South Carolina Ryan White Part B
Division of STD/HIV and Viral Hepatitis

# SOUTH CAROLINA RYAN WHITE PART B

## MEDICAL CASE MANAGEMENT STANDARDS

**February 25, 2022**

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# NOTE

The information in this document applies to South Carolina RW Part B (SC RWB) Medical Case Management (MCM) recipients and sub-recipients (agencies). SC RWB MCM agencies can present Client or Agency needs that may not be considered in the information in this document. Each SC RWB MCM Agency may present concerns in writing to SC RWB Program staff.

Checklists included and/or referenced herein are meant to provide roadmaps to ensure 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, as is the case with this program and its different components. To that end, whereas the South Carolina Department of Health and Environmental Control (SC DHEC) Ryan White Part B (RWB) program is not requiring any contracted Provider/partner to use any or all 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 require the routine use of an applicable checklist(s), among other necessary corrective measures.

# FUNDER EXPECTATIONS

## Regulatory Authorities

The United States (US) Congress enacted the Ryan White (RW) Program in 1990. The program was 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. SC DHEC is the Agency in SC responsible for administering the RWB grant.

## SC RWB Monitoring Standards

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

## SC RWB Service Standards

SC 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 with SC RWB Service Standards is evaluated annually during

SC RWB Programmatic Site Visits.

## SC RWB 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.

| Measure | Continuum Stage | Measure Summary | Target |
|---|---|---|---|
| 11.0 - Core | Retention | Percent of MCM Clients with an updated Care Plan | 85% |
| 12.0B - Core | Retention | Percent of MCM Clients who keep their medical appointments every six months | 80% |
| 13.0B - Core | Retention | Percent of active MCM Clients who have not had a medical appointment in the past six months | 20% |
| 1.0A - ADAP | ART | Percent of SC ADAP applications that were incomplete and returned to the Provider | 5% |
| 2.0A - ADAP | Retention/ART | Percent of SC ADAP recertification that were incomplete and returned to the Provider | 5% |
| 2.0C - ADAP | Retention/ART | Percentage SC ADAP enrollees who were closed for "no recertification" in the measurement year | 15% |

# RYAN WHITE PART B ELIGIBILITY

To be eligible for SC RWB services, each Client must meet the following criteria:

- Confirmed diagnosis of HIV or AIDS prior to receiving Service
- Residence in SC and not a state or federal prison
- Income at or below 550% of the Federal Poverty Level (FPL)
- Third-party payment must be used to ensure RW is the payer of last resort

Refer to SC ADAP Eligibility Guidelines for more detailed information on eligible income limits and eligibility details.

HRSA HAB PCN 21-02 has eliminated the six-month recertification requirement and has given HRSA HAB recipients the ability to determine client eligibility, including complying with payor of last resort requirement, while minimizing the administrative burden and enhancing continuity of care and treatment services of individuals living with HIV/AIDS. SC DHEC has determined, based off the guidance provided by PCN 21-02, that eligibility verification will only be required once, during the enrollment into the RWB and/or ADAP program, and once annually, from that enrollment date or the date of the last eligibility verification.

PCN 21-02 states people are eligible to receive RWHAP services when they meet each of the following factors:

- HIV Status
    - A documented diagnosis of HIV. (Note: People who do not have an HIV diagnosis are eligible to receive certain services as outlined in HRSA HAB PCN 16-02 Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds,3 and as otherwise stipulated by HRSA HAB.)
- Low Income
    - The RWHAP recipient defines low-income. Low-income may be determined based on percent of Federal Poverty Level (FPL), which can be measured in several ways (e.g., Modified Adjusted Gross

Income, Adjusted Gross Income, Individual Annual Gross Income, and Household Annual Gross Income).

- Residency
    - The RWHAP recipient defines its residency criteria, within its service area.

Note: Immigration status is irrelevant for the purposes of eligibility for RWHAP services.6 RWHAP recipients or subrecipients should not share immigration status with immigration enforcement agencies.

RWHAP funds may be used to fill in coverage gaps for individuals who are either underinsured or uninsured to maintain access to care and treatment services as allowable and defined by the RWHAP. RWHAP funds may be used for core medical and support services if those services are not covered or are only partially covered by another payer (such as private or employer insurance, Medicaid, or Medicare), even when those services are provided at the same visit.

While SC DHEC has allocated SC RWB funding by service area, clients can be served outside their service area if the SC RWB Agency has funds available. SC RWB service areas include counties (regions) that differ from state health regions.

Medical Case Management and related services cannot be conditioned upon where medical care is provided. Clients may receive RW medical case management services from more than one provider.

Medical Care Services cannot be conditioned upon where medical case management services and related services are provided.

Ryan White Part B funded providers must be open to all eligible clients in accordance with federal and state laws. Ryan White Part B providers must see all clients regardless of past or current medical conditions.

