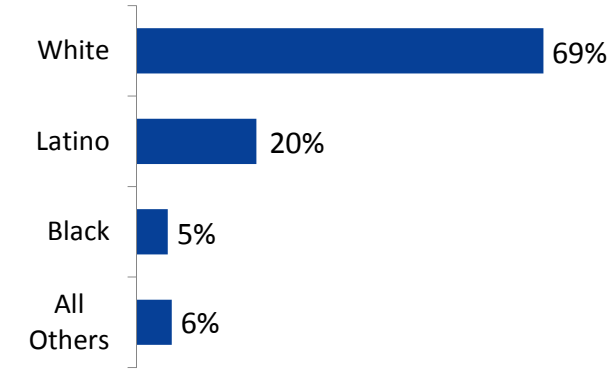


*In West Hollywood, Gay and Bisexual men account for 98% of diagnoses and PLWH.

7

Race/Ethnicity of PLWH

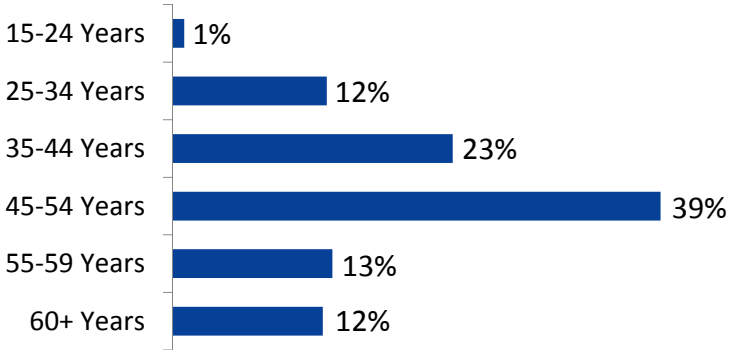
Persons living with HIV infection by race/ethnicity, 2015 (N=2,475)



8

Age of Persons Living with HIV

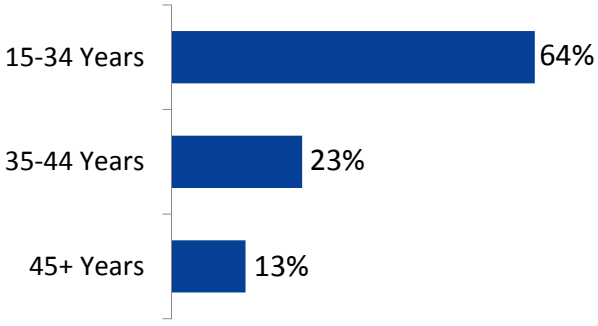
Persons living with HIV infection by Age, 2015 (N=2,475)



9

Age of New HIV Diagnoses

Diagnoses of HIV among males* by age, 2015 (N=61)



***The number of diagnoses among women is to small for DHSP to report by age.**

10

County Goals 2020 & Beyond

1. Reduce annual HIV Infections
2. Increase Proportion of PLWH who are Diagnosed
3. Increase Proportion of Diagnosed PLWH who are Virally Suppressed

West Hollywood Goals HIV Zero Initiative

1. Expand access to healthcare for PLWH and persons currently at an elevated risk
2. Reduce HIV infections
3. Reduce HIV related disparities & health inequalities
4. Slow disease progression from HIV to Stage 3 (AIDS)

11

Strategies

1. Healthcare Enrollment
2. Prevention Outreach and Education
3. Biomedical Interventions
4. Substance Abuse Treatment
5. Mental Healthcare
6. Testing and Linkage
7. Retention in Care
8. Build Inclusive Community Regardless of HIV Status
9. HIV Public Awareness

12

Program Targets

HIV Negative

1. Gay and Bisexual Men: especially younger men (15-34 years), men who are sexually active, and those with a history of sexually transmitted infections.

2. Women (including Transgender Women): especially those who are sexually active, low income, have a history of sexually transmitted infections and engage in sex work.

3. Use Meth (Methamphetamine): anyone who actively or occasionally uses.

4. Injection Drugs: anyone who actively or occasionally uses.

HIV Positive

5. Newly Diagnosed

6. Living with HIV But Not Linked to Care

7. Viral Load is Detectible

13

Indicators of Progress

1. Healthcare Coverage
2. HIV Diagnoses
3. Linkage to Care
4. Retention in Care
5. Viral Suppression
6. Stage 3 Diagnoses
7. Stigma

14

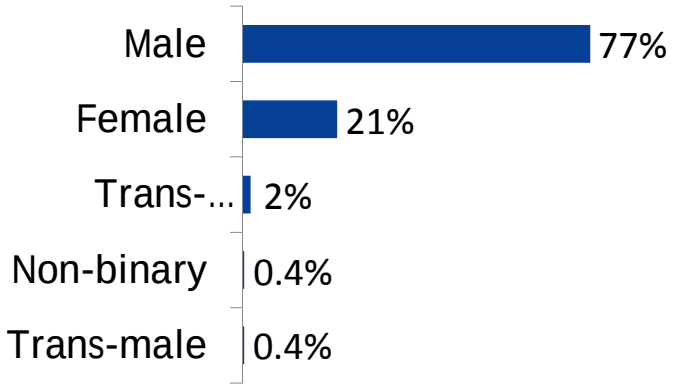
Core Social Services

- Health/Mental Health
- Nutrition
- HIV/AIDS
- Senior/Disability Services
- Substance Abuse
- Employment
- Homeless Services
- Youth Services
- Legal

15

Survey on Stigma

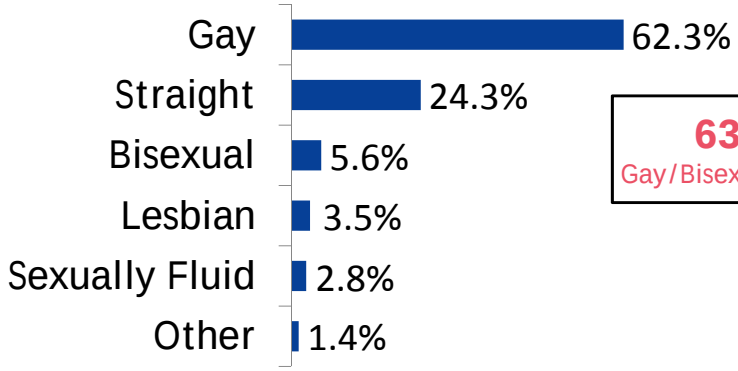
Gender Identity of Participants (N=286)



16

Survey on Stigma (cont.)

Sexual Identity of Participants (N=286)

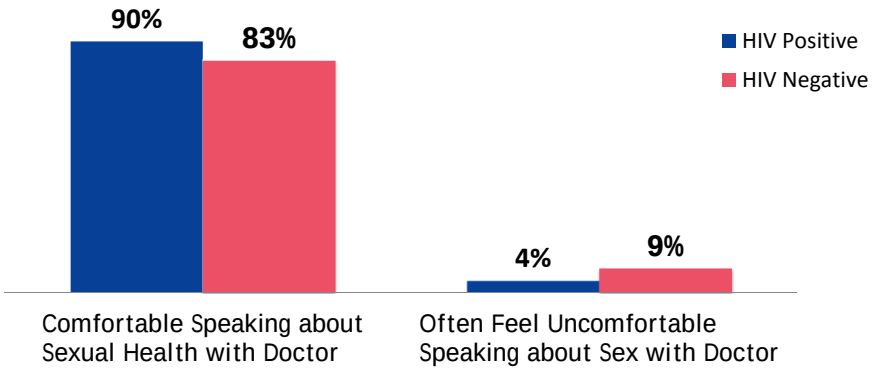


63%
Gay/Bisexual Male

17

Survey on Stigma

Comfort Speaking with Doctor
among Gay and Bisexual Men (n=176)



18

Survey on Stigma (cont.)

Experiences of Discrimination in Daily Life

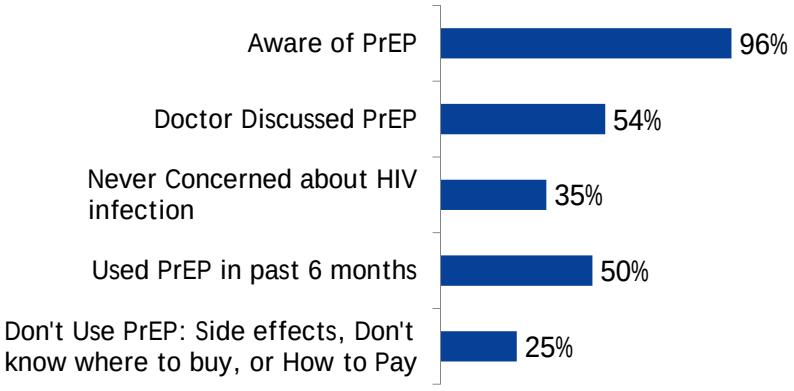
Sources of Discrimination	HIV Positive + Gay/Bisexual Men (N = 77)	%	HIV Negative - Gay/Bisexual Men (N = 101)	%
Sexual Identity	22	28.6%	21	20.8%
HIV Positive Status	27	35.1%	0	0.0%
Race/Ethnicity	6	7.8%	17	16.8%
Gender Identity	2	2.6%	0	0.0%
Role as bottom/receptive	8	10.4%	5	5.0%
Age	20	26.0%	15	14.9%
Body Type	15	19.5%	14	13.9%
No - Don't Experience it	27	35.1%	47	46.5%

19

Survey on Stigma (cont.)

PrEP Knowledge, Use & HIV Risk Assessment

among Young (17-34 years) HIV Negative Gay and Bisexual Men (n=24)



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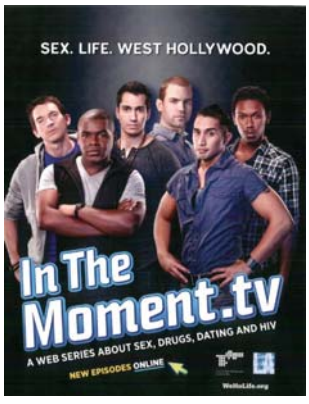
Challenges

1. Data Collection for service providers
2. Data Dissemination Schedule of DHSP
3. Communicating results to stakeholders

21

Questions



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LOS ANGELES HIV/AIDS STRATEGY: HEALTH DISTRICT OVERVIEW

Los Angeles County Commission on HIV

February 8, 2018

LA County HIV/AIDS Strategy (LACHAS) for 2020 and Beyond

"The success of the Strategy will require state, county, and city governments including associated commissions, councils, and boards; networks of persons living with HIV; community-based organizations; local health care and other HIV service organizations; education agencies; professional organizations; and other partners to work together to maximize efforts and better coordinate responses for HIV prevention and care."

