State of Alaska • Department of Health and Social Services • Senior and Disabilities Services

Care Coordination Services
Conditions of Participation

Care coordination services are provided for every recipient of home and community-based waiver services. By means of a person-centered process led by the recipient and the planning team of his or her choosing, care coordinators assist eligible 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 recipients, care coordinators facilitate the process of planning for services, developing a plan of care, on-going monitoring of services, and renewing the plan of care annually. Throughout the year, care coordinators remain in contact with recipients in a manner, and with a frequency, appropriate to the needs of the recipients.

The provider who chooses to offer care coordination services must be certified as a provider of care coordination services under 7 AAC 130.220 (a)(2), meet with the requirements of 7 AAC 130.240, and operate in compliance with the Provider Conditions of Participation and 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 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 plans of care 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 plan of care;
         (B) assessing whether the services assist the recipients to attain the goals outlined in plans of care; and
         (C) evaluating the quality of care rendered;
      vi. development and implementation of corrective action plans for identified problems or deficiencies in delivery of care coordination services; and
      vii. submission of required reports to Senior and Disabilities Services, including critical incident 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 provider must ensure that the individual in the program administrator position is certified as a care coordinator, and renews that certification as required under 7 AAC 130.238.
   d. The program administrator must be at least 21 years of age, and qualified through experience and education in a human services field or setting.
      i. Required experience: one year of full-time or equivalent part-time experience providing services to individuals in a human services setting in a position with responsibility for planning, development, and management or operation of programs involving service delivery, fiscal management, needs assessment, program evaluation, or 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 or equivalent part-time experience working with human services recipients; or
(C) four years of full-time or equivalent part-time experience working with human services recipients 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 or equivalent part-time experience working with human services recipients.

e. 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 plan of care to meet, the needs of the population to be served; and
(B) 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, or equivalent part-time experience working with human services recipients; 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, or equivalent part-time experience working with human services recipients; or
iii. three years of full-time or equivalent part-time experience working with human services recipients 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 or equivalent part-time experience working with human services recipients.
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 recipients.
ii. The care coordination skill set must include:
(A) the ability to evaluate, and to develop a plan of care 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.

d. Senior and Disabilities Services may certify as care coordinator, under 7 AAC 130.238, an applicant whose education was completed in a country other than the United States if the applicant can show that his/her foreign education is comparable to that received in an accredited educational institution in the United States.
   i. Applicants licensed under AS 08 may submit a copy of a State of Alaska license to show the applicant's foreign education is comparable to education in the United States.
   ii. Applicants not licensed under AS 08 are responsible for providing to Senior and Disabilities Services the following with an initial application for certification:
      A) a foreign educational credentials evaluation report, from an evaluation service approved by the National Association of Credential Evaluation Services, that includes, at a minimum, a description of each course and semester or quarter hour credits earned for that course, and a statement of degree equivalency to education in the United States; and
      B) certified English translations of any document submitted as part of the application, if the original documents are not in English.

B. **Training**.

1. An individual who seeks certification to provide care coordination services
   a. must enroll in the Senior and Disabilities Services Beginning Care Coordination course;
   b. demonstrate comprehension of course content through examination; and
   c. provide proof of successful completion of that course not more than 365 days prior to the date of submission of an application for certification.
2. A certified care coordinator who wishes to renew his or her certification
   a. must successfully complete
      i. at least one Senior and Disabilities Services care coordination training course during the individual's first year of certification, and thereafter, every 24 months to qualify for certification renewal;
      ii. 16 hours annually of continuing education that is relevant to a care coordinator's job responsibilities; and
   b. when submitting an application for recertification, provide proof of successful completion of the Senior and Disabilities Services training course and 16 hours annually of continuing education.
3. The provider agency must document, for each care coordinator, attendance and successful completion of 16 hours of continuing education annually in the care coordinator's personnel file; the provider agency's in-service training may qualify as continuing education if
   a. the training increases the knowledge, abilities, or skills of the care coordinator; and
   b. the content of the in-service training, date, and time in attendance is documented.

