

# NC Tailored Plan Behavioral Health Team Huddle & Case-Review Template

**Purpose:** This template guides regular team huddles (case conferences) for NC Tailored Plan behavioral health care teams. Per NC Medicaid Tailored Care Management (TCM) requirements, care managers must hold regular interdisciplinary case conferences (aka team huddles/ planning meetings) to coordinate member care, communicate across settings, and update the shared care plan. Use this fillable template in Word to document meeting details, discuss member status, and assign action items with clear outcomes and follow-ups.

## Meeting Details

- **Meeting Date:** \_\_\_\_\_ (e.g. 09/30/2025)
- **Attendees (Role – Name):**
  - RN Care Manager: \_\_\_\_\_
  - BH Clinician: \_\_\_\_\_
  - Peer Specialist: \_\_\_\_\_
  - PCP: \_\_\_\_\_
  - Community Health Worker: \_\_\_\_\_
  - Supervisor: \_\_\_\_\_
  - [Add others as needed]
- **Member(s) Discussed (Name & ID):**
  - \_\_\_\_\_
  - \_\_\_\_\_
- **Agenda (Planned Topics):**
  - *Member Status Update (clinical, behavioral, social)*
  - *Care Plan Review (goals, progress, barriers)*
  - *Resource Needs (social supports, housing, benefits)*
  - *Action Items (tasks, responsibilities)*
  - *Next Steps/Follow-Up (dates, next meeting)*

## Discussion & Agenda Points

- **Behavioral Health Status:** Sample Language: “Discussed member’s current behavioral health status, including symptom changes, mood, and recent stressors (e.g. increased anxiety, sleep disturbance).”
- **Medical/Physical Update:** Sample: “Reviewed member’s physical health issues (e.g. chronic conditions), recent PCP visits, and medication adherence.”

- **Care Plan Goals:** Sample: “Reviewed existing care plan goals (e.g. attend therapy weekly, adhere to medications) and progress toward each.”
- **Social Supports & Needs:** Sample: “Noted changes in social determinants (housing stability, employment, transportation needs) and identified new resources.”
- **Risk Factors:** *Sample:* “Assessed any new risk factors (substance use, suicidality) and crisis plans as needed.”
- **Agenda Items as Needed:** *Sample:* “Any additional agenda topics: e.g. peer support interventions, crisis response, etc.”

## Updates to Care Plan/EHR

- **Care Plan Updates:** Document all discussion outcomes in the shared Care Plan/ISP and EHR. Update goals, strengths, and interventions as needed to reflect the team’s decisions.
- *Sample:* “**Care Plan Updated:** Added goal – ‘Attend 4 therapy sessions by next month’; updated intervention – ‘Peer specialist to provide daily motivational coaching.’ Enter in EHR.”
- *Sample:* “**Medication Update:** Noted new prescription (Sertraline 50 mg daily); confirmed adherence plan. Logged in EHR medication list.”
- *Sample:* “**Resource Coordination:** Added: Member will meet CHW weekly for housing assistance. Documented in Care Plan and noted next CHW visit in EHR.”

## Action Items & Follow-Up

Define specific Action Items, assign a responsible person, and set a deadline. Link each action to a care plan goal or desired outcome. Track any unresolved issues from prior meetings and schedule follow-up, ensuring problems are addressed.

- **Peer Specialist – Motivational Coaching:** Provide one-on-one coaching on medication adherence. Due: //. Outcome: Supports “improved daily medication adherence” goal.
- **RN Care Manager – Appointment Follow-up:** Confirm transportation arranged for next psychiatrist appointment. Due: //. Outcome: Ensures “attends psychiatric follow-up” goal.
- **CHW – Housing Assistance:** Follow up on housing application and report status. Due: //. Outcome: Progress toward “secure stable housing” goal.

