LOS ANGELES COUNTY
COMMISSION ON HIV HEALTH SERVICES

CASE MANAGEMENT STANDARDS OF CARE

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The Case Management Task Force of Los Angeles County
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Case Management Task Force of L.A. County
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HIV/AIDS CASE MANAGEMENT STANDARDS

Executive Summary

These standards are formulated in full recognition that there is no universally accepted definition of case management as practiced among HIV/AIDS-service prociders. The purpose of these standards is to help clarify the nature of case management as well as the role of the case manager.

Case management standards describe the responsibilities of social service providers to ensure quality of case management services. These standards provide direction for professional case management practice and a framework for the evaluation of the practice. Standards also define the case manager's accountability to the public and the client outcomes for which case managers are responsible.

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SECTION I – CASE MANAGEMENT STANDARDS OF CARE

I. Definition of HIV/AIDS Case Management

HIV/AIDS case management services are client-centered activities through which services for persons who have HIV disease or AIDS is coordinated. The goal of case management is to improve health outcomes and facilitate client self-sufficiency. The case manager acts as a liaison and advocates for the client with other agencies. While educating the client on relevant information and available resources. Case managers assess, and monitor the needs, strengths, and progress of the client on an ongoing basis. Case managers identify and address needs in areas relating to the client's physical, psychosocial, environmental, financial, health education and high risk needs and facilitate the client's access to appropriate sources of health care, financial assistance, HIV education, mental health care, and other support services that promote access to and maintenance of primary medical and support services.

II. Goals of HIV/AIDS Case Management

- To ensure that each client receives and maintains access to appropriate services to promote maximum quality of life, independence and self sufficiency.
- Increase access to and utilization of medical and social services to promote early and on-going intervention.
- Increase access to HIV Health education information for primary and secondary prevention needs and foster harm-reduction activities.
- Reduce disparities by promoting continuity-of-care and follow-up of clients.
- Foster resource development, increase the coordination of linkages among service providers, to promote efficient use of community resources and eliminate service duplication

III. Major components of HIV/AIDS Case Management

HIV/AIDS Case management services most often include, but are not limited to the following:

- Intake
- Comprehensive Assessment
- Individual Service Plan (ISP) Development
- Implementation of ISP, General follow-up and Reassessment
- Acuity Level Reduction
- Case Closure

A. Client Intake

Determines if a person is eligible to register as a case management client. If the person is registered as a case management client, staff will obtain demographic data, emergency contact information and gather eligibility documentation. If the person is deemed inappropriate for services, the client will be referred to an appropriate agency for service.

Process:

* Intake is initiated by a prospective client who requests or is referred for case management services.

- Prospective client is informed of agency services and limitations, client rights and responsibilities, and client grievance procedures.

- Demographic information and required documentation is collected from the prospective client to complete the eligibility screening.

- A decision is made by the prospective client and agency case management staff to do the following: 1) open a case for the client, 2) not open a case for the client, and/or 3) refer the client to an appropriate agency or service.

Documentation:

- Date of intake
- Client name, home address, mailing address and telephone numbers
- Emergency contact name, address and phone numbers
- HIV diagnosis form
- Proof of Los Angeles County residence
- Release of Information Form (This form should be updated yearly. A new form must be initiated any time there is a need for communication with an individual not listed on the current form.)
- Limits of confidentiality form
- Statement of informed consent to receive case management services
- Client rights, responsibilities and grievance procedures form

The Release of Information, Limits of Confidentiality, Client Rights, Responsibilities and Grievance Procedures, and Statement of Informed Consent to Receive Case Management Services forms should be in client's primary language.

B. **Comprehensive Assessment**

The comprehensive assessment is a process in which the case manager has the opportunity to gather information from the client about their individual needs. It is a cooperative and interactive face-to-face interview process during which the client's medical, physical, psychosocial, environmental, risk behaviors and financial needs are identified. Educational needs are identified including the client's knowledge of transmission, re-infection, safer sex and harm-reduction, disease progression and treatment information. This information is gathered for the purpose of developing an Individual Service Plan, which is used to guide clients as they progress towards their goals and ultimately self-sufficiency.