LACHAS Goals by 2022

Reduce annual HIV infections to 500

- Increase access to Biomedical Prevention
- Increase workforce capacity of healthcare and CBOs
- Decrease syphilis and gonorrhea among groups at risk for HIV

Increase proportion of Persons Living with HIV who are diagnosed to at least 90%

- Normalize HIV testing
- Develop strategies to address health inequities

Increase viral suppression of PLWH to at least 90%

- Coordinated medical treatment including seamless testing, disclosure and linkage to care
- Support holistic treatment and programming focused on social determinants of health

LACHAS goals are aligned with:

- National HIV/AIDS Strategy
- 90-90-90
- Undetectable = Untransmittable (U=U) and Treatment as Prevention (TasP)
- Various local, State and regional efforts
- LA County Comprehensive HIV Plan

LACHAS Identified Roles

Government

- Enact legislation
- Share data
- Fight discrimination of people based on HIV status
- Address social determinants of health
- Engage with community

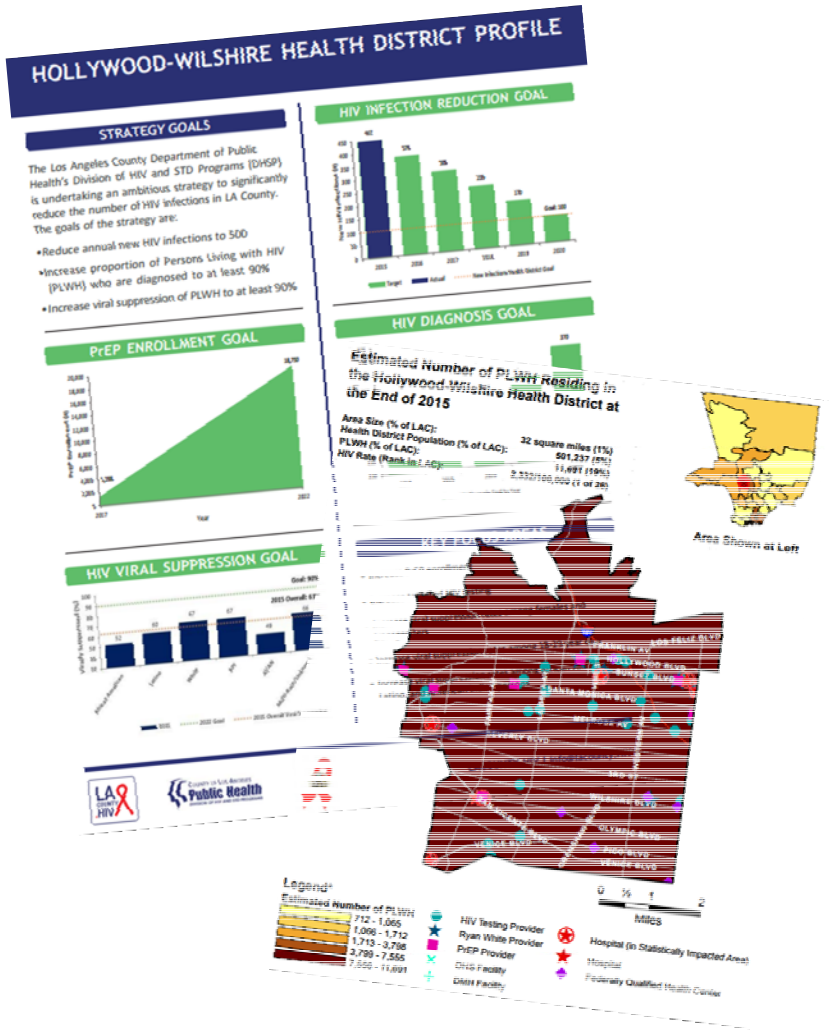
Healthcare

- Share data
- Adopt service standards and best practices
- Address disparities in accessing medical services
- Increase awareness of PrEP/PEP
- Strengthen integrated and patient centered HIV prevention & care

Community

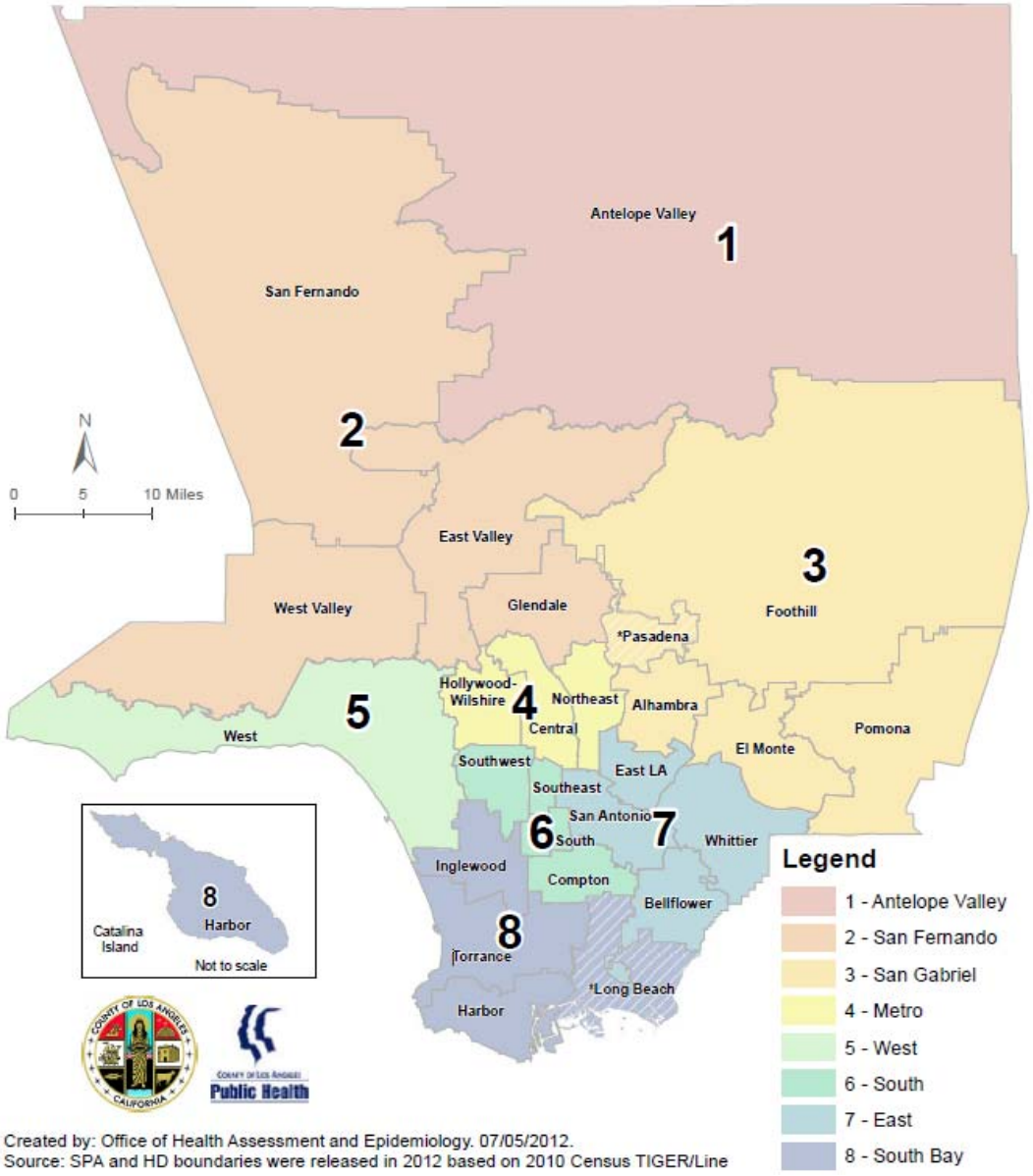
- Participate in community planning processes
- Develop partnerships including entities that can address the social determinants of health
- Promote PrEP
- Serve as watchdogs for discrimination
- Support employment opportunities
- Raise awareness about anti-discrimination policies

What are Health Districts?



- SPAs initially created to recognize health indicators vary across the County
- Health Districts (HDs) align with census tracts and subdivision of Service Planning Areas (SPAs)
- Used to collect population level data and plan health service delivery

Health Districts



Created by: Office of Health Assessment and Epidemiology. 07/05/2012.
Source: SPA and HD boundaries were released in 2012 based on 2010 Census TIGER/Line

Data Comparison: SPA vs HD

- LAC Health Survey collects data for health indicators by SPA and Health Districts
- LAC Health Survey data can be accessed via: http://www.publichealth.lacounty.gov/ha/LACHSDataTopics2015.htm
- Data presented at different geographic levels allows for more targeted story telling
- HDs and SPAs are analytical and planning tools

EXAMPLE: Percentage who reported that obtaining medical care when needed is somewhat or very difficult

SPAs

- Antelope Valley 28.0%
- San Fernando 21.6%
- San Gabriel 25.5%
- Metro 28.6%
- West 13.1%
- South 32.5%
- East 22.9%
- South Bay 19.1%

Health Districts

- Antelope Valley 28.0%
- East Valley 29.8%
- Glendale 12.3%
- San Fernando 17.9%
- West Valley 23.5%
- Alhambra 35.1%
- El Monte 31.4%
- Foothill 18.0%
- Pasadena 26.1%
- Pomona 19.1%
- Hwood-Wilshire 26.5%
- Central 31.2%
- Northeast 29.2%
- West 13.1%
- Southwest 31.2%
- Southeast 36.7%
- South 39.4%
- Compton 27.5%
- East LA 28.3%
- San Antonio 32.1%
- Whittier 13.8%
- Bellflower 18.1%
- Inglewood 19.7%
- Torrance 16.9%
- Harbor 9.4%
- Long Beach 24.9%

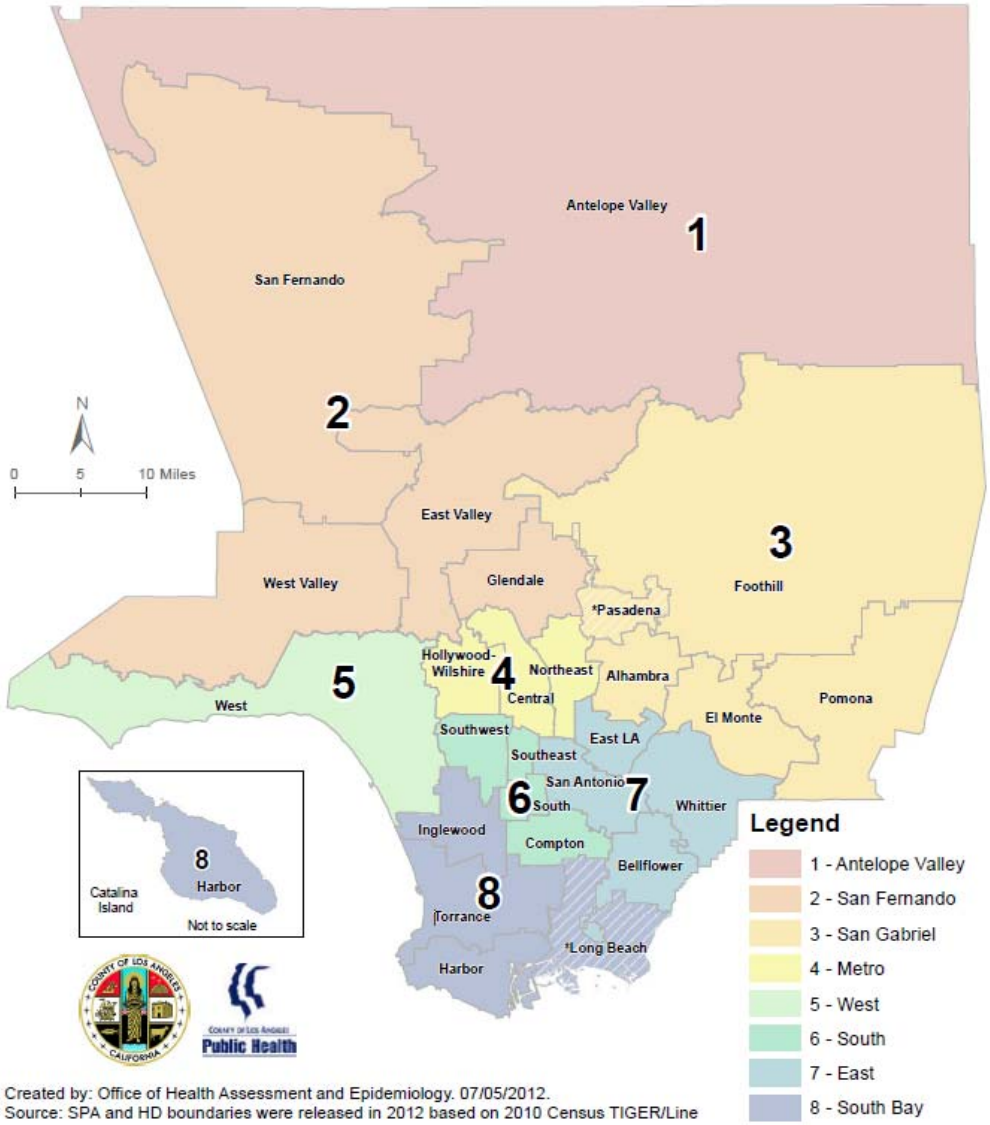
Source: LAC Health Survey, 2015

Highest HIV Rate

Top 5 HDs

1. Hollywood Wilshire
2. Central
3. Long Beach
4. Southwest
5. Northeast

*Rate per 100,000



Source: LACHAS, 2017

Health District Engagement

Learn about your HD - Review your District Profile!

