Tailored Care Management Technical Advisory Group (TAG)

Meeting #11:

Department's Vision for Integrated Care Management and

Role of Clinical Consultants

September 23, 2022

Agenda

- Welcome and Roll Call (5 min)
- Key Updates (5 min)
- Department's Vision for Integrated Care Management (20 min)
- Role of Clinical Consultants on the Care Team (15 min)
- Public Comments (10 min)
- Next Steps (5 min)

Welcome and Roll Call

Department of Health and Human Services

Kelly Crosbie, MSW, LCSW	Gwendolyn Sherrod, MBA, MHA	Eumeka Dudley, BS	Regina Manly, MSA	Loul Alvarez, MPA
Chief Quality Officer	Senior Program Manager, Tailored Care Management	Tailored Care Management Program Manager	Tailored Care Management Program Manager	Associate Director, Population Health
Contact: Medicaid.TailoredCareMgmt@dhhs.nc.gov				

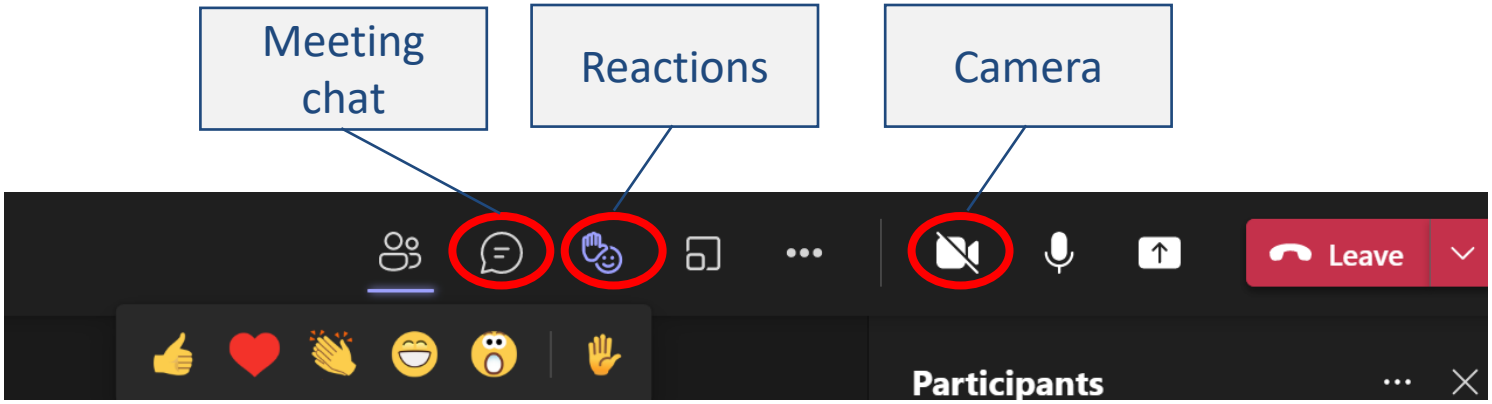
NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Tailored Care Management TAG Membership

Name	Organization	Stakeholder
Erin Lewis	B&D Integrated Health Services	Provider Representative
Lauren Clark	Coastal Horizons Center	Provider Representative
Denita Lassiter	Dixon Social Interactive Services	Provider Representative
Jason Foltz, D.O.	ECU Physicians	Provider Representative
Natasha Holley	Integrated Family Services, PLLC	Provider Representative
DeVault Clevenger	Pinnacle Family Services	Provider Representative
Lisa Poteat	The Arc of NC	Provider Representative
John Gilmore, M.D.	UNC Center for Excellence in Community Mental Health	Provider Representative
Sean Schreiber	Alliance Health	Tailored Plan Awardee
Beverly Gray	Eastpointe	Tailored Plan Awardee
Lynne Grey	Partners Health Management	Tailored Plan Awardee
Sabrina Russell	Sandhills Center	Tailored Plan Awardee
Cindy Ehlers	Trillium Health Resources	Tailored Plan Awardee
Rhonda Cox	Vaya Health	Tailored Plan Awardee
Cindy Lambert	Cherokee Indian Hospital Authority	Tribal Option Representative
Jessica Aguilar	N/A	Consumer Representative
Pamela Corbett	N/A	Consumer Representative
Alicia Jones	N/A	Consumer Representative
Cheryl Powell	N/A	Consumer Representative

Increasing Engagement

We encourage those who are able to turn on cameras, use reactions in Teams to share opinions on topics discussed, and share questions in the chat.



