WHO IS QUALIFIED TO COORDINATE CARE?

Recommendations presented to the
New York State Department of Health and the New York State Office for the Aging

By the
Social Work Leadership Institute of
The New York Academy of Medicine
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BACKGROUND
In the advance towards health care reform, care coordination has arrived center stage as a key component in the delivery of health and long term care services to older adults. Much of the recent literature on care coordination is focused on analyzing its effectiveness in increasing quality while containing costs with outcomes measure like reduced hospital admissions and improvements in functional status.

Although the function of case management, a close relative of care coordination, is well established in state programs that focus on areas such as disability, mental health, and HIV/AIDS- the process of defining the competencies and training requirements for effective care coordination for older adults has only just begun. Uncertainty regarding the necessary qualifications and training a care coordinator needs, arises from the diversity of care coordination programs, the different approaches found therein, and a great deal of confusing terminology around care coordination, case management, care management, and transitions in care, to name but a few.

In New York, as elsewhere across the country, there is a need for significant improvements in the current care delivery system for the state’s aging population, including better integration between the acute health and long-term care systems. In order to address the gap in research and understanding about the integration, The Social Work Leadership Institute of the New York Academy of Medicine was commissioned by the New York State Department of Health (NYSDOH) and the State Office for the Aging (NYSOFA) to develop a blueprint of a best-practice care coordination model for older adults in New York State. This blueprint is based on a nationwide review and assessment of care coordination programs, an analysis of standards promulgated by national case management organizations, a review of supporting literature, focus groups and six roundtable discussions with over 75 key stakeholders from the provider, consumer and policymaking worlds in New York. The culmination of this work is the report, Towards the Development of Care Coordination Standards: An Analysis of Care Coordination in Programs for Older Adults’ which was submitted to the NYSDOH and the NYSOFA in November of 2008. Also at that time, the NYAM put forth policy goals for the state to consider related to the care coordination blueprint; these goals would help to ensure its successful implementation. The following policy recommendations were made:

- Amend an existing waiver program that provides for case management, such as the Long Term Home Health Care Program and the Nursing Home Transition and Diversion Waiver program to incorporate the agreed upon quality care coordination standards in the delivery of waiver services.

- Using the waiver amendment as a foundation to incorporate these standards of care into Medicaid delivered services and programs serving older adults and individuals with disabilities throughout New York State.

- Develop criteria for education, experience, training and code of ethics that could be put into legislation.

1 Towards the Development of Care Coordination Standards can be accessed online at:
• Pass legislation that creates a title for a care coordinator to create an identifiable workforce of individuals who the general population can turn to for assistance in navigating the health care delivery system.

• Work towards creating a reimbursement mechanism for care coordination that meets the quality standards discussed and is delivered by a qualified care coordinator in state waiver programs and ultimately in all Medicaid funded programs in NYS that serve older adults and individuals with disabilities.

• Work towards creating a mandated benefit in NYS Insurance Law for coverage of care coordination in all LTC insurance policies.

Further, the NYAM provided an assessment of the potential for resistance for each of the blueprint’s core elements; that assessment used a simple rating scale (high, medium or low) and the scores were based on knowledge gained over the course of the project. It was during that assessment that the component, Qualified Care Coordinator, was identified as needing further investigation and development in order to be successfully implemented in New York. Developing a comprehensive set of recommendations in this area has required further research and data gathering. To this end NYAM deepened their research efforts and analyzed guidelines for care coordinator qualifications from prominent national case management/care coordination organizations, analyzed care coordination qualifications put forth by national and state level programs, conducted focus groups with caregivers and consumers and conducted a survey of providers in NYS care coordination programs.

No matter how well-designed a care coordination program may be it requires skilled, knowledgeable professionals to fulfill its goals. As a result, it is vital to ensure that we first understand what education, training and competencies are required of a care coordinator, and then take steps to ensure that these requirements will be met. It is also important to understand the current practices in New York State so that any standards promulgated are both realistic and assure that New York providers are among the best in the country.
METHODOLOGY

The Social Work Leadership Institute of the New York Academy of Medicine conducted research using three major sources of information. This research was then used to generate the set of recommendations on the characteristics of a qualified care coordinator in a state sponsored program. The three sources of information and methodology for data collection, extraction and analysis are as follows:

1) Identification and Analysis of National Guidelines

Seven nationally recognized organizations, that have put forth guidelines on care coordination / case management competencies, were identified. The competencies from each set of guidelines were compiled, analyzed and then grouped by theme. The data used in this analysis can be found in APPENDIX A: Information and Data Sources Used to Inform Each Recommendation. The seven organizations reviewed were:

a. The Commission for Case Manager Certification
b. The Medicare Chronic Care Practice Research Network
c. The Case Management Society of America
d. The National Association of Social Work: Case Management
e. The National Association of Professional Geriatric Care Managers
f. The International Academy of Elder/Professional Geriatric Care Managers
g. Veterans Affairs Social Work Case Management Competency Standards

2) Analysis of Care Coordination/Case Management Competencies and Qualifications in Select State Programs

Data obtained from an analysis in the report, Towards the Development of Care Coordination Standards, about education, training requirements, experience and credentialing of case managers in select state programs was extracted, plotted along a continuum, and analyzed for commonalities and differences. The data used in this analysis can be found in APPENDIX B: Case Manager Educational and Training Requirements for Select States. Additionally, the competencies found in APPENDIX C: Care Coordinator Competencies/Responsibilities, which were also taken from Towards the Development of Care Coordination Standards, were analyzed, grouped by theme and added to analysis of the national guidelines above.

