STANDARDS OF CARE FOR YOUTH TRANSITIONAL CASE MANAGEMENT SERVICES

Approved by the Commission on HIV on 4/13/2017

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Transitional Case Management (TCM) Definition
HIV transitional case management is a client-centered activity that coordinates care for special transitional populations living with HIV. TCM includes:

- Intake and assessment of available resources and needs
- Development and implementation of individual service plans
- Coordination of services
- Interventions on behalf of the client or family
    - Engagement in HIV Care
    - Risk Reduction
    - HIV Education
    - Disclosure and Partner Notification Activities
- Linked referrals
- Enhancing self-care practices and health promotion, including safer sex behaviors and harm reduction strategies through the provision of Brief Interventions.
- Active, ongoing monitoring and follow-up
- Periodic reassessment of status and needs
- Ongoing assessment of the client's and other key family members' needs and personal support systems

Youth Transitional Case Management (YTCM)
For the purposes of these standards, "youth" is defined as adolescents and young adults aged 13-29 years living with HIV, including homeless, runaways, and emancipating/emancipated youth at risk for HIV/STIs. HIV/AIDS case management - youth transitional case management services (YTCM) are client centered, comprehensive services designed to promote access to and utilization of HIV care by identifying and linking youth living with HIV/AIDS to HIV medical and supportive services. The goals of youth transitional case management include:

- Locating youth not engaged in HIV care;
- Identifying and addressing client barriers to care (e.g., homelessness, substance use, and emotional distress);
- Improving the health status of youth
- Easing a youth's transition from youth-focused supportive and health care services to adult-focused supportive and health care services
- Increasing access to education, job training, employment and other services that foster self-sufficiency
- Helping youth increase their self-efficacy and self-sufficiency
- Facilitating access and adherence to primary HIV health care
- Ensuring access to developmentally appropriate services and to the continuum of HIV prevention and care services
- Increasing access to HIV and STI information, education, and behavioral and biomedical

interventions to keep their partners HIV-negative
- Reducing homelessness
- Reducing substance use
- Developing resources and increasing coordination between providers, regardless of funding source

Attributes of Youth-Friendly Services

Many of the barriers that adolescents and young adults face in accessing health and social services are unique to young people due to their developmental stage in life and associated special needs, perceptions, and abilities. Youth-friendly services are services that all youth are able to obtain, and these services should meet developmental needs and improve their health well-being. Youth-friendly services are able to effectively attract young people, meet their needs comfortably and responsively, and succeed in retaining young clients for continuing preventive care and treatment.

Advocates for Youth, a national organization that advocate for policies and champion programs that recognize young people's rights to honest sexual health information, has developed a publication titled, *"Best Practices for Youth-Friendly Clinical Services".* YTCM service providers are expected to use these guidelines as a tool for creating and creating safe, youth-friendly organizational culture. The key attributes to youth-friendly services are:

Confidentiality – Confidentiality means that the provider keeps an adolescent's sensitive health care issues in strict confidence between the adolescent and the provider. The imperative need to guard the adolescent's confidentiality extends, as well, to every member of the agency's staff, including receptionists and technicians.

Respectful Treatment - Adolescents are particularly sensitive to rude, judgmental, or overbearing attitudes and behaviors on the part of adults. In fact, such attitudes and behaviors can cause adolescents to:
- Leave the clinic before they get the care or service they need;
- Fail to comply with treatment requirements (such as taking medicine on time, getting physical therapy, etc.); and/or
- Refuse or forget follow-up care.

Integrated Services - Integrated care allows youth to obtain different services in a single location. Often known as 'one-stop shopping', integrated care is important to young men and women. Integrated care operates from a comprehensive health lens which includes addressing HIV, STIs, and overall health and well-being of adolescents and young adults. Agencies must strive to have strong referral networks to ensure integrated services for youth.

Cultural Competence (Diverse, Well Trained Staff) - Cultural competence in health care acknowledges and incorporates the importance of culture(s); assesses cross-cultural relations; is vigilant regarding dynamics that result from cross-cultural differences; expands cultural

knowledge; and adapts services to meet the culturally unique needs of clients. For youth services, cultural competency extends to developmentally-appropriate services. Programs should consider adolescent development stages and models when creating services and delivering services.