Clients with one positive immunoassay may be linked to a Ryan White Part B provider for the purpose of confirmatory testing. Ryan White services should not be provided until the Client has confirmed HIV disease, confirmed through one of the following options:

- Positive HIV immunoassay and positive Western Blot or Multispot,
- Positive HIV immunoassay and detectable HIV RNA, or
- Two positive HIV immunoassays (should be different assays based on different antigens or different principles).

## PROVIDE ENTERPRISE® (PE)

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

The PE 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 PE allows MCMs to capture, review, and report a wide range of health, service, and Client-centered information to support the Client's HIV Care Plan.

The PE 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:

- Refill history for all ADAP service tiers
- Recertification and returned mail alerts
- Application/recertification processing status
- Third-party benefit enrollment and utilization status

# MEDICAL CASE MANAGEMENT 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 MCMs include:

- Initial assessment of service needs
- Development of a comprehensive, individualized Care Plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous Client monitoring to assess the efficacy of the Care Plan
- Re-evaluation of the Care Plan at least every six (6) months with adaptations as necessary
- On-going assessment of the Client and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments, and
- Client-specific advocacy and/or review of utilization of services

Each SC RWB Agency that is funded by SC DHEC for MCM services is required to use the SC DHEC required Intake/Reassessment form, which is available on the SC DHEC website. These forms cannot have any components removed; however, agencies may add additional Agency-specific questions to the forms. While discouraged, an Agency that needs to use an alternate Intake/Reassessment form must submit the form to the SC DHEC RWB program for review and approval for each grant year prior to use.

Medical Case Management and related services cannot be conditioned upon where medical care is provided. Clients may receive RW medical case management services from more than one provider.

# SC RYAN WHITE PART B MEDICAL CASE MANAGEMENT STANDARDS

## MCM 1.0: Ryan White Eligibility Screening & Verification

### MCM 1.1: Initial Contact Registration

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 two (2) days but should not exceed five (5) days. The first contact may occur face-to-face or by telephone.

SC RWB Medical Case Managers (MCM) are required to attempt to register each Client in PE immediately upon referral, even if proof of eligibility has not been obtained. Each SC 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 PE.

If a Client is already registered in PE, 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 SC DHEC RWB Program staff to facilitate the request. All efforts must be made to avoid duplicate Client records.

Prior to verification of eligibility:

- Progress Logs should be entered with a Contact Type of "Incoming Referral Services Contact"
- Services Provided should be entered with a Category of "Monitoring." These documentation steps are critical to avoid reporting Clients as "served" prior to SC RWB Eligibility Verification

For questions about a "Possible Duplicate Alert," contact the PE Help Desk (i.e., to determine who to contact to request the release). SC RWB MCMs are expected to follow the Intake Pre- and Post-Visit Checklist steps to ensure all recommended steps are completed to avoid duplicate records and duplication of effort.

### MCM 1.2: Brief Assessment

#### *Eligibility Screening*

The Brief Assessment may be used as tentative eligibility screening while awaiting proof of eligibility when starting the Comprehensive Intake Assessment and the 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 45 days, the Client must be Discharged from SC 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.

SC 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.

Often a Client may need MCM assistance obtaining proof of eligibility or transportation to an 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 SC RWB services are not provided without screening and subsequent proof of eligibility.

The Brief Assessment form is contained on pages 1-2 of the Comprehensive Intake Assessment form.

### MCM 1.3: Eligibility Verification

MCMs must complete Eligibility Verification once a year, during the Comprehensive Intake Assessment and during the Reassessment for each Client who is enrolled to receive SC RWB MCM services.

Eligibility verification is no longer required as part of the 6 Month Check-in. MCMs will assess for changes in Client's income, residency, and phone number during the 6 Month Check-in and will use the 6 Month Check-in Sample Text when creating a Progress Log in PE. Eligibility documentation is only required during the 6 Month Check-in if the Client's income and/or residency has changed.

SC RWB services provided outside the eligibility verification timeline will be deemed ineligible for payment with SC RWB funds. Acceptable forms and time limits for the income documentation will follow the SC AIDS Drug Assistance Program (SC ADAP) guidelines. Proof of eligibility documentation must be scanned into PE.

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

The Intake Pre- and Post-Visit Checklists explain steps for scanning eligibility documentation as required.