Process:

The Comprehensive Assessment is conducted by a face-to-face interview with a case manager or other appropriate professional staff according to agency guidelines, immediately following or within two weeks of the intake.

- Continuity-of-care involves the participation of the client and their support network which may include family members, significant others, medical providers and other social service agencies. Any contact with other individuals must be done with the client's consent.

* If an agency or health-care provider is the referral source, notify them of the commencement of case management services to promote continued coordination.

* Assign an acuity level to the client according to their overall functioning and the intensity of follow-up required. (high acuity = lower functioning/higher intensity needed; medium acuity = higher functioning/lower intensity needed; low acuity = high functioning/no case management services required).

Documentation:

The Comprehensive Assessment identifies clients' current status and needs in each of the following areas and shall be signed and dated by person conducting assessment:

Environmental and Family Status (Housing, Financial and Health Care Provider), Adherence to appointments, treatments, medications; Physical Health including CD4 and Viral load levels; Employment; Education; Transportation; Legal Issues including Arrests and Probation; Social Support System; Cultural/Religious/ Spiritual factors; Risk behaviors including Substance Use, Sexual Risk Practices and Readiness to Change Baseline; Mental Health; Adjustment to illness; Counseling/Psychiatric History; and Acuity level.

C. Individual Service Plan Development

An individual service plan (ISP) is used to guide clients as they progress towards attaining self-sufficiency. The process of developing an ISP involves a series of steps that build on one another. The first step is gathering date in a thorough assessment. Although there may be a number of co-existing issues that surface during an initial assessment, the case manager must ferret out those that are most significant. The second step is to identify goals based on the information gathered in the comprehensive assessment. The third step is to continually evaluate the progress of the goals, to share this information with the client, and to revise the goals as needed.

The ISP is developed in conjunction with the client, based on the intake and assessment data. This includes the client's short-and long – term goals, steps to be taken by the client, case manager or others to meet goals, dates and disposition of goals as they are met, changed, or determined to be unattainable. The ISP is updated as frequently as needed through ongoing contact, follow-up and reassessment of client.

Process:

- The ISP is completed immediately following the Comprehensive Assessment or within two weeks from the date of Intake and Comprehensive Assessment and is implemented immediately after development. The Client signs and receives a copy of the ISP.
- After completing the Comprehensive Assessment, the case manager, along with the client develops a list of priority clients needs and sets goals that focus on long-term outcomes.
- Each goal contains objectives that are most appropriate for a given client. Each objective is a series of steps that, when completed, will result in the achievement of the long-term-goal.
- The disposition is recorded as goals are met, changed, in progress, or determined to be unattainable.
- The ISP is updated on an ongoing basis, and at a minimum of every six months.

Documentation:

- Individual Service Plan includes:
- Goals, which indicate the date established.
- Steps to be taken by the case manager, client or and/others, to reach goals.
- Time-frame by which the goals are expected to be completed.
- Disposition of the goals and date completed.
- The date and signature of both the case manager and the client.
- Supervisory signature indicating input and review, where applicable

D. Implementation of ISP, General follow-up and Reassessment

Implementation and follow-up is an on-going proc4ss that ensures that services are consistent with the ISP and evaluates whether goals and steps are being carried out. In addition, follow-up evaluation is necessary in determining whether any changes in the client's condition or circumstances warrant a change in the array of services that the client is receiving,. Assures that the care and treatment that the client is receiving from different providers is coordinated to avoid duplication or gaps in services. Through monitoring and evaluation, the Case Manager constantly re-evaluates the clients' strengths and progress towards self-sufficiency, and identifies any additional needs. Reassessment is an updated evaluation of client needs that includes the gathering of client data by the case manager. The information is gathered for the purpose of developing an updated ISP with the newly established goals.

