

PROPOSED PROGRAM REQUIREMENTS

INTERDISCIPLINARY CARE TEAM

Each Organization contracting with the Department of Disabilities, Aging and Independent Living (DAIL) to provide services to MyCare Vermont Participants shall provide services through a comprehensive interdisciplinary services delivery system that addresses both health care and long term care needs.

Interdisciplinary Care Team Members

The Organization shall establish an Interdisciplinary Care Team (ICT) consisting of, at a minimum, the Participant (or designee selected by the Participant), a Primary Care Provider¹, Case Manager/Social Worker, and Registered Nurse. The team members will be employed or staff under contract with the Organization. The team will operate in accordance with the MyCare Vermont program requirements and the Organization's policies and procedures. It is the responsibility of the Organization to ensure Participant and/or designee involvement with the team to the extent needed or desired by the Participant. If appropriate, other members may be added to an individual Participant's team, based on the Participant's condition and/or needs.

Decisions are made jointly by all team members, including the Participant and/or designee. Each team member is responsible for communicating his or her position on issues and preferred course(s) of action. In practice, Participant participation in decision-making is on a continuum. Although joint decision making may be ideal, participation should be considered satisfactory when the individual is participating to the degree he or she desires and at his or her comfort level. If there is disagreement between the Participant and the other team members, the Participant has a right of appeal.

I. Interdisciplinary Care Team Responsibilities

A. Team:

- Educate, empower and facilitate the Participant to exercise his or her rights and responsibilities.
- Involve the Participant as an active team member and stress Participant-centered collaborative goal setting.
- Provide the supports necessary for the Participant to keep doing things he or she enjoys, to follow through on prescribed treatments, and to remain physically active.
- Establish a set of guidelines or care responsibilities for the entire team and distribute these responsibilities to all team members.
- Provide information and support to the Participant in making choices within the parameters of the Organization.
- Develop, monitor and review the Participant's care plan with the Participant.

¹ This may be either a primary care physician or a nurse practitioner.

- Ensure Participant's goals and preferences are identified, documented in the care plan and addressed.
- Provide case management, including assessing needs, and authorizing and coordinating services.
- Evaluate the effectiveness of the current plan of care and implement modifications as needed in collaboration with the Participant and other providers as appropriate.
- Provide in-home assessment of safety issues, and work with the Participant to manage identified risks.
- Provide education to the Participants and families regarding health and social needs.
- Identify the Participant's informal support systems/networks in relationship to his or her functional and safety needs.
- Report information to team, Participant and other appropriate health care providers as needed.
- Assess and assist the Participant in identifying and addressing quality of life issues.
- Meet documentation and reporting requirements in a timely and accurate manner.
- Provide links/coordination/integration with care providers across settings.
- As appropriate, represent the Participant's point of view when the member is unable to participate in decisions.
- Provide Participant with necessary equipment and supplies.

II. Individual Team Members' Responsibilities

A. Participant and/or designated representative:

1. Understand the disease process, chronic illness, and/or disability.
2. Realize his/her role as the daily self-manager.
3. Engage family and caregivers in the Participant's self-management.

B. Primary Care Provider:

- Provide initial history and physical exam.
- Provide periodic re-evaluation of medical status.
- Provide, in the member's residence or in an office/clinic setting, evaluation of episodic acute illness.
- Provide prevention and health maintenance education to Participant.
- Assume leadership role in collaborating with appropriate providers prior to, during, and at discharge from hospital, rehabilitative and nursing facility settings.
- Order diagnostic or therapeutic interventions.

C. Registered Nurse:

- Assess physical health status and response to illness and/or disability.
- Assess effectiveness of medications including intended effect, side effects, and Participant knowledge and method of administration.
- Provide in-home assessment to identify functional limitations and adaptations to environment.

- Provide face-to-face skilled nursing services as required to manage care and maintain current knowledge of Participant needs.
- Delegate appropriate aspects of Participant care to supportive home care service providers including Personal Care Attendants (PCAs), Homemakers, or Licensed Nursing Assistants (LNAs); and supervise and evaluate the effectiveness of care given.
- Provide, in conjunction with the Primary Care Provider, prevention and health maintenance education to Participant.
- Assess the need for and coordinate supportive home care services provided to Participant.
- Ensure that the supportive home care provider's written plan is reflective of Participant needs, is current, and provides sufficient direction to the supportive home care provider.
- Communicate acute changes in health status to Participant in a timely manner and collaborate with Participant in implementing interventions.

D. Case Manager/Social Worker:

- Complete basic psychosocial, environmental and economic assessments.
- Provide on-going coordination of psychosocial services.
- Explore financial options and eligibility for services, including employment services.
- Provide information about and assist Participant in maintaining and establishing community links.
- Provide information about and assist Participant with housing and transportation issues.
- Assist in crisis intervention.
- Provide assessment and coordination of mental health, alcohol and/or drug abuse services.
- Coordinate supportive counseling as appropriate.