OneCare Connect

CalOptima

A Public Agency

Better. Together.

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

Interdisciplinary Care Team

2020

Learning Objectives

After completing this module, you will:

- Understand the roles of the Interdisciplinary Care Team (ICT) in planning and coordinating care for OneCare Connect members.
- Identify when members will have an ICT.
- Understand the requirements of the ICT meeting.
  - What the ICT does
  - When they meet
  - Why it is important
  - Understand the purpose of the member's Individual Care Plan (ICP).

Course Content

- OneCare Connect Program
- Model of Care
- Person-Centered Planning
- Interdisciplinary Care Team
  - Definition
  - Goals
  - Composition
  - Roles and Responsibilities
- Care Management Levels
- Individual Care Plan
  - Purpose and Content
  - Requirements
- Coordination of Services

Note: Content of this course was current at the time it was published. As Medicare policy changes frequently, check with your immediate supervisor regarding recent updates.

OneCare Connect Plan

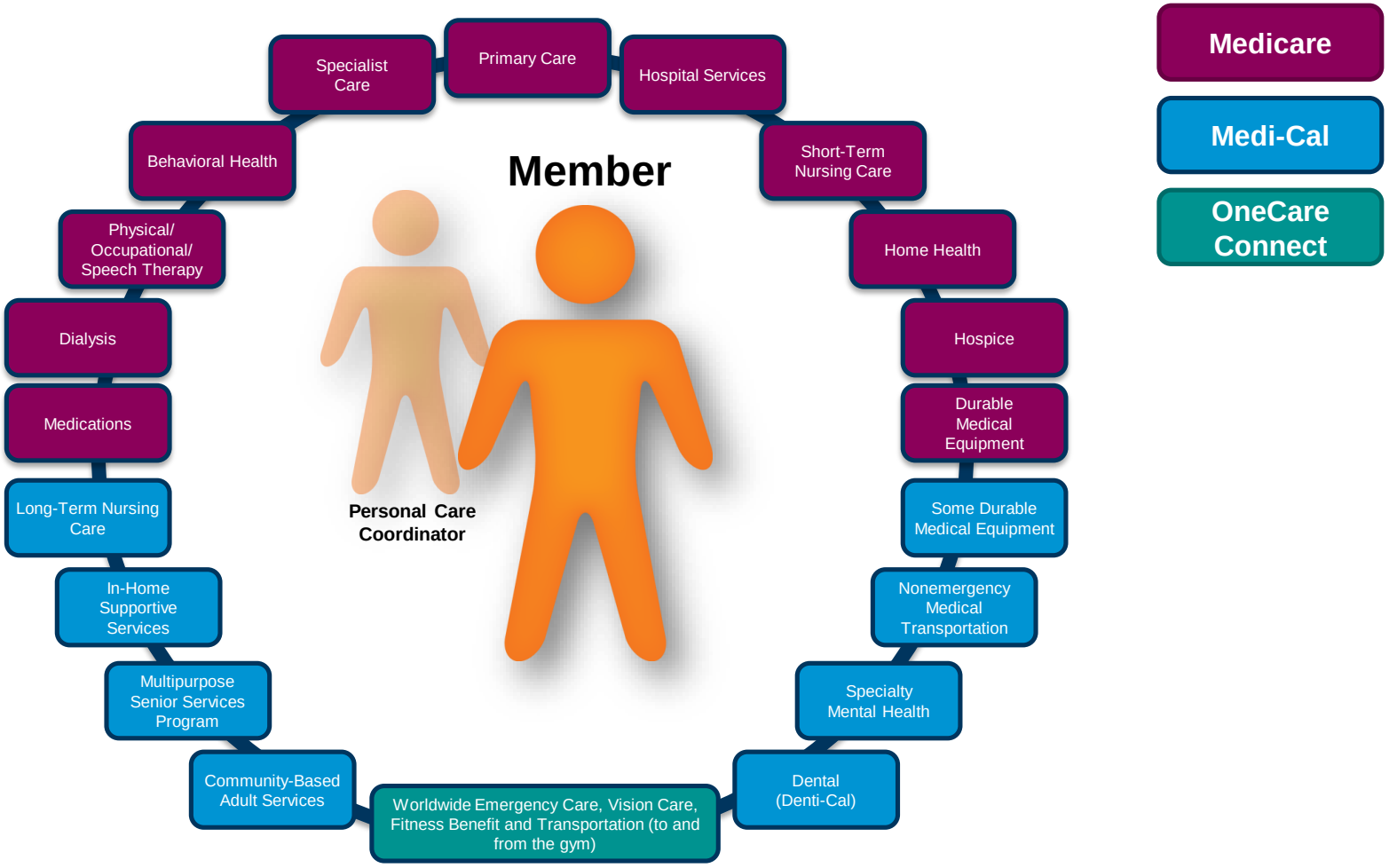
- California's Cal MediConnect plan:
  - Combines Medicare and Medi-Cal benefits.
  - Coordinates all care, supports and services via one plan — CalOptima OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan).
  - Integrates behavioral health benefits with physical health benefits.
  - Offers improved access to Long-Term Services and Supports, including nursing facilities, community-based adult services (CBAS), and Multipurpose Senior Services Program (MSSP).
- Coordination of care through OneCare Connect enables the member to receive quality services to achieve optimal outcomes, independence, health and quality of life.