Process:

- Direct face-to-face or telephone contact with the client, family or significant other.

- Indirect contact with the client through agency staff, health-care or social service providers. This contact may include meetings, telephone communications, written reports and letters, review of client records and related materials and agency supervision and case conferencing.

- Monitoring and reassessment of client's needs, risks, and progress through ongoing client contact. Ongoing evaluation of the client, family and significant others' status; satisfaction of case management services; and quality and appropriateness of services provided.

- The Individual Service Plan is updated with new goals and/or disposition of previous goals to follow-up and reassessment information.

- If client is continually not adhering to the Individual Service Plan goals or is exhibiting unacceptable behavior towards agency staff, clientele, property or services, a behavioral contract is established.\

Documentation:

- Progress notes including:
  - All contacts with clients, family, significant others or other service providers.
  - Changes in the client's status and progress made towards fulfilling the Individual Service Plan.
* Progress notes describing:
  * Date and type of contact
  * Time spent on behalf of the client
  * What occurred during the contact
  * Referrals, linkages, and intervention strategies identified
  * Barriers to implementation of the Individual Service Plan
  * Results of interventions/referrals, and documented linkages
- Progress notes are signed and dated by the case manager
- Updated Individual Service Plan reflecting the information gathered in follow up and reassessment.
- Updated demographic and emergency contact data
- Behavioral contract, as needed, to include what the unacceptable behavior is, expectation of acceptable behavior for future use of case management services, consequences of failure to comply with contract, and signatures of the client, Case Manager and supervisor.

E. Acuity level reduction

Case management services are intended to foster client self-sufficiency. Acuity levels are determined by the intensity of the client's needs, and the level of involvement in coordinating services by a case manager. As clients are meeting their Individual Service Plan goals, their acuity level may be reduced to reinforce their self-sufficiency. Acuity level reduction includes:

- Consistently meeting ISP goals
- Reduction of high intensity needs
- Client's ability to better coordinate their own system of care
- Client's regular adherence to medical care and support services

Process:

- After reassessment of client needs, reduce client's acuity-level as the client becomes more self-sufficient, able to negotiate community resources successfully and needing less intensive Case Management involvement.

F. Case Closure

Case closure may occur for the following reasons: client relocation outside of service area, completion of ISP goals through the acuity level reduction process, continued non-adherence to Individual Service Plan, inability to contact client, client chooses to terminate services, unacceptable client behavior, voluntary termination, or client death. If necessary, clients can utilize the agency's grievance procedure to challenge case closure decisions. Grievance procedures must be made available. Case closure includes:

- Reassessment of the client to ensure that no new needs are identified
- Completion of ISP goals and acuity level reduction process
- Establishing a means for re-entry into the case management program, if applicable
- Writing a case closure summary to include evaluation of services, plan for Continued success and ongoing resources to be utilized

* When a case is closed due to continued non-adherence to Individual Service Plan, failure to comply with behavioral contract, or inability to contact client:

- Case manager will report to supervisor the intent to close case
- Case manager makes attempt to notify the client of impending case closure through face-to-face meeting, telephone conversation or letter
- Written documentation is provided to client explaining the reason for case closure, resources available to them in the community and the grievance process to be followed if client elects to challenge the reason for case closure
- Write case closure summary to include reason for case closure and resources provided to client

* When a case is closed due to client death:

- Provide appropriate referrals to family and significant others
- Write case closure summary to include interventions and referrals provided to others involved in client's case.

Documentation:

* Case closure summary and progress note documentation

* Copy of written notification of case closure provided to the client

- Case closure summary is reviewed, approved and signed by the supervisor

IV. Direct Client, Family, Significant Other Services

A. Advocacy and Linkage- Assisting client, when necessary to access various resources and services. This may include contacting referral sources to ensure that the client's needs are being addressed.

B. Provision of Referrals: Providing client referrals and ensuring linkages to community resources to assist clients in meeting their needs.

