

Division of Senior and Disabilities Services
Care Coordination Standards
June 1993

Definition

Care coordination services are a component of the community care system. The purpose of care coordination services is to make the community care system work most effectively in order to assure individuals receive assistance responsive to their needs.

Care coordination services assist persons in gaining access to needed medical, social, educational and other services, regardless of the funding source for the services. Care coordination links persons who have complex personal circumstances (that place them at risk of diminished independence) to appropriate services, and insures coordination of these services.

The care coordination process includes:

- screening a person to determine the need for care coordination;
- assessing a person's functional level and impairments—physical, cognitive, social, emotional—in order to identify what needs and problems are present as well as the individual's current capacity and support—family, friends financial and environmental;
- developing a plan of care that addresses the need and problems presented and incorporates the services that are needed to enhance the current support system;
- identifying and arranging for coordinated delivery of those services;
- monitoring changes in the person's condition and circumstances, and in the provision of services;
- reassessing the person's needs on a regular basis; and
- discharging the person from the care coordination process when appropriate.

These core functions of care coordination are further defined under Elements of the Care Coordination Process on page 5. Supplemental supportive functions may include outreach, client advocacy, assistance, consultation, networking, family support and crisis intervention.

Care coordination differs from information and referral or personal advocacy in that the care coordinator:

- spends more time with each individual client,
- coordinates all available services (formal and informal) to assist each client,
- assists the client with problems,
- provides an informal quality assurance on services provided to the client by other agencies and persons,
- remains in contact with a client until the client's needs change to the extent that assistance from the care coordinator is no longer needed, and
- focuses on a specific senior population with multiple functional restrictions or disabling conditions.

There is also an important distinction between the type of care coordination that is provided in conjunction with specific services and comprehensive, long term "system" care coordination. The former may be simply intake for one service or program. "System" care coordination is an inclusive look across a person's needs and resources, linking him or her to a full range of appropriate services, using all available funding sources and monitoring the care provided over an extended period of time. These standards apply to this broader process.

Service Provider Qualifications:

All agencies funded to provide care coordination services whether funded through DSDS by a grant or through eligibility for Medicaid waiver billing shall meet the minimum standards as stated in this document.

Service Eligibility Criteria:

1. Generally, care coordination services should be targeted to persons in one or more of the following categories:
 - persons for whom preventive services may avoid or delay the need for institutional care;
 - people most vulnerable or "at risk" of institutionalization;
 - individuals with multiple impairments that are expected to continue over a long period of time;
 - persons needing multiple services that are expected to continue over a long period of time;
 - persons that are unable to coordinate their own care.

Caution is needed when targeting a population to serve. A very broad target group may well result in a waiting list for services and the possibility of spreading resources too thinly or including people who do not need the service. If the target population is too narrowly defined, the risk is denying assistance to people in need. The target population needs to be consistent with the goals of the program and may need to be periodically re-examined and modified.

2. Persons are eligible for care coordination services dependent upon several factors including funding source(s), caseload size of care coordinators, and training and background of care coordinator (i.e., whether the care coordinator is familiar with the needs of the population being served). Due to the various factors, the following persons may be eligible for care coordination services:
 - A. persons 60 years of age or older having multiple service needs and living at home or in a residential supported living arrangement; or
 - B. persons of any age who have Alzheimer's Disease or a related disorder having multiple service needs and living at home or in a residential supported living arrangement; or
 - C. adults 18 years of age or older with similar disabilities and service needs to older Alaskans. The provision of care to such persons should not diminish services to the primary group of persons being served.
 - D. other persons determined appropriate for the provision of services based on other criteria set by the agency.

3. Funding Source Requirements. Persons identified in 2 A. and B. above are eligible for care coordination services funded by ACoA grants available through the Older Alaskans Services Program and the Mental Health Trust Fund. Persons identified in 2 C. and D. above are eligible for care coordination services if their cost of care is paid in full by some source other than DSDS funds.

