MULTIDISCIPLINARY CARE TEAM (MCT)

The PCCM-e must establish a Multidisciplinary Care Team (MCT), a group of health care professionals (such as physicians, nurses, social workers, pharmacists), who are members of different disciplines, each providing specific services to the recipient. The recipient, caregiver, or designated family member shall have the right to participate in the recipient's MCT meeting and the planning of the meeting(s).

Purpose

The MCT allows for health professionals from different disciplines to work together to provide coordinated and individualized care to patients with complex or chronic needs. The team collaborates on a detailed care plan of care, communicates regularly, and accesses a range of health and community services to support the recipient's goals and well-being. The team also works to prevent unnecessary hospital care and adapts to the changing needs and circumstances of the recipient over time.

MCT Meeting

A MCT meeting is defined as a setting where all of the attendees are present at the same time to discuss the identified issue(s) collaboratively. Examples of an appropriate MCT meeting setting:

- In-person/face-to-face
- Virtual with, at a minimum, audio capability; audio and visual preferred

MCT meetings are held in accordance with the Care Management Activity Schedule.

The MCT shall meet at an appropriate location or venue in the Region such as the PCCM-e's office, hospital, community mental health center, clinical practice or clinical group practice, an academic health center, or virtual platform.

The following criteria must be met to be eligible for payment:

- Recipient or their designee must be present.
    - If the recipient chooses to not attend prior to the meeting being scheduled, the PCCM-e must maintain attestation documentation within the HIMS to support the refusal. In these instances, Agency approval will be needed prior to payment. This approval must be granted prior to the meeting being conducted.
    - If the recipient had agreed to attend but due to unforeseen

circumstances cannot attend, the PCCM-e must maintain attestation documentation within the HIMS and document the unforeseen circumstance. In these instances, the MCT meeting can still occur and be eligible for payment.

- Primary care provider or their designee must be present
- Attendee presence must be documented
- If face-to-face, signatures required
- If virtual, documentation of presence required
- Document in detail, activities of the MCT and subsequent meetings, in an approved HIMS, including the name and title of participating MCT members and method of participation.

Additionally, the MCT must:

- Include the recipient as an integral member of the MCT meetings;
- Include multi-disciplines;
- Hold meetings that are person-centered, built on the recipient's specific preferences, needs, and input;
- Discuss recipient's needs, solutions, and potential outcomes and timelines for addressing such needs;
- Document, in detail, issues as described above and participating staff; and
- Be an essential component of the care plan process and documented as care plan activities in an approved HIMS.

PCCM-e Responsibilities

The PCCM-e must:

- Assign a Care Manager or Transitional Care Management staff to establish and coordinate a MCT for eligible actively managed recipients.
- Inform the recipient, in writing, of their rights and responsibilities to participate in the MCT meeting. The PCCM-e shall notify the recipient, in writing, of the date, time, location, and purpose of the MCT at least 10 business days before the date of the recipient's MCT meeting. The notification can be telephonic but must be followed-up with a written recipient MCT meeting notification letter via postal service.

- Maintain documentation that a recipient MCT meeting notification letter was generated and mailed to the recipient. Documentation shall be maintained in an approved HIMS for auditing and compliance purposes.
- Organize a MCT that will develop a comprehensive person-centered care plan to meet the needs of the recipient and independently address various issues a recipient may have, focusing on the issues in which each professional specializes.

The PCCM-e shall ensure that the MCT includes the following:

- transparency,
- individualization,
- support,
- acknowledgement and respect for linguistic and cultural differences, competences, and
- Preservation of dignity.

