

Care Coordination Services Conditions of Participation

Care coordination services are provided for every participant. Care coordinators assist individuals to gain access to waiver and other state plan services, as well as medical, social, educational, and other services with funding sources other than Medicaid. For participants, care coordinators manage the process of planning for services, developing a service plan, on-going monitoring of services, and renewing the service plan annually. Throughout the year, care coordinators remain in contact with participants in a manner and with a frequency appropriate to the needs of the participants.

The provider who chooses to offer care coordination services must be certified as a provider of care coordination services under 7 AAC 130.216 (b)(2), meet with the requirements of 7 AAC 130.240, and operate in compliance with the following standards.

I. Program Administration

A. Personnel.

1. Care coordination services program administrator.

- a. The provider must designate a care coordination services program administrator who is responsible for the day-to-day management of the program including the following:
 - i. orientation, training, and supervision of care coordinators;
 - ii. implementation of policies and procedures;
 - iii. intake processing and evaluation of new admissions to the services;
 - iv. participation in the development of service plans in collaboration with other providers of services;
 - v. ongoing review of the delivery of services, including
 - A) monitoring the amount, duration, and scope of services to assure delivery as outlined in the service plan;
 - B) assessing whether the services assist the participants to attain the goals outlined in service plans; and
 - C) evaluating the quality of care rendered;
 - vi. development and implementation of corrective action plans for identified problems or deficiencies; and
 - vii. submission of required reports to Senior and Disabilities Services, including critical incident reports and service evaluation reports.
- b. The provider may use a term other than program administrator for this position, e.g., program director, program manager, or program supervisor.
- c. The program administrator must be at least 18 years of age, and qualified through experience and education in a human services field or setting.
 - i. Required experience:
 - (A) one year of full-time paid experience working with human services participants and their families, programs and grants administered by Senior and Disabilities Services, and providers of program and grant services; and
 - (B) one year (which may be concurrent) of full-time, paid experience, as a supervisor of two or more staff who worked full-time in a human services field or setting, in a position with responsibility for planning, development, and management or operation of programs involving service delivery, fiscal management, needs assessment, program evaluation and similar tasks.
 - ii. Required education and additional experience or alternatives to formal education:
 - (A) Bachelor of Arts or Bachelor of Science degree from an accredited college or university in social work, psychology, rehabilitation, nursing or a closely related human services field; or
 - (B) Associate of Arts degree from an accredited college or university in psychology, rehabilitation, nursing or a closely related human services field, and two years of full-time, paid experience

- working with human services participants in addition to the required one year of experience as a supervisor; or
- (C) four years of full-time paid experience working with human services participants in social work, psychology, rehabilitation, nursing, or a closely related human services field or setting; or
 - (D) certification as a rural community health aide or practitioner, and one year of full-time, paid experience working with human services participants in addition to the required one year of experience as a supervisor.
- c. In addition to meeting education and experience requirements, the administrator must possess the knowledge base and skills necessary to carry out the care coordination services program.
- i. The administrator knowledge base must include:
 - (A) the medical, behavioral, habilitative, and rehabilitative conditions and requirements of the population to be served; and
 - (B) the laws and policies related to Senior and Disabilities Services programs.
 - ii. The administrator skill set must include:
 - (A) the ability to evaluate, and to develop a service plan to meet, the needs of the population to be served;
 - (B) the ability to organize, evaluate, and present information orally and in writing; and
 - (C) the ability to supervise professional and support services staff.
2. **Care coordinators.**
- a. Care coordinators shall be at least 18 years of age, and qualified through experience and education in a human services field or setting.
 - b. Required education and additional experience or alternatives to formal education.
 - i. Bachelor of Arts , Bachelor of Science, or Associate of Arts degree from an accredited college or university in social work, psychology, rehabilitation, nursing or a closely related human services field, and one year of full-time, paid experience working with human services participants; or
 - ii. two years of course credits from an accredited college or university in social work, psychology, rehabilitation, nursing or a closely related human services field, and one year of full-time, paid experience working with human services participants; or
 - iii. three years of full-time paid experience working with human services participants in social work, psychology, rehabilitation, nursing, or a closely related human services field or setting; or
 - iv. certification as a rural community health aide or practitioner and one year of full-time, paid experience working with human services participants.
 - c. In addition to meeting education and experience requirements, care coordinators must possess, or develop before providing program services, the knowledge base and skills necessary to carry out the care coordination process.
 - i. The care coordination knowledge base must include:
 - A) the medical, behavioral, habilitative, and rehabilitative conditions and requirements of the population to be served by the care coordinator;
 - B) the laws and policies related to Senior and Disabilities Services programs;
 - C) the terminology commonly used in human services fields or settings;
 - D) the elements of the care coordination process; and
 - E) the resources available to meet the needs of participants.
 - ii. The care coordination skill set must include:
 - A) the ability to evaluate, and to develop a service plan to meet, the needs of the population to be served;
 - B) the ability to organize, evaluate, and present information orally and in writing; and
 - C) the ability to work with professional and support staff.