3) Research and Analysis of the New York Sources of Information

a. Stakeholder Roundtable Discussions

Six roundtable discussions, with just over 75 participants, were held with the goal of gathering input from stakeholders throughout New York State about effective care coordination models and the qualifications of an ideal care coordinator. Participants included providers of care coordination or case management services, representatives from provider agencies, membership organizations policy directors, government officials, long-term care coalition organizers, physicians/geriatricians, academic scholars, community based organization leaders and consumer advocates. Selection of the stakeholders was done to ensure that the group represented a continuum of long term care services; were geographically dispersed; and included perspectives of the consumer, provider, academic and policy making worlds. The NYS Department of Health and the State Office for the Aging offered assistance in the selection process. Data about the stakeholders recommendations about the qualifications of a care coordinator was compiled, grouped by theme and added to analysis of the Nationally Recognized Guidelines above.
b. Focus Groups with Frail Community Dwelling Older Adults
This report is based on sixteen qualitative interviews and four focus group discussions (with a total of twenty-nine focus group participants) with older NYC residents conducted between April and June, 2009. The research was conducted in collaboration with four community-based organizations (CBOs) that provide services to older NYC residents: the Institute for Puerto Rican/Hispanic Elderly (IPRHE), Korean Community Services (KCS), Lenox Hill Neighborhood House, and Spring Creek Senior Partners. The collaborating organizations - selected for diversity on a range of salient characteristics, including client population, catchment area, and service model - facilitated recruitment of and introductions to study participants and provided administrative support for study activities. All interviews and focus groups discussions, except those in Korean, were conducted by NYAM staff. Korean interviews and focus groups were conducted by bilingual KCS staff, who provided detailed reports describing participant characteristics and responses. The focus group and interview guides covered similar content areas, including background information, challenges to and supports for aging in place, residential preferences, navigation of the health and social services systems, use of care coordinators and related staff, and attitudes and perceptions of services received. The research protocol was approved by the Institutional Review Board of NYAM. Study participants received $25 for each interview or focus group, to show our appreciation of their time and effort.

c. A Survey of Care Coordination/Case Management Programs in New York
In June 2009, the New York Academy of Medicine concluded a survey of 35 operational care coordination/case management programs in New York in order to determine their current practices. Programs were identified using several means: suggestion by DOH and/or SOFA; identifying Medicaid waiver programs that had case management; and by suggestion of other stakeholders. The survey questions were constructed in consultation with DOH and SOFA; the protocol was submitted to NYAM's Institutional Review Board and deemed exempt. Introductory emails were sent to each of the programs directors, informing them about the purpose of our research, the nature of the survey and timeframe and options for completing it. If email addresses were not available, telephone calls were made. Directors were given the opportunity to be interviewed over the telephone or complete a written survey, to be electronically mailed in. If there was no response within 1½ weeks of the initial contact, a follow up call and/or email was sent; this pattern was continued until the completion of the survey in June. Fifteen of the 35 providers responded. In phone and email correspondence information was obtained about educational qualifications, training requirements, salaries, caseloads, and job functions of care coordinators in their programs. The data on educational qualifications and training was plotted on a continuum, analyzed and served as the foundation of many of the recommendations in this report. Some of the data used in this analysis can be found in APPENDIX D: NY State Survey of Programs on Care Coordinator Education, Training and Function.
**DISCUSSION**

In the 2008 report *Towards the Development of Care Coordination Standards*, four recommendations for the improvement of care coordination practices and programs in New York were made. They are as follows:

1. Develop quality standards for care coordination that incorporate six essential elements:

   1. Assessment Driven
   2. Comprehensive Care Plan
   3. Ongoing Evaluation
   4. Qualified Care Coordinator
   5. Client Centered
   6. Accessible

2. Include these quality standards in a statutory framework.

3. Strive to develop a qualified workforce to provide care coordination as a foundation for the success of the movement toward restructuring more home and community based care services.

4. Ensure that any state and/or federally funded program that has care coordination as a service explicitly provides for payment either independently or as a designated portion of an administrative fee.

These four recommendations, including the standards for care coordination, lay the groundwork for our subsequent research and analysis of the essential criteria related to educational preparation, training and continuing education, and competencies (knowledge, skills and attitudes) of a qualified care coordinator.

**New York: Criteria for a Qualified Care Coordinator**

Given a national trend towards certifying professional care coordinators and an emerging school of thought on the criteria for certification, it is important to know how New York is positioned in order to determine a reasonable set of goals and a realistic transition period to reach them. In order to assure an effective level of practice, an analysis of the round table discussions, focus group findings and data collected in a survey of NYS program providers/directors was conducted to form the basis of realistic criteria that, if met, should help ensure the supply of qualified care coordinators in the state.

**Education**

*National*: In reviewing national data, the three degrees most commonly held by case managers and care coordinators are the Bachelor of Science in Nursing, Bachelor of Social Work, and Master of Social Work. In one instance, a program hired care coordinators who did not hold a degree from an institution of higher education, but had significant personal experience in the role; this program also requires that person to take a written/oral exam.

*New York*: Our analysis of state data showed that the most common educational backgrounds for care coordinators are in social work or nursing, as these provide, to varying degrees, knowledge of the health and long term care systems, knowledge of social support and services, clinical knowledge of chronic illness, ethical practice guidelines, amongst other relevant areas. Many programs employed non-social work or nursing bachelor’s level case managers. One program hired licensed practical nurses (LPN’s) without bachelor’s degrees to serve in the role of assistant care
Medicaid managed care programs in New York most often used a nurse in the role of coordinator. Some of the same programs employ nurses to assess a patient’s health status (and contribute to the care plan) while hiring social workers or other bachelor’s degree social service professionals to coordinate care and services. Whilst commonalities were found, it is important to note that significant variation in the educational and training requirements exist; in many instances a degree or license in a relevant professional domain is required, while in other instances a bachelor’s or associate’s degree in a more generalized field could be complemented by the appropriate work experience or on the job training to be considered qualified.

It is the variations in existing programs nationally and at the state level, that make it most appropriate to recommend a multiple-option approach for entry into the care coordinator role in terms of educational background.

**Certification and Licensure**

It is important to make the distinction between licensure and certification. Credentialing or certification is a self regulatory process that is distinguishable from licensing. Certification in a discipline represents a declaration of an individual’s competence; most commonly a certified individual has gone through a process to ensure competence in a particular area, e.g. passing a competency related examination. A license is typically granted by government agency at the state level and provides the state with formal legal authority to control various aspects of the practice of a given profession.

