PACE in Rural Areas:

A Curriculum Development Guide for Training Health Professionals in Interdisciplinary Geriatric Care

U.S. Department of Health and Human Services • Health Resources and Services Administration

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Health Resources and Services Administration

Spring 2007

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Resources:

This curriculum development guide was prepared for the Rural PACE Technical Assistance Program funded by the Health Resources and Services Administration under contract 250-03-0018.

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Background

Since 1983, Programs of All-inclusive Care for the Elderly (PACE) have offered a comprehensive, community-based long term care option to frail older adults. PACE programs help those they serve to live as independently as possible, maintaining them in their own homes and communities. The model began in San Francisco as an effort to support Chinese-American families looking to avoid placing their elderly relatives in nursing homes. It accomplished this goal by offering a comprehensive set of services including medical care, physical and occupational therapy, nutrition, transportation, respite care, and socialization that kept people happier and healthier. It also created a way to pay for this care using Federal, State, and private funds that are pooled at the program level, allowing maximum flexibility, effectiveness, and even cost-savings.

The innovative design of the PACE approach and the success it has had in keeping hospitalizations and nursing home admittance at a minimum prompted its replication around the country. After a national demonstration program which began in 1986, Congress authorized permanent provider status for PACE programs in 1997. Today, there are 35 PACE programs operating in 19 States, all of which are in predominantly urban settings.

Rural communities and rural elders could also benefit from PACE programs. One-fifth of the Nation's elderly live in rural areas and the need for PACE in rural communities is in some ways greater than in urban America. Compared to their urban counterparts, rural elders:

- report worse health status;
- are generally older;
- have more functional limitations;

- are more likely to live alone at age 75 and older;
- are more likely to be poor or near poor; and
- are at greater risk of nursing home placement.

While many rural areas lack the full range of long term care services that their frail older residents require, PACE can help meet some of this need. In addition to offering a community-based model of care, by serving as health professions training sites PACE programs can help address the scarcity of providers in rural areas, particularly providers with geriatric expertise.

The PACE model's inherently interdisciplinary approach to care is likely to be a good fit for rural areas. The challenges all rural health providers face, including large service area distances, low population density, limited access to services and a scarcity of providers, has in many cases fostered a less hierarchical and more collaborative approach to care across disciplines. This presents a fertile environment in which to teach interdisciplinary care. Advances in telehealth and electronic communications now also make it increasingly feasible to establish effective interdisciplinary teams in rural areas in spite of the large distances that may separate team members from one another and from those in their care.

A Flexible Blueprint

Bringing PACE to rural America will require creativity and flexibility on the part of providers, regulators and policymakers. Because rural communities differ from urban areas in some very important aspects, rural PACE programs will likewise differ from urban programs. One size will not fit all in rural settings any more than in urban ones. Successful PACE programs are tailored to meet individual community needs rather than pulled from a rack, ready to wear.

With that said, there are five core elements of PACE that, according to the Centers for Medicare and Medicaid Services (CMS), must be maintained:

- **Serve the frail elderly**: participants in PACE programs must be 55 or older and nursing-home eligible;
- **Provide a comprehensive set of services**: PACE participants must receive a coordinated and integrated range of preventive, acute and long term care services;
- **Use an interdisciplinary team of service providers**: PACE participants' care must be provided and managed by a team of providers ranging from primary care physicians and nutritionists to physical and occupational therapists;
- **Accept capitated payment**: PACE providers receive a capitated rate that pools payment from Medicare, Medicaid and private sources; and
- **Assume full financial risk**: PACE providers must pay for all required services without compensation beyond the capitated rate; there are no benefit limitations, co-payments or deductibles.

While these core elements must be maintained for any PACE model, mechanisms exist to provide rural PACE programs the flexibility they will need to succeed in their individual contexts.

The Opportunity for Interdisciplinary Training

In October, 2003, the Health Resources and Services Administration funded the Rural PACE Technical Assistance Program (RP-TAP) which is operated by the National PACE Association. The RP-TAP assists 21 sites as they seek to assess the viability of a PACE program for the communities they serve and to identify strategies for developing an operational rural PACE program. Recently, the Centers for Medicare and Medicaid Services awarded 15 rural PACE development grants of $500,000 each. For a listing of these sites please see the section titled "Rural PACE Grant Sites" at the end of the guide. Within the next 2 years, the development of the 15 rural grantee sites will present a real opportunity to train interdisciplinary, geriatric teams in a PACE setting.

The goal of developing health professions training sites at future rural PACE programs was to utilize the inherently interdisciplinary care model of PACE as a platform to teach interdisciplinary geriatric care and address the sites' workforce needs. This goal responds to one of the most significant challenges rural PACE providers will face – the need for health professionals who know how to operate in an interdisciplinary care planning, decision-making, and care delivery system. By supporting rural PACE providers as educational settings, a rural PACE curriculum can help to generate more, and better trained, health professional staff. Beyond the limited number of health professionals who train and go on to work at a PACE program, developing rural PACE programs as educational sites will support the training of health professionals that know how to integrate care for frail elders. This knowledge and skill has significant promise to improve care of the elderly across a wide range of practice settings.

