



SC RYAN WHITE PART B – HIV/AIDS PROGRAM

MEDICAL CASE MANAGEMENT STANDARDS

SC Department of Health and Environmental Control



The Requirements, Clarification, and Support Provided in this document apply to SC RW Part B (RWB) – Medical Case Management (MCM) recipients and sub-recipients (agencies). RWB MCM agencies are able to present Client or agency needs that may not be considered in the Requirements, Clarification, and Support Provided in this document. Each RWB MCM agency may present concerns in writing to RWB Program staff only via the following processes: 1) during annual review of standards prior to the start of each grant year and 2) during agency-specific, technical assistance forums with RWB Program Staff (i.e. prior to the RWB annual Programmatic Site Visit). The Requirements, Clarification, and Support Provided will be reviewed and updated annually prior to the start of the upcoming grant year.

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Note about Checklists

Please note that checklists included and/or referenced herein are meant to provide roadmaps that are aimed at ensuring that **ALL** components of respective Points-in-Care are met and complete. As is common knowledge, checklists are designed to ensure that no step is missed or forgotten during a clinical care continuum/process, such as is the case with this program and its different components. To that end, whereas the SCDHEC Ryan White program is not requiring any contracted provider/partner to use any or all of the checklists, completion of the components in each, and adherence to the described and agreed upon standards, is neither optional nor negotiable. Failure to meet any of the standards will result in requiring the routine use of applicable checklist(s), among other necessary corrective measures.

Thank you!

SC RYAN WHITE PART B: MEDICAL CASE MANAGEMENT STANDARDS

I. Funder Expectations

Regulatory Authorities:

The United States (US) Congress enacted the Ryan White (RW) Program in 1990. The program has been reauthorized in 1996, 2000, 2006, and 2009 with each reauthorization accommodating new and emerging needs. The US Department of Health and Human Services (DHHS) - Health Resources and Service Administration (HRSA) entrusts the HRSA HIV/AIDS Bureau (HAB) to monitor and support RW grant recipients and sub-recipients. The South Carolina (SC) Department of Health and Environmental Control (SC DHEC) is the agency in SC responsible for administering the Ryan White Part B (RWB) grant.

RWB Monitoring Standards:

HRSA National Monitoring Standards (NMS) require all recipients and sub-recipients to establish, monitor, and adhere to RWB Service Standards.

RWB Service Standards:

RWB Service Standards function to ensure that People Living with HIV or AIDS (PLWH) have access to the same fundamental components of service across the state, in a manner consistent with the goals and intent of the RW HIV/AIDS Program (RWHAP). Compliance to RWB Service Standards is evaluated annually during RWB Programmatic Site Visits.

SC RW Quality Management (SCQM):

SC RWB Medical Case Managers (MCM) are responsible for six (6) performance measures that ensure timely and coordinated access to medical and supportive services and support continuity of care within the HIV Care Continuum.

Table A: SC QM Performance Measures related to Medical Case Management (MCM)

<u>Measure # and Category</u>	<u>Continuum Stage</u>	<u>Measure Summary</u>	<u>Target</u>
11.0 – Core Measure	Retention (Quality of Care)	Percent of MCM clients with an updated care plan	85%
12.0B – Core Measure	Retention (Quality of Care)	Percent of MCM clients who keep their medical appointments every six months ^{1,2}	80%
13.0 B – Core Measure	Retention (Quality of Care)	Percent of active MCM clients who have not had a medical appointment in the past 6 months ^{1,2}	20%
1.0a – ADAP Measure	ART	Percent of SC ADAP applications that were incomplete and returned to provider	5%
2.0 a – ADAP Measure	Retention/ART	Percent of SC ADAP recertification that were incomplete and returned to provider	5%
2.0C – ADAP Measure	Retention/ART	Percentage SC ADAP enrollees who were closed for "no recertification" in the measurement year	15%

II. Ryan White Part B (RWB) Eligibility

Requirement:

To be eligible for SC Ryan White Part B (RWB) services, each Client must meet the following criteria: 1) Confirmed diagnosis of HIV or AIDS prior to receiving service; 2) Residence in SC and not a state or federal prison; 3) Income at or below 550% of the Federal Poverty Level (FPL); and 4) Third-party payment must be used to ensure RW is payer of last resort¹.

1. Eligibility for or enrollment in Medicaid or other health care programs may not be the sole factor in determining whether RWB services may also be needed to support the Client care plan (i.e. accessibility limits to Medicaid transportation or non-RW Case Management).

Clarification:

While DHEC has allocated RWB funding by service area, Clients are eligible to be served outside their service area, as long as the RWB agency has funds available. RWB service areas include groups of counties (regions) that currently differ from state health regions.

Support Provided:

Refer to [RWB Eligibility Guidelines](#) and [RWB Service Standards](#) for more detailed information on eligible income limits and eligibility details.

III. Provide Enterprise® (PE)

Requirement:

Ryan White Part B requires all MCM and support services to be entered into the customized *Provide Enterprise*® care management system for RWB and SC AIDS Drug Assistance Program (SC ADAP) Clients.

Clarification:

The *Provide Enterprise*® care management system is licensed and customized by the SC DHEC RWB Program for SC RW providers (including the SC ADAP). The SC design of *Provide Enterprise*® allows MCM to capture, review, and report a wide range of health, service and Client-centered information, in order to support the Client HIV care plan.

Support Provided:

The *Provide Enterprise*® data model in SC enables real-time information-sharing between multi-disciplinary providers and the SC ADAP, as authorized by the Client. Information released from SC ADAP includes: 1) refill history for all ADAP service tiers; 2) recertification and returned

mail alerts; 3) application/recertification processing status; and 4) third-party benefit enrollment and utilization status.

IV. Medical Case Management (MCM) - Funder Definition

HRSA defines MCM (including Treatment Adherence), as “the provision of a range of Client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of Case Management encounters (e.g., face-to-face, phone contact, and any other forms of communication).”

“Key activities of MCM include: 1) Initial assessment of service needs, 2) Development of a comprehensive, individualized care plan, 3) Timely and coordinated access to medically appropriate levels of health and support services and continuity of care, 4) Continuous Client monitoring to assess the efficacy of the care plan, 5) Re-evaluation of the care plan at least every 6 months with adaptations as necessary, 6) Ongoing assessment of the Client and other key family members’ needs and personal support systems, 7) Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments, and 8) Client-specific advocacy and/or review of utilization of services.”

