
PACE Interdisciplinary Team Policy and Procedure

I. PURPOSE

To outline the components of the Program of All-Inclusive Care for the Elderly (PACE) Interdisciplinary Team (IDT) and the purpose and parameters of IDT meetings.

II. POLICY

- A. The IDT is the core service delivery provider for PACE participants and respectful collaboration and cooperation among IDT members is critical to quality care for participants and their caregivers.
- B. The PACE IDT is the core clinical decision making body of PACE and serves as the authorizing agent for services offered by PACE. The IDT is responsible for the assessment, development, implementation, and evaluation of the treatment plan of each participant assigned to it who is enrolled in PACE.
- C. In addition, each IDT member is responsible for informing the other IDT members of the medical, functional and psychosocial condition of each participant. All IDT members must also remain alert to pertinent input from other IDT members, participants, and caregivers. This communication may take place by formal and informal means.
- D. The IDT collaborates in the provision and monitoring of participants' long term care services, including day health care and in-home support services. The IDT meets on a regularly scheduled basis to coordinate care and to report updates to participants' plans of care, as outlined in this policy.
- E. At a minimum each IDT shall consist of:
 - 1. Primary Care Physician;
 - 2. Registered Nurse;
 - 3. Master's level Social Worker;
 - 4. Physical Therapist;
 - 5. Occupational Therapist;
 - 6. Recreational Therapist or Activity Coordinator;
 - 7. Dietitian;
 - 8. Center Manager;
 - 9. Home Care Coordinator;
 - 10. Personal Care Attendant Representative; and
 - 11. Driver/Representative.

III. PROCEDURE

A. Initial Assessments and Plans of Care

1. The Initial Comprehensive Assessment (ICA) shall be comprehensive, as it is the basis for the development of the treatment plan.
2. As part of the ICA, each of the following members of the IDT must individually evaluate the potential enrollee in-person and develop a discipline-specific assessment of the potential enrollee's health and social status:
 - a. Primary Care Physician;
 - b. Registered Nurse;
 - c. Master's level Social Worker;
 - d. Physical Therapist;
 - e. Occupational Therapist;
 - f. Recreational Therapist or Activity Coordinator;
 - g. Dietitian; and
 - h. Home Care Coordinator.
3. At the recommendation of individual IDT members, other disciplines may participate in the ICA if the potential participant's needs warrant their inclusion.
4. The ICA should include:
 - a. Physical and cognitive function and ability;
 - b. Medication use;
 - c. Participant and caregiver preferences for treatment;
 - d. Socialization and availability for family support;
 - e. Current health status and treatment needs;
 - f. Nutritional status;
 - g. Home environment, including home access and egress;
 - h. Psychosocial status;
 - i. Medical and dental status;
 - j. Participant language; and
 - k. Participant behavior.

5. Assessments are completed by the IDT at the time of enrollment, three (3) months after enrollment, and later, at intervals assigned by the IDT that are consistent with regulatory requirements, at least semi-annually and annually. Goals and objectives for care planning are based on three (3) core areas of care: the participant's medical, functional, and psychosocial status that impact the care needs identified by the IDT.
6. The *Plan of Care* should include:
 - a. Designation of level of care;
 - b. Problems, goals, objectives for each discipline and specific service elements, including equipment, assistive devices and safety precautions;
 - c. Participant/caregiver goals;
 - d. Number of days participant is to attend day health each week;
 - e. Plan for transportation;
 - f. Plan for home care services;
 - g. Recommendations for additional assessments by medical specialist or other services needed;
 - h. Families roles and responsibilities in the care plan;
 - i. Emergency care plan; and
 - j. IDT goals and plan to address participant/caregiver goal(s).
7. Once a Plan of Care is developed by the IDT, during a scheduled IDT meeting, it is authenticated by the PACE physician and approved by the participant, or designated surrogate. If the participant, or surrogate, does not approve of the Plan of Care, PACE shall inform the participant or surrogate of the appeal process.

B. Scheduled Reassessments

1. Scheduled reassessments ensure the continued accuracy and effectiveness of the developed Plan of Care and ensure appropriate monitoring of those participants who are not clinically active. At a minimum, the following disciplines shall conduct an in-person reassessment at least every six (6) months:
 - a. Primary Care Physician;
 - b. Registered Nurse;
 - c. Master's level Social Worker;
 - d. Recreational therapist or Activity Coordinator;
 - e. Home Care Coordinator; and
 - f. Other IDT members actively involved in the development or implementation of the participant's *Plan of Care*. This can include Nutrition and/or other therapies.