**National:** In 2006 the National Association of Professional Geriatric Care Managers designated four approved certifications for geriatric care managers: Care Manager Certified- offered by the National Academy of Certified Care Managers; Certified Case Manager - offered by the Commission for Case Manager Certification, and Certified Social Worker Case Manager - and Certified Advanced Social Worker in Case Management- offered by the National Association of Social Workers. These programs for certification demonstrate a national movement to professionalize case managers/care coordinators and a commitment to work towards uniform standards of eligibility, training, and standards of care coordination/case management practice.

Just over a third of the programs researched nationally required certification, of those, most tied this certification to a state sponsored training program. Of those requiring certification, about half required case managers to pass an exam. Only one program required that professional licensure be maintained (e.g. social work) while the person serves in the role of care coordinator. At this time, none of the programs researched required a nationally recognized certification from one of the entities named above.

**New York:** Of the programs researched, none certified case managers using any of the means discussed above and yet there is a trend in opinion amongst stakeholders that certification/credentialing of case managers would provide a degree of accountability, standardization, and consistency and should be considered for newer care coordinators in the field. We also found that NY Connects puts forth competency standard guidelines for county level units to follow. Of note however, there are stakeholders in strong opposition to this notion- noting that the generalist training achieved through social work or nursing education is sufficient.

Although national certification of case managers has been utilized as a tool to ensure competency, New York programs have yet to adopt this practice. Given that this is an emerging profession and that there are multiple ways to enter into it, we believe that certification is an area that deserves
further exploration, as it is one of several measures that can be taken to ensure competency in practice in state funded programs.

**Work Experience**

Experience in the field and the community is an important determinant of high-quality care coordination. Many assert that success in care coordination is often based on knowledge, networking and relationships within the community, which take time to build. However, a strict requirement for extensive experience can be a deterrent to filling positions for care coordinators. This problem may be met by embracing a certain amount of flexibility in terms of educational and experience requirements, where strength in one area may compensate for weakness in the other.

*National:* Experience is always measured in years; and is almost always tied to an educational degree. The eligibility requirements for each of the four accepted certifications by the National Association of Professional Geriatric Case Managers referenced above is instructive in this regard: in general where the candidate for certification has a more general degree at a bachelor’s or associate’s level, more direct experience is required in terms of supervised experience or working with persons with chronic disabilities.

*New York:* New York is reflective of the national findings. Agreement can be found in the data collected that the lower the degree, the higher the number of years of experience is required. There is a general agreement by stakeholders that those who were more experienced and more knowledgeable of the community made for better care coordinators. Although it is an area of general agreement, there is a downside pointed out by many that raising the number of years of experience required diminishes the pool of candidates as the position becomes unattainable by some.

Based on national and state standards, we have made recommendations around *work experience* that are linked to educational requirements.

**In-service Training and Continuing Education Requirements**

*National:* Pre-service (orientation) and in-service training are both very common practices in state based care coordination programs. Most programs established set guidelines related to the number of in-service training hours required and the timeframes in which training should occur. Of the programs surveyed, 6 hours of in-service training per year was the lowest common denominator for ongoing training; at the other end, one program requires eight days of pre-service training with 20 hours of additional in-service training (over a two year period). It was not uncommon for states to establish guidelines related to the content areas of the training.

*New York:* In New York State, training was also a widely accepted practice for building case manager’s competence. Most NYS stakeholders agreed that some form of ongoing training for care coordinators is needed. Data sources revealed that the frequency, amount and content of training vary greatly. And although general agreement exists on the need for training, training should remain *accessible* and *affordable*, and should not duly burden the case manager or the employer.

It’s undeniable that nationally and in New York, training is a widely accepted practice to ensure competence. For the most part, on the job training is the most accessible and widely used practice in New York. Our recommendations reflect this trend.
Role of the Care Coordinator

Educational preparation, in-service training and work experience as well as decisions about certification and formal continuing professional education requirements should reinforce the ability of the care coordinator to perform core job functions and continue to develop the skills and knowledge required to perform these functions well. From our analysis of national guidelines, select state program components, New York stakeholder input and current New York State program practices, we developed a framework that outlines four areas of primary importance to the fulfillment of the care coordinator role: Essential functions, skills, knowledge and attitudes and values.

The specific details of the recommended role requirements are presented below along with recommendations for educational qualifications, work experience and in-service training requirements.
RECOMMENDATIONS: THE QUALIFIED CARE COORDINATOR

The New York Academy of Medicine has made a concerted effort to make recommendations for a qualified care coordinator based on evidence gained from national standards and practices and has grounded them in the realities of current New York standards and practice. Our recommendations are purposely broad and flexible and should provide a realistic basis for a State strategy to phase them into new, old and transitioning care coordination programs across the state. Also reflected in the recommendations is the need for the care coordinator to bridge the health and social service worlds of long term care, promoting better integration and the seamless delivery of services.

1. EDUCATION, EXPERIENCE, AND TRAINING

We recommend the following options for entry into the position of care coordinator related to EDUCATION and EXPERIENCE:

**Option 1**: A bachelor's degree in gerontology, social work, public health or nursing. If the degree is in social work or gerontology, the person must have at least one year experience working in a health care setting, preferably with older adults. If the degree is in nursing or public health, the person must have at least one year experience working with older adults, preferably in a community setting.

**Option 2**: A bachelor’s degree in sociology, psychology, or related human service field and have at least 2 years experience in public or private social service program or health care setting. One year experience as a case manager/care coordinator can be substituted for 2 years of experience in a social service program or health care setting, preferably with older adults.

**Option 3**: A registered nurse, with at least two years public health and/or home care experience related to assessment and service planning, and preferably working with older adults.

**Option 4**: A master’s degree in social work, nursing, psychology, counseling, rehabilitation, gerontology, sociology or other human service field with demonstrated knowledge in working with older adults preferably in a community based and/or public health setting.

