# STAFFING AND TRAINING

## Staff Qualifications

Each member of the Program of All-Inclusive Care for the Elderly (PACE) organization's staff that has direct beneficiary contact (employee or contractor) must have a minimum of 1 year experience working with a frail or elderly population and meet the staffing requirements as specified in 42 Code of Federal Regulations (CFR) 460.71. In addition to the staffing requirements the PACE interdisciplinary team (IDT) must also include, but not limited to, the following qualifications:

- Primary care physician (PCP) must meet additional qualifications and conditions, as defined in 42 CFR 410.20;
- Social worker must have a master's degree in social work from an accredited school of social work;
- Dietitian must have a bachelor of science degree or advanced degree from an accredited college with major studies in food and nutrition or dietetics;
- Registered nurse (RN) must be a graduate of a school of professional nursing;
- Physical therapist (PT) must be a graduate of a physical therapy curriculum approved by the American Physical Therapy Association, the Committee on Allied Health Education and Accreditation of the American Medical Association, or the Council on Medical Education of the American Medical Association and the American Physical Therapy Association or other equivalent organizations approved by Centers for Medicare and Medicaid Services (CMS);
- Occupational therapist (OT) must be a graduate of an occupational therapy curriculum accredited jointly by the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Occupational Therapy Association or other approved equivalent organization, be eligible for the National Registration Examination of the American Occupational Therapy Association, have 2 years' experience as an OT and have achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service, except for the proficiency does not apply to

persons initially licensed by a state or seeking initial qualification as an OT therapist after December 31, 1977; and

- Transportation driver must have a valid driver's license to operate a van or bus in the state of operation and have the ability and experience in transporting individuals with special mobility needs.

## Staff Responsibilities

The PACE organization must employ, or contract in accordance with 42 CFR 460.70, the following:

- Program director who is responsible for oversight and administration of the entity; and

- Medical director who is responsible for the delivery of beneficiary care, for clinical outcomes, and the implementation, as well as oversight, of the Quality Assessment and Performance Improvement (QAPI) program.

A PACE organization must comply with 42 CFR 460.102, to establish an 11 member IDT at each PACE center. Each beneficiary must be assigned to an IDT at the PACE center that the beneficiary attends. The IDT is responsible for conducting health assessments, care planning, and coordination of 24 hours care delivery.

The IDT members may be employed or contracted staff. If the PACE organization uses contracted staff they must meet the same personnel requirements and perform the same responsibilities as employed IDT members.

The PACE IDT must include, at a minimum, the following members:

- Primary care physician;

- Registered nurse;

- Physical therapist;

- Occupational therapist;

- Recreational therapist or activity coordinator;

- Masters level social worker;
- Personal care attendant (PCA) or his or her representative;
- Dietitian;
- Transportation driver or his or her representative;
- PACE center supervisor/manager; and
- Home care liaison/coordinator.

Mid-level practitioner(s) may be used to supplement the physician's care to beneficiaries, within the scope of practice authorized by the state, by assisting the physician with the delivery of clinical care. They may participate but must not replace the physician on the IDT or perform beneficiary assessments/reassessments.

The PACE IDT must conduct an initial in-person comprehensive assessment as described in 42 CFR 460.104(a) and periodic in-person reassessments as described in 42 CFR 460.104(c) (d). Beneficiary unscheduled reassessments by the IDT must be completed when there is a significant change in health or psychosocial status and the beneficiary or his/her designated representative believes that the beneficiary needs to initiate, eliminate, or continue a particular service. The IDT members must meet to consolidate the findings into the care plan.

The IDT members that must conduct the initial in-person assessment or an unscheduled reassessment include the primary care physician, registered nurse, master's level social worker, physical therapist, occupational therapist, recreational therapist, dietitian, and home care coordinator. The IDT may identify other healthcare specialists that are required to conduct additional assessments outside of the IDT members' expertise or scope of practice.

The IDT primary care physician, registered nurse, master's level social worker, and recreational therapist/activity coordinator must all conduct periodic health reassessments at least every 6 months and more often if the beneficiary's condition dictates. Other IDT members or specialty practitioners actively involved in the beneficiary's care plan must also be included.

The physical therapist, occupational therapist, dietitian, and home care coordinator, at a minimum must conduct, at least on an annual basis, an in-person reassessment. Other IDT members or specialty practitioners actively involved in the beneficiary's care plan must also be included.