Key Updates

Key Updates

Recently Released Guidance

- On August 29th, the Department issued an update to the Tailored Care Management Provider Manual and guidance on various topics including the use of care manager extenders, care manager and supervising care manager qualifications, and data/security (summarized here). *See August 26th TAG meeting materials for an overview of the changes.*
- The Department has also published a comprehensive Frequently Asked Questions (FAQ) document to provide clarity to the field on recent stakeholder questions (link to FAQ document here).

Readiness Reviews

- NCQA is working to finalize Readiness Review decisions and notify providers as soon as possible.
- A total of *53* providers have officially passed Readiness Reviews so far.
- The Department will publish this list on the Tailored Care Management Plan page next week.

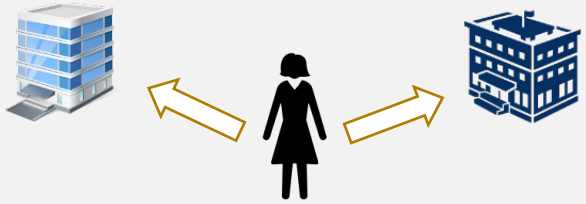
Department's Vision for Integrated Care Management

Vision for Medicaid Transformation

The Department's vision for Medicaid transformation is to improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care that addresses both the medical and non-medical drivers of health. In the transition to managed care, beneficiaries will be enrolled in integrated, comprehensive Medicaid managed care plans.

Pre-Managed Care State

Medicaid beneficiaries received services through a bifurcated system

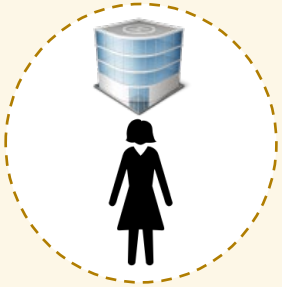


Medicaid Fee-For-Service provided:
- Physical health services
- Pharmacy
- Long-term services and supports (LTSS)

Local Management Entities/Managed Care Organizations (LME/MCOs) provided:
- Behavioral health,
- Intellectual and developmental disabilities (I/DD), and
- Traumatic brain injury (TBI) services

Integrated Medicaid Managed Care

Medicaid beneficiaries receive integrated services and whole-person care



Medicaid managed care plans provide access to a broad set of services to address:
- Physical health
- Behavioral health
- I/DD and TBI
- LTSS needs
- Pharmacy needs
- Unmet health-related resource needs

Care Management Is Key to Integration

- **Care management is foundational to the success of Medicaid Transformation and will provide the "glue" for integrated care, fostering coordination and collaboration among care team members across disciplines and settings.**

- **Integration is particularly important for the Tailored Plan population given that by design, all Tailored Plan members have complex needs associated with a behavioral health condition, I/DD, or TBI.**

- **Tailored Care Management was built on the principle that provider- and community-based care management is crucial to the success of fully integrated managed care. The same expectations for whole-person care management exist regardless of whether the member is obtaining Tailored Care Management at a Tailored Plan, AMH+ practice, or CMA.**

