HOME-BASED CASE MANAGEMENT SERVICES SERVICE STANDARDS

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LOS ANGELES COUNTY
COMMISSION ON HIV

HOME-BASED CASE MANAGEMENT SERVICES
SERVICE STANDARDS

IMPORTANT: The service standards for Home-Based 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:

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

HIV/AIDS Bureau, 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 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 developed the Home-Based Case Management Services standards to establish the minimum standards of care necessary to ensure people living with HIV (PLWH) can receive quality Home-Based Case Management services when attending core medical and/or support services appointments and meetings. 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 Program (DHSP), members of the Los Angeles County Commission on HIV, Standards & Best Practices Committee, Women's Caucus, and the public-at-large.

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SERVICE INTRODUCTION

Home-based case management services are client-centered case management and social work activities that focus on care for people living with HIV who are functionally impaired and require intensive home and/or community-based care. Services are conducted by qualified Registered Nurse (RN) case managers and master's [1]degree-level social workers who facilitate optimal health outcomes for functionally impaired people living with HIV through advocacy, liaison, and collaboration.

Home-based case management services may include:

- Assessment
- Service planning
- Attendant care
- Homemaker services
- Medical case management
- Care coordination
- Psychosocial case management
- Mental health therapy

The goals of home-based case management for functionally impaired people living with HIV include:

- Assessing and facilitating in-home services
- Helping clients locate needed health care and supportive services
- Helping service providers coordinate care for clients
- Helping clients understand and manage their medical diagnoses, including comorbidities and other health-related diagnoses that impact HIV care treatment
- Educating clients on reducing risks for HIV infection
- Helping patients adhere to medical regimens and drug therapies
- Helping clients transition appropriately to self-management and care
- Providing appropriate, quality, cost-effective care

All contractors must meet the Universal Standards of Care in addition to the following Home-Based Case Management Services service standards outlined in Table 2. Universal Standards of Care can be accessed at: http://hiv.lacounty.gov/service-standards

[1] Social workers providing home-based case management services will hold an MSW (or related degree) or on a case-by-case basis, the agency may consider candidates with a bachelor's degree and 2-3 years of experience and practice

Table 2. HOME-BASED CASE MANAGEMENT SERVICE REQUIREMENTS

SERVICE COMPONENT	STANDARD	DOCUMENTATION
OUTREACH	Home-based case management programs will outreach to potential patients and providers.	Outreach plan on file at provider agency.
INTAKE	Intake process will begin during first contact with client.	Intake tool, completed and in client file, to include (at minimum): • Documentation of HIV status • Proof of LA County residency • Verification of financial eligibility • Date of intake • Client name, home address, mailing address and telephone number • Emergency and/or next of kin contact name, home address and telephone number
	Confidentiality Policy and Release of Information will be discussed and completed.	Release of Information signed and date by client on file and updated annually.
	Consent for Services will be completed.	Signed and dated Consent in client file.
	Client will be informed of Rights and Responsibility and Grievance Procedures.	Signed and dated forms in client file.
ASSESSMENT	Assessments will be completed within 30 days following intake. Updates to the assessment will be done on a continuous basis, but no less than once every 90 days.	Assessment or update on file in client record to include: • Date • Signature and title of staff person • Client's educational needs related to treatment • Assessment of psychological

		adjustment and coping • Consultation (or documented attempts) with health care and related social service providers • Assessment of need for home-health care services • Assessment of need for housing stability A client's primary support person should also be assessed for ability to serve as client's primary caretaker.
SERVICE PLAN	Home-based case management service plans will be developed in conjunction with the patient.	Home-based case management service plan on file in client record to include: • Name of client, RN case manager and social worker • Date/signature of RN case manager and/or social worker • Documentation that plan has been discussed with client • Client goals, outcomes, and dates of goal establishment • Steps to be taken to accomplish goals • Timeframe for goals • Number and type of client contacts • Recommendations on how to implement plan

		• Contingencies for anticipated problems or complications
IMPLEMENTATION AND EVALUATION OF SERVICE PLAN	RN case managers and social workers will: • Provide referrals, advocacy and interventions based on the intake, assessment, and case management plan • Provide referrals for housing assistance to clients that may need them based on housing stability assessment conducted on intake • Monitor changes in the client's condition • Update/revise the case management plan • Provide interventions and linked referrals • Ensure coordination of care • Conduct monitoring and follow-up • Advocate on behalf of clients • Empower clients to use independent living strategies • Help clients resolve barriers • Follow up on plan goals • Maintain ongoing contact based on need • Be involved during hospitalization or follow-up after discharge from the hospital • Follow up on missed appointments by the end of the next business day • Ensuring that State guidelines regarding	Signed, dated progress notes on file to 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 plan goals • Barriers to plan 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 • RN case manager's or social worker's signature and title

	ongoing eligibility are followed	
ATTENDANT CARE	Attendant care will be provided under supervision of a licensed nurse, as necessary.	Record of attendant care on file in client chart.
	When possible, programs will subcontract with at least Home Care Organizations (HCO) or Home Health Agencies (HHA).	Contracts on file at provider agency.
HOMEMAKER SERVICES	Homemaker services will be provided under the supervision of a licensed nurse, as necessary.	Record of homemaker services on file in client record.
	Homemaker services will be monitored at least once every 6 months.	Record of monitoring on file in the client record.
	When possible, programs will subcontract with at least HCOs or HHAs.	Contracts on file at provider agency.
HIV PREVENTION, EDUCATION AND COUNSELING	RN case manager and social worker will provide prevention and risk management education and counseling to all clients, partners, and social affiliates.	Record of services on file in client medical record.
	RN case managers and social workers will: • Screen for risk behaviors • Communicate prevention messages • Discuss sexual practices and drug use • Reinforce safer behavior • Refer for substance abuse treatment • Facilitate partner notification, counseling, and testing • Identify and treat sexually transmitted diseases including Hepatitis C[2]	Record of prevention services on file in client record.