Client's Bill of Rights

The following is a statement of the rights of persons receiving care coordination. This statement is not intended to be exclusive; it does contain an outline of the basic tenets that must be followed in providing care coordination.

- The rights of clients of care coordination include:
- The right to be treated with respect and dignity.
- The right to self-determination, including participation in developing one's own plan of care.
- The right to privacy and confidentiality.
- The right to be given a fair and comprehensive assessment of their health and functional, psychosocial and cognitive ability.
- The right to have access to needed health and social services.
- The right to know the cost of service prior to receiving the service.
- The right to be notified in writing of any change in services, termination of service, or discharge.
- The right to refuse any portion of the care plan.
- The right to withdraw from the process at any time.
- The right to a grievance procedure in the event that the client feels his or her rights have been violated or he or she has been treated improperly.

Goals

A set of program goals should be established based on the needs of individuals within a particular community. Common care coordination goals include:

- maintaining the greatest amount of independence and human dignity for the individual
- enabling the person to remain in the most appropriate environment
- providing an appropriate, comprehensive, and coordinated response to the person's need(s) that addresses prevention as well as rehabilitation and maintenance
- serving as an integral link to increase access to community-based services
- building and strengthening family and community support
- improving availability and quality of services
- reaching a specified target population
- containing costs by assuring use of appropriate community-based services.

Goal Conflict

It is important to acknowledge the potential for conflict between goals in care coordination. Following are examples of potential conflict areas: the client and the care coordinator do not agree on the problem, the need, or appropriate service; a family member and the client or the care coordinator do not agree on the problem, the need, or appropriate service; cost containment may limit ability to be responsive to client needs and preferences; community resources do not exist to meet the client's needs; and program goals do not coincide with the desire of the client.

There should be an established process for dealing with goal conflicts. This can take place at various levels including family meetings, care coordinator peer support groups, supervisory sessions, and administrative or governing body meetings. Grievance procedures for clients and staff should be clearly stated and understood by both parties.

Roles of the Care Coordinator

Care coordination crosscuts a variety of disciplines, such as nursing and social work, in order to view an individual's entire spectrum of need. The care coordinator should assume most or all of the following roles:

- As a service coordinator—the care coordinator does not usually provide direct services to an individual or his or her family, but rather acts to identify and coordinate delivery of services on the person's behalf. Depending on the setting in which the care coordinator works, he or she may have the power to arrange for services, directly authorize certain services, and/or control payment for those services.
- As an advocate—the care coordinator assures that the person and/or caregiver receives appropriate services and that the services received are of high quality; seeks to change or expand services to meet the person's needs, and intervenes to make the current system more responsive to the person's needs. Although care coordinators may need to work within the requirements of their funding source, they should be knowledgeable of and use all funding or volunteer sources that would help their clients get the services they need.
- As a counselor—the care coordinator assists individuals and their families in recognizing and identifying their strengths, problems and needs, teaching them how to judge the quality and appropriateness of services, and encouraging them to assume responsibility for the care to the extent possible.
- As a gatekeeper—the care coordinator's role may be to contain costs, justify expenditure of funds and assure that only those clients appropriate for care coordination receive the service.

Depending on the program, one or more of these roles may be emphasized.

Elements of the Care Coordination Process

1. Intake/Screening. Intake/screening is a preliminary evaluation of a person's need for care coordination. The purpose is to obtain enough information to determine the person's

likelihood of needing care coordination and whether or not a full assessment is warranted. The individual conducting the screening should:

- obtain background information, such as name, age, marital status, living arrangement;
- determine reason for the referral or for the individual's seeking help;
- determine what supports are already available (informal and formal);
- evaluate need for immediate action (e.g., crisis intervention, protective services);
- determine eligibility of the applicant in relation to income, age, or other requirements;
- determine sufficient need to warrant assessment.

If the person is determined inappropriate for care coordination, (for example, because only information or a single service is needed), a referral should be made to other services and resources. If the person appears appropriate for care coordination, procedures should be explained and arrangements made for an assessment visit.