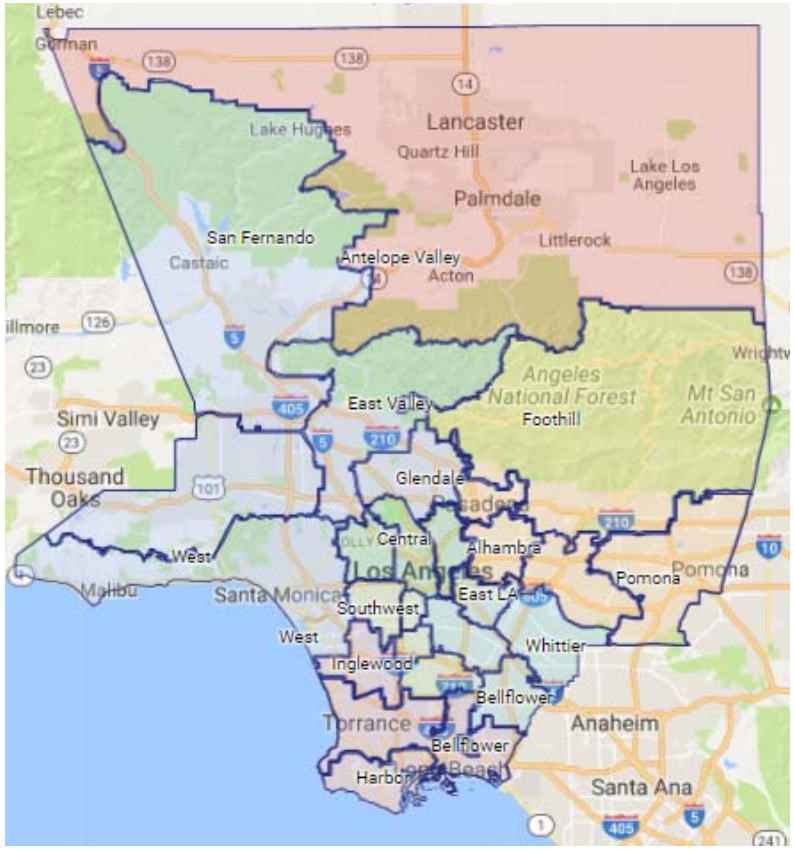
Identify key partners within HD

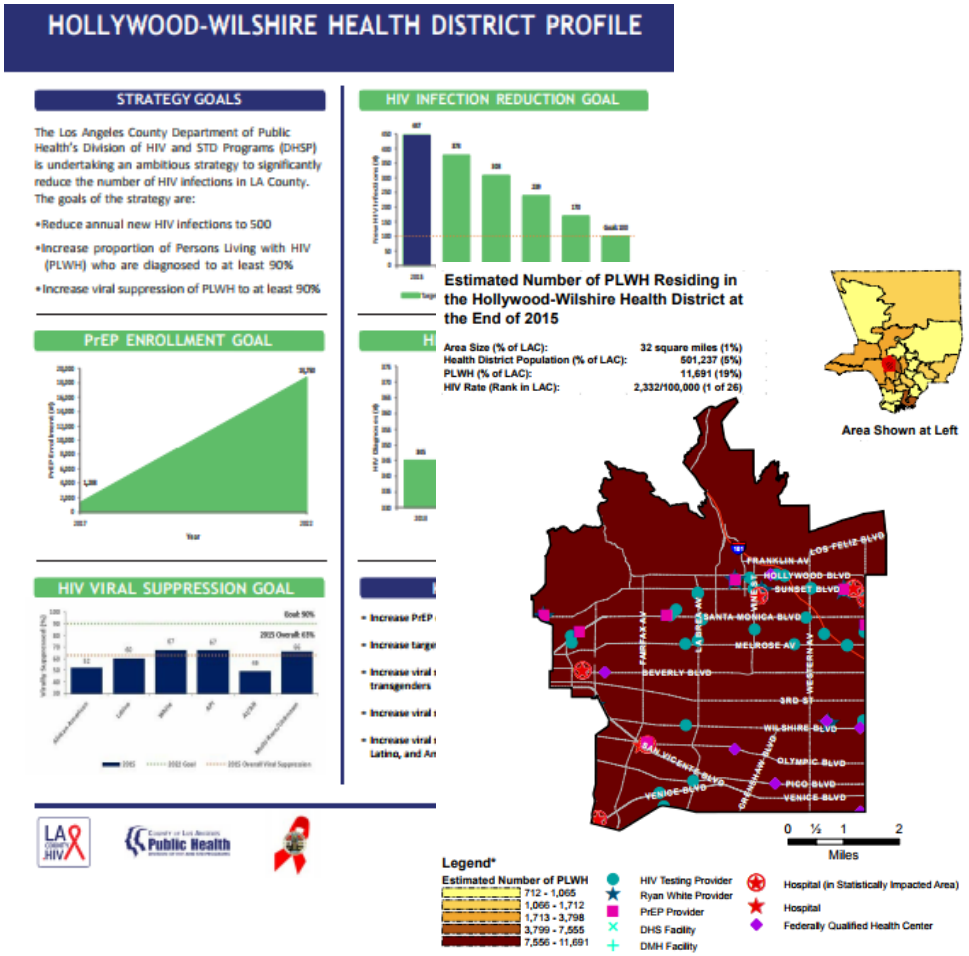
Build upon assets identified in HD profiles

Review *Recommendations for Community Engagement* from COH January Meeting Packet

Interactive Health District Map

https://tinyurl.com/HealthDdistricts





Health District Engagement

Key Activities

- Learn about your HDs
- Work with HD team
- Create information kit for meetings
- Attend community events
- Engage stakeholders
- Conduct presentations and one-on-one meetings

Potential Partners to Start

- DPH Area Health Offices
- Providers/Clinics
- Elected Officials
- Faith Based Organizations
- Neighborhood Councils
- Community Members

Next Steps

- Work towards full understanding of HDs and key stakeholders
- Develop talking points for Commissioners
- Organize Commissioners into HD teams

Join the movement in ending the HIV/AIDS epidemic in Los Angeles County, once and for all.

Visit www.LACounty.HIV

Julie Tolentino, MPH
Health Program Analyst
Email: jtolentino@lachiv.org
Commission website: http://hiv.lacounty.gov

LOS ANGELES COUNTY COMMISSION ON HIV

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http://hiv.lacounty.gov

Commissioners' Los Angeles County HIV/AIDS Strategy (LACHAS) Talking Points (DRAFT 2/8/18)

I. Introduction

My name is (INSERT NAME HERE) and I am a member of the Los Angeles County Commission on HIV representing (INSERT MEMBERSHIP SEAT HERE). I am here to talk about an important county-wide effort to significantly reduce the impact of HIV in our communities. I hope you will join me and our public health partner, the Division of HIV and STD Programs (DHSP) in supporting the Los Angeles County HIV/AIDS Strategy for 2020 and Beyond.

II. Why Now and Why We Must Act with Urgency

We have the tools to end the HIV/AIDS pandemic. As noted by Dr. Anthony Fauci, Director of the National Institute of Allergy and Infectious Diseases at the National Institutes of Health, in January 2016, "it is not that we lack the medical advances to and interventions to end the pandemic. It is that our proven tools have not been implemented adequately or uniformly."

Due to advances in medicine and science, we now have the following tools to end HIV:

- Highly effective anti-viral drugs
- Studies demonstrating that treating individuals with HIV sooner than later dramatically diminish the likelihood that they would transmit the virus to their sexual partners
- Pre-exposure prophylaxis (PrEP) for HIV-negative, at risk individuals—PrEP is now available in various community and public health clinics in the County.
- Post-exposure prophylaxis (PEP), which prevents seroconversion within 72 hours of exposure
- Expanded access to healthcare through the Affordable Care Act
- Expansion of Medical Care Coordination services throughout the County
- Improved and targeted HIV testing
- Better use of data to zoom in on locations of HIV transmission clusters and outbreaks
- Saturation of social media to spread prevention and treatment widely

But we have to work harder to provide these services and medical advances to all communities disproportionately affected by HIV.

Equally important, we have to address racism, stigma, homophobia, transphobia and the social determinants of health that hinder our success to end HIV.

III. Which Communities are Most Affected?

As of 2016 there were an estimated 60,946 persons living with HIV/AIDS in Los Angeles County, and of those individuals, 8,654 (14.1%) are undiagnosed.[1] In 2016, 1,881 HIV cases were newly diagnosed; 84% were men who have sex with men (MSM). The epidemic continues to be driven by sexual activity between males. HIV incidence is highest among MSM of color, young MMSM (YMSM) ages 18-29, and transgender persons.[2] The highest HIV & STD burden among health districts from 2010-2014 span across all supervisorial districts including the Hollywood-Wilshire, South, Southwest, Central, Southeast, Inglewood, Compton, Long Beach, Northeast, and East Valley.[3] (these are the top 10 health districts; out of 26)

IV. What is the Los Angeles County HIV/AIDS Strategy for 2020 and Beyond?

The Los Angeles County HIV/AIDS Strategy for 2020 and Beyond outlines key goals to help bring an end to the epidemic. It has 3 main goals:

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

Please go to lacounty.hiv to read the full Strategy and learn how you or your agency can help end HIV in Los Angeles County.

Share the link with people who are familiar and not familiar with HIV. I need your help in spreading the word.

V. How Can You Get Involved Now?

I ask that if you do not know your HIV status, to get tested. We will need to have 1,975,000 HIV tests in the next 5 years to diagnose all undiagnosed HIV infections in Los Angeles County. This action starts you and all of us. Get tested today and ask a friend to get tested. By doing so, you help normalize HIV testing.

Attend Commission on HIV meetings - visit http://hiv.lacounty.gov/ to find out about our meetings.

Visit the Division of HIV and STD Programs website - http://publichealth.lacounty.gov/dhsp/ to find out about HIV/STD services and data.

VI. Closing

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[1] County of Los Angeles Division of HIV and STD Programs. Los Angeles County HIV/AIDS Strategy for 2020 and Beyond. December 2017.

[2] Division of HIV and STD Programs, Los Angeles County Department of Public Health. Los Angeles County HIV/AIDS Strategy. http://publichealth.lacounty.gov/dhsp/Presentations/DPH_PRESENTATION_7.13.17_FINAL.pdf. July 2017.

[3] Division of HIV and STD Programs, Los Angeles County Department of Public Health. 2010-2014 HIV & STD Burden by Health District. http://public health.lacounty.gov/dhsp/Mapping.htm. Published May 2016. Accessed 11/2/17.

Thank for allowing me to speak about the LACHAS today and I hope you join us in this important and urgent county-wide effort to end HIV.

