



LOS ANGELES COUNTY
COMMISSION ON HIV



TRANSITIONAL CASE MANAGEMENT SERVICES: JUSTICE-INVOLVED INDIVIDUALS

SERVICE STANDARDS FOR RYAN WHITE HIV/AIDS PROGRAM CARE
AND TREATMENT SERVICES

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Contents

Introduction.....	3
Service Description	3
HRSA Guidance for Non-Medical Case Management	4
General Eligibility Requirements for Ryan White Services	4
Transitional Case Management for Justice-Involved Individuals.....	5
Appendix 1: Recommended Training Topics	10

IMPORTANT: The service standards for Justice-involved individuals, Transitional Case Management Services adhere to requirements and restrictions from the federal agency, Health Resources and Services Administration (HRSA). The key documents used in developing standards are as follows:

[Human Resource Services Administration \(HRSA\) HIV/AIDS Bureau \(HAB\) Policy Clarification](#)

[Notice \(PCN\) # 16-02 \(Revised 10/22/18\): Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds](#)

[HRSA HAB Policy Clarification Notice \(PCN\) # 18-02: The use of Ryan White HIV/AIDS Program Funds for Core Medical Services and Support Services for People Living with HIV Who Are Incarcerated and Justice Involved](#)

[HRSA HAB, Division of Metropolitan HIV/AIDS Programs: National Monitoring Standards for Ryan White Part A Grantees: Program – Part A](#)

[Service Standards: Ryan White HIV/AIDS Programs](#)

Introduction

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 is 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.

Service Description

Transitional Case Management (TCM) is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services for special populations living with HIV/AIDS to mitigate and eliminate barriers to HIV care services.

- Intake and assessment of available resources and needs
- Periodic reassessments of status and needs
- Development and implementation of Individual Release Plans
- Appropriate linked referrals to housing, community case management, medical/physical healthcare, mental health, dental health, and substance use disorder treatment
- Coordination of services that facilitate retention in care, achieve viral suppression, and maintain overall health and wellness

- Access to HIV and STI information, education, partner services, and behavioral and biomedical interventions such as Pre-Exposure Prophylaxis (PrEP) and Doxycycline Post-Exposure Prophylaxis (Doxy PEP) to prevent acquisition and transmission of HIV/STIs
- Active, ongoing monitoring and follow-up
- Ongoing assessment of the client's needs and personal support systems

HRSA Guidance for Non-Medical Case Management

Description:

Non-Medical Case Management Services (NMCM) provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. NMCM services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicare, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans. This service category includes several methods of communication including face-to-face, phone contact, and any other forms of communication deemed appropriate by the RWHAP Part recipient. Key activities include:

- Initial Assessment of service needs
- Development of a comprehensive, individualized care plan
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family member's needs and personal support systems

Program Guidance:

Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services whereas Medical Case Management services have as their objective improving health care outcomes.

General Eligibility Requirements for Ryan White Services

- Be diagnosed with HIV or AIDS with verifiable documentation.
- Be a resident of Los Angeles County
- Have an income at or below 500% of Federal Poverty Level.

Clients must provide documentation to verify eligibility, including HIV diagnosis, income level, and residency. Given the barriers with attaining documentation, contractors are expected to follow the Los Angeles County, Department of Public Health, Division of HIV and STD Programs (DHSP) guidance for using self-attestation forms for documentation eligibility for Ryan White services.

Transitional Case Management for Justice-Involved Individuals

The goal of TCM for Justice-Involved individuals is to improve HIV health outcomes among justice-involved people living with HIV/AIDS by supporting post-release linkage and engagement in HIV care. The objectives of TCM for Justice-Involved individuals include:

- Identify and address barriers to care
- Assist with health and social service system navigation
- Provide health education and risk reduction counseling
- Refer and link to culturally competent HIV medical providers
- Support reentry through community or jail-based resources

SERVICE STANDARDS

All contractors must meet the [Universal Service Standards](https://hiv.lacounty.gov/service-standards) approved by the COH in addition to the following TCM service standards. The Universal Service Standards can be accessed at:

<https://hiv.lacounty.gov/service-standards>

IN-REACH AND OUTREACH

Programs providing TCM services for justice-involved individuals will conduct in-reach and outreach activities to educate clients, and HIV/AIDS primary health care and support services providers about the availability and benefits of TCM services. In-reach refers to pre-release activities including promotion and initiation of services to justice-involved individuals. Outreach refers to post-release activities including promotion, initiation or continuation of services to people who have been released from incarceration.