Intake/screening should be performed by highly trained staff experienced with interviewing, knowledgeable about community resources, and familiar with eligibility requirements and program goals. It should involve:

- a standardized intake tool to be completed for all persons referred to the program;
- phone or in-person interviews at the individual's home, community program (e.g., nutrition site, adult day care program) or care coordination office;
- a minimum time response between intake and assessment as established by agency policy.

2. Assessment. Assessment determines actual eligibility for care coordination, confirming or altering the preliminary screening decision. During assessment a more thorough collection and analysis of information on the applicant's personal situation is obtained in the person's home. The assessment should identify the person's care needs beyond the presenting problem in the areas of physical, cognitive, social, and emotional functioning as well as financial and environmental needs. It should also include a detailed review of the person's current support from family, friends, and formal service providers. The assessment should identify the need for protective services for clients who are abused, neglected, or mentally incompetent. With the client's permission, information should also be obtained from physicians and other professional health and social services providers, family, friends, and others involved in the person's care. The point is to assemble enough information to analyze the situation fully.

Assessment is the foundation of the care coordination process and should be performed by highly skilled staff. Because the needs of the individual generally cross disciplines, the skills and expertise of several professions may be needed to make an accurate assessment of the person's situation. One approach is to use a multidisciplinary team to conduct the assessment. Another is to have such a team review assessment findings. Yet another is to have trained specialists available for involvement in the assessment as needed. Such specialists generally include a social worker and a nurse (or related health practitioners); additional experts might include physician, psychiatrist, nurse practitioner, nutritionist, oral health specialist, pharmacist, and rehabilitative therapists.

Assessment should:

- use the Alaska Long Term Care Assessment Form;
 - establish a minimum response time between assessment and development of a care plan.
3. Care Plan Development. Care planning is the bridge from the assessment to actual delivery of services. Working with the person and his or her caregivers, the care coordinator develops a plan to address:
- the problems and strengths identified in the assessment;
 - the establishment of desired client-specific goals;
 - the development of a complete list of services to achieve these goals;
 - the responsibilities of the care coordinator, client, and informal and formal supports;
 - the payment source for services.

The result is a plan of care that outlines the services to be provided: the days, times, amount, and duration of service; who will provide the services including informal care; frequency of monitoring contacts; and the source of funds to pay for the services.

The care plan should:

- have a standard format;
- be agreed to by the client;
- include services that support and enhance, and do not replace unless necessary, what is already being done by the family and other informal caregivers.

A minimum response time should be established between development of the care plan and service delivery.

4. Care Plan Implementation. Care plan implementation is the process through which the care coordinator arranges and/or authorizes services to implement the care plan. This may involve arranging for services to be provided through collaboration, formal request, or the use of purchase-of-service agreements; and coordinating help given by family, friends, and volunteers.

Arranging for service delivery should include:

- the arrangement of appropriate services and supports to achieve the goals of the care plan;
 - sending written service requests to service providers, as needed and appropriate;
 - establishment of a minimum response time between ordering services and the first monitoring contact, to determine whether the service has been provided in a timely manner.
5. Monitoring. Monitoring is the maintenance of regular contact with the client, informal caregivers, and other providers of service. The purpose is to evaluate whether the services are appropriate, of high quality, and are meeting the client's current needs. Monitoring includes

the function of verifying whether a service has been delivered and altering the care plan as the client's needs change.

Monitoring should involve:

- reviewing the quality and adequacy of services and taking adequate steps to assure that substandard care is improved, or arranging for alternate service provision;
- establishing a minimum required frequency of contact with the client, depending on the client's current condition and the availability of informal and formal supports;
- establishing whether contacts should be made by telephone or in person.

6. Reassessment. Reassessment is the formal review of the client's status to determine whether the client's situation and functioning have changed in relation to the goals established in the initial care plan. Again, service is reviewed for quality and appropriateness. If the client's needs have changed, the care plan should be adjusted.

