Interdisciplinary Care Team

Policy Title: Interdisciplinary Care Team
Department: Government Programs
Business Unit: State Public Programs

Approved By: Director of SPP Products
Approved Date: 3.8.09
Original Effective Date: 3.8.09
Review Date(s) (no char) 1.27.11, 01.11.13, 12.12.16, 3.7.18
Revision Dates: 1.27.11, 12.15.14, 11.3.15

PRODUCTS AFFECTED:
- Medica DUAL Solution® – for Minnesota Senior Health Options (MSHO) enrollees
- Medica Choice CareSM – for Minnesota Senior Care Plus (MSC+) enrollees
- Medica AccessAbility Solution® – for Special Needs Basic Care (SNBC) enrollees

DEFINITIONS:
Care Management for all Enrollees: means the overall method of providing on-going health care in which Medica manages the provision of primary health care services with additional appropriate services provided to an Enrollee.

Care Plan: Medica does not require the use of a specific Care Plan. Any Care Plan that meets the Department of Human Services (DHS) Elderly Waiver (EW) audit protocol requirements and all of the elements of the Community Support Plan (CSP) DHS e-doc form #2925 may be used.

Virtual Meeting: A virtual meeting is defined as the Care Coordinator collecting input from the interdisciplinary team members from discussions, correspondence, review of records, and incorporating relevant input into the plan of care.

PURPOSE:
To assure that all Care Systems, Agencies, and Counties that provide Care Coordination for Medica members have a policy to provide guidance to Care Coordinators regarding Interdisciplinary Care Teams (ICT).

POLICY:
Care Systems, Agencies, and Counties that provide Care Coordination for Medica members are required to have procedures in place to guarantee that Care Coordinators
are aware of the benefits of Interdisciplinary Care Teams (ICT) to discuss the member’s needs, create the care plan, and provide updates on the member’s progress.

PROCEDURE:

1. Every member receiving Care Coordination will have an Interdisciplinary Care Team (ICT). If the member refuses Care Coordination, there is no requirement to establish an ICT until the member agrees to Care Coordination.

2. The ICT will be added based on individual member’s assessed physical, behavioral, and service needs.

3. ICT meetings may be a virtual meeting, telephonic meeting, face-to-face meeting, or any combination of these.

4. ICT members may change based on the member’s needs. The Care Coordinator will identify other ICT members that could assist in maintaining and maximizing the member’s functional abilities and quality of life as needed.

5. At a minimum, the ICT for a community member will consist of:
   a. the member and/or his representative
   b. the Care Coordinator
   c. the Primary Care Practitioner

6. ICT for members living in skilled nursing facilities is met by Care Conferences as the state law on ICT exceeds Centers for Medicare & Medicaid Services (CMS) and Department of Human Services (DHS) requirements.
   a. Care Coordination with facility staff as part of and ICT will be established to address risk areas and manage services as needed.
   b. The Care Coordinator will ask to be added to the care conference attendee list.
   c. The Care Coordinator will attempt to attend a care conference at least annually.
   d. At a minimum, the ICT for an institutional member will consist of:
      i. the member and/or his representative
      ii. the Care Coordinator
      iii. the Primary Care Practitioner
      iv. a Registered Nurse with responsibility for the resident
      v. other appropriate staff in disciplines as determined by the resident's needs

7. A member’s request not to involve family, specific providers or caregivers in ICT will be honored.
8. The Care System, Agency, or County will have a process in place for communicating with other ICT members.

9. Documentation of recommendations from any ICT source will be included in the Care Plan or in member case notes.

10. The Care Coordinator should notify ICT members of significant changes in the member’s condition or in the plan of care that impact the ICT members work with the member.

11. Annually Medica will evaluate adherence to this ICT policy through one or more of the following:
   a. Review of Care System, Agency, or County care plans during Health Risk Assessment and Care Plan Audits.
   b. Evidence of collaboration and/or other communication with providers in members medical file.
   c. Enrollee input (e.g., stakeholder meetings, DHS survey, complaints)

12. Medica will evaluate effectiveness of ICT process through one or more of the following:
   a. Monitoring of utilization data such as Emergency Room (ER) or hospitalization rates, High Risk Reporting lists, preventive visit rates, etc.
   b. Ongoing discussions with Care Coordinators
   c. Enrollee dissatisfaction or complaints

<table>
<thead>
<tr>
<th>Possible ICT members</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community based members, including assisted living, board and care</strong></td>
</tr>
<tr>
<td><strong>PCP</strong></td>
</tr>
<tr>
<td>Current or previous behavioral issues</td>
</tr>
<tr>
<td>Polypharmacy [9+ medications]</td>
</tr>
<tr>
<td>3 or more psychotropic Medications</td>
</tr>
<tr>
<td>Medically complex and/or unstable chronic disease</td>
</tr>
<tr>
<td>Housing concerns</td>
</tr>
<tr>
<td>Condition</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Chemical dependency or abuse</td>
</tr>
<tr>
<td>Pain Management</td>
</tr>
<tr>
<td>Palliative or Hospice Care</td>
</tr>
<tr>
<td>Dementia</td>
</tr>
<tr>
<td>Chronic Wounds (&gt;6 months with little/no improvement)</td>
</tr>
<tr>
<td>Need for additional services</td>
</tr>
</tbody>
</table>

**Definitions:** PCP: Primary Care Physician; SCP: Specialty Care Physician; Waiver CM: Waiver County Case Manager; DD worker: Developmental Disability County Worker; MH: Mental Health or Behavioral Health Practitioner; CD: Chemical Dependency Practitioner; MTM: Medication Treatment Management Pharmacist; MLTSS: Managed Long Term Services and Supports.

**Cross References:**
MSHO.MSC+ DHS Contract

© 2013-2018 Medica. Medica® is a registered service mark of Medica Health Plans. "Medica" refers to the family of health plan businesses that includes Medica Health Plans, Medica Health Plans of Wisconsin, Medica Insurance Company, Medica Self-Insured Medica Health Management, LLC and MMSI, Inc..