Rural Interdisciplinary Care Training Considerations

Rural health care providers and health professionals are challenged by the dispersed populations they serve, limited access to services, and already strained resources. To overcome these challenges, rural PACE programs will rely on interdisciplinary teams that can span large distances, multiple communities, and numerous partner organizations. A curriculum that will provide training to health professionals will need to reflect the changes in the PACE model required to adapt it to rural areas. For example:

- Care delivery experience across a range of settings and partner organizations will be needed in rural PACE programs. The training program will need to address how these experiences are coordinated and proctored.
- Interdisciplinary team members will likely be dispersed across a large service area. The curriculum will need to model effective communication, problem solving and decision making processes for the interdisciplinary team that overcomes these distances.

- Interdisciplinary team members will contribute needs assessment and care planning information from multiple locations. The curriculum will need to address the coordination and exchange of this information.
- Interactive distance learning and use of remote health technologies will likely play a greater role in rural PACE programs. Curriculum designers will need to ensure these technologies are available to provide experience in applying them to the development and implementation of effective care plans.

Developing a Curriculum for Health Professionals at a PACE Setting

The model training curriculum outline which follows provides educators and rural PACE organizations with learning objectives and modules for training a range of health professionals in the fundamentals of interdisciplinary geriatric care. The outline is designed to be flexible and adaptable to accommodate the learning objectives of a range of disciplines at varied levels of experience and professional development. The outline's design reflects the expectation that health professions educators and rural PACE providers will collaborate on its implementation. Working collaboratively, educators and rural PACE providers will need to refine the learning objectives to ensure their appropriateness. Implementing the curriculum outline also requires development of the educational content and approach of each module. To assist educators and rural PACE providers, the curriculum outline provides an attached list of resources related to the outlined learning modules. Many of these resources are available to the public for little or no cost.

It should be noted that while the original target audience for this curriculum is students in training in various health professions who do a portion of their clinical experience in a PACE site (particularly as rural PACE sites currently in development become increasingly available), the materials are easily adaptable for use with those planning to work in other than PACE sites (e.g., assisted living facilities). Similarly, the materials can be applied to additional disciplines not directly addressed in this curriculum (e.g., pharmacists) and also to those at various stages in their professional development, training, and work experience, including in-service education. Geriatric Education Centers (GECs) and Area Health Education Centers (AHECs) are other potential users of this information.

LEARNING OBJECTIVES

The learning objectives of the Interdisciplinary Curriculum for PACE are to provide students with the knowledge, skills and attitudes necessary to:

- work with interdisciplinary teams and within a managed care structure,
- understand the need for and importance of interdisciplinary teams; and
- provide quality care for nursing home eligible elderly who wish to remain in the community.

LEARNING APPROACH

The curriculum learning approach combines didactic and experiential learning modules. The didactic modules provide students with a background in interdisciplinary geriatric care and the PACE program. The experiential modules are designed to provide students with the opportunity to work as part of an interdisciplinary team with a home and community based frail elder population. The experiential modules are designed to be based at a Program of All-Inclusive Care for the Elderly (PACE), though, as noted above, other care settings may offer opportunities for similar experiences. For the experiential modules, each student will be assigned a preceptor. The didactic and experiential modules can be completed by interdisciplinary class groups, single discipline class groups, or through individual study.

DIDACTIC LEARNING MODULES

The following didactic learning modules are sequential and are a prerequisite for the experiential modules:

Didactic Module 1: **An Overview of Interdisciplinary Approaches to Geriatric Care**

This module will review interdisciplinary approaches to geriatric care that are in practice across a range of settings and payment plans. Particular consideration will be given to the population served, the differences and similarities of interdisciplinary team composition and functions, and the impact of regulatory and financial requirements on team composition and process. Students will assess the effectiveness of different alternatives and the common attributes of successful interdisciplinary team approaches to geriatric care.

Didactic Module 2: **PACE as a Model of Interdisciplinary Geriatric Care**

This module will present the Program of All-Inclusive Care for the Elderly and the role of its interdisciplinary team. Students will learn what population PACE serves, how PACE programs vary in their service delivery design and operations, and how these variations relate to the functions of the interdisciplinary team and roles of the team's members.

Didactic Module 3: **Effective PACE Interdisciplinary Teams**

This module will examine how PACE interdisciplinary team characteristics and PACE program design relate to overall effectiveness. Students will identify the attributes of an effective PACE team, an effective interdisciplinary team member, and an effective organization that is able to implement the team's care planning decisions. Students will also consider how each discipline contributes to the overall effectiveness of the team and the PACE program.

EXPERIENTIAL LEARNING MODULES

The experiential modules allow the student to participate in providing care to a PACE participant across a range of settings, in interdisciplinary team decision-making, and in communicating with participants regarding their care needs and care plans.

Experiential Module 1: **Discipline Appropriate Participant Care**

This module will provide the student with experience in providing discipline-appropriate care across a range of care settings used by the PACE program, including: the PACE Center, the participant's home, and an institutional long term care setting (nursing home, assisted living). If relevant for the discipline, the student may also participate in providing care in a hospital setting.