[2] Contractors should consider expanding the clinical scope of RN Case Managers to include home-based testing for communicable infections such as Sexually Transmitted Infections (STIs), COVID-19, and blood pressure screening, blood glucose screening, and urinalysis.

	When indicated, clients will be referred to appropriately credentialed/licensed professionals for prevention education and counseling.	Record of linked referral on file in client record.
REFERRAL AND COORDINATION OF CARE	Home-based case management programs will maintain a comprehensive list of providers for full spectrum HIV-related services referrals.	Referral list on file at provider agency.
	Home-based case management programs will collaborate with other agencies and providers to provide effective, appropriate referrals.	Memoranda of Understanding detailing collaborations on file at provider agency.
	Home-based case management programs will develop procedures and protocols for referrals.	Written procedures and protocols on file at provider agency that includes process for tracking and monitoring referrals.
CASE CONFERENCE	Case conferences held by RN case managers and social workers, at minimum, will review and revise services plans at least every 60 days. Client or representative feedback will be sought.	Documentation of case conferences on file in client record to include names and titles of those participating in the review and client or representative input.
PATIENT RETENTION	Programs will develop a broken appointment policy to ensure continuity of service and retention of clients.	Written policy on file at provider agency.
	Programs will provide regular follow-up procedures to encourage and help maintain a client in home-based case management.	Documentation of attempts to contact in signed, dated progress notes. Follow-up may include: • Telephone calls • Written correspondence • Direct contact
CASE CLOSURE	Clients will be formally notified of pending case closure.	Contact attempts and notification about case closure on file in client record

	Home-based case management cases may be closed when the client: • Has achieved their home-based case management service plan goals • Relocates out of the service area • Has had no direct program contact in the past six months • Is ineligible for the service • No longer needs the service • Discontinues the service • Is incarcerated long term • Uses the service improperly or has not complied with the client services agreement • Has died	Case closure summary on file in client chart to include: • Date and signature of RN case manager and/or social worker • Date of case closure • Service plan status • Statue of primary health care and service utilization • Referrals provided • Reason for closure • Criteria for re-entry into services
POLICIES, PROCEDURES AND PROTOCOLS	Home-based case management programs will have written policies procedures and protocols, including eligibility criteria.	Policies, procedures, and protocols on file at provider agency.
STAFFING REQUIREMENTS AND QUALIFICATIONS	RNs providing home-based case management services will: • Hold a license in good standing form the California State Board of Registered Nursing • Have graduated from an accredited nursing program with a BSN or two-year nursing associate degree • Have two year's post-degree experience and one year's community or public health nursing experience • Practice within the scope defined in the California Business & Professional Code, Section 2725	Resumes on file at provider agency to verify experience. Program review and monitoring to confirm.

	Social workers providing home-based case management services will hold an MSW (or related degree) or on a case-by-case basis, the agency may consider candidates with a bachelor's degree and 2-3 years of experience and practice according to State and Federal guidelines and the Social Work Code of ethics	Resumes on file at provider agency to verify experience. Program review and monitoring to confirm.
	RN case managers and social workers will attend an annual training/briefing on public/private benefits.	Documentation of attendance in employee files.
	Staff will maintain licenses by completing continuing education requirements of their respective professional boards.	Record of continuing education in employee files at provider agency.

DEFINITIONS AND DESCRIPTIONS

Assessment is a comprehensive evaluation of each client's physical, psychological, social, environmental, and financial status to determine the type and level of service needs. Assessments will be performed in accordance with guidelines set forth by the California Department of Public Health (CDPH) Case Management Program (CMP).

Attendant Care includes the provision of non-medical personal care by a home health aide or nurse assistant certified by the CDPH. Services are provided under the direct supervision of a licensed nurse.

Home Care Organization (HCO) is an entity that provides attendant care and/or homemaker services only. HCOs are not licensed by the CDPH and are not subject to State-issued service standards or criteria.

Home Health Agency (HHA) is a public or private entity that provides skilled nursing and other therapeutic services to clients in their place of residence under a treatment plan prescribed by an attending physician. HHAs must be qualified and licensed by the CDPH as a home health agency.

Homemaker Services include general household activities performed when the client is unable to manage home care for himself or herself at home. Services are provided under the direct supervision of a licensed nurse.

Registered Nurse (RN) Case Management Services include the provision of comprehensive medical case management for people living with HIV who require intensive home and/or community-based services.

Service Plan is a written document identifying a client's problems and needs, intended interventions, and expected results, including short- and long-range goals written in measurable terms.

Social Work Case Management Services include the provision of comprehensive social work case management services including, but not limited to, psychosocial, financial, housing, and related concerns for people living with HIV who require intensive home- and/or community-based services.

Social Workers, as defined in this standard, are individuals who hold a master's degree in social work or on a case-by-case basis, the agency may consider candidates with a bachelor's degree and 2-3 years of experience that would translate well to the position.