LOS ANGELES COUNTY COMMISSION ON HIV

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http://hiv.lacounty.gov

Los Angeles County HIV/AIDS Strategy (LACHAS) for 2020 and Beyond:
Recommendations for Community Engagement (Updated 2/6/18)

Charge to the Commission on HIV:

- Monitor and advise the Board of Supervisors on the implementation of the LACHAS
- Ensure frequent and intentional communication and collaboration between the COH and the Division of HIV and STD Programs (DHSP)
- In January 2018, DHSP and COH will convene planners and stakeholders to identify a process for engaging stakeholders at the Health District (HD) level

1. **Ensure the Commissioners fully understand the LACHAS, HD-level data and geographic boundaries. Start with a review of the HD profiles.**
   - Agendize regular discussion on LACHAS at COH and Committee/task forces and caucus meetings
   - Use colloquia topics to facilitate community dialogues key LACHAS goals and strategies
   - Use core guiding questions at COH meetings community outreach by COH members
     a. Who are the partners missing at the table? How do we secure their long-term commitment?
     b. What specific contributions do we want from each partner? Consider the strengths of each partner and target their contributions to a specific LACHAS goal or strategy.
     c. How do we reward, recognize and incentivize long-term contributions and commitment to the LACHAS?
     d. What are Commissioners learning, hearing, and seeing in the community that would contribute to our success (or forecast possible threats to success)
     e. Who are partners we can engage in addressing the social determinants of health that drive the HIV epidemic?
   - Align Committee activities around the implementation of the LACHAS. Start 2018 meetings with LACHAS discussion and selection of top 3 LACHAS-aligned activities.
   - Align priority setting and allocation process to achieve the LACHAS goals
   - Establish standing meetings with the DHSP and COH leadership to facilitate open communication and ongoing strategic thinking and re-shifting of efforts based on data and community feedback
   - Develop talking points targeted to various audiences for Commissioners on the LACHAS
   - Develop visuals, infographics and 1 page information sheet
   - Tell the whole story beyond HIV and add social determinants of health data in HD profiles
   - Show how people can participate in safe spaces and encourage ongoing community feedback and buy-in
   - Have a plan for what we do with the feedback we get

- Prioritize high yield activities and strategies (examples: target health plan, influence statewide and local policies, leverage funding, impact health systems)
- Provide public speaking training to Commissioners
- Develop different tools to understand different geographic areas and needs in the County.
- Develop cross-walk analysis between the LACHAS and Comprehensive HIV Plan

2. **Organize Commissioners into Health District Teams**
   - Assign Commissioners to Health Districts based on their COH seats, networks, relationships and knowledge of community strengths.
   - Develop talking points for Commissioners on the LACHAS
   - Increase accountability for all Commissioners by encouraging attendance at community meetings by their assigned Health Districts
   - Provide easy and multiple opportunities for reporting activities, successes, and opportunities for improvement
   - Assign Commissioner co-leads to ensure robust community engagement at the HD level
   - Schedule Health District level meetings for 2018 in partnership with DHSP. Consider holding COH meetings at HDs.

3. **Secure long-term support from the BOS and City-level elected officials**
   - Agree on key "asks" from the BOS. Examples of key "asks":
     i. Embrace LACHAS as a District priority
     ii. Support funding and partnership development with LAC cities and departments
   - Develop talking points for Commissioners on the LACHAS
   - Schedule BOS and City-level meeting with COH Co-Chairs and other Commissioners as strategically appropriate. Prioritize meetings with the BOS on January-February 2018
   - Consider a Mayor's Challenge to adopt and champion LACHAS at the HD level

4. **Recognize Commissioners for significant contributions to implementing the LACHAS and efforts to reduce HIV stigma and disparities.**
   - Establish recognition award at Annual Meeting; nominations from the community at large and the COH with specific requirements to be established by Commissioners.
   - Revise membership interview questions to assess understanding of LACHAS and commitment to achieving its goals
   - Revamp Commissioner membership renewal process and expectations around commitment to supporting the LACHAS implementation
   - Support Commissioners in developing personal goals and contributions to implementing the LACHAS

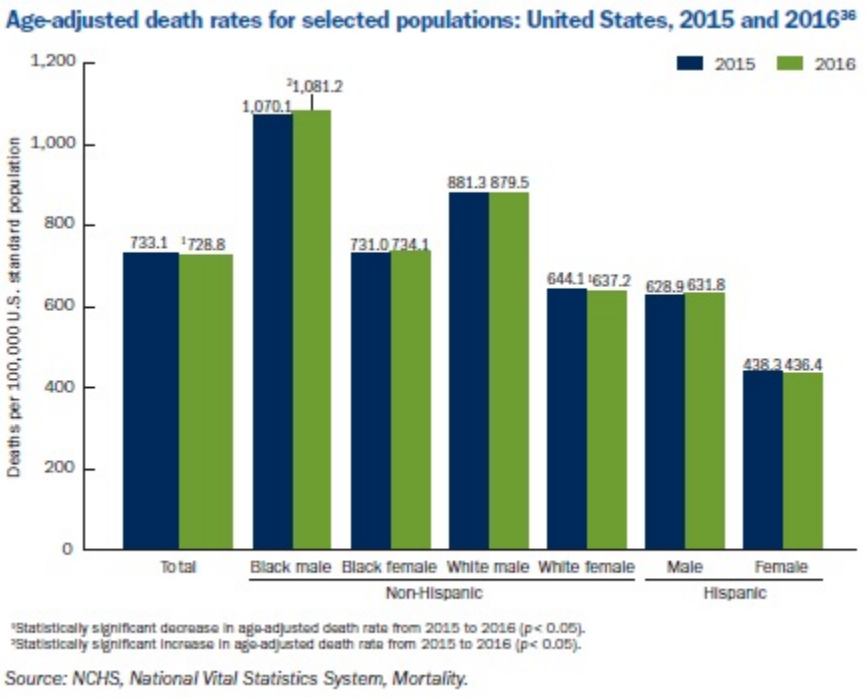
Racial Healing and Achieving Health Equity in the United States

January 16, 2018

Today, Trust for America's Health (TFAH) released *Racial Healing and Achieving Health Equity in the United States*, which highlights and acknowledges health inequities, the factors that influences them and highlights policy recommendations that can help the nation achieve health equity.

TFAH issued the brief in conjunction with The Truth, Racial Healing & Transformation's second annual National Day of Racial Healing, which is intended to identify key steps that will help take collective action to promote positive and lasting change across issues.

"As we mark the annual Martin Luther King Day, we are reminded he said that 'of all the forms of inequality, injustice in health care is the most shocking and inhumane'," said John Auerbach, president and CEO, TFAH. "TFAH is proud to be joining the National Day of Racial Healing to acknowledge health inequities in the country and to focus on building a pathway forward toward an equitable and socially just future."



TFAH has issued the following set of recommendation to help the nation to achieve health equity:

- **Create strategies to optimize the health of all Americans, regardless of race, ethnicity, income or where they live.** All levels of government must invest in analyzing needs and increasing effective policies and programs to address the systematic inequities that exist and the factors that contribute to these differences, including poverty, income, racism and environmental factors. Solutions should feature community-driven tactics, including using place-based approaches to target programs, policies and support effectively.

- **Expand cross-sector collaborations.** Improving equity in health will require supporting and expanding cross-sector efforts to make communities healthy and safe. Efforts should engage a wide range of partners, such as schools and businesses, to focus on improving health through better access to high-quality education, jobs, housing, transportation and economic opportunities.
- **Fully fund and implement health equity, health promotion and prevention programs in communities. And, partner with a diverse range of community members to develop and implement health improvement strategies.** Federal, state, local and tribal governments must engage communities in efforts to address both ongoing and critical health threats. The views, concerns and needs of community stakeholders, such as volunteer organizations, religious organizations and schools and universities, must be taken into account in this process. Proven, effective programs, such as the U.S. Centers for Disease Control and Prevention's REACH (Racial and Ethnic Approaches to Community Health) program should be fully-funded and expanded.
- **Collect data on health and related equity factors – including social determinants of health – by neighborhood.** There should be a priority on improving data collection at a very local level to understand connections between health status and the factors that impact health to help identify concerns and inform the development of strategies to address them.
- **Support Medicaid coverage and reimbursement of clinical-community programs to connect people to services that can help improve health.** Medicaid should reimburse efforts that support improved health beyond the doctor's office – for example asthma and diabetes prevention programs and other community-based initiatives can help address the root causes that contribute to inequities.
- **Communicate effectively with diverse community groups.** Federal, state, local and tribal officials must design culturally competent, inclusive and linguistically appropriate communication campaigns that use respected, trusted and culturally competent messengers to communicate their message. Communication channels should reflect the media habits of the target audience.
- **Prioritize resiliency in health emergency preparedness efforts.** Federal, state, local and tribal government officials must work with communities and make a concerted effort to address the needs of low-income, minority and other vulnerable groups during health emergencies. Public health leaders must develop and sustain relationships with trusted organizations and stakeholders in diverse communities on an ongoing basis—including working to improve the underlying health of at-risk individuals, sub-population groups and communities, so these relationships are in place before a disaster strikes. Communication and community engagement must be ongoing to understand the needs of various populations.
- **Eliminate racial and ethnic bias in healthcare.** Policies should incentivize equity and penalize unequal treatment in healthcare, and there should be increased support for programs to increase diversity in and across health professions. In addition, efforts should be increased to train more healthcare professionals from under-represented populations so that the workforce reflects the diversity of the patient population.
- **Incorporate strategies that foster community agency—or a community's collective ability and opportunity to make purposeful choices—into the design, implementation and governance of multi-sector collaborations**. Building community agency can contribute to improved community health by yielding a deeper understanding of the challenges and opportunities influencing a community, and relies on an asset-based approach to leverage existing community strengths and resources. Multi-sector collaborations should include dedicated resources for fostering and measuring community agency. Efforts should maximize and bolster community voice and power as a means to influencing larger policy- and systems-level changes (including those within and outside of the traditional health sector).

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11. STANDING COMMITTEE REPORTS:

A. PUBLIC POLICY COMMITTEE:

1. Healthcare Access Update

B. STANDARDS AND BEST PRACTICES (SBP) COMMITTEE:

1. Updated Housing Standards

C. OPERATIONS COMMITTEE:

1. Membership Management:
   a. Commissioner Training Schedules
3. Assessment of the Administration Mechanism (AAM) Overview and Project Update

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

1. Ryan White Program Year 27 Expenditure Projections

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11. STANDING COMMITTEE REPORTS (cont'd):

A. PUBLIC POLICY COMMITTEE:

1. Healthcare Access Update

THE HENRY J. KAISER FAMILY FOUNDATION

Filling the need for trusted information on national health issues...

February 2018 | Fact Sheet

How Are Health Centers Responding to the Funding Delay?

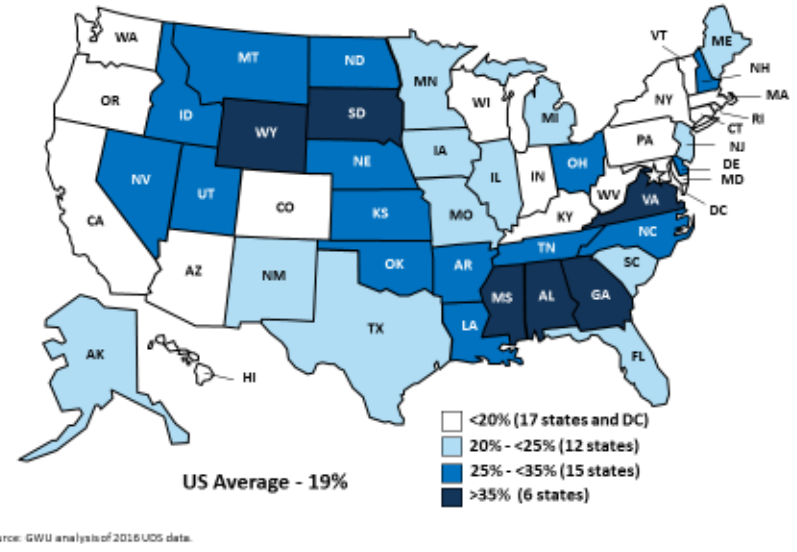
Health centers play an important role in our health care system, providing comprehensive primary care services as well as dental, mental health, and addiction treatment services to over 25 million patients in medically underserved rural and urban areas throughout the country. Health care anchors in their communities and on the front lines of health care crises, including the opioid epidemic and the current flu outbreak, health centers rely on federal grant funds to support the care they provide, particularly to patients who lack insurance coverage. However, the Community Health Center Fund (CHCF), a key source of funding for community health centers, expired on September 30, 2017, and has since been extended through only March 31, 2018. The CHCF provides 70% of grant funding to health centers. With these funds at risk, health centers have taken or are considering taking a number of actions that will affect their capacity to provide care to their patients. This fact sheet presents preliminary findings on how health centers are responding to the funding uncertainty.