B. Training.

1. An individual who seeks certification to provide care coordination services must enroll in the Senior and Disabilities Services basic training course, and demonstrate comprehension of course content through examination.
2. A certified care coordinator must enroll in at least one Senior and Disabilities Services care coordination training course during the individual's one or two year period of certification, and provide proof of successful completion when submitting an application for recertification.

II. Program operations**A. Quality management.**

1. Service plan tracking system.
 - a. The provider must develop a system to monitor service plan development and implementation to ensure that service plans for participants
 - i. are complete and submitted within required timeframes;
 - ii. address all needs identified in the participant's assessment;
 - iii. include the personal goals of the participant; and
 - iv. address participant health, safety, and welfare.
 - b. The provider must develop and implement
 - i. a protocol for analysis, once per calendar quarter at a minimum, of the data collected through its tracking system;
 - ii. a procedure for correcting problems uncovered by the analysis;
 - iii. a process for summarizing the quarterly analyses and corrective actions for inclusion in a report to be submitted to Senior and Disabilities Services with the provider's application for recertification or to be made available upon request.
2. Quality improvement process.
 - a. The provider must develop and implement a quality improvement process that includes
 - i. a review committee with the coordination services program administrator and others capable of evaluating the services as members of the committee;
 - ii. a protocol for quarterly random-sample case records review and analysis by that committee; and
 - iii. a procedure for taking corrective action to improve services when indicated by committee findings.
 - b. At a minimum, the committee must determine whether
 - i. services meet the needs of the participants;
 - ii. services are effectively coordinated among the various providers;
 - iii. participants and their informal supports are encouraged to actively participate in the care coordination process;
 - iv. participant are accorded the right to make choices regarding their care; and
 - v. services are integrated with informal care and supports.

B. Backup care coordinator.

1. The provider must designate, for each care coordinator, another care coordinator to serve as backup when the primary care coordinator will not be available to provide services for more than three consecutive days.
2. The backup care coordinator may provide combined services for no more than 14 days if the additional workload results in responsibilities for 40 or more participants.
3. The provider, when notifying Senior and Disabilities Services of the end of an association with a care coordinator employee, must
 - a. submit a list of participants affected by the change on a form provided by Senior and Disabilities Services; and
 - b. inform each participant on that list of the name and contact information for a care coordinator who will serve as backup until the participant chooses another care coordinator to provide services.

C. Billing for services.

1. The provider may not submit a claim for reimbursement for care coordination services until the services have been rendered.
2. Claims for monthly case management for participants may not be submitted until the first day of the month following the month in which services were rendered.

III. Participant relationships.**A. Conflicts of interest.**

1. The care coordinator must
 - a. accord to the participant the right to choose to receive services from any certified provider;
 - b. inform the participant of any employment relationship or any other relationship with provider personnel or ownership if he/she plans to recommend services from that provider; and
 - c. facilitate the transfer process when the participant chooses to receive care coordination services from another care coordinator.
2. The care coordinator may not offer, promote, or sell products or non-program services to, or engage in any commercial transaction with, participants or their families or their representatives without the written consent of Senior and Disabilities Services.
3. The provider must develop a process for resolution of conflicts that might arise between the care coordinator and the participant, family, or informal supports, regarding needs, goals, or appropriate services.