In addition to their primary educational degree and experience, we recommend the following pre-service and in-service TRAINING requirements for care coordinators:

1. Care Coordinators will complete a state approved competency-based training within three months of employment. If a universal client assessment tool is adopted by the state, an orientation goal would be competence in using the tool.

2. In addition to the training within the first three months of employment, care coordinators will attend six hours of documented continuing education/training related to the Skills, Knowledge, Attitudes/Values identified below with special emphasis on aging, within each calendar year. Content should take in account the Care Coordinator’s need for professional growth and upgrading of skills. For part time employees, training shall be prorated to equal .25 hours for each full month of employment.

The state should make an effort to provide affordable methods for training to provider organizations and individual care coordinators while ensuring that the training is meeting its intended purpose.
2. ESSENTIAL FUNCTIONS

Based on review of national and NYS data, below are the primary functions and tasks performed by a care coordinator. Each function or task requires a unique set of competencies in order to perform them. The competencies (which can be categorized into skills, knowledge and value/attitudes) are described in the sections to follow.

Develop and maintain relationships
*Establish effective and respectful relationships with patients, families, professionals, payers and other relevant parties.* One way to do this is to build and maintain trust.

Assessment and reassessment
*Accurately conduct face-to-face assessments on the person’s physical, social, psychological, neuropsychological and financial status, and the needs and situation of the family caregiver, as appropriate; to identify the person’s strengths and limitations related to the principal concerns.*

Train and educate patients, families, and medical and social service providers
*When appropriate, use the skills of teaching to ensure understanding by patients, families and service providers in case management, its goals, skills and knowledge base, available services, and self-management.*

Goal setting
*The care coordinator works with the patient and the family to set appropriate goals to work towards and supports the patient and family in reaching the goals using the skills of coaching and consultation.*

Care planning
*Develop an individualized care/service plan with the patient (and family when appropriate) that identifies priorities, desired outcomes/goals, and strategies and resources needed to achieve those outcomes. Provide continuous monitoring of the care plan to ensure quality of care/services; and continued appropriateness. Adjust care plan as seen appropriate. Care planning and coordination is done in collaboration with an interdisciplinary team.*

Coordination of services
*In order to streamline and integrate the health and social service delivery systems to prevent delays in receiving care, the care coordinator, depending on the setting, will refer and facilitate access to the services or will directly coordinate the services set out in the care plan. Thereafter, the care coordinator will establish a system for monitoring and subsequently monitor the delivery of the services. On occasion, the care coordinator will act as an advocate if a conflict arises.*

Ensure cost effectiveness while maintaining quality
*The care coordinator is mindful of economic cost of services and works to remain within the program’s and/or patient’s budget while maintaining the quality of care/service.*

Ongoing quality improvement
*The care coordinator participates in evaluating outcomes at the individual level with each patient/client and at the same time participates in agency-wide evaluative efforts to ensure and improve the overall quality of services being delivered.*
A. SKILLS
The skills laid out below are needed to effectively perform the Essential Functions of a Care Coordinator.

Assessment Skills
The care coordinator must be able to assess the patient/family’s needs from a strengths perspective taking into consideration cultural, spiritual or other value/belief systems. She/he must be able to identify barriers and potential ethical dilemmas with the patient, family or caregiver.

Intervention Skills
The care coordinator is equipped with skills that enable him/her to work effectively with the client/family in discussing options and setting goals. She/he also uses intervention skills to coordinate and mobilize services/resources to maximize the client’s physical, social, and emotional well-being as well as client and family involvement. On occasion, the care coordinator intervenes in crisis situations; finds resolutions to problems; and negotiates complex systems and situations and between parties.

Communication Skills
The coordinator should be an excellent listener. The coordinator uses different communication styles in interpersonal communication and is able to counsel, manage group dynamics, build relationships, interview, and facilitate understanding and cooperation among interdisciplinary team members. The care coordinator is skilled at passing on information verbally and in writing.

Health and Social Care Related Clinical Skills
Depending on the model and role of the care coordinator, she/he must be able to manage directly or as coordinator of an appropriate professional team a person’s acute or chronic illness from a clinical perspective; and assess the level of care. The care coordinator must be able to manage the care of clients relevant to the disease, condition or circumstance for which she/he is in need of services (e.g. substance use/abuse problems, mental illness and/or dementia, hospice, amongst others).

Program Research and Evaluation
Consistent with level of education, the care coordinator participates in research and evaluation at the program level to improve the quality of care, services and cost effectiveness.

Administrative Skills
The care coordinator must be able to organize, evaluate, and present information clearly both verbally and in written communication; maintain documentation according to agency policy, and keep patient records according to agency policy. She/he must be able to manage a caseload as specified by the agencies or professions guidelines that allows the case manager to effectively plan, provide and evaluate case management tasks related to client and system interventions. Additionally, the coordinator must be knowledgeable about the range of service options, inform the patient/family and monitor service delivery once the care plan is enacted. The care coordinator is fluent and/or able to learn the technology and programs.
B. KNOWLEDGE
The areas of knowledge laid out below are needed to effectively perform Essential Functions of a Care Coordinator.

Case Management Theory and Emerging Models of Practice
The care coordinator should be familiar with various models of care coordination (e.g. transitional care, case management, gatekeeping, targeted case management, life care planning.) The care coordinator should know the goals and objectives; functions and roles of the care coordinator, and the care coordination model used in the employing organization.

Client Population
The care coordinator must be competent in and know how and be competent in different diagnoses, cultures, and/or other background factors affect the successful delivery of care and in particular the aging population across the continuum.

Interpersonal and Group Dynamic Theories
The care coordinator understands and is knowledgeable about different communication patterns (including conflict) and is aware of family and group dynamics and how they affect service delivery and the client.

Health and Wellness
The care coordinator is knowledgeable about medical terminology; common symptoms and diseases progression of frequently seen diseases (e.g. CHF, Alzheimer's disease, ALS); and common medications (names and side effects). She/he should be knowledgeable about how to promote wellness and prevent illness from a general sense. The care coordinator should only practice within any professional guidelines of his/her profession/license.