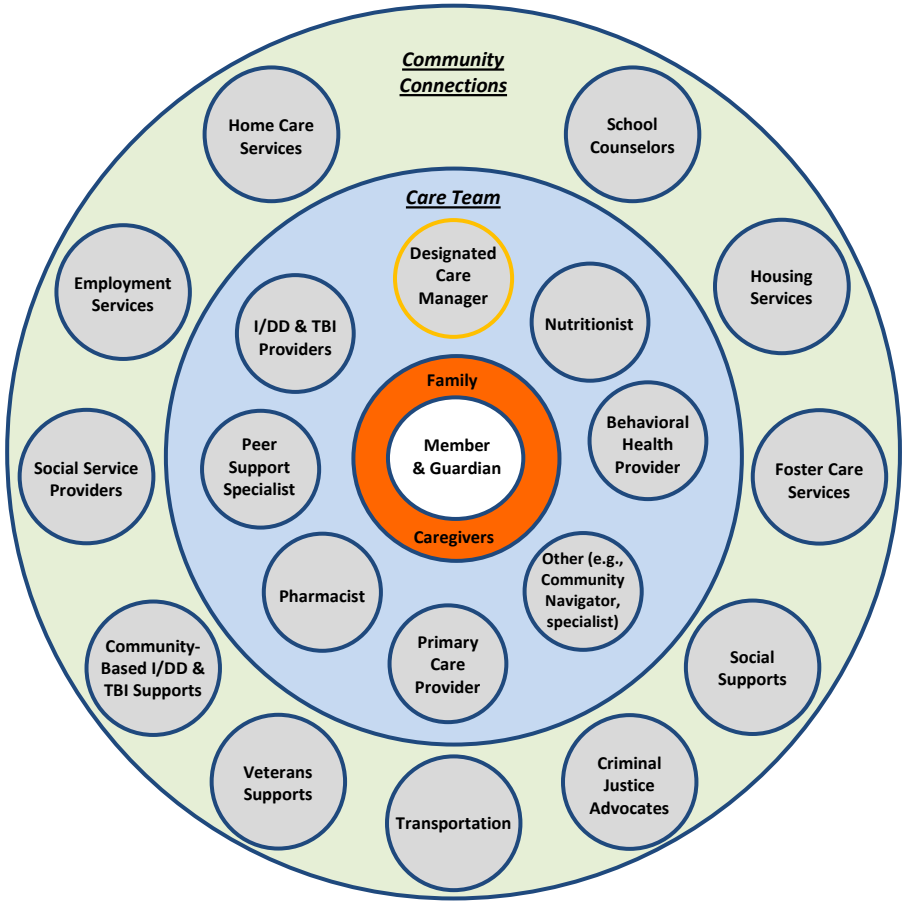
What Is Integrated Care Management?

Under Tailored Care Management, members will have a single care manager who will be equipped to manage all of members' needs, spanning physical health, behavioral health, I/DD, TBI, pharmacy, LTSS, and unmet health-related resource needs.

Integrated care management places the person at the center of a multidisciplinary care team and recognizes interactions across all of their needs—ranging across physical health, behavioral health, I/DD, TBI, LTSS, and unmet health-related resources—developing a holistic approach to serve the whole person.

In integrated care management, care managers:

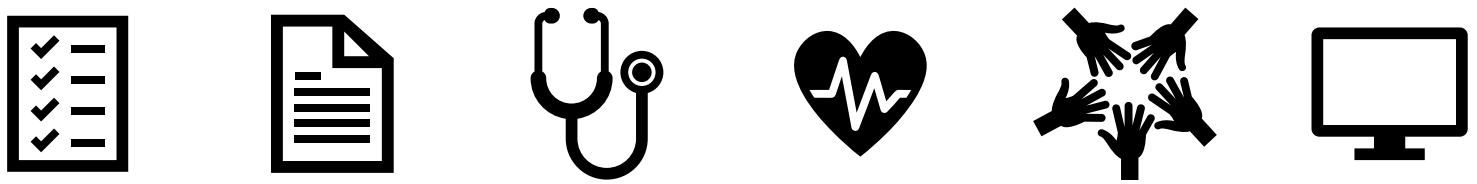
- **Coordinate a comprehensive set of services** addressing all of the member's needs; members will not have separate care managers to address physical health, behavioral health, TBI, and I/DD-related needs.
- **Provide holistic, person-centered planning.** Members receive a care management assessment that evaluates all of their needs—from physical health, behavioral health, I/DD, and TBI services to employment and housing—and drive the development of a care plan that identifies the goals and strategies to achieve them.
- **Address unmet health-related resource needs** (e.g., housing, food, transportation, interpersonal safety, employment) by connecting members to local programs and services.
- **Are part of multidisciplinary care teams** made up of clinicians and service providers who communicate and collaborate closely to efficiently address all of the member's needs.
- **Utilize technology** that bridges data silos across providers and plans.



How Will Care Managers Deliver Integrated Care Management?