Each RWB agency that is funded by DHEC for MCM services are required to use the DHEC required Point-in-Care forms (Intake, Mid-Year Review, and Reassessment) that are available on the DHEC website. Point-in-Care forms cannot have any components removed; however, agencies may add additional agency specific-questions to the forms. While discouraged, an agency with a need to use an alternate Point-in-Care form, the agency must submit the form to the DHEC RWB program for review and approval for each grant year, prior to use.

V. SC Ryan White Part B Medical Case Management (MCM) Standards

MCM 1.0 RW Eligibility Screening and Verification

MCM 1.1 Initial Contact and Registration

Requirement:

The time from initial referral (first contact from referring agency or Client) to the time a Medical Case Manager (MCM) contacts the Client is **typically within 2 days but should not exceed five (5) days**. First contact may occur face-to-face or telephone.

RWB Medical Case Managers (MCM) are **required to attempt to register each Client in Provide Enterprise® immediately upon referral, even if proof of eligibility has not been obtained.** Each RWB MCM agency has flexibility in determining which staff will attempt the registration. However, MCM involvement may be required to obtain the actual release in *Provide Enterprise®*.

Clarification:

If a Client is already registered in *Provide Enterprise®*, the “duplicate-check” feature will provide the name of the RW-funded agency that may have previously registered the Client. For release requests that have not been completed within **five (5) days**, the MCM Lead or Supervisor may contact DHEC RWB Program staff to facilitate the request. All efforts must be made to avoid duplicate Client records.

Prior to verification of eligibility: 1) Progress Logs should be entered with a Contact Type of “*Incoming Referral Services Contact*” and 2) Services Provided should be entered with a Category of “*Monitoring*”. These documentation steps are critical to avoid reporting Clients as “served” prior to RWB Eligibility Verification.

Support Provided:

For questions about a “Possible Duplicate Alert,” contact the *Provide Enterprise®* Help Desk (i.e. to determine who to contact to request the release).

RWB MCM are expected to follow the steps in the Intake Pre-visit and Post-Visit Checklist to ensure all recommended steps are completed to avoid duplicate records and duplication of effort.

MCM 1.2 Brief Assessment – [Eligibility Screening]

Requirement:

The Brief Assessment may be used as tentative eligibility screening while awaiting proof of eligibility when starting any of the following Points-in-Care (PIC): 1) Intake/Assessment; 2) Mid-Year Review; and 3) Reassessment. The Brief Assessment may be completed in-person or via telephone. Stated income and other eligibility screening information must be obtained from the Client or authorized representative.

The Brief Assessment expires **within 45 days** from the date completed if all proof of eligibility has not been obtained. **After the 45-day period**, the Client must be discharged from RWB. The Client may be re-enrolled (re-opened) with the previously started Brief Assessment when proof

of eligibility is obtained within **15 days** of the discharge. If unable to contact Client, discharge client and refer for Outreach Services.

RWB agencies that are concurrently serving the Client may share or exchange the Brief Assessment to expedite access to care and support services, as authorized by the Client.

Clarification:

Often a Client may need MCM assistance obtaining proof of eligibility or transportation to a MCM Intake/Assessment appointment. The Brief Assessment expedites access to care in accordance with the National HIV/AIDS Strategy (NHAS). Completing the Brief Assessment ensures RWB services are not provided without screening and subsequent proof of eligibility.

Support Provided:

The Brief Assessment form is contained in page 1-2 of the Comprehensive Intake/Assessment form.

MCM 1.3 Eligibility Verification

Requirement:

MCM must complete Eligibility Verification at Intake, Mid-Year review and Reassessment for each Client who is enrolled to receive RWB services, in accordance with HRSA's twice-annual (**every six months**) requirement. RWB services provided outside of the eligibility verification timeline will be deemed ineligible for payment with RWB funds. Acceptable forms and time limits for the income documentation will follow the same guidelines as the SC AIDS Drug Assistance Program (SC ADAP). Proof of eligibility documentation must be scanned into *Provide Enterprise®*.

Clarification:

Electronic storage (scanning) eligibility verification serves as a safeguard to ensure documentation is auditable for RWB Programmatic Site Visits and when applying a Client for services such as ADAP, Emergency Financial Assistance, SNAP, etc.

Support Provided:

The Intake Pre-Visit and Post-Visit Checklist explains steps for scanning eligibility documentation as required.

MCM 2.0 RW Points-in-Care and Recertification

MCM 2.1 Comprehensive Intake/Assessment - [Initial Assessment of Service Needs]

Requirement:

The Comprehensive Intake/Assessment: 1) Must be initiated no later than **30 days** from the initial contact with the Client; 2) Is considered an application for Ryan White Part B (RWB) MCM services; 3) Will **not be considered completed until proof of eligibility** is obtained from the Client and; 4) Must **be signed by the Client and the assigned MCM**.

The Comprehensive Intake/Assessment must be completed **via face-to-face** interview with the Client. Proof of eligibility must be obtained and updated during the Intake process. Acceptable forms and time limits for income documentation will follow the same guidelines as the SC AIDS Drug Assistance Program (SC ADAP). Proof of eligibility documentation must be scanned into *Provide Enterprise*®.

The Benefit Assessment Tool (BAT) must be completed for each Client to document RW as payer of last resort. MCM are expected to vigorously pursue eligibility for benefit programs. MCM or other designated staff may complete the BAT with the Client. MCM or other designated staff **must check Client Medicaid eligibility in *Provide Enterprise*®** to ensure RW is the payer of last resort. However, eligibility for or enrollment in Medicaid or other health care programs may not be the sole factor in determining whether RWB services may also be needed to support the Client care plan (i.e. accessibility limits to Medicaid transportation or non-RW Case Management).

During the Intake process, the Client should be assessed for housing stability, and a referral for housing services may be suggested in the Comprehensive Intake/Assessment form. The MCM agency must develop a system to complete all required sections of the Comprehensive Intake/Assessment and any related sub-form(s), including the Homelessness Assessment attachment/sub-form.

The Intake Action Plan must meet the following criteria: 1) Be completed within **45 days** of completing the Comprehensive Intake/Assessment; 2) Be based on Client individualized identified needs; and 3) **Be signed by the Client and MCM**. Refer to Section 2.1 for general Action Plan requirements.

Clarification:

The Intake process includes the following: 1) RWB Eligibility Verification with proof of eligibility, 2) Signed Authorization(s) for Release of medical and other service records, 3) Consent(s) for Services, 4) Client Rights and Responsibilities (including grievance process), 5) Notification of future contact for Outreach, and 6) Initial Assessment of Service Needs.

