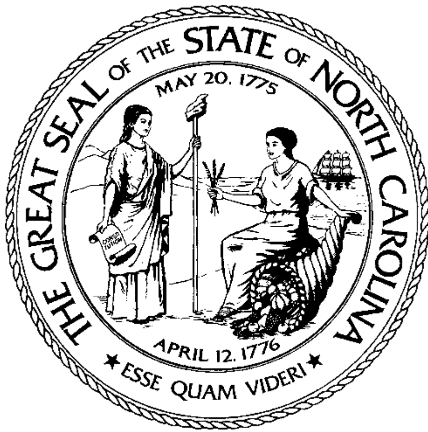


Tailored Care Management 105:

Delivery of Tailored Care Management

October 29, 2021

Tailored Care Management Webinar Series

Today's webinar is a part of a series to help develop a shared understanding of the Tailored Care Management model across the North Carolina provider community and any anyone else who is interested.

Date *Fridays 12 -1 PM*	**Topic**
October 1, 2021	Introduction to Tailored Care Management
October 8, 2021	Becoming an AMH+/CMA
October 15, 2021	Health IT Requirements and Data Sharing
October 22, 2021	Partnering with a Clinically Integrated Network and Other Partners
October 29, 2021	**Delivery of Tailored Care Management**
November 5, 2021	Transitional Care Management Community Inclusion Activities
November 19, 2021	Conflict-Free Care Management and Additional Care Coordination Functions for Members Enrolled in the Innovations or TBI Waiver
December 3, 2021	Billing
December 10, 2021	Oversight and Quality Measurement/Improvement

Tailored Care Management Webinar Series

- Time permitting, we will be holding a Q&A session at the conclusion of today's presentation.
  - You may ask a question at any time throughout the presentation, using the Q&A text box
  - Q&A Text Box is located at the lower right-hand side of the screen
  - Simply type in your question and click send

For additional questions on Tailored Care Management, please email:
Medicaid.TailoredCareMgmt@dhhs.nc.gov

- A recording of today's presentation and the slide deck will be available at https://medicaid.ncdhhs.gov/transformation/tailored-care-management/tailored-care-management-training.

For more information on Tailored Care Management, please visit:
https://medicaid.ncdhhs.gov/transformation/tailored-care-management

Presenters

Gwendolyn Sherrod, M.B.A., M.H.A.	Keith McCoy, MD	Mya W. Lewis, MHA
Senior Program Manager for Special Programs, NC Medicaid, Quality and Population Health	Deputy CMO for Behavioral Health and IDD Community Systems, Chief Medical Office for Behavioral Health and IDD	IDD and TBI Section Chief, Division of Mental Health, Developmental Disabilities and, Substance Abuse Services

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

Agenda

- Recap: Tailored Care Management Model
- Delivery of Tailored Care Management
- Care Team Requirements
- Question & Answer

Recap: Tailored Care Management Model Overview

What is Tailored Care Management?

Key Features of Tailored Care Management

Tailored Care Management is the primary care management model for Tailored Plans.

- All Tailored Plan Members are eligible for Tailored Care Management*, including individuals enrolled in the 1915(c) Innovations and TBI waivers.
- Individuals enrolled in NC Medicaid Direct (e.g., dual eligibles) will also have access to Tailored Care Management, if they otherwise would be eligible for a Tailored Plan if not for belonging to a group delayed or excluded from managed care.

