

South Carolina Ryan White Part B Medical Case Management Standards

Medical Case Management Guidance 1.0: Intake and Assessment

MCM 1.1 Initial Contact and Registration

The time from the first call by referring agency or by the client to the time a medical case manager contacts the client should not exceed two (2) working days. Registration can be done by a registration person or the medical case manager. Each agency will establish written guidelines for respective registration procedures, but should include the collection of basic demographics and contact information.

MCM 1.2 Intake

The Intake and Assessment must be completed no later than thirty (30) working days from the date of registration. The Intake will consist of signed releases of information, consents for services, and client rights and responsibilities, as well as an assessment. The assessment, which must be signed by the client and the medical case manager, shall include information on housing and household members, risk reduction, dental, legal, education, employment, insurance, financial, medical (including a screening of the client's HIV knowledge), mental health, substance use/abuse, domestic violence, cultural beliefs and practices, and help required. In addition to the assessment form, the benefit assessment tool must be completed on each client. An action plan must also be completed at the time of assessment, based on identified needs, and should be signed by the client and medical case manager.

A sample Intake/Assessment form is available from S.C. D.H.E.C. for interested service providers. This sample provides an example of the minimum requirements. Agencies may add additional information to better fit their needs, however, since these are minimum requirements, information should not be DELETED. Each agency will establish written guidelines for respective assessment procedures.

MCM 1.3 Reassessment

The reassessment should be done in person, annually, with the client, and should be signed by the client and the medical case manager. The reassessment should include updated releases, consents, and client rights and responsibilities as well as information on housing and household members, risk reduction, dental, legal, education, employment, insurance, financial, medical (including a screening of the client's HIV knowledge), mental health, substance use/abuse, domestic violence, cultural beliefs and practices, and help required. A new benefit assessment tool must also be completed with the client. An action plan must also be completed or updated at the time of assessment, based on identified needs, and should be signed by the client and medical case manager.

A sample reassessment is available from S.C. D.H.E.C. for interested service providers. This sample provides an example of the minimum requirements. Agencies may add additional information to better fit their needs, however, since these are minimum requirements, information should not be DELETED.

Medical Case Management Guidance 2.0: Tracking

MCM 2.1 Mid-Year Review

A mid-year review must be completed on all active clients receiving Medical Case Management services. This review is to be completed six months after the client's intake/assessment or annual reassessment date. This review shall include HIV knowledge screening, an action plan review, most recent CD4 and viral load, and a clinical summary. The mid-year review does not have to be completed face-to-face.

HIV knowledge screening must address the following topics: 1) Importance of CD4 count/viral load monitoring; 2) HIV transmission risk/factors; 3) Importance of regular medical care; and 4) Assessment of the client's understanding of HIV information. The action plan does not have to be signed at mid-year review, but the mid-year review must be signed by the medical case manager. A clinical summary must be printed and attached to mid-year review.

MCM 2.2 Action Plan

The action plan is a shared-responsibility contract. It is required that an action plan be completed at intake/assessment with all clients and serve as the guide for services provided. The action plan includes what is to be done by the medical case manager, what is needed from the client, and a time frame for completion. The action plan should be signed by the client and the medical case manager and be reflective of identified client needs and services being provided. The action plan will change and be updated as needed; however, the action plan must be reviewed with the client at the client's mid-year review and annual reassessment. The action plan must be signed at Intake or re-assessment, but not at mid-year review.

MCM 2.3 Referral Tracking

Referral tracking should be done for all Ryan White core services, including substance abuse, mental health, medical and dental referrals. Referrals to other agencies can also be tracked as program capacity allows. All required referrals should be followed up within thirty (30) days. Factors impacting the required time to follow-up include the urgency of the needed service, referral agencies' procedures, etc.

MCM 2.4 Face to Face Contact

First contact must be an Intake/Assessment. Subsequent contacts, depending on the needs of the client, are to be scheduled as deemed appropriate between the medical case manager and the client. In addition, the Intake and Annual Reassessment must be a face to face contact.

MCM 2.5 Home Visits

Home Visits are one of the best ways to know how a client lives and to determine what services are needed. A home visit should be made at least once in the first year of service (new clients). Home visits, however, depend on the level of comfort expressed by the client with the medical case manager entering their home, residence status (e.g. homeless), client trust, confidentiality, safety of the medical case manager, etc. Subsequent visits, depending on the needs of the client may be scheduled as deemed appropriate between the medical case manager and the client.

Medical Case Management Guidance 3.0: Discharge

MCM 3.1 Case Discharge Summary

A client's case is to be closed when he/she requests discharge or when he/she is deemed inactive, deceased, or discharged in accordance with each agency's guidelines. Client discharges should be signed by the medical case manager and Medical Case Management supervisor.

Medical Case Management Guidance 4.0: Documentation

MCM 4.1 Progress Logs/Notes

Documentation is to be entered into in the SC DHEC supported Provide Enterprise (PE) software. Medical case managers (MCM) will complete a minimum of one progress log per day for each client served. This allows a medical case manager to complete one progress log that explains all activity and services provided to a client (CL) during the course of a day. Multiple services can be linked to the progress log to account for the different services that may be provided to a client throughout the day. Each agency will establish written guidelines for respective documentation.

For guidance in completing progress logs and other PE documentation, go to scdhec.gov/rwhopwata, click PE Technical Assistance (under HIV Care and Support for Communities), the information is listed under the heading 'Training.'