C. HIV Education and Risk Reduction Activities- Providing basic information and educational materials, e.g.HIV/AIDS prevention/transmission/re-infection information and availability of treatment options. Involves identifying high-risk behaviors and developing a plan for risk reduction within the Individual Service Plan.

D. Benefits/Financial Counseling – Counseling client regarding the availability of private and/or public benefits, assisting with determination of eligibility, and providing information regarding access to benefits. This could include assisting clients with budgeting techniques.

E. Crisis Intervention – Contact with client during a time when the client is experiencing a situational or environmental crisis, e.g. loss of living accommodations, recent bereavement, etc. This includes ensuring referrals to appropriate mental health professionals.

F. Emotional Support – Contact which primarily focuses on emotional needs and feelings. When appropriate referrals to support groups and mental health professionals.

G. Case Conferences – Discussing selected clients with supervisor (Master's level professional) and peers to assist in problem-solving related to clients and to ensure that professional guidance and high-quality case management services are provided.

H. Consultation – Multidisciplinary interactions with other service providers to assist in the coordination of client care.

V. Administrative Services

A. Supervision – Participation in clinical (with Master's level professional) and administrative supervision sessions. Clinical supervision involves the clinical supervisor's review of the client's psychosocial needs with the case manager and providing appropriate guidance. Administrative supervision involves all other supervision that is non-client related, e.g., personnel, employee-relation issues, policies and procedures, day-to-day operations, etc.

B. Community/Agency Meetings – Participation in meetings, task-forces, working groups, networking meetings, commission and advisory board meetings. Meetings provide an opportunity for case managers to advocate for the needs of their clients, network and create linkages with other service providers and promote the availability of case management services for people living with HIV/AIDS.

B. Participation/Provision of Trainings- Attending or con-Ducting any trainings or conferences where case management and/or HIV-related information is provided.

C. Documentation- Documenting the Intake, Comprehensive Assessment, Individual Service Plans and all contacts with, or on behalf of, clients in a record/file system.

D. Quality Improvement – Developing a plan to obtain input from a committee comprised of case managers, case management supervisors, program administrators, and clients to evaluate the appropriateness of service, timeliness with which services are rendered and the availability, competency, reliability and cultural sensitivity of case managers.

SECTION 11 – PROGRAMMATIC STANDARDS OF CARE

A. Qualifications

The case manager shall possess a bachelor's degree in a human services area; or hold a high school diploma (or GED equivalent) and possess at least one year of experience working as a case manager, in the field of HIV disease, or within a related field of health and human services; or possess at least three years' experience working in the field of HIV disease, or within a related field of health and human services.

Eligible candidates shall possess:

-knowledge of HIV/AIDS and related issues
-effective interviewing and assessment skills
-sensitivity and knowledge of relevant social-diversity issues, which may impact client care. Issues include culture, race, ethnicity, gender, religion, sexual orientation, political beliefs and physical disability
-ability to appropriately interact and collaborate with others
-effective written/verbal communication skills
-abioity to work independently
-ability to work well under pressure
-effective problem-solving skills
-ability to respond appropriately in crisis situations
-effective organizational skills
-computer literacy

B. Professionalism

The case manager shall use his/her professional skills and competence to serve the client whose interests is of primary concern. It is the case manager's role to ensure that the client receives accurate and complete information about all available services based on the ongoing assessment of the client. Personal or professional gains shall never be put before a client's needs. Case managers shall not exploit relationships with clients to meet personal or agency interests.

C. Client Involvement

The case manager shall ensure that clients are involved in all phases of case management practice to the greatest extent possible. Every effort shall be made to

foster and respect maximum client self-determination., The case manager is responsible for presenting all available options so that the client can make informed decisions when selecting services.

D. Confidentiality

The case manager shall ensure the client's right to privacy and confidentiality when information about the client is released to others. All information about a client and their significant others/family members shall be held in the strictest confidence. Information may be released to other professionals and agencies only with the written permission of the client or his/her guardian. The release shall detail what information is to be disclosed, to whom, and for what purpose. The client has the right to revoke this release by written request at any time.