II. Program operations

A. **Quality management**.

1. The provider agency must develop a system to monitor plan of care development and implementation to ensure that plans of care for recipients
   a. are complete and submitted within required timeframes;
   b. address all needs identified in the recipient's assessment;
   c. include the personal goals of the recipient; and
   d. address recipient health, safety, and welfare.
2. The provider agency must implement
   a. a protocol for analysis, annually at a minimum, of the data collected through its tracking system;
   b. a procedure for correcting problems uncovered by the analysis;
   c. a process for summarizing the annual analysis 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.

3 At a minimum, the provider agency must determine whether
   a. services meet the needs of the recipients;
   b. services are effectively coordinated among the various providers;
   c. recipients and their informal supports are encouraged to participate in the care coordination process;
   d. recipients are afforded the right to make choices regarding their care; and
   e. services are integrated with informal care and supports.

B. **Billing for services**.

1. The provide agency may not submit a claim for reimbursement for
   a. development of a plan of care for a recipient until the plan has been approved by Senior and Disabilities Services; or
   b. care coordination services until the services have been rendered.
2. The provider agency may not submit claims for monthly care coordination services for recipients until the first day of the month following the month in which services were rendered.

C. **Conflicts of interest**.

1. The care coordinator must
   a. afford to the recipient the right to choose to receive services from any certified provider;
   b. inform the recipient, documenting the occasion in writing of any business or familial relationship with other provider personnel or owners who could be selected by the recipient to provide services; and
   c. facilitate the transfer process when the recipient chooses to receive care coordination services from another care coordinator.
2. The care coordinator may not
   a. solicit as clients any recipients known to be receiving services from another care coordinator or provider agency;
   b. after deciding to leave a provider agency for employment at another agency, attempt to influence any recipient to retain him or her as care coordinator or to initiate the process of transferring any recipient to the hiring agency for care coordination services; or
   c. offer, promote, or sell products or non-program services to, or engage in any commercial transaction with, recipients, their families, or their representatives.
3. The provider agency must develop a process for resolution of conflicts that might arise between the care coordinator and the recipient, family, or informal supports, regarding needs, goals, or appropriate services.

D. **Backup care coordination**.

1. The provider agency must
   a. develop a plan for back-up care coordination services in collaboration with the recipient, and give a copy of the plan to the recipient; and
   b. ensure that any care coordinator identified as a backup care coordinator is currently certified by SDS and associated with a care coordination agency in accordance with 7 AAC 10.900 (b).
2. The back-up plan must include
   a. the extent to which the primary care coordinator or the recipient is responsible for obtaining care coordination services if the primary care coordinator will be unavailable for a period that exceeds 72 hours;
   b. a contingency plan that defines the primary care coordinator's responsibilities to educate the recipient regarding a plan of action to ensure the health, safety, and welfare of the recipient if the primary care coordinator will be unavailable for a period that exceeds 30 days; and
   c. information about the potentials risks involved if back-up care coordination services are not secured.
2. The backup care coordinator may provide services to no more than the number of recipients, including that of the primary care coordinator's usual case load, for which service coordination and response to any recipient needs can be managed effectively.
3. The provider must inform each recipient, affected by the end of the provider's association with a care coordinator employee, of the name and contact information for a care coordinator who will serve as backup until the recipient chooses another care coordinator to provide services.