Experiential Module 2: **Participation in Interdisciplinary Team Meetings**

This module will allow the student to participate in PACE interdisciplinary team meetings that address: intake of a new PACE participant, initial needs assessment and care planning, problem-solving to address a change in health status and care needs, problem solving to address participant or caregiver requests for care, and allocation of scarce program resources to meet all participants care needs.

Experiential Module 3: **Participant and Caregiver Needs Communication**

This module will engage the student in working with PACE participants and their informal and formal caregivers to discuss and identify care needs, develop and implement care plans, and monitor transitions in health status and care settings.

CURRICULUM WORK PRODUCT

Completion of the didactic learning modules will be assessed based on the students' development and submittal of short essays addressing each module's topic. Completion of the experiential learning modules can be assessed based on a weekly journal maintained by the student and reviewed by the preceptor, a self-evaluation completed by the student and discussed with the preceptor, and the practice of safe and effective care of PACE participants under the supervision of the student's preceptor.

Using this Guide

This guide was developed to assist rural PACE providers and their academic partners in designing and implementing an interdisciplinary training program that reflects their specific needs, communities and resources. Resources available to support you in adapting the guide are summarized in the next section. This summary is followed by sections for collecting materials related to each of the didactic and experiential modules. Copies of some of the materials identified in the resource summary are provided in the corresponding module sections. As you develop your curriculum, you can use these sections to add your own resources and materials.

Acknowledgements

The Rural PACE Technical Assistance Program gratefully acknowledges the following individuals for their contributions to the development of this curriculum:

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Curriculum Resources Available for Modules

Curriculum Administration and Planning

1. Sample Course Schedule for 8-week Multidisciplinary Class – **Attachment 1**
2. Trainee Evaluation Form – **Attachment 2**

Didactic Module 1: An Overview of Interdisciplinary Approaches to Geriatric Care

1. Topic 1: Teams and Teamwork, The Geriatric Interdisciplinary Team Training (GITT) program, GITT Resource Center, New York University, College of Nursing, *www.gitt.org*
2. Interdisciplinary Teamwork, Journal of Medical Ethics, Vol. 2, Issue 2 52-57, Copyright © 1976 by Institute of Medical Ethics. Description: A group of consultants of different disciplines working as a close-knit team is not a new idea in Britain, but including the patient or client in that team is a new concept when constructing an interdisciplinary team. Some of the lessons learned in working in interdisciplinary teams may have been tacitly understood in the past but in this paper Dr. De Wachter expands and illustrates the philosophy behind interdisciplinary teamwork. He explains how communication grows into "another language" and how those of disparate disciplines become one in their thinking when solving a problem together. There is an ethic of teamwork, too, which is elucidated in this paper, especially in relation to the pitfalls of power and shared responsibility. A number of case histories illustrate the argument.
3. Medicare Reimbursement for Collaborative Care – **Attachment 3**
4. Case Studies and Experiential Exercises, two workbooks with accompanying videos, from the UNC/Chapel Hill Program on AGING (produced for the John A. Hartford Rural GITT grant)

Didactic Module 2: PACE as Model of Interdisciplinary Geriatric Care

1. Lee, W, Eng, C, Fox N, Etienne M. PACE: a model for integrated care of frail older patients. Geriatrics, 1998 Jun;53(6):62, 65-6, 69, 73; quiz 74. Available at *www.pubmed.gov*.
2. Eng, C., Pedulla J., Eleazer GP, McCann R, Fox N. Program of All-Inclusive Care for the Elderly (PACE): an innovative model of integrated geriatric care and financing. Journal of American Geriatrics Society, 1997 Feb; 45(2):223-32. Available at *www.pubmed.gov*.

Didactic Module 3: Effective PACE Interdisciplinary Teams

1. Mukamel, Dana et al. Team Performance and Risk-Adjusted Health Outcomes in the Program of All-Inclusive Care for the Elderly (PACE). The Gerontologist, Vol. 46, No. 2, 227-237, 2006.

Experiential Module 1: Discipline Appropriate Participant Care

1. Interdisciplinary Care of the Elderly: Concordia Care–Cleveland's PACE site. A resident training outline developed by the PACE program in Cleveland, Ohio – **Attachment 4**