## MCM 2.0: Ryan White Points-In-Care

### MCM 2.1: Comprehensive Intake Assessment

#### *Initial Assessments of Service Needs*

The Comprehensive Intake Assessment:

- Must be initiated no later than 30 days from the initial contact with the Client

- Must be completed via a face-to-face interview with the Client
- Is considered an application for SC RWB MCM services
- Will not be considered complete until proof of eligibility is obtained from the Client
- Must include the Benefit Assessment Tool (BAT to document RW as the payer of last resort
- Must be signed by the Client and the assigned MCM
- Signed document must be scanned into PE (unless signed electronically)

The Intake process includes the following:

- SC RWB Eligibility Verification with proof of eligibility
- Signed Authorization(s) for release of medical and other service records
- Consent(s) for Services
- Client Rights and Responsibilities (including grievance process)
- Notification of future contact for Outreach
- Initial Assessment of Service Needs

Proof of eligibility must be obtained and updated during the Intake process. Acceptable forms and time limits for income documentation will follow the SC AIDS Drug Assistance Program (SC ADAP) guidelines. Proof of eligibility documentation must be scanned into PE.

The Comprehensive Intake Assessment may be signed electronically if allowed by the Agency.

MCMs are expected to vigorously pursue eligibility for benefit programs. MCMs or other designated staff may complete the BAT with the Client. MCM or other designated staff must check Client Medicaid eligibility in PE to ensure RW is the payer of last resort.

RWHAP funds may be used to fill in coverage gaps for individuals who are either underinsured or uninsured in order to maintain access to care and treatment services as allowable and defined by the RWHAP. RWHAP funds may be used for core medical and support services if those services are not covered or are only partially covered by another payer (such as private or employer insurance, Medicaid, or Medicare), even when those services are provided at the same visit.

Medical Case Management and related services cannot be conditioned upon where medical care is provided. Clients may receive RW medical case management services from more than one provider.

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:

- Be completed within 45 days of completing the Comprehensive Intake Assessment
- Be based on Client individualized identified needs
- Be signed by the Client and MCM. Action Plans may be signed electronically if allowed by the Agency.

Refer to Section 2.2 for general Action Plan requirements.

The Comprehensive Intake Assessment form includes the following assessments:

- Medical and Medication Needs
- Challenges to HIV Care
- HIV Medication Adherence
- Legal

- Risk
- Benefits
- Housing and Homelessness
- Substance Use and Mental Health
- Service Needs
- Referrals Needed

SC RWB MCMs are highly recommended to follow all steps indicated in the Intake Pre- and Post-visit Checklist. The checklist steps should begin 2-5 business days prior to the scheduled Point-in- Care (PIC) visit. Steps in the checklist reduce:

- Client barriers to obtaining proof of eligibility
- Duplication of effort
- Missed opportunities for MCM, Client and other Care Providers

For a Client who appears for a PIC visit without a scheduled appointment (walk-in), MCMs must (at a minimum) follow the steps from the Routine Visit Pre- and Post-visit Checklist and indicate the walk-in status in the visit Progress Log.

### HOPWA-funded Providers Only

If Client responses indicate a need for on-going housing monitoring, the MCM must complete two (2) Progress Logs when documenting the completed Comprehensive Intake Assessment:

- Progress Log with a Category of "Medical Case Management" and Funding Source as "Ryan White"
- 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:

- Program Enrollment Housing
- Housing Goal in the Action Plan

The Housing Goal must describe:

- Housing stability factors
- Monitoring activities to maintain stable housing

Refer to Section 2.2 for general Action Plan requirements.

## MCM 2.2: Action Plan (Care Plan)

### *Comprehensive, Individualized Care Plan*

MCMs must complete and review the Action Plan (also known as a Care Plan) with the Client within 45 days of the completed Comprehensive Intake Assessment or Reassessment. The following must be completed as part of the Action Plan:

- Must be signed by the Client and the assigned MCM
- Signed document must be scanned into PE (unless signed electronically)
- Must reflect any individualized Client needs for services
- MCMs must update the Action Plan as the Client's needs change
- Must be reviewed and updated during Points-in-Care

SC RWB requires the Action Plan to be reviewed and updated with the Client at a minimum during the following Points-in-Care:

- Intake Assessment
- 6 Month Check-in
- Reassessment

- As Client's service needs change

MCMs must click the "Reviewed" button in PE at minimum during each Point-in-Care or as service needs change.

MCMs must include the following goals for all Clients being medically case managed:
- Adherence
- Medical Case Management
- HIV Specialty Care

Action Plans may be signed electronically if allowed by the Agency.

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:
- Support needed from the MCM and other Care Providers
- Action(s) needed from the Client
- Specific timeframe for completion of each action

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

## MCM 2.3: Referrals

### *Timely & Coordinated Access to Core & Supportive Services*

Referral monitoring is required for all referrals for Core Services, including initial and on-going. The following must be completed as part of entering and monitoring Referrals:
- Should be created and tracked in PE in a manner consistent with required performance measures and best practices
- Should be entered during the Post-visit process and during the 6 Month Check-in
- Should be reviewed and updated in PE, indicating Appointment Date and Status (i.e., Kept, Missed, Rescheduled)
- Status updates should be entered during Pre-visit Planning, which occurs prior to each subsequent scheduled appointment with the MCM (including Routine Visits), and during the 6 Month Check-in,

It is essential and required for MCMs to track Referrals. Referral follow-up must consider the urgency of the need, referral Agency procedures, etc.

