

MIAMI-DADE COUNTY RYAN WHITE PROGRAM



MEDICAL CASE MANAGEMENT STANDARDS OF SERVICE

(Revised March 1, 2011)

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**MIAMI-DADE COUNTY
RYAN WHITE PROGRAM
MEDICAL CASE MANAGEMENT STANDARDS OF SERVICE**

In addition to the System-wide Standards of Care applicable to all Part A and Minority AIDS Initiative (MAI)-funded providers, the following program specific standards apply to **medical case management providers only**. These standards are an essential component of the Ryan White quality management program and form the basis on-going monitoring and evaluation of Part A and MAI-funded medical case management providers by the Miami-Dade County Office of Grants Coordination.

With the exception of staff qualifications (*Standard #1*), it is not expected that contracted organizations be in full compliance with the Medical Case Management Standards of Service at the time of contract execution. It is assumed, however, that the service provider has read and understands the standards, and by signing a contract the provider is agreeing to make every effort to progress towards full compliance with these standards. The County recognizes that progress towards achieving compliance with the standards will differ from one service provider to another, both in terms of rate of progress and substance. However, all providers are expected to maintain full compliance at all times with the standards for documentation of client eligibility (*Standards #4 & #7*).

Medical case management is a client-centered collaborative process that meets an individual's health and support service needs by assessing, planning, implementing, coordinating, monitoring, and evaluating available options and services. Medical case management addresses situational needs and promotes continuity of care for the client. Medical case management is predicated upon client empowerment, realized through the identification of client needs and subsequent facilitation of access to appropriate services. Medical case management addresses the needs of both individual and family entities, including both adults and children.

The purpose and goals of medical case management are: 1) to maintain the client in on-going medical care and treatment; 2) to coordinate services across funding streams; 3) to reduce service duplication across providers; 4) to assist the client with accessing needed services; 5) to use available funds and services in the most efficient and effective manner; 6) to increase the client's adherence to the care plan (i.e., including coordination and follow-up of medical treatment and the medication regimen) through counseling; 7) to empower clients to remain as independent as possible; 8) to improve service and client health outcomes; and 9) to control costs while ensuring that client needs are properly addressed.

Staff Qualifications

Standard #1

All medical case management supervisors, medical case managers and peer counselors shall have sufficient education, knowledge, skills, and experience to competently serve the HIV/AIDS client population.

Guidelines	Indicators	Data Source
<p>(1.1 – 1.9) All medical case management supervisors, medical case managers and peer counselors must meet the qualifications of education and experience required by the Miami-Dade County Office of Grants Coordination.</p>	<p>Medical Case Management Supervisors: 1.1 Master’s degree OR Bachelor’s degree with 5 years work experience in HIV/AIDS 1.2 HIV/AIDS and supervisory experience preferred 1.3 Completion of a proficiency test based on required system-wide training within 12 months of hire</p> <p>Medical Case Managers:*</p> <p>1.4 Bachelor’s degree in a social science area OR, Bachelor’s of Science in Nursing (BSN) degree with 6 months of case management experience OR, Bachelor’s degree not in a social science with 1 year of case management experience 1.5 Knowledge of HIV/AIDS disease and the Miami-Dade HIV/AIDS service delivery system preferred 1.6 Completion of a proficiency test based on required system-wide training within 12 mos. of hire. <i>*An individual in a case management position prior to the effective date of these standards (August 12, 2002) may substitute applicable experience on a year-to-year basis for the required education.</i></p> <p>Peer Counselors 1.7 High school degree 1.8 One year’s experience in HIV/AIDS services 1.9 Training on funding streams for HIV/AIDS services and eligibility criteria for these services</p>	<ul style="list-style-type: none"> ➤ Personnel files <ul style="list-style-type: none"> • Copies of degrees • Documentation, validation of work experience (for example, letter from former employer or documented telephone interview with former employer) • Copies of degrees • Documentation, validation of work experience (for example, letter from former employer or documented telephone interview with former employer) • Proof of knowledge on HIV/AIDS services, eligibility for these services and funding streams • Training Certificate • Copy of degree • Documentation of HIV/AIDS service system experience (letters of reference, documented telephone interview) • Proof of training on HIV/AIDS services , eligibility for these services and funding streams

Training

Standard #2

To ensure the highest level of medical case management service, medical case management supervisors, medical case managers and peer counselors, through initial and ongoing monthly trainings, shall be continuously updated on changes in HIV/AIDS health care, the community-wide service system (services and limitations), community resources, local, state, and federal programs in the area.