Easy Access to Care - Easy access to health services is important to youth. Access issues may include lack of transportation; difficulties making appointments; not knowing where to go; hours and days when services are available; and requirements to return for follow-up.

Free or Low Cost Services - Fear about costs is a major barrier to healthcare for youth. Whether youth have insurance or not, cost can be a major factor in whether they even attempt to get medical care. Clinics should offer free services and/or use sliding fee scales to ensure that young people get the services they need.

Reproductive & Sexual Health Services - Reproductive and sexual health services can include education and counseling, contraceptive services, STI/HIV testing and treatment, in addition to prenatal and obstetrical care, and fertility counseling and treatment. Most of these services are important to adolescents and young adults.

Services for Youth Communities Most impacted by HIV – providers must recognize the unique needs of young gay and bisexual men, and transgender youth to facilitate a safe and welcoming environment for young men.

Promoting Parent/Caregiver/Guardian-Child Communication - Today, many clinicians work to promote parent/caregiver/guardian-child communication about sexuality, drug use, and other critical health issues. Studies have shown that parents' improved communication skills resulted in better communication with their teens and improved behavioral health outcomes for youth.

Youth-Adult Partnerships – Services should be developed in collaboration with youth or with input from youth through the use of Youth Community Advisory Boards. Young people are the experts on their own lives and have valuable insight on how to develop and maintain effective, relevant, and culturally responsive services.

Trauma-Informed Services – Adolescent behaviors should be understood through the lens of trauma-informed care. Providers should have a basic of understanding of trauma triggers and trauma responses in adolescents and young adults.

Additional resources to assist agencies develop a youth-friendly culture and atmosphere:

- http://www.advocatesforyouth.org/publications/publications-a-z/1347--best-practices-for-youth-friendly-clinical-services
- http://www.healthyteennetwork.org/blog/characteristics-youth-friendly-health-care-services/
- https://www.engenderhealth.org/pubs/gender/youth-friendly-services.php
- https://www.iywg.org/topics/youth-friendly-services

- http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/training/Assests/2014%20Conference/youthfriendlyclinic.pdf
- http://www.umhs-adolescenthealth.org/

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

A. OUTREACH

Outreach activities are defined as targeted activities designed to bring youth who are HIV-positive into HIV medical treatment services. This includes effective and culturally relevant methods to locate, engage, and motivate HIV+ youth to engage in HIV medical services.

A. Outreach	
Standard	**Measure**
Transitional case management programs will outreach to potential clients and providers.	Outreach plan on file at provider agency.

B. COMPREHENSIVE ASSESSMENT AND REASSESSMENT

Comprehensive assessment/reassessment is completed in a cooperative, interactive, face-to-face interview process. Youth friendly assessment should consider the length of the questionnaire. Providers are highly encouraged to use or adapt youth-friendly assessment tools such as the HEADSS assessment for adolescents (Home and Environment; Education and Employment; Activities; Drugs; Sexuality; Suicide/Depression).

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 engaging in HIV medical care and treatment, and supportive services
- Client's current capacity to meet those needs
- Ability of the client's social support network to help client gain access to, engage in, and maintain adherence to HIV care and treatment.
- Extent to which other agencies are involved in client's care
- Areas in which the client requires assistance in securing services
- Readiness for transition to adult/mainstream case management services (Youth may remain in youth transitional case management services until age 29. Appropriateness of continued transitional case management services will be assessed annually and clients shall be transitioned into non-youth specific HIV care as appropriate but not later than

aged 30. Planning will be made for eventual transition to adult/non-youth specific case management at least by the client's 30th birthday.)

- Eligibility for the Los Angeles County Department of Mental Health (DMH) Transition Age Youth Services, Adult Services Full Service Partnership Program, and other DMH and Los Angeles County-funded programs to ensure continuing support while the client is in the YTCM program or once the client has completed or aged out of the HIV/STI YTCM services.

