# SERVICE STANDARDS FOR TRANSITIONAL CASE MANAGEMENT: JUSTICE-INVOLVED INDIVIDUALS

LOS ANGELES COUNTY
COMMISSION ON HIV

Approved by the Commission on HIV on 12/8/22.

# SERVICE STANDARDS: TRANSITIONAL CASE MANAGEMENT- JUSTICE-INVOLVED INDIVIDUALS

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

## INTRODUCTION

Service standards for the Ryan White HIV/AIDS Part A Program outline the elements and expectations a service provider should follow when implementing a specific service category. The standards are written for providers for guidance on what services may be offered when developing their Ryan White Part A programs. The standards set the minimum level of care Ryan White funded agencies offer to clients, however, providers are encouraged to exceed these standards. The Los Angeles County Commission on HIV (COH) developed Transitional Case Management Services for justice-involved individuals standards to establish the minimum services necessary to coordinate care for individuals who are living with HIV and are transitioning back to the community and those that continue to experience recidivism. The development of the standards includes guidance from service providers, people living with HIV, the Los Angeles County Department of Public Health, Division of HIV and STD Programs (DHSP), members of the Los Angeles County Commission on HIV, Standards & Best Practices Committee, caucuses, and the public-at-large.

**SERVICE DESCRIPTION**

Transitional Case Management: Justice-Involved Individuals is a client-centered activity that coordinates care for justice-involved individuals who are living with HIV and are transitioning back to the community and experiencing recidivism. TCM services include:

- Intake and assessment of available resources and needs
- Periodic reassessment of status and needs
- Development and implementation of Individual Release Plans
- Appropriate referrals to housing, community case management, medical, mental health, and substance use treatment, dental health
- Services to facilitate retention in care, viral suppression, and overall health and wellness
- Access to HIV and STI information, education, partner services, and behavioral and biomedical interventions (such as pre-exposure prophylaxis (PrEP)) to prevent acquisition and transmission of HIV/STIs)

**RECOMMENDED TRAINING TOPICS FOR TRANSITIONAL CASE MANAGEMENT STAFF**

Transitional Case Management staff should complete ongoing training related to the provision of TCM services. Staff development and enhancement activities should include, but not be limited to:

- 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 including Grief and Loss
- Legal Issues, including Jails/Corrections Services
- Alternatives to Incarceration Training
- Integrated HIV/STI prevention and care services including Hepatitis C screening and treatment
- Sexual identification, gender issues, and provision of trans-friendly services
- Stigma and discrimination and HIV/AIDS
- Health equity and social justice
- Motivational interviewing
- Knowledge of available housing, food, and other basic need support services

The following are resources to assist agencies the health and social needs of this community:
https://wdacs.lacounty.gov/justice-involved-support-services/
https://careacttarget.org/sites/default/files/JailsLinkageIHIPPocketCard.pdf
https://www.cdc.gov/correctionalhealth/rec-guide.html
http://www.enhancelink.org/

**SERVICE STANDARDS**

All contractors must meet the Universal Standards of Care approved by the COH in addition to the following Incarcerated/Post-Release Transitional Case Management Services standards. The Universal Standards of Care can be accessed at: https://hiv.lacounty.gov/service-standards

| SERVICE COMPONENT | STANDARD | DOCUMENTATION |
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| **Outreach** | Transitional case management programs will conduct outreach to educate potential clients and HIV and STI services providers and other supportive service organizations about the availability and benefits of TCM services for justice-involved persons living with HIV. | Outreach plan on file at provider agency. |
| | Transitional case management programs will provide information sessions to incarcerated people living with HIV that facilitate enrollment into TCM services. | Record of information sessions at the provider agency. Copies of flyers and materials used.<br><br>Record of referrals provided to clients. |
| | Transitional case management programs establish appointments (whenever possible) prior to release date. | Record of appointment date. |
| **Client Intake** | Initiate a client record | Client record to include:<br>• Client name and contact information including: address, phone, and email<br>• Written documentation of HIV/AIDS diagnosis<br>• Proof of LAC Residency or documentation that client will be released to LAC residency<br>• Verification of client's financial eligibility for services<br>• Date of intake<br>• Emergency and/or next of kin contact name, home address, and telephone number<br>• Signed and dated Release of Information, Limits of |

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| | | Confidentiality, Consent, Client Rights and Responsibilities, and Grievance Procedures forms |
| **Comprehensive Assessment** | Comprehensive assessment and reassessment are completed in a cooperative process between the TCM staff and the client and entered into DHSP's data management system within 15 days of the initiation of services.<br><br>Perform reassessments at least once per year or when a client's needs change or they have re-entered a case management program.<br><br>Comprehensive assessment is conducted to determine the:<br>• Client's needs for treatment and support services including housing and food needs<br>• Client's current capacity to meet those needs<br>• Client's Medical Home post-release and linkage to Medical Case Management (MCC) team prior to release to ensure continuity of care<br>• Ability of the client's social support network to help meet client need<br>• Extent to which other agencies are involved in client's care | Comprehensive assessment or reassessment on file in client chart to include:<br>○ Date of assessment/reassessment<br>○ Signature and title of staff person conducting assessment/reassessment<br>○ Client strengths, needs and available resources in the following areas:<br>○ Medical/physical healthcare<br>○ Medications and Adherence issues<br>○ Mental health<br>○ Substance use and substance use treatment<br>○ HCV/HIV dual diagnosis<br>○ Nutrition/food<br>○ Housing and living situation<br>○ Family and dependent care issues<br>○ Access to hormone replacement therapy, gender reassignment procedures, name change/gender change clinics and other transition-related services.<br>○ Transportation<br>○ Language/literacy skills<br>○ Religious/spiritual support<br>○ Social support system<br>○ Relationship history |

