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| Policy: | PA.2001 |
| Title: | **Interdisciplinary Team (IDT) & Participant Assessments** |
| Department: | CalOptima Health PACE |
| Section: | Not Applicable |
| *CEO Approval:* | */s/ Michael Hunn 10/31/2024* |
| Effective Date: | 10/01/2013 |
| Revised Date: | 01/01/2025 |
| Applicable to: | ☐ Medi-Cal<br>☐ OneCare<br>☒ PACE<br>☐ Administrative |

## I. PURPOSE

This policy outlines the components of the CalOptima Health 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 CalOptima Health PACE IDT is the core clinical decision-making body of CalOptima Health PACE and serves as the authorizing agent for services offered by CalOptima Health PACE. The IDT is responsible for the assessment, development, implementation, and evaluation of the treatment plan of each Participant who is enrolled in CalOptima Health PACE.

C. Responsibilties of the IDT for each Participant:

1. The Initial Comprehensive Assessment (ICA), periodic reassessments, and Plan of Care.

2. Coordination and implementation of twenty-four (24) hour care delivery that meets Participant needs across all care settings, including but not limited to the following:

   a. Ordering, approving, or authorizing all necessary care;

   b. Communicating all necessary care and relevant instructions for care;

   c. Ensuring care is implemented as ordered, approved, or authorized by the IDT;

   d. Monitoring and evaluating the Participant's condition to ensure that the care provided is effective and meets the Participant's needs; and

   e. Promptly modifying care when the IDT determines the Participant's needs are not met in order to provide safe, appropriate, and effective care to the Participant.

3. Documenting all recommendations for care or services and the reason(s) for not approving or providing recommended care or services, if applicable.

4. The IDT must review, assess, and act on recommendations from emergency or urgent care providers, employees, and contractors, including medical specialists. Specifically, the IDT must ensure the following requirements are met:

    a. The appropriate member(s) of the IDT must review all recommendations from hospitals, emergency departments, and urgent care providers and determine if the recommended services are necessary to meet the participant's medical, physical, social, or emotional needs as expeditiously as the Participant's health condition requires, but no later than forty-eight (48) hours from the time of the Participant's discharge.

    b. The appropriate member(s) of the IDT must review all recommendations from other employees and contractors and determine if the recommended services are necessary to meet the participant's medical, physical, social, or emotional needs as expeditiously as the Participant's health condition requires, but no later than seven (7) calendar days from the date the recommendation was made.

    c. If recommendations are authorized or approved by the IDT or a member of the IDT, the services must be promptly arranged and furnished.

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' Plan of Care, as outlined in this policy.

E. IDT and PACE case manager will coordinate care with any out of network providers to support Participants care.

F. At a minimum each IDT shall consist of:

1. Primary Care Provider;
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. Transportation Services/Representative.

G. Primary medical care shall be furnished to Participants by a PACE Primary Care Provider.

1. Each Primary Care Provider shall be responsible for the following:

    a. Managing a Participants' medical conditions; and

    b. Overseeing a Participant's use of medical specialists and inpatient care.

## III. PROCEDURE

A. Level of Care Presentation for Enrollment

1. The PACE Nurse shall evaluate potential Participants and determine eligibility, and if there is a need for additional support from the IDT to assess further for areas that may require additional support. The IDT member assigned to assess potential Participants will make the following decisions regarding the case:

    a. Confirm the prospective Participant is safe in the community with the support of CalOptima Health PACE.

        i. If the team denies the enrollment based on safety, the case is referred back to the Intake Coordinator with reasons detailed.

        ii. If the team does not have enough information, it will be assigned back to the Enrollment Coordinator to assist with gathering information (i.e., medical records).

    b. Assign a PACE Primary Care Provider and social worker.

    c. Assign preliminary days of attendance.

    d. Identify a Tuberculosis clearance plan for day center attendance.

    e. Prioritize IDT assessments based on the presenting high risk needs of the Participant.

B. Initial Assessments and Plans of Care

1. The Initial Comprehensive Assessment (ICA) shall be thorough, as it is the basis for the development of the treatment plan.