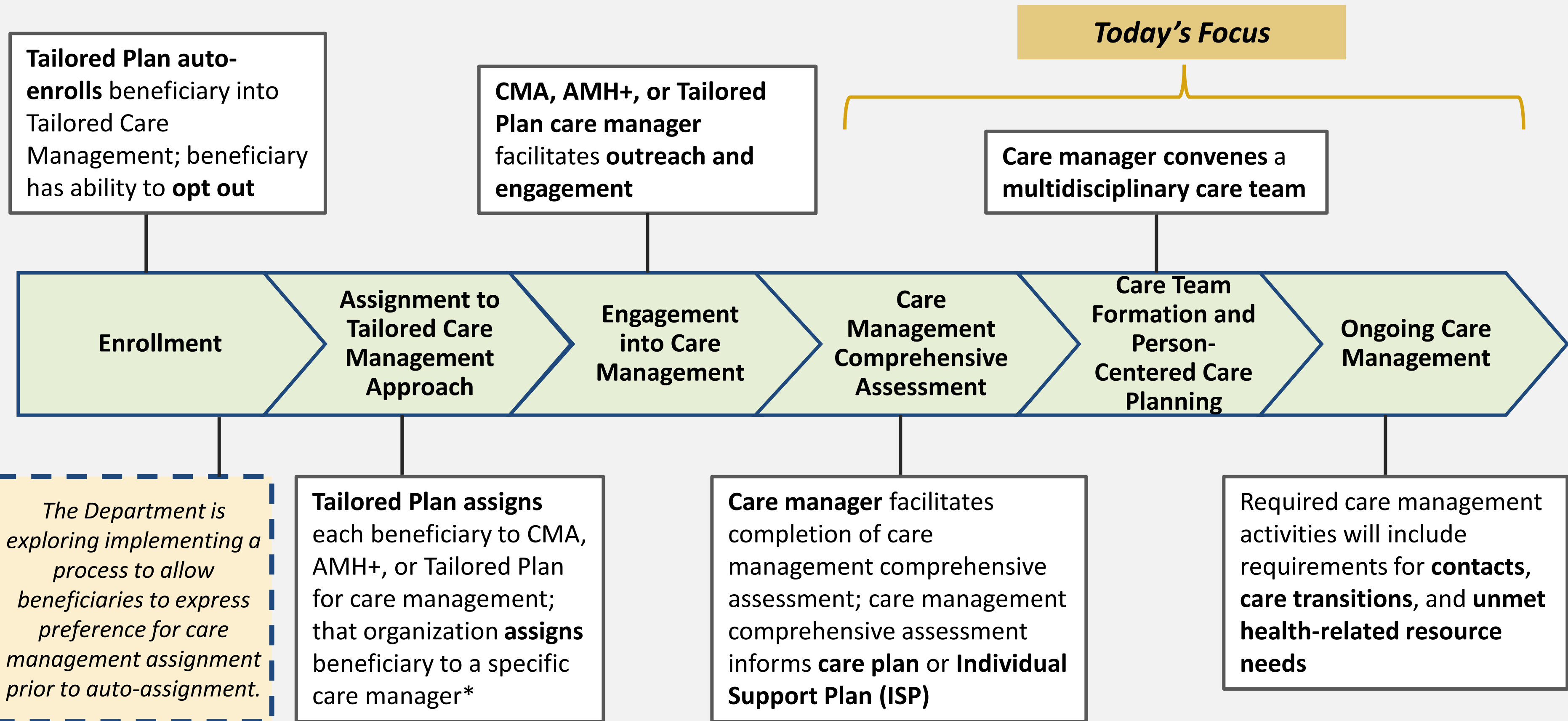
Tailored Plan members will be assigned to one of three approaches for obtaining Tailored Care Management: an Advanced Medical Home Plus (AMH+) practice, Care Management Agency (CMA), or a plan-based care manager.

- The Department strongly believes that care management should be provider-based and performed at the site of care (i.e., at an AMH+/CMA) to the maximum extent possible.
- Providers must be certified as an AMH+ practice or CMA to perform Tailored Care Management.

Under Tailored Care Management, members will have a single care manager who will be equipped to manage all of their needs, spanning physical health, BH, I/DD, TBI, pharmacy, long-term services and supports (LTSS), and unmet health-related resource needs.

*Unless they are receiving a duplicative service

Tailored Care Management Process



NOTE:
Members can change the organization they are assigned to for Tailored Care Management and/or change care managers twice per year without cause and anytime with cause (see provider manual for description of what qualifies as cause)

*Innovations and TBI waiver beneficiaries will have the choice of keeping their current care coordinators if the care coordinators meet all of the care manager requirements to serve Tailored Plan beneficiaries and federal requirements for conflict-free case management.