The Comprehensive Intake/Assessment form includes the following assessments: 1) Medical and Medication Needs, 2) Challenges to HIV Care, 3) HIV Medication Adherence, 4) Legal, 5) Risk, 6) Benefits, 7) Housing and Homelessness, 8) Substance Use and Mental Health, 9) Service Needs, and 10) Referrals Needed.

Support Provided:

RWB MCM are highly recommended to follow all steps indicated in the Intake Pre-visit and Post-visit Checklist. The checklist steps should begin **2-5 days** prior to the scheduled Point-in-Care (PIC) visit. Steps in the checklist reduce: 1) Client barriers to obtaining proof of eligibility, 2) duplication of effort, and 3) missed opportunities for MCM, Client and other Care Providers. For a Client who appears for a PIC visit without a scheduled appointment (walk-in), MCM must (at a minimum) print and follow steps from the Routine Visit Pre-visit and Post-visit Checklist and indicate the walk-in status in the visit Progress Log.

For HOPWA-funded Providers Only:

If Client responses indicate need for on-going housing monitoring, the MCM must complete two (2) Progress Logs when documenting the completed Comprehensive Intake/Assessment: 1) Progress Log with a Category of “*Medical Case Management*” and Funding Source as “*Ryan White*” and 2) Progress Log with a Category of “*Housing Case Management*” and Funding Source as “*HOPWA*”. The Progress Logs will require the following before the MCM or Housing Case Manager may mark it complete: 1) Program Enrollment Housing; 2) Housing Goal in the Action Plan. The Housing Goal must describe: 1) housing stability factors and 2) monitoring activities to maintain stable housing. Refer to Section 2.1 for general Action Plan requirements.

MCM 2.2 Action Plan - [Comprehensive, individualized care plan]

Requirement:

MCM must complete and review the Action Plan with Client **within 45 days** of the completed Comprehensive Intake/Assessment. The Action Plan must be signed by the Client and the assigned MCM and must reflect any individualized Client needs for services.

MCM must update the Action Plan as Client needs change. RWB requires the MCM Action Plan to be updated and reviewed with the Client at the following Points-in-care (at a minimum) in follow-up to: 1) Intake, 2) Mid-Year Review, 3) Reassessment, and 4) Client service needs change.

Clarification:

The Action Plan is a shared-responsibility plan among care providers and the Client. The Action Plan must include the following for each Goal and/or Step: 1) Support needed from the MCM and other Care Providers, 2) Action(s) needed from the Client, and 3) Specific timeframe for completion of each action.

Support Provided:

Each Point-in-Care Checklist contains a [Point-in-Care] Session Summary, which helps the MCM to quickly summarize the Comprehensive Intake/Assessment results immediately after the interview with the Client. For example, the Intake Session Summary helps the MCM to quickly develop the Action Plan and shortens time needed to enter the Progress Log after the Intake interview.

MCM 2.3 Referral Monitoring – [Timely and coordinated access to health/support services]

Requirement:

Referral monitoring is **required for all referrals for core services, including initial and on-going referrals**. Referrals should be created and tracked in *Provide Enterprise*®, in a manner consistent with required performance measures and best practices. Referrals should be **entered during the Post-visit process**. Referrals should be reviewed and updated in *Provide Enterprise*®, indicating Appointment Date and Status (i.e. Kept, Missed, Rescheduled). Referral **status updates should be entered during Pre-visit Planning**, which occurs prior to each subsequent scheduled appointment with the MCM (including Routine Visits).

Refer to SC QM Performance Measure [12.0B – Frequency of Visits] and [13.0B – Gaps in Visits]. Refer to SC QM Performance Measures for Screening for Oral Health, Mental Health, Substance Use Screenings, and Risk Behavior.

Clarification:

Nationally, the RW HIV/AIDS Program (RWHAP) awards \$3 billion annually (FY2015) ¹for HIV/AIDS programs to avail a wide range of multi-disciplinary care providers for each Client, in support of the National HIV/AIDS Strategy. It is essential and required for MCM to track Referrals. Referral follow-up must consider urgency of the need, referral agency procedures, etc.

Support Provided:

Each Point-in-Care Checklist contains detailed steps and systems of managing Referral Monitoring.

MCM 2.4 Mid-Year Review – [Continuous monitoring to assess efficacy of care plan]

Requirement:

HRSA requires MCM to recertify each Client enrolled to receive services at least every six months. The Mid-Year Review form: 1) Must be completed within **six (6) months** from the Intake or last Reassessment for each Client enrolled to receive services; 2) Is considered a recertification for RWB MCM services; 3) **Will not be considered completed until proof of eligibility** is obtained from the Client; and 4) **Must be signed by the MCM**.

The Mid-Year Review form may be completed up to **60 days** prior to its due date. If a Mid-Year Review is not completed within **60 days after the due date**, the MCM must discharge the Client due to ineligibility to receive Ryan White Part B (RWB) services.

The Mid-Year Review process may be completed via **face-to-face or telephone** interview with the Client. Proof of eligibility must be obtained and updated during the Mid-Year Review process. Acceptable forms and time limits for the income documentation will follow the same guidelines as the SC AIDS Drug Assistance Program (SC ADAP). Proof of eligibility documentation must be scanned into *Provide Enterprise*®.

¹ Kaiser Family Foundation, *State Health Facts* (HIV Funding - United States – FY2015), <http://kff.org/state-category/hivaids/>

MCM or other designated staff **must check Client Medicaid eligibility in *Provide Enterprise***[®] to ensure RW is the payer of last resort. However, eligibility for or enrollment in Medicaid or other health care programs may not be the sole factor in determining whether RWB services may also be needed to support the Client care plan (i.e. accessibility limits to Medicaid transportation or non-RW Case Management).

The Action Plan is **not required to be signed by the Client at Mid-Year Review**. The Action Plan update at Mid-Year Review must be reviewed and **updated in *Provide Enterprise***[®] **and signed by the MCM**. A **Medical Encounter must be completed 2-5 days** prior to the scheduled Mid-Year Review and **must include a printed Patient Clinical Summary** that was reviewed with the Client. MCM will update information collected in *Provide Enterprise*[®]. Refer to Section 2.1 for general Action Plan requirements.