Reassessment should:

- involve the use of the Alaska Long Term Care Assessment Form (or an approved adaptation of the form);
- be conducted within a predetermined time period;
- if necessary, take place in addition to the regularly scheduled intervals for reassessment, in order to respond to an unscheduled event, such as a hospitalization, loss of caregiver, or change in worker.

7. Discharge or Termination. Discharge or termination is the process that ends the involvement with the client or the caregiver. Possible reasons for discharge include: improvement in the person's condition so that care coordination is no longer needed, death, or relocation of the client. When the decision to terminate is made by the agency, not the client or caregiver, serious consideration for the safety and well being of the person should be considered prior to any discharge. Programs need to establish a procedure for discharge that incorporates, at a minimum, supervisory review. Discharged persons should:

- be notified in writing of the reason for discharge when the discharge is not a mutual decision between the client and care coordinator;
- be informed of procedures to appeal the decision;
- receive information on other sources of assistance (when appropriate).

8. Other Functions Supportive of the Care Coordination Process

In addition to the core elements described in 1-7 above, the following functions are essential to the care coordination process. Exactly how these functions are carried out will vary with the particular goals and structure of the organization providing care coordination.

A. Outreach. It is important to make care coordination known to the general public and other service providers in order to:

- assure appropriate referral;
- coordinate service delivery;
- maximize resources to meet the needs of clients;
- disseminate information on the goals and eligibility requirements of care coordination.

Outreach activities should include:

- establishment of a network of organizations and people known to have contact with the target population, such as hospitals, nursing homes, home care-agencies, lawyers, physicians, religious institutions, caregiver support groups, etc.;
- development and dissemination of printed materials that clearly inform the public about the program (identifying the sponsoring organization, services provided, etc.).

B. Other supportive functions include client advocacy, assistance, consultation, networking, family support and crisis intervention.

Staffing Standards:

Care coordination staff should be adequate in number and skills to meet the goals of the program and carry out the care coordination components described earlier.

1. Each staff member shall be competent, ethical, and qualified for the position held. Staff shall hold personal information about participants in strict confidence and shall treat all participants with respect and dignity.
2. Individual Care Coordinator Qualifications/Standards:

The care coordinator is responsible for conducting, either alone or as a part of a team, assessments and reassessments; developing care plans; organizing and monitoring services.

All individuals providing care coordination services must be an employee or subcontractor with a care coordination agency and shall be a:

- A. professional nurse (RN or LPN) licensed under AS 08.68;
- B. physician's assistant regulated under 12 AAC 44.490;
- C. practicing personal care or chore service coordinator;
- D. certified community health aide; or
- E. have a bachelor's degree in social work or a closely related field with a background in gerontology, long term care, delivery of community-based services; or
- F. have an equivalent combination of education and/or experience in other applicable fields.

All persons must:

- A. be free of communicable diseases and other conditions that would pose a substantial safety or health risk to those whom the person would serve under the conditions and circumstances in which services would be provided; and

- B. not have been convicted in any jurisdiction for abuse, neglect, or any other crime, excluding misdemeanors or traffic violations, that would pose a safety or health risk to clients.

If client condition or other factors demand it, the academic requirements may be a master's level professional degree, e.g., in social work or nursing.

It is also desired that each care coordinator possess a minimum of two years experience in the human service field for persons with a bachelor's degree and one year of experience for persons at the master's degree level.

3. Caseload. The most effective ratio of clients to care coordinator is dependent on the following:
 - characteristics of the target population served (e.g., very frail, disoriented, without family support);
 - complexity of the care plan;
 - geographical size of the area covered, taking transportation difficulties into account;
 - the amount of case aide, clerical, and supervisory support;
 - availability of community-based services; and,
 - the extent of responsibility and control over funds that is exercised by the care coordinator.
4. The agency shall have an evaluation system that:
 - provides performance appraisal and feedback to the employee and an opportunity for employee feedback to the agency and
 - adheres to reasonably established timeliness for performance appraisal.
5. All paid and volunteer staff shall be provided:
 - general orientation to the facility (location, staff, activities, etc.).
 - information on fire and safety measures/codes.
 - overview of types of participants and activities.
 - information of the staff training plan.
6. The agency shall periodically assess the need for specific staff training programs.
7. The agency shall comply with all mandatory personnel licensure and training schedules.
8. Orientation and Training. Individuals doing care coordination need to be trained in skills and techniques to assure that each component of service is performed appropriately and competently.
 - The agency shall provide all new staff with a timely orientation that transmits the agency values, philosophy and mission. All staff should receive an in-depth orientation on policies and procedures; client's rights; characteristics and resources of the community; and techniques for conducting the assessment, care planning, service arrangement, and monitoring.