The case manager shall explain the limits of confidentiality to all clients. The limits of confidentiality are situations that involve a client being at risk of harming themselves or another person or suspected abuse or neglect of a child or dependent adult.

E. Advocacy

Case managers have a responsibility to advocate for their clients on a public policy level. Case managers are responsible for understanding the systems that dictate the services they provide. This may include being knowledgeable about local, state and federal legislation that impacts the health and well-being of clients, and taking action to impact these systems. Likewise, case managers need to advocate for clients within their agencies and communities to ensure that client's medical and psychosocial needs are appropriately addressed. Additionally, case managers should work with clients in building advocacy skills, as a step towards increasing self-sufficiency.

F. Coordination of Services

The case manager shall provide direct services and coordinate the delivery of services to clients and their significant others/families. The case manager shall assist the client in developing and maintaining an effective and appropriate system-of-care. It is the responsibility of the case manager to ensure consistent quality care utilizing available resources and avoiding duplication of services.

G. Quality Improvement

The case manager shall participate in evaluative and quality assurance activities designed to monitor specific outcomes that ensure the appropriateness and effectiveness of both the service-delivery system in which case management operates as well as the case manager's own case management services, and to otherwise ensure full professional accountability. The quality, effectiveness, and appropriateness of case management services shall be regularly reviewed, evaluated, and ensured using established criteria and standards.

H. Caseload Size

The case manager's caseload should be appropriate to effectively meet the needs of clients being served and to the scope of services being provided. It is the joing responsibility of the case manager and the agency to address and remedy caseload issues and concerns.

I. Professional Courtesy and Respect

The case manager shall treat clients and colleagues with professional courtesy and respect. Interactions should be characterized by a spirit of respect and caring that is critical to the case manager-client relationship. The respectful treatment of colleagues enhances the delivery of case management services to the client and increases collaboration among agencies.

J. Supervision

Case managers that provide services to clients (including any or all staff with a case management caseload) shall be supervised by a staff member (or a consultant) with three years experience providing case management services and possessing appropriate professional credentials such as a Master's in Social Work (MSW); Masters in a behavioral science, e.g. psychology, sociology, etc; or a nursing degree, medical degree; or a Ph.D. in a behavioral science with specialized case management training.

K. Training

Agencies shall provide an orientation and general case management training to all new case managers before they are assigned cases. All case managers must be certified through the Los Angeles County Case Management Certification Program. To maintain certification, case managers must attend a minimum of four Los Angeles County Case Management Certification Program approved follow-up trainings per year.

APPENDIX A

HIV CASE MANAGEMENT SYSTEM
STATEMENT OF CLIENT RIGHTS AND RESPONSIBILITIES

Sample

To participate in the development and revision of the Individual Service Plan and be informed of all services to be provided, as well as when and how it will be received.

To be given the name, agency address, agency telephone number and function of any person and affiliated agencies providing care or services to the client.

To decline any portion of the plan after being fully informed and understanding the consequences of not receiving such services.

To be involved in acuity-level reduction and case closure.

To recommend changes in policies and services.

To voice complaints and to seek protection from mental, physical and financial abuse, mistreatment and neglect.

To be informed both verbally and in writing of available grievance procedures.

To be informed of all agency rules and regulations related to the services provided.

To be treated with respect and dignity.

To have all information treated confidentially.

To communicate about services in a language and format that you understand.

To withdraw your consent for services and/or seek services at another agency and to do so without pressure or intimidation.

To receive services without regard to age, race, creed, color, gender, sexual orientation, marital status, political affiliation, or disability.

Client signature:______________________________Date:____________________

Case manager:________________________________Date:____________________

Sample

A. To participate in the development and implementation of your Individual Service Plan to the extent you are able.

B. To inform your case manager when you do not understand instructions or information received.

C. To keep your scheduled appointments with your case manager and other service providers and to notify them when you need to cancel or reschedule.

