Santa Clara Family Health Plan™

ICT Training - Overview

40166

Regulatory References

- California Department of Health Care Services Dual Plan Letter (DPL) 15-001 – Interdisciplinary Care Team and Individual Care Plan Requirements for Medicare-Medicaid Plans
- 3-Way Contract between the US Department of Health and Human Services Centers for Medicare & Medicaid Services, In Partnership with California Department of Health Care Services and Santa Clara County Health Authority (SCFHP)
- SCFHP Policy & Procedures

Learning Objectives

After completing this module, you will:

- Understand the role of the Interdisciplinary Care Team (ICT) in planning and coordinating care between the member, case manager, primary care physician (PCP) and other participants
- Understand how the ICT supports a member's Individual Care Plan (ICP)
- Understand the requirements for the ICT
  - Responsibilities
  - How ICT members communicate (email, fax, phone, letters, etc.)
  - Why it is important
- Understand the role of ICT members including the care manager, PCP and member

Course Content

- Cal MediConnect (Medicare - Medicaid Plan) Overview
- Care Delivery Model & Care Manager Role
- Interdisciplinary Care Team Requirements for Cal MediConnect
  - Definition
  - Goals
  - Functions
  - Composition
  - Roles and Responsibilities
  - ICT Communication
- ICT & the Individual Care Plan

SCFHP Cal MediConnect Overview

- Combines Medicare and Medi-Cal benefits
- Person-centered care coordination supported by ICTs
- Coordinates all medical and behavioral health care with long term services and supports (LTSS) via one plan
- Offers improved access to LTSS benefits including nursing facilities, community based services (CBAS) and multipurpose senior services program (MSSP) as well as in-home supportive services (IHSS) and other community resources

Cal MediConnect Eligibility

Cal MediConnect members must meet all of the following criteria to be eligible for the Cal MediConnect program:

- Age 21 and over
- Residing in Santa Clara County
- Enrolled in Medicare parts A, B, and D
- Receiving full Medi-Cal benefits ($0 share of cost)

Excluded are people; under 21, with other health insurance, with other share of cost, in certain waiver programs, receiving services through state or regional developmental centers or intermediate care facilities, confined to correctional facilities, or living in veterans homes.

Care Management Delivery Model

Person-Centered Approach to Care Includes:

- Coordination of access to medical, behavioral health, and LTSS services
- A focus on providing benefits and services in the least restrictive setting
- Care Coordination led by an assigned Care Manager with the member and an Interdisciplinary Care Team

Care Coordination Includes:

- Health Risk Assessment (HRA) - a survey used to collect a member's self identified health and social needs and used to inform the care planning process. HRAs are done at the time of initial eligibility and annually thereafter.
- Care Planning - a collaborative process to develop an Individualized Care Plan (ICP) that addresses member-identified gaps in care and ongoing needs. Works to engage members to increase self management and achieve health related goals.
- Interdisciplinary Care Team (ICT) - a team, lead by the care manager, that coordinates efforts to help the member implement the care plan.