Community Resources
The care coordinator is familiar with the continuum of care concept and the functions and roles of various health and long term care providers. The care coordinator is knowledgeable about a wide range of public and private community resources, services and other forms of support available to the client.

Organizational Knowledge
The care coordinator should be knowledgeable about the policies/procedures and organizational structure of his/her own organization. She/he should also be knowledgeable and respectful of any organization she/he works with in the course of coordinating a person’s care and services.

Financing and Payment Options
From a conceptual place, the care coordinator should be knowledgeable about managed care, health insurance, cost containment, revenue management, and gate-keeping. The care coordinator should be knowledgeable about reimbursement policies related to eligibility guidelines for the program that the client is enrolled in or to be enrolled in. The care coordinator should be familiar with budgeting, particularly with low income clients.

Federal, State and Local Laws and Policies related to delivery systems, resources and benefits as well as law and ethical standards related to client autonomy.
The care coordinator must have current knowledge about the laws and regulations that regulate the delivery of health and social services for the population in which she/he works. The care coordinator must be familiar with the various systems in which services are delivered (e.g. healthcare, social service, rehabilitation, vocational rehabilitation). The care coordinator must have fluency in public (SSI, SSDI, Medicare, Medicaid, VA) and private programs. (e.g. pharmacy benefits management, indemnity, employer sponsored health coverage, individual-purchased insurance, home care benefits) benefit programs.
C. ATTITUDES AND VALUES
The attitudes and values laid out below are needed to effectively perform Essential Functions of a Care Coordinator.

Respectful Communication
Care coordinators treat colleagues (inter and intra agency), clients and other involved parties with respect and in a culturally competent way.

Confidentiality and Ethical Practice
The care coordinator works to safeguard the interests and rights of clients when releasing information (verbal, in writing or electronically) by gaining permission from the client, legal guardian, or appointed surrogate. The coordinator safeguards the client’s right to privacy and interviews the client privately. The care coordinator abides by the ethical standards of his/her profession or organization.

Client Self-Determination and Family Involvement
The care coordinator maximizes client self-determination and decision-making at all stages of the process, making the client’s goals, choices and needs a priority. The care coordinator safeguards the interests/rights of the client when it is necessary to act on behalf of a client who has been judged incompetent and appropriately assists family when a client has dementia or other cognitive deficits. Family and other informal caregivers are involved in the decision making when the client chooses or when the client’s mental or physical condition makes self-determination and self-management impossible. Self-management services are available to maximize client and family knowledge and skills.

Disclosure and Conflicts of Interest
The care coordinator discloses to client and family (prior to accessing and coordinating services) any fees related to the service, professional fees she/he may charge, any known aspects or limitations of resources/benefits/services being recommended, and the extent of his/her own qualifications. The care coordinator avoids or discloses all conflicts of interest.
FUTURE DIRECTIONS

The New York Academy of Medicine is pleased to have had the opportunity to research and recommend a best-practice care coordination model for New York State and subsequently provide specific recommendations on the qualifications of a care coordinator. Further, we believe it to be a privilege to present the New York State Department of Health and the State Office for the Aging with three research reports Towards the Development of Care, Coordination Standards; Perspectives on Care Coordination: Voices of Older New Yorkers, and this paper; Who is Qualified to Coordinate Care?

This final section contains possible future directions for this critical work related to the recommendations for a Qualified Care Coordinator. The possibilities presented are based on knowledge gained in conducting research for the paper; our extensive history in eldercare workforce development; and from our research on evidence-based practices in care coordination at the national level.

The Qualified Care Coordinator
Several areas emerged as potential future directions to consider in order to increase the supply of qualified care coordinators in New York State.

Competency Development and Certification
Worth noting is that was sparse evidence was found to support licensing care coordinators/case managers at the national level. And despite the data indicating the common practice of certifying care coordinators nationally, NYAM is reluctant to make a recommendation that NY care coordinators become certified for several reasons.

Though it does license a number of professions and enforces scope of practice for these professions, historically, New York has not engaged in the process of certifying individuals in health care professions. Generally, New York has deferred to trade associations and membership organizations to provide credentialing and certification for various professions. This is in large part due to the complexity and difficulty that arises from the various stakeholders around any discussion of amending laws governing professions.

However, evidence exists nationally in support of competency testing and certification in state programs. Moreover, the consumers and caregivers we spoke to felt certification increased the level of quality and reliability of individuals providing care. Given the two poles (resistance to certification in NY state vs. evidence to support certification), we recommend the state carefully enter into an open dialogue with stakeholders about certification of care coordinators towards a goal of providing care coordination in a high quality way.

Possibilities:
- Commission a survey of current providers and care coordinators about interest in a certification;
- Catalogue potential avenues for certification and identify methods of implementing a care coordination certification;
- Assess the cost to the state/provider/individual for certification; and/or
- Convene a workgroup to establish a consensus-built set of care competencies for care coordinators.
Training
Based on our findings, we have recommended a state-approved competency-based training within the first three months of employment and an additional 6 hours of training a year for full time employees.

Possibilities:
- Convene a series of workgroups to identify a core set of competencies to be addressed in the initial training, determine the best way for approving this training; and develop an core curriculum for care coordinator training; and/or
- Commission a private organization to develop and maintain a high quality, free, web-based clearinghouse for training materials related to the competencies and maintain an online training capacity.

Workforce Development
There is an undeniable workforce shortage in acute health, social and long term care for older adults. Because of other factors feeding into the looming crisis, like the aging out of seasoned social workers and nurses, current and future efforts need to be made now to ensure a competently trained, care coordination workforce.