Experiential Module 2: Participation in Interdisciplinary Team Meetings

1. Topic 2: Team Member Roles and Responsibilities, The Geriatric Interdisciplinary Team Training (GITT) program, GITT Resource Center, New York University, The Steinhardt School of Education, Division of Nursing, 212/998-5562 or *www.gitt.org*.
2. What Are the Functions of Each Discipline – **Attachment 5**
3. What Makes An Effective Team – **Attachment 6**
4. Experience of Each Discipline – **Attachment 7**
5. 12 Case Modules: Healthy Aging in the Southwest. Developed by Dr. Lynn Bickley, Dr. Betsy Jones. (Texas Tech School of Medicine, Texas Tech University HSC). These 12 Problem Based Learning tools (PBLs) reinforce positive attitudes toward aging, knowledge of related issues of health and disease, and skills in geriatric assessment. Students explore each PBL in groups of 10, guided by a team of faculty from basic science, clinical medicine, or an interdisciplinary school (allied health, nursing, pharm). Small group meets twice: first to discuss the case and identify issues for further study, then to report on literature searches. Problem-solving requires synthesis of basic science and clinical medicine. Available at *www.pogoe.org*.
6. *Interdisciplinary Geriatric Assessment: Mr. Ames*, Center for Interdisciplinary Geriatric Assessment, School of Health Professions and School of Medicine, University of Missouri, Columbia, *www.vhct.org/CIGA_Ames/index.shtm*.
7. Interdisciplinary Geriatric Assessment Form, Certification in Interdisciplinary Geriatric Assessment Program (CIGAP), School of Health Professions, University of Missouri-Columbia, last revised 2004. See Web site *www.muciga.org*.
8. "Principles of Successful Teamwork," pp. 8 – 12, in Topic 1: Teams and Teamwork, The Geriatric Interdisciplinary Team Training (GITT) program, GITT Resource Center, New York University, The Steinhardt School of Education, Division of Nursing, 212/998-5562 or *www.gitt.org*.
9. "Team Member Roles and Responsibilities," pp. 82 – 114, in Topic 1: Teams and Teamwork, The Geriatric Interdisciplinary Team Training (GITT) program, GITT Resource Center, New York University, The Steinhardt School of Education, Division of Nursing, 212/998-5562 or *www.gitt.org*.
10. Upham's Elder Service Plan (ESP), a PACE program, Interdisciplinary Team Meetings – **Attachment 8**
11. Ethical Patient Care: A Casebook for Geriatric Health Care Teams, ed.s Mathy D. Mezey, Christine K. Cassel, Melissa M. Bottrell, Kathryn Hyer, Judith L. Howell, Terry T. Fulmer; Johns Hopkins University Press, 2002.

Experiential Module 3: Participant and Caregiver Needs Communication

1. Performance-Based Assessment of Communication Skills, developed by Dr. Louise Arnold, University of Missouri-Kansas City School of Medicine, and Carolyn K. Shue, Ball State University. A Performance Based Assessment (PBA) tool used to evaluate medical students' ability to prepare and execute an abbreviated life history interview. The students conduct an interview with a senior volunteer. The senior volunteer evaluates the students' communication behavior providing feedback regarding their strengths and areas in need of improvement. Available at the POGOe Web site, *www.pogoe.org*.

2. Using Brief Clinical Life Review with Medical Students, developed by Dr. Kay McFarland, Dr. Donna Rhoades, Dr. Ellen Roberts, University of South Carolina. Communication greatly influences satisfaction with health care. Patient or client-centered encounters improve both patient and health care provider satisfaction. Brief clinical life review provides a humanistic approach to interviewing, which enables health care providers to learn about clients' values and beliefs, which significantly affect their health behaviors and outcomes. The life review interview helps the health care provider see the patient as a whole person within a psychosocial and spiritual context. We teach brief clinical life review as a way to center attention on the patient's perspective and encourage the listening part of communication. Available at the POGOe Web site, *www.pogoe.org*.

Attachment 1: Sample Schedule

Week 1	**Instructive Classroom Training with workshops and participatory Seminars**
Week 2	**Instructive Classroom Training on PACE, Interdisciplinary Teams, and what to expect during the Clinical Rotation at the PACE program**
Week 3	**First week participating as a member of an Interdisciplinary Team**
Week 4	**IDT, Meetings with Patient and Caregivers, Patient visits at Home and at PACE Site, Care planning, Care documentation, Instructive Training**
Week 5	**IDT, Meetings with Patient and Caregivers, Patient visits at Home and at PACE Site, Care planning, Care documentation, Instructive Training**
Week 6	**IDT, Meetings with Patient and Caregivers, Patient visits at Home and at PACE Site, Care planning, Care documentation, Instructive Training**
Week 7	**IDT, Meetings with Patient and Caregivers, Patient visits at Home and at PACE Site, Care planning, Care documentation, Instructive Training**
Week 8	**Completion of Health Professions Training in an Interdisciplinary Team setting. All Work Products are due.**

Attachment 2: Trainee Rotation Performance Evaluation {Name of PACE Program}

Trainee: _____

Affiliation: _____

Date of Rotation: _____

Preceptor: _____

[continued on next page]

Trainee Rotation Performance Evaluation

{Name of PACE Program}

1. Please rank the following on a scale of 1 to 5:

   Evaluation: 1 = Excellent; 2 = Good; 3 = Average; 4 = Poor; 5 = Not able to evaluate

   _____Attendance
   _____Initiative
   _____Self-direction
   _____Interaction with staff
   _____Interaction with participants
   _____Understanding of team care concept
   _____Presentation
   _____Ability to function effectively with members of the health care team
   _____Participation during team meetings
   _____Thorough home care visits
   _____Documentation of Care Plan
   _____Completion of patient documentation
   _____Overall safety skills
   _____Clinical skills overall
   _____Overall rating