B. Comprehensive Assessment/Reassessment	
Standard	**Measure**
Complete and enter comprehensive assessments into DHSP's data management system within 30 days of the initiation of services. Perform reassessments at least once per year or when a client's needs change or he or she has re-entered a case management program.	Comprehensive assessment or reassessment on file in client chart to include: • Date • Signature and title of staff person • Client strengths, needs and available resources in: • Medical/health care • Medications • Adherence issues • Nutrition/food • Housing and living situation • Family and dependent care issues • DCFS and other agency involvement • Transportation • Language/literacy skills • Cultural factors • Religious/spiritual support • Social support system • Relationship history • Domestic violence/Intimate Partner Violence (IPV) • Gang impact • Violence and/or trauma • Financial resources • Public benefits • Employment • Education • Legal issues/incarceration history • Risk behaviors • HIV and STI prevention issues

	• Harm reduction services and support • Environmental factors • Resources and referrals • Assessment of readiness for transition to adult services. Readiness for adult services should link clients to programs that foster self-sufficiency, such as job training and employment programs, permanent supportive housing, and facilitate access to full range of services under the Department of Mental Health, Substance Abuse Prevention Control, and other health, medical, and social services provided in Los Angeles County.

C. Service Plan (SP)

In conjunction with the client, a SP is developed to determine the case management goals to be reached. A service plan is a tool that enables the youth transitional case manager to assist the client in systematically addressing barriers to HIV medical care by developing a concrete strategy to improve access and engagement to needed medical and other support services. A SP shall be developed within two (2) weeks of the Comprehensive Assessment/Reassessment's completion. All goals shall be determined by utilizing information gathered during assessment and subsequent reassessments.

C. **Service Plan (SP)**	
Standard	**Measure**
SPs will be developed in conjunction with the client within two weeks of completing the assessment or reassessment.	SP on file in client chart to include: • Name of client and case manager • Date and signature of case manager and client • Date and description of client goals and desired outcomes • Action steps to be taken by client, case manager and others • Goal timeframes • Disposition of each goal as it is met, changed or determined to be unattainable

D. Brief Interventions

Brief intervention sessions actively facilitate a client's entry into HIV medical care through the resolution of barriers to primary HIV-specific health care. The interventions focus on specific barriers identified through a client assessment, and assists the client in successfully addressing those barriers to HIV care. Youth transitional case managers must prepare clients for the transition into non-youth specific HIV medical services and a lifetime of managing HIV disease. This means empowering youth with information and skills necessary to increase youths' readiness to engage in non-youth specific HIV medical care.

D. Brief Interventions	
Standard	**Measure**
Case managers will: • Provide brief interventions and linked referrals • Risk Reduction Counseling: Provide risk reduction/harm reduction sessions for clients that are actively engaging in behaviors that put them at risk for transmitting HIV and acquiring other sexually transmitted infections (STIs). • Linkage to HIV Medical Care: to assist the client with access to and engagement in primary HIV-specific health care by linking them to an HIV medical clinic. • Disclosure and Partner Notification: Addressing disclosure and partner notification for clients who have not disclosed their HIV status to partner(s) or family member(s). • Help clients resolve barriers	Signed, dated progress notes on file that detail (at minimum): • Description of client contacts and actions taken • Date and type of contact • Description of what occurred • Changes in the client's condition or circumstances • Progress made toward goals • Barriers to SPs and actions taken to resolve them • Linked referrals and interventions and current status/results of same • Barriers to referrals and interventions/actions taken • Time spent with, or on behalf of, client • Case manager's signature and title • Detailed transition plan to adult services with specific linkage to health, medical, and social services.

E. Implementation of SP, Monitoring and Follow-up

Implementation, monitoring and follow-up involve ongoing contact and interventions with (or on behalf of) the client to ensure that SP 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 SP. These activities ensure that referrals are completed and services are obtained in a timely, coordinated fashion.

E. Implementation of SP, Monitoring and Follow-up	
Standard	**Measure**
Case managers will: • Provide referrals, advocacy and interventions based on the intake, assessment and SP • Monitor changes in the client's condition • Update/revise the SP • Provide brief interventions and linked referrals • Ensure coordination of care • Help clients obtain health benefits and care • Conduct monitoring and follow-up to confirm completion of referrals and service utilization • Advocate on behalf of clients with other service providers • Help clients resolve barriers • Follow up on SP goals • Maintain/attempt contact at a 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 adult case manager when appropriate • Transition clients out of transitional case management when appropriate • Develop a transition plan to adult services such as Medical Care Coordination (MCC), job placement, permanent supportive housing, or other appropriate services at least 6 months prior to the formal date of release from the YTCM program. • Upon transition case, communicate to client the availability of case manager for occasional support and role as a resource to maintain stability for client.	Signed, dated progress notes on file that detail (at minimum): • Description of client contacts and actions taken • Date and type of contact • Description of what occurred • Changes in the client's condition or circumstances • Progress made toward goals • Barriers to SPs and actions taken to resolve them • Linked referrals and interventions and current status/results of same • Barriers to referrals and interventions/actions taken • Time spent with, or on behalf of, client • Case manager's signature and title • Detailed transition plan to adult services with specific linkage to health, medical, and social services. • Documentation of expedited linkage to MCC for eligible clients.

