Tailored Care Management Technical Advisory Group (TAG)

Meeting #39

Care Transitions Overview

August 22, 2025

Announcement

Please note that we request that no one record this call or use an AI software/device to record or transcribe the call. DHHS is awaiting additional direction from our Privacy and Security Office on how we need to support these AI Tools. Thank you for your cooperation.

HIPAA-covered DHHS agencies which become aware of a suspected or known unauthorized acquisition, access, use, or disclosure of PHI shall **immediately** notify the DHHS Privacy and Security Office (PSO) by reporting the incident or complaint to the following link: https://security.ncdhhs.gov/

Agenda

- Welcome and Roll Call
- TCM Care Transitions Overview
- Public Questions/Comments

Welcome and Roll Call

Department of Health and Human Services

Kristen Dubay, MPP	Loul Alvarez, MPA	Regina Manly, MSA	Eumeka Dudley, MHS	Gwendolyn Sherrod, MBA, MHA	Tierra Leach, MS, LCMHC-A, NCC
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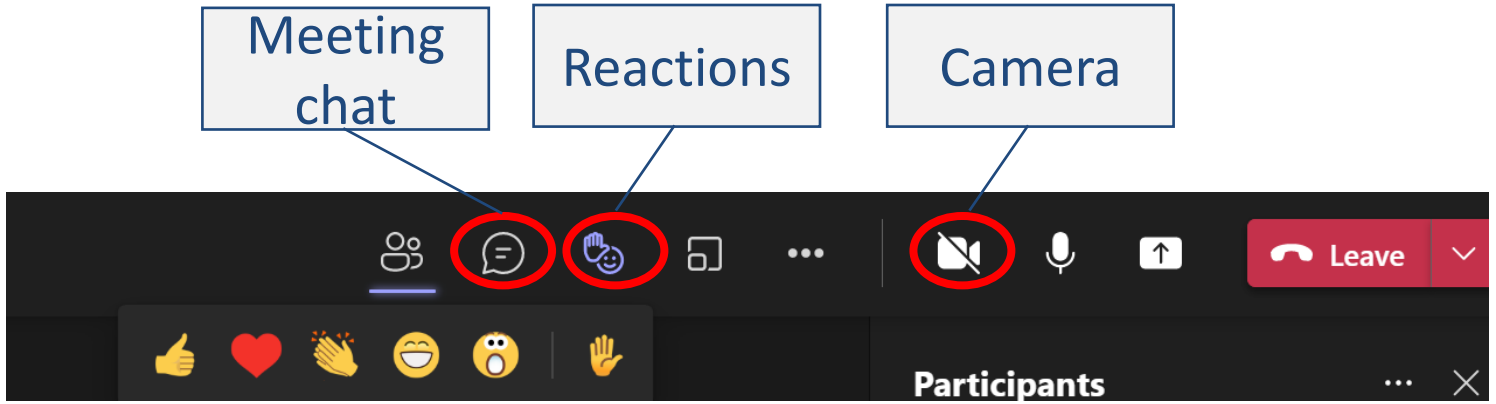
NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Tailored Care Management TAG Membership

Name	Organization	Stakeholder
Erin Lewis	B&D Integrated Health Services	Provider Representative
Julie Quisenberry	Coastal Horizons Center	Provider Representative
Billy West	Daymark	Provider Representative
Denita Lassiter	Dixon Social Interactive Services	Provider Representative
Luevelyn Tillman	Greater Vision Counseling and Consultants	Provider Representative
Keischa Pruden	Integrated Family Services, PLLC	Provider Representative
Joanna Finer	Pinnacle Family Services	Provider Representative
Sandy Feutz	RHA	Provider Representative
Lisa Poteat	The Arc of NC	Provider Representative
Eleana McMurry, LCSW	UNC Center for Excellence in Community Mental Health	Provider Representative
Donna Stevenson	Alliance Health	Tailored Plan Awardee
Lynne Grey	Partners Health Management	Tailored Plan Awardee
Cindy Ehlers	Trillium Health Resources	Tailored Plan Awardee
Chris Bishop	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
Jonathan Ellis	N/A	Consumer Representative
Alicia Jones	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.



Tailored Care Management: Care Transitions Overview

Tailored Care Management: Care Transitions Overview

Agenda

- Pillars of Care Transitions
  - Overview
- Define Care Transitions within Tailored Care Management [TCM]
  - Who, When, What, Why
  - Documentation and communication
  - Care Transition in action
- Post Discharge
  - Safety Precautions when returning home
  - Medication Reconciliation – who can do this

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Agenda Continued

- Maximizing Physical Function
  - Durable Medical Supplies and Equipment (DME) – who can help
  - Occupational/Physical and Speech Therapies
- Addressing Social Determinants of Health (SDOH)
- The Value of Discharge Planning and Follow up Care

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Pillars of Care Transitions

- Identification of both behavioral/physical self-management needs. Begin development of 90- day post discharge transition plan.
- Review of personal health needs. Change in status assessment.
- Timely primary care/specialty care follow up. Not to exceed 7-days with a BH provider and as soon as possible for physical health needs.
- Collaborating with member to identify knowledge of red flags that indicate a worsening in condition and how to respond.
- Member centered focused care- DME, Home Health, referrals to community-based support, identification of SDOH impacting resilience.

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What is Care Transitions?

- It is defined support for members moving between care settings (ie: member who is in an acute care hospital who is then discharged home)
  - For example: a member discharged from the hospital may require oxygen at home or have other medical needs that must be addressed in the transition process.
- It is integrated within the Tailored Care Management (TCM) model
- It supports whole-person, team-based care
- Addresses SDOH and follow up needs
- The goal is to reduce fragmentation, improve outcomes and prevent readmission to the hospital

Who is Responsible for Care Transitions?