Guidelines	Indicators	Data Source
<p>(2.1 – 2.4) Medical case management supervisors, medical case managers, and peer counselors shall comply with all training requirements mandated and approved by the Miami-Dade County Office of Grants Coordination.</p> <p>(2.5) Medical case managers and peer counselors shall maintain all updated materials and lists of resources provided at trainings.</p>	<p>Medical case management supervisors, medical case managers and peer counselors shall complete:</p> <p>2.1 HIV/AIDS 104¹ within 1 month of hire</p> <p>2.2 Medical case management supervisors: 32 hours annually of quarterly Ryan White Program Medical Case Manager Supervisor Training, of which up to 8 hours may be substituted by another Ryan White Program-approved supervisory management-related training</p> <p>2.3 Medical case managers and peer counselors: 20 hours annually of monthly system-wide case management related training (i.e., monthly Ryan White Program Medical Case Manager Training)</p> <p>2.4 In addition to the training hours in 2.3, medical case managers and peer counselors in the Ryan White Program System less than 2 yrs: 20 hours of basic case management training¹</p> <p>2.5 Provider/service listings, updated Ryan White Program Case Management Handbook, other training materials as appropriate</p>	<p>➤ Personnel files</p> <ul style="list-style-type: none"> • 104 Certificate dated within 1 month of hire • Proof of attendance, certificate or other documentation including training subject matter, date(s) of attendance, hours in training. • Agency training record • Case management system- wide attendance logs • Training Certificate • Training agendas • On-site inspection/observation

¹HIV/AIDS 104 and basic case management training are not part of the 20-hour system-wide training requirement (item 2.3).

No Barriers to Service

Standard #3

Client access to medical case management and peer counseling services shall be facilitated in a timely and orderly manner.

Guidelines	Indicators	Data Source
<p>(3.1 – 3.2) Initial intake and financial eligibility assessment initiated.</p>	<p>No later than 5 workdays from a request for service or receipt of referral:</p> <p>3.1 Appointment made for intake/financial eligibility assessment</p> <p>3.2 Medical case manager assigned</p>	<ul style="list-style-type: none"> ➤ Record review <ul style="list-style-type: none"> • Intake/financial eligibility forms dated within 5 days of filed referral or date of service request AND • Intake progress note reflects: Date of referral or service request and date of intake/financial eligibility assessment • Record reflects name of assigned medical case manager and date of assignment
<p>(3.3) If client wishes to meet with a peer counselor, an appointment is facilitated.</p>	<p>3.3 Meeting will take place no later than 2 workdays from the date of request for service or receipt of referral.</p>	<ul style="list-style-type: none"> ➤ Record review <ul style="list-style-type: none"> • Dated progress note reflects date of referral OR date of request for service AND service rendered or refused per progress note from peer counselor documenting appointment completed or appointment declined <i>(See Standards #4 and #5)</i>

Eligibility and Financial Assessment *

Standard #4

A comprehensive eligibility and financial assessment shall be completed taking into account all funding streams and services for which the client may qualify: the client’s education and orientation to the service delivery system and to client rights and responsibilities shall be initiated.

Guidelines	Indicators	Data Source
<p>(4.1 – 4.11) Eligibility and financial assessment shall ensure all required documents are present and filed in the eligibility section of the client chart. Clients shall be informed of their right to: confidentiality in accordance with state and federal laws, choice of providers, explanation of grievance procedures, privacy in compliance with HIPAA regulations (4.11), and rights and responsibilities (4.2).</p>	<p>No later than 10 workdays from receipt of referral or date of request for service, the following shall be completed:</p> <ul style="list-style-type: none"> 4.1 Client Chart/Record Face Sheet 4.2 Composite Consent (includes Client Bill of Rights and Responsibilities) 4.3 Consent to Release and Exchange Information (SDIS) 4.4 Proof of HIV 4.5 Proof of Income 4.6 Financial Assessment 4.7 Current and valid proof of Miami-Dade County residency 4.8 Picture ID (for identification purposes only, may be expired) 4.9 Social Security (if client has SS Number) 4.10 Eligibility screening for third party payers 4.11 Miami-Dade County Notice of Privacy Practices 4.12 Outreach Consent 	<ul style="list-style-type: none"> ➤ Record review <ul style="list-style-type: none"> • All required forms are complete, initialed, dated, and signed as appropriate. <i>(See Standard #5, 5.9- 5.11)</i> • Copies of required eligibility documents are present and legible. • Documentation of eligibility screening for third party payers is present. <i>(See Standard #11, 11.1 – 11.4)</i>