Eligible Members

- OneCare Connect members must meet all criteria to be eligible for benefits:
  - Age 21 and older
  - Residing in Orange County
  - Enrolled in Medicare Parts A, B, D
  - Receiving full Medi-Cal benefits ($0 Share of Cost)
    - Share of Cost exception: members who reside in a nursing home, are enrolled in Multipurpose Senior Services Program (MSSP) or have In-Home Supportive Services (IHSS).

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 a veteran's home.

CalOptima Model of Care



Model of Care

- **Member-centric** approach to care
- Program components include:
  - **Personal Care Coordinator (PCC)** — specialized staff assigned to assist with completion of HRAs and serve as point of contact for members
  - **Health Risk Assessment (HRA**) — a member's health status information used to improve the care process and offer providers actionable information
  - **Care Management Levels (CML)** — Identified from the HRA; HRA analysis leads to initial recommendations, including identification of Basic, Care Coordination or Complex care management levels and ICT participants
  - **Interdisciplinary Care Team (ICT)** — a team in which all participants coordinate their efforts to benefit the member
  - **Individual Care Plan (ICP)** — an actionable plan of care developed by the ICT and delivered to the member with a focus on cultural differences, language, alternative formats and health literacy

Interdisciplinary Care Team

- An ICT is a collaborative, multidisciplinary team who:
  - Analyzes and incorporates information from a member's initial or annual HRA
  - Develops an ICP for all members
  - Communicates the ICP to the member and all participants of the ICT
  - Recommends and coordinates referrals to appropriate medical, behavioral health or home/community-based providers and resources

Goals of the ICT

- Support the member's right to self-direct care
- Engage the member or caregiver/authorized representative in care plan development
- Facilitate linkage to appropriate behavioral health and Long-Term Services and Supports (LTSS)
- Improve member engagement
- Improve member and provider communication
- Prevent duplication of services
- Improve member satisfaction
- Improve member outcomes
- Prevent transition of the member to a higher level of care

Participants of an ICT

- Health care professionals:
  - Knowledgeable and credentialed (as appropriate) individuals involved or closely associated with the care of the member.
  - Selected based on member's needs, such as:
    - Clinicians experienced in geriatric and/or chronically ill needs
    - Providers serving vulnerable disadvantaged populations
    - Licensed behavioral health practitioners
    - Staff with expertise in Medicare and Medi-Cal benefits
- Members or their authorized representative
  - Have the right to:
    - Select and delegate health care decisions to an authorized representative
    - Decide composition of and level of their involvement in the ICT and ICP

NOTE: ICTs addressing a member's LTSS and/or behavioral health (BH) service needs should include appropriate LTSS and BH provider participation.