IN-REACH AND OUTREACH	
STANDARD	DOCUMENTATION
Transitional Case Management programs will conduct in-reach and outreach activities to clients and providers.	In-reach/Outreach plan on file at provider agency
Transitional Case Management programs will provide information sessions to incarcerated people living with HIV/AIDS.	Record of information sessions at provider agency. Copies of flyers and materials used. Record of referrals provided to clients.

COMPREHENSIVE ASSESSMENT

Comprehensive assessment/reassessment is completed in a cooperative, interactive, face-to-face interview process. Assessment/reassessment identifies and evaluates a client's medical, physical, psychosocial, environmental and financial strengths, needs and resources.

Comprehensive assessment is conducted to determine the:

- Client's needs for treatment and support services
- Client's current capacity to meet those needs
- Ability of the client's social support network to help meet client need(s)
- Extent to which other agencies are involved in client's care
- Areas in which the client requires assistance in securing services
- Client's medical home post-release and linkage to Medical Care Coordination (MCC) program prior to release to ensure continuity of care

COMPREHENSIVE ASSESSMENT	
STANDARD	DOCUMENTATION
Completed and enter comprehensive assessments into DHSP's data management system within 15 days of the initiation of services.	Comprehensive assessment or reassessment on file in client chart to include: • Date • Signature and title of staff person
Perform reassessments at least once per year or when a client's needs change or they have re-entered a case management program.	Client strengths, needs and available resources in: • Medical/physical healthcare • Medications and Adherence issues • Housing and living situation • Benefits and resources available • Potential barriers to care • Gender affirming care • Lega issues/incarceration history • Social support system

INDIVIDUAL RELEASE PLAN (IRP)

An Individual Release Plan (IRP) determines the case management goals for a client and is developed in conjunction with the client and case manager within two weeks of the conclusion of the comprehensive assessment or reassessment. An IRP is a tool that enables the case manager to assist the client in systematically addressing barriers to HIV medical care by developing a concrete strategy to improve access and engagement in medical and other support services. All goals shall be determined by using information gathered during assessment and reassessments.

INDIVIDUAL RELEASE PLAN	
STANDARD	DOCUMENTATION
Individual Release Plans (IRPs) will be developed in conjunction with the client within	IRP on file in client chart to include: • Name of client and case manager

two weeks of completing the assessment or reassessment. IRPs will be updated on an ongoing basis.	• Date and signature of case manager; notation of verbal consent from client • Date and description of client goals and desired outcomes • Action steps to be taken by client, case manager and others • Customized services offered to client to facilitate success in meeting goals, such as referrals to peer navigators and other social or health services • Goal timeframes • Disposition of each goal as it is met, changed, or determined to be unattainable
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IMPLEMENTATION, MONITORING, AND FOLLOW-UP OF IRP

Implementation, monitoring, and follow-up involved ongoing contract and interventions with (or on behalf of) the client to ensure that IRP goals are addressed, and that the client is linked to and appropriately accesses and maintains primary health care and community-based supportive services identified on the IRP. These activities ensure that referrals are completed, and services are obtained in a timely, coordinated fashion.