E. **Care coordinator appointment and transfer**.

1. The care coordinator must notify Senior and Disabilities Services, in a format provided by Senior and Disabilities Services, of
   a. the care coordinator's appointment when selected by a recipient to provide services; and
   b. the transfer of care coordination services to another care coordinator.
2. The provider agency must send to each recipient, affected by the end of the provider's association with a care coordinator employee, written notice that includes the name of the care coordinator ending employment and statements indicating
   a. the recipient's right to choose to receive care coordination services from any care coordination provider certified to offer those services in the census area in which the recipient lives; and
   b. the provider agency will facilitate the transfer process if the recipient chooses to receive care coordination services from another provider agency.
3. The care coordinator must send to the new care coordinator, within five working days of notice of appointment of that care coordinator, the following materials:
   a. current plan of care and amendments to the plan,
   b. most recent assessment,
   c. case notes for the past 12 months, and
   d. additional documents or information necessary for a safe transition.
4. The former and the new care coordinators must cooperate to ensure that all services outlined in the recipient's plan of care continue during a transfer of care coordination services.
5. The newly appointed care coordinator must send a copy of the appointment form to all providers listed in the plan of care to notify them of the change in care coordination services.

F. **Care coordinator communications**.

All certified care coordinators must individually subscribe to and review SDS electronic email, http://list.state.ak.us/mailman/listinfo/sds-e-news.

III. 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 recipient;
2. to enable the recipient to remain in the most appropriate environment in the home or community;
3. to build and strengthen family and community supports;
4. to treat recipients with dignity and respect in the provision of services;
5. to secure for recipients 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. **Person-centered planning process.**

1. Recipient orientation. The care coordinator must
   a. orient the recipient, the recipient's family, and informal supports to the care coordination process;
   b. advise the recipient of, and support, the recipient's right to lead the planning process where possible and to define the role of other individuals he or she chooses for participation in the process;
   c. provide information about service options for medical, social, educational, employment, and other services;
   d. affirm the recipient's right to choose to receive services from any certifiedprovider; and
   e. offer assistance in identifying potential providers for the recipient.

2. Comprehensive needs assessment. The care coordinator must complete a comprehensive needs assessment that includes
   a. the recipient's history;
   b. the recipient's strengths, preferences, goals, and interest; and
   c. identification and documentation of each need of the recipient.
3. Planning team.
   a. The care coordinator must
      i. facilitate the recipient's role as the leader of the planning process to the maximum extent possible;
      ii. with direction from the recipient, identify, meet with, and consult each member of the planning team for the purposes of developing an individualized, person-centered plan of care;
      iii. provide an opportunity for the recipient and family
         a). to express outcomes they wish to achieve,
         b) to request services that meet identified needs, and
         c) to explain how they would prefer that the services to be delivered.
   b. The planning team must identify
      i. the recipient's strengths, and focus on understanding needs in the context of those strengths;
      ii. risk factors and measures to minimize those risks;
      iii. cultural considerations to be included in the planning process;
      iv. the overarching purpose of the plan of care; and
      v. strategies for solving disagreements during the planning process.
4. Integrated program of services. The planning team must
   a. incorporate the findings of the most recent evaluation or assessment in the plan of care;
   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, including
      i, individually-designed activities, experiences, services, or therapies needed to achieve goals and objectives or identified, expected outcomes;
      ii. supports that will assist the recipient to become gainfully employed in the general workforce in an integrated workplace; and
   d. write a plan of care that meets program requirements, and that specifies the responsibilities of the care coordinator, the recipient, and the recipient's informal and formal supports.
5. The care coordinator must deliver a copy of the approved plan of care, to the recipient and to each provider of services for the recipient, within 10 business days of receiving the plan of care from Senior and Disabilities Services.