Responsibilities of the ICT

- The general responsibilities of an ICT are:
  - Analyze and incorporate the initial and annual HRA results into the member's ICP.
  - Collaborate on development or update of each member's ICP.
  - Communicate coordinated care plans to all participants of the ICT.
  - Assess and address social or other barriers to achieving goals.
  - Assess LTSS needs to allow members to remain at home and in their communities as long as possible.
  - Coordinate ICP integration of medical, behavioral health, Long-Term Services and Support and social needs.
  - Engage members to self-direct care.
  - Document, process and address a member's complaint or grievance.
  - Provide and support person-centered care coordination and planning.
  - Identify needed community-based resources and facilitate referrals.

Basic Care Management

- OneCare Connect identifies a member's risk or care management level – basic, care coordination, or complex.
- When members are identified as low risk or requiring basic care management, the ICT participants are identified.
  - ICT participants may include but are not limited to:
    - Member
    - Caregiver or authorized representative, when appropriate
    - Primary care provider (PCP)
    - PCP support staff, when appropriate
    - Specialist(s), when appropriate
    - Assigned PCC, when appropriate
    - Others based on member need

Basic Care Management (cont.)

- ICT roles and responsibilities include, but are not limited to:
  - Basic care management, including advanced care planning
  - Medication reconciliation
  - Identification of a member at risk for transitions
  - Referral and coordination with specialists
  - Development and implementation of ICP
  - Referrals to and coordination with behavioral health or LTSS
  - Referrals to and coordination with community-based services
  - Communication with member/representative and medical group
  - ICP review and update at least annually and with changes to the member's health status

Care Coordination Care Management

- For members identified as moderate risk or requiring care coordination, the ICT participants are identified.
  - ICT potential participants include but are not limited to:
    - Member
    - Caregiver or authorized representative (with member's consent)
    - Primary care provider (PCP)
    - Specialist(s), when appropriate
    - Assigned PCC
    - Ambulatory case manager
    - Behavioral health specialist
    - Health network medical director and UM staff
    - Social worker
    - Hospitalist
    - Hospital case manager and/or discharge planner
    - Others based on member need

Care Coordination Care Management (cont.)

- ICT roles and responsibilities include, but are not limited to:
  - Same responsibilities as basic care management plus:
    - Identification and management of transitions
    - Care management of higher risk members
    - Communication of ICPs to other care providers for higher risk members
    - Facilitating member, PCP, specialists and other caregiver communication
    - Coordination with and referrals to behavioral health or LTSS
    - Meetings as needed to coordinate care and stabilize member's medical condition

Complex Care Management

- For members identified as high risk or who have had a recent clinical event or diagnosis requiring extensive use of resources and assistance to navigate the health care system, the ICT participants are identified.
  - ICT potential participants included but not limited to:
    - Same as for care coordination level
    - May include various other health care professionals based on member needs

Complex Care Management (cont.)

- ICT roles and responsibilities include, but are not limited to:
  - Same responsibilities as basic care management plus
  - Consult with PCP, specialist and health network teams.
  - Ensure member engagement and participation in ICT process.
  - Coordinate management of members with complex transition needs and development of ICP.
  - Support ICP implementation by PCP and health network.
  - Analyze data to evaluate management of transitions and ICT activities to identify areas for improvement.
  - Meet as often as needed until member's condition is stabilized.

Who Leads the ICT?

- Basic Care Management
  - Member's PCP is responsible for overseeing the member's care and leads the ICT.
  - For members in Long-Term Care facilities, the facility leads the ICT.
- Care Coordination and Complex Care Management
  - The health network care manager organizes and leads the ICT.

