KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Inter-Disciplinary Care Team (ICT)				POLICY #: 18.19-P	
DEPARTMENT: Health Homes					
Effective Date: 5/20/2020	Review/Revised Date:	DMHC		PAC	
		DHCS	X	QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date_____
Douglas A. Hayward
Chief Executive Officer

_____ Date_____
Chief Medical Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Chief of Provider Network Management

_____ Date _____
Director of Claims

_____ Date _____
Chief Network Administration Officer

_____ Date _____
Administrative Director of Health Homes Program

PURPOSE:
The purpose of the interdisciplinary team is to foster frequent, structured, and documented communication amongst disciplines to establish, prioritize and achieve treatment goals.

POLICY:
All Community Based Care Management Entities (CB-CME)'s will have an Interdisciplinary Care Team (ICT) for management of all Health Home Program (HHP) members.

PROCEDURE:
The Interdisciplinary Care Team Meeting (ICTM) allows the members of the treatment team to coordinate care and to document the communication among all members of the team related to the Health Home Member's (HHM) plan of care and treatment goals. Key objectives include:

- To establish an Interdisciplinary team care planning process to ensure that Health Homes Program (HHP) member care and treatment is planned appropriately for his/her needs and severity of condition, impairment, disability or disease.
- To assure a planning process that maximizes and maintains each Health Homes Member's optimal mental, physical, psychosocial, cultural, spiritual and functional status.
- To establish a system in which the care and treatment planning process is timely, systematic, and comprehensive and incorporates input from all disciplines and Health Homes Member's (HHM's) support team.
- To provide a mechanism for HHM, caregiver, and/or member designated support system to participate in the member's care planning

ICT team core members are:

- Physician – MD
- Case manager
- Social worker
- Care navigator
- Pharmacist

Other: Based on member needs

- Other:
    - Community Health Worker
    - Community Based Case Managers
    - Substance Abuse Program Dietician
    - In Home Support Services
    - Community Based Adult Services (CBAS) Center
    - Correctional Counselors
    - Home Health Case Managers
    - Support Counselors
    - Chaplain
    - Homeless Program
    - Any other as appropriate to the HHM's needs, the team may include

Functions of the ICT meetings:

The ICT meeting is a formal process to facilitate the fundamental development and once completed, ongoing maintenance as needed to support the HHM's Health Assessment Plan (HAP) (also may be referred to as a plan of care or care plan). This formal process should occur as soon as possible after member acceptance into the HHP and has participated in the HHP health assessment process but no later than 30 days after completion of the initial assessments. The member or member's designee is always invited and encouraged to attend all ICT meetings during which their care is discussed.

The HHP Director (CB-CME) or Health Plan based will oversee and manage multi-disciplinary care teams. This role is supported by primary providers, physician consultants RN case managers, coordinators and other administrative staff to manage day to day multi-disciplinary touch points and attending formal committee meeting conference presentations.

1. There is an expectation that the Registered Nurse (RN) Case Manager will present and the primary designated M.D. for CB-CME Health Home designation leads the conference and appropriate members of the ICT are in attendance.

2. During the ICT meetings, the ICT participants will address the HHM's needs, progress, goals, interventions, barriers to goal achievement, and changes in the HAP required to meet the HHM's needs. The meeting provides an opportunity for all members of the treatment team to coordinate HHM's care to best degree meet the needs of the HHM.

3. Individual care and initial treatment goals are identified.

4. These goals are reasonable and measurable.

5. Each HHM's care plan identifies goals that:
    a. Reflect the HHM's or care-giver designee's input and unique needs.
    b. Include a time frame for achievement, when appropriate.
    c. Interventions are identified and planned to meet each HHM's goals.

6. The responsible discipline or HHP support staff for each intervention provided will be identified.

7. The HAP should identify how frequent specific services will be provided.

8. If indicated, the HHM's education process is interdisciplinary and:
    d. A part of the HAP planning process the HHM is educated appropriate to his or her assessed needs, abilities, readiness, preferences, and prioritized self-goals.
    e. The HHM's care planning process incorporates information from the health assessment about his or her education needs.

Maintaining the HAP

1. The plan of care is revised when appropriate to reflect the HHM's current needs, based on evaluation of:
    a. Progress towards goals.
    b. Response to care and treatment.

c. Significant changes in the HHM's status.

2. The plan of care may be superseded by doctors' order as it is recognized that changes occur.

3. If the HHM's status changes, then the effective plan of care becomes the doctors' orders until the changes are incorporated into the HAP.

4. Any member of the ICT team has the ability to apply input based upon an assessment of a HHM's status at any given time.

5. The recommendation and when applicable HAP change would be communicated to the rest of the ICT team.

6. Changes may be incorporated into the HHM's HAP. It is not necessary to wait for a team meeting to implement important measures such as interventions to meet the HHM's immediate needs or change in condition that appropriately constitutes the need for the change or for the HHM's safety.

Team Attendance

1. Telephonic participation in the meeting is permitted provided that the specific reasons the attendee was not physically present are well documented and the record reflects the required level of participation in the meeting.

2. At minimum, documentation of conference attendance must include the names and professional designations of those who participated in the meeting.

Documentation of Collaboration and Coordination

1. When barriers arise that slow or limit goal achievement, it should be clearly documented as to what changes in the HAP have been made to address those barriers. This includes medical, behavioral, or resource issues that have occurred in with the HHM to impact their care from the last ICT or other significant event that caused a change in the HHM's condition or circumstance. Any issues from a prior ICT meeting with planned action should be documented and reviewed by the ICT in the next scheduled HHM's ICT meeting.

Standardized TOOL and Documents

1. The formal structure and flow process of the ICT is supported by the following documents and forms:
    a. Standard Agenda
    b. Minute Taking Template
    c. Attendance Sign in Sheet
    d. Confidentiality Statement and Attestation
    e. ICT Presenter Presentation Format
    f. Kern Health Systems (KHS) HHM Care Gaps
    g. HAP