* *Eligibility and financial assessment need not be done by a case manager. This function may be performed by a trained eligibility clerk or a peer counselor with the appropriate training to conduct financial assessment and eligibility screening.*

Initial Client Assessment and Plan of Care

Standard #5

The medical case manager shall develop a comprehensive and individualized Needs Assessment and Plan of Care (POC); orientation and education on the service delivery system shall continue; the client shall be assisted to access timely, appropriate services; medication adherence shall be reinforced and medical information necessary to appropriately serve the client shall be obtained; and the POC will include activities related to the coordination and follow-up of the client’s medical treatment.

Guidelines	Indicators	Data Source
<p>(5.1 – 5.3) An initial comprehensive assessment and plan of care shall be completed for all case management clients to include:</p> <p>Adherence assessment with appropriate client referrals to existing adherence programs as part of the POC.</p> <p>Referrals to the University of Miami for pregnant women shall be made within 24 hours of initial contact with the case manager.</p>	<p>No later than 5 workdays from completion of the eligibility/financial assessment the medical case manager shall complete:</p> <p>5.1 Initial Comprehensive Assessment 5.2 Initial Plan of Care (POC) 5.3 Referrals</p>	<p>➤ Record review ➤ SDIS review</p> <ul style="list-style-type: none"> • Completed, dated, signed (medical case manager and client) comprehensive assessment • Completed, dated, signed (medical case manager and client) POC based on needs identified in the comprehensive assessment
<p>(5.4 – 5.7) All referrals shall be documented in the POC. <i>(Applies to the referring agency.)</i></p>	<p>Referrals documented in the POC will include:</p> <p>5.4 Date and purpose of referral 5.5 Frequency of the requested service, if applicable 5.6 Provider of the requested service (agency receiving the referral) 5.7 Documentation reflecting follow-up of referral(s)</p>	<ul style="list-style-type: none"> • SDIS Referral Report • POC • Progress notes <p><i>(See Standards# 6, 6.2 – 6.8; #11, 11.1 – 11.4)</i></p>
<p>(5.8) The client will be scheduled to meet with a peer counselor, unless the client refuses and the refusal is documented.</p>	<p>5.8 Progress note reflecting date of appointment with a peer counselor or documentation that an appointment was refused.</p>	<p>➤ Record review ➤ Progress notes ➤ SDIS review</p>

Guidelines	Indicators	Data Source
<p>(5.9 – 5.10) Medical case managers shall ensure all required medical data is complete, legible, dated, filed in the appropriate section of the client chart and entered into the SDIS.</p> <p>(5.11) Applications for eligibility under entitlement and benefit programs must be completed and filed with the appropriate entities.</p> <p>(5.12) A progress note shall document the needs assessment and POC.</p>	<p>Medical Certification of Diagnosis 5.9. The medical case manager shall obtain Medical Certification of Diagnosis within 90 days of completion of the initial POC. The form shall be filed in the client record and the information entered into SDIS within 48 hours of availability.</p> <p>Quarterly/Annual Lab Results 5.10 The case manager shall obtain initial (using Quarterly/Annual Lab Results Form) quarterly labs within 90 days of completion of the initial POC: the form shall be filed in the client record and the information entered into the SDIS within 48 hours of availability.</p> <p>5.11 Within 45 days of completion of eligibility and financial screening: dated, signed copies of applications, referral and progress note reflecting screening and submission of forms.</p> <p>5.12 Dated, signed progress note corresponding to completion date of POC</p>	<ul style="list-style-type: none"> ➤ Record review ➤ SDIS review <ul style="list-style-type: none"> ➤ Record review ➤ SDIS review <ul style="list-style-type: none"> ➤ Record review ➤ SDIS review • POC • Progress notes <ul style="list-style-type: none"> ➤ Record review • POC • Progress notes

Referrals/Follow-Up

Standard #6

Medical case managers and peer educators shall follow-up to verify clients are receiving necessary services as documented in the Plan of Care and coordinate their efforts with other service providers to ensure service delivery is as seamless as possible to the client. The client's satisfaction with services received shall be assessed.