2. Comments:

   Strengths:_____
   _____
   _____
   _____
   _____

   Weaknesses: _____
   _____
   _____
   _____
   _____

   Areas for Improvement: _____
   _____
   _____
   _____
   _____

   Additional Comments: _____
   _____
   _____
   _____
   _____

Signature of Preceptor/Date: _____

Attachment 3: Medicare Reimbursement for Collaborative Care

Medicare reimbursement policies are encouraging physician involvement in interacting with other disciplines using the Care Plan Oversight codes. There is also a code for Interdisciplinary conferences that some insurances, including Medicaid, recognize and reimburse. Information and support for those interested in reimbursement options for collaborative care are available from the Family Physician Web site, *www.aafp.org*, and the Tools for Geriatric Practice on the American Geriatrics Society Web site, *www.americangeriatrics.org*. If one can access the My AGS site, for AGS members, there is relevant material for Geriatric Practice Management.

An article that includes a discussion of relevant codes for physician collaboration with other disciplines can be found on the Family Practice Management Web site at *http://www.aafp.org/online/en/home/publications/journals/fpm.html*.

Another area of Medicare support for team collaboration is under the Code 99361. The following excerpt provides information about the most commonly used codes: *http://www.aafp.org/fpm/20060400/coding.html*. The last section addresses the use of the 99361 code:

Q: Can you explain the requirements for billing 99361, "Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient not present)"?

A: This code is for case management services that require the physician to be responsible for direct care of the patient. It also requires that the physician coordinate or supervise other health care services needed by the patient. For example, some Medicaid carriers accept this code for face-to-face case conferences between a physician and health professionals or community agency representatives to coordinate care for children who have been sexually abused. Medicare and other payers that do not accept this code may accept care plan oversight codes for these types of services.

Attachment 4: Interdisciplinary Care of the Elderly: Concordia Care–Cleveland's PACE site

GOALS AND OBJECTIVES:

Educational Purpose:

To provide residents with knowledge, skills, and attitudes necessary to work with interdisciplinary teams and within a managed care structure to provide quality care for nursing home eligible elderly who wish to remain in the community.

Level of Training:

PGY II-III (Elective)

Length of Rotation:

2 or 4 weeks

Principal Teaching Methods:

The objectives for Interdisciplinary care of the elderly will be achieved through bedside teaching, patient care, interdisciplinary team meetings, and interaction with the entire interdisciplinary team along with independent reading. Teaching sites include:

- Concordia Care Day Health Center and Clinic
- Metrohealth Center for skilled nursing care
- Keithley House nursing facility
- Patient homes

Patient Characteristics:

Age: over 55
Gender: male and female
Race: diverse
PCPs: Dr. M. Dietz, MD and Dr. P. Campbell, MD

Educational Content:

Objective 1: History

- Take an appropriate geriatric history including medical, social, cognitive, functional information
- Obtain history from family and team members when appropriate
- Focus ROS to screen for common geriatric conditions

Objective 2: Physical Exam

- Do a thorough general medical exam
- Perform a mini-mental status exam
- Use functional assessment tools

Objective 3: Diagnostic Studies

- Recommend diagnostic studies as appropriate based on age, life expectancy and functional status as well as patient preference.
- Choose diagnostic studies based on patient comfort, cost, and information obtained.

Objective 4: Diseases

- Understand physiology of aging and how it pertains to disease processes
- Understand common geriatric syndromes
  - cognitive impairment
  - incontinence
  - osteoporosis
  - sensory impairment
  - pressure ulcers
  - polypharmacy
  - falls
  - frailty syndrome

Objective 5: Health Policy

- understand Medicaid and Medicare
- describe PACE organizations, philosophies and compare to traditional nursing facility based long term care.
- provide medical care within a managed care structure
- provide care for the elderly utilizing the strengths of an interdisciplinary team

Ancillary Educational Materials:

- Packet to be provided to residents on first day of rotation
- Geriatric Review Syllabus available in library, geriatric department office or at Concordia Care site

Conferences:
Optional-monthly geriatric grand rounds

Evaluation:
Standard ABIM form

Strengths/Limitations:
Strengths: interdisciplinary team approach; demonstration of comprehensive care of the elderly; diverse patient population all at one site; opportunity to participate in broad spectrum of geriatric care from urgent care to geriatric assessment.

Limitation: off site

WHAT RESIDENTS WILL DO AT CONCORDIA CARE:

Interdisciplinary Team Meeting

Daily meeting including physicians, nurses, nurse practitioners, therapists, dieticians, social workers, activities coordinators, drivers, and other team members reviewing significant events that require further attention and creating care plans for new participants, or revising care plans semiannually for current participants

Concordia Clinic

A combination of geriatric urgent care and comprehensive geriatric assessment center

PACE Activities (any combination of the following):

- Home visits with physician or nurse
- Therapy evaluations of new patients, evaluations for DME, evaluations for fall risk
- Intake department review of criteria for admission to program, financing
- Social work department review of geriatric social issues, e.g. elder abuse/neglect, alcoholism, etc.
- Activities department review activities for cognitively impaired and physically disabled persons to prevent further decline
- Nursing home visits for routine and acute care with physician

Readings

Assigned reading about PACE programs as an alternative to nursing home placement

Attachment 5: What are the Functions of an Interdisciplinary Team?