The IDT must promptly develop the comprehensive Plan of Care for each beneficiary after

completing the assessments as specified in 42 CFR 460.106. The IDT must implement, coordinate and monitor the Plan of Care whether the services are furnished by PACE staff or contractors. The team must collaborate with the beneficiary or caregiver, or both, to ensure there is agreement with the Plan of Care and that the beneficiary's concerns are addressed. The IDT must continuously monitor the beneficiary's health and psychosocial status, as well as the effectiveness of the Plan of Care through the provision of services, informal observation, input from the beneficiaries or caregivers, and communications among members of the IDT and other providers. On at least a semi-annual basis, the IDT must reevaluate the Plan of Care, define outcomes and make revisions as necessary. Anytime there is a significant change in health status the Plan of Care must be updated. The PACE staff (employees and contractors), as part of the IDT process, must communicate relevant changes in a beneficiary's care plan to transportation personnel as required by 42 CFR 460.76(e).

The PACE applicant must receive a face-to-face Minimum Data Set-Home Care (MDS-HC) assessment initially and then annually to verify that the applicant continues to meet the required nursing facility level of care criteria for enrollment in PACE. The MDS-HC must be completed only by OAAS MDS-HC trained and certified PACE staff.

The PACE organization must designate an individual to coordinate and oversee implementation of the quality assessment and performance improvement activities as specified in 42 CFR 460.136(b). The quality improvement coordinator must encourage PACE beneficiaries and caregivers to be involved in quality assessment and performance activities, including information about their satisfaction with services.

The PACE organization must designate a staff member to ensure that all PACE staff furnishing care directly to beneficiaries demonstrate the skills necessary for performance of their position. The designated staff person must oversee the orientation program and competency evaluation program for employees and work with PACE contracted liaison to ensure compliance in accordance with 42 CFR 460.71(a) (4).

## Orientation and Training

The PACE organization must provide to staff (employees and contractors) with an orientation that includes, at a minimum, the organization's mission, philosophy, practices and protocols of the PACE organization, policies on beneficiary's rights, emergency plan, ethics, the PACE benefit, and any policies related to job duties of specific staff.

In addition the orientation must include but not limited to:

- Organizational chart;

- Role of the team;
- Standards of care and conduct;
- QI program (including an overview, principles, and the staff role);
- List of providers;
- Personnel policies;
- Body mechanics;
- Care of the elderly;
- Beneficiary safety;
- Occupational Safety and Health Administration (OSHA), standard precautions, infection reporting, waste management; and
- Health Insurance Portability and Accountability Act (HIPPA) laws in accordance with 42 CFR 460.200(e).

A PACE organization must develop a competency evaluation program that identifies those skills, knowledge and abilities that must be demonstrated by all direct beneficiary care staff as specified in 42 CFR 460.66(a). The competency program must be evidenced as completed before performing personal care services independently and on an on-going basis. Certification of satisfactory completion of the competency program must be in the personnel files of all employees and contracted staff.

In accordance with 42 CFR 460.66 (b) & (c) the PACE organization must develop a training program for each employed and contracted PCA. The skills of each PCA must be evaluated upon hire to establish a baseline competency before providing personal care services independently. A training plan must be specific to the competencies and deficiencies demonstrated.

OSHA training must be provided on hire and annually by a qualified trainer. This training must be given in an interactive session with a trainer present.

The PACE staff (employees and contractors) must be trained on the PACE organization's grievance and appeals processes.

The PACE organization must provide emergency training and periodic orientation to all staff (employees and contractors) and beneficiaries to ensure knowledge of emergency procedures, including informing beneficiaries what to do, where to go, and whom to contact in case of an emergency. The PACE organization must have at least one staff member trained in cardiopulmonary resuscitation (CPR) during the hours the beneficiaries are in the PACE center.

The PACE organization must train all transportation personnel (employees and contractors) in managing the special needs of beneficiaries, how to and types of issues to communicate to the PACE center staff about beneficiaries, and in handling emergency situations as described in 42 CFR 460.76(d).

The PACE organization must provide on-going training to maintain and improve the skills and knowledge of all PACE personnel (employee and contracted staff). The annual training must be related to specific positions which include relevant topics. The training needs to be staggered throughout the year to enable all staff to participate. The training program needs to describe plans for in-service training, the methods of teaching (including handouts, pre and post-test if applicable, and the person/position conducting the training).