CAROLINA FAMILY HEALTH CENTERS, INC.
POLICY

TITLE: IBH-500 Tailored Care Management

EFFECTIVE DATE: February 25, 2025

SECTION: IBH
REFERENCE PROCEDURE:
IBH-500.01 Tailored Care Management Program Manual
IBH-500.02 Communication with Members of Tailored Care Management
IBH-500.03 Contact Requirements for Tailored Care Management

RESPONSIBLE CHIEF OF STAFF: Chief Medical Officer
RESPONSIBLE COMMITTEE: Medical CIT

REVIEWED:

I. PURPOSE

The purpose of this policy is to state Carolina Family Health Centers, Inc.'s (CFHC, Inc.'s) involvement in providing Tailored Care Management (TCM) to patients with significant behavioral health conditions.

II. POLICY

CFHC, Inc. is an Advanced Medical Home Plus (AMH+) practice and as such, provides Tailored Care Management to adult patients with significant behavioral health conditions (serious mental illness and serious emotional disturbance) and severe substance use disorders under the North Carolina Medicaid Program.

Tailored Care Management includes these core principles:

- Broad access to care management
- Single case manager taking an integrated, whole-person approach
- Person- and family-centered planning
- Provider-based care management
- Community-based care management
- Community inclusion
- Choice of care managers
- Consistency across the state
- Harness existing resources

Tailored 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, and unmet health-related resources—developing a holistic approach to serving the whole person. In integrated care management, case managers:

- Coordinate a comprehensive set of services addressing all of the member's needs; members will not have separate case managers to address physical health and behavioral health needs.

- Provide holistic, person-centered planning. Members receive a care management assessment that evaluates all of their needs—from physical and behavioral health services to employment and housing—and drives 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.

Tailored Care Management includes the following activities:

- Development of care management comprehensive assessments and care plans/individual support plans
- Coordination of services
- Care coordination for individuals with intellectual/developmental disabilities or Traumatic Brain Injury (if applicable)
- Consultation with a multidisciplinary care team
- Transitional care management
- Diversion from institutional settings
- In-reach and transitions from institutional settings (for certain populations)
- Addressing unmet health-related resource needs
- Management of rare diseases and high-cost procedures; high-risk care management; chronic care management
- Medication monitoring
- Development and deployment of prevention and population health programs