STANDARDS OF CARE FOR INCARCERATED/POST-RELEASE TRANSITIONAL CASE MANAGEMENT SERVICES

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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 and those living with HIV. TCM includes:

- Intake and assessment of available resources and needs
- Development and implementation of individual release plans or transitional independent living plans
- Coordination of services
- Interventions on behalf of the client or family
- Linked referral
- 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
- 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

Incarcerated and Post-Release Transitional Case Management (IPRTCM) provides services to incarcerated individuals who are living with HIV and are transitioning back to the community. These services include: complete psychosocial assessment; individual care plan development; appropriate referrals to housing, community case management, medical, mental health and drug treatment.

Unique Needs of the Incarcerated/Post-Release Individuals

Assuring and maintaining access to medical care and social support services for incarcerated/post-release individuals facilitate retention in care, viral suppression and overall health. However, the needs of the incarcerated and post-incarcerated individuals are unique and complex.

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

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

A. OUTREACH

Programs providing Incarcerated and Post-Release Transitional Case Management services will conduct outreach to educate potential clients, HIV and STI services providers and other supportive service organizations about the availability and benefits of transitional management services for incarcerated and post-released persons with HIV within the Los Angeles County Jail system. Promotion and outreach will include the provision of information sessions to HIV-positive inmates that facilitate enrollment into incarcerated TCM programs. Programs will collaborate with HIV primary health care and support services providers, as well as HIV and STI testing sites.

A. Outreach	
Standard	**Measure**
Transitional case management programs will outreach to potential clients and providers.	Outreach plan on file at provider agency.
Transitional case management programs will provide information sessions to HIV-positive inmates.	Record of information sessions at the provider agency. Copies of flyers and materials used. Record of referrals provided to clients.
Transitional case management programs establish appointments (whenever possible) prior to release date.	Record of appointment made with the client prior to release date.

B. COMPREHENSIVE ASSESSMENT AND REASSESSMENT

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
- 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 will remain in transitional case management services at least until age 29. Appropriateness of continued transitional case management services will be assessed annually through age 29. Planning will be made for eventual transition to adult/mainstream case management at least by the client's 29th birthday.)

B. Comprehensive Assessment	
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: o Date o Signature and title of staff person o Client strengths, needs and available resources in: o Medical/health care o Medications o Adherence issues o Physical health o Mental health o Substance use, history and treatment o Nutrition/food o Housing and living situation o Family and dependent care issues o Access to hormone replacement therapy, gender reassignment procedures, name change/gender change clinics and other transition-related services. o Transportation o Language/literacy skills o Cultural factors o Religious/spiritual support o Social support system o Relationship history o Domestic violence/Intimate Partner Violence (IPV) o Financial resources o Employment o Education o Legal issues/incarceration history o Risk behaviors o HIV and STI prevention issues o Environmental factors o Resources and referrals

C. Individual Release Plan (IRP)

In conjunction with the client, an IRP is developed that determines the case management goals to be reached. IRPs will be completed for each client within two weeks of the conclusion of the comprehensive assessment or reassessment. IRPs will be updated on an ongoing basis. At a minimum, IRPs should be updated when clients are re-assessed for their needs.

Programs will ensure that IRP goals include transportation, housing/shelter, food, primary health care, substance use treatment and community-based case management.

C. **Individual Release Plan (IRP)**	
Standard	**Measure**
IRPs will be developed in conjunction with the client within two weeks of completing the assessment or reassessment	IRP on file in client chart to includes: • 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 • 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

D. Implementation of IRP, Monitoring and Follow-up

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 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.

D. Implementation of IRP, Monitoring and Follow-up	
Standard	**Measure**
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 • Provide 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 • Empower clients to use independent living strategies • Help clients resolve barriers • Follow up on IRP 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 community-based case manager for coordination and follow-up when appropriate • Transition clients out of incarcerated transitional case management at six month's post-release.	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 IRP goals • Barriers to IRPs 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

E. Case Conferences

Programs will ensure that each case manager participates in group and/or multidisciplinary 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' IRP goal progress.

E. 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

F. Staffing Requirements and Qualifications

At minimum, all transitional case management staff will be able to provide linguistically and culturally appropriate care to people living with HIV 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.

F. **Staffing Requirements and Qualifications**	
Standard	**Measure**
Case managers will have: • Knowledge of HIV/AIDS/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	Resume, training certificates, interview assessment notes, reference checks, and annual performance reviews on file.

assessment skills • 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; 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 incarcerated individuals 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 recertification as required by DHSP and in at least 20 hours of continuing education annually. Management, clerical and support staff must attend a minimum of eight hours of HIV/ AIDS/STIs 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 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): • 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 IPRTCM staff:

- Integrated HIV/STI prevention and care services
- Substance use harm reduction models and strategies
- The role of substances in HIV and STI prevention and progression
- Sexual identification, gender issues, and provision of trans-friendly services
- Cultural competence
- Correctional 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

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