Guidelines	Indicators	Data Source
(6.1) The peer counselor shall follow-up, either face to face or by telephone, within 2 weeks of his/her initial meeting with a newly enrolled client.	6.1 Dated, signed progress note	<ul style="list-style-type: none"> ➤ Record review ➤ SDIS review
(6.2 – 6.4) Certified referrals between Ryan White Program providers shall be generated electronically through the SDIS using the Ryan White Program Certified Referral Form and recertified as appropriate for the service.	6.2 POC 6.3 SDIS 6.4 Progress notes	<ul style="list-style-type: none"> ➤ Record review ➤ SDIS review ➤ Record Review (See Standard #5, 5.4 – 5.7)
(6.5) Medication referrals shall note the name of the medication, dosage, strength and quantity.	6.5 POC	<ul style="list-style-type: none"> ➤ Record review • POC
(6.6 – 6.7) Referral follow up for medications and other services shall be done in a timely way to ensure coordination and benefit of service. All follow-up shall be documented in the progress notes.	Progress notes shall reflect: 6.6 Medication referrals followed-up no later than 5 workdays from the referral date 6.7 Referrals for other services followed-up no later than 30 days from the appointment date or service delivery date.	<ul style="list-style-type: none"> ➤ Record review • Progress notes ➤ Record review ➤ SDIS review • Progress notes
(6.8) All follow up on referrals shall assess the client's satisfaction with the service.	6.8 Client satisfaction, or lack thereof, documented in progress note.	<ul style="list-style-type: none"> ➤ Record review ➤ SDIS review • Progress notes

Updates to Client Record

Standard #7

Appropriate client contact shall be maintained as needed to monitor the client's personal/medical status. Coordination and follow-up of the client's medical treatment shall be conducted. The efficacy of the Plan of Care (POC) shall be assessed to ensure service needs, goals, objectives, and barriers as noted in the POC are addressed.

Guidelines	Indicators	Data Source
(7.1) An update (client contact) shall be documented no less than once every 3 months, or more often as client need may dictate per documentation.	7.1 Dated, signed progress note documenting client contact and adherence monitoring.	➤ Record review • Progress notes
(7.2 – 7.3) Client medical care and compliance shall be monitored to ensure optimal health results.	7.2 Quarterly/Annual Lab Results updated every quarter with CD4 and VL entered in SDIS within 7 business days of availability. 7.3 Annual medical data entered in SDIS prior to end of the calendar year.	• Quarterly/Annual Lab Results • SDIS
(7.4 – 7.9) Financial eligibility, client chart/record face sheet, needs assessments and plans of care shall be updated no less than once every 6 months, more often as client need may dictate per documentation. ¹ The Medical Certification of Diagnosis for non-AIDS clients shall be updated every 6 months.	Dated and signed as appropriate: 7.4 Client Chart/Record Face Sheet 7.5 Financial assessments 7.6 Needs Assessments and Plans of Care 7.7 Medical Certification of Diagnosis 7.8 Progress notes 7.9 Quarterly/Annual Lab Results	➤ Record review ➤ SDIS review • Updated forms • Progress notes reflecting update and noting Medical Certification of Diagnosis has been addressed
(7.10) The Composite Consent for Enrollment and the Consent to Release and Exchange Information in the SDIS shall be renewed annually. Client must sign and date both forms annually.	7.10 Dated, signed Composite Consent and Consent to Release and Exchange Information in the SDIS Forms	➤ Record review

¹ A six-month reassessment must include, at a minimum, updating the financial assessment, the needs assessment (Sections 1-5 and 12), Plan of Care and Medical Certification of Diagnosis, as needed. Individual client need may require updating additional sections of the needs assessment and Plan of Care. A complete assessment process is required once every 12 months.

Documentation Standards

Standard #8

To ensure consistency and quality of care across the medical case management service system, standardized forms shall be used and uniform standards of documentation shall be followed.