Clarification:

The Mid-Year Review is a Point-in-Care to review the following with the Client: 1) Contact Information, 2) Clinical Outcomes including medication refill history, 3) HIV Knowledge Screening, 4) Action Plan, 5) Proof of eligibility, and 6) Medical Benefits review.

Support Provided:

RWB MCM are highly recommended to follow all steps indicated in the Mid-Year Review Pre-visit and Post-visit Checklist. The checklist steps should begin **2-5 days prior** to the scheduled Point-in-Care (PIC) visit. Steps in the checklist reduce: 1) Client barriers to obtaining proof of eligibility, 2) duplication of effort, and 3) missed opportunities for MCM, Client and other Care Providers. For a Client who appears for a PIC visit without a scheduled appointment (walk-in), MCM must (at a minimum) print and follow steps from the Routine Visit Pre-visit and Post-visit Checklist and indicate the walk-in status in the visit Progress Log.

MCM 2.5 Reassessment – [Re-evaluation and adaptation of the care plan]

Requirement:

HRSA requires MCM to recertify each Client enrolled to receive services at least **every six months**. The Reassessment process: 1) Must be completed **within 12 months** from the Intake or last Reassessment for each Client enrolled to receive services; 2) Is considered a recertification for RWB MCM services; 3) **Will not be considered completed until proof of eligibility** is obtained from the Client; and 4) **Must be signed by the Client and MCM**.

The Comprehensive Intake/Assessment form may be completed up to **60 days** prior to its due date. If a Reassessment is not completed within **60 days** after the due date, the MCM must discharge the Client due to ineligibility to receive RWB services.

The Reassessment must be completed via **face-to-face interview** with the Client. Proof of eligibility must be obtained and updated during the Reassessment process. Acceptable forms and time limits for the income documentation will follow the same guidelines as the SC AIDS Drug Assistance Program (SC ADAP). Proof of eligibility documentation must be scanned into *Provide Enterprise*®.

The Benefit Assessment Tool (BAT) must be completed during Reassessment for each Client to document RW as payer of last resort. MCM are expected to vigorously pursue eligibility for benefit programs. MCM or other designated staff may complete the BAT with the Client. MCM or other designated staff **must check Client Medicaid eligibility in *Provide Enterprise*®** to ensure RW is the payer of last resort. However, eligibility for or enrollment in Medicaid or other health care programs may not be the sole factor in determining whether RWB services may also be needed to support the Client care plan (i.e. accessibility limits to Medicaid transportation or non-RW Case Management).

The Action Plan must be: 1) Updated and reviewed at least **45 days** upon completion of the Reassessment, 2) Based on individualized identified needs, and 3) **Signed by the Client and MCM**. Refer to Section 2.1 for general Action Plan requirements.

Clarification:

The Reassessment process includes the following: 1) RWB Eligibility Verification with proof of eligibility, 2) Signed Authorization(s) for Release of medical and other service records, 3) Consent(s) for Services, 4) Client Rights and Responsibilities (including grievance process), 5) Notification of future contact for Outreach, and 6) Reassessment of Service Needs.

The Comprehensive Intake/Assessment form includes the following assessments: 1) Medical and Medication Needs, 2) Challenges to HIV Care, 3) HIV Medication Adherence, 4) Legal, 5) Risk, 6) Benefits, 7) Housing and Homelessness, 8) Substance Use and Mental Health, 9) Service Needs, and 10) Referrals Needed.

Support Provided:

RWB MCM are required to follow all steps indicated in the Reassessment Pre-visit and Post-visit Checklist. The checklist steps should begin **2-5 days prior to** the scheduled Point-in-Care (PIC) visit. Steps in the checklist reduce: 1) Client barriers to obtaining proof of eligibility, 2)

duplication of effort, and 3) missed opportunities for MCM, Client and other Care Providers. For a Client who appears for a PIC visit without a scheduled appointment (walk-in), MCM must (at a minimum) print and follow steps from the Routine Visit Pre-visit and Post-visit Checklist and indicate the walk-in status in the visit Progress Log.

MCM 3.0 On-going Monitoring

MCM 3.1 Routine Visit

Requirement:

Routine Visit(s) include face-to-face, telephone, and other Client contacts beyond the required Points-in-Care monitoring, to support the Client care plan. Routine visits must be entered via Progress Logs as Category “*Medical Case Management*”.

Support Provided:

Ryan White Part B (RWB) MCM are required to follow all steps indicated in the Routine Visit Pre-visit and Post-visit Checklist. The checklist steps should **begin 2-5 days prior** to the scheduled Point-in-Care (PIC) visit. Steps in the checklist reduce: 1) Client barriers to obtaining proof of eligibility, 2) duplication of effort, and 3) missed opportunities for MCM, Clients and other Care Providers.

MCM 3.2 Home Visit (including travel time)

Home Visits are an ideal way to assess housing and service needs. A Home Visit is advised at least once in the first year of service for new Clients. However, Home Visits are not required for RWB MCM since Client comfort level, residence status (e.g. homeless), trust, and systems to ensure confidentiality may vary by Client and RWB agency.

MCM 3.3 Pre-and Post-visit Planning - Medical Encounter

Requirement:

Since 2010, all SC DHEC-contracted, RW-funded core providers are required to create a Medical Encounter and review a Patient Clinical Summary 2-5 day prior to a visit with a core service provider, including MCM. Medical Encounters created prior to visit are included in monthly MCM Productivity minutes.

Clarification:

The Medical Encounter in *Provide Enterprise*® is an assembly of clinical and service utilization information for each Client that includes: 1) visit history, 2) labs, 3) vaccinations, 4) treatment history including tuberculosis and prophylaxis, 5) PAP smears and pregnancy monitoring, 6) screenings and referrals, and 7) medical problems/coinfections. Information is posted to the Medical Encounter from a variety of service disciplines that use *Provide Enterprise*®. The process alerts providers of missed clinical events and data gaps that are discussed with the Client in the upcoming visit. For example, clinical information that is missing may require MCM to obtain/renew the Authorization for Release during the upcoming visit, in order request release of information from the medical provider.

MCM should review pre-visit information from SC ADAP including: 1) refill history for all SC ADAP service tiers; 2) recertification and returned mail alerts to reduce gaps in refills; 3) application/recertification processing status to ensure continued eligibility for ADAP services; and 4) third-party benefit enrollment and utilization status.

Support Provided:

Pre-visit Planning steps are included in each Point-In-Care Checklist. These steps avoid missed opportunities and duplication of effort for the Client, MCM, and other Care Providers (including SC ADAP) who are part of the inter-disciplinary care team.