- Each staff person should participate in a pre-determined number of hours of in-service training per year. Content should be based on the care coordinator's need for professional growth and upgrading of skills and include information on cultural sensitivity.
 - All individuals conducting assessment and reassessment should attend a training session, and thereafter refresher sessions, on the use of the standardized instrument.
 - All staff shall be informed of all laws, policies, procedures and individual reporting responsibilities regarding client abuse, neglect and mistreatment, prior to actual service delivery.
9. The agency shall maintain a system for periodic review and revision of all job descriptions.
 10. The pre-employment screening process shall include background and criminal checks (when appropriate), personal and professional references and follow-up on required references.
 11. The agency's personnel system shall comply with all applicable laws, statutes, regulations and equal employment opportunity mandates.

Agency Standards:

1. Agencies certified by the Division of Senior Services to provide both care coordination services and residential supported living services (RSLs) will not receive Medicaid reimbursement for a waiver client receiving care in that agency's residential facility whose "approved plan of care" was prepared by a care coordination provider that has a close familial or business relationship with the residential supported living services provider" (7 AAC 43.1080). Under certain circumstances, the limitation on reimbursement for RSLs may be waived by DSS **for the benefit of the recipient**.

Administrative Standards:

1. The administering agency shall have a method to assure client and family input on matters pertaining to administration of program activities. This may be accomplished through an advisory board or some other method. When the program is a subdivision of a multifunction organization, a committee or subcommittee of the governing body of the multifunction organization may serve as the advisory body. Client/family input shall include representation of minorities and low-income persons.
2. The agency with full legal authority for the program shall have an organizational chart that includes the relationship with the advisory body (if applicable).
3. The agency shall have an organizational staffing chart that shows the lines of authority and communication channels.
4. Clients must be charged the full cost of service, although a portion thereof may be discounted based on the client's income according to an established fee schedule. If the client has insurance or is eligible for any relevant benefits, those benefits must be sought, and the full cost of service must be charged to the third party payer. If the client is a legal dependent of another party for tax purposes, the other party's income may be considered in calculating the amount to be charged according to the fee schedule.
5. A program director shall be appointed and given full authority and responsibility to plan, staff, and manage the provision of services.
6. Personnel Policies and Practices. Each employee shall receive:

A. A copy of his/her job description that specifies:

- Qualifications for the job;
- Duties and/or responsibilities;
- Title of supervisor; and
- Salary range and benefits

B. Recruitment, hiring, performance and evaluation procedures, probation and dismissal procedures

C. Employee benefits (leave policies, promotion opportunities, etc.)

D. Grievance procedures

7. The agency shall maintain administrative records that include personnel, fiscal, statistical, regulations, etc.

8. The agency shall not disclose information about a participant in a form that identifies the person without the informed consent of the participant or his or her legal representative, unless the disclosure is required by court order or for program monitoring by authorized federal and state monitoring agencies.

9. Recordkeeping.

A. General Records. A system should be maintained that includes, but is not limited to:

- a written policy on the protection of client records that defines procedures governing their use and removal; conditions for release of information contained in the records and requirements or authorization in writing by the client or legally authorized representative for release of information not otherwise authorized by law;
- a written policy providing for the retention and storage of records for at least five (5) years from the date of the last service to the client and for the retention and storage of such records in the event the program discontinues operation depending on the requirements of funding sources;
- maintenance of records in a secure storage area.