Delivery of Tailored Care Management

Comprehensive Assessment

The care management comprehensive assessment is a person-centered assessment of a member's health care needs, functional and accessibility needs, strengths and supports, goals, and other characteristics that will inform the care plan or Individual Support Plan (ISP) and treatment. A comprehensive assessment must be completed for all assigned members.

Care Management Comprehensive Assessment

- **Organizations providing Tailored Care Management must:**
  - **Begin** the comprehensive assessment **within 30 days of Tailored Plan enrollment**
  - **Complete** the comprehensive assessment within the following timeframes:

For Members Identified as High Acuity	For Members Identified as Medium/Low Acuity
Within **60 days** of Tailored Plan enrollment	Within **90 days** of Tailored Plan enrollment

  - **Implement tools and methodologies** developed by Tailored Plans to conduct the care management comprehensive assessment

Organizations providing Tailored Care Management must make best efforts* to complete the care management comprehensive assessment in person, in a location that meets the member's needs.

In limited circumstances, the care management comprehensive assessment may be completed via technology conferencing tools (e.g., audio, video, and/or web).

"Best effort" is defined as including at least three documented strategic follow-up attempts to contact the member if the first attempt is unsuccessful

Comprehensive Assessment, cont.

Results of the care management comprehensive assessment must be shared with the appropriate providers/entities (e.g., primary care provider, behavioral health provider) to inform care and treatment planning, with the member's consent.

Care Management Comprehensive Assessment

- **Must include an assessment of a minimum set of domains, including:**
  - Immediate care needs
  - Current service and providers across all needs
  - Available informal, caregiver, or social supports
  - Functional needs, accessibility needs, strengths, and goals
  - Physical health conditions, including dental conditions
  - Physical, intellectual, or developmental disabilities

Organizations providing Tailored Care Management must complete a reassessment at least annually and when members' circumstances and needs change, including:

- After "**triggering events**" (e.g., inpatient hospitalization)

See the Tailored Care Management Provider Manual for detailed requirements

Care Plans/Individual Support Plans (ISPs)

Informed by the results of the care management comprehensive assessment and other available data, organizations providing Tailored Care Management must develop an initial care plan for each member with BH needs and/or an ISP for each member with I/DD or TBI needs.

Care Plan/ISP Requirements

- **Must include a minimum set of domains, including:**
  - Names and contact information of key providers, care team members, family members, and others chosen by the member to be involved in planning and service delivery
  - Measurable goals
  - Strategies to improve self-management and planning skills
  - Strategies to increase social interaction, employment, and community integration
  - Social, educational, and other services needed by the member

Care plans/ISPs must be individualized, person-centered, and developed using a collaborative approach including member and family participation.

See the Tailored Care Management Provider Manual for detailed requirements

Care Plans/Individual Support Plans (ISPs), cont.

The care plan/ISP must be documented, stored, and made available to the member and the appropriate representatives, including care team members.

Care Plan/ISP Requirements

- **Must incorporate data including:**
  - Results of the care management comprehensive assessment
  - Claims analysis and risk scoring
  - Available medical records
  - Screening and/or level of care determination tools (e.g., LOCUS and CALOCUS)

Similar to requirements for the care management comprehensive assessment, organizations providing Tailored Care Management must update care plans/ISPs at least annually and when members' circumstances and needs change, including:

- After "**triggering events**" (e.g., inpatient hospitalization)

See the Tailored Care Management Provider Manual for detailed requirements

Ongoing Care Management: Care Coordination

Through organized care coordination, members' needs and preferences are known and communicated to the right people at the right time, ensuring appropriate and effective care.