MCM 3.4 Care Conference and Group Level Interventions

Care Conferences are value-added, staff sessions to enhance inter-disciplinary support for Clients and their care providers. Staff meetings are considered Care Conferences by the RWB Program when participating staff: 1) Discuss specific Clients and 2) Propose and implement interventions as needed to support each Client care plan. Care Conferences typically occur weekly or bi-weekly.

As RWB agencies expand the variety of care providers (i.e. MCM, Specialized MCM, Peer Adherence Coaches, Van Drivers, Outreach Specialists, etc.), Care Conferences are increasingly useful. Documenting Care Conferences and other Group Level Interventions (GLI) in *Provide Enterprise*® requires special consideration to avoid inaccurate capturing of time each Client received during the Care Conference.

MCM 3.5 Treatment Adherence Counseling (Every Visit)

Requirement:

HRSA expects MCM to discuss HIV treatment adherence during every Client visit.

Clarification

The goal of RWB MCM is for each Client to achieve **sustained viral suppression** through access to medical care and lifelong adherence to HIV therapy.

MCM 3.6 Duty Medical Case Management Visit

Requirement:

Duty Case Management visits must be entered in Progress Logs and Services Provided. Duty Case Management visits should be entered as Progress Logs with a Category of “*Medical Case Management.*”

Clarification:

Duty Case Management is a system of availing MCM services to each Client while assigned MCM are meeting with other Clients or conducting Pre-visit Planning (i.e. during Planning Period). Duty Case Managers may also be assigned to a Client during staff transition (i.e. assigned MCM has retired or left the agency). Duty Case Management must also be used to support Clients who have Graduated from RWB MCM with minimal need for MCM services.

Support Provided:

Duty Case Management models may vary to include: 1) designated Duty Case Manager who provides services beyond benefit enrollment [ADAP/Health Insurance]; 2) MCM rotation system; or 3) Tiered staffing model.

MCM. 3.7 Caseload Monitoring

Requirement:

MCM must review and update Provider Relationships in *Provide Enterprise*® for roles of “*HIV Case Manager*” and “*Physician*” (at a minimum) during each visit with a Client. Full-time RWB MCM caseloads should be limited to 70-75 Clients.

Clarification:

Provider Relationship records in *Provide Enterprise*® are flags in each Client record that are used for the following purpose(s): 1) MCM caseload reports; 2) ADAP-related reports such as “*My ADAP Clients Needing Recertification*”; and 3) RWB Programmatic Site Visit - Chart Review.

Support Provided:

Steps and reminders to update Provider Relationships are included in each [Point-In-Care] Pre-visit and Post-visit Checklist.

MCM. 3.8 Point-in-Care Checklists

Requirement:

RWB MCM facilitates a wide range of Client-centered support for each Client care plan. The steps included are consistent with **RWB Programmatic Site Visit requirements and goals of RWB funding**.

Clarification:

MCM and MCM Supervisors should promote the use of the Point-in-Care (PIC) Checklists considering the following benefits to MCM: 1) safeguards MCM from forgotten or skipped steps that MCM were not aware should be completed; 2) establishes systems of perpetual training and standards for new and existing MCM; 3) serves as a tool for Peer-to-Peer chart review; and 4) avoids duplication of effort for the MCM and Client.

Support Provided:

Point-in-Care (PIC) Checklists (excluding Intake) auto-populate from *Provide Enterprise*® for SC RWB MCM with information on file for each Client. Point-in-Care Checklists require only the checklist itself to be printed. There are some steps to review Client Activity Summaries under the “Client Profile - Print” button. However, the summaries do not AUTOPRINT. MCM are not advised to send the summaries to the printer since they can be qualitatively reviewed on-screen.

MCM 4.0 Documentation

MCM 4.1: Progress Logs

Requirement:

MCM must complete at least **one (1) Progress Log per day for each Client served**. This allows MCM to complete one Progress Log to document all activity and services provided to/for a Client during the course of a day. The Progress Log Category should capture the primary purpose of the initial visit [that day] with the Client.

RWB allows agencies flexibility in separating or in bundling Progress Log documentation when multiple contacts are required. For bundled Progress Logs, the following safeguards exist: 1) multiple services can be linked to the Progress Log and 2) the RW Services Report (RSR) will de-duplicate visits to count only: 1 Visit/Client/Category/Day.

Each agency must maintain written guidelines for these documentation requirements and agency-required timeframe for Progress Logs to be entered into the system.

Clarification:

Progress Logs serve as the connecting fibers of the Client HIV care plan. Progress Logs demonstrate efforts of MCM to meet program guidelines, even if the Client does not appear for Points-in-Care in the required timeframe. Progress Logs also support other Care Providers who assist the MCM (i.e. Duty Case Managers) to know what assistance was offered to or utilized by the Client.

Support Provided:

MCM agencies may utilize Progress Log Sample Text to reinforce standards of care and documentation. Sample Text may be designed as “sub-forms” to ensure that key information is captured for each Client at the Point-of-Service (POS). MCM agencies may use “*All Providers*” Sample Text or create customized Sample Texts. MCM may alter Sample Text, as allowed by the RWB agency. If agencies choose to create a customized Sample Text, each sample text are required to include the same components included in the DHEC created sample texts.

MCM 4.1a: Goals Addressed

Requirement:

Provide Enterprise® for SC RWB MCM will require Progress Logs with a Category of “*Medical Case Management*” or “*Housing Case Management*” to be linked to a goal in the Client Action Plan. Refer to Section 2.1 for general Action Plan requirements.

Clarification:

The Goals Addressed tab in the Progress Log in *Provide Enterprise*® is important in linking MCM ongoing involvement to the Client Action Plan.

MCM 4.1b: Services Provided (Service Grid)

Requirement:

MCM must enter Services Provided with each Progress Log. Services Provided that have “*Minutes*” as the Unit of Measure may be captured as: [Method 1: units of 15 minutes] or [Method 2: actual minutes]. Total time in Service Grid should not exceed overall time with Client “*Length of Time in Minutes*” in the Progress Log Main tab.

Each agency must select one (1) data entry method for all MCM and maintain guidance on capturing services using 1 of the 2 methods described.

Clarification:

The Service Grid in the Progress Log allows an MCM to capture the wide-range of services provided to the Client in a single visit. MCM should enter the time or other units in the Service Grid considering the following purposes: 1) to report multiple RWHAP categories in a single step; 2) to collect data for time study when needed; and 3) to report services by funding source and units.