Each Point-In-Care Checklist contains detailed steps and systems for managing Referral Monitoring.

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.

## MCM 2.4: 6 Month Check-in

### *Continuous Monitoring & Update Client Information*

The 6 Month Check-in must be completed within six (6) months from the Intake Assessment or the last Reassessment, for each Client enrolled to receive MCM services. The 6 Month Check-in may be completed face-to-face or by telephone interview with the Client. The following must be completed as part of the 6 Month Check-in:
- Assess adherence to medical care, medication, and referrals/appointments
- Assess any service needs and update the Client's Action Plan accordingly

- Assess changes to the Client's income, residency, and phone number and update Client's PE profile accordingly

Medical Encounters during the 6 Month Check-in are optional but highly recommended.

MCMs will assess for changes in Client's income, residency, and phone number during the 6 Month Check-in and use the 6 Month Check-in Sample Text when creating a Progress Log in PE. MCMs are no longer required to submit Eligibility documentation during the 6 Month Check-in unless income and/or residency changes are indicated by the Client.

The 6 Month Check-in may be completed up to 60 days prior to its due date. If the 6 Month Check-in is not completed within 60 days after the due date, the MCM must discharge the Client and refer to Outreach, if applicable.

The Action Plan is not required to be signed by the Client at the 6 Month Check-in. The Client's Action Plan must be reviewed, updated, and documented in PE. MCMs must click the "Reviewed" button in PE during the 6 Month Check-in.

Refer to Section 2.2 for general Action Plan requirements.

### MCM 2.5: Reassessment

***Reevaluation & Adaptation of the Action Plan***

SC DHEC requires MCMs to recertify each Client enrolled to receive services once a year. The Reassessment process:

- Must be completed within 12 months from the Intake or last Reassessment for each Client enrolled to receive services
- Is considered a Recertification for SC RWB MCM services
- Will not be considered complete until proof of eligibility is obtained from the Client
- Must be signed by the Client and the MCM
- Signed document must be scanned into PE (unless signed electronically)

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 SC RWB services and refer to Outreach, if applicable.

The Reassessment must be completed via a face-to-face interview with the Client. Alternative means of completing the Reassessment may be used for special circumstances, if approved by a Supervisor. These alternative means may include telephone interviews, video conferencing, or other telehealth communications. Justification for completing the Reassessment utilizing these alternative methods must be documented in the Client's Profile.

Proof of eligibility must be obtained and updated during the Reassessment process. Acceptable forms and time limits for the income documentation will follow the SC AIDS Drug Assistance Program (SC ADAP) guidelines. Proof of eligibility documentation must be scanned into PE.

The Benefit Assessment Tool (BAT) must be completed during Reassessment for each Client to document RW as the payer of last resort. MCMs are expected to vigorously pursue eligibility for benefit programs. MCMs or other designated staff may complete the BAT with the Client. MCMs or other designated staff must check Client Medicaid eligibility in PE to ensure RW is the payer of last resort. RWHAP funds may be used to fill in coverage gaps for individuals who are either underinsured or uninsured in order to maintain access to care and treatment services as allowable and defined by the RWHAP. RWHAP funds may be used for core medical and support

services if those services are not covered or are only partially covered by another payer (such as private or employer insurance, Medicaid, or Medicare), even when those services are provided at the same visit.

The Action Plan must be:

- Updated and reviewed at least 45 days upon completion of the Reassessment
- Based on individualized identified needs
- Signed by the Client and MCM. Action Plans may be signed electronically if allowed by the Agency.

Refer to Section 2.2 for general Action Plan requirements.

The Reassessment process includes the following:

- SC RWB Eligibility Verification with proof of eligibility
- Signed Authorization(s) for release of medical and other service records. Authorization(s) of release may be signed electronically if allowed by the Agency.
- Consent(s) for Services
- Client Rights and Responsibilities (including grievance process)
- Notification of future contact for Outreach
- Reassessment of Service Needs

The Comprehensive Intake Assessment form includes the following assessments

- Medical and Medication Needs
- Challenges to HIV Care
- HIV Medication Adherence
- Legal
- Risk
- Benefits
- Housing and Homelessness
- Substance Use and Mental Health
- Service Needs
- Referrals Needed

SC RWB MCMs are required to follow all steps indicated in the Reassessment Pre- and Post-visit Checklist. The checklist steps should begin 2-5 business days prior to the scheduled Point-In-Care (PIC) visit. Steps in the checklist reduce:

- Client barriers to obtaining proof of eligibility
- Duplication of effort
- Missed opportunities for MCM, Client, and other Care Providers.