Guidelines	Indicators	Data Source
(8.1) Standardized forms shall be used.	8.1 Required SDIS forms are complete, dated and signed as necessary, and filed in the client record.	➤ Record review ➤ SDIS review • SDIS printouts
(8.2 – 8.4) Agencies shall have available in 3 languages: Composite Consent for Enrollment (includes the Client Bill of Rights and Responsibilities), Consent to Release and Exchange Information in the SDIS, and Miami-Dade County Notice of Privacy Practices	8.2 Signed, dated Composite Consents and Outreach Consent 8.3 Signed, dated Consents to Release and Exchange Information (SDIS) 8.4 Signed, dated Miami-Dade County Notice of Privacy Practices	➤ Record review
(8.5) All client contacts shall be documented in the progress notes no later than 2 business days after occurrence.	8.5 Dated, signed progress notes	➤ Record review ➤ SDIS
(8.6) All peer counseling and medical case management units of service billed to the Ryan White Program shall be documented in the client chart.	8.6 Dated, signed progress notes	➤ Record review • Progress notes • Reimbursement requests
(8.7) Documentation shall accurately record the time services began and ended and number and type of service units provided (15 minute encounters).	8.7 Dated, signed progress notes documenting time and units, (e.g. 11:30 AM to 11:58 AM, 2 units, FFE)	➤ Record review • Progress notes • Reimbursement requests

Guidelines	Indicators	Data Source
(8.8) All documentation shall be complete and legible, dated, signed and include the name and title of the individual making the entry.	8.8 All required forms and progress notes	<ul style="list-style-type: none"> ➤ Record review <ul style="list-style-type: none"> • Progress notes • Forms

Quality Assurance / Performance Improvement

Standard #9

Ongoing, systematic record reviews shall be performed with feedback provided to case managers resulting in continuously improving quality of service and performance.

Guidelines	Indicators	Data Source
(9.1 – 9.4) Medical case management supervisors shall implement and document ongoing record reviews as part of quality assurance and performance improvement activity. Review tools will be dated and signed by the supervisor.	9.1 Record reviews conducted and submitted to Behavioral Science Research on a quarterly basis 9.2 No less than 20 records or 10% (whichever is less) of Ryan White Part A or MAI population reviewed 9.3 Review documents information is entered in a timely fashion, is complete, legible and appropriate 9.4 Dated, signed review tools including client identification information	<ul style="list-style-type: none"> ➤ Record review <ul style="list-style-type: none"> • Review of client records • Review of supervisor’s reviews
(9.5 – 9.6) Quarterly client care review and/or quality improvement meetings shall be documented.	9.5 Meeting attendance logs 9.6 Meeting minutes reflect issues discussed, problems identified, actions for correction and a time frame for completion of same	<ul style="list-style-type: none"> ➤ Attendance logs ➤ Minutes

Standard #10

The medical case manager shall carry a reasonable case load that allows the medical case manager to effectively plan, provide, and evaluate tasks related to client and system interventions.

Guidelines	Indicator	Data Source
(10.1 – 10.3) Case loads shall be reviewed between the supervisor and medical case manager to determine and document caseload size.	10.1 Case review at least every 6 months 10.2 Active case load not to exceed 70 clients, not including situational clients 10.3 Active case load for medical case management supervisors not to exceed 35 clients	<ul style="list-style-type: none"> ➤ SDIS <ul style="list-style-type: none"> • Case load (print out of active case load per medical case manager) ➤ Administrative <ul style="list-style-type: none"> • Supervisory logs or records documenting case review • Case load lists (medical case managers and supervisors)

Service Delivery Information System (SDIS)

Standard #11

Service access for clients, data collection and reporting requirements shall be facilitated by requiring all pertinent client data be entered into the SDIS in a timely manner.

Refer to Standards #4, #5, #6, #7, #8, #9, #10, and #13.

Guidelines	Indicators	Data Source
(11.1) All Ryan White Program intake information shall be entered into the SDIS in a timely manner.	11.1 Ryan White Program Intake information entered into the SDIS at time of initial contact.	<ul style="list-style-type: none"> ➤ Record review ➤ SDIS review
(11.2 – 11.4) Financial eligibility, needs assessment and POC information shall be completed and entered into SDIS.	11.2 Financial eligibility, needs assessments and POCs entered into the SDIS within 48 hours 11.3 Dated, signed eligibility, assessment and POC 11.4 SDIS print outs	<ul style="list-style-type: none"> ➤ Record review ➤ SDIS review

Advance Directives

Standard #12

The client shall be assisted in developing a legally binding advance directive that is on file in the event of personal incapacitation.