2. Initial Assessments and Plan of Care shall be completed and developed by the IDT within 30 days of enrollment, in accordance with this Policy and CalOptima Health Policy PA.2002: Care Planning.

3. As part of the ICA, each of the following members of the IDT must individually evaluate the new Participant in-person, and develop a discipline-specific assessment of the Participant's health and social status:

    a. Primary Care Provider;

    b. Registered nurse;

    c. Master level social worker;

    d. Physical therapist;

    e. Occupational therapist;

f. Recreational therapist or activity coordinator;

g. Dietitian; and

h. Home care coordinator.

4. Other disciplines may participate in the ICA, at the recommendation of individual IDT members, if the Participant's needs warrant their inclusion.

5. 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.

6. Initial Assessments and Plan of Care are completed by the IDT within 30 days of enrollment and reassessments completed at subsequent intervals assigned by the IDT that are consistent with regulatory requirements. Goals and objectives for care planning are based on five (5) core areas of care: the Participant's medical, functional, emotional, social, and cognitive status that impact the care needs identified by the IDT.

7. The PACE Center Manager shall facilitate the IDT to consolidate discipline-specific assessments into a single Plan of Care for each Participant through discussion in team meetings and eventual consensus of the entire IDT.

8. The IDT shall document interim care management strategies for the time period from when a Participant enrolls, to when the Plan of Care is finalized in discipline-specific progress notes in the Participant's medical record.

9. Once a Plan of Care is developed by the IDT during a scheduled IDT meeting, it is reviewed and approved by the Participant or designated Representative. If the Participant or Representative does not approve of the Plan of Care, CalOptima Health PACE shall inform the Participant or Representative of the appeal process.

C. 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 one-hundred eighty (180) calendar days in accordance with CalOptima Health Policy PA.2002: Care Planning:

    a. Primary Care Provider;

    b. Registered nurse;

    c. Master's level social worker; and

    d. 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;

    b. Nutritionist; and

    c. Home care coordinator.

D. Unscheduled Reassessments

1. In addition to annual and semiannual reassessments, unscheduled reassessments may be required as follows:

    a. If there is a Significant Change in the Participant's status in any of the five (5) categories of care that involves two (2) or more disciplines, the pertinent IDT members must reassess the Participant within five (5) business days. Also, if necessary, 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. The following disciplines shall conduct an unscheduled in-person reassessment when a participant has a significant change of condition:

        i. Primary Care Provider;

        ii. Registered Nurse;

        iii. Master's Level Social Worker; and

        iv. Other IDT members may be asked to be involved in the development or implementation of the Participants Plan of Care.

    b. If a Participant, or designated Representative, believes that the Participant needs to initiate, eliminate, or continue a particular service, the Participant or designated representative may initiate a Service Determination Request (SDR), in accordance with CalOptima Health Policy PA.2022: Service Determination Requests (SDR). The appropriate members of the IDT, as identified by the IDT, must conduct an in-person assessment. However, the interdisciplinary team members may conduct the reassessment via remote technology when the IDT determines the use of remote technology appropriate and that the service request will likely be deemed necessary to improve or maintain the Participant's overall health. The

Participant or designated representative must agree to the use of remote technology. An in person reassessment must be conducted when the participant or designated representative declines the use of remote technology.

i. The IDT must notify the Participant or designated Representative of its decision to approve, or deny, the request from the Participant or designated Representative as expeditiously as the Participant's condition requires, but no later than seventy-two (72) hours after the date the IDT receives the request for reassessment.

ii. The IDT may extend the seventy-two (72) hour timeframe for notifying the Participant or designated Representative of its decision to approve, or deny, the request by no more than five (5) additional calendar days for either of the following reasons:

a) The Participant or designated Representative requests the extension.

b) The IDT documents its need for additional information, and how the delay is in the interest of the Participant.

iii. The IDT must explain any denial of a SDR to the Participant, or the Participant's designated Representative, orally and in writing, and must provide:

a) A Notice of Action (NOA) will be given to the Participant or designated Representative outlining the specific reasons for the denial of services presented in a language and format appropriate for the Participant;

b) Information to the Participant or designated Representative of their right to appeal the decision;

c) A description of both the standard and expedited appeals processes, including the right to, and conditions for, obtaining expedited consideration of an appeal of a denial of services; and

d) An explanation of the right to, and conditions for, continuation of appealed services through the period of an appeal.

