Consolidated TCM Learning Collaboratives and TCM Office Hours

Tailored Care Management Monitoring and Documentation

February 11, 2026

Presentation Overview

- This presentation provides guidance and best practices for effective Tailored Care Management (TCM) monitoring and documentation to support compliance, service quality, and accurate billing.
- **Topics Covered:**
- **Service Note Requirements**
  - Billable service note criteria
  - Qualifying contacts
  - Overview of the **Six Core Health Home Services**
- **TCM Monitoring Documentation Trends**
  - Common monitoring findings
  - Frequent documentation gaps and risk areas
- **Effective TCM Documentation**
  - Required elements for compliance
  - Aligning documentation with service delivery and outcomes
- **TCM Documentation Examples**
  - Sample service notes
  - Compliant vs. non-compliant documentation comparison
- **Strategies for Improving Documentation**
  - Best practices for clear, accurate, and timely service notes
  - Reducing errors and strengthening compliance
  - Using monitoring feedback to improve documentation quality

TCM Service Note Requirements

(TCM Provider Manual, Section IX.2. Components of TCM Service Notes)

All service notes should include, but are not limited to the following:

- Name of the individual on each service note page
- Name of collateral contact, as applicable
- Name of legally responsible person/guardian contact, as applicable
- Health Home service/care management activity attempted or provided
- Date of care management activity: It must accurately reflect activities and services for all time indicated for the service
- Goal addressed/tasks performed: This must include description of the care management activities provided, which relate to a goal/activity in the Care Plan/ISP (once developed) and a description of the results or outcome of the care management activities, any progress noted, and next steps, when applicable
- Staff Signature

Billable TCM Service Note Requirements

To bill for and obtain the TCM monthly rate, in any given month, the care manager, or extender where appropriate, must have at least one qualifying contact with the member.

A qualifying contact is defined as:

- ✓ Member-facing interaction (i.e., in-person, telephonic, or two-way real time audio/video and using assistive technologies, if applicable) that includes the member and/or legally responsible person/guardian, as indicated.
- ✓ Fulfills one or more of the six core Health Home services.
  - Health Home activities that are not member-facing (e.g., care manager/care manager extender to other provider contact) do not count as a qualifying contact.
  - One-way outreach where the member does not respond and engage with the care manager does not count as a qualifying contact.

Billable TCM Service Note Requirements (cont.)

Six Core Health Home Services

1. Comprehensive care management – Phone or in-person meeting focused on chronic care management, completing CMCA/Care Plan/ISP
2. Care coordination – appointment/ wellness reminders, referrals, assisting with scheduling and preparing members for appointments (transportation)
3. Health promotion – education, teaching self-management skills
4. Comprehensive transitional care/follow-up- visiting member during stay at institution, reviewing d/c plan with member/staff, 90-day post-discharge transition plan
5. Individual & family support – education and guidance on self-advocacy, connecting/referring member and family to education and training, information on rights/protections etc.
6. Referral to community & social support services – referral/information/assistance in obtaining and maintaining community resources; assistance in completing applications

Additional Examples of each Core Health Home Service can be found in the TCM Provider Manual

TCM Monitoring - Documentation

Documentation Trends

- No evidence of staff signature; electronic or digital, on service notes
- Missing required components of Tailored Care Management Service Notes
- Documentation that lacks specific connection to a Core Health Home Service
- Not connecting the care management activities to member goals
- Not adhering to general documentation guidance
- Individualized and person-centered service documentation
- Not documenting key collateral contacts
- Not adequately documenting coordination of care
- Not addressing care gaps in documentation
- Not documenting all ongoing attempts to engage members
- Lack of follow up when indicated

Effective TCM Documentation

Content of TCM Notes

❑ **Who was contacted, title/agency and contact number**

- CM contacted LRP

→ CM called Sally Jones, parent/LRP (919-555-5555) - **it is best practice to include the phone number (or email for non-billable TCM activities) of the person you are contacting*

❑ **What was discussed. Contacts should have a purpose that relates to one or more of the Six Core Health Home Services and relates to a Care Plan/ISP goal once the Care Plan/ISP is completed.**

- CM made contact with LRP. LRP states there are no issues at this time.

→ CM held a Teams meeting with member and Sally Jones, parent/LRP, to discuss member's CLS services and goals to ensure LRP is satisfied with service delivery. LRP stated that she did not have any concerns at this time. CM asked LRP to contact her back if changes or updates were needed.

Effective TCM Documentation

Content of TCM Notes

❑ **Information in notes that is specific, concise, and descriptive**

- CM called LRP, no answer. CM left voicemail.

CM called Sally Jones, parent/LRP (919-555-5555) to schedule annual CMCA reassessment, due 2/1/26. No answer. CM left voicemail, asking LRP to call CM back to schedule CMCA reassessment.