Primary Care Provider Role

- Collaborates with member and specialists regarding access to care:
  - Identifies specialty and ancillary care needs of member
  - Coordinates appropriate referrals to medically necessary services and community resources
  - Provides preventive, acute and chronic health care services
  - Advocates for members
  - Annually performs a comprehensive assessment of medical, psychosocial, cognitive and functional needs or as condition changes
  - Identifies care gaps
  - Collaborates with member, family, specialists and case management on development and implementation of the ICP

Specialty Provider Network

- OneCare Connect's provider network includes a variety of specialists to meet the needs of frail or disabled members and members with multiple chronic conditions.
  - Specialists include, but are not limited to:
    - Cardiologists
    - Geriatricians
    - Gynecologists
    - Nephrologists
    - Neurologists
    - Oncologists
    - Ophthalmologists
    - Orthopedic specialists
    - Pain management specialists
    - Psychiatrists
    - Surgeons

Specialist Provider Role

- The role and responsibilities of the specialist include, but are not limited to:
  - Identification of specialty care needs
  - Coordination of appropriate referrals
  - Specialty care for the related needs within scope of their training
  - ICT participation
  - Advocating for member
  - Collaborating with PCP, member and family, and other specialists to create the ICP
  - Implementation of the member's ICP
  - Documentation of communications with PCP and member

Behavioral Health Professionals

- Behavioral health providers actively participate in the ICT and in the development and update of the ICP. They may include:
  - Physicians
  - Clinical psychologists
  - Clinical social workers
  - Psychiatric nurse practitioners
  - Psychiatric physician assistants
- Members with Serious Persistent Mental Illness (SPMI) will have an ICT that includes:
  - Specially trained psychiatrists or other mental health professionals
  - Providers with expertise in managing SPMI needs
  - Participation of appropriate care staff to address medical needs

Behavioral Health Collaboration

- The primary care provider (PCP):
  - Conducts an assessment after a member HRA is completed.
    - History and physical, Alcohol Misuse Screening and Counseling (AMSAC), lab work, etc.
    - Patient Health Questionnaire (PHQ)-9, Generalized Anxiety Disorder (GAD)-7, Alcohol Use Disorders Identification Test (AUDIT) or AUDIT-C
  - Identifies if a member is receiving behavioral health services from:
    - CalOptima Behavioral Health
    - County of Orange Health Care Agency Behavioral Health Services or county-contracted provider
    - Drug Medi-Cal Organized Delivery System (DMC-ODS)
  - Health network's Personal Care Coordinator (PCC) assists in identifying the member's behavioral health provider(s), as needed.

Member Receiving Behavioral Health Services

- Member's behavioral health provider(s) is requested to participate in ICT.
  - CalOptima Behavioral Health provider, County care coordinator, or Drug Medi-Cal provider
- Behavioral health providers may include the member's psychiatrist, psychologist, care coordinator, social worker and/or nurse practitioner.
- ICT to review:
  - Mental health diagnoses
  - Frequency and type of treatment
  - Behavioral health treatment plan (inpatient, partial hospitalization, outpatient care)
  - Psychiatrist prescribed medications, including recent changes or intent to change

Member Receiving Behavioral Health Services (cont.)

- ICT to review (cont.):
  - Metabolic monitoring request/coordination of all lab monitoring
  - Answers to PCP behavioral health consultation questions (differential diagnosis, depression/anxiety/psychological factors affecting pain management)
  - Suggestion for PCP's behavioral health follow up and/or resumption of care
- Behavioral health providers evidence participation in ICT by signing the member's ICP.

Member Not Yet Receiving Behavioral Health Services

- PCP to communicate to member reason for behavioral health referral.
- Member may contact CalOptima Behavioral Health and request services.
- Or the health network care manager or PCC completes the referral to CalOptima Behavioral Health and includes:
  - Reason for referral
  - Differential diagnosis or other consultation question
  - Psychiatric medication recommendations vs. assume management of psych meds
  - Psychotherapies to address psychological factors affecting medical condition
  - Evaluate and manage concurrent co-morbid serious mental illness

Personal Care Coordinator

- All OneCare Connect members have an assigned PCC.
  - Liaison between member, providers, health network and CalOptima.
  - Helps member navigate the health care delivery system and facilitates access to care and services.
  - Experienced in working with seniors or persons with disabilities.
  - Knowledgeable about health care service delivery and managed care.
    - Medicare and Medi-Cal benefits
    - Community resources
    - Delivery system across the continuum of health care
    - OneCare Connect
  - Communicates effectively, both verbally and in writing, with individuals from varying cultural and ethnic backgrounds.
  - Licensure is not required.