Care Coordination Requirements

- Ensuring the member has an ongoing source of care
- Coordination across settings of care
- Coordination of services (e.g., appointment/wellness reminders and social services coordination/referrals)
- Following up on referrals and working with the member's providers to help coordinate resources during any crisis event
- Assistance scheduling and preparing members for appointments (e.g., reminders and arranging transportation)
- Providing referral, information, and assistance in obtaining and maintaining community-based resources and social support services, including LTSS, I/DD, and TBI services

Ongoing Care Management: Addressing Unmet Health-Related Resource Needs

Organizations providing Tailored Care Management will be responsible for linking members to services that help address unmet health-related resource needs, including providing referral, information, and assistance (e.g., filling out applications) for the services listed below, as needed.

Community-based resources and social support services:

- Disability benefits
- Food and income supports
- Housing; Transportation
- Employment services
- Education
- Financial literacy programs
- Child welfare services
- After-school programs
- Rehabilitative services
- Domestic violence services
- Legal services
- Services for justice-involved populations
- Other services that help individuals achieve their highest level of function and independence

Health-related services:

- Food and Nutrition Services
- Temporary Assistance for Needy Families
- Child Care Subsidy
- Low Income Energy Assistance Program
- ABLEnow Accounts (for individuals with disabilities)
- Women, Infants, and Children (WIC) Program
- Other programs managed by the Tailored Plan that address unmet health-related resource needs

Programs and resources to assist with:

- Securing employment
- Supported employment (e.g., Individual Placement and Support - Supported Employment (IPS-SE) program)
- Volunteer opportunities
- Vocational rehabilitation and training
- Other types of productive activity that support community integration

Ongoing Care Management: Health Promotion

Organizations providing Tailored Care Management will engage members with or at risk for chronic conditions or other emerging health problems in health promotion activities.

Health Promotion Services Include:

- Providing education on members' chronic conditions
- Teaching self-management skills and sharing self-help recovery resources
- Providing education on common environmental risk factors (e.g., health effects of exposure to second- and third-hand tobacco smoke)
- Conducting medication reviews and regimen compliance
- Promoting wellness and prevention programs.

Definition of Health Promotion

Health promotion is defined as the education and engagement of members in making decisions that promote achievement of

- Good health
- Proactive management of chronic conditions
- Early identification of risk factors, and
- Appropriate screening for emerging health problems

Ongoing Care Management: Individual and Family Supports

Individual and Family Supports Requirements

- **Educating the member in self-management and self-advocacy**
- **Promoting wellness and prevention programs**
- **Connecting the member, caregivers, and family members to:**
  - Education and training to help the member improve function, develop socialization and adaptive skills, and navigate the service system
  - Resources that support maintaining employment, community integration, and success in school
- **Providing information to the member, family members, and support members on:**
  - Needed services and supports (e.g., self-help services, peer support services, and respite services)
  - Member rights, protections, and responsibilities (e.g., right to change providers, the grievance and complaint resolution process, and fair hearing processes)
  - Establishing advance directives and guardianship options/alternatives
- **For high-risk pregnant women:**
  - Inquiring about broader family needs, offering guidance on family planning, and beginning discussions about the potential for an Infant Plan of Safe Care

Ongoing Care Management: Other Requirements

Twenty-four-Hour Coverage

Organizations providing Tailored Care Management must provide or arrange for coverage for services, consultation or referral, and treatment for emergency medical conditions, 24 hours per day, seven days per week

- Organizations providing Tailored Care Management must be able to:
  - Share information such as care plans and psychiatric advance directives
  - Coordinate care to place the member in the appropriate setting during urgent and emergent events

System of Care

Organizations providing Tailored Care Management must utilize strategies consistent with a System of Care framework to address the unique needs of children and youth receiving behavioral health services

- Organizations providing Tailored Care Management must:
  - Promote family-driven, youth-guided service delivery
  - Have knowledge of the child welfare, school, and juvenile justice systems

See the Tailored Care Management Provider Manual for detailed requirements

Ongoing Care Management: Other Requirements

Continuous Monitoring

Organizations providing Tailored Care Management must conduct continuous monitoring of progress toward goals identified in the care plan or ISP through face-to-face and collateral contacts and routine care team reviews

