

# LOS ANGELES COUNTY COMMISSION ON HIV HOUSING SERVICE STANDARDS

Permanent Supportive Housing Services

Approved by Commission on HIV on February 8, 2018



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**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)**

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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: <ul style="list-style-type: none"> <li>• HIV medical treatment</li> <li>• History of trauma</li> <li>• Substance use and history</li> <li>• ADL needs</li> <li>• Spiritual/religious needs</li> <li>• Social support system</li> <li>• Legal issues</li> <li>• Family issues</li> <li>• Financial/insurance status</li> <li>• Nutritional needs</li> <li>• Harm reduction practices</li> <li>• Mental health treatment history</li> <li>• History of housing experiences</li> <li>• Case management history and needs</li> <li>• Needs and current services</li> </ul>
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>

<b>TRANSITIONAL HOUSING LINKAGE TO MEDICAL CARE COORDINATION</b>	
<b>STANDARD</b>	<b>MEASURE</b>
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., 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.

**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 or in any building that receives Shelter Plus Care and/or HUD 811 subsidies.

**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.

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

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