INTERDISCIPLINARY CARE TEAM

TRAINING 2020

INTERDISCIPLINARY CARE TEAM (ICT)

NMM assures an Interdisciplinary Care Team (ICT) to coordinate the delivery of services and benefits to all enrollees when a need is demonstrated, or a request has been made in accordance with the members' functional needs based on the care plan, medical records, behavioral health and LTSS needs.

ICT MEMBERSHIP

The care manager leads and determines ICT membership with the member, and may include:

- Member / Caregiver / Authorized representative
- Designated PCP
- Nurse / Care manager / Care coordinator
- Pharmacist
- County IHSS social worker and provider (if applicable)
- Multipurpose senior services program (MSSP) coordinator
- Pharmacist
- Behavioral health service providers (if applicable)
- CBAS, LTSS providers
- Other professional staff within the provider network

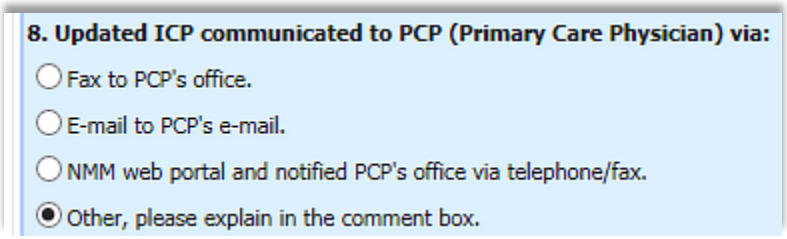
ICT ROLES AND RESPONSIBILITIES

- Basic case management, including advanced care planning
- Medication reconciliation
- Identification of a member at risk for transitions
- Referral and coordination with specialists
- Development and implementation of ICP
- Referrals to, and coordination, with services such as (not limited to) behavioral health, long term support services, multipurpose senior services program, waiver programs.
- Referrals to, and coordination with, community-based services
- Communication with member/representative and medical group
- ICP review and update (at least annually) with changes to the member's health status
- Consult with PCP, specialist and health network teams
- Ensure member engagement and participation with ICT process
- Coordinate management of members with complex transition needs and development of ICP
- Support ICP implementation by PCP and health network
- Analyze data to evaluate management of transitions and ICT activities to identify areas for improvement

INDIVIDUALIZED CARE PLANS (ICP)

The individual ICTs identify opportunities for improvement in areas of clinical and nonclinical management and determine priorities. An individualized care plan (ICP) is implemented with the member and the caregivers that include clearly defined goals. The ICP promotes the use of the least restrictive, and most inclusive, setting the member chooses to provide care across the full continuum of service providers including medical, behavioral health and long term support services (LTSS).

Member's ICP will be updated according to ICT's recommendation – updated ICP will be communicated to member's PCP.



ICT MEETING

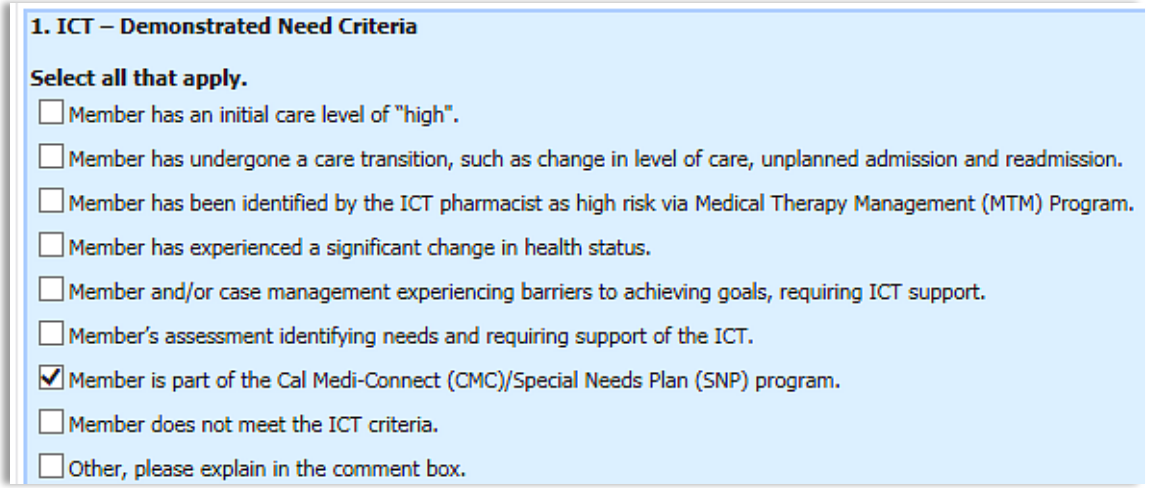
The individual ICTs meet (at least annually) to discuss cases that have been referred by PCPs, other members of the ICT, or cases in which the member is experiencing changes in status that require intervention of other professionals.