Support Provided:

Submit Service Grid change requests to *Provide Enterprise*® *HelpDesk*. All Service Provided additions require DHEC prior-approval. The RW Services Report (RSR) will de-duplicate visits captured as Services Provided to count only: 1 Visit/Client/Category/Day.

MCM 4.1c: Care Actions

Requirement:

Care Actions must be entered and updated for each Service Provided in the given visit. Each RWB MCM Supervisor is encouraged to standardize Care Action entry for all MCM and other staff capturing Care Actions.

Clarification:

Care Actions are requirements of a Service Category. For example, all Clients receiving MCM [Service] must have an “*Initial Assessment of Service Needs*” [Care Action], and Clients receiving Risk Reduction [Service] will receive a “*Health Education/Risk Reduction Kit*” [Care Action].

Support Provided:

Each RWB MCM agency has flexibility in the Intake/Reassessment process (i.e. Agency A has one MCM to complete the entire form and Agency B has different staff complete portions of the form). For Intake or Reassessment, MCM should select Care Actions to reflect how the process was completed with the Client. For example, Care Actions where the entire Intake is completed by the MCM may be entered as “*Initial Assessment of Service Needs*”.

MCM 4.1d: Applications

MCM must select any applications completed with the Client during the visit. For Applications that are started but not completed, do not enter the Application in the Progress Log until the day it is completed with the Client.

MCM 4.1e: Referrals

MCM must enter required Referrals as part of post-visit documentation. Where possible, Referrals should be related to goals in the Action Plan. Refer to Section 2.2 for general Referral requirements.

MCM 4.1f: Medical Encounters

A Medical Encounter must be completed in *Provide Enterprise*® as part of RWB MCM Pre-visit Planning 2-5 days, prior to the scheduled Client visit. Duty Case Managers are not required to enter a Medical Encounter for Clients receiving Duty Case Management. Refer to Section 3.3 for pre-visit Medical Encounter requirements.

MCM 4.2: Productivity Monitoring

Requirement:

Each RWB MCM is expected to meet **7,200 minutes of Productivity each month**. The expected minutes reflect the full-time efforts of staff.

The **7,200 minutes** reflects **3 working weeks** of a **4-week work month**, allowing the one excluded week to estimate time for staff meetings, trainings, and other time accountability intangibles. Estimation Method Productivity equals [Amount of time spent with Clients] / [Amount of time available for Clients].

Clarification:

The Estimation Method of monitoring Productivity intends to minimize the burden of tracking exact time variables for each MCM such as paid time off, exact time spent in meetings/training, etc.

Each RWB agency may choose to develop more exact measures of staff time monitoring. However, the following conditions must be met: 1) DHEC RWB Program staff must approve the formula and goal; 2) the agency must maintain auditable records for the contract-required retention period; and 3) denominator should consider **four (4) weeks** of a **four-week work month**.

Support Provided:

Refer to “*Productivity Report*” [report in *Provide Enterprise*®] for detailed eligible events and requirements. The report supports coaching techniques to assist MCM in meeting their monthly Productivity goals. MCM who struggle with Productivity goals are advised to attempt to contact 3 different Clients per day in the active caseload. This frequency of contact will assist MCM in learning Client needs and best approach to take, in building rapport, in managing Points-in-Care requirements, and in reducing Client crises that undermine MCM Time Management techniques.

MCM 4.3 Discharge

Requirement:

RWB enrollment is closed when the Client requests discharge, is deemed inactive (i.e. deceased or moved), or is discharged involuntarily. Each Client Discharge should be signed by the MCM and MCM Supervisor.

Clarification:

A Discharge should be documented for all Clients closed – regardless of reason (positive outcome or negative outcome). Each agency must inform Clients of the Discharge policy and steps to be taken by the agency prior to closure such as number of phone attempts, letter, etc. RWB does not require a Progress Log at Discharge. Referrals to Outreach should not delay RWB-required Discharge (i.e. no proof of eligibility) since Outreach may assist in locating closed Clients.

Support Provided:

Entering the discharge Progress Log incorrectly will inadvertently document the Discharge as a MCM visit. If MCM chooses to create a Discharge Progress Log, the Progress Log Category should be entered as “*Monitoring*,” Contact Type as “*CM Documentation*,” and Contact Flag as “*None*.” Services entered in Progress Logs should only include services with a Category of “*Monitoring*”. The Discharge Checklist contains detailed steps and systems for discharging in *Provide Enterprise*®.

MCM 4.4 Graduation Discharge

Requirement:

RWB accepts Discharge Reason “*Graduation*” when the Client needs less support from MCM. However, the following retention-oriented services must be available to the Client: 1) Duty Case Management, 2) Support Group, and 3) Outreach services (at least one contact per year).

To qualify for RWB MCM Graduation a Client must: 1) Each agency must request and receive approval from DHEC; 2) Complete at least one (1) Comprehensive Intake/Assessment form with the agency; 3) Be adherent to ART regimen; 4) Be adherent to medical care and MCM appointments; and 5) Achieve **sustained** viral suppression. MCM Supervisor must approve Graduation. Client must agree to Graduation. Client must sign written Notification of Future Outreach.

Clarification:

Each RWB MCM agency may implement RWB MCM Graduation at a pace that fits the agency. Each RWB MCM is advised to implement RWB MCM Graduation in phases, where Phase I is to review each Client for Graduation at Reassessment. The Graduation process will be reviewed by DHEC RWB Program staff at least annually, to ensure that level of service accessibility and Client outcomes are maintained.

Support Provided:

MCM may review the self-populating “*Graduation Review Summary*” report at Reassessment for review with the MCM Supervisor.