Personal Care Coordinator (cont.)

- PCCs are employed both at the health network and at CalOptima.
  - CalOptima PCCs
    - Assist the member with telephonic and in-person completion of the HRA
    - Collaborate with health network PCCs and CalOptima Customer Service on behalf of the member
    - Assist with coordination of continuity of care requests
  - Health network PCCs and CalOptima Community Network PCCs
    - Function as the member's primary point of contact at the health network
    - Support member in accessing and using health care system
    - Assist with scheduling appointments
    - Notify the health care team of triggers or key events to ensure real time response
    - Work with case management to resolve access, medical and psychosocial issues .

Who Will Have an ICT?

- All members with a care management level of complex or care coordination **will have** an ICT.
- Low risk (basic) members will have a less formal ICT composed of the member, the PCP and others as needed.
- Moderate risk (care coordination) members will have an ICT composed of the member, PCP, PCC and other appropriate care team members.
- High risk (complex) members will have the most complex ICTs which may include a broader range of participants.
- Any member may request and participate in an ICT if desired.

ICT Meetings

- ICT meetings 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 meet?
  - Initially, upon completion of the HRA, to develop the ICP
  - Annually to review and revise the ICP as needed
  - When a member's condition(s) changes
  - At member's request

How Do I Become Part of an ICT?

- Participants in an ICT may join a meeting when:
  - Assigned by CalOptima
  - Requested by the PCP or health network
  - Requested by the member
- Education is provided for all OneCare Connect staff and potential ICT participants on five core concepts:
  - Person-centered planning process
  - Cultural competence
  - Accessibility and accommodations
  - Independent living and recovery, and wellness principles
  - Information on LTSS

ICT Mode of Communication

- Basic care management
  - ICP is maintained in the member's medical record.
- Care coordination and complex care management
  - ICP is shared with all ICT participants.
  - A member friendly version of the ICP is given to the member.
  - ICP is maintained in a HIPAA (Health Insurance Portability and Accountability Act)-compliant format in the health network's and in OneCare Connect's care management record system.

ICT Process: Basic Care Management

- ICT
  - Formal meeting not required, but may be requested by the member
- ICP
  - Developed by the PCP
  - Reviewed and updated annually and when there is a change in health status
  - Changes and revisions to the ICP are shared with member/ caregiver/authorized representative and other providers, when appropriate.
  - Stored in PCP medical record, meeting HIPAA, contractual, statutory and regulatory requirements
  - Contains member's signature as acknowledgment of participation in ICP updates
  - Copy of updated member friendly ICP sent to member by secure email, fax or mail

ICT Process: Care Coordination or Complex Care Management

- ICT
  - Meetings are required; may be telephonic, virtual or face-to-face.
  - Meeting frequency is individual to member's need.
  - Health network care manager facilitates the meeting.
  - Initial ICT may have a follow up to evaluate progress of meeting goals or resolving barriers.
  - Member/caregiver/authorized representative is encouraged to engage in discussion.
  - All participants discuss member's medical, behavioral and social support needs.
  - Develops an ICP with member's prioritized goals.
  - ICT meeting is documented in the health network's and CalOptima's HIPAA-compliant record system.

ICT Process: Care Coordination or Complex Care Management (cont.)