Stakeholders have raised questions about care manager responsibilities related to integrated care management. Tailored Care Management includes the following components that help identify and address a member's whole-person needs:

1. Care management comprehensive assessment
2. Care plan/Individual Support Plan (ISP)*
3. Engagement and coordination with a member's Primary Care Physician (PCP)
4. Engagement and coordination with other members of the care team
5. Referrals to services addressing unmet health-related resource needs
6. Access to member data and insights from the care management data system



* An ISP is a plan of care for members with an I/DD or TBI that is developed through a person-centered planning process with the member, legally responsible person, and family.

Care Management Comprehensive Assessment

Completing the care management comprehensive assessment enables care managers to identify a member's needs related to physical health, behavioral health, I/DD, and TBI, in addition to unmet health-related resource needs.

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
  - Physical health conditions, including dental conditions
  - Detailed medication history
  - Available informal, caregiver, or social supports
  - Functional needs, accessibility needs, strengths, and goals
  - Physical, intellectual, or developmental disabilities

What additional supports do providers need to effectively administer the care management comprehensive assessment?

Care Plan/ISP

The care plan/ISP documents a member's health-related needs and the key providers that are serving the member to assist the care manager in coordinating services. The care plan/ISP must be made available to other care team members to assist with this coordination.

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
  - Clinical needs and interventions
  - Measurable goals
  - Strategies to improve self-management and planning skills
  - Strategies to mitigate risks to the health, well-being, and safety
  - Social, educational, and other services needed by the member
- **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)

Engagement and Coordination with Member's PCP

Every member engaged in Tailored Care Management will select or be assigned to a PCP. Care managers should regularly engage and coordinate with a member's PCP.

Coordination Requirements

- Care managers should also coordinate with the PCP on preventive care. For example, the care manager should ensure the member has an annual physical exam and other wellness visits, is vaccinated, and undergoes recommended screenings.
- Care managers can assist members with scheduling, prepare them for PCP appointments (e.g., reminders and arranging transportation), and follow up on referrals.
- Care managers also have a role in delivering health promotion services to engage members with or at-risk for chronic conditions or other emerging health problems.

How do provider organizations and Tailored Plans intend to facilitate coordination and communication between care managers and PCPs?

What additional supports would be helpful in preparing care managers to do this?

Engagement and Coordination with Other Care Team Members

Care managers will coordinate with other members of the care team, including physical health specialists, to ensure the member is obtaining integrated care.

Other Members of the Care Team

- 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
- Other providers and individuals, as determined by the care manager and member

What additional supports would be helpful in preparing care managers to do this?

What other ways can DHB prepare those providers to understand and be receptive to Tailored Care Management care managers?

Referrals to Services Addressing Unmet Health-Related Resource Needs

Care managers are responsible for linking members to services that help address unmet health-related resource needs (e.g., housing, transportation, food), 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

***Note:** Some members will also have access to Healthy Opportunities Pilots to address unmet health-related resource needs.

Data and the Care Management Data System

Data is a critical tool for integration – care managers must have access to and use data across multiple domains to assess and address a member's whole-person needs. The care management data system provides the baseline level of health information technology for care managers to meaningfully share and use data.

AMH+ practices and CMAs must use a care management data system*, which may comprise EHRs and/or separate care management platforms or analytic/reporting tools, that can:

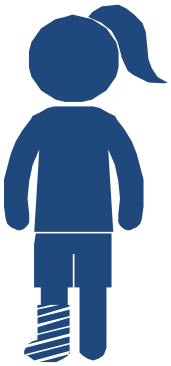
- Maintain up-to-date documentation of members enrolled in Tailored Care Management and assignments of individual members to care managers;
- Electronically document and store care management comprehensive assessments, re-assessments, care plans and ISPs;
- **Consume and store claims and encounter data;**
- Track referrals; and
- Provide access to – and electronically share, if requested – member records with the member's care team to support coordinated care management, as well as the member, in accordance with federal, state, and Department privacy, security, and data-sharing requirements.

*Care management data systems are not required to perform data analytics, but they must, at a minimum, be able to transmit data that supports data analytics performed by other systems and data tools.

See the Tailored Care Management Provider Manual for additional detail on the HIT requirements for AMH+ Practices and CMAs.

Integrated Care Management – Scenario #1

Member is enrolled in a Tailored Plan and selects AMH+ practice as her care management provider.