- **Information-sharing**
- **Education for other team members about the content presented**
- **Interdisciplinary problem-solving**
- **Interdisciplinary exchange**
- **Interdisciplinary assessment and care planning**
- **Routine assessment of participants**
- **Review cost/effectiveness of care plans**
- **Prevent duplication of interventions**
- **Assess follow-through of plans**
- **Problem-focused care planning**
- **Documentation of patient care**
- **Compliance with regulatory requirements**
- **Conflict resolution**
- **Ethical review and decision-making**
- **Establishing cultural competence**

Attachment 6: What Makes an Effective Team?

- **Develop team cohesion and trust**
- **Efficient use of limited time**
- **Clear definition of problems, interventions, and goals**
- **Follow-up to previous care plan**
- **Involvement of patients and caregivers**
- **Advance preparation**
- **Use of concise summaries, including recognition of stability**
- **Adherence to schedule**

See also: "Principles of Successful Teamwork," pp. 8 – 12, in Topic 1: Teams and Teamwork, The Geriatric Interdisciplinary Team Training (GITT) program, GITT Resource Center, College of Nursing at the College of Dentistry, New York University, 212/998-5562 or *www.gitt.org*.

Attachment 7: Experiences of Each Discipline

NURSE

- Manages medication administration
- Describes treatments and skin care
- Describes voiding problems
- Describes bowel problems
- Monitors weights, vital signs, blood sugars
- Describes functional status of members being discussed
  - Demonstrate increasing skill in the application of the nursing process
  - Apply the principles of collaboration
  - Analyze the application of nursing process in the care of vulnerable individuals, families, and communities

PHYSICAL THERAPIST

- Describes functional and mobility status
- Defines equipment needs
- Describes safety issues with respect to mobility
- Participates in transitional planning
- Provides modalities for pain management
- Provides exercises to improve physical capacity
- Provides strategies to improve gait and maintain balance

OCCUPATIONAL THERAPIST

- Describes functional (ADL, IADL) status when involved in care
- Describes safety issues with regard to cognitive function
- Defines adaptive device needs
- Describes home setting as observed during home visits
- Describes upper extremity and manual function issues
- Provides caregiver training to assist with/adapt daily activities
- Describes occupational patterns including habits, routines, and meaningful occupations

PHYSICIAN/NURSE PRACTITIONER

- Describes diagnoses and their impact on function
- Describes active medical issues
- Notes medication changes as they affect function
- Describes active psychiatric issues
- Provides updates on hospitalized members
- Shares reports from consultants
- Educates about medical and geriatric problems
- Prescribes medication and other treatment modalities

SOCIAL WORKER

- Establishes personal context for each member
- Describes home situation
- Describes family and caregiver issues
- Describes psychosocial issues
- Manages social issues
  - identifies and facilitates addressing psychosocial issues
  - builds on strengths
- Provides liaison to community caregivers and programs
- Identifies and helps promote development of community programs
- Identifies mental health problems and provides counseling and therapy
- Facilitates support groups for specific medical, mental, health, or social needs
- Facilitates care at end of life

PHARMACIST

- Describes medication history
- Assesses all medications (including prescription, non-prescription, alternative/herbal supplements) for efficacy, safety, drug interactions, adverse effects, and alternatives
- Assists with formulating and implementing drug therapy plans
- Monitors response to drug therapy

Attachment 8: Upham's Elder Service Plan (ESP), a PACE Program, Interdisciplinary Team Meetings

This overview of Team Meetings at Upham's ESP addresses the following topics:

1. Define the goals for Team Meetings
2. Define what each Team member needs to contribute
3. Develop a system for documentation
4. Review what preparation is required for Team Meetings
5. Define the sequence for each Team Meeting review

1. Goals

A. information sharing
B. interdisciplinary exchange
C. routine assessment of members
D. care planning
E. mutual education
F. develop team cohesion and trust
G. review cost/effectiveness of care plans
H. prevent duplication of interventions
I. assess follow-through of plans
J. problem-focused care planning
K. efficient use of limited time
L. documentation to effectively guide care

2. Approach to Team Meetings

A. adherence to schedule
B. clear definition of problems, interventions, and goals
C. follow-up to previous care plan
D. involvement of ESP members and caregivers
E. advance preparation
F. use of concise summaries, including recognition of stability

3. Roles of Team Members

A. Clinical Director
- facilitates meeting
- sets agenda
- manages time during meeting
- reviews and contains costs
- authorizes and orders equipment
- provides clinical overview
- brings agenda to each meeting