For a Client who appears for a PIC visit without a scheduled appointment (walk-in), MCMs must (at a minimum) follow steps from the Routine Visit Pre- 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

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."

SC RWB MCMs are required to follow all steps indicated in the Routine Visit Pre- and Post-visit Checklist. The checklist steps should begin 2-5 business days prior to the scheduled Point-In-Care (PIC) visit. Steps in the

checklist reduce

- Client barriers to obtaining proof of eligibility
- Duplication of effort
- Missed opportunities for MCM, Clients, and other Care Providers

## MCM 3.2: Home Visits

### *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 SC RWB MCMs since Client comfort level, residence status (e.g., homeless), trust, and systems to ensure confidentiality may vary by Client and SC RWB Agency.

## MCM 3.3: Medical Encounter

All SC DHEC-contracted, RW-funded core Providers are required to create a Medical Encounter and review a Patient Clinical Summary 2-5 business days prior to a visit with a core service Provider, including MCM. Medical Encounters created prior to a Reassessment are included in monthly MCM Productivity minutes.

Medical Encounters during the 6 Month Check-in are optional.

The Medical Encounter in PE is an assembly of clinical and Service utilization information for each Client that includes:

- Visit history
- Labs
- Vaccinations
- Screenings and referrals
- Treatment history including tuberculosis and prophylaxis
- PAP smears and pregnancy monitoring
- Medical problems/coinfections

Information is posted to the Medical Encounter from various service disciplines that use PE. The process alerts Providers of missed clinical events and data gaps discussed with the Client in the upcoming visit. For example, missing clinical information may require MCMs to obtain/renew the Authorization for Release during the upcoming visit to request release of information from the medical Provider.

MCMs should review pre-visit information from SC ADAP, including:

- Refill history for all SC ADAP service tiers
- Recertification and returned mail alerts to reduce gaps in refills
- Application/recertification processing status to ensure continued eligibility for ADAP services
- Third-party benefit enrollment and utilization status

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 interdisciplinary care team.

## MCM 3.4: Care Conference & 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 SC RWB Program when participating staff:

- Discuss specific Clients
- Propose and implement interventions as needed to support each Client's Care Plan

As SC RWB agencies expand the variety of Care Providers (i.e., MCMs, Specialized MCMs, Peer Adherence

Coaches, Van Drivers, Outreach Specialists, etc.), Care Conferences are increasingly helpful. Documenting Care Conferences and other Group Level Interventions (GLI) in PE requires special consideration to avoid inaccurate capturing of time each Client received during the Care Conference.

### MCM 3.5: Treatment Adherence Counseling

HRSA expects MCMs to discuss HIV treatment adherence during every Client visit. The goal of SC 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

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."

Duty Case Management is a system of availing MCM services to each Client while assigned MCMs 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 SC RWB MCM with minimal need for MCM services.

Duty Case Management models may vary to include:

- Designated Duty Case Manager who provides services beyond benefit enrollment (ADAP/Health Insurance)
- MCM rotation system
- Tiered staffing model

### MCM 3.7: Caseload Monitoring

MCMs must review and update Provider Relationships in PE for roles of "HIV Case Manager" and "ID Physician" (at a minimum) during each visit with a Client. Full-time SC RWB MCM caseloads should be limited to 70-75 Clients.

Provider Relationship records in PE are flags in each Client record that are used for the following purpose(s):

- MCM caseload reports
- ADAP-related reports such as "My ADAP Clients Needing Recertification"
- SC RWB Programmatic Site Visit - Chart Review

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

### MCM 3.8: Point-In-Care Checklists

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

MCMs and MCM Supervisors should promote the use of the Point-in-Care Checklists, considering the following benefits to MCM:

- Safeguards MCM from forgotten or skipped steps that MCMs were not aware should be completed
- Establishes systems of perpetual training and standards for new and existing MCMs
- Serves as a tool for Peer-to-Peer chart review
- Avoids duplication of effort for the MCM and Client

Point-in-Care Checklists (excluding Intake) auto-populate from PE with information on file for each Client. Point-In-Care Checklists are not required to be printed. There are some steps to review Client Activity Summaries under

the "Client Profile - Print" button. However, the summaries do not auto print. MCMs are not advised to print these summaries since they can be qualitatively reviewed on-screen.

# MCM 4.0: Documentation

## MCM 4.1: Progress Logs

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

SC RWB allows agencies flexibility in separating or bundling Progress Log documentation when multiple contacts are required. For bundled Progress Logs, the following safeguards exist:

- Multiple services can be linked to the Progress Log
- The RW Services Report (RSR) will de-duplicate visits to count only: one (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.

Progress Logs serve as the connecting fibers of the Client's HIV Care Plan. Progress Logs demonstrate efforts of MCMs 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.