Figure 4.4 Graduation Review Summary report – Section: *Pre-visit Clinical Outcomes Review*

Client Id: 1234	Gender: Female	Age: 36
Test Results:	CD4: 600	Date: 2/15/16
	VL: 100,000	Date: 2/15/16
Decrease in CD4 in the last 12 months?	<input type="checkbox"/> Yes	From _____ to _____ <input checked="" type="checkbox"/> No
Increase in viral load in the last 12 months?	<input checked="" type="checkbox"/> Yes	From: 75,000 to 100,000 <input type="checkbox"/> No
Achieved viral suppression (less than 200)?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Maintained viral suppression for two or more years?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Number of missed ARV refills in last 6 months?	<input checked="" type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 or more	
Is client pregnant?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Other chronic conditions?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (Systems: Cardiovascular, Endocrine, Respiratory, Renal, Digestive, Neurological, Reproductive, Muscular, Immune, Skeletal, Integumentary) Diabetes, Pregnancy	
Medical visit in last six months?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Rescheduled Date: 2/15/16	
Need to contact any of the following care providers?	<input checked="" type="checkbox"/> Clinic <input checked="" type="checkbox"/> Pharmacy <input type="checkbox"/> SC ADAP <input type="checkbox"/> Other MCM <input type="checkbox"/> Caregiver <input type="checkbox"/> Transportation <input type="checkbox"/> Peer <input type="checkbox"/> Outreach <input checked="" type="checkbox"/> Other (OB)	

MCM 4.5 MCM Re-entry Appeal Process

Requirement:

Each agency must have a process for the Client to request to re-enter MCM after an involuntary Discharge. If the Client appeal is denied, the agency must work with DHEC RWB Program Staff to refer the Client to another provider when authorized by the Client.

MCM 5.0 Health Literacy (Roles of Care Providers)

MCM 5.1 Peer Adherence Coach Services (RWB)

RWB Peer Adherence Coaches provide valuable, experienced-based interventions to: 1) work with new Clients to the agency to enhance service literacy and 2) work with Clients who experience adherence **issues**. The Peer Adherence Coach is a successful consumer of HIV services and ideally has achieved optimal health outcomes (i.e. sustained viral suppression). Peer Adherence Coaches may not serve as Duty Case Managers or primary transporters. Refer to “*NHAS Initiatives Guidance*” [separate document] for detailed Peer Adherence Coach expectations and guardrails.

MCM 5.2 Outreach Specialists (RWB)

RWB Outreach Specialists use a compassionate approach to re-link a Client to care, often working with Specialized Medical Case Management (SMCM) upon the return to care. For Clients unable to be reached, refer to Outreach services immediately when MCM becomes aware of the care plan interruption. Outreach Specialists may not serve as Duty Case Managers or primary transporters. Refer to “*NHAS Initiatives Guidance*” [separate document] for detailed Outreach Specialist expectations and guardrails.

MCM 5.3 Specialized Medical Case Manager (SMCM)

RWB SMCM support Clients who are Returning to Care (RTC). Upon re-entry through SMCM, many prior steps may need to be repeated but at a slower pace. SMCM focuses heavily on building Client support system (family/friend/partner/spouse). SMCM and the Client develop an Enhanced Care Plan, where the Client sets service priority. SMCM may serve as Duty Case Managers. Refer to “*NHAS Initiatives Guidance*” [separate document] for detailed distinctions between SMCM and Traditional MCM.

MCM 6.0 MCM Lead/Supervisor Responsibilities

MCM 6.1 MCM Lead/Supervisor Caseload Limits

RWB MCM Supervisor caseloads must be limited to 15-20 Clients. MCM Lead caseloads should also be capped to ensure time demands placed on Lead MCM do not distract from care quality for Clients in the Lead MCM Caseload.

MCM 6.2 MCM Lead/Supervisor – Client-Related

MCM Lead and Supervisor Client-related review includes:

- All Client Comprehensive Intake/Assessments including those at Reassessment;
- Sample of Mid-Year Review;
- Action Plan sign-off, using “*Supervisor Review*” button in *Provide Enterprise®* as required by RWB or requested by Client or MCM;
- Discharge approval and review, including Graduation Review at Reassessment (if applicable);
- Payment Request Forms or Voucher-based service approval;
- Monitor MCM Visit Frequency for required Points-in-Care for open Clients in MCM Caseload.

MCM 6.3 MCM Lead/Supervisor – MCM Program-Related

MCM Lead and Supervisor program-related review includes **establishing and/or maintaining:**

- Caseload assignment system and reports;
- Productivity (monthly) and Productivity Improvement Plan;
- Policies/procedures/processes;
- Service modeling and improvement;
- Staff training and tracking systems;
- RWB-required Service Standards;
- Develop Sample Text(s);
- Ensure evaluative capacity (i.e. chart review readiness in accordance with RWB and agency requirements);
- Process efficiency;
- RWB required meeting attendance tracking;
- Supervise and/or integrate Specialized Interventions (i.e. NHAS Interventions);
- Communicate workgroup topics/decisions to staff in timely manner.

Clarification:

MCM Lead and/or Supervisor are essential to RWB MCM operations and service. The activities listed include direct and indirect Client service, thus excluding MCM Lead and Supervisor from the 10% Grant Administration cap.

VI. Required Trainings

Training Requirements for Ryan White Part B (RWB) Medical Case Management (MCM) New Hires

All Medical Case Managers, Medical Case Management Leads and Supervisors must complete the MCM Educational Training Series within the first year of employment.

- HIV 101
- New MCM Orientation & Provide Enterprise Training
- Benefits Navigation & ADAP Training
- Basic Counseling

Completion of all required courses and a minimum passing score of 80% on the SC Ryan White Part B Medical Case Management Knowledge exam, will result in a RWB MCM Certification of Completion.

Training Requirements for RWB MCM Continuing Education

All Medical Case Managers and Supervisors must complete at least 12 hours of continuing education in Case Management practices and/or HIV/AIDS each grant year. Documentation of completion of continuing education must be kept on file for each MCM and made available for programmatic review (i.e. site visit).

VII. Medical Case Management (MCM)-Related Resources/Policies/Tools

A. HRSA Monitoring Standards

(<https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf>)

B. SC Ryan White Part B (RWB) Service Standards

<http://www.scdhec.gov/Health/docs/stdhiv/Ryan%20White%20Part%20B%20Service%20Standards%20November%202016.pdf>

C. SC RWB Eligibility Guidelines

<https://hab.hrsa.gov/sites/default/files/hab/Global/pcn1302clienteligibility.pdf>
<http://www.scdhec.gov/Health/docs/stdhiv/RyanWhitePrtBEligibilityGuidelines.pdf>

D. HRSA Ryan White Service Definitions

<http://www.scdhec.gov/Health/docs/stdhiv/RWServiceDefinitions.pdf>

<http://www.dhec.sc.gov/health/docs/stdhiv/Core%20vs%20Support%20Services.pdf>

E. SC RW Quality Management (SCQM): 2015 SCQM Performance Measures

<http://www.scdhec.gov/Health/docs/stdhiv/2015%20SC%20Quality%20Management%20Performance%20Measures.%20Core.%20ADAP.%20Optional.%20July.2016.pdf>