What Funding Is at Stake for Health Centers

The Community Health Center Fund represents 70% of federal grant funding for health centers. Established by the Affordable Care Act, the CHCF increased federal grant fund support for health centers, growing from $1 billion in 2011 to $3.6 billion in 2017.[1] Authorized for five years beginning in 2010, and extended for two years through September 2017, the CHCF also provided a more stable source of grant funding for health centers that was separate from the annual appropriations process. Prior to the CHCF, federal 330 grant funds were appropriated annually. In fiscal year 2017, federal section 330 grant funding totaled $5.1 billion, $3.6 billion from the CHCF and $1.5 billion from the annual appropriation.

Figure 1

Federal Section 330 Grants as a Share of Total Health Center Revenues, 2016



Source: GWU analysis of 2016 UDS data.

Federal health center grants represent nearly one-fifth of health center revenues. Federal Section 330 grant funds are the second largest source of revenues for health centers behind revenues from Medicaid. Overall, 19% of health center revenues (including US territories) come from federal grants;

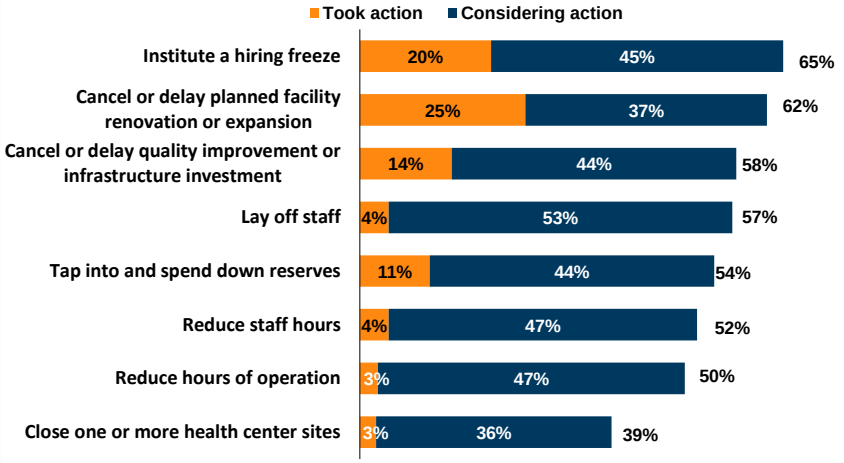
however, reliance on 330 grant funds varies across health centers. Federal grant funds are especially important for health centers in southern and rural non-expansion states where Medicaid accounts for a smaller share of revenue (Figure 1).[2] These funds finance care for uninsured patients and support vital services, such as transportation and case management, that are not typically covered by insurance

How Are Health Centers Responding to the Loss of Federal Funds?

Health centers have taken or are considering taking a number of actions that will affect their ability to serve their patients. Overall, seven in ten responding health centers indicated they had taken or planned to take action to put off large expenditures or curtail expenses in face of reduced revenue. Some of these actions involve delaying or canceling capital projects and other investments or tapping into reserve funds. Other actions, however, have or will reduce the number of staff or the hours they work, which may in turn, affect the availability of services. Already 20% of health centers reported instituting a hiring freeze and 4% have laid off staff. Another 45% are considering a hiring freeze and 53% said they might lay off staff. While health centers seemed to focus on shorter-term actions that could easily be reversed were funding to be restored, 3% of responding health centers had already taken steps to close one or more sites and an additional 36% indicated they are considering doing so (Figure 2).

Figure 2

Actions Taken or Considered by Health Centers in Response to Funding Uncertainty

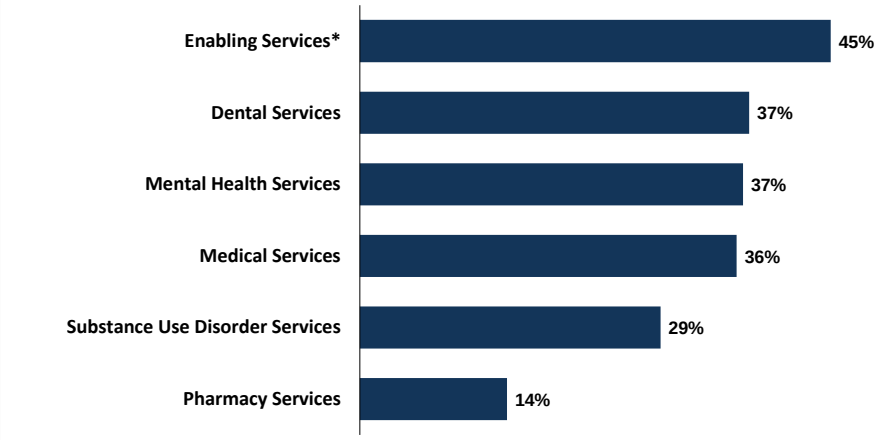


SOURCE: Preliminary data as of January 30, 2018 from the 2018 Survey of Community Health Centers conducted by George Washington University.

Health centers are considering cuts to patient services. While most health centers have not yet taken steps to cut or reduce patient care services, many reported they are weighing such actions if funding is not restored (Figure 3). Over four in ten indicated they might eliminate or reduce some enabling services, such as case management, translation, or transportation services. Additionally, over a third of reporting health centers indicated they might have to

Figure 3

Services Health Centers Are Considering Eliminating or Reducing in Response to Funding Uncertainty



*Enabling services are non-clinical services, such as case management, transportation, education, and translation services.
SOURCE: Preliminary data as of January 30, 2018 from the 2018 Survey of Community Health Centers conducted by George Washington University.

reduce the dental, medical, and/or mental health services they provide while 29% said cuts to addiction treatment services are being contemplated. Fewer health centers reported that cuts to pharmacy services might be made.

What Are the Implications of the Funding Delay?

Continued delays in restoring funding will likely lead to cuts in health center services and staff. To date, health centers have tried to mitigate the effects of the funding delay by forgoing major investments or dipping into reserve funds. However, the longer the funding delay continues, the greater the likelihood health centers will be compelled to cut services and staff, actions they are currently considering but have not yet adopted in large numbers. These cuts could reverse gains health centers have made in recent years in increasing patient care capacity and expanding the range of services they provide, particularly in the areas of mental health and addiction treatment. Health centers play a particularly important role in rural and medically underserved areas. The failure to reauthorize the CHCF and restore health center funding could jeopardize access to care for millions of vulnerable patients.

This analysis is based on preliminary data from the 2018 Survey of Community Health Centers designed by George Washington University's Geiger Gibson/RCHN Community Health Foundation Research Collaborative and the Kaiser Family Foundation.

Appendix Table 1: Health Center Delivery Sites, Patients, and Revenues, by State, 2016						
State	Number of Health Centers	Number of Delivery Sites	Total Patients	Total Patient Visits	Total Revenues	Federal BHPC Funding as Share of Total Revenues
Alabama	14	128	347,694	1,084,685	$173,627,218	44%
Alaska*	28	183	113,027	545,430	$316,966,135	20%
Arizona*	21	159	548,487	2,080,644	$506,266,156	16%
Arkansas*	12	120	195,397	721,288	$157,423,550	30%
California*	176	1,529	4,438,827	20,078,878	$4,922,877,855	12%
Colorado*	20	202	594,959	2,446,065	$571,663,876	17%
Connecticut*	16	250	373,182	1,943,325	$376,031,580	14%
Delaware*	3	15	49,900	171,842	$37,114,507	35%
District of Columbia*	8	60	178,324	874,310	$239,842,150	10%
Florida	48	535	1,397,966	5,276,142	$1,033,408,471	21%
Georgia	35	225	457,644	1,437,176	$294,596,676	37%
Hawaii*	14	75	152,155	715,612	$181,561,177	15%
Idaho	14	87	171,126	658,290	$174,323,258	26%
Illinois*	45	402	1,265,889	4,665,853	$897,271,451	21%
Indiana*	25	183	473,237	1,675,508	$343,283,730	20%
Iowa*	14	72	188,969	680,595	$163,280,598	25%
Kansas	18	61	193,843	582,658	$123,037,617	29%
Kentucky*	23	232	423,515	1,609,691	$344,167,330	20%
Louisiana*	34	229	384,893	1,409,006	$288,753,388	31%
Maine	18	130	186,039	818,065	$179,110,303	23%
Maryland*	17	126	313,411	1,478,011	$370,440,582	14%
Massachusetts*	39	288	751,918	3,839,821	$1,044,753,296	11%
Michigan*	39	262	672,753	2,554,782	$580,783,107	21%
Minnesota*	16	77	174,811	675,680	$171,499,152	22%
Mississippi	21	203	295,052	887,060	$177,107,230	41%
Missouri	28	228	527,054	1,925,230	$431,807,263	23%
Montana*	17	79	106,342	407,084	$104,950,776	34%
Nebraska	7	48	84,556	296,136	$72,574,862	26%
Nevada*	5	35	88,962	275,210	$73,240,156	25%
New Hampshire*	11	42	89,280	380,772	$89,972,159	25%
New Jersey*	23	144	511,947	1,892,603	$330,427,532	24%
New Mexico*	17	195	320,163	1,482,714	$298,922,222	23%
New York*	65	654	2,038,538	9,468,465	$2,023,496,947	12%
North Carolina	38	229	508,599	1,771,333	$370,692,573	33%
North Dakota*	4	22	40,331	133,261	$35,312,258	29%
Ohio*	45	271	667,007	2,326,809	$465,135,801	29%
Oklahoma	20	98	200,937	699,203	$155,357,831	34%
Oregon*	31	212	383,691	1,723,557	$570,120,560	15%
Pennsylvania*	44	264	774,921	2,660,676	$588,427,739	19%
Rhode Island*	8	55	164,057	683,021	$162,316,505	16%
South Carolina	22	176	374,257	1,386,551	$349,309,120	23%
South Dakota	5	48	69,137	239,716	$55,349,502	35%
Tennessee	29	182	396,877	1,413,029	$244,800,059	32%
Texas	73	466	1,309,020	4,918,538	$1,100,636,445	22%
Utah	13	56	151,250	496,233	$125,521,294	28%
Vermont*	11	66	171,828	677,293	$147,117,961	14%
Virginia	26	145	304,756	1,093,227	$217,530,129	38%
Washington*	27	306	1,035,629	4,188,973	$1,084,448,992	12%
West Virginia*	27	301	430,084	1,682,705	$338,912,992	19%
Wisconsin	17	115	303,266	1,147,896	$296,292,458	14%
Wyoming	6	10	17,582	53,786	$17,277,753	44%
US Total	**1,337**	**10,280**	**25,413,089**	**102,334,438**	**$23,419,142,282**	**18%[1]**

NOTES: * Medicaid expansion state. [1] US Total excludes territories. SOURCE: GWU analysis of 2016 UDS data

[1] C. Stephen Redhead et al., Discretionary Spending Under the Affordable Care Act, (Congressional Research Services, 2017), available at https://fas.org/sgp/crs/misc/R41390.pdf (Accessed online January 230, 2018)

[2] Peter Shin et al, What are the Possible Effects of Failing to Extend the Community Health Center Fund? (George Washington University, 2017), available at https://publichealth.gwu.edu/sites/default/files/images/GG%20Health%20Center%20Fund%20Brief_9.18_Final.pdf

POLITICS & GOVERNMENT

After approving Medicaid work requirements, Trump's HHS aims for lifetime coverage limits

BY TONY PUGH
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Updated 3 hours ago

WASHINGTON — After allowing states to impose work requirements for Medicaid enrollees, the Trump administration is now pondering lifetime limits on adults' access to coverage.