B. Social Worker
- establishes personal context for each member
- describes home situation
- describes family and caregiver issues
- describes psychosocial issues (emotional, interpersonal, grief, loss, bereavement)
- manages social issues
- provides liaison to community caregivers
- brings to each meeting
    - social history (detailed on initial and annual reviews; otherwise brief)
    - current home and family situation
    - current psychosocial problems

C. Physical Therapist (PT)
- describes functional and mobility status
- defines equipment needs
- describes safety issues with respect to mobility
- updates Team about PT programs of members
- participates in transitional planning
- educates about PT and equipment
- describes findings from initial assessment
- helps define optimal functional potential
- brings to each meeting
    - updates on PT programs
    - mobility status for each member discussed

D. Occupational Therapist (OT)
- describes functional (ADL, IADL) status when involved in care
- describes safety issues with regard to cognitive function
- defines adaptive device needs
- describes home setting as observed during home visits
- describes upper extremity and manual function issues when involved
- updates Team about OT programs of members
- participates in transitional planning
- educates about OT and equipment
- brings to each meeting
    - updates on OT programs
    - home visit observations
    - functional status for each member discussed

E. Activities Coordinator
- describes members participation in ADHC activities
- shares observations of psychosocial problems in ADHC
- shares observations of physical problems in ADHC
- shares observations of sensory problems in ADHC
- describes members past and present interests
- brings to each meeting
    - Adult Day Health Center (ADHC) observations
    - profiles of members interests

F. Nurse
- manages medication administration
- describes treatments and skin care
- describes voiding problems
- describes bowel problems
- monitors weights, vital signs, blood sugars
- describes functional status of members being discussed
- brings to each meeting
  - medication administration system for each member discussed
  - updates on bowel and bladder programs
  - updates on skin care
  - weights, vital signs, and blood sugars for past quarter
  - functional status for each member discussed

G. Home Care Liaison
- supervises HHA issues
- coordinates care with visiting nurses
- works with families regarding difficult issues
- follows through with home-based care plans
- follows through with home-based equipment
- participates in transitional planning
- provides information on home-based ADL and IADL function and assistance
- describes home setting as observed during home visits
- identifies teaching needs for members
- describes medication adherence at home
- describes service package
- brings to each meeting
  - profile of home-based care for each member discussed

H. Physician/Nurse Practitioner
- describes diagnoses and their impact on function
- describes active medical issues
- notes medication changes as they affect function
- describes active psychiatric issues
- provides updates on hospitalized members
- shares reports from consultants
- educates about medical and geriatric problems
- participates in transitional planning
- brings to each meeting
  - diagnoses and medications
  - updates on hospitalized members
  - profile of active medical, psychiatric, and cognitive issues
  - Superbill for submission of diagnoses

I. Center Manager
- provides overview of ADHC issues
- reviews and schedules ADHC-based consultants
- monitors ADHC attendance and cancellations
- coordinates care plan

- summarizes information on functional status provided by multidisciplinary team
- documents ADL/IADL status
- brings to each meeting
  - updates on ADHC-based issues

J. Health Aide
- describes ADL function in ADHC
- describes Health Aide assistance needs in ADHC
- describes mobility (transfer and ambulation) in ADHC
- reports on how bladder and bowel programs are working in ADHC
- describes feeding and nutritional activity in ADHC
- describes social interactions in ADHC
- brings to each meeting
  - picture of ADHC-based ADL function for clients
  - picture of social interactions in ADHC

4. Documentation

A. use stickers for updates at update meetings
B. review outcomes for old problem list/care plan
C. create new problem list/care plan
D. documentation of sharing care plan with ESP member/caregivers
E. rotate recording responsibilities weekly

5. Preparation for Team Meetings

A. all Team members should prepare discipline-specific information as above
B. agenda will be limited to seven semiannual reviews; initial reviews count as two

6. Sequence of Reviews

A. recorder reads old problem list, including interventions and goals
B. presentations by each Team member
- social worker
- home care liaison
- MD/NP
- RN
- health aides
- OT
- PT
- nutrition
- activities coordinator
- transportation

C. center manager (as needed)
- review old problem list/care plan
- develop new problem list
- open problem solving
- develop new care plan
- recorder reads new care plan, including interventions and goals

7. **Sharing of Care Plan with ESP members and/or caregivers**
   A. Recorder to review Care Plan with ESP member and/or caregivers within 2 weeks
   B. Review can be in person or by phone
   C. Recorder to document that care plan was reviewed
   D. Recorder to bring information about additions or changes to subsequent Team meeting
8. **Food**
   A. recorder brings food

Currently Operating PACE Programs

Alexian Brothers Community Services
3900 S. Grand Blvd.
St. Louis, MO 63118-3414
Phone: (314) 771-5800

Alexian Brothers Community Services
425 Cumberland Street, Suite 110
Chattanooga, TN 37404-1905
Phone: (423) 495-9104

AltaMed Senior BuenaCare
5425 E. Pomona Boulevard
Los Angeles, CA 90022-1716
Phone: (323) 832-7603

Bienvivir Senior Health Services
2300 McKinley Avenue
El Paso, TX 79930-2240
Phone: (915) 562-3444