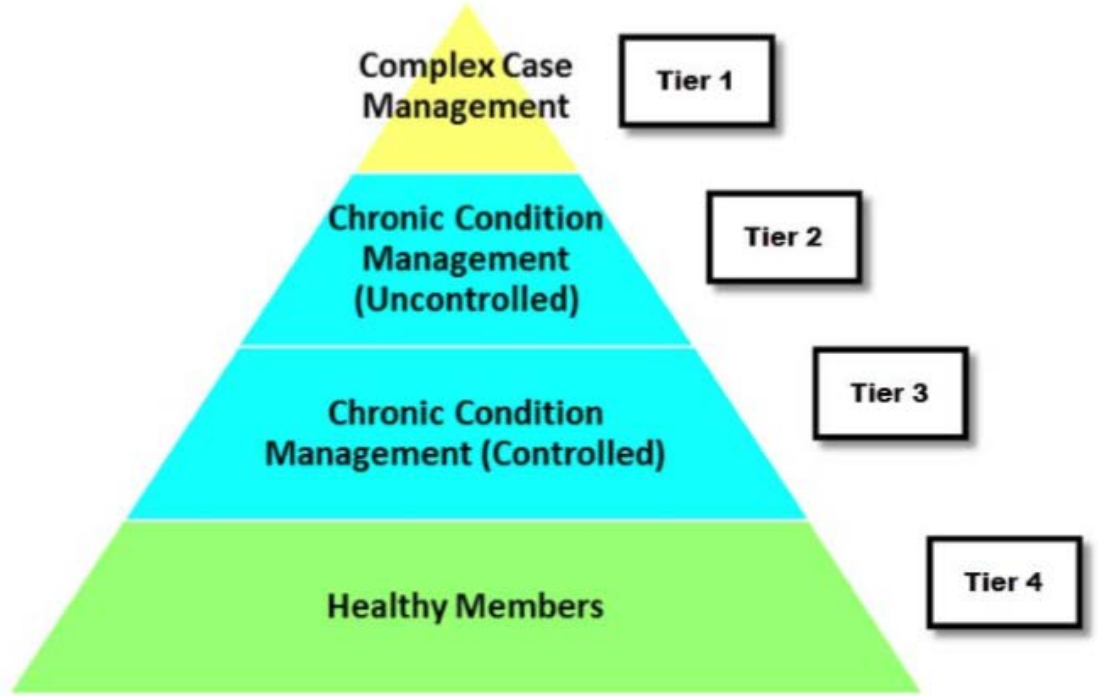
Care Managers

All Cal MediConnect members have an assigned Care Manager who will:

- Provide care coordination services including HRA, ICP and ICT management
- Help members navigate the health care delivery system and facilitate access to care and services
- Obtain reliable and timely information about services other than those provided by the PCP
- Support safe transitions in care for members moving between settings
- Organize and lead the ICT by coordinating the timely exchange of information among all ICT members. Coordination includes:
  - Communicating member needs, identifying services and member health outcomes
  - Communicating changes to the ICP in writing
  - Ensuring follows-ups on member referrals to appropriate services or providers

Care Management Tiers

Population Health Management Case Management Program Tiers



Care Coordination and the ICT

- An ICT must be offered to a Cal MediConnect member when a need arises or if it is requested by the member, an authorized representative, family member or caregiver
- ICTs must ensure the integration of the member's medical care and LTSS and the coordination of behavioral health services
- The ICT must work closely with the member to stabilize medical conditions, increase compliance with ICPs, maintain functional status and meet care plan goals

Goals of the ICT

- Support the member's right to self-direct care
- Engage the member, their caregiver, or authorized representative in developing a care plan
- Facilitate the linkage to appropriate behavioral health, LTSS and other community resources
- Improve member engagement
- Improve communication between the member and their providers
- Prevent duplication of services
- Improve member satisfaction
- Improve member health outcomes
- When possible, prevent transition of the member to a higher level of care

ICT Functions

The ICT will facilitate care management which includes assessment, care planning, authorization of services, and transitional care issues. ICTs work closely with members to stabilize medical conditions, increase compliance with care plans, maintain functional status, and meet individual member care plan goals. At a minimum, ICT functions will include:

- Developing and implementing a care plan with member and/or caregiver participation.
- Conducting meetings periodically, including at the member's request.
- Managing communication and information flow regarding changes in condition, transitions of care, progress towards goals and delegation of ICP elements.
- Maintaining a mechanism for ICT members to communicate and share information.
- Conducting conference calls among the MMP, provider and member.
- Providing communication methods per members preferences.

ICT Composition

The participants of the ICT are selected based on the members needs and preferences.

At a minimum, an ICT includes:

- Member and/or their authorized representative
- Formal or informal caregiver designated by the member
- SCFHP Care Manager
- PCP

ICTs can also include:

- Specialists
- LTSS provider representatives such as IHSS caregiver, MSSP case manager or CBAS representative
- Behavioral health providers
- Hospital or nursing facility discharge planners or social workers
- Health plan internal interdisciplinary staff
- Other professionals, as appropriate

How Do I Become Part of an ICT?

PCPs are mandatory participants in the ICT and do not need to request to participate. Any other provider may become a participant when:

- Assigned by SCFHP
- Requested by the PCP of the health network
- Requested by the member
- They complete the Center for Medicare and Medicaid Services (CMS) required ICT Training: Core Competencies

Training is provided and required for all SCFHP staff and potential ICT participants on five core concepts:

1. Person-Centered Planning Process
2. Cultural Competence
3. Accessibility and Accommodations
4. Independent Living and Recovery & Wellness Principles
5. Information on LTSS

Provider training tools are accessible on the SCFHP website.

Primary Care Provider Role in the ICT

The PCP is an active participant of the ICT and is directly involved in Individual Care Planning (ICP). PCPs are responsible for the following:

- Completing the CMS required SCFHP ICT provider training
- Reviewing and providing feedback in the member's initial ICP
- Taking accountability for identified ICP elements that support the member's stated goals
- Communicating with SCFHP care management staff on a regular basis to ensure member access to necessary care
- Attending the scheduled ICT meetings

Primary Care Provider Role (continued)

The PCP collaborates with member and specialists regarding access to care by performing the following duties:

- Identifying specialty and ancillary care needs of member
- Coordinating appropriate referrals to medical necessary services
- Advocating for members
- Performing an annual comprehensive assessment of medical, psychosocial, cognitive and functional needs or as condition changes
- Identifying care gaps
- Collaborating with ICT on development and implementation of the ICP