Capping health care benefits — like federal welfare benefits — would be a first for Medicaid, the joint state-and-federal health plan for low-income and disabled Americans.

If approved, the dramatic policy change would recast government-subsidized health coverage as temporary assistance by placing a limit on the number of months adults have access to Medicaid benefits.

The move would continue the Trump administration's push to inject conservative policies into the Medicaid program through the use of federal waivers, which allow states more flexibility to create policies designed to promote personal and financial responsibility among enrollees.

However, advocates say capping Medicaid benefits would amount to a massive breach of the nation's social safety net designed to protect children, the elderly and the impoverished.

In January, the Trump administration approved waiver requests from Kentucky and Indiana to terminate Medicaid coverage for able-bodied enrollees who do not meet new program work requirements. Ten other states have asked to do the same.

"We must allow states, who know the unique needs of their citizens, to design programs that don't merely provide a Medicaid card but provide care that allows people to rise out of poverty and no longer need public assistance," said a statement posted on Twitter on Monday by Medicaid administrator Seema Verma.

At least five states — Arizona, Kansas, Utah, Maine and Wisconsin — are seeking waivers from the Trump administration to impose lifetime Medicaid coverage limits. The Department of Health and Human Services said it could not comment on the pending applications.

The reporter Margot Sanger-Katz examines how the Republican health plan aims to roll back a program that insures nearly one in five Americans. — New York Times

But the proposals appear to reflect the administration's position that Medicaid coverage should be retained for vulnerable populations like children, pregnant women and those with disabilities. The administration has been open, however, to coverage limits for healthy adults, particularly those with no dependent children who gained coverage under Obamacare's Medicaid expansion.

Critics say Medicaid time limits will pose an enormous administrative burden by requiring states to track recipients' employment, eligibility and disability status. It could also shave valuable coverage months from people with health problems that impede their ability to work.

In addition, low-wage workers who may not get health coverage through their jobs could also reach their Medicaid coverage limit "as if it's their fault that their job isn't offering insurance," said Leonardo Cuello, director of health policy at the National Health Law Center. "And this would happen to thousands upon thousands of people across the country," if the policy catches on nationwide.

Others argue that attaching time limits and work requirements to Medicaid coverage does not meet a basic requirement of HHS waiver experiments and demonstration projects: to further the objectives of the Medicaid program, such as improving coverage, health outcomes and access to providers.

"All of these policies that we are seeing are inconsistent with the objectives of Medicaid. They don't seem to seem to have a legal basis and, as such, our stance is that they should not be approved. And we will work very hard with our partners to make that opinion well known," said Suzanne Wikle, a senior policy analyst at the Center for Law and Social Policy.

Time limits, work requirements, eligibility lockouts and similar policies are part of a new wave of Medicaid restrictions that appear to have gained favor with the Trump administration. In a March 2017 letter to the nation's governors, Verma said HHS would review and approve "meritorious innovations" for Medicaid "that build on the human dignity that comes with training, employment and independence."

They also pledged to streamline and expedite the waiver process, which can take more than six months.

But unlike capping cash welfare assistance or food stamp benefits, time-limiting health coverage runs the risk of pushing sick people into costly emergency rooms where they'll receive indigent care paid for by taxpayers.

"I think you have to be very thoughtful here in a way that's quite different from cash assistance," said Gail Wilensky, a senior fellow at Project HOPE who ran the Medicaid program from 1990 to 1992 under President George H.W. Bush. "It depends on what the safeguards and defaults are in a program like this. Otherwise it does not make a lot of sense and seems to be cruel and inappropriate."

Arizona and Utah both want a 5-year lifetime limit on coverage. Utah's would apply only to childless adults and would come "with the expectation that they do everything they can to help themselves before they lose coverage," according to the state's waiver application.

In Arizona, time-limited coverage would only accrue during months when enrollees don't meet their work requirements, which the state is also seeking in their waiver application. Wisconsin wants to limit lifetime coverage for childless adults to 48 months. Kansas would limit coverage to 36 months.

In Utah, Wisconsin and Kansas, the time-limited coverage would apply even to Medicaid enrollees who meet employment and work requirements.

In Maine, Medicaid enrollees who don't meet program work requirements could only get up to three months of coverage in a 36-month period. And only in special circumstances could these enrollees get an extra month of coverage.

The Obama administration previously denied Arizona's request for Medicaid coverage limits and work requirements, saying they didn't meet the program's goal of ensuring coverage for vulnerable populations.

Jessica Schubel, a senior policy analyst at the Center on Budget and Policy Priorities, said there's a "50-50 chance" that the Trump administration approves the time limits.

"I feel like the Trump administration is hell-bent on trying to keep people out of coverage … So, I don't know. I hope not, but I'm not holding my breath. And I guess I wouldn't be too terribly surprised to see it approved," said Schubel, a former senior policy advisor at HHS' Center for Medicare and Medicaid Services during the Obama administration.

The Department of Health and Human Services said it could not comment on the pending applications.

Tony Pugh: 202-383-6013, @TonyPughDC

Kristyn Herbert, who has cerebral palsy, has her own apartment — and she's worried about potential cuts to Medicaid that could affect her ability to live independently. She relies on 24-hour personal assistant care. **Katherine Jones** — kjones@idahostatesman.com

LOS ANGELES COUNTY COMMISSION ON HIV
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11. STANDING COMMITTEE REPORTS (cont'd):

B. STANDARDS AND BEST PRACTICES (SBP) COMMITTEE:

1. Updated Housing Standards

Purpose of Standards

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

Housing SoC Update Process

- Monthly reviews of the documents at SBP meetings from April-December 2017
- Public comment period 12/14/17-1/12/18
- Sought guidance from housing consultant and DHS Housing for Health program
- Multiple reviews from Housing Task Force, SBP, PP&A, and DHSP partners, Housing Subject Matter Experts, current RW and HOPWA housing providers
- Ensure Ryan White funds are used as last resort

Housing Standards Process Highlights

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

LOS ANGELES COUNTY COMMISSION ON HIV

FINAL FOR COH APPROVAL ON 2/8/18
MOTION #4

LOS ANGELES COUNTY COMMISSION ON HIV HOUSING SERVICE STANDARDS

Temporary Housing Services

Covers:

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

TABLE OF CONTENTS

PURPOSE AND GENERAL ELIBILITY REQUIREMENTS

PURPOSE: Service standards outline the elements and expectations a Ryan White service provider follows when implementing a specific service category. The purpose of the service standards are to ensure that all Ryan White service providers offer the same fundamental components of the given service category across a service area. Service standards establish the minimal level of service or care that a Ryan White funded agency or provider may offer in Los Angeles County. Evidence shows that housing assistance improves HIV health outcomes at each stage of the HIV Care Continuum. Housing supports increase stability and connection to care for PLWHA experiencing homelessness or unstable housing, and are consistently linked to improved HIV treatment access, continuous care, better health outcomes, and reduced risk of ongoing HIV transmission (https://www.hudexchange.info/resources/documents/The-Connection-Between-Housing-and-Improved-Outcomes-Along-the-HIV-Care-Continuum.pdf)

GENERAL ELIGIBILITY REQUIREMENTS

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

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

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

GENERAL REQUIREMENTS

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

Case management services will ensure that the client:

- Is engaged in care
- Has a definitive housing plan that assesses his/her housing needs and assists them in obtaining longer term housing within the 60-day limit (residential substance abuse or mental health treatment program, residential care facility for the chronically ill, transitional housing or permanent housing)
- Is receiving supporting services that promote stabilization, including needs assessments, case management, mental health counseling and treatment, substance abuse counseling and treatment, benefits counseling, individual case planning, budget counseling, assistance in locating and obtaining affordable housing and follow-up services
- Case managers should attempt to secure other types of housing prior to exhausting a client's emergency voucher limit. Under extenuating circumstances, a client may receive more than 60 days of hotel/motel and meal vouchers under this program (e.g., a client is on a waiting list for a housing program with a designated move-in date that extends past the 60-day period). Such extensions are made on a case-by-case basis and must be carefully verified.

REQUIRED DOCUMENTATION

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

- Client Intake Form - signed by both client and the case manager
- Case Management Housing Plan/Consent to Release Information - signed by client

- Rules and Regulations - reviewed by case manager and signed by both the case manager and the client
- Diagnosis Form
- Identification for all adults over 18 included on the voucher
- Other documentation may be required by agencies in order to comply with funding agency requirements.

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

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

INTENSIVE CASE MANAGEMENT (ICM)

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

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

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

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

LINKAGE TO MEDICAL CARE COORDINATION

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

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

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

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

GENERAL REQUIREMENTS

Each ES must adhere to the following general requirements:

- Maintain a current, written, definitive plan of operation that includes (at minimum):
  - Admission/discharge policies and procedures
  - Admission/discharge agreements
  - Staffing plan, qualifications and duties
  - In-service education plan for staff
- Assist with transportation arrangements for clients who do not have independent arrangements
- Provide ample opportunity for family participation in activities in the facility
- Include a safety plan to include precautions enacted to protect clients (for those facilities that admit or specialize in care for clients who have a propensity for behaviors that result in harm to self or others)
- Adhere to basic facility safety requirements under Federal laws and State of California Health and Safety Codes.
- Since Ryan White HIV/AIDS Program funds must be considered funds of last resort, providers must develop criteria and procedures to determine client eligibility and to ensure that no other options for residential services are available. Providers must document client eligibility, and must further demonstrate that third party reimbursement (e.g., Medi-Cal) is being actively pursued, where applicable.

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

Client is informed of Rights and Responsibility and Grievance Procedures.	Signed and dated forms in client file.

ASSESSMENT

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

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

INDIVIDUAL SERVICE PLAN (ISP)

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

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

LINKAGE TO MEDICAL CARE COORDINATION

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

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

PROGRAM RECORDS

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

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

1C: TRANSITIONAL HOUSING (Up to 24 months)

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

GENERAL REQUIREMENTS

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

- Maintain a current, written, definitive plan of operation that includes (at minimum):
  - Admission/discharge policies and procedures
  - Admission/discharge agreements
  - Staffing plan, qualifications and duties
  - In-service education plan for staff
- Assist with transportation arrangements for clients who do not have independent arrangements
- Provide ample opportunity for family participation in activities in the facility
- Include a safety plan to include precautions enacted to protect clients and staff (for those facilities that admit or specialize in care for clients who have a propensity for behaviors that result in harm to self or others)
- Adhere to basic facility safety requirements under Federal laws and State of California Health and Safety Codes.
- Since Ryan White HIV/AIDS Program funds must be considered funds of last resort, providers must develop criteria and procedures to determine client eligibility and to ensure that no other options for residential services are available. Providers must document client eligibility, and must further demonstrate that third party reimbursement (e.g., Medi-Cal) is being actively pursued, where applicable.