- ICP
  - Includes the same steps as for basic care management
    - Written plan developed with member's prioritized goals
    - Sent to all ICT participants
  - Stored in PCP medical record, meeting HIPAA, contractual, statutory and regulatory requirements

ICT Process: Requirements

- Upon receiving a member's initial or annual HRA, the PCP or care manager must convene the ICT and document an ICP within the required time frames.
- Meeting minutes must document all invited ICT participants, their attendance by phone or in person or decline to participate, especially the PCP and member or caregiver.
- ICT recommendations and the ICP is distributed to the member, the member's legal representative, the PCP and pertinent providers, and CalOptima.
- Documentation (ICT minutes and ICP) is required to be sent to CalOptima within the required time frames.

Knowledge Check

1. An ICT is composed of the following participants:
   a) OneCare Connect staff only
   b) Providers only
   c) Behavioral health providers only
   d) The member, caregiver, OneCare Connect staff, PCP and all service providers

2. The member can choose ICT participants and can exclude ICT participants.
   a) True
   b) False

3. Who leads the ICT?
   a) The PCP for basic care level ICTs, the OneCare Connect PCC/care manager for care coordination and complex level ICTs
   b) Leadership rotates quarterly
   c) The most senior physician

Knowledge Check (cont.)

4. When does the ICT meet?
   a) Initially to develop the ICP and at least annually thereafter
   b) When there is a change in the member's condition(s)
   c) At the request of the member
   d) All of the above

5. The PCC/care manager must convene the ICT and complete an ICP after receiving the HRA for a member identified as care coordination.
   a) True
   b) False

Knowledge Check Answers

1. d) The member, caregiver, OneCare Connect staff, PCP and all service providers
2. a) True
3. a) The PCP for basic care level ICTs, the OneCare Connect PCC/care manager for care coordination and complex level ICTs
4. d) All of the above
5. a) True

Individual Care Plan

- Dynamic and person-centered plan of care for all members:
  - Includes comprehensive input from the member and/or member's caregiver, PCP, specialists and other providers, according to member's wishes
  - Identifies member strengths, capacities and preferences
  - Provides care options to support member needs, including transitions of care settings
  - Identifies long-term care needs and the resources available
  - Must be completed within 30 days of the HRA collection

Member Engagement

- Member and/or authorized representative and/or caregiver 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 change goals
  - If telephonic communication is unsuccessful in obtaining engagement in care, then face-to-face interactions are an option.

Member Engagement (cont.)

- To ensure that the member is prepared to participate in the ICT, the following must be provided:
  - Educational materials
  - Information on involving caregivers and social supports in planning
  - Self-directed care options
  - Information on accessing LTSS, if applicable
  - Other available treatment options, supports and/or alternative courses of care
  - Information on the right to opt-out of the care planning process
  - Information in alternative formats and in their preferred written or spoken language upon member's request

Member Engagement (cont.)

- The member has the option to opt-out or decline involvement in the ICT or ICP process:
  - Member asked at the beginning of each encounter if they choose to participate; the decision is documented in ICT minutes and care plan record.
  - Communication for care planning process occurs via telephone, mail or in-person (e.g. members in skilled nursing facility) per member preference.
- If member designates authority to another to act on their behalf, the PCP or other appropriate staff will follow policy to confirm legal authority, including:
  - Member verbal consent
  - Caregivers may fax or mail the legal documentation
  - Documentation filed in the care management record

ICP: Development

- PCP and/or 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 systems, resources, involvement
  - Mental health, cognitive functions, cultural and linguistic needs
  - Motivational status or readiness to learn
  - Visual/hearing needs, preferences or limitations
  - Life-planning activities
  - Functional status — ADL (activities of daily living) and IADL (instrumental activities of daily living)
  - Current status and treatment plan
  - Barriers to quality, cost-effective care and treatment plan

ICP: Development (cont.)

- Items assessed and evaluated (cont.):
  - 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
- 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:
  - 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 appropriate level of care
  - Planning for continuity of care, including transition of care and transfer
  - Collaborative approaches to be used, including family participation

ICP: Essentials (cont.)