D. To notify your case manager of services you obtained independently.

E. To keep your case manager informed about the quality, appropriateness, and timeliness of services that you are receiving.

F. To communicate your needs to your case manager as quickly as possible, understanding that your case manager may not be able to satisfy "last-minute" requests.

G. To conduct yourself appropriately when interacting with persons involved in providing you services. Inappropriate behavior includes intoxication, threats, harassment as well as physical and verbal abuse.

Client signature: ________________________Date:_____________________

Case manager___________________________Date:_____________________

Note: A copy of the Client Rights, Responsibilities, and Grievance Procedures are to be given and explained to the client. The original form must be signed and dated by the client and Case Manager and placed into the client's chart.

Contractors must include their Agency Grievance Procedures Protocol.

LOS ANGELES COUNTY
COMMISSION ON HIV HEALTH SERVICES

STANDARDS OF CARE DOCUMENT

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SECTION 1. STANDARDS OF CARE COMMITTEE

In January l996, the Standards of Care Committee (SCC) formed as a Committee of the Los Angeles County Commission on HIV health Services in order to define minimum level standards of care for people living with HIV/AIDS. The SCC embarked on their task to develop standards to guide providers in their provision of care to the HIV positive community.

A. **Mission Statement** (approved March 26, l996)

Within the context of a rapidly evolving environment, the Standards of Care Committee is committed to the development and implementation of HIV Standards of Care that promote the health and well-being of all persons infected and affected by HIV. To this end, through collaboration with existing agencies and expert groups, the work of this Committee shall be based on: published professional recommendations, scientifically-based clinical practice and documented consumer experience.

B. **Standards of Care Defined** (approved March 26, l996)

Standards of Care represent tools by which individuals with, or at risk for, HIV disease can actively determine, in concert with service providers, a regimen by which they can best maintain their health.

In addition, Standards of Care represent a dynamic collection of community and scientifically-based clinical practices, through which consumers can be reasonably assured of receiving, and by which service providers can be reasonably expected of providing a comparable level of necessary HIV/AIDS-related services throughout an evolving county-wide, public-private system of healthcare.

Achievement of a countywide Standards of Care document entails public-private coordination of, and accountability for, administrative and clinical activities which support a patient-centered healthcare service delivery system embracing the following core elements.

- Patient-informed decision-making, which includes informed consent and Informed refusal

* A relatively stable system of HIV/AIDS service delivery, which supports a patient targeted coordination of resources in order to ensure continuity-of-care through a full spectrum of HIV/AIDS services

* Universal access to HIV/AIDS education and evolving body of knowledge and understanding of HIV/AIDS disease process

- Universal access to a full continuum of HIV/AIDS service delivery options, which takes into account evolving community norms and standards

- Universal access to participation in ongoing HIV/AIDS clinical trials

C. **Patient and Client Rights** (approved April 25, l996)

l. A patient or client has the right to be tested in an environment that meets Appropriate standards and offers medical/psychosocial linkages. That individual has the fight to keep their HIV status confidential or anonymous.

2. A patient or client has the right to receive culturally appropriate pre-test/risk assessment education and counseling. This session must include enough information to allow an individual to give informed consent regarding testing.

   At minimum, this session should include a group viewing of a comprehensive HIV/AIDS video. The optimum session should be one-to-one counseling focused on meeting each individual's needs.

3. A patient or client has the right to receive culturally appropriate and comprehensive post-test/disclosure education and counseling. This information should include risk reducing and preventive measures.

   The content and depth of the post-test or disclosure counseling session should address the needs of each patient or client.

4. The patient or client has the right to receive coordinated care linkages focused on their needs whether they test negative or positive, including medical/clinical referrals, a complete pyscho-social needs assessment, and a comprehensive care plan. These services need to be culturally and geographically appropriate.

- Care linkages refer to an open flow of information, open communication, and ongoing dialogue among providers in order to achieve and maintain a patient or client focused coordination of care.