Guidelines	Indicators	Data Source
(12.1 – 12.2) No later than one year from the date of the initial POC completion, the medical case manager will ensure that the client has completed an advance directive and a copy of it is on file; or will document that the client refused said service.	12.1 Advance directive to address the client's care and treatment decisions in the event of incapacitation is indicated in the progress notes or POC 12.2 Progress note or POC reflects client declined to develop an advance directive.	<ul style="list-style-type: none"> ➤ Record review ➤ SDIS review <ul style="list-style-type: none"> • Needs Assessment • Plan of Care • Progress Notes

Case Closure/Case Transfer

Standard #13

Client records shall be closed with a case closure form; clients who wish to transfer shall be enabled to do so in a timely manner.

Guidelines	Indicators	Data Source
(13.1) Client records shall be closed with a Case Closure or Case Transfer Form.	Client records shall include: 13.1 A Case Closure Form detailing the reasons for closure	<ul style="list-style-type: none"> ➤ Record review ➤ SDIS review <ul style="list-style-type: none"> • Progress notes • Case Closure Form • Case Transfer Form • Outgoing record log • Current (at time of request) Consent to Release Information
(13.2 – 13.5) Clients who wish to transfer shall be assisted to do so.	Copies of client records for transfers shall be mailed: 13.2 No later than 10 days from the date of the receipt of a written request from the client or the client's legal representative	<ul style="list-style-type: none"> ➤ Record Review

Guidelines	Indicators	Data Source
<p>(13.6) Closure information shall contain an address/phone number/emergency contact where the client may be reached or detail the reason why said information cannot be obtained.</p> <p>(13.7) Case closures and transfers shall be entered into the SDIS.</p>	<p>13.3 Prior to releasing information a current Consent to Release Information must be in the record</p> <p>13.4 A completed Transfer Form.</p> <p>13.5 Initial agency shall make necessary changes in SDIS within 2 business days of transfer</p> <p>13.6 Completed Case Closure or Case Transfer Form</p> <p>No later than 24 hours after completing a closure or transfer:</p> <p>13.7 Data in SDIS</p>	<ul style="list-style-type: none"> ➤ Record review ➤ SDIS review • Closure or Transfer Form

Program Specific Operating Requirements (PS)

Standard #PS 1

Standard	Indicators	Data Source
<p>Medical case management providers must offer both medical case management and peer education and support network services.</p>	<p>PS1.1 Progress notes</p> <p>PS1.2 Reimbursement requests</p>	<ul style="list-style-type: none"> ➤ Personnel files ➤ Record review ➤ SDIS

Standard #PS 2

Standard	Indicators	Data Source
<p>Medical case management providers must have trilingual capabilities.</p>	<p>PS2.1 Progress notes</p> <p>PS2.2 Staff interviews</p>	<ul style="list-style-type: none"> ➤ Record review ➤ Personnel files ➤ Observation

Standard #PS 3

Standard	Indicators	Data Source
Medical case management agencies must document they have sought enrollment in the Medicaid PAC Waiver Program within 30 days of the contract execution date.	PS3.1 Copy of completed, dated application PS3.2 PAC Waiver number(s)	➤ Agency records

Standard #PS 4

Standard	Indicators	Data Source
Medical case management agencies shall ensure clients are aware of their rights and responsibilities.	PS4.1 Copy of the Client Rights and Responsibilities posted in a public area.	➤ Observation

Standard #PS 5

Standard	Indicators	Data Source
Medical case management providers shall ensure the provision of interpreters/assistance to the hearing, vision, and reading impaired.	PS5.1 Providers shall allocate funds in their budgets to ensure provision of interpreters/assistance to the hearing, vision, and reading impaired.	➤ Budget review ➤ Invoices

Standard #PS 6

Standard	Indicators	Data Source
Providers shall ensure continuity and coordination of care across services.	PS6.1 Providers shall maintain linkage agreements with other service providers throughout the community.	➤ Administrative Review ➤ Linkage Agreements