The PCCM-e's designated care manager shall serve as the lead professional in the MCT process. The care manager shall:

- Coordinate the recipient's MCTs by connecting with healthcare professionals who were an essential part of the recipient's care and who would be instrumental in contributing to the recipient's health outcomes;
- Review the each MCT member's documentation related to the recipient;
- Ensure delivery of the care plan to each MCT member to assist the recipient with achieving goals documented within the care plan;
- Be present at various meetings / appointments, if requested;
- Assist the recipient and/or their caregiver by answering questions pertaining to their care plan and its related services, as well as, helping the recipient obtain the treatment and services needed;
- Correspond with the recipient's family or caregiver as needed and/or requested by the recipient when appropriate;
- Determine when additional MCT meetings are needed with other specialized professionals;
- Engage the PCP in the MCT process. The care manager shall determine the best way to engage the PCP and communicate with the PCP to support a

collaborative, seamless process. A nurse, nurse practitioner (NP) or physician assistant (PA) or physician extender employed by the provider can serve for the PCP as an active participant in the MCT process. A general office staff, clerk, receptionist, lab technician or any other personnel, employed, contracted or a volunteer, cannot participate in the MCT process on the PCP's behalf. Active participation of PCPs is required for all MCT meetings.

- Ensure the person-centered care plan exhibits a team approach, supported through documentation. The care plan shall serve as the center of the MCT process;

- Review all specialty and MCT entries in the care plan, collaborate with other disciplines as needed for reviews and updates, ensure the care plan is current, interventions are implemented, and goals are identified and evaluated timely. Documentation of completion of this requirement shall be maintained in HIMS for auditing and compliance purposes;

- Ensure the recipient's needs are addressed based on care plan documentation in HIMS;

- Ensure care plans are reviewed by MCT members as specified in the Care Management Activity Schedule:

    - Ensure the care plan is updated when:
    - there is a change in the recipient's health status or needs,
    - there is a change in diagnosis(es),
    - there is a change in caregiver status,
    - changes in functional status or a significant health care event occurs (e.g., hospital admission or transition between care settings), or
    - as requested by the recipient's caregiver and/or the recipient's provider; and

- Close care plan when goals are met.

<u>MCT Composition</u>

The MCT, under the ACHN Program, may consist of the recipient and at least six different disciplines or professionals. The disciplines/professionals may include, but not limited to, the following:

1. PCCM-e Care Manager (required): The leader of the MCT and care plan process.

2. Primary Care Provider or appropriate representative (required): The PCP, through review of medical record documentation, shall contribute to the care plan process through consulting with the PCCM-e staff, other members of the team and the recipient, as applicable and documenting identified needs, goals and intervention in the care plan.

3. Pharmacist (required): Through the medication list and medication reconciliation process, the pharmacist shall contribute to the care plan process through consulting with the PCCM-e staff, other members of the team and the recipient, as applicable and documenting identified needs, goals and intervention in the care plan.

4. Transitional Care Staff (when applicable): Through the transitional care process, the transitional care nurse shall contribute to the care plan by addressing the recipient identified needs, consulting with the PCCM-e staff and other members of the MCT and documenting identified needs, goals and intervention in the care plan.

5. Behavior Health Staff (when applicable): Through the behavior health process and contact with the recipient, the Behavior Health staff shall contribute to the care plan and address the recipient's needs through consulting with the PCCM-e staff, substance use disorder screening processes, reflecting goals, needs and interventions in the care plan.

6. Community Health Worker (when applicable): Through working with the recipient and identifying recipient needs, valuable information can be shared to support the MCT process.

To be considered a valid MCT meeting, the meeting shall consist of any three of the six disciplines/ professionals based on the recipient's needs. At least one of the three disciplines must be the recipient's PCP or appropriate PCP representative. The recipient, his or her family member, or caregiver cannot be counted as one of the three levels of disciplines.

Recipient Participation

If the recipient cannot attend the MCT meeting in person or virtually on the scheduled date and time of the MCT, the PCCM-e's care manager shall review with the recipient notes from the MCT and the recipient's care plan during the next face-to-face encounter. This encounter must be documented in the HIMS and the recipient's signature for the encounter is required. The documentation must be maintained in an approved HIMS for monitoring and compliance purposes. Should the recipient choose not to sign, all efforts to attempt to collect the signature must be documented in the PCCM-e's HIMS.