Possibilities:
- Data on the existing eldercare workforce in New York is limited by the way in which it is collected and by the siloed nature of the departments who collect and use the data. To fully develop and strengthen the care coordination workforce, it would be beneficial to understand it more deeply. It may not be possible to quantify the care coordination workforce directly but it is possible to survey the two prime ‘feeder’ professions (nursing and social work) to determine of who in each profession is serving older adults and who is serving older adults in a care coordination capacity. The state could commission a survey using membership rosters from existing associations (NY State Association for Nurses and the two NY chapters of the National Association of Social Workers). Conducting this kind of study would be helpful in planning for the future needs of the older adult population. A recent bill in the NY State Senate around social work licensure called for a survey, illustrating the need for quantifiable data.

- To provide an opportunity for recent college graduates to enter into the field and gain the experience necessary, the state could support a pilot apprenticeship program for care coordinators that would provide a year-long on the job training for new graduates; and also provide a career ladder for seasoned care coordinators (serving in the role of mentor, supervisor, preceptor or instructor). The pilot would assist the state in assessing the feasibility of implementing a permanent registered apprenticeship. The US Department of Labor- Education and Training Administration along with the New York State Department of Labor offer guidance on how to create and register apprenticeships. Currently in the United States there are over 1,000 registered careers in a myriad of industries, including health and long term care, with about a quarter of a million employers in the nationwide network. There are just under 300 approved apprenticeship trades in New York, with many more in the approval process. Some apprenticeship models are time based models, where apprentices earn full accreditation as a specific profession based on the number of hours served; some are competency based, while others are a hybrid of the two.
Financial incentives often attract service-oriented individuals to the field who might not have considered it otherwise. The state could sponsor and financially support the following financial incentives once the criteria for a qualified care coordinator are defined:

- **Loan forgiveness programs** for those entering the care coordination field and/or for those who stay in the field for predetermined length of time. Currently, the NYS Licensed Social Worker Loan Forgiveness program is operating in 28 counties and could be expanded to others through the Higher Education Service Corp (HESC); HESC also offers loan forgiveness to nursing faculty. A similar program exists for nurses, but at the federal level through Health Resources and Service Administration. Moreover, many health care facilities offer private loan forgiveness programs to employees. The state, through the Higher Education Service Corp could sponsor a loan forgiveness program for individuals serving in a care coordination capacity.

- **Sign-on bonuses.** These are often used in hospital and other healthcare settings to attract professionals in high vacancy rate careers. Sign-on bonuses are typically privately financed; however the state could fund such sign-on bonuses in publicly owned and operated health/social service facilities.

Turnover in the acute health and social service professions is a documented and persistent phenomenon that employers have primarily addressed at the provider level. Turnover, especially when factoring in vacancy rates, carries a financial cost to the employer and ultimately to the payers (the state in many instances). Turnover is preventable and cost savings can be realized if retention of employees is minded. The state could conduct a research study to determine why employees stay and why employees leave a position currently characterized as care coordination (e.g. case management) to shed light on factors that will influence the retention of the workforce. Subsequently, the state could create an initiative that would provide financial support and technical assistance to providers engaged in high quality recruitment and retention initiatives. Drawing from other professions, some methods used to promote retention at the workforce level include:

- Thoughtful recruitment and screening into the profession (e.g. realistic job previews, interview guides)
- Mentoring programs
- Supportive workplace environments
- Training and education opportunities
- Opportunities for advancement within the profession itself
- Participatory workplaces practices
CONCLUSION
The Social Work Leadership Institute of the New York Academy of Medicine has been pleased to have had this opportunity to work with the NY State Department of Health and the State Office for the Aging. We would welcome the opportunity to further a care coordination model, or any component of it, with you strengthen the eldercare workforce for an aging population in New York State.
APPENDIX

APPENDIX A: Information and Data Sources Used to Inform Each Recommendation

APPENDIX B: Case Manager Educational and Training Requirements for Select States

APPENDIX C: Care Coordinator Competencies/Responsibilities

APPENDIX D: NY State Survey of Programs on Care Coordinator Education, Training and Function
APPENDIX A: Information and Data Sources Used to Inform Each Recommendation

This Appendix contains the specific items (taken from the sources cited below) that support each area of our recommendations on a Qualified Care Coordinator. For a further explanation on our process for developing the recommendations (left hand column) from the cited sources (right hand column), please see the Methodology section of this report.

Data Sources

Research and Analysis of Nationally Recognized Guidelines
1. The Commission on Case Manager Certification (CCMC)
2. The Medicare Chronic Care Practice Research Network (MCCPRN)
3. The Case Management Society of America (CMSA)
4. The National Association of Social Work: Case Management (NASW)
5. The National Association of Professional Geriatric Care Managers (NAPGCM)
6. The International Academy of Elder/Professional Geriatric Care Managers (IAECM)
7. Veterans Affairs Social Work Case Management Competency Standards (VACM)

Research and Analysis of Care Coordination/Case Management Competencies and Qualifications in Select State Programs
8. State Medicaid or Medicaid Waiver Programs
   a. IL: Illinois Case Coordination Units for the CCP Program;
   b. OH: Ohio PASSPORT Program;
   c. PA: Pennsylvania Independence Waiver;
   d. NJ: Community Care Program for the Elderly and Disabled (CCPD);
   e. SC: South Carolina Care Coordination;
   f. IA: Case Management Program For the Elderly;
   g. AK: Alaska’s Older Alaskan’s Waiver;
   h. ME: Maine’s Elder Independence of Maine, and
   i. TX: Texas’ Star+Plus

New York Based Data Sources
9. NY Stakeholders: NYAM surveyed case managers, policymakers, membership association leaders, providers, consumers and caregivers about various topics; one of them being the role and function of case managers (NY Stakeholders)
### ESSENTIAL FUNCTIONS