Member

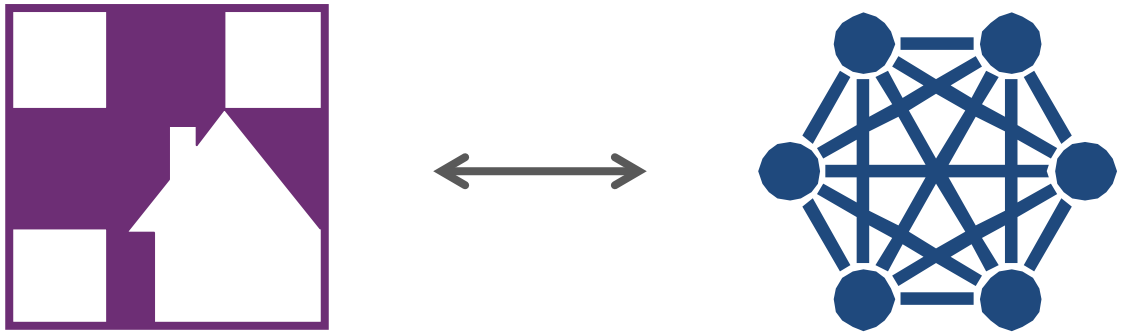
- History of opioid use disorder, not on medication-assisted treatment
- Stable, now in outpatient SUD care after SAIOP, but at risk for relapse

Scenario

- Injured in car crash
- Discharged from ED with nonoperative fracture
- At risk of untreated pain or relapse due to self-medication

Integrated Care Management – Scenario #1, *cont.*

AMH+ practice has partnered with a CIN/Other Partner to support care management for HIT requirements, including access to ADT alerts.



AMH+ Practice

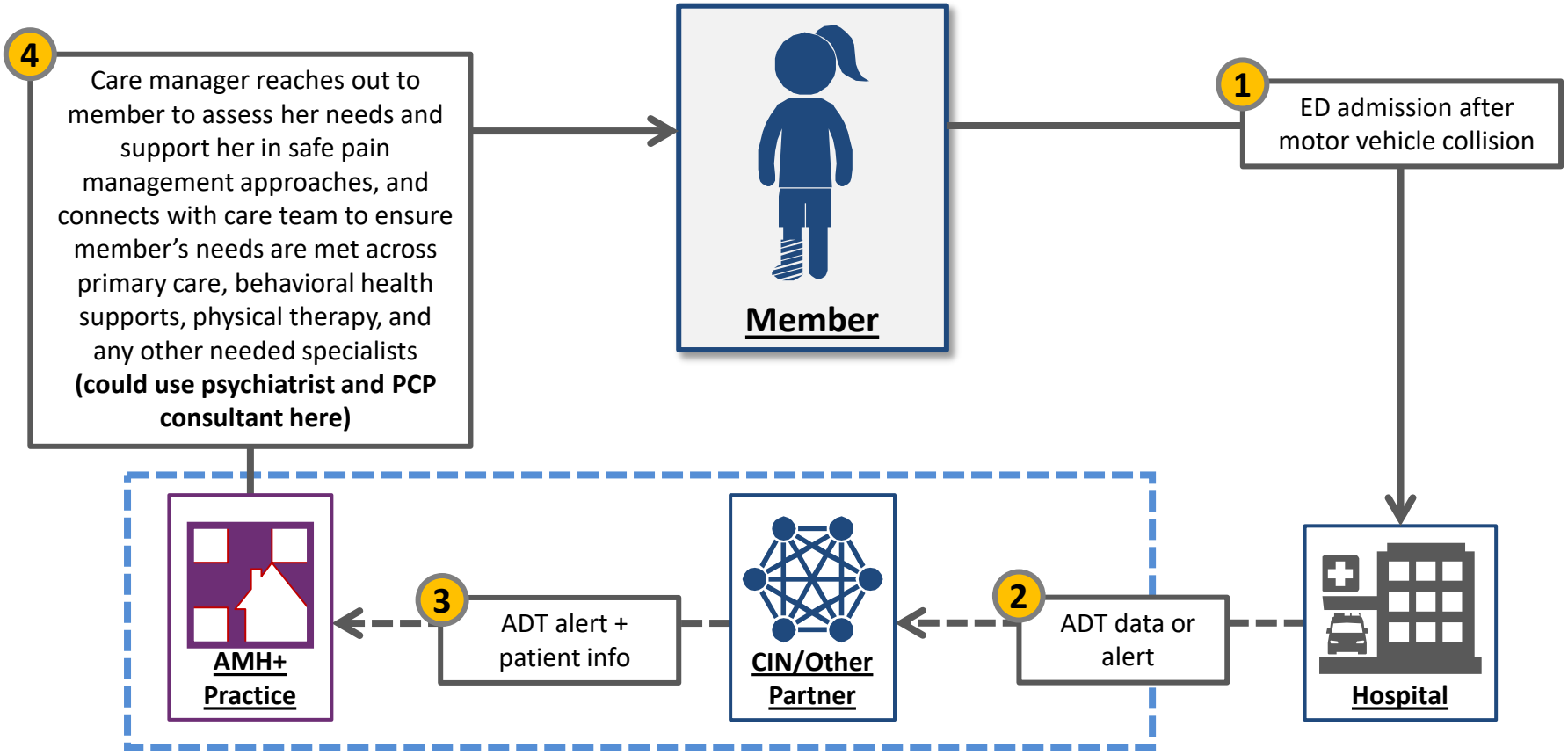
- Conducts care planning
- Has care management staff in-house
- Leads transitional care management with assistance from CIN/Other Partner