INTAKE

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

TRANSITIONAL HOUSING INTAKE	
STANDARD	**MEASURE**
Intake process is begun as soon as possible upon acceptance.	Intake tool is completed and in client file.
Eligibility for services is determined	Client files include: • Proof of HIV diagnosis • Proof of income • Proof of residence in Los Angeles County

	• Proof client is not eligible for Housing Opportunities for People with AIDS (HOPWA) or other housing services. Ryan White is the payor of last resort.
Confidentiality Policy, Consent to Receive Services and Release of Information is discussed and completed. Release of Information (must be updated annually). New forms must be added for those individuals not listed on the existing Release of Information (specification should be made about what type of information can be released)	Release of Information signed and dated by client on file and updated annually.
Client is informed of Rights and Responsibility and Grievance Procedures	Signed and dated forms in client file.

ASSESSMENT

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

TRANSITIONAL HOUSING ASSESSMENT	
STANDARD	**MEASURE**
Clients or representatives will be interviewed to complete eligibility determination, assessment and participant education.	Record of eligibility, assessment and education on file in client chart.
Assessments will include the following: • Age • Health status • Family involvement • Family composition • Special housing needs • Level of independence • ADLs • Income • Public entitlements • Current engagement in medical care • Substance use	Signed, dated assessment on file in client chart.

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

INTENSIVE CASE MANAGEMENT (ICM)

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

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

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

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

LINKAGE TO MEDICAL CARE COORDINATION

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

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

PROGRAM RECORDS

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

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

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

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

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

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

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

INCOME-BASED RENTAL SUBSIDIES INTAKE	
STANDARD	**MEASURE**
Intake process is begun as soon as possible upon acceptance.	Intake tool is completed and in client file.
Eligibility for services is determined	Client files include: • Proof of HIV diagnosis • Proof of income • Proof of residence in Los Angeles County • Proof client is not currently receiving Housing for People Living with AIDS (HOPWA) rental assistance, Housing Choice Voucher Program, or other housing assistance
Confidentiality Policy, Consent to Receive Services and Release of Information is discussed and completed. Release of	Release of Information signed and dated by client on file and updated annually.

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

ASSESSMENT

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

INCOME-BASED RENTAL SUBSIDIES ASSESSMENT	
STANDARD	**MEASURE**
Clients or representatives will be interviewed to complete eligibility determination, assessment and participant education.	Record of eligibility, assessment and education on file in client chart.
Assessments will include the following: • Age • Health status • Family involvement • Family composition • Special housing needs • Level of independence • ADLs • Income • Public entitlements • Current engagement in HIV medical care • Substance use • Mental health • Personal finance skills • History of evictions • Level of resources available to solve problems • Co-morbidity factors • For clients with substance use	Signed, dated assessment on file in client chart.

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

INTENSIVE CASE MANAGEMENT (ICM)

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

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

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

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

LINKAGE TO MEDICAL CARE COORDINATION

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

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

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

PROGRAM RECORDS

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

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

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

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

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

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

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

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

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

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

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

RCFCIs are licensed under the California Code of Regulations, Title 22, Division 6, Chapter 8.5 to provide services in a non-institutional, homelike environment in any building or housing arrangement which is maintained and operated to provide 24-hour care and supervision. The

capacity of a RCFCI may not exceed 50 beds.

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

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

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

Service providers must ensure:

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

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

- Policies and procedures for drug and/or alcohol use on-site and off-site, including steps to deal with relapsing residents to ensure their ability to remain in the housing
- Policies and procedures for protecting the privacy and confidentiality of residents
- Policies and procedures for ensuring safety and security of staff and residents, including instances of violence and the sale and use of controlled and/or illegal drugs/substances
- Policies and procedures for all staff to be initially and periodically trained in the appropriate and immediate response to resident crises, such as when residents become a danger to themselves or others
- Policies and procedures for all staff to be initially and periodically trained in

handling relapse, substance misuse on-site, and harm reduction
- Grievance procedures

RCFCI GENERAL REQUIREMENTS	
STANDARD	**MEASURE**
RCFCIs are licensed to provide 24-hour care and supervision to any of the following: • Adults 18 years of age or older with living HIV/AIDS • Emancipated minors living with HIV/AIDS • Family units with adults or children, or both, living with HIV/AIDS	Program review and monitoring to confirm.
RCFCIs may accept clients that meet each of the following criteria: • Have an HIV/AIDS diagnosis from a primary care physician • Be certified by a qualified a qualified health care professional to need regular or ongoing assistance with ADL • Have a Karnofsky score of 70 or less • Have an unstable living situation • Be a resident of Los Angeles County resident • Have an income at or below 500% Federal Poverty Level • Cannot receive Ryan White services if other payor source is available for the same service	Program review and monitoring to confirm.

RCFCIs may accept clients with chronic and life threatening diagnoses requiring different levels of care, including: • Clients whose illness is intensifying and causing deterioration in their condition • Clients whose conditions have deteriorated to a point where death is imminent • Clients who have other medical conditions or needs, or require the use of medical equipment that the facility can provide	Program review and monitoring to confirm.
RCFCIs will not accept or retain clients who: • Require inpatient care • Require treatment and/or observation for more than eight hours per day • Have communicable TB or any reportable disease • Require 24-hour intravenous therapy • Have dangerous psychiatric conditions • Have a Stage II or greater decubitus ulcer • Require renal dialysis in the facility • Require life support systems • Do not have chronic life-threatening illness • Have a primary diagnosis of Alzheimer's • Have a primary diagnosis of Parkinson's disease	Program review and monitoring to confirm.
Maximum length of stay is 24 months with extensions bases on resident's health status.	Program review and monitoring to confirm.
RCFCI will develop criteria and procedures to determine resident eligibility to ensure that no other options for residential services are available.	Program review and monitoring to confirm.
Programs may charge up to 30% of the income of adult family members who are not the primary service recipient to help cover the costs of providing services not covered by the RCFCI contract. Sliding scale fee plan as	Program review and monitoring to confirm.

follows: • For SSI/SSP recipients who are residents, the basic services will be provided and/or made available at the basic rate with no additional charge to the resident. This will not preclude the acceptance by the facility of voluntary contributions from relatives on behalf of an SSI/SSP recipient. • An extra charge to resident will be allowed for a private room upon the resident's request (and if such room is available). If a double room is available but the resident prefers a private room, it must be documented in the admission agreement and charge is limited to 10% of the board and room portion of the SSI/SSP grant. • The extra charge to the resident will be allowed for special food services or products beyond that specified above when the resident wishes to purchase the services and agree to the extra charge in the admission agreement.	

ASSESSMENT

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

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

The medical assessment will provide a record of any infectious or contagious disease which would preclude care of the person. A chest X-ray which was obtained not more than three

months prior to placement or a Mantoux tuberculin skin test recorded in a millimeter which was performed not more than three months prior to placement. A person who has had a previous positive reaction should not be required to obtain a Mantoux tuberculin skin test, but will be required to obtain chest X-ray results and a physician's statement that he/ she does not have communicable TB.

Residents receiving DHSP-funded RCFCI services must be reassessed on a quarterly basis to monitor and document changes in health status, progress toward treatment goals, and progress towards self-sufficiency with ADL. Upon reaching and sustaining a Karnofsky score above 70, RCFCI residents will be expected transition towards independent living or another type of residential service more suitable to his/her needs.

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

RCFCI ASSESSMENT	
STANDARD	**MEASURE**
Written medical assessments completed or supervised by a licensed physician not more than three months old are required within 30 days of acceptance.	Signed, dated medical assessment on file in client chart.

Assessments will include the following: • Need for palliative care • Age • Health status, including HIV and STD prevention needs • Record of medications and prescriptions • Ambulatory status • Family composition • Special housing needs • Level of independence • Level of resources available to solve problems • ADLs • Income • Benefits assistance/Public entitlements • Substance use and need for substance use services, such as treatment, relapse prevention, and support groups • Mental health • Personal finance skills • History of evictions • Co-morbidity factors • Physical health care, including access to tuberculosis (TB) screening and routine and preventative health and dental care • Treatment adherence • Educational services, including assessment, GED, and school enrollment • Linkage to potential housing out-placements should they become appropriate alternatives for current residents (e.g., residential treatment facilities and hospitals) • Representative payee Legal assistance on a broad range of legal and advocacy	Signed, dated assessment on file in client chart.
Residents must be reassessed on a quarterly basis to monitor and document changes in health status, progress toward treatment goals, and progress towards self-sufficiency with ADL.	Record of assessment on file in client chart.
If a RCFCI cannot meet a client's needs a	Documentation of resident education on file in

referral must be made to an appropriate health facility.	client chart.
Upon intake, facility staff must provide resident with the following: • Information about the facility and its services • Policies and procedures • Confidentiality • Safety issues • House rules and activities • Resident rights and responsibilities • Grievance procedures • Risk reduction practices • Harm reduction • Licit and illicit drug interactions • Medical complications of substance use hepatitis • Important health and self-care practices information about referral agencies that are supportive of people living with HIV and AIDS.	Documentation of resident education on file in client chart.

INDIVIDUAL SERVICE PLAN (ISP)

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

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

All health services components of the plan will be developed and monitored in coordination with the provider of service and will reflect the elements of the resident's plan of treatment

developed by the ISP team. The plan will be updated every three months or more frequently as the resident's condition warrants.

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

While the plan will be updated as frequently as necessary to ensure its accuracy and to document significant occurrences that result in changes in the resident's physical, mental and/or social functioning, residents receiving DHSP-funded RCFCI services must be reassessed on a quarterly basis to monitor and document changes in health status, progress toward treatment goals, and progress towards self-sufficiency with ADL. Upon reaching and sustaining a Karnofsky score above 70, RCFCI residents will be expected transition towards independent living or another type of residential service more suitable to his/her needs.

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

RCFCI INDIVIDUAL SERVICE PLAN (ISP)	
STANDARD	**MEASURE**
ISP will be completed prior to admission.	Needs and services plan on file in
The plan will include, but not be limited to: • Current health status • Current mental health status • Current functional limitations and abilities • Current medications • Medical treatment/therapy • Specific services needed • Intermittent home health care required • Agencies or persons assigned to carry out services • "Do not resuscitate" order, if applicable • For each un-emancipated minor, the specific legal means of ensuring continuous care and custody when the parent or guardian is hospitalized, relocated, becomes unable to	Needs and services plan on file in client chart.

Plans should be updated every three months or more frequently to document changes in a resident's physical, mental, emotional and social functioning.	Updated needs and services plan on file in client chart.
Residents must be reassessed on a quarterly basis to monitor and document changes in health status, progress toward treatment goals, and progress towards self- sufficiency with ADL.	Record of reassessment on file in client chart.
If a resident's needs cannot be met by facility, the facility will assist in relocating the resident to appropriate level of care.	Record of relocation activities on file in client chart.
The provider will ensure that the ISP for each resident is developed by the ISP team. In addition to the RN case manager, the following persons will constitute the ISP team and will be involved in the development and updating of the resident's ISP: • The resident and/or his/her authorized representative • The resident's physician • Facility house manager • Direct care personnel • Facility administrator/designee • Social worker/placement worker • Pharmacist, if needed • For each un-emancipated minor, the child's parent or guardian and the person who will assume legal custody and control of the child upon the hospitalization, incapacitation, or death of the parent or guardian	Record of ISP team on file in client chart.

MONTHLY CASE CONFERENCE

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

services and support for the resident.