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Source</th>
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<tbody>
<tr>
<td><strong>Develop and maintain relationships</strong>&lt;br&gt;Establish effective and respectful relationships with patients, families, professionals, payers and other relevant parties. One way to do this is to build and maintain trust.</td>
<td>- Establish an effective and respectful relationship with the client/family, payer, physician, other healthcare providers, and other relevant parties (MCCPRN)&lt;br&gt;- Build and maintain trust (CMSA)&lt;br&gt;- Treat colleagues respectfully as a prerequisite for effective communication and cooperation among professionals (NASW)&lt;br&gt;- Have a spirit of respect and caring in the social worker-client relationship (NASW)&lt;br&gt;- Provide support to family members who serve as resources to the client to avoid overburdening them and inadvertently facilitating caregiver burnout (NASW)&lt;br&gt;- Supports the client/family in moving toward self-care (MCCPRN)&lt;br&gt;- Collaborate with various agencies and types of people (CMSA)&lt;br&gt;- Outreach or referral activities (NASW)&lt;br&gt;- Maintain professional collaboration and communication with the client and family (MCCPRN)&lt;br&gt;- Facilitate understanding, communication and cooperation among members of the healthcare team (MCCPRN)&lt;br&gt;- Professionalism of the relationship (NAPGCM)&lt;br&gt;- Interpersonal communication (e.g. group dynamics, relationship building, interviewing) (CCMC)</td>
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<td><strong>Assessment and reassessment</strong>&lt;br&gt;Accurately conduct face-to-face assessments on the person’s physical, social, psychological, neuropsychological, and financial status to identify the person’s strengths and limitations related to the principal concerns.</td>
<td>- Psychological and neuropsychological assessment (CCMC)&lt;br&gt;- Ability to assess treatment needs of individuals who experience physical and/or intellectual disabilities (states)&lt;br&gt;- Ability to reassess, evaluate outcomes and transfer/terminate; ability to assess level of care review (states)&lt;br&gt;- Assessment of physical functioning (CCMC)&lt;br&gt;- Accurately assess patient status and functioning (CMSA)&lt;br&gt;- Assess caregiver or family needs (CMSA)&lt;br&gt;- Ability to conduct a comprehensive bio-psychosocial assessment (VACM)&lt;br&gt;- Ability to assess mental status and psychopathology (VACM)&lt;br&gt;- Conducts a face-to-face comprehensive assessment (NASW)&lt;br&gt;- Identify strengths and limitations&lt;br&gt;- Identify the social, financial, and institutional resources related to the principal concerns identified during the assessment</td>
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<tr>
<td><strong>Train and educate patients, families, and medical and social service providers</strong>&lt;br&gt;When appropriate, use the skills of teaching to ensure understanding by patients, families and service providers in case management, its goals, skills and knowledge base, available services, and self-management.</td>
<td>- Education of the health, medical and social service providers about case management and other areas (MCCPRN)&lt;br&gt;- Education of patient and family about case management and other areas (MCCPRN)&lt;br&gt;- Ability to educate patient and family regarding risk factors for optimal psychosocial functioning: community resources, wellness and health promotion (VACM)&lt;br&gt;- Ability to educate professional staff and community providers regarding psychosocial factors and family dynamics having an impact on response to treatment (VACM)&lt;br&gt;- Educate patient, family and other providers (CMSA)&lt;br&gt;- Ability to conduct skills training (ME)&lt;br&gt;- Educates the client/family and supports moving toward self-care (MCCPRN)&lt;br&gt;- Identifying and addressing education needs of client, family, support system, or service provision team; (IAECM S/P 9)&lt;br&gt;- Ability to engage and mobilize patient and family coping strengths and community resource (VACM)</td>
</tr>
<tr>
<td><strong>Goal setting</strong>&lt;br&gt;The care coordinator works with the patient and the family to set appropriate goals to work towards and supports the patient and family in reaching the goals using the skills of coaching and consultation.</td>
<td>- Assist in patient in setting appropriate goals (individual or long term) (CMSA)&lt;br&gt;- Provide consultation to patients (CMSA)&lt;br&gt;- Act as a coach or guide to patient (CMSA)&lt;br&gt;- Foster self-determination (NAPGCM S/P 2)&lt;br&gt;- Fosters the client's/family's informed decision making, independence, growth, and development (MMCPGRN)&lt;br&gt;- Set clear, attainable goals (IAECM)</td>
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</table>
### Care planning

**Develop an individualized care/service plan with the patient (and family when appropriate) that identifies priorities, desired outcomes/goals, and strategies and resources needed to achieve those outcomes. Provide continuous monitoring of the care plan to ensure quality of care/services; and continued appropriateness. Adjust care plan as seen appropriate. Care planning and coordination is done in collaboration with an interdisciplinary team.**

- Develop an appropriate plan of care to reach clinical goals (CMSA)
- Ability to develop a care and/or service plan (IL, IA, NJ, PA)
- Continuously monitor the quality of care and make appropriate adjustment to the care plan (CMSA)
- Monitor the quality of care and make appropriate adjustment to the care plan (CMSA)
- Develop contingency plans (CMSA)
- Development of plans of care (NAPGCM S/P 7)
- Discharge planning to ensure most appropriate and reimbursable care (MCCPRN)
- Ability to work with professional and support staff in an interdisciplinary team (AK, OH, TX)
- Develops an individualized service plan with the client: identify priorities; identify desired outcomes; identify strategies and resources to be used in attaining the outcomes (NASW)
- Revisions of care plan as indicated based on reassessment of client status, effectiveness of interventions, attainment of outcomes with revision of the service plan as indicated (NASW)
- Engage in the objective use of available resources and reference data in developing a plan of care. (IAECM)
- Developing/Implementing a plan that integrates the client and/or parties in the decision-making process to meet recommended and cost-effective short- and long-term goals and objectives, and recognition of potential complications. Plan may involve the identification, procurement, and coordination of services and resources to implement the plan and may involve ongoing evaluation of client’s progress and the effectiveness or appropriateness of the plan; (IAECM S/P 4)
- Involve ongoing evaluation of client’s progress and the effectiveness or appropriateness of the plan (IAECM S/P 3)

### Coordination of services

**In order to streamline and integrate the health and social service delivery systems to prevent delays in receiving care, the care coordinator, depending on the setting, will refer and facilitate access to the services or will directly coordinate the services set out in the care plan. Thereafter, the care coordinator will establish a system for monitoring and subsequently monitor the delivery of the services. On occasion, the care coordinator will act as an advocate if a conflict arises.**

