Department of Health Care Services




CAL MEDICONNECT:

Understanding the Individualized Care Plan & Interdisciplinary Care Team

Physician Group Webinar Series

Today's Webinar

- This webinar is part of a series designed specifically for physicians.

- For a general overview of the initiative, we recommend visiting CalDuals.org and reviewing the "What Doctors Need to Know" powerpoint.

- Today's subject matter will be more in-depth on the topic of the Individualized Care Plans (ICP) and Interdisciplinary Care Team (ICT) in the Cal MediConnect program.

Today's Webinar

- Cal MediConnect & Care Coordination
- About the Individualized Care Plan
- About the Interdisciplinary Care Team
- How the Care Team & Care Plan Promote Care Coordination

Medicare & Medi-Cal Today

Medicare Services

- Hospital care
- Physician & ancillary services
- Short-term skilled nursing facility care
- Hospice
- Home health care
- Prescription drugs
- Durable medical equipment

Medi-Cal Services

- Medicare cost sharing (Medicare wrap)
- Long-term nursing home (after Medicare benefits are exhausted)
- Long-term home and community based services (including CBAS, MSSP, IHSS, Nursing Facilities, HCBS waivers)
- Prescriptions and durable medical equipment, and supplies not covered by Medicare

Why Cal MediConnect?

- Some people with multiple chronic conditions see many different doctors and have multiple prescriptions.

- This is common among people with both Medicare and Medicaid, referred to as “dual eligibles” or Medi-Medis here in California, who often are sicker and poorer than other beneficiaries.

- Today’s care delivery system doesn’t always support the care coordination of medical, behavioral health, social services and long-term care services and support many people need. This leads to increased risk of admission to the hospital or nursing home.

- Coordinated care is a critical component of the Cal MediConnect program, which combines Medicare and Medi-Cal services in one health plan.

Cal MediConnect & Care Coordination

- Last week, we reviewed the Health Risk Assessment:
  - How plans will identify high risk beneficiaries who could benefit from care coordination.
  - Provides information to help physicians understand a patient's many needs.
  - Will help inform creation of the care team and the care plan.

Cal MediConnect & Care Coordination

- Today, we will discuss two further tools to help support physicians and care coordination:
  - Individualized Care Plan
  - Interdisciplinary Care Team
- These are the mechanisms by which the plan will ensure your patients get the care and services you know they need.

Individualized Care Plan (ICP)

GOAL: Help enrollees optimize their health and functional status.

- Person-centered, built around an enrollee's specific needs and preferences.
- Identifies what services and supports an enrollee needs.
- Facilitates an enrollee accessing those services and supports.
- Includes measurable objectives and timelines to meet an enrollee's needs.
- Developed by the Interdisciplinary Care Team (ICT).

Which Enrollees Get ICPs?

- Plans will use the health risk assessment to determine which enrollees need an ICP.
- Enrollees can always request an ICP.
- Providers can request a plan assemble an ICP for an enrollee.

What is in an ICP?

- Enrollee goals and preferences.
- Data:
  - Medical records
  - Behavioral health utilization
  - Referrals
  - Input from ICT members
- Objectives for an enrollee, such as maintaining health status or remaining in their home.
- Timelines for meeting those objectives.

What Can ICPs Be Used For?

- Identifying the enrollee's needs including:
  - Medical needs: primary and specialty care, medications
  - Ancillary needs: DME, transportation
  - Long-term supports and services (LTSS): IHSS, MSSP, CBAS
  - Behavioral health needs: mental health and substance use services
  - Carved out and linked services: Dental, specialty mental health
  - Social services and community resources: Meals on Wheels, energy assistance, etc
  - Care plan options (CPOs): Services beyond the Medi-Cal benefit package that help keep enrollees in their homes and community

What Can ICPs Be Used For?

- Care Coordination
  - Tracking and ensuring enrollees are actually getting access to the services and supports they need.
  - Tracking and ensuring enrollees are meeting their objectives in a timely way.
  - Facilitating referrals to providers.
  - Assisting care transitions.