- Coordination of benefits and services
  - Add-on benefits such as: no-cost taxi transportation, access to a gym and vision benefit
  - Community resources
  - Services provided in and out of plan
  - Treatment plan via an interdisciplinary approach
  - 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

ICP Review and Assessment

- The ICP for all care management levels is reviewed and updated by the PCP in collaboration with member and ICT:
  - At each PCP visit and member contact
  - When additional information is obtained from member/ caregiver/authorized representative, case manager, specialist(s) or annual HRA
  - When health status changes, e.g., hospital or skilled nursing facility (SNF) admissions, ER visits, readmission in 30 days, change to medication regimen, new diagnosis or exacerbation of current condition or change in DME supply requirements
  - When psychosocial barriers are identified
    - Need for LTSS
    - Unsafe home environment or potential for change in care setting
    - Change in adherence to medication/treatment plan or in mental status
  - When goals are met, or case closed

ICP: Updates

- Modifications to the ICP include but are not limited to:
  - Increased frequency of monitoring
  - Medication reconciliation and monitoring of adherence
  - Implementation of a transition of care plan
  - Home safety assessment
  - Assessment for additional services and benefits
  - Community resource referrals
  - Behavioral health or LTSS referrals
  - Assessment and coordination of palliative/hospice services and alternate care settings

Barriers to Meeting Goals

- PCC and/or care manager identifies and manages barriers:
  - Obstacles to members receiving or participating in ICP
  - To ICP compliance or meeting goals
- Steps include:
  - Identify, discuss and report identified barriers to ICT
  - ICT members assist in resolving identified barriers
  - Document barriers assessed, even if none identified
  - Assessments include:
    - Understanding member's condition and treatment
    - Desire to participate in the case management plan
    - Belief that their participation will improve their health
    - Financial or transportation limitation hindering participation in care
    - Mental and physical capacity

ICP: Review Requirements

- The ICP will be reviewed and revised:
  - At least annually
  - Upon notification of change in health status or living situation
  - Upon member's request
- The ICP is reviewed during scheduled ICT meetings
  - Times set to follow up on the status of the member's progress toward their goals

ICP: General Maintenance

- Considerations for managing ICP records:
  - ICP disseminated to member/caregiver/authorized representative, PCP and all participants included in the ICT
  - ICT documentation and ICP summaries stored in HIPAA-compliant member record system.
  - ICP stored in PCP medical record according to all regulations with copies sent to CalOptima
  - ICP developed with other providers (e.g., behavioral health, drug and alcohol abuse providers, county mental health plan providers, etc.) included in the member ICP
  - PCP or other providers must designate the individual responsible for medical records maintenance and storage

ICP Maintenance: Care Management Level

- Basic:
  - ICP document maintained in member's medical record
    - PCP provides ICP to member and other ICT participants.
- Care Coordination and Complex:
  - ICP documented in health network HIPAA-compliant system
    - ICP stored in the member's medical record at PCP office, according to all regulations
    - ICP copies mailed to member, provider and ICT participants
    - ICT minutes and ICP record sent via secure file transfer to CalOptima

Medical Records Maintenance

- Maintenance of Medical Records
  - Active records should be labeled and stored in secured area that protects records from loss, tampering, alteration, destruction and access by unauthorized individuals.
  - Inactive records must be maintained and stored for ten (10) years in either electronic or hard copy format.
  - Providers ensure that members have access to their medical records, including the ICP.
  - Providers ensure that all staff complies with confidentiality requirements.

Medical Records Maintenance (cont.)

- Maintenance of Medical Records (cont.)
  - CalOptima and providers must ensure physical access to PHI (protected health information) aligns with personnel role and function according to minimum necessary.
  - Physical controls must ensure that only authorized users can access information systems that process/store EPHI (electronic protected health information).
  - A data backup plan that includes scheduled backups and offsite storage.
  - OneCare Connect, health networks and ICT participants who store ICPs in their systems must ensure compliance with EPHI in accordance with CalOptima policy.
  - Physical access controls in place to prevent unauthorized access, tampering, theft, damage and breach.