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

SERVICE AGREEMENTS

The provider will obtain and maintain written agreements or contracts with:

RCFCI SERVICE AGREEMENTS	
STANDARD	**MEASURE**

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

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

MEDICATION MANAGEMENT

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

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

SUPPORT SERVICES

Support services that are to be provided or coordinated must include, but are not limited to:

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

EMERGENCY MEDICAL TREATMENT

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

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

DISCHARGE PLANNING

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

RCFCI DISCHARGE PLANNING	
STANDARD	**MEASURE**
Discharge planning services include, but are not limited to, RCFCIs providing discharge planning services to clients that include (at minimum): • Linkage to primary medical care, emergency assistance, supportive services and early intervention services as appropriate • Linkage to supportive services that enhance retention in care (e.g., case management, meals, nutritional support and transportation) • Early intervention services to link HIV-positive people into care, including outreach, HIV counseling and testing and referral • Housing such as permanent housing, independent housing, supportive housing, long-term assisted living or other appropriate housing	Discharge plan on file in client chart.

A Discharge/Transfer Summary will be completed for all residents discharged from the agency. The summary will include, but not be limited to: • Admission and discharge dates • Services provided • Diagnosis(es) • Status upon discharge • Notification date of discharge • Reason for discharge • Transfer information, as applicable	Discharge/Transfer Summary on file in client chart.

PROGRAM RECORDS

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

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

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

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

TRCF PROGRAM GOALS

The goals of TRCF services for PLWHA are to:

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

TRCF SERVICE COMPONENTS

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

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

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

TRCF GENERAL REQUIREMENTS

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

Service providers must ensure:

- Service provision is flexible and responsive to residents' needs
- Services are culturally-specific and linguistically and developmentally appropriate

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

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

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

Eligibility Requirements:

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

- Be homeless or at risk of becoming homeless

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

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

INTAKE

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

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

ASSESSMENT

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

Residents receiving TRCF services must be reassessed on a quarterly basis to monitor and document changes in health status, progress toward treatment goals, and progress towards self-sufficiency with independent living skills (ILS). TRCF residents will be expected to transition towards independent living or another type of residential service more suitable to his/her needs.

TRCF ASSESSMENT	
STANDARD	**MEASURE**
Clients will be assessed to identify strengths and gaps in his/her support system as a means to move towards permanent housing. Assessments will include the following: • Age • Health status • Family involvement • Family composition • Special housing needs • Level of independence • ADLs • Income • Benefits assistance/Public entitlements • Substance use and need for substance use services, such as treatment, relapse prevention, and support groups • Mental health needs • Personal finance skills • History of evictions • Level of resources available to solve problems • Co-morbidity factors • Physical health care, including access to tuberculosis (TB) screening and routine and preventative health and dental care • Treatment adherence • Educational services, including	Signed, dated assessment on file in client chart.

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.

ATTACHMENT A: INTENSIVE CASE MANAGEMENT SERVICES (ICMS)

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

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

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

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

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

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

- Ongoing outreach and engagement to the client population including field and community based locations, health and behavioral health facilities, interim and bridge housing settings, criminal justice and custody facilities, and other locations as needed to engage the target population.

- Assisting clients with rental application including paperwork required by Housing Authorities and the Section 8 program.
- Assistance with mental health and life skills services and referrals.
- Establishment of a case management plan based on their authorization including but not limited to establishing future goals, improvement of behaviors associated with drug use, reduction in frequency and quantity of drug and alcohol use, coping with mental health disorders, coping with chronic medical problems, improvement of interpersonal relationships.
- Help accessing public benefits and educational opportunities as appropriate.
- Assistance with budgeting and money management.
- Assistance with substance use disorder services and referrals with a focus on harm reduction.
- Referrals to primary medical care, mental health services, and other community services as needed.
- Assistance in obtaining clothing and food.
- Group programming ranging from life-skills groups to community activities.
- Eviction prevention counseling and advocacy.
- Assistance with educational, vocational, and employment services as appropriate for each client.
- Assistance with domestic violence and safety planning services and referrals.
- Transportation assistance.
- Assisting clients with maintaining medication regimen.
- Housing location services including assisting clients with locating affordable permanent housing, establishing relationships with landlords/agencies willing to provide affordable permanent housing to DHS clients, and providing assistance with negotiating rental agreements. (Note: The need for housing location services will vary by project. Housing location experience is not a minimum qualification.)
- Administer move-in assistance funds to assist clients with timely security deposits, household goods and furnishings, utility deposits, etc.
- Assistance with temporary housing until client moves into supportive housing unit.
- Assistance with monitoring any legal issues and making appropriate referrals while addressing any barriers to accessing and maintaining housing and services (e.g., Personal finance skills, criminal records, pending warrants, etc.).
- Collaboration with Property Related Tenant Services (PRTS) and property owner to ensure clients provide authorization to receive the support they need to remain housed and stable, including attending and/or convening periodic meetings with partners to problem-solve around client, building, and community issues.
- Provision of on-going training to ICMS staff to ensure services are appropriate and to promote continuous quality improvement.
- Maintenance of program and client records and legally permissible data systems as may be required.

- Submit reports and invoices as requested and in a timely manner and provide all required supporting documentation.
- Comply and deliver services in accordance with contract deliverables and objectives.

ATTACHMENT B: RECOMMENDED TRAINING TOPICS FOR STAFF

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

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

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

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

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

ATTACHMENT C: DEFINITIONS AND DESCRIPTIONS

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

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

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

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

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

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

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

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

Hospice nurse means a registered nurse (RN) who has acute care experience and training

and experience in the delivery of nursing care to the terminally ill who have accepted the hospice concept.
Housing specialist assists clients with housing searches and placement and works with other community based organizations to work collaboratively to meet the clients' needs.

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

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

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

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

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

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

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

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

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

Respiratory therapist means a person with a California State respiratory Care Practitioner's Certificated issued by the Respiratory Care Examining Committee, and has: a one year's

experience at the level of a Respiratory Therapy Technician; b) an associate degree in respiratory therapy from an accredited college; or c) a certificate of completion from an approved two-year training program in respiratory therapy.

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

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

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

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

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

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

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

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

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

Eligible housing can include either housing that:

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

Resources used:

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

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FINAL FOR COH APPROVAL
2/8/18
MOTION #4

LOS ANGELES COUNTY COMMISSION ON HIV HOUSING SERVICE STANDARDS

Permanent Supportive Housing Services

TABLE OF CONTENTS

PURPOSE: Service standards outline the elements and expectations a Ryan White service provider follows when implementing a specific service category. The purpose of the service standards are to ensure that all Ryan White service providers offer the same fundamental components of the given service category across a service area. Service standards establish the minimal level of service or care that a Ryan White funded agency or provider may offer in Los Angeles County.

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

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

PERMANENT SUPPORTIVE HOUSING PROGRAMS (PSHPS)

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

GENERAL REQUIREMENTS

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

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

SERVICE COMPONENTS REQUIREMENTS FOR PERMANENT SUPPORTIVE HOUSING PROGRAMS

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

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

ASSESSMENT

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

Assessment information should include (at minimum):

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

EDUCATION

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

- Confidentiality
- Safety issues
- House rules and activities
- Client rights and responsibilities
- Grievance procedures
- Risk reduction practices
- Harm reduction
- Licit and illicit drug interactions
- Medical complications of substance abuse
- Hepatitis
- Health and self-care practices
- Referral information

- Pet-owner responsibilities
- Neighbor relations
- TB

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

INTENSIVE CASE MANAGEMENT (ICM) OR SIMILAR SUPPORTIVE SERVICES

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

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

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

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

LINKAGE TO MEDICAL CARE COORDINATION

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

HIV medications, and HIV risk reduction. Based on assessment and client needs, eligible individuals should be linked to MCC services. MCC service providers must follow the Division of HIV and STD Programs MCC Protocol (http://ph.lacounty.gov/dhsp/Contractors/MCC/MCCprotocolMay2015.pdf)

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

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

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

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

- Ongoing outreach and engagement to the client population including field and community based locations, health and behavioral health facilities, interim and bridge housing settings, criminal justice and custody facilities, and other locations as needed to engage the target population.

- Assisting clients with rental application including paperwork required by Housing Authorities and the Section 8 program.
- Assistance with mental health and life skills services and referrals.
- Establishment of a case management plan based on their authorization including but not limited to establishing future goals, improvement of behaviors associated with drug use, reduction in frequency and quantity of drug and alcohol use, coping with mental health disorders, coping with chronic medical problems, improvement of interpersonal relationships.
- Help accessing public benefits and educational opportunities as appropriate.
- Assistance with budgeting and money management.
- Assistance with substance use disorder services and referrals with a focus on harm reduction.
- Referrals to primary medical care, mental health services, and other community services as needed.
- Assistance in obtaining clothing and food.
- Group programming ranging from life-skills groups to community activities.
- Eviction prevention counseling and advocacy.
- Assistance with educational, vocational, and employment services as appropriate for each client.
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- Transportation assistance.
- Assisting clients with maintaining medication regimen.
- Housing location services including assisting clients with locating affordable permanent housing, establishing relationships with landlords/agencies willing to provide affordable permanent housing to DHS clients, and providing assistance with negotiating rental agreements. (Note: The need for housing location services will vary by project. Housing location experience is not a minimum qualification.)
- Administer move-in assistance funds to assist clients with timely security deposits, household goods and furnishings, utility deposits, etc.
- Assistance with temporary housing until client moves into supportive housing unit.
- Assistance with monitoring any legal issues and making appropriate referrals while addressing any barriers to accessing and maintaining housing and services (e.g., credit history, criminal records, pending warrants, etc.).
- Collaboration with Property Related Tenant Services (PRTS) and property owner to ensure clients provide authorization to receive the support they need to remain housed and stable, including attending and/or convening periodic meetings with partners to problem-solve around client, building, and community issues.
- Provision of on-going training to ICMS staff to ensure services are appropriate and to promote continuous quality improvement.
- Maintenance of program and client records and legally permissible data systems as may be required.

- Submit reports and invoices as requested and in a timely manner and provide all required supporting documentation.
- Comply and deliver services in accordance with contract deliverables and objectives.

ATTACHMENT B: DEFINITIONS AND DESCRIPTIONS

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

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

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

Certified nursing assistant or **home health aide** means a person who is certified as such by the California State Department of Public Health.

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

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and experience in the delivery of nursing care to the terminally ill who have accepted the hospice concept.

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Pharmacist means a person licensed as such by the California Board of Pharmacy.

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

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

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

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

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

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

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

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

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

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

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

Grissel Granados, MSW*	Joseph Cadden, MD*	Thomas Puckett*
Ace Robinson*	Wendy Garland*	Angelica Palmeros*
Pamela Ogata, MPH	Terina Keresoma	Rebecca Ronquillo
Terry Goddard	Lois Starr	Michael Green, Ph.D.
Noah Kaplan, LCSW	Brigitte Tweddell	

LOS ANGELES COUNTY COMMISSION ON HIV
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11. STANDING COMMITTEE REPORTS (cont'd):

C. OPERATIONS COMMITTEE:

1. Membership Management:
3. Assessment of the Administration Mechanism (AAM) Overview and Project Update

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

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

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

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

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

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

STD & HIV 101: April 24
Learn the basics of STDs and HIV/AIDS as well as up-to-date information on prevention, care, and data within Los Angeles County.

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

Ryan White HIV/AIDS Treatment Extension Act

Administrative Overview Ryan White Part A

July 29-31, 2013

Steven R. Young, MSPH
Director, Division of Metropolitan HIV/AIDS Programs

U.S. Department of Health and Human Services
Health Resources and Services Administration
HIV/AIDS Bureau

Assessment of the Administrative Mechanism

- **Planning Council responsibility**
- Should be done annually – directly or through a consultant
- Involves assessing how efficiently the grantee does procurement, disburses funds, monitors contracts, supports the Council's planning process and adheres to Council priorities and allocations
- Written report goes to grantee, which indicates what action it will take to address any identified problem areas

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11. STANDING COMMITTEE REPORTS (cont'd):

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

1. Ryan White Program Year 27 Expenditure Projections

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18. ANNOUNCEMENTS

END OF COMMISSION PACKET