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 essential 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. MCMs may alter Sample Text, as allowed by the SC RWB Agency. If agencies choose to create a customized Sample Text, each Sample Text are required to include the same components included in the SC DHEC created Sample Texts.

Refer to MCM Progress Log Documentation Document.

## MCM 4.1a: Goals Addressed

PE for SC RWB MCMs will require Progress Logs with a Category of "Medical Case Management" or "Housing Case Management" linked to a goal in the Client's Action Plan. The Goals Addressed tab in the Progress Log in PE are essential in linking MCM on-going involvement to the Client Action Plan.

Refer to Section 2.2 for general Action Plan requirements.

## MCM 4.1b: Services Provided Service Grid

MCMs must enter Services Provided with each Progress Log. Services Provided that have "Minutes" as the Unit of Measure may be captured as the following methods:

- Units of 15 minutes
- 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 one (1) of the two (2) methods described.

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. MCMs should enter the time or other units in the Service Grid considering the following purposes:

- To report multiple RWHAP categories in a single step
- To collect data for time study when needed
- To report services by funding source and units

Submit Service Grid change requests to PE Help Desk. All Service Provided additions require SC 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

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

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).

Each SC 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 a different staff complete portions of the form). For Intake or Reassessment, MCMs 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

MCMs 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

MCMs 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 2.3 for general Referral requirements.

### MCM 4.1f: Scan Documents

The Scan Documents tab allows MCMs to link pre-scanned documents, such as Point-In-Care documentation, to a Progress Log.

### MCM 4.2: Productivity Monitoring

Each SC 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 three (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).

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 SC RWB Agency may choose to develop more exact measures of staff time monitoring. However, the following conditions must be met:

- SC DHEC RWB Program staff must approve the formula and goal

- The Agency must maintain auditable records for the contract-required retention period
- The denominator should consider four (4) weeks of a four-week work month

Refer to "Productivity Report" (report in PE) for detailed eligible events and requirements. The report supports coaching techniques to assist MCMs in meeting their monthly Productivity goals. MCMs who struggle with Productivity goals are advised to attempt to contact three (3) different Clients per day in the active caseload. This frequency of contact will assist MCMs in learning Client needs and the best approach to build rapport, manage Points-in-Care requirements, and reduce Client crises that undermine MCM Time Management techniques.

## MCM 4.3: Discharge

SC 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.

A Discharge should be documented for all Clients closed – regardless of the 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 the number of phone attempts, letters, etc. SC RWB does not require a Progress Log at Discharge. Referrals to Outreach should not delay SC RWB-required Discharge (i.e., no proof of eligibility) since Outreach may assist in locating closed Clients.

Entering the discharge Progress Log incorrectly will inadvertently document the Discharge as an 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 PE.

## MCM 4.4: Graduation Discharge

SC 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:

- Duty Case Management
- Support Group
- Outreach services at least one contact per year

To qualify for SC RWB MCM Graduation, a Client must:

- Each Agency must request and receive approval from SC DHEC
- Complete at least one (1) Comprehensive Intake Assessment form with the Agency
- Be adherent to ART regimen
- Be adherent to medical care and MCM appointments
- Achieve sustained viral suppression

MCM Supervisor must approve Graduation. The Client must agree to Graduation and must sign a written Notification of Future Outreach.

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

MCMs may review the self-populating "Graduation Review Summary" report at Reassessment for review with the MCM Supervisor.

## MCM 4.5: MCM Re-entry Appeal Process

Each Agency must have a process for the Client to request to re-enter MCM after an involuntary discharge. If the Client's appeal is denied, the Agency must work with SC DHEC RWB Program Staff to refer the Client to another RWB-funded agency.

# MCM 5.0: Care Provider Team

## MCM 5.1: SC RWB Peer Adherence Coach Services

SC RWB Peer Adherence Coaches provide valuable, experienced-based interventions to:

- Work with new Clients to the Agency to enhance service literacy
- 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" (a separate document) for detailed Peer Adherence Coach expectations and guardrails.

## MCM 5.2: SC RWB Outreach Specialists

SC RWB Outreach Specialists use a compassionate approach to re-link a Client to care, often working with Specialized Medical Case Management (SMCM) upon returning 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" (a separate document) for detailed Outreach Specialist expectations and guardrails.

## MCM 5.3: SC RWB Specialized Medical Case Manager

SC RWB Specialized Medical Case Managers (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 a Client's support system (family/friend/partner/spouse). SMCMs and the Client develop an Enhanced Care Plan, where the Client sets service priority. SMCMs may serve as Duty Case Managers.

Refer to "NHAS Initiatives Guidance" (a separate document) for detailed distinctions between SMCMs and Traditional MCMs.