CIN/Other Partner

- Aggregates data from Tailored Plan
- Receives high-risk ADT alerts
- Delivers panel-specific information that may be incorporated into AMH+ practice workflows

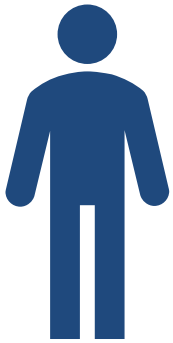
Integrated Care Management – Scenario #1, *cont.*

After ED discharge, AMH+ practice engages in transitional care management to ensure member has good pain relief and avoids relapse.



Integrated Care Management – Scenario #2

Member is enrolled in a Tailored Plan and selects a CMA as his care management provider.



Member

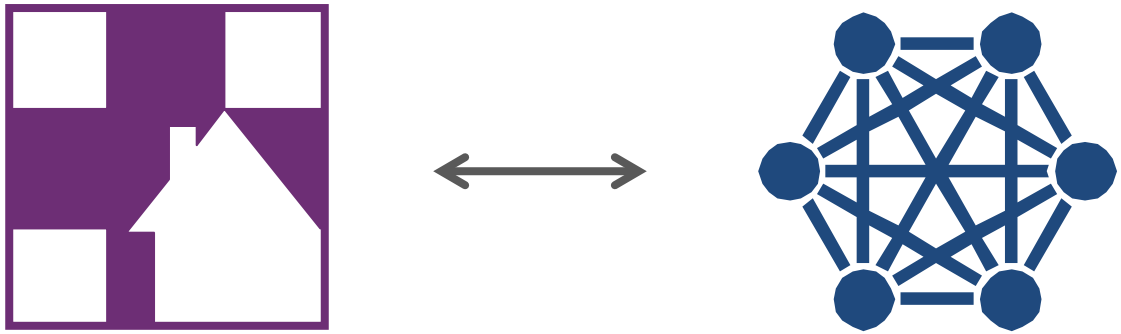
- Individual with SMI and long-term use of medication, as well as kidney disease

Scenario

- Requires regular dialysis treatment (several times a week) and medication monitoring for SMI medication
- Care team includes nephrologist and endocrinologists
- Does not have reliable form of transportation

Integrated Care Management – Scenario #2, *cont.*

CMA has partnered with the Tailored Plan for health IT and analytics support.