2. On at least an annual basis, the following disciplines shall conduct an in-person reassessment:
 - a. Physical and Occupational Therapist; and
 - b. Nutritionist.

C. Unscheduled Reassessments

1. In addition to annual and semiannual reassessments, unscheduled reassessments may be required:
 - a. If there is a significant change in the participant's status in any of the three (3) categories of care that involves two (2) or more disciplines, then the IDT shall revise the *Plan of Care* to meet the newly defined needs of the participant, within two (2) weeks of the significant change.
 - i. All IDT members shall conduct an in-person reassessment and revise the Plan of Care based on the newly identified needs of the participant.
 - ii. PACE adapted the definition of "significant change" to coincide with the current definition used in Nursing Home Regulations, which is defined as: "a 'significant change' means a major decline or improvement in the participant's status that shall not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the participant's health status, and requires interdisciplinary review or revision of the *Plan of Care* or both."
 - iii. If a participant, or his/her designated representative, believes that the participant needs to initiate, eliminate, or continue a particular service, the appropriate members of the IDT, as identified by the IDT, must conduct an in-person reassessment.

D. Intake and Assessment Meetings (I&A)

1. Interdisciplinary meetings are held at regular weekly intervals to conduct new intake, scheduled reassessment, and unscheduled reassessment care planning sessions. The PACE Center Manager shall coordinate the meeting. The PACE Center Manager shall:
 - a. Assist the IDT in decision making and revisions (where appropriate) in the participant's *Plan of Care*;
 - b. Summarize IDT decisions;
 - c. Propose new or alternative view points for IDT consideration;
 - d. Provide administrative input as needed; and
 - e. Prepare the IDT meeting agenda with an established order for presentation by disciplines.
2. The PACE agenda schedule is prioritized by discussion of individuals who require updating, new intakes, and reassessments. If time precludes full discussion of all individuals, the PACE Center Manager summarizes those with limited changes.

3. The I&A Meeting must include, at a minimum, the following disciplines for reporting:
 - a. Medical;
 - b. Nursing;
 - c. Social Work;
 - d. Physical Therapy;
 - e. Occupational Therapy;
 - f. Dietary;
 - g. Recreation;
 - h. Home Care;
 - i. Personal Care; and
 - j. Transportation (or representative).
 - k. PACE Center Manager
4. PACE shall document any recommendations and/or changes in the *Plan of Care* and maintain and incorporate such recommendation in the respective participant's medical records.

E. Regular IDT Meetings

1. The PACE Center-based IDT shall meet as often as warranted, depending on the IDT's participant census, to coordinate PACE Center activities, collaboratively problem-solve, and discuss resource allocation issues. As the participant census increases, the IDT will also meet more often to ensure proper coordination and monitoring of participant care. The core IDT shall consist of, at a minimum:
 - a. Center Manager;
 - b. Registered Nurse;
 - c. Master's level Social Worker;
 - d. Recreational Therapist;
 - e. Center Nursing Technician;
 - f. Primary Care staff;
 - g. Rehabilitation staff;
 - h. Personal care representative; and
 - i. Transportation staff (or representative).

- j. Dietician
 - k. Home Care Coordinator
2. The PACE Center Manager shall coordinate and facilitate meetings.
 3. The agenda for the meetings may include, but is not limited to:
 - a. Reporting and discussing needed changes in participant care plan based on changes observed and/or assessed the previous day or very recently;
 - b. Coordinating revisions in participant care plans to insure interdepartmental communications and follow-through;
 - c. Announcing and coordinating special activities for the day (e.g., recreational activities, family conferences, admissions, and discharges from inpatient facilities, medical appointments), and reviewing and begin discussion of participants who are scheduled for their re-evaluation during the week;
 - d. Requests from participants and/or designated representative, such as day center attendance or in-home service hours;
 - e. Review of grievance log;
 - f. End of life care planning;
 - g. Fall Reports;
 - h. New Wounds; and
 - i. Action items – Delegation and Follow-up.
 4. Minutes of meetings are maintained in a central location for access of those unable to attend. It is the responsibility of each individual who is unable to attend the meeting to read the minutes or obtain the necessary information from the Center Manager or his/her designee and to follow-up on any action items accordingly.

IV. ATTACHMENTS

Not Applicable

V. APPROVALS OR BOARD ACTION

Not Applicable

VI. REVISION HISTORY

Not Applicable