# MCM 6.0: MCM Lead/Supervisor Responsibilities

## MCM 6.1: MCM Lead/Supervisor Caseload Limits

SC 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 include:

- All Client Comprehensive Intake Assessments
- All Client Reassessments
- Review an appropriate sample size of MCM's 6 Month Check-in Progress Notes
- Action Plan sign-off, using "Supervisor Review" button in PE as required by SC RWB or requested by Client or MCM
- Approve MCM to use alternative methods to complete a Client's Reassessment
- 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's Caseload

### MCM 6.3: MCM Lead/Supervisor MCM Program-Related

MCM Lead and Supervisor program-related review include 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
- SC RWB required Service Standards
- Develop Sample Text(s)
- Ensure evaluative capacity (i.e., chart review readiness in accordance with SC RWB and Agency requirements)
- Process efficiency
- SC RWB required meeting attendance tracking
- Supervise and/or integrate Specialized Interventions (i.e., NHAS Interventions)
- Communicate workgroup topics/decisions to staff in a timely manner
- Maintain documentation of completion of required trainings and continuing education completed for each MCM

MCM Lead and/or Supervisor are essential to SC 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.

# REQUIRED TRAININGS

## MCM New Hires

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

Below is the list of required trainings based on the type of intervention. Completing all required courses and a minimum passing score of 80% on the SC RWB Medical Case Management Competency Test will result in an SC RWB MCM Certification of Completion. MCMs are only required to take these trainings once; however, it is recommended that MCMs retake any trainings when a refresher is deemed necessary by either the MCM and/or their Supervisor. Documentation of completion of required trainings must be kept on file for each MCM and made available for programmatic review (i.e., site visit).

| Trainings/Courses | MCM | SMCM |
|---|---|---|
| **HIV 101** | **Required** | **Required** |
| **Benefits Navigation Part 1** | **Required** | **Required** |
| **Benefits Navigation Part 2** | **Required** | **Required** |
| **Basic Counseling & Motivational Interviewing** | **Required** | **Required** |
| **Trauma Informed Care** | **Required** | **Required** |
| **Provide Enterprise Webinar** | **Required** | **Required** |
| **New MCM Orientation + PE Training** | **Required** | Not Recommended |
| **SMCM In-Service** | Not Recommended | **Required** |
| **Outreach In-Service** | Not Recommended | **Required** |
| **12 Hours of CEUs** | **Required** | Recommended |

## 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. MCMs who retake required trainings as a refresher can count those hours towards their 12 hours of continuing education. Documentation of completion of continuing education must be kept on file for each MCM and made available for programmatic review (i.e., site visit).

# RESOURCES, POLICIES, & TOOLS

**HRSA Monitoring Standards (April 2013)**
https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf

**SC RWB Service Standards (March 2021)**
http://www.scdhec.gov/Health/docs/stdhiv/Ryan%20White%20Part%20B%20Service%20Standards%20November%202016.pdf

**SC RWB Eligibility Guidelines**
https://scdhec.gov/aids-drug-assistance-program

**HRSA PCN 21-02**
https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/pcn21-02-determining-eligibility-polr.pdf

**HRSA Ryan White Service Definitions**
https://scdhec.gov/sites/default/files/docs/Health/docs/stdhiv/RyanWhite/PartB/RWServicedefinitions.pdf

**Core and Supportive Services**
https://scdhec.gov/sites/default/files/docs/Health/docs/stdhiv/RyanWhite/PartB/Core%20vs%20Support%20Services_%2005.2017.pdf

**SC RW Quality Management Plan (August 2021)**
https://scdhec.gov/sites/default/files/media/document/2021-ryan-white-quality-mgmt-plan.pdf

**SC RW Quality Management Performance Measures for Part B Providers**
https://scdhec.gov/sites/default/files/docs/Health/docs/stdhiv/rwqm_SC%20Quality%20MeasuresSummer2011.pdf

**SC RWB MCM Forms**
https://scdhec.gov/infectious-diseases/hiv-std-viral-hepatitis/ryan-white-part-b-technical-assistance

**MCM Trainings**
https://scdhec.gov/health-professionals/diseases-conditions-clinical-guidance-resources/hiv-aids-std-resources/hiv-support-communities

**Provide Enterprise® - Groupware Technologies Inc. (GTI)**
Helpdesk: Provide.Help@grouptech.com
Website: http://www.providecm.com
Telephone: (414) 454-0161

**SC DHEC RWB Staff Directory – Who to Call List**
https://scdhec.gov/infectious-diseases/hiv-std-viral-hepatitis/getting-help-who-call