This includes supporting the member's adherence to prescribed treatment regimens and wellness activities

Medication Monitoring

Organizations providing Tailored Care Management must conduct medication monitoring, including regular medication reconciliation (conducted by the appropriate care team member) and support of medication adherence

This role may be assumed by a community pharmacist at the CIN level

Annual Physical Exam

Organizations providing Tailored Care Management must ensure that the member has an annual physical exam or well-child visit

Ongoing Care Management: Contact Requirements

Organizations providing Tailored Care Management must meet the minimum contact requirements for members according to their acuity tier. The Department will send information about a member's acuity tier to Tailored Plans. Contacts that are not required to be in-person may be telephonic or through two-way real time video and audio conferencing.

The forthcoming guidance on care manager extenders will explain how extenders can support meeting contact requirements.

Tailored Care Management Contact Requirements

Acuity Tier	Members with Behavioral Health Needs	Members with an I/DD or TBI
High	At least **4** care manager-to-member contacts per month, including at least 1 in-person contact	At least **3** care manager-to-member contacts per month, including 2 in-person contacts and 1 telephonic contact
Moderate	At least **3** contacts per month and at least 1 in-person contact quarterly	At least **3** contacts per month and at least 1 in-person contact quarterly
Low	At least **2** contacts per month and at least 2 in-person contacts per year, approximately 6 months apart	At least **1** contact per month and at least 2 in-person contacts per year, approximately 6 months apart

NOTE: For members dually diagnosed with a BH condition and I/DD or TBI, the organizations providing Tailored Care Management shall determine whether the contact requirements for BH or I/DD conditions apply, based on what is clinically appropriate.

Transitional Care Management

Organizations providing Tailored Care Management must manage care transitions for members who are moving from one clinical setting to another to prevent unplanned or unnecessary readmissions, ED visits, or adverse outcomes.

Details on required transitional care management functions will be reviewed during the upcoming Tailored Care Management Webinar on November 5, 2021.

Care Team Requirements

Care Team Formation

Organizations providing Tailored Care Management must establish a multidisciplinary care team for each member. The care team should include the member, the member's care manager and the following individuals, depending on the member's needs:

- Supervising care manager
- Primary care provider
- Behavioral health provider(s)
- I/DD and/or TBI providers, as applicable
- Other specialists
- Nutritionists
- Pharmacists and pharmacy techs
- Obstetrician/gynecologist (for pregnant women)
- In-reach and transition staff, as applicable
- Care manager extenders (see next slide)
- Other providers and individuals, as determined by the care manager and member

The AMH+ or CMA does not need to have all the care team members on staff or embedded onsite.

Providers of various specialties may participate in care teams virtually from other settings.

Forthcoming Guidance: Use of Care Management Extenders in Tailored Care Management

Providers and other stakeholder have raised questions regarding how Community Navigators, Peer Support Specialists, and community health workers (CHWs) fit into the Tailored Care Management model. The Department recognizes that these experienced individuals will play an important role in Tailored Care Management care teams and is in the process of developing guidance to provide clarification on their roles.

The Department is committed to building a robust Tailored Care Management workforce that is led by care managers and includes care manager extenders (e.g., Community Navigators, Peer Support Specialists, and Community Health Workers).

Forthcoming guidance will address:

- Functions that extenders can perform within the model
- How extenders can help fulfill the member contact requirements
- Training and supervision requirements
- Qualifications needed to serve as an extender

To inform the guidance, the Department will seek input from the Tailored Care Management Technical Advisory Group

The Department is also considering the extent to which the care management extender policies as well as other feedback we have received will affect Tailored Care Management rates.

Clinical Consultants

Organizations providing Tailored Care Management should develop relationships with clinical consultants to provide subject matter expert advice to the care team.

- An adult psychiatrist or child and adolescent psychiatrist (depending on the population being served)
- A neuropsychologist or psychologist
- For CMAs: A primary care physician appropriate for the population being served, to the extent the member's PCP is not available for consultation

AMH+ practices and CMAs may employ or contract with consultants or do so through a CIN or Other Partner.