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- **Behavioral Health Clinician – Therapy Engagement:** Reach out to member about missed therapy sessions and schedule makeup. Due: //. Outcome: Improves “consistent therapy attendance” goal.
- **Unresolved Issues:** List any ongoing issues. Example: “Member still lacks stable housing; CHW to continue outreach (next status report at next meeting).”

**Next Meeting:** \_\_\_\_\_ (Schedule date; e.g. 10/07/2025) – to review action items and unresolved issues.

## Accountability & Documentation

A supervising care manager or team lead should review and sign off on this meeting summary. This oversight ensures complete, high-quality care planning as required by TCM. All team members should ensure the meeting notes are entered in the member’s EHR or care management system immediately after the huddle. Document key decisions and follow-ups as service notes (including outcomes and next steps) to maintain accountability.

- **Supervisor/Lead:** \_\_\_\_\_ (Name/Signature) – Verified meeting documentation and care plan updates.
- **Documentation:** “Entered notes in EHR; emailed summary to care team and Tailored Plan contact.”

**Tracking:** Maintain a log of huddle dates and attendees for quality oversight and continuous monitoring of high-risk members, per NC Tailored Plan standards. Each follow-up should be checked at the next meeting, and any delays or issues escalated accordingly.

**Sources:** North Carolina Tailored Care Management Provider Manual – sections on care team communication, case conferences, documentation standards, and oversight. These inform the template’s structure and prompts.

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## NC Tailored Plan – Behavioral Health Team Huddle & Case-Review Template

(For use in regular interdisciplinary case conferences per NC TCM requirements)

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### Meeting Details

- Date: \_\_\_\_\_
- Attendees (Role – Name):
  - RN Care Manager: \_\_\_\_\_
  - Behavioral Health Clinician: \_\_\_\_\_
  - Peer Specialist: \_\_\_\_\_
  - Community Health Worker: \_\_\_\_\_
  - Primary Care Provider: \_\_\_\_\_
  - Supervisor/Lead: \_\_\_\_\_
  - Other(s): \_\_\_\_\_
- Member(s) Discussed (Name & ID): \_\_\_\_\_

### Agenda

Member status update (clinical, behavioral, social)  
Care plan review (goals, progress, barriers)  
Resource needs (housing, transportation, benefits)  
Risk factors (SUD, suicidality, safety)  
Additional items: \_\_\_\_\_

### Discussion Notes

- Behavioral Health Status: \_\_\_\_\_
- Medical/Physical Update: \_\_\_\_\_
- Care Plan Goals Reviewed: \_\_\_\_\_
- Social Supports & SDOH Needs: \_\_\_\_\_
- Risk Factors / Crisis Planning: \_\_\_\_\_
- Other Agenda Items: \_\_\_\_\_

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## Care Plan / EHR Updates

- Care Plan Goal Updates: \_\_\_\_\_
- New/Modified Interventions: \_\_\_\_\_
- Medication/Health Updates: \_\_\_\_\_
- Resource Coordination Updates: \_\_\_\_\_

( Updates entered in EHR / Care Plan revised)

## Action Items & Follow-Up

Task	Responsible Person	Due Date	Linked Goal/Outcome	Status/Notes
Motivational coaching for med adherence	Peer Specialist		Improve daily medication adherence	Complete Pending
Confirm transportation for psychiatry appt	RN Care Manager		Ensure appt attendance	Complete Pending
Follow up on housing application	CHW		Secure stable housing	Complete Pending
Schedule makeup therapy sessions	BH Clinician		Consistent therapy engagement	Complete Pending
Unresolved Issues:				

## Next Meeting

- Date: \_\_\_\_\_
- Focus/Follow-Up Items: \_\_\_\_\_

## Accountability

- Supervisor/Lead Verification: \_\_\_\_\_ (Signature/Date)
- Documentation: Entered in EHR    Summary shared with team    Tailored Plan notified

## Tracking

Added to huddle log (date, attendees, members discussed).

Unresolved issues flagged for follow-up at next meeting.