B. Participant contacts.

1. The care coordinator must meet in-person with the participant at least once in each service environment during the plan year.
2. During each in-person meeting, the care coordinator must address the following topics with the participant or the participant representative
 - a. whether services have been delivered in the scope, duration, and frequency described in the plan care;
 - b. whether the delivery of services was acceptable in terms of safety and respect for the participant;
 - c. whether adjustments to the plan of care or to arrangements with providers might be needed because of changes in the participant's health or other circumstances.
3. The care coordinator must document the content of each contact with the participant, and the method used to make that contact.
 - a. The record of each in-person contact must be signed by the participant or the participant's representative.
 - b. If the participant is unable or unwilling to sign the record, the care coordinator
 - i. must indicate the cause of the inability or unwillingness, and
 - ii. may request that other providers who are present at the time sign the record.

IV. The care coordination process.**A. Care coordination goals.**

The provider must operate its care coordination services program for the following purposes:

1. to foster the greatest amount of independence for the participant;
2. to enable the participant to remain in most appropriate environment in the home or community;
3. to build and strengthen family and community supports;
4. to treat participants with dignity and respect in the provision of services;
5. to secure for participants appropriate, comprehensive, and coordinated services that will promote rehabilitation and maintenance of current abilities;
6. to serve as a link to increase access to community-based services; and
7. to improve the availability and quality of services.

B. Service plan development.

1. Participant orientation. The care coordinator must

- a. orient the participant, family and informal supports to the care coordination process;
 - b. provide information about service options for medical, social, educational, and other services;
 - c. affirm the participant's right to choose to receive services from any qualified provider; and
 - d. offer assistance in identifying potential providers for the participant.
2. **Planning team.** The care coordinator must identify and constitute a planning team for the purposes of
- a. developing an individualized, person-centered service plan that identifies problems and strengths, and focuses on understanding needs in the context of strengths; and
 - b. providing an opportunity for the participant and family
 - i. to express outcomes they wish to achieve,
 - ii. to request services that meet identified needs, and
 - iii. to explain how they would prefer the services to be delivered.
3. **Integrated program of services.** The planning team must
- a. incorporate the findings of the most recent evaluation or assessment in the service plan;
 - b. recommend services that support and enhance, but do not replace unless necessary, care and support provided by family and other informal supports;
 - c. develop an integrated program of individually-designed activities, experiences, services, or therapies necessary to achieve identified, expected outcomes or goals and objectives; and
 - d. write a service plan that meets program requirements, and specifies the responsibilities of the care coordinator, of the participant, and of informal and formal supports.
4. The care coordinator must deliver copies of the service plan to all providers of services included in the service plan.

C. Service plan implementation.

The care coordinator must

1. arrange for the services and supports outlined in the service plan, and coordinate the delivery of the services on behalf of the participant;
2. support the participant's independence by encouraging the participant, family, and informal supports to be responsible for care to the greatest extent possible; and
3. teach the participant and family how to evaluate the quality and appropriateness of services.

D. Service monitoring.

1. The care coordinator must contact the participant at least once a month, and as frequently as necessary, to evaluate whether the following conditions are met.
 - a. The services are furnished in accordance with the service plan and in a timely manner.
 - b. The services are delivered in a manner that protects the participant's health, safety and welfare.
 - c. The services are adequate to meet the participant's identified needs.
2. The care coordinator must evaluate whether changes in the needs or status of the participant require adjustments to the service plan or to arrangements with providers.
3. The care coordinator must contact each provider of services for a participant
 - a. every three months, at a minimum, to verify service utilization in the amount, duration, and frequency specified in the service plan; and
 - b. as needed to
 - i. ensure coordination in the delivery of multiple services by all providers,
 - ii. address problems in service provision or goal achievement,
 - iii. consult regarding need to alter service plans, and
 - iv. intervene to make providers more responsive to the participant's needs.
4. The care coordinator must act to ensure substandard care is improved or arranges for service delivery from other providers.
5. The care coordinator must notify, within five business days, any provider affected by a participant's termination of a service or move to another residence.