F. SC RW MCM Standards: *Appendix 1 - Progress Log Documentation*

[http://www.scdhec.gov/health/docs/stdhiv/Appendix%201%20--%20CM%20Progress%20Log%20Documentation%20in%20Provide%20Enterprise%20\(Revised%20March%202011\).pdf](http://www.scdhec.gov/health/docs/stdhiv/Appendix%201%20--%20CM%20Progress%20Log%20Documentation%20in%20Provide%20Enterprise%20(Revised%20March%202011).pdf)

G. *Provide Enterprise*® - Groupware Technologies Inc.

Helpdesk: Providehelp@grouptech.com

Website: <http://www.providecm.com/provide.aspx>

Telephone number: (414) 454-0161

H. *Provide Enterprise*® TA for Service Providers (SC DHEC)

<http://www.scdhec.gov/Health/DiseasesandConditions/InfectiousDiseases/HIVandSTDs/ProvideEnterprise/>

I. DHEC RWB Staff Directory – Who to Call List

To access the RW HOPWA-Who to Call list please use the following link:

<http://scdhec.gov/Health/DiseasesandConditions/InfectiousDiseases/HIVandSTDs/GettingHelp/>

VII. MCM Standards Quick-summary of Requirements and Timeline (Chart)

MCM Standard ID	Content Area	Required Delivery Channel	Required Timeline
<u>MCM 1.0.</u>	<i>MCM 1.0 RW Eligibility Screening and Verification</i>	<i>Face-to-Face or Phone</i>	<i>Register in PE immediately upon referral</i>
<u>MCM 1.1</u>	Initial Contact and Registration	Face-to-Face or Phone	Must occur within 2 – 5 days from initial referral
<u>MCM 1.2</u>	Brief Assessment – [Eligibility Screening]	Face-to-Face or Phone	Expires in 45 days from date completed; Must close Client if no proof of eligibility
<u>MCM 1.3</u>	Eligibility Verification	Face-to-Face Must Scan Proof of Eligibility in Provide Enterprise	May re-open Client within 15 days after 45-day closure Must re-start process with client if more than 15 days after 45-day closure
<u>MCM 2.0</u>	<i>Points-In-Care and Recertification</i>	<i>See each Point-in-Care</i>	<i>See each Point-in-Care</i>
<u>MCM 2.1</u>	Comprehensive Intake/Assessment	Face-to-Face Form Signed by Client and MCM	Must be started within 30 days of initial contact with client Must check Medicaid in <i>Provide Enterprise</i> Incomplete without Proof of Eligibility

MCM Standard ID	Content Area	Required Delivery Channel	Required Timeline
<u>MCM 2.2</u>	Action Plan	At Intake – Signed by Client and MCM At Mid-Year Review (MYR) – Signed by MCM At Reassessment – Signed by Client and MCM	At Intake – within 45 days At MYR updated during post-visit At Reassessment – within 45 days
<u>MCM 2.3</u>	Referral Monitoring	Face-to-Face or Phone	Enter Post-visit Reviewed and Updated Pre-visit 2-5 days prior to next MCM appt. All Core services initial and subsequent
<u>MCM 2.4</u>	Mid-Year Review (MYR)	Face-to-Face or Phone Form signed by MCM Must Scan Proof of Eligibility in Provide Enterprise	Six months from Intake; Must create Medical Encounter 2-5 days prior to MYR AND Must Print and Review “ <i>Patient Clinical Summary</i> ” with Client MYR may occur up to 60 days early Must check Medicaid in <i>Provide Enterprise</i> ® Incomplete without proof of eligibility Must close after 60 days if not completed

MCM Standard ID	Content Area	Required Delivery Channel	Required Timeline
<u>MCM 2.5</u>	Reassessment	Face-to-Face Form Signed by Client and MCM Must Scan Proof of Eligibility in Provide Enterprise	12 months from Intake; May occur up to 60 days early Must check Medicaid in <i>Provide Enterprise</i> Incomplete without proof of eligibility Must close after 60 days if not completed
<u>MCM 3.0</u>	On-going Monitoring		Determined by Action Plan
<u>MCM 3.1</u>	Routine Visit	Face-to-Face or Phone	Determined by <u>Action Plan</u>
<u>MCM 3.2</u>	Home Visit	Face-to-Face	Determined by <u>Action Plan</u>
<u>MCM 3.3</u>	Pre-and Post-visit Planning - Medical Encounter	Planning Period	Required to print 2-5 prior to visit
<u>MCM 3.4</u>	Care Conference and Group Level Interventions	Staff Meeting	Weekly or semi-weekly
<u>MCM 3.5</u>	Treatment Adherence Counseling	Face-to-Face or Phone	Every visit
<u>MCM 3.6</u>	Duty Medical Case Management Visit	Face-to-Face or Phone	Every day via rotation system
<u>MCM 3.7</u>	Caseload Monitoring	Documentation	On-going
<u>MCM 3.8</u>	Point-in-Care Checklists	Planning Period	2-5 days prior every Point In Care including Routine Visit
<u>MCM 4.0</u>	Documentation	In Provide Enterprise	On-going
<u>MCM 4.1</u>	Progress Logs	Post-visit	Determined by agency
<u>MCM 4.1A-F</u>	Goals Addressed-Service Grid-Care Actions – Applications- Referrals	Post-visit	During PL Entry
<u>MCM 4.2</u>	Productivity	Report	Monthly Review
<u>MCM 4.3</u>	Discharge	CM Documentation	Determined by <u>Action Plan</u>
<u>MCM 4.4</u>	Graduation Discharge	Face-to-Face or Phone	Review at Reassessment
<u>MCM 4.5</u>	MCM Re-entry Appeal Process	Face-to-Face	Requested by Client

MCM Standard ID	Content Area	Required Delivery Channel	Required Timeline
<u>MCM 5.0</u>	Health Literacy (Roles of Care Providers)	Information Only	Information Only
<u>MCM 5.1</u>	Peer Adherence Coach Services (RWB)	Information Only	New Clients and Adherence Issues
<u>MCM 5.2</u>	Outreach Specialists	Information Only	When Falling or Fallen Out of Care
<u>MCM 5.3</u>	Specialized Medical Case Manager (SMCM)	Information Only	When Returning to Care
<u>MCM 6.0</u>	MCM Lead/Supervisor Responsibilities	Information Only	On-going