Clinical consultants should be available by phone to staff within AMH+ practices and CMAs to advise on complex clinical issues on an ad hoc basis.

Costs associated with clinical consultants are included in the Tailored Care Management rates.

Questions & Answers

Appendix

Tailored Care Management Webinar Series

Date *Fridays 12 -1 PM*	Topic
October 1, 2021	Introduction to Tailored Care Management
October 8, 2021	Becoming an AMH+/CMA
October 15, 2021	Health IT Requirements and Data Sharing
October 22, 2021	Partnering with a Clinically Integrated Network and Other Partners
October 29, 2021	Delivery of Tailored Care Management
November 5, 2021	**Transitional Care Management** **Community Inclusion Activities**
November 19, 2021	Conflict-Free Care Management and Additional Care Coordination Functions for Members Enrolled in the Innovations or TBI Waiver
December 3, 2021	Billing
December 10, 2021	Oversight and Quality Measurement/Improvement

Care Management Comprehensive Assessment: Minimum Required Elements

- ✓ Immediate care needs
- ✓ Current services and providers across all health needs
- ✓ Functional needs, accessibility needs, strengths and goals
- ✓ Other state or local services currently used
- ✓ Physical health conditions, including dental conditions
- ✓ Current and past mental health and substance use status and/or disorders, including tobacco use disorders
- ✓ Physical, intellectual or developmental disabilities
- ✓ Detailed medication history—a list of all medicines, including over-the-counter medication and prescribed medication, dispensed, or administered – and known allergies;
- ✓ Advanced directives, including advance instructions for mental health treatment
- ✓ Available informal, caregiver or social supports
- ✓ Standardized Unmet Health-Related Resource Needs questions to be provided by the Department covering four (4) priority domains:
  - Housing
  - Food
  - Transportation
  - Interpersonal Violence/Toxic Stress
- ✓ Any other ongoing conditions that require a course of treatment or regular care monitoring
- ✓ For adults only, exposure to adverse childhood experiences (ACEs) or other trauma
- ✓ Risks to the health, well-being, and safety of the member and others (including sexual activity, potential abuse/exploitation, and exposure to second-hand smoke and aerosols)
- ✓ Cultural considerations (ethnicity, religion, language, reading level, health literacy, etc.)
- ✓ Employment/community involvement
- ✓ Education (including individualized education plan and lifelong learning activities)
- ✓ Justice system involvement (adults) or juvenile justice involvement and/or expulsions or exclusions from school (children and adolescents);
- ✓ Risk factors that indicate an imminent need for LTSS
- ✓ Caregiver’s strengths and needs
- ✓ Upcoming life transitions (changing schools, employment, moving, change in caregiver/natural supports, etc.)
- ✓ Self-management and planning skills
- ✓ Receipt of and eligibility for entitlement benefits, such as Social Security and Medicare.

Care Plan/ISP
Minimum Required Elements

- ✓ Names and contact information of key providers, care team members, family members, and others chosen by the member to be involved in planning and service delivery
- ✓ Measurable goals
- ✓ Clinical needs, including any BH, I/DD-related, TBI-related, or dental needs
- ✓ Interventions including addressing medication monitoring, including adherence
- ✓ Intended outcomes
- ✓ Social, educational, and other services needed by the member
- ✓ Strategies to increase social interaction, employment, and community integration
- ✓ An emergency/natural disaster/crisis plan
- ✓ Strategies to mitigate risks to the health, well-being, and safety of the members and others
- ✓ Information about advance directives, including psychiatric advance directives, as appropriate
- ✓ A life transitions plan to address instances where the member is changing schools, experiencing a change in caregiver/natural supports, changing employment, moving or entering another life transition
- ✓ Strategies to improve self-management and planning skills
- ✓ For members with I/DD, TBI, or SED, the ISP should also include caregiver supports, including connection to respite services, as necessary