iv. If the IDT fails to provide the Participant with timely notice of the resolution of the request or does not furnish the services required by the revised Plan of Care this failure constitutes an "adverse decision", and the Participant's request must be processed as an Appeal, in accordance with CalOptima Health Policy PA.7002: Appeal Process.

v. IDT members who conduct a reassessment must re-evaluate the Participant's Plan Of Care, discuss any changes in the Plan of Care with the IDT, obtain approval of the revised Plan of Care from the IDT and the Participant, or designated Representative, and furnish any services included in the revised Plan of Care to the Participant as necessary as the Participant's health condition requires.

vi. IDT members shall document all assessment and reassessment information in the Participant's medical record.

E. Initial and Assessment Meetings (I&A)

1. I&A meetings, also referred to as "Care Planning," are held on scheduled days throughout the month or more often if necessary, to conduct initial assessments, scheduled reassessments, and unscheduled reassessment care planning sessions. The CalOptima Health PACE Center

Manager shall coordinate the meeting and send a monthly schedule to the IDT. The CalOptima Health 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;

e. Prepare the IDT meeting agenda with an established order for presentation by disciplines; and

f. Receive requests from Participants and/or designated Representatives for services, such as day center attendance or in-home service hours.

2. CalOptima Health PACE agenda scheduling is prioritized following employee discussions regarding Participants who require updating, initial assessments, and reassessments. If time precludes full discussion of all individuals, the CalOptima Health PACE Center Manager shall summarize those with minimal changes.

3. The Care Planning Meeting must include, at a minimum, the following disciplines for reporting:

a. Primary Care Provider;

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).

4. CalOptima Health PACE shall document recommendations and/or changes in the Plan of Care and maintain and incorporate such recommendations in the respective Participant's medical records.

F. Center-Based Team Meetings:

1. The CalOptima Health PACE IDT shall meet regularly to support Participants care needs and resources:

a. Center Manager;

b. Registered Nurse;

c. Master's level Social Worker;

d. Recreational Therapist;

e. Home Care Coordinator;

f. Primary Care Provider

g. Physical Therapist;

h. Occupational Therapist;

i. Personal care representative;

j. Transportation employee (or report); and

k. Dietitian.

2. In the absence of one of the IDT members, one individual may fulfil two separate roles as long as the individual meets applicable state licensure requirements and is qualified to fill the two roles and able to provide appropriate care to meet Participant needs. All eleven (11) IDT roles will continue to be represented at IDT meetings.

3. The CalOptima Health PACE Center Manager shall coordinate and facilitate meetings.

4. 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 and services provided as part of Participant care plans to ensure 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);

   d. End of life care planning;

   e. Fall reports;

   f. New wounds; and

   g. Action items – delegation and follow-up.

5. 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 CalOptima Health PACE Center Manager or their designee, and to follow-up on any action items accordingly.

## IV. ATTACHMENT(S)

Not Applicable

## V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for PACE
B. CalOptima Health PACE Program Agreement
C. California Department of Health Care Services (DHCS) Nursing Facility Services Level of Care Determination Tool
D. CalOptima Health Policy PA.2002: Care Planning
E. CalOptima Health Policy PA.2022: Service Determination Requests (SDR)
F. CalOptima Health Policy PA.7002: Appeal Process
G. Centers for Medicare and Medicaid Services (CMS) Programs of All-Inclusive Care for the Elderly Manual
H. Centers for Medicare and Medicaid Services (CMS) Programs of All-Inclusive Care for the Elderly Manual, Chapter 8, Revised 06/09/2011.
I. Desk Reference Assessment & Reassessment Schedule
J. Title 42, Code of Federal Regulations (CFR), §§460.98, 460.102, 460.104, and 460.106

## VI. REGULATORY AGENCY APPROVAL(S)

| Date | Regulatory Agency | Response |
|---|---|---|
| 03/30/2017 | Centers for Medicare & Medicaid Services (CMS) | Approved as Submitted |