F. Case Conferences

Programs will ensure that each case manager participates in group and/or multi-disciplinary team case conferences. Case conferences can be conducted in accordance with client care-related supervision or independently from client care-related supervision. Those case conferences conducted independently from client care-related supervision will be discussions of selected clients to assist in problem-solving related to clients' SP goal progress.

F. Case Conferences	
Standard	**Measure**
All case managers will participate in case conferences either in client care-related supervision or independently. Independent case conferences will be documented.	Documentation on file in client chart to include: • Date of case conference • Notation that conference is independent of supervision • Names and titles of participants • Issues and concerns identified • Guidance and/or follow-up plan • Results of implementing guidance/follow-up

G. Staffing Requirements and Qualifications

At minimum, all transitional case management staff will be able to provide linguistically and culturally appropriate care to clients and complete documentation as required by their positions. Case management staff will complete an agency-based orientation before providing services. Staff will also be trained and oriented regarding client confidentiality and HIPAA regulations. See Personnel and Cultural Linguistic Competence Universal Standards.

G. Staffing Requirements and Qualifications	
Standard	**Measure**
Case managers will have: • Knowledge of HIV/AIDS/STIs and related issues • Knowledge of and sensitivity to runaway, homeless or emancipated/emancipating youth • Effective interviewing and assessment skills • Knowledge of adolescent development	Resume, training certificates, interview assessment notes, reference checks, and annual performance reviews on file.

• Knowledge of, and sensitivity to, lesbian, gay, bisexual and transgender persons • Ability to appropriately interact and collaborate with others • Effective written/verbal communication skills • Ability to work independently • Effective problem-solving skills • Ability to respond appropriately in crisis situations • Effective organizational skills	
Case managers will hold a Bachelor's degree in an area of human services, social services, sociology, and other related humanities field; or high school diploma (or GED equivalent) and at least one year's experience working as an HIV case manager or at least two years' experience working within a related health services field. Prior experience providing services to runaway, homeless or emancipated/emancipating youth is preferred. Personal life experience with relevant issues is highly valued and should be considered when making hiring decisions.	Resumes on file at provider agency documenting experience. Copies of diplomas on file.
All staff will be given orientation prior to providing services.	Record of orientation in employee file at provider agency.
Case management staff will complete DHSP's required case management certifications/training within three months of being hired. Case management supervisors will complete DHSP's required supervisor's certification/training within six months of being hired.	Documentation of certification completion maintained in employee file.
Case managers will participate in in at least 20 hours of continuing education annually. Management, clerical and support staff must attend a minimum of eight hours of HIV/AIDS/STI training each year.	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	All client care-related supervision will be

minimum of four hours of client care-related supervision per month from a Master's degree-level mental health professional.	documented as follows (at minimum): • 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.
Client care-related supervision 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 for YTCM staff:

- Integrated HIV/STI prevention and care services
- 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
- Youth development issues
- Risk reduction and partner notification
- 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

Resources for Providers: Providers must use existing services in Los Angeles County to ensure the delivery of a comprehensive, client-centered YTCM program.

Department of Mental Health (DMH)
http://dmh.lacounty.gov/wps/portal/dmh/aboutdmh
Access Hotline 1-800-854-7771 (for screening, assessment, referral, and crisis counseling)

Department of Health Services (DHS)
http://dhs.lacounty.gov/wps/portal/dhs

Department of Public Social Services (DPSS)
http://dpss.lacounty.gov/wps/portal/dpss
Customer Service Center (866) 613-3777 (single point of contact for Cal-WORKS, CalFresh, Medi-Cal, and General Relief.

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