Specialist Provider Role

The role and responsibilities of the specialist include but are not limited to the following:

- Completing the CMS required SCFHP ICT provider training
- Reviewing and providing feedback on the member's initial ICP
- Assigning ICP elements that support members stated goals as necessary
- Sharing information with the member's PCP
- Communicating with SCFHP care management staff on a regular basis to ensure access to necessary care
- Attending scheduled ICT meetings

ICT Communication and Meetings

ICT communications are forums to:

- Discuss complex needs
- Identify linkages to home and community based services
- Follow up on utilization, level of care, or other specialized services

When does an ICT communicate?

- Upon completion of the HRA to develop the ICP
- Annually to review and revise the ICP or more frequently as needed
- As a member's condition changes
- At member's request

ICT Process: Requirements

ICT Participants

- Care manager will evaluate the need for an ICT upon receipt of member's initial or annual HRA
- Care manager will work with the member to identify ICT participants
- All ICT participants are documented in the case management system
- Meeting minutes must include an attestation of completion of required training for all participants

ICT Communication

- Maintain a mechanism for ICT communication
- Establish and support multiple levels of ICT communication
- Schedule meetings periodically or at the member's discretion
- Communicate ICP updates with the ICT

Documentation

- Document all ICT communications in the case management system
- Document ICT recommendations that result in the development of or changes to the ICP
- Meeting minutes must document all invited ICT participants, their attendance by phone, in person, or notice to decline to participate

Individual Care Plan (ICP)

An ICP is a dynamic and person-centered plan of care for all members. The plan provides the following:

- Comprehensive input from the member and/or member's caregiver, PCP, specialists and other providers participating in the ICT
- Identification of the member's strengths, capacities and preferences
- Care options to support member needs, including transitions of care settings
- Identification of long-term care needs and the resources available

ICP must be completed within 30 days of HRA completion.

Member Engagement in ICP and ICT

Member, authorized representatives, and/or caregivers are encouraged to actively participate in development of the initial and re-assessment care plan.

- Strategies include:
  - Applying health coaching techniques
  - Empowering members to identify successes and set goals
- Communication for care planning process are based on member preference and occurs via telephone, mail, or in-person (e.g. members in skilled nursing facility). If phone calls are unsuccessful in obtaining engagement in care, face-to-face interactions are an option.
- Members may opt-out or decline involvement in the ICT or ICP process:
  - Members will be asked at the beginning of each encounter if they choose to participate. The decision is documented in ICT minutes and care plan record.

ICP: Development

The PCP, care manager, and other ICT participants review and evaluate the following to develop a comprehensive ICP:

- HRA results and past medical history/co-morbidities
- Medication reconciliation and compliance
- Member/caregiver support system resources and involvement
- Mental health, cognitive functions, and cultural and linguistic needs
- Motivational status or readiness to learn
- Visual/hearing needs, preferences or limitations
- Life-planning activities
- Functional status – activities of daily living (ADL) and instrumental activities of daily living (IDAL)
- Current status and treatment plan
- Barriers to quality, cost-effective care and treatment plan
- Implications of resources and coverage availability and limitations
- Current living arrangements and resources utilized
- Need for referrals to LTSS and/or community resources
- Palliative/hospice services and alternate care settings

ICP: Development (continued)

- Care management planning by the ICT promotes care in the least restrictive or most inclusive setting
- ICT considers member preferences and appropriate LTSS for independent living
  - Current living arrangements and resources utilized
  - Adaptive aids
  - Home modifications
  - Personal Care

ICP: Essentials

ICP key elements include:

- Prioritized goals that take into account:
  - Member/caregiver's goals or preferences
  - Member/caregiver's desired level of involvement in case management plan
- Barriers to meeting goals and complying with plan
- Self-management plan
- Scheduled time frame for re-evaluation
- Assessment of progress towards goal, with modifications as needed
- Resources to be utilized, including transition of care and transfer
- Collaborative approaches to be used, including family participation

ICPs are required to be shared annually upon initial care planning and as needed with the ICT.

The ICP is maintained in a HIPAA (Health Insurance Portability and Accountability Act) compliant format in the health plans care management record system Essette and is distributed electronically.

ICP: Essentials (continued)

ICP coordination of benefits and services include:

- Add-on benefits such as no-cost taxi transportation, access to a gym, enhanced dental and vision benefits
- Community resources
- Services provided in and out of plan
- Communication of plan to ensure continuity of care
- Communication regularly with individuals and support systems
- Member referrals to resources
- Follow-up to determine if member acts on referrals
- LTSS
- Carve out services

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Questions?

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