C. **Plan of care implementation**.

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

D. **Service monitoring**.

1. Recipient contacts.
   The care coordinator must
   a. contact the recipient at least twice a month, and as frequently as necessary, to evaluate whether
      i.. services are furnished in accordance with the plan of care and in a timely manner;
      ii. services are delivered in a manner that protects the recipient's health, safety, and welfare;
      iii. services are adequate to meet the recipient's identified need; and
      iv. changes in the needs or status of the recipient require adjustments to the plan of care or to arrangements with providers;
   b. meet in-person with the recipient at least once in each service environment during the plan year; and
   c. document the content of each contact with the recipient, including
      i. the method used to make that contact meaningful in terms of monitoring the health, safety, and welfare of the recipient;
      ii. a summary of the meeting, and the names of those in attendance;
      iii. whether services are adequate, delivered safely and respectfully, and acceptable to the recipient; and
      iv. whether the plan of care should be amended;
2. Provider contacts.
   The care coordinator must
   a. contact each provider of services for a recipient 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 plans of care;
      iv. intervene to make providers more responsive to the recipient's needs;
      v. ensure substandard care is improved, or arrange for service delivery from other providers; and
      vi verify service utilization in the amount, duration, and frequency specified in the plan of care.
   b. Within one business day of learning of a recipient's death, termination of a service, or move to another residence, the care coordinator must notify every provider affected by such change in recipient status

V. Environmental modification projects

A. Environmental modification evaluation

1. The care coordinator must review the need for physical adaptations to the recipient's residence with the recipient and the home owner, and obtain preliminary permission from the home owner to proceed with the environmental modification project.
2. The care coordinator must verify that project can be accommodated within the funding limits set by 7 AAC 130.300 (c).

B. Request for cost estimates

1. The care coordinator must notify all certified and enrolled environmental modification service providers of the proposed project by electronic mail in a format provided by Senior and Disabilities Services.
2. The care coordinator's notification to environmental modification providers must include
   a. the care coordinator's name and contact information;
   b. the location of the proposed project, and a statement indicating providers may arrange with the care coordinator for on-site viewing of the area to be modified;
   c. the *Request for Cost Estimate* form or forms appropriate to the type of physical adaptation included in the environmental modification project;
   d. photographs of the area to be modified with sufficient detail for provider review; and
   e. notice of a time limit of at least 14 days for submission of estimates, unless different timeframe was approved by Senior and Disabilities Services.
3. The care coordinator may not disclose, except to Senior and Disabilities Services, financial information regarding the project or competing estimates, or the identity or number of providers expressing interest in the project.

C. Selection of the project provider

1. The care coordinator must
   a. review all *Request for Cost Estimate* forms received by the date specified for submission to determine
      i. which environmental modification provider submitted the lowest cost estimate for the project; and
      ii. whether that provider can complete the project in time to meet the recipient's needs; and
   b send to Senior and Disabilities Services
      i. a Plan of Care that includes
         (A) a description of proposed physical adaptations with a photograph of the area to be modified, and any measurements, sketches, or other relevant representations, developed by the environmental modifications provider to show the project plan;
         (B) justification for the project based on the recipient's functional or clinical needs;
         (C) the name of the environmental modification provider recommended for the project;
         (D) if applicable, a *Waiver of Requirement for Provider Selection* form with an explanation regarding the need to select an environmental modification provider other than the one submitting the lowest cost estimate; and
         (E) the *Property Owner's Consent to Environmental Modification* form; and
      ii. all *Request for Cost Estimate* forms received in regard to the project.
2. Upon written notice of approval by Senior and Disabilities Services, of selection of the environmental modification provider, the care coordinator must notify
   a. the provider selected of that provider's approval for the project; and
   b. any other providers that submitted estimates of that provider's selection.

D. Collaboration with interested parties

1. The care coordinator must advise the environmental modification provider of any recipient conditions or needs to ensure that the health, safety, and welfare of the recipient are protected throughout the project.
2. The care coordinator must review, with the environmental modification provider, any proposed changes for equivalent facilitation to ensure that the needs of the recipient will be met; the care coordinator may contact Senior and Disabilities Services regarding questions.
3. The care coordinator must work with the recipient, the home owner, and the environmental modification provider to resolve any disagreements regarding dissatisfaction with the project or with work performance; the care coordinator may contact Senior and Disabilities Services if unable to resolve any issues that remain after discussion with the parties.