IMPLEMENTATION, MONITORING, AND FOLLOW-UP OF IRP	
STANDARD	DOCUMENTATION
Transitional Case Management programs establish appointments (whenever possible) prior to release date.	Record of appointment date.
Case managers will: • Provide referrals, advocacy, and interventions based on the intake, assessment, and IRP • Monitor changes in the client's condition • Update/revise the IRP • Ensure coordination of care • Help clients submit applications and obtain health benefits and care • Conduct monitoring and follow-up to confirm completion of referrals and service utilization	Signed, dated progress notes on file that detail the following: • Date and type of action taken (client contact, advocacy, follow-up on referral, etc.) • Description of what occurred • Update on the client's condition or circumstances • Progress made toward IRP goals • Barriers to IRP goals and actions taken to resolve them • Status of referrals and interventions • Barriers to referrals and interventions and actions taken to resolve them

• Advocate on behalf of clients with other service providers • Empower clients to use independent living strategies • Help clients resolve barriers • Follow-up on IRP goals • Maintain/attempt contact at minimum of once every two weeks and at least one face-to-face contact monthly • Follow-up missed appointments by the end of the next business day • Collaborate with the client's community-based case manager for coordination and follow-up when appropriate • Transition clients out of TCM services at six month's post-release.	• Time spent with, or on behalf of, client • Case manager's signature and title
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STAFFING REQUIREMENTS AND QUALIFICATIONS

Case management staff will complete an agency-based orientation and be trained and will be able to provide linguistically and culturally appropriate care to people living with HIV/AIDS and complete documentation as required by their positions.

STAFFING REQUIREMENTS AND QUALIFICATIONS	
STANDARD	DOCUMENTATION
Case managers will have: • Knowledge of HIV/STIs and related issues • Knowledge of and sensitivity to incarceration and correctional settings and populations • Knowledge of and sensitivity to lesbian, gay, bisexual, and transgender persons • Effective Motivational Interviewing and assessment skills • Ability to appropriately interact and collaborate with others • Effective written/verbal communication skills • Ability to work independently • Effective problem-solving skills	Resume, training certificates, interview assessment notes, reference checks, and annual performance reviews on file.

• Ability to respond appropriately in crisis situations • Effective organizational skills • Prioritize caseload • Patience • Multitasking skills	
Case managers will meet one of the following educational requirement criteria: • A bachelor's degree in a Health or Human Services field and have completed a minimum of eight hours of course work on the basics of HIV/AIDS prior to providing services to clients • An associate degree plus one-year direct case management experience in health or human services • A high school diploma or GED and a minimum of three years of experience providing direct social services to patients/clients within a medical setting or in the field of HIV. Prior experience providing services to justice-involved individuals is preferred. Personal life experience is highly valued and should be considered when making hiring decisions.	Resumes on file at provider agency documenting experience.
All staff will be given orientation prior to providing services.	Record of orientation in employee file at provider agency.
Case managers and other staff will participate in training as recommended by DHSP.	Documentation of training maintained in employee files to include: • Date, time, and location of function • Function type • Staff members attending • Sponsor or provider of function • Training outline, handouts, or materials • Meeting agenda and/or minutes
Case management staff will receive a minimum of four hours of client care-related supervision per month from a master's level mental health professional.	All client care-related supervision will be documented as follows: • Date of client care-related supervision • Supervision format • Name and title of participants

	• Issues and concerns identified • Guidance provided and follow-up plan • Verification that guidance and plan have been implemented • Client care supervisor's name, title, and signature.
Clinical supervisor will provide general clinical guidance and follow-up plans for case management staff.	Documentation of client care related supervision for individual clients will be maintained in the client's individual file.

Recommended Training Topics

Transitional Case Management staff should complete ongoing training related to the provision of TCM services. Staff development and enhancement activities should include:

- HIV/AIDS Medical and Treatment Updates
- Risk Behavior and Harm Reduction Interventions
- Addiction and Substance Use Treatment
- HIV Disclosure and Partner Services
- Trauma-informed Care
- Person First Language
- Mental health and HIV/AIDS
- Legal Issues, including Jails/Corrections Services
- Alternatives to Incarceration Training
- Integrated HIV/STI prevention and care services including Hepatitis C screening and treatment
- Gender and sexuality
- Stigma and discrimination and HIV/AIDS
- Health equity and social justice
- Motivational interviewing
- Knowledge of available housing, food, and other basic need support services