Seaside Health Plan Policies and Procedures	**Effective Date:** May 17, 2013 **Note: For origination date see History at the end of Policy**
SUBJECT: INTERDISCIPLINARY CARE TEAM, SNP	**Approval Signature:** Barry Smith, MD Chief Medical Officer
Manual: Case Management **Policy/Procedure #** SNP-220 **Section:** Special Needs Population	**Sponsor Signature:** Kimberly Ward, RN Director, Utilization Management
☐ **COMMERCIAL** ☐ **HEALTHY FAMILIES** ☐ **MEDI-CAL** ☒ **MEDICARE**	

AUTHORITY
Medicare Managed Care Manual
42 CFR §422.101(f)(ii); 42 CFR §422.152(g)(v)

POLICY
The CMS Model of Care defines that care is coordinated for Special Needs Plan (SNP) members through an interdisciplinary care team (IDCT) to address the members' medical, cognitive, psychosocial, and functional needs. Each Seaside Health Plan SNP member is assigned to an interdisciplinary care team.. The interdisciplinary care team is responsible for overseeing, coordinating, and evaluating the care delivered to assigned members.

The purpose of the Special Needs Program Interdisciplinary Care Team policy is to provide the specific requirements for defining the team assigned to each SNP member, the roles of the team, and the instructions for how the team will coordinate and evaluate care delivered to assigned SNP members.

PROCEDURE

I. IDCT Assignment

A. Each Seaside Health Plan SNP member is assigned to an interdisciplinary care team minimally composed of a medical expert, a behavioral health and a social services expert appropriate for the population. Additional team members may be added based on issues identified through assessment.

B. IDCT Meetings will be held monthly. Prior to the IDCT meeting, beneficiary/caregiver will be contacted telephonically to offer them participation in the IDCT meeting and it

will be documented if Beneficiary/Caregiver accepted or declined in the members file, IDCT meeting minutes and worksheet.

C. The member's file, IDCT meeting minutes and worksheet will reflect if the beneficiary/caregiver accepted or declined participation in the IDCT Meeting. The worksheet will be utilized for data analysis or take action to improve deficiencies if noted on a monthly basis.

D. The IDCT collectively manages the medical, cognitive, psychosocial, and functional needs of beneficiaries, ensuring incorporation of the Health Risk Assessment results into the members individualized Care Plan.

E. Seaside Health Plan develops and implements effective processes to support case management services including, but not limited to:

1. Using evidence-based clinical guidelines or algorithms to conduct assessment and management.

2. Automatic documentation of the staff member's ID and date and time action on the case or interaction with the member occurred.

3. Automated prompts for follow-up, as required by the case management plan.

To achieve this, the following procedures are followed:

II. **Role and Composition of Interdisciplinary Care Team**

A. The role of the Interdisciplinary Care Team is to:

1. Analyze and incorporate the results of the initial and annual health risk assessment into the Care Plan.

2. Collaborate to develop and annually update an individualized Care Plan for each SNP member.

3. Manage the medical, cognitive, psychosocial, and functional needs of the members.

4. Communicate to team members and providers of care to coordinate the member Care Plans.

B. The Interdisciplinary Care Team (IDCT) is composed of primary, ancillary, and specialty care providers. At minimum, IDCT members include:

1. Medical Expert (e.g. Primary Care Physician, Specialty Physician, Board Certified Physician, or Registered Nurse Care/ Case Manager)

2. Behavioral and/or mental health specialist (e.g. psychiatrist, psychologist, or drug or alcohol therapist), if an identified need

3. Social Services Expert (e.g. Social Worker, or Community Resource Specialist)

C. Other IDCT members may include:

1. Pharmacist

2. Restorative Health Specialist (e.g. physical, occupational, speech, or recreational therapist)

3. Nutrition Specialist (e.g. Dietician or Nutritionist)

4. Health Educator (Nurse Educator)

5. Pastoral Specialist

6. Disease Management Specialist (e.g. Preventive Health or Health Promotion Specialist)

7. Member/Caregiver/Family

III. Coordination and Evaluation of Care through the Interdisciplinary Team

A. The Primary Health Plan will attempt to administer a Health Risk Assessment (HRA) within 90 days of enrollment to each new Health Plan SNP member. The Primary Health Plan will notify Seaside Health Plan once a member has been identified as a SNP member and member will be assigned to a Care/Case Manager.

B. Seaside Health Plan's Care/Case Management also systematically identifies SNP members who qualify for case management, to include new members and HRA results, by accessing the Primary Health Plan's portal and/or eligibility list, at least monthly.

C. The Care/Case Manager will conduct an initial standardized assessment through direct phone contact with the SNP member and/or caregiver. Health Plan utilizes a standardized assessment process to define and document the member's health status including condition specific issues and need for individualized case management services.

D. After the assessment is completed and an initial Care Plan is developed for the member, the Care/Case Manager will identify members of the Interdisciplinary Care Team (IDCT) based on the medical, cognitive, psychosocial, and functional needs and barriers to care identified. Each team member will be notified by the Care/Case Manager via phone, e-mail, fax, face-to-face, or report that he/she is part of the SNP member's IDCT.

E. IDCT members will review the SNP member's HRA, clinical and psychosocial history and participate in the member's Care Plan development and care coordination as outlined in the documented Care Plan. IDCT team members will make recommendations, take responsibility for clinical or social elements of care, and document member interventions as appropriate.

F. Care Plans are updated annually, at minimum, and when the SNP member's status changes. The Care/Case Manager will coordinate IDCT team activities to review Care Plans and progress towards meeting goals.

G. IDCT member activities and outcomes will be documented in the member care record. SNP members and/or caregivers may request team meetings through their assigned Care/Case Managers and such activities will be documented in the member care record.

History: New

Origination Date: May 17, 2013