CMA

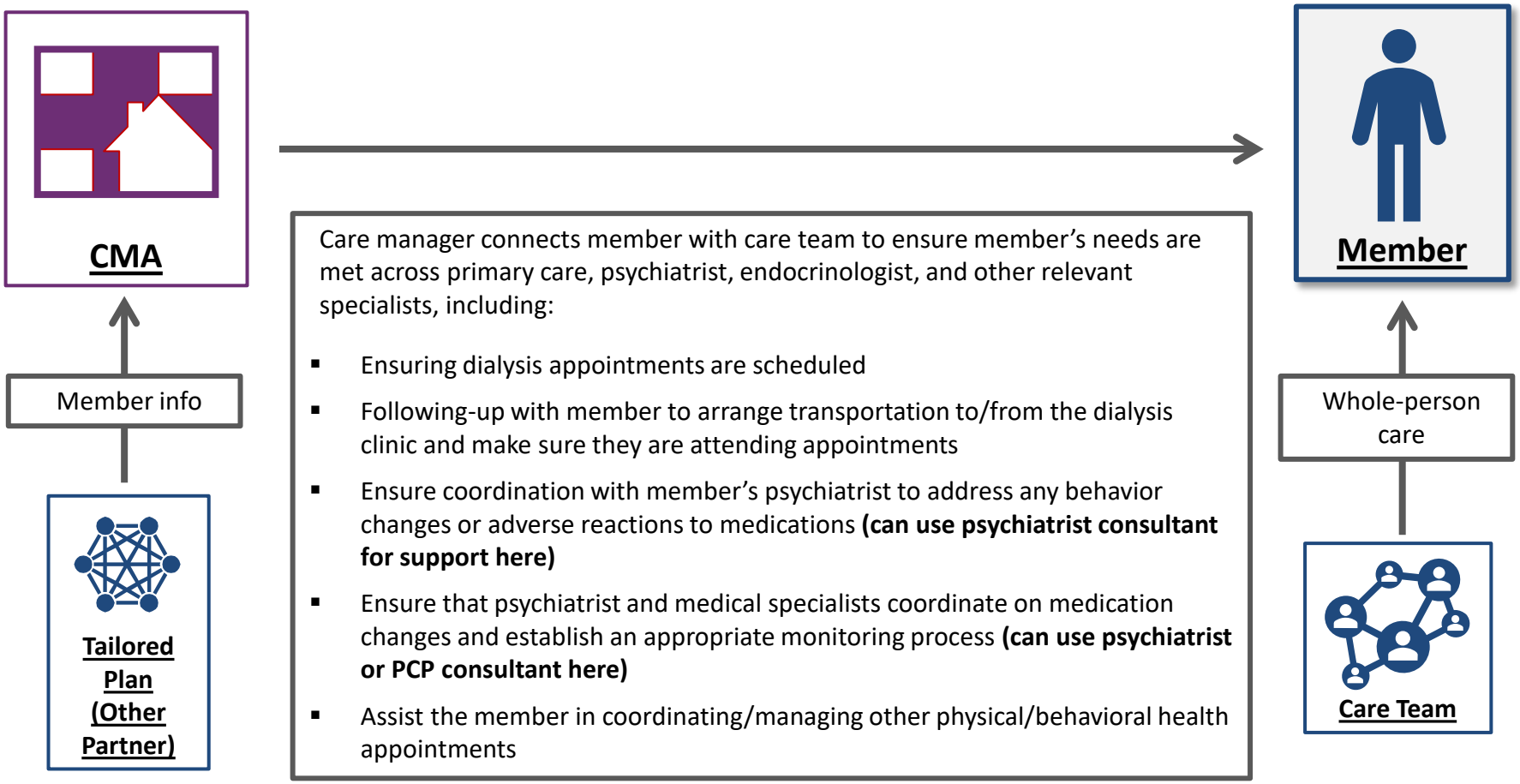
- Has in-house care managers
- Has an EHR, but otherwise has limited technical and staff capacity to consume and analyze patient data to inform care interventions
- Does not have its own care management data system

Tailored Plan

- Provides access to a care management data system
- Imports and analyzes claims/encounter data to support care management

Integrated Care Management – Scenario #2, *cont.*

CMA care manager coordinates care across physical health and behavioral health providers to address the member's whole-person needs.



Role of Clinical Consultants on the Care Team

Role of Clinical Consultants

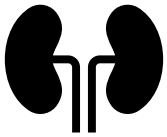
Clinical consultants are:

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

AMH+s/CMAs should develop relationships with clinical consultants to provide subject matter expert advice to the care team. AMH+s/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+s/CMAs to advise on complex clinical issues on an ad hoc basis.

