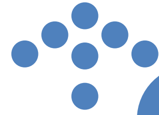
CARE MANAGEMENT SERVICES



Interdisciplinary Care Team (ICT) meetings are conducted on ALL CSNP patients ; ICT-2 meetings on most vulnerable

Patient determined to be High Risk

HRA and claims information collected

Interdisciplinary Care Team Members Can Include

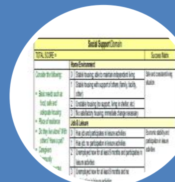
- Medical Directors – PHM, Behavioral Health, UM
- Primary Care Physician
- Specialist
- Practice Back Office Staff
- Medicare Case Managers
- Care Coordinators/Disease Managers
- Population Coordinators
- Pharmacy
- Social Workers
- PHM Management
- Net Ops Team (optional)
- Patient/Significant Other

STEP 1 DEVELOP CARE PLAN

Review HRA, Risk Score, RAF data

Review Drug compliance information

Review Chronic condition needs



Review ED, hospital, SNF Records

Review barriers to Care Transportation Family Support, Etc.

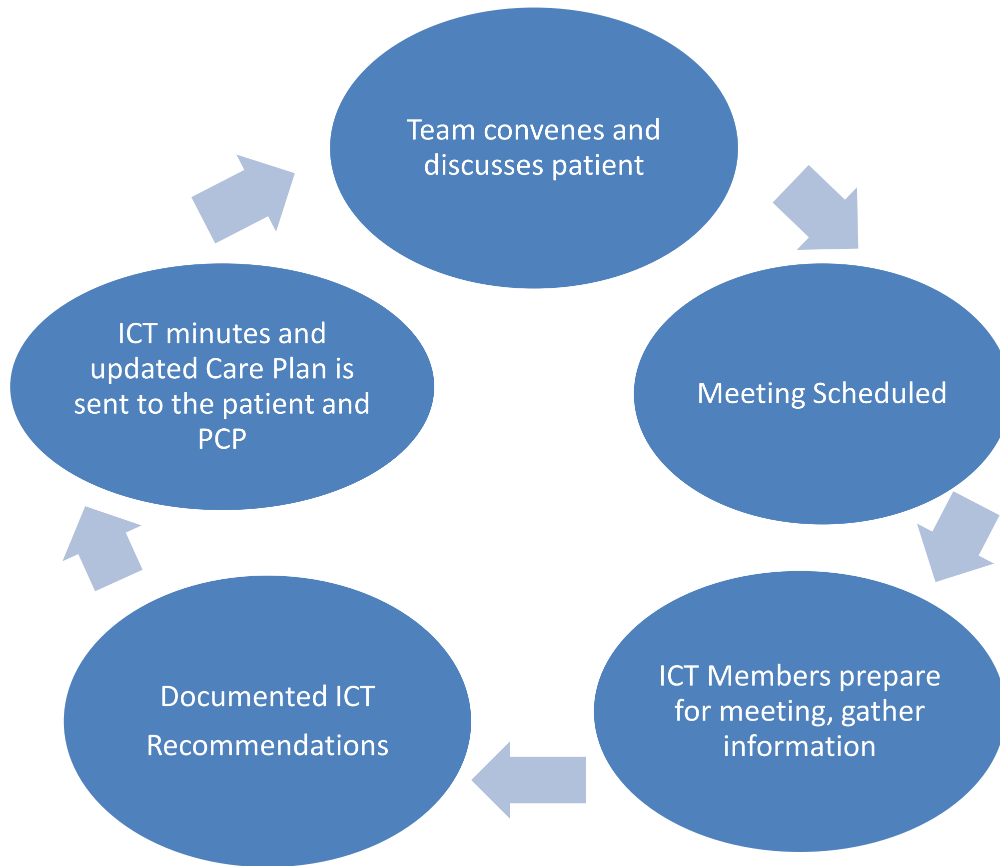
Reviews End of Life Needs

Reviews gaps in Care

Reviews behavioral health needs if applicable.

Care plans are dynamic Completed with care team, member then reviewed/ revised as status changes

STEP 2 - ICT-2 PROCESS



1. Conducted on High Risk patients or based on need
2. Care Plan Update following ICT
3. Can be held as often as needed
4. Value comes from assisting patient to reduce admissions/readmits
5. ICT meetings are not billable
6. Minutes of meetings provided to clinicians

24/7 CARE COORDINATION LINE for Clinicians 602-402-0003

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