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| | | ○ Domestic violence/Intimate Partner Violence (IPV)<br>○ History of physical or emotional trauma<br>○ Financial resources<br>○ Employment and Education<br>○ Legal issues/incarceration history<br>○ HIV and STI prevention issues |
| **Individual Release Plan (IRP)** | IRPs will be developed in conjunction with the client within two weeks of completing the assessment or reassessment<br><br>The IRP should address, at minimum, the following:<br>• Document discharge viral load<br>• Document discharge medications ordered<br>• Reasons for incarceration and prevention of recidivism<br>• Transportation<br>• Housing/shelter<br>• Food<br>• Primary health care<br>• Mental health<br>• Substance use treatment<br>• Community-based case management<br><br>IRPs will be updated on an ongoing basis. | IRP on file in client chart to includes:<br>• Name of client and case manager<br>• Date and signature of case manager and client<br>• Date and description of client goals and desired outcomes<br>• Action steps to be taken by client, case manager and others<br>• Customized services offered to client to facilitate success in meeting goals, such as referrals to peer navigators and other social or health services.<br>• Goal timeframes<br>• Disposition of each goal as it is met, changed, or determined to be unattainable |
| **Monitoring and** | Implementation, monitoring, and follow-up involve ongoing contact 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 access | Signed, dated progress notes on file that detail (at minimum):<br>• Description of client contacts and actions taken<br>• Date and type of contact<br>• Description of what occurred |

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| **Follow-up** | and maintains primary health care and community-based supportive services identified on the IRP.<br><br>Case managers will:<br>• Provide referrals, advocacy and interventions based on the intake, assessment, and IRP<br>• Monitor changes in the client's condition<br>• Update/revise the IRP<br>• Provide interventions and linked referrals<br>• Ensure coordination of care<br>• Help clients submit applications and obtain health benefits and care<br>• Conduct monitoring and follow-up to confirm completion of referrals and service utilization<br>• Advocate on behalf of clients with other service providers<br>• Empower clients to use independent living strategies<br>• Identify available familial or partner resources<br>• Help clients resolve barriers<br>• Follow up on IRP goals<br>• Maintain/attempt contact at a minimum of once every two weeks and at least one face-to-face contact monthly<br>• Follow up missed appointments by the end of the next business day<br>• Collaborate with the client's community-based case manager for coordination and follow-up when appropriate<br>• Transition clients out of incarcerated transitional case management at six month's | • Changes in the client's condition or circumstances<br>• Progress made toward IRP goals<br>• Barriers to IRPs and actions taken to resolve them<br>• Linked referrals and interventions and current status/results of same<br>• Barriers to referrals and interventions/actions taken<br>• Time spent with, or on behalf of, client<br>• Case manager's signature and title |

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| | post-release. Transitioning may include sharing assessment documents and other documents that were collected with the receiving provider agency | |
| **Staffing Requirements and Qualifications** | Case managers will have:<br>• Knowledge of HIV//STIs and related issues<br>• Knowledge of and sensitivity to incarceration and correctional settings and populations<br>• Knowledge of and sensitivity to lesbian, gay, bisexual, and transgender and gender-fluid persons<br>• Effective motivational interviewing and assessment skills<br>• Ability to appropriately interact and collaborate with others<br>• Effective written/verbal communication skills<br>• Ability to work independently<br>• Effective problem-solving skills<br>• Ability to respond appropriately in crisis situations<br>• Effective organizational skills<br>• Prioritize caseload<br>• Patience<br>• Multitasking skills<br><br>Refer to list of recommend training topics for Transitional Case Management Staff | Resume, training certificates, interview assessment notes, reference checks, and annual performance reviews on file. |
| | Case managers will hold a bachelor's degree in an area of human services; high school diploma (or GED equivalent) and at least one year's | Resumes on file at provider agency documenting experience. Copies of diplomas on file. |

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| | 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 justice-involved individuals is preferred. Personal life experience with relevant issues is highly valued and should be considered when making hiring decisions. | |
| | 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 certifications/training as defined in the contract. Case management supervisors will complete DHSP's required supervisor's certification/training as defined in the contract. | Documentation of certification completion maintained in employee file. |
| | Case managers and other staff will participate in recertification as required by DHSP. | Documentation of training maintained in employee files to include:<br>• Date, time, and location of function<br>• Function type<br>• Staff members attending<br>• Sponsor or provider of function<br>• Training outline, handouts, or materials<br>• 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 degree-level mental health professional. | All client care-related supervision will be documented as follows (at minimum):<br>• Date of client care-related supervision<br>• Supervision format<br>• Name and title of participants<br>• Issues and concerns identified<br>• Guidance provided and follow-up plan<br>• Verification that guidance and plan have been |

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| | | implemented<br>• 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. |