- In this example, the call would count as one of the required best effort attempts to schedule/complete the CMCA reassessment.

Effective TCM Documentation

Content of TCM Notes

❑ **Note is clear, concise, objective**

- CM called LRP to obtain verbal consent. Forms will be sent to LRP.”
  - Consent is implied, not documented.

CM called Bob Ross, Mecklenburg DSS Guardian Rep (919-555-5555), to inform him of Tailored Care Management and obtain consent. CM discussed their role and how the service could assist the member. LRP stated that they are interested in member receiving the service. CM supplied their contact information and informed LRP that they will be sending forms via DocuSign for signatures.”

The monitoring team cannot score on implied information. If it is not documented, it did not happen.

TCM Documentation Example

Note Example (1)

Core Health Home Service: Care Coordination

Member left a message saying he is now homeless. CM called member back and member reported he was “kicked out” of his friend's house last night when they had an argument. CM asked what they argued about. Member said Danny’s girlfriend Lisa doesn’t want him staying there anymore. CM asked why Lisa doesn’t want him staying there anymore and member said Lisa lied and told Danny he is always staring at her. Member said Lisa never liked him and just wanted Danny to kick him out. Member said he slept in a park last night and might have other friends he can stay with. CM asked member to call back to let her know where he’s staying. CM will look into homeless shelters and other housing options for member.

Note Example 1

- **Is this a billable contact? What evidence is documented that the activity fulfills one or more of the six core Health Home services?**
  - **No, this is not a billable contact. There is no evidence of one of the six Core Health Home activities. Documentation does not show evidence the Tailored Care Manager attempted to assist the member with housing, transportation, referral/information in obtaining community resources, etc.**

TCM Documentation Example

Note Example (2)

Core Health Home Service: Referral to community & social support services

CM returned call to member at (919-555-5555) after receiving a voicemail from member stating he is now homeless. Member reports he was “kicked out” of his friend’s house last night when they had an argument. CM asked where member stayed last night and member stated he slept in a park. CM asked about member's belongings, access to food, and other options for shelter. Member reported he has his belongings with him, has some money for food and knows where to get meals, but didn’t want to spend his money on a hotel last night. Member stated he might have other friends he can stay with. CM called the Raleigh Rescue Mission (919-828-9014) and the South Wilmington Street Shelter (919-857-9428) to ask about available beds and learned they both have beds available. CM also researched other housing options. CM called member back and provided the phone numbers and addresses for both shelters and asked about member’s transportation options. Member stated he would take the bus. CM also explained the Coordinated Entry program to member and provided information for the Oak City Cares access site. Member stated he would go to the South Wilmington Street Shelter today and Oak City Cares later this week. CM completed housing referrals in NCCare360. CM will call member tomorrow to ensure he got in the shelter and to encourage follow-up with Oak City Cares and coordinated entry.

Note Example 2

- **Is this a billable contact? What evidence is documented that the activity fulfills one or more of the six core Health Home services?**

- **Yes, this is a billable contact. Documentation shows evidence the Tailored Care Manager attempted to assist the member by:**
  - **Researching housing options**
  - **Calling two housing resources to assess availability**
  - **Providing information (phone numbers and addresses) to the member to obtain community resources/housing**
  - **Completing housing referrals in NCCARE 360**
  - **Ensuring the member has transportation to the housing resources**

Strategies to Improve Documentation

- Follow the documentation DOs and DON'Ts in the TCM Provider Manual.
- Notes should be accurate, clear, concise, objective, and timely.
- Notes should tell the complete story of what happened during a TCM activity.
- Regular training sessions for staff on the importance of good documentation practices can help reinforce these principles and ensure compliance.
- Conduct periodic reviews and audits of documentation practices to identify areas for improvement and ensure adherence to established guidelines.

Strategies to Improve Documentation

Documentation Audits

Develop and implement a solid documentation review policy if there is not one in place. Ensure the policy covers all requirements as indicated in the TCM Provider Manual. Develop and use a documentation audit tool. Use the TCM Monitoring Tool during internal reviews, the column on the tool entitled "Documentation of Evidence to Meet the Criteria" clearly describes what monitors are looking for during the review process.

Resist CMs and Supervisors self-auditing their own documentation as the only auditing function. Most people can read their own writing and understand the meaning of records they wrote even if the documentation is not clearly in the record. Removing bias and maintaining objectivity is important.
Choose staff members not directly involved in a member's care (a different CM supervisor, agency QM staff, other CMs or clinicians) to audit documentation. Decide how many records should be reviewed and select a random sample of records for a specific time-period.

Use the audit results for improving practice compliance. Review and analyze the audit findings. Identify the common documentation problems, educate staff members and hold them accountable for making changes. After implementing any corrective action, audit the process again to ensure improved compliance and successful implementation.

Questions