B. Client records. Client records should include at least the following:

- intake information;
- assessment information;
- identified problems and goals to be accomplished;
- plan of care;
- documentation of all contacts with and on behalf of clients, changes in condition, changes in services, etc.;
- signed authorizations for release of medical information;
- typewritten or legibly written, in ink, notes and reports that are dated and signed by the care coordinator or other staff authorized to write in client records;
- reports from provider agencies or others involved in the care plan, including dates of service delivery;

- signed authorization or purchase of service orders in cases where the care coordinator has control over funding sources and;
 - discharge plan and summary.
10. The agency shall maintain a system of fiscal accountability according to generally accepted accounting procedures.
 11. The agency shall provide workers' compensation insurance; comprehensive general liability insurance; and comprehensive automobile liability insurance, if automobiles are used as part of the provision of services. All insurance coverage shall be at least at the minimum levels required by law.
 12. The agency shall comply with all federal, State, and local laws requiring nondiscrimination in employment and delivery of services.
 13. The agency shall maintain complete, accurate, and current program and financial records of service activities for an audit. All required records shall be maintained until an audit is completed and all audit questions are resolved, or for five years, whichever is sooner.
 14. The agency shall provide federal and state officials and independent auditors access to financial and program records.
 15. The agency shall assure accessibility of services to persons with disabilities.
 16. When transportation is provided by the program, drivers must hold valid Alaska licenses to operate the vehicle being used. The vehicle must be covered by comprehensive automobile liability insurance in at least the minimum amount and type required by law.
 17. A list shall be maintained for persons waiting to receive services.

Administrative Standards 18-21 Apply to Government and Nonprofit Agencies Only

18. A formal governing body shall have full legal authority and responsibility for the operation of the agency.
19. Board meetings shall be open to the public.
20. The agency shall have established policies and procedures for dealing with conflicts of interest. Should a member of the governing body have a conflict of interest, the agency shall show evidence of procedures that document the disclosure of the conflict and removal of the conflict or a determination that the conflict is not material.
21. If the agency receives a grant for these services from the State of Alaska, the State of Alaska shall be named as additional insured for liability insurance of any kind. The State of Alaska, its officers, agents, and employees shall be indemnified, held harmless, and defended from all liability, including costs and expenses, for all actions or claims resulting from injuries or damages sustained by any person or property arising directly or indirectly as a result of any error, omission, or negligent act of the provider, provider's subcontractors, or anyone directly or indirectly employed by them in the performance of this grant project.

Program Evaluation:

The purpose of evaluation is to find out how well a program is meeting its stated goals. This information can be used to improve practice; meet funding requirements; document need for future funding; and improve, coordinate, or expand services in a particular community.

Each care coordination program shall conduct an internal evaluation, at least annually, of its operation and services. A written report of the evaluation must be kept on file.

At a minimum, the evaluation should address the following:

- Target Population—Are the people receiving care coordination a part of the intended target population?
- Response Time—How much time does it take to conduct the assessment and complete the care plan?
- Implementation—Is the care plan actually implemented as written?
- Adequacy of Services—Do services provided according to the care plan meet the client's need?
- Cost Effectiveness—Are care plans designed to provide adequate and appropriate services in a cost-effective manner?

The evaluation shall include:

1. Involvement of the governing body, and to the extent considered appropriate by the governing body, the program director, staff, clients, families/caregivers, advisory body, and other relevant agencies/organizations.
2. Review of the performance of the program director and all staff.
3. Review of the extent to which the program assisted clients and their families and caregivers.
4. Measurement of the achievement of goals and objectives.
5. Assessment of the cost-effectiveness of the program.
6. Assessment of the relationship of the program to the rest of the community service network.
7. Recommendations for improvement, corrective action of problems areas, and future program directions.

Standard Alternatives:

Agencies may seek a waiver from specific requirements under these standards by submitting a written request to DSDS specifying what standard would be waived and describing how the agency proposes to meet the intent of the standard before implementing the proposed alternative. DSDS will inform the agency of approval or disapproval of the proposed alternative.