Meetings may occur face-to-face or via telephone conference. Case discussions may include a review of the member's current issues and the specific situation that may be giving rise to the issues, as well as:

- Diagnoses
- Activities of daily living
- Incapacities
- Utilization Patterns
- Treatments
- Measure of Rehabilitation
- PCP's Plan of Care
- Physical, social, economic or emotional barriers
- Significant care transition

DEMONSTRATED NEED CRITERIA

ICT meetings must be conducted within the necessary time frame to meet member needs, but no later than 90 days after the occurrence of one of the demonstrated need criteria. When a need is demonstrated, the member will be invited to an ICT meeting via phone or an invitation letter mailed to the member's address with ICT information.



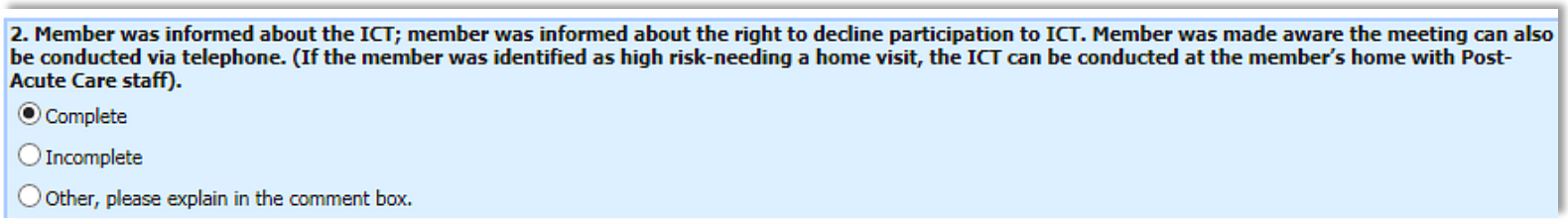
1. ICT – Demonstrated Need Criteria

Select all that apply.

- ☐ Member has an initial care level of "high".
- ☐ Member has undergone a care transition, such as change in level of care, unplanned admission and readmission.
- ☐ Member has been identified by the ICT pharmacist as high risk via Medical Therapy Management (MTM) Program.
- ☐ Member has experienced a significant change in health status.
- ☐ Member and/or case management experiencing barriers to achieving goals, requiring ICT support.
- ☐ Member's assessment identifying needs and requiring support of the ICT.
- ☑ Member is part of the Cal Medi-Connect (CMC)/Special Needs Plan (SNP) program.
- ☐ Member does not meet the ICT criteria.
- ☐ Other, please explain in the comment box.

MEMBER CENTRIC

ICT meetings are member centric and may be held as needed to manage members at all risk levels. Any Cal Medi-Connect (CMC) and Special Needs Plan (SNP) member will have at least one meeting annually. Members are provided with the ability to participate or opt-out of the meeting, as well as a call line for inquiries / input.



ICT DOCUMENTATION

The dates, participants, notes, and action plans discussed during ICT meeting must be documented, including managed communication and information flow regarding referrals, transitions, and care delivered outside the primary care site through the use of secure email, fax, web portals or written correspondence.