# QUICK-SUMMARY & TIMELINES

| MCM 1.0: RW Eligibility Screening and Verification | | | |
|---|---|---|---|
| **Standard** | **Content Area** | **Delivery Channel** | **Timeline/Information** |
| MCM 1.1 | Initial Contact and Registration | • Face-to-Face or Phone | • Must occur within 2-5 business days from initial referral |
| MCM 1.2 | Brief Assessment – (Eligibility Screening) | • Face-to-Face or Phone | • Expires in 45 days from the date completed<br>• Must close Client if no proof of eligibility |
| MCM 1.3 | Eligibility Verification | • Face-to-Face<br>• Must Scan Proof of Eligibility in Provide Enterprise | • May re-open Client within 15 days after 45-day closure<br>• Must re-start process with Client if more than 15 days after 45- day closure |
| **MCM 2.0: Points-In-Care and Recertification** | | | |
| **Standard** | **Content Area** | **Delivery Channel** | **Timeline/Information** |
| MCM 2.1 | Comprehensive Intake Assessment | • Face-to-Face or by approved alternative means<br>• Form signed by Client and MCM | • Must be started within 30 days of initial contact with Client<br>• Must check Medicaid in Provide Enterprise<br>• Incomplete without Proof of Eligibility |
| MCM 2.2 | Action Plan | • At Intake – Signed by Client and MCM<br>• At 6 Month Check-in<br>• At Reassessment – signed by Client and MCM | • At Intake – within 45 days<br>• At 6 Month Check-in<br>• At Reassessment – within 45 days |
| MCM 2.3 | Referral Monitoring | • Face-to-Face or Phone | • Enter Post-visit<br>• Reviewed and Updated Pre-visit 2-5 days prior to next MCM appt.<br>• All Core services initial and subsequent |

| | | | |
|---|---|---|---|
| MCM 2.4 | 6 Month Check-in | • Face-to-Face or Phone or alternative means indicated by Agency<br>• Assess adherence to medical care, medication, and referrals/appointments<br>• Must use 6 Month Check-in Sample Text in PE<br>• Assess any service needs and update the Client's Action Plan appropriately<br>• Update Client's profile information in PE | • Six months from Intake<br>• May occur up to 60 days early<br>• Must close after 60 days if not completed |
| MCM 2.5 | Reassessment | • Face-to-Face<br>• Form signed by Client and MCM<br>• Must Scan Proof of Eligibility in Provide Enterprise | • 12 months from Intake<br>• May occur up to 60 days early<br>• Must check Medicaid in Provide Enterprise<br>• Incomplete without proof of eligibility<br>• Must close after 60 days if not completed |
| **MCM 3.0: On-going Monitoring** | | | |
| **Standard** | **Content Area** | **Delivery Channel** | **Timeline/Information** |
| MCM 3.1 | Routine Visit | • Face-to-Face or Phone | • Determined by Action Plan |
| MCM 3.2 | Home Visit | • Face-to-Face | • Determined by Action Plan |
| MCM 3.3 | Pre- and Post-visit Planning – Medical Encounter | • Planning Period | • Required to review 2-5 prior to visit |
| MCM 3.4 | Care Conference and Group Level Interventions | • Staff Meeting | • Weekly or semi-weekly |
| MCM 3.5 | Treatment Adherence Counseling | • Face-to-Face or Phone | • Every visit |
| MCM 3.6 | Duty Medical Case Management Visit | • Face-to-Face or Phone | • Every day via a rotation system |
| MCM 3.7 | Caseload Monitoring | • Documentation | • On-going |
| MCM 3.8 | Point-In-Care Checklists | • Planning Period | • 2-5 business days prior to every Point In Care including Routine Visit |
| **MCM 4.0: Documentation** | | | |
| **Standard** | **Content Area** | **Delivery Channel** | **Timeline/Information** |
| MCM 4.1 | Progress Logs | • Post-visit | • Determined by Agency |
| MCM 4.1a-f | Goals Addressed-Service Grid-Care Actions – Applications-Referrals | • Post-visit | • During Progress Log Entry |
| MCM 4.2 | Productivity | • Report | • Monthly Review |
| MCM 4.3 | Discharge | • CM Documentation | • Determined by Action Plan |

| | | | |
|---|---|---|---|
| MCM 4.4 | Graduation Discharge | • Face-to-Face or Phone | • Review at Reassessment |
| MCM 4.5 | MCM Re-entry Appeal Process | • Face-to-Face | • Requested by Client |

| MCM 5.0: Health Literacy (Roles of Care Providers) | | | |
|---|---|---|---|
| **Standard** | **Content Area** | **Delivery Channel** | **Timeline/Information** |
| MCM 5.1 | Peer Adherence Coach Services (SC RWB) | • Information Only | • New Clients and Adherence Issues |
| MCM 5.2 | Outreach Specialists | • Information Only | • When Falling or Fallen Out of Care |
| MCM 5.3 | Specialized Medical Case Manager (SMCM) | • Information Only | • When Returning to Care |