- LME/MCO's
  - Alliance Health
  - Partners Health Management
  - Trillium Health Resources
  - Vaya Health
  - Advanced Medical Home Plus (AMH+) practices
  - Care Management Agencies (CMAs)
  - Local Management Entities

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When Do Care Transitions Occur?

- Care Transitions are triggered by admission and discharge from the following the Care Settings:
  - Inpatient psychiatric units
  - Inpatient acute care hospitals
  - Emergency departments (EDs)
  - Facility-Based Crisis Centers (FBCs)
  - Skilled Nursing Facilities (SNFs)
  - State Developmental Centers for individuals with I/DD Intermediate Care Facilities (ICFs)
  - State Hospitals for individuals with BH
  - Adult Care Homes
  - Assisted Living Facilities (ALFs)
  - Alcohol and Drug Abuse Treatment Centers (ADATCs)
  - Other BH, IDD, SU residential facilities [PRTF]

What Happens During a Care Transition?

- The care management staff:
  - engages the individual early (during or shortly after admission)
  - is present or available, on the day of discharge to facilitate aftercare needs
  - completes a 90-day transition plan and updates the care plan to reflect condition changes, which is part of the members overall plan of care
  - in conjunction with the clinical support team creates and reviews the discharge plan

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What Happens During a Care Transition? (Cont'd)

- The care management staff schedules and confirms follow-up appointments
- The care manager coordinates resources such as, DME, home supports, transportation
- Ensures that a qualified professional conducts medication reconciliation post-discharge
- The care management staff educates members and caregivers
- The care manager ensures warm handoffs to providers

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Documentation and Communication

- All Care Transition activities must be documented in the care management record
- Communication with Primary Care Providers (PCPs), discharge planners, pharmacies and community-based service providers is essential
- Always align the Care Transitions with the broader Care Plan goals
- Communication is key to successful aftercare

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Care Transition in Action

- A depressed patient stops eating and taking medications for depression and diabetes resulting in Diabetic Ketoacidosis and suicidal ideation. They go to the Emergency department for treatment and are admitted.
- How is this condition treated in the home after discharge?
  - Continuous Glucose Monitoring Device
  - Equipment to remind member to take meds
  - Outpatient therapy for symptoms of depression
  - Safety plan development including crisis line resources
  - Review of the member's safety/crisis plan when suicidal ideations are present and ensuring this is documented
  - Educate caregivers and providers on importance of medications for both conditions and proper follow up care

Post Discharge and Safety

- **Reminder** – The TCM is present on day of discharge
- After discharge the TCM continues to work with the member however, they choose to be engaged (telephonic, face-to-face)
- The TCM continues to ensure that all needs identified while in the hospital are secured or in process. This is best if done at discharge site
- The TCM verifies and ensure follow up reminders are sent to the members for appointments
- Determine if anything else is needed and update all documents (care plan, assessments). This includes review of post discharge transportation needs to identify if there are support options in place for the member will get to follow up appointments or services

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Post Discharge – Medication Reconciliation

- The care manager will ensure the appropriately qualified professional conducts a med reconciliation this includes:
  - Reaching out to a qualified member of the Care Team , as detailed below

*It's important to document all outreach attempts

- The medication reconciliation must be completed by one of the following care team members:
  - Pharmacist (Rph)
  - Pharmacist Tech (CPht)
  - Medical Doctor (MD)

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Post Discharge – Medication Reconciliation

- To prepare for the medication reconciliation, the TCM should
  - Create an accurate list of the individual's medications to include:
    - Name
    - Dosage
    - Frequency and route
    - It’s important to note that that the TCM provider is not responsible for actions being taken by a doctor or pharmacist

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Post Discharge – Medication Reconciliation

- Why is a Medication Reconciliation important?
  - Ensures safety and prevents medication errors
  - New medications can have different names but duplicate other medications
  - Side effect awareness
  - Determine where medications get filled and how often
  - Create a list of medication for after-care visits

  - Promote safety after discharge:
    - medication misunderstandings are the number one reason for readmissions, as members may not take them correctly

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Maximizing Physical Function Pre/Post Discharge

- Medical supplies and equipment
- A change in condition may necessitate durable medical equipment (DME) or supplies
  - What is DME
  - How does DME differ from medical supplies
- Early Planning is important because some items require prior authorization
  - Understand the authorization process in Utilization Management
  - Know the in-network providers and DME vendors
  - Access LME/MCO or NC Tracks provider directories
  - Outreach to community supports such as NC Assistive Tech Program (NCATP) if barriers exist

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Maximizing Physical Function Pre/Post Discharge

- Review of potential home care needs to include medication, mobility and safety needs
- **Therapies:** Improving Physical Status
  - The TCM should ensure that the providers are aware of the need for authorization post discharge for any therapies
  - There are three primary forms of therapy for physical health:
    - Physical Therapy
    - Occupational Therapy
    - Speech Therapy

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Addressing Social Determinants of Health (SDOH)

- The TCM should continuously be working to identify SDOH but specifically related to the barriers impacting this episode of care:
  - Housing instability
  - Transportation
  - Food insecurity
  - Health literacy
  - Community and Social Support
  - Economic stability
  - Access to Primary/Specialty care provider
  - Rural setting

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The Value of Discharge Planning and Follow Up Care

- Why is follow up care important?
  - It allows the TCM to loop in the primary care provider and other care providers
  - It allows the TCM to work to eliminate barriers that may result in a readmission
  - It allows the individual to experience a planned, smooth transition
  - Promotes mechanisms to facilitate recovery
  - Prevents or minimizes readmissions
  - Supports the need for follow up care within 7 days of discharge

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Questions?

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Public Comments