blue california
Promise Health Plan

POLICY & PROCEDURE
Medical Services

Policy Title: Interdisciplinary Care Team – Medicare-Medicaid Plans (MMP)		
Policy No: 90.2.21	**Original Date: 3/13**	
Effective Date: 12/18	**Revision Date: 7/13, 12/18**	**Revision No: 2**
Department Head: **Date:**	**Medical Services/P&T Committee:** **Date:**	
P&P Committee: **Date:**	**Department(s):** **UM**	

PURPOSE:

To achieve a level of care coordination that is facilitated through the collaboration of an Interdisciplinary Care Team (ICT) that meets the expectations of the Medicare-Medicaid Demonstration Program goals that include but are not limited to: improving quality of care, promoting a patient-centered approach, and providing seamless delivery of services across the continuum of care by maximizing the use of benefits that are available to dual eligible individuals enrolled in the Demonstration.

POLICY:

Blue Shield Promise will offer an Interdisciplinary Care Team (ICT) for each enrollee, as necessary, which will be built around the enrollee and ensure the integration for the member's medical, behavioral health, and LTSS care.

The ICT will be person-centered: build on the enrollee's specific preferences and needs, delivering services with transparency, individualization, respect, linguistic and cultural competence, and dignity.

The ICT will consist of a composite of members that are knowledgeable on key competencies including, but not limited to: person-centered planning processes, cultural competence, accessibility and accommodations, independent living and recovery, and wellness principles.

PROCEDURE:

Through the participation and efforts of the interdisciplinary care team a process will be implemented that assures the coordinated the delivery of services and benefits to every enrollee.

The process includes securing authorization from the enrollee, or his/her legal representative, to include the enrollee's selected IHSS provider as a member of the interdisciplinary Care Team.

ICT Composition:

- Designated ICT Leaders
- The Enrollee/caregiver/authorized representative
- Designated primary physician
- Nurse Case Manager
- Social Worker
- Patient Navigator
- County IHSS Social Worker
- MSSP coordinator
- Pharmacist
- Behavioral health service providers
- Other professional staff within the provider network
- IHSS provider with approval from the IHSS beneficiary. (The enrollee can choose to limit or disallow altogether the role of IHSS providers, family members and other caregivers on the team)
- Additional ICT participants are invited depending on the member's circumstances Ad hoc:
    - Physical therapist
    - Nutritionist
    - Caregiver/family
    - Concurrent Review nurse
    - Quality department representative Home Health Vendor
    - Hospice
    - Psychiatric Case Manager

ICT Care Coordination Functions

ICT functions include at a minimum, the following:

1. Evaluate the outcomes of the health risk assessment responses:
2. Identify the strengths, capacities, and preferences of the enrollee including options as appropriate for transitioning a person from a nursing facility to the community.
    a. The planning process also identifies the enrollee's long-term care needs and the resources available to meet those needs.
3. Develop and implement an individualized care plan with enrollee and/or caregiver participation;
4. Conduct ICT meetings periodically, including at the enrollee's discretion
5. Manage communication and information flow regarding referrals, transitions and care delivered outside the primary care site
6. Maintain a call line or other mechanism for enrollee inquiries and input, and a process for referring to other agencies, such as LTSS or behavioral health agencies, as appropriate
7. Conduct conference calls among the MMP, providers, and enrollees
8. Maintain a mechanisms for enrollee complaints and grievances; and
9. Use secure email, fax, web portals or written correspondence to communicate

a. The MMP must take the enrollee's individual needs (e.g., communication, cognitive, or other barriers) into account in communicating with the enrollee.

Blue Shield Promise will assign a care navigator to each enrollee. The care navigator will have the appropriate training, experience, and qualifications based on an enrollee's assigned risk level and individual needs (e.g., communication, cognitive, or other barriers)

Blue Shield Promise will conduct training for ICT members and potential ICT members initially and on an annual basis on:

a. The person-centered planning processes
b. Cultural competence
c. Accessibility and accommodations
d. Independent living and recovery, and wellness principles
e. Information about available LTSS services, eligibility for these services, and program limitations.

Blue Shield Promise will make training opportunities available to IHSS providers if they choose to participate.

The ICT's structure and membership determination is based on the member's specific clinical and psychosocial needs. All members are provided the opportunity to complete a Health Risk Assessment (HRA). The HRA generates an Individualized Care Plan (ICP) which is based on the member's responses to the HRA questions. The ICP will include an itemized list of identified Problems, Interventions and Goals which will then be communicated and documented in the Blue Shield Promise member centric, HIPPA compliant electronic medical record system called CCMS. Documentation of the ICT communication and discussion is structured within CCMS.

The goals of the ICT are as follows:

- Develop, implement and revise as needed individualized care plans for members based on utilization, medical history, member's information and preferences, and concurrent clinical information
- Provide a multi-disciplinary team approach to ensure appropriate utilization of services
- Incorporate community based services to help maintain independence
- Emphasize primary care and prevention
- Coordinate continuity of care and services
- Engage members providers of care to optimize treatment plan
- Engage member or caregiver to maximize outcomes

Definitions:

Health Risk Assessment (HRA) – Survey tool used to assess an enrollee's medical, behavioral, and social support needs.

Interdisciplinary Care Team (ICT) – A team of primary care provider and Care Coordinator, and other providers at the discretion of the enrollee that work with the enrollee to develop, implement, and maintain the Individualized Care Plan.

Individualized Care Plan (ICP) – The plan of care developed by an enrollee and an enrollee's Interdisciplinary Care Team or health plan.

ICT Documentation:
All member discussions, assessments and subsequent action plans are documented in CCMS. The member's HRA and care plan is discussed with the ICT. The CCMS information is available to all ICT members either electronically or via fax. The ICT agenda, attachments and meeting minutes are stored in a network folder available to all ICT participants to view or edit as indicated. The disciplines presenting at the ICT are responsible for preparing the agenda and documenting appropriately in both CCMS and populating the associated ICT minutes. CCMS is enhanced to capture all relevant member documentation to support the ICT process in a standardized format by using specifically designed assessments. The completed assessments generate a CCMS Note which is used in preparing the ICT minutes. In addition, the CCMS assessment which supports the ICT Meeting generates an automated care plan dependent on the answers to specific questions. The CCMS system generated care plan consists of Problems, Interventions and Goals. Ongoing assessment of enrollee progress towards goals will be monitored. Based on these findings, revisions to the ICP will be determined by the ICT members.

ICT Meetings
The ICT participants are notified of meetings. The notification is sent by email and fax using administrative support staff.

REFERENCES/AUTHORITIES:

1. CMS- CA MOU for Medicare-Medicaid Enrollees
2. SB 1008 Chapter 33