CareLink, Inc.
225 Chapman Street, Suite 103
Providence, RI 02905-4507
Phone: (401) 490-7610

Center for Elders Independence
510 17th Street, Suite 400
Oakland, CA 94612-1367
Phone: (510) 433-1150

Center for Senior Independence
7800 W. Outer Drive, Suite 240
Detroit, MI 48235-3458
Phone: (313) 653-2222

Community Care
1555 S. Layton Boulevard
Milwaukee, WI 53215-1924
Phone: (414) 385-6600

Community LIFE
2400 Ardmore Boulevard, Suite 700
Pittsburgh, PA 15221-5238
Phone: (412) 436-1341

Comprehensive Care Management
612 Allerton Avenue
Bronx, NY 10467-7404
Phone: (718) 519-5925

Concordia Care
2373 Euclid Heights Boulevard
Cleveland Heights, OH 44106-2705
Phone: (216) 791-3580

Eddy SeniorCare
504 State Street
Schenectady, NY 12305-2414
Phone: (518) 382-3290

Elder Service Plan of Harbor Health Services, Inc.
2216 Dorchester Avenue
Dorchester, MA 02124-5607
Phone: (617) 296-5100

Elder Service Plan of the Cambridge Health Alliance
270 Green Street
Cambridge, MA 02139-3312
Phone: (617) 381-7102

Elder Service Plan of the East Boston Neighborhood Health Center
10 Gove Street
East Boston, MA 02128-1920
Phone: (617) 568-6413

Elder Service Plan of the North Shore, Inc.
20 School Street
Lynn, MA 01901-2952
Phone: (781) 715-6608

Florida PACE Centers, Inc.
5200 NE 2nd Avenue
Miami, FL 33137-2706
Phone: (305) 795-8416

Hopkins ElderPlus
4940 Eastern Avenue
Baltimore, MD 21224-2780
Phone: (410) 550-7044

Independent Living for Seniors
2066 Hudson Avenue
Rochester, NY 14617-4300
Phone: (585) 922-2836

LIFE - Pittsburgh. Inc.
One Parkway Center
875 Greentree Road, Suite 200
Pittsburgh, PA 15220-3508
Phone: (412) 388-8042

LIFE - St. Agnes
1900 South Broad Street
Philadelphia, PA 19145-2304
Phone: (215) 339-4528

LIFE - University of Pennsylvania School of Nursing
4101 Woodland Avenue
Philadelphia, PA 19104-4510
Phone: (215) 898-4417

On Lok Senior Health Services
1333 Bush Street
San Francisco, CA 94109-5691
Phone: (415) 292-8880

PACE CNY
100 Malta Lane N.
Syracuse, NY 13212-2375
Phone: (315) 458-8173

Palmetto SeniorCare
15 Richland Medical Park, Suite 203
Columbia, SC 29203-6843
Phone: (803) 434-3770

Providence ElderPlace - Seattle
4515 Martin Luther King Junior Way S.
Seattle, WA 98108-2174
Phone: (206) 760-6300

Providence ElderPlace in Portland
13007 NE Glisan Street
Portland, OR 97230-2545
Phone: (503) 215-3612

Summit ElderCare
10 Chestnut Street
Worcester, MA 01608-2898
Phone: (508) 368-9437

Sutter SeniorCare
1234 U Street
Sacramento, CA 95818-1433
Phone: (916) 491-3404

The Basics at Jan Werner
3108 S. Fillmore Street
Amarillo, TX 79110-1026
Phone: (806) 374-5516

Total Community Care
904-A Las Lomas NE
Albuquerque, NM 87102-2633
Phone: (505) 924-2606

Total Longterm Care
200 E. 9th Avenue
Denver, CO 80203-2903
Phone: (303) 869-4664

TriHealth SeniorLink
4750 Wesley Avenue, Suite J
Cincinnati, OH 45212-2244
Phone: (513) 458-8801

Upham's Elder Service Plan
1140 Dorchester Avenue
Boston, MA 02125-3305
Phone: (617) 288-0970

Via Christi HOPE, Inc.
3720 East Bayley Street
Wichita, KS 67218-3002
Phone: (316) 946-5202

Rural PACE Grant Sites

State	City	Grantee
Arkansas	Jonesboro	AllCare of Arkansas
Colorado	Grand Junction/Montrose	Volunteers of America
Hawaii	Kahului	Hale Makua
Iowa	Sioux City	Hospice of Siouxland
Montana	Billings	Billings Clinic Foundation
New York	Olean	Community Care of Western New York
North Carolina	Carrboro	Piedmont Health Services
North Dakota	Bismarck	Northland Healthcare Alliance
Pennsylvania	Danville	Geisinger Health System Foundation
Pennsylvania	Chambersburg	Lutheran Social Services of South Central Pennsylvania
South Carolina	Orangeburg	The Methodist Oak
Vermont	Rutland	PACE Vermont
Virginia	Cedar Bluff	Appalachian Agency for Senior Citizens
Virginia	Big Stone Gap	Mountain Empire Older Citizens
West Virginia	Charleston	CAMC Health Ed and Research