Policy Title:	**Interdisciplinary Care Team**
Department:	**Government Programs**
Business Unit:	**State Public Programs**
Approved By:	Director of SPP Products
Approved Date:	3/8/2009
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PRODUCTS AFFECTED:

- Minnesota Senior Health Options (MSHO) – Medica DUAL Solution®
- Minnesota Senior Care Plus (MSC+) – Medica Choice Care℠ MSC+
- Special Needs BasicCare (SNBC) – Medica AccessAbility Solution®
- Special Needs BasicCare (SNBC) Integrated – Medica AccessAbility Solution Enhanced®

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 meet the Department of Human Services (DHS) audit protocol requirements and all of the elements of the Community Support Plan (CSP) DHS e-doc form #2925 may be used. If a delegate plans to use a care plan other than those provided by Medica (Collaborative Care Plan or Medica AccessAbility Solution® / Medica AccessAbility Solution® Enhanced Special Needs BasicCare (SNBC and SNBC SNP) Member Care Plan or Medica Unable to Contact Refusal Care Plan, prior approval is required by the Medica Regulatory Oversight & Improvement Department. Upon implementation of the MnCHOICES online assessment tool, Medica Care Coordinators (CC's) will complete the care plan in the MnCHOICES support plan module.

Interdisciplinary Care Team- A team may consist of the member, the CC, the provider, other support professionals, and family members/caregivers. The composition of this team will vary based on an individual member's assessment and discussion with the member regarding who they want to be included in their care team. This team works collaboratively to develop and implement a care plan to meet the members' medical, behavioral, long-term care, and social services needs with a goal of avoiding fragmentation, ensuring access to appropriate person-centered care, and providing a team approach to address member needs.

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 ensure 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) that could provide assistance in maintaining and maximizing the member's functional abilities and/or quality of life.

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, to develop, monitor, and update the member's care plan.

PROCEDURE:
Every member receiving Care Coordination (CC) will have an Interdisciplinary Care Team (ICT) based on their individually assessed needs. If the member refuses Care Coordination or is unable to be contacted, the ICT will include the member the CC and the Primary Care Provider, if known. The member is the primary participant in the ICT, if they are unable to participate due to cognitive or other conditions, attempts are made to include the member representative or responsible party.

1. The ICT will be based on individual member's individually assessed physical, behavioral health, and service needs.

2. ICT meetings may be a virtual meetings, EMR communications, telephonic meetings, face-to-face meetings, secure email or relay services, letters, or any combination of these.

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

4. 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, if known

5. ICT for members living in nursing facilities is met by Care Conferences. The state law pertaining to ICT requirements of nursing facilities 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, if known
iv. a Registered Nurse with responsibility for the resident
v. other appropriate staff in disciplines as determined by the resident's needs

6. A member's request not to involve family, specific providers or caregivers in ICT will be honored.

7. The Care System, Agency, or County/Tribe will have a process in place for communicating with other ICT members.

8. Documentation of recommendations from any ICT source will be included in the Care Plan, member case notes, in the EMR, or in stand-alone documents.

9. The Care Coordinator should notify ICT members of changes in the member's condition or in the plan of care that impact the ICT member's interaction with the member.

10. Annually Medica will evaluate adherence to this ICT policy through one or more of the following:
    a. Review of Care System, Agency, or County/Tribe care plans during Health Risk Assessment and Care Plan Audits.
    b. Evidence of collaboration and/or other communication with providers in members medical file.

Cross References:
MSHO.MSC+ DHS Contract
SNBC Contract

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