Note: CINs or Other Partners are a valuable resource to assist AMH+s/CMAs with identifying and contracting with clinical consultants. The Department encourages providers to contact and collaborate with CINs/Other Partners to address any issues with finding and securing the services of clinical consultants.

Example #1: Use of Clinical Consultants



- A member engaged in Tailored Care Management at a CMA has diabetes and schizophrenia and is taking Zyprexa. The care manager notices the member is losing weight and the member reports being tired and really thirsty all of the time.
- The care manager may choose to have the CMA's primary care physician (PCP) clinical consultant review this member's medical case to make recommendations, especially in situations where the member's assigned PCP is not available or responsive.
- A PCP consultant may decide to specifically reach out to the member's PCP with identified concerns or recommendations for collaboration regarding diabetic treatment goals and psychotropic use (Zyprexa).

Example #2: Use of Clinical Consultants

- An adult member, with recent cancer diagnosis and severe SUD on medications for opioid use disorder (MOUD) through the PCP is engaged in Tailored Care Management at an AMH+ practice. The member reports feeling very overwhelmed and depressed with the news.
- The care manager can set up a rapid consultation for the member's PCP with the AMH+'s psychiatrist/ psychologist consultant to provide guidance about how to best address this urgent situation.

Example #3: Use of Clinical Consultants

- An adolescent member with ADHD and type-1 diabetes, both managed by the PCP, is recently discharged from Intensive In-Home (IIH) services and engaged in Tailored Care Management at an AMH+ practice.
- Her new outpatient therapist contacts the Tailored Care Management care manager and reports that the member appears to be developing early symptoms of psychosis in the context of increasing marijuana use and the therapist is unsure how to connect her to the right clinical resources in their rural area.
- The care manager notifies the supervising care manager and contacts the psychiatrist or psychologist serving as a clinical consultant to advise on this urgent situation.

Example #4: Use of Clinical Consultants

- A young adult member with I/DD and high blood pressure, both managed by the PCP, is experiencing a significant loss as her mom recently passed away. The member has moved to her sister's home and is grieving her mom and having difficulty adjusting to all the changes to her routine.
- The Tailored Care Management care manager contacts the member and her sister frequently to check for additional needs during this transition and it appears that she may be experiencing depression.
- The care manager notifies the supervising care manager and contacts the psychologist serving as a clinical consultant to advise on this situation.

For Discussion

How do TAG members plan to use clinical consultants?

What support do TAG members need from the Department to use clinical consultants effectively?

Public Comments

Next Steps

Next Steps

Tailored Care Management TAG Members

- Review FAQ document and other updates on Tailored Care Management web page

Department

- Discuss feedback received during today's Tailored Care Management TAG meeting
- Prepare for October 28 Tailored Care Management TAG session

Tailored Care Management TAG Meeting Cadence

Tailored Care Management TAG meetings will generally take place the fourth Friday of every month from 3:30-4:30 pm ET.

Upcoming 2022 Meetings:

October 28

Previous Meetings:

- **Meeting #1:** Friday, October 29, 2021. 3:00 – 4:30 pm ET (presentation, minutes)
- **Meeting #2:** Friday, November 19, 2021, 3:30 – 4:30 pm ET (presentation, minutes)
- **Meeting #3:** Friday, December 17, 2021, 3:30 – 4:30 pm ET (presentation, minutes)
- **Meeting #4:** Friday, January 28, 2022, 3:30 – 4:30 pm ET (presentation, minutes)
- **Meeting #5:** Friday, February 25, 2022, 3:30 – 4:30 pm ET (presentation, minutes)
- **Meeting #6:** Friday, March 25, 2022, 3:30 – 4:30 pm ET (presentation, minutes)
- **Meeting #7:** Friday, June 3, 2022, 3:30 – 4:30 pm ET (presentation, minutes)
- **Meeting #8:** Friday, June 24, 2022, 3:30 – 4:30 pm ET (presentation, minutes)
- **Meeting #9:** Friday, July 22, 2022, 3:30 – 4:30 pm ET (presentation, minutes)
- **Meeting #10:** Friday, August 26, 2022, 3:30 – 4:30 pm ET (presentation, minutes)