Alliance Health

Provider Practice Transformation Academy

Member Contact and Documentation Requirements for Tailored Care Management

What counts as a Tailored Care Management contact?

Tailored Care Management (TCM) is built around the six core health home services:

1. Comprehensive care management
2. Care coordination
3. Health promotion
4. Comprehensive transitional care from inpatient to other settings (including follow-up)
5. Individual and family supports (which includes authorized representatives)
6. Referral to community and social support services

Below are examples of activities care managers may complete as part of these health home services in delivering a TCM contact (see the NC DHHS Tailored Care Management Provider Manual for additional details):

- Comprehensive care management, including
  - Completion of care management comprehensive assessments and care plan/ISP.
  - Phone call or in-person meeting focused on chronic care management (e.g., management of multiple chronic conditions).

Continued

- Care coordination, including
  - Working with the member on coordination across settings of care and services (e.g., appointment/wellness reminders and social services coordination/referrals).
  - Help with scheduling and preparing members for appointments (e.g., phone call to provide a reminder and help arrange transportation).
- Health promotion, including
  - Providing education on members' chronic conditions.
  - Teaching self-management skills and sharing self-help recovery resources.
  - Providing education on common environmental risk factors including but not limited to the health effects of exposure to second- and third-hand tobacco smoke and e-cigarette aerosols and liquids and their effects on family and children.
- Comprehensive transitional care/follow-up, including
  - Visiting the member during the member's stay in the institution and being present on the day of discharge.
  - Reviewing the discharge plan with the member and facility staff.
  - Referring and helping members access needed social services and supports identified as part of the transitional care management process, including access to housing.
  - Developing a 90-day post-discharge transition plan before discharge from residential or inpatient settings, in consultation with the member, facility staff and the member's care team.
- · Individual and family support, including
  - Providing education and guidance on self-advocacy to the member, family members and support members.
  - Connecting the member and caregivers to education and training to help the member improve function, develop socialization and adaptive skills, and navigate the service system.
  - Providing information to the member, family members and support members about the member's rights, protections and responsibilities, including the right to change providers, the grievance and complaint resolution process, and fair hearing processes.
- · Referral to community and social support services, including
  - Providing referral, information and assistance, and follow-up in obtaining and maintaining community-based resources and social support services.
  - Providing comprehensive assistance securing key health-related services (e.g., filling out and submitting applications).

CMAs/AMH+s should document encounters for member-specific internal staffing/clinical consultation under the health home service that most closely corresponds the topic of the staffing/consultation.

What are the "types of contact"?

- In-person: being physically present with the member (or guardian if applicable).
- Face-to-face: contacts completed virtually, i.e., FaceTime, Skype, Duo or another electronic means. To qualify as a "face-to-face" contact, the member must be seen, not just heard.
- Telephonic: any contact completed via telephone.
- Collateral: any contact with others involved in the member's care (i.e., parents, guardians, service providers, community contacts, etc.).

Note: Email/text exchanges do not count as a "contact."

Continued

How will the number of contacts be measured/monitored?

Tailored Plans will pay AMH+s/CMAs based on the completion of the first contact each month. While only one contact per month is required to receive the TCM payment, AMH+s/CMAs will need to document all contact attempts.

Alliance will monitor TCM contacts on a quarterly basis at the full panel level, not the specific member level. Only the members who have engaged will be included in this number. Compliance will be calculated as follows:

$$\frac{\text{Sum of all completed contacts}}{\text{Sum of minimum required contacts for engaged members}}$$

The data for completed contacts that is used in this calculation comes from the BCM051 report, which tracks member contacts.

During the "soft launch" period from December 1, 2022, to April 1, 2023, CMAs and AMH+s are expected to complete an average of two contacts per member per month. This average is monitored at the entire panel level, not the individual member level. Each TCM agency's entire panel will be looked at to determine if an average of two contacts was made per member across the agency's panel; some members may have more than two contact and some may have less, but it's the average across the panel that is measured. Only engaged members (i.e., members for whom there is a claim) are included in this measure.

How should a Tailored Care Management contact be documented?

There is no specific format requirement for TCM contact notes. However, notes should include, at minimum:

- Member name
- Member ID (i.e., Medicaid ID, LME, record #)
- Date of contact
- Name of TCM health home component (assessment, care planning, care coordination, health promotion, transitional care management, individual/family support, referral)
- Type of contact (in-person, face-to-face, telephonic, collateral)
- Place of service (if applicable)
- Brief description of intervention and activities
- Time spent
- Progress toward goals
- Person providing the service

Per NC Medicaid standards, all contact notes must be signed and dated by the person who provided the contact/wrote the note. For information about electronic signatures, please see the NC DHHS Records Management and Documentation Manual (APSM 45-2).

References:

- 42 U.S.C. § 1396w-4 18001
- NC DHHS Tailored Care Management Provider Manual
- NC DHHS Records Management and Documentation Manual, 12/1/16 (APSM 45-2)