- Clinical/medical needs assessment includes evaluation for referrals for substance misuse, tuberculosis and sexually transmitted disease control, nutrition, dental, vision, diagnostic studies, and medication needs.

- Psychosocial needs assessment includes evaluation for referrals for substance misuse, housing needs, mental health and transportation.

- Comprehensive care plan includes therapy options, referrals, education and alternative/complementary therapies.

D. Patient and Client Responsibilities (approved April 23, l996)

l. To participate in informed, shared decision-making, a patient or client has the responsibility to educate themselves on various HIV/AIDS issues to the best of their ability.

2. It is a patient's/client's responsibility to follow through with their risk assessment and disclosure education, counseling and/or testing sessions. This includes HIV/AIDS risk reduction and preventive measures.

3. As the ultimate decision-maker, it is a patient's or client's responsibility to communicate to providers their willingness or reluctance to participate in the processes of informed consent or informed refusal.

4. A patient or client has the responsibility to respond to provider follow-up attempts in a timely manner.

5. Patients or clients whom are either unable or unwilling to attend scheduled HIV/AIDS educational counseling or testing sessions are requested to notify their provider at least 24 hours prior to their scheduled appointment. This will allow the provider to accommodate other patient or client needs.

E. **Summary Chart of Foundational Elements** (Approved April 23, l996; revised August 26, l997)

The following chart provides a breakdown of <u>when</u> specific aspects of clinical care should be provided to HIV/AIDS consumers.

IDENTIFY/EARLY INTERVENTION		PRIMARY CARE/O.I. MANAGEMENT		LATE STAGE
Patient/s Rights & Responsibilities	Patient's Rights & Responsibilities	Patient's Rights & Responsibilities	Patient's Rights & Responsibilities	Patient's Rights & Responsibilities
Anti-Retrovirals	Anti-Retrovirals	Anti Retrovirals	Anti Retrovirals	Anti Retrovirals
Care Linkage/ Appropriate Referrals	Care Linkage/ Appropriate Referrals	Care Linkage/ Appropriate Referrals	Care Linkage/ Appropriate Referrals	Care Linkage/ Appropriate Referrals
Substance Use/ Mental Health	Substance Use/ Mental Health	Substance Use/ Mental Health	Substance Use/ Mental Health	Substance Use/ Mental Health
Labs	Labs	Labs	Labs	Labs
Patient Education	Patient Education	Patient Education	Patient Education	Patient Education
Cultural Issues	Cultural Issues	Cultural Issues	Cultural Issues	Cultural Issues
		Palliative Care	Palliative Care	Palliative Care
				End-of-Life Care

SECTION 11. STANDARDS OF CARE

This section contains the individual Standards of Care created by the Standards of Care Committee and approved by the Los Angeles County Commission on HIV Health Services. Together, these standards span the services provided within Los Angeles County's Continuum of Care. The Commission intends that each category of standards be able to exist both as a stand alone document and together as part of a whole. As a result of this dual purpose, there may be redundancies of information in some instances. This serves to ensure that each Standard of Care section is able to stand by itself without further supporting documentation

Finally, immediately following each Standard of Care section, the Commission has created and approved an condensed version of each standard to act as a quick reference guide for providers. However, in no case does this abbreviated version replace the larger, complete document.

The following Standards of Care are contained herein.

A. **COUNSELING AND TESTING**

B. **CASE MANAGEMENT**

C. **OPPORTUNISTIC INFECTION (O.I.) PROPHYLAXIS**
(Includes full text of USPHS/IDSA Guidelines for the Prevention of Opportunistic Infection in Persons Infected with Human Immunodeficiency Virus: A Summary. MMWR (July 14, l995, Vol. 44/No. RR-8) (ftp://ftp.cdc.gov/pub/Publications/mmwr/rr/rr4408.pdf)

D **GUIDELINES FOR THE USE OF ANTIRETROVIRAL AGENTS IN HIV-INFECTED ADULTS AND ADOLESCENTS, June 17, l998**

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