Oversight

- CalOptima OneCare Connect monitors delegated entities' compliance to ICT and ICP processes and record maintenance through:
  - Review of ICT and ICP records
  - Analysis of reports
  - Periodic audits
  - Monitoring activities proscribed by CalOptima policy

Coordination of Services

- PCC and/or care manager facilitates care coordination for a OneCare Connect member:
  - With the PCP and other providers, e.g. behavioral health, non-emergent medical transportation, DME, LTSS
  - Share pertinent member information
  - Ensure ICT team follows up on member referrals to appropriate services or providers
  - Share identified services and member health care outcomes with ICT and PCP during ICT planning
  - Communicate ICP changes to ICT/ PCP in writing or via phone or virtually
  - Inform members and encourage discussion with PCP
  - Incorporate outcomes of the intervention into the ICP

Member Transitions

- PCC and/or care manager coordinates care for OneCare Connect members transitioning from one care setting to another:
  - Assists with the transfer of clinical and pharmacy records
  - Assists with identification of needed providers or facilities
  - Reconvenes the ICT when indicated
  - Updates ICP to reflect new provider, facility, or services and care needs
  - Shares the ICP between the sending and receiving settings, ICT and member/caregiver/authorized representation within one business day of notification that transition occurred
  - Sends ICP by faxing, mailing or electronic medical record transfer or face-to-face hand-off to member

Transitions to New Providers

- PCC and/or care manager coordinates care for OneCare Connect members transitioning from one PCP to another:
  - Receive notification or identify the new provider from member assessments, clinical reports, ICP discussions or utilization data
  - Confirm ICT is aware of the new provider
  - Provide new provider with ICT participation information and ICP
  - Ensure new provider receives appropriate training to participate in ICT

Knowledge Check

1. Which is used as a basis for the ICP?
   a) Health Risk Assessment
   b) Member input
   c) Other previous assessments such as medical, LTSS (IHSS, CBAS, MSSP), nursing facility and behavioral health assessments
   d) All of the above

2. The ICP contains prioritized goals that are self-managed by the member, i.e., member activities that help them manage their health
   a) True
   b) False

Knowledge Check (cont.)

3. For all member transitions, the personal care coordinator/care manager:
   a) Assists member or responsible party in transitioning any necessary clinical and pharmacy records
   b) Updates the ICP to reflect the applicable provider, facility and/or services
   c) Shares the ICP with the ICT, member and caregiver
   d) All of the above

4. What are the three general levels of ICT?
   a) Basic, Care Coordination, Complex
   b) Simple, Complicated, Complex
   c) PCP, Specialist, LTSS

5. All PHI is required to be stored in a HIPAA-compliant system.
   a) True
   b) False

Knowledge Check Answers

1. d) All of the above
2. a) True
3. d) All of the above
4. a) Basic, Care Coordination, Complex
5. a) True

Authorities

- DHCS/CMS/CalOptima Cal Medi-Connect 3-way Contract
- H8016-2018 Model of Care, Orange County Health Authority
- CMS/DHCS — California Duals Demonstration Memorandum of Understanding
- CMS National Financial Alignment Initiative
- NCQA Model of Care Review Process
- Dual Plan Letter (DPL) 15-001 ICT and ICP Requirements for Medicare- Medicaid Plans
- Dual Plan Letter (DPL) 15-005 HRA

References

- CalOptima Policy CMC.1003: CalOptima OneCare Connect Staff Education and Training
- CalOptima Policy CMC.6021: Continuity of Care for Members Involuntarily Transitioning Between Providers or Practitioners
- CalOptima Policy CMC.6026: Coordination of Care for OneCare Connect
- CalOptima Policy CMC.6031: Health Risk Assessment
- CalOptima Policy CMC.6033: Behavioral Health Assessment, Referral, Coordination and Information Sharing for OneCare Connect Members
- CalOptima Policy EE.1103: Provider Education and Training
- CalOptima Policy IS.1101: EPHI Physical Controls
- CalOptima Policy HH.2022: Record Retention and Access

CalOptima's Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner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