Role of Plan Care Coordinator in ICP

- Sharing ICP with all members of ICT within 90 days of enrollment.
- Facilitating communication about the ICP.
- Care coordination – managing referrals, smoothing care transitions.

Role of Physician Group in ICP

- The physician group will help facilitate communication between the physician, members of the ICT, and the plan's care coordinator.
- Plan contracts will outline:
  - How the group and physicians will interact with the plan's care coordinator;
  - How the group and physicians will contribute towards the development of the ICP; and
  - How communication of information will flow.

Role of Physician in ICP

- It is important that physicians participate in the development of the care plan to ensure the plan reflects the enrollee needs the physician has identified.
- ICP also should be important source of information to physician about all of a patient's needs and what services they will be receiving.

Questions about Individualized Care Plans?

Interdisciplinary Care Team (ICT)

- Person-centered, built around an enrollee's specific needs and preferences.
  - Enrollees determine the appropriate involvement of providers and caregivers.
- Ensures an enrollee received the services and supports they need in the right setting.
- Facilitates communication for providers.

Which Enrollees Get ICTs?

- Plans will use the health risk assessment to determine which enrollees need an ICT.
- Enrollees can always request an ICT.
- Providers can request to join an ICT – or request a plan assemble an ICT for an enrollee.

ICT Participants

Core Members:

- The enrollee or their representative
- Primary care physician (in some situations, the specialist is the primary care provider)
- Plan care coordinator

May also include the following persons:

- Specialists
- Hospital discharge planner
- Nursing facility representative
- Pharmacist
- Physical therapist
- IHSS social worker
- IHSS provider if approved by member
- MSSP care manager
- CBAS provider
- Behavioral health specialist

What does the ICT do?

- The ICT's primary functions are:
  - Assessing health status and needs
  - Care planning
  - Facilitating enrollee access to services
  - Coordinating delivery of services
  - Facilitating transitions between institutions and the community
  - Facilitating enrollee engagement in their own care plans

Communication in the ICT

- Being a member of an ICT will give providers increased – and easy – access to information about their patients.
  - ICT will be notified of changes in an enrollee's health status, care plan, discharge plan, hospital admission and nursing facility placements
- The plan's care coordinator is responsible for ensuring this flow of information through:
  - Meetings and conference calls
  - Individual consultations
  - Directly providing information to ICT participants

Role of Care Coordinator in ICT

- Providing timely, useful information about the enrollee's care and status to members of the ICT.
- Assessing appropriate services and coordinated delivery.
- Supporting safe transitions between care settings.

Role of Physician Group in ICT

- The ICT can relieve administrative burdens on physician group office staff.
  - Simplify referrals
  - Manage social service needs
  - Provide and collect information about enrollee

- Plan contracts will outline how the group and physicians will interact in the ICT and how communication of information will flow.
  - Groups will be responsible for sharing information about services provided to an enrollee.

Role of Physician in ICT

- The ICT is designed make it easier for physicians do their job.
  - Timely, updated information about patients
  - Facilitate referrals

Questions about Interdisciplinary Care Teams?

Wrap-up: ICPs & ICTs

- ICPs and ICTs are important Cal MediConnect tools to help care coordination.
- These tools should facilitate communication to physician groups and physicians.
- ICPs and ICTs should also minimize the burden of ensuring patients receive all the services and supports they need, including referrals.

Continuity of Care

REMINDER - Continuity of Care:
if a physician is not in the plan network

- Medicare Services
  - Up to six months
  - This applies to doctors including specialists like cardiologists, ophthalmologists, and pulmonologists
- Medi-Cal Services
  - Up to 12 months
  - Note: does not apply to providers of ancillary services like durable medical equipment (DME)

Other Upcoming Webinars

- **Wednesday, February 12th, 12 – 1 pm:** Working with In-Home Supportive Services (IHSS)
- **Wednesday, February 19th, 12 – 1 pm:** Introduction to Care Plan Option (CPO) Services

References & Questions

- Provider Relations at the Health plans: visit www.calduals.org and select your county from the navigation

- Email info@calduals.org