## VII. BOARD ACTION(S)

None to Date

## VIII. REVISION HISTORY

| Action | Date | Policy | Policy Title | Program(s) |
|---|---|---|---|---|
| Effective | 10/01/2013 | PA.2001 | Interdisciplinary Team (IDT) & Participant Assessments | PACE |
| Revised | 10/01/2014 | PA.2001 | Interdisciplinary Team (IDT) & Participant Assessments | PACE |
| Revised | 01/01/2015 | PA.2001 | Interdisciplinary Team (IDT) & Participant Assessments | PACE |
| Revised | 02/01/2016 | PA.2001 | Interdisciplinary Team (IDT) & Participant Assessments | PACE |
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| Revised | 07/01/2018 | PA.2001 | Interdisciplinary Team (IDT) & Participant Assessments | PACE |
| Revised | 03/01/2019 | PA.2001 | Interdisciplinary Team (IDT) & Participant Assessments | PACE |
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| Action | Date | Policy | Policy Title | Program(s) |
|---|---|---|---|---|
| Revised | 04/01/2023 | PA.2001 | Interdisciplinary Team (IDT) & Participant Assessments | PACE |
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| Revised | 01/01/2025 | PA.2001 | Interdisciplinary Team (IDT) & Participant Assessments | PACE |

## IX. GLOSSARY

| Term | Definition |
|---|---|
| Initial Comprehensive Assessment (ICA) | As defined in Title 42, Section 460.104 of the Code of Federal Regulations, a comprehensive multi-discipline assessment conducted on each participant's health and social status to which is consolidated into a single plan of care. |
| Interdisciplinary Team (IDT) | A team composed of members qualified to fill, at minimum, the following roles, in accordance with 42 CFR 460.102. One individual may fill two separate roles on the interdisciplinary team where the individual meets applicable state licensure requirements and is qualified to fill the two roles and able to provide appropriate care to meet the needs of Participants:<br><br>1. Primary Care Provider; Primary medical care must be furnished to a Participant by any of the following<br>a. A primary care physician.<br>b. A community-based physician.<br>c. A physician assistant who is licensed in the State and practices within their scope of practice as defined by State laws with regard to oversight, practice authority and prescriptive authority.<br>d. A nurse practitioner who is licensed in the State and practices within their scope of practice as defined by State laws with regard to oversight, practice authority and prescriptive authority.<br>2. Registered Nurse;<br>3. Master's – level Social Worker;<br>4. Physical Therapist;<br>5. Occupational Therapist;<br>6. Recreational Therapist or Activity Coordinator;<br>7. Dietician;<br>8. PACE Center Manager;<br>9. Home Care Coordinator;<br>10. Personal Care Attendant or their representative; and<br>11. Driver or their representative |
| Participant | An individual enrolled in the CalOptima Health PACE program. |
| Plan of Care | As defined in Title 42, section 460.106 of the Code of Federal Regulations, a comprehensive care plan developed by the interdisciplinary team for each Participant to identify the care needed to meet the medical, physical, emotional, and social needs of the participant, as identified in the initial comprehensive assessment. |
| Primary Care Provider (PCP) | A provider responsible for supervising, coordinating, and providing initial and Primary Care to Participants; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner. |
| Program of All-Inclusive Care for the Elderly (PACE) | PACE is a long-term comprehensive health care program that helps older adults to remain as independent as possible. PACE coordinates and provides all needed preventive, primary, acute and long-term care services so seniors can continue living in their community. |
| Representative | A person who is acting on behalf of or assisting a participant, and may include, but is not limited to, a family member, a friend, a CalOptima Health PACE employee, or a person legally identified in a Power of Attorney for Health Care/Advanced Directive, Conservator, Guardian, etc. |

| Term | Definition |
|---|---|
| Service Delivery Request (SDR) | A request to initiate a service; a request to modify an existing service, including to increase, reduce, eliminate, or otherwise change a service. The SDR can also be defined as a request to continue coverage of a service that the PACE Interdisciplinary Team (IDT) recommends be discontinued or reduced. |
| Significant Change | For the purposes of this policy, means a major decline or improvement in the Participant's status that will not normally resolve itself without further intervention by employees 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. |