- Coordinates tests, procedures and services to prevents delays in care and care transitions (MCCPRN)
- Streamlining the healthcare delivery process by facilitating communication and collaboration among the client/family; the primary care provider, members of the healthcare team, the payer, and other relevant parties from the legal, educational and religious communities (MCCPRN)
- Facilitate, coordinate, and maintain continuity of care (CMSA)
- Monitor the delivery of services to patient (CMSA)
- Organize/coordinate medical, social, and educational services that are and that are not covered by Medicaid and make appropriate referrals (NASW)
- Maintain continuity of care by coordinating all services seamlessly(CMSA)
- Focuses on continuum care and facilitates safe movement between levels and settings (MCCPRN)
- Advocates both for client and for the payer to facilitate positive outcomes but when conflict arises, makes the needs of the client the priority (MCCPRN)
- Advocates on behalf of the plan (NASW)
- Facilitate access to providers and services, as needed (CMSA)
- Act as patient advocate with physicians or various organizations (CMSA)
- Terminate/transfer the case (NASW)
- Ability to organize/coordinate medical, social, and educational services that are and that are not covered by Medicaid and make appropriate referrals (IL, IA, ME, NJ, PA, SC, TX)
- Ability to work with professional and support staff in an interdisciplinary team (AK, OH, TX)
- Coordinating services among medical or allied health professionals and inpatient, outpatient, home services, or environmental modification providers; (IAECM S/P 6)
- Coordinating vendor and resource utilization involving medical equipment, supplies ,medication and services (IAECM S/P 8)
### Ensure cost effectiveness while maintaining quality

The care coordinator is mindful of economic cost of services and works to remain within the program’s and/or patient’s budget while maintaining the quality of care/service.

- Ensures delivery and use of cost effective care (MCCPRN)
- The social work case manager shall be knowledgeable about resource availability, service costs, and budgetary parameters and be fiscally responsible in carrying out all case management functions and activities (NASW S/P 7)

### Ongoing quality improvement

The care coordinator participates in evaluating outcomes at the individual level with each patient/client and at the same time participates in agency-wide evaluative efforts to ensure and improve the overall quality of services being delivered.

- Program evaluation and research methods (e.g. outcome, satisfaction) (CCMC)
- Evaluate outcomes (NASW)
- Program evaluation and research (MCCPRN)
- Act as a change agent by assessing relevant systems and organizations (CMSA)
SKILLS
The skills laid out below are needed to effectively perform Essential Functions of a Care Coordinator.

<table>
<thead>
<tr>
<th>Recommendation</th>
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<tbody>
<tr>
<td><strong>Assessment Skills</strong></td>
<td>• Identify patient needs and issues (CMSA)</td>
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<tr>
<td><strong>The care coordinator must be able to assess the patient/family’s needs from</strong></td>
<td>• Assess clinical, social and other patient needs (CMSA)</td>
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<tr>
<td><strong>a strengths perspective taking into consideration cultural, spiritual or</strong></td>
<td>• Ability to assess treatment needs of individuals who experience</td>
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<td><strong>other value/belief systems. She/he must be able to identify barriers and</strong></td>
<td>physical and/or intellectual disabilities (NASW)</td>
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<td><strong>potential ethical dilemmas with the patient, family or caregiver.</strong></td>
<td>• Assess caregiver or family needs (CMSA)</td>
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<td>• Determine the type and level of cultural influences on client (CMSA)</td>
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<td>• Identify and acknowledge the client’s belief or value system (CMSA)</td>
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<td>• Identify potential barriers to client goals or treatment plan (CMSA)</td>
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<td></td>
<td>• Reassess plan of care (CMSA)</td>
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<td></td>
<td>• Recognize and identify the potential ethical dilemmas with patient,</td>
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<td></td>
<td>family or caregiver (CMSA)</td>
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<td></td>
<td>• Evaluate service and fiscal resources (NASW)</td>
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<td></td>
<td>• Respect the cultural, spiritual, racial, ethnic beliefs of others (OH)</td>
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<td></td>
<td>• Ability to conduct a comprehensive bio-psychosocial assessment (VACM)</td>
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<td>• Ability to assess mental status and psychopathology (VACM)</td>
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<td></td>
<td>• Understanding conditions of the assessment/evaluation</td>
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<td>• Recognizing importance of timely client assessment (e.g., onset of</td>
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<td>injury/illness)</td>
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<td></td>
<td>• Release(s) of information</td>
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<td>• Medical/Mental health status review</td>
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<td></td>
<td>• Client’s understanding/learning needs related to the diagnosis,</td>
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<td>treatment, resources, adjustment, and coping mechanisms</td>
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<td></td>
<td>• Family knowledge base and need for education, health status,</td>
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<td>expectations, support or caregiver potential; (IAEC M S/P 3)</td>
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<td><strong>Intervention Skills</strong></td>
<td>• Conflict resolution (CCMC)</td>
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<tr>
<td><strong>The care coordinator is equipped with skills that enable him/her to work</strong></td>
<td>• Negotiation (CCMC)</td>
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<tr>
<td><strong>effectively with the client/family in discussing options and setting goals.</strong></td>
<td>• Negotiate on behalf of others (CMSA)</td>
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<td><strong>She/he also uses intervention skills to coordinate and mobilize services/</strong></td>
<td>• Facilitation (MCCPRN)</td>
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<td><strong>resources to maximize the client’s physical, social, and emotional</strong></td>
<td>• Collaboration with families and professionals (MCCPRN)</td>
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<td><strong>well-being as well as client and family involvement. On occasion, the care</strong></td>
<td>• Coordination (MCCPRN)</td>
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<td><strong>coordinator intervenes in crisis situations; finds resolutions to problems;</strong></td>
<td>• Assist in negotiating complex, sometimes intimidating, service</td>
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<td><strong>and negotiates complex systems and situations and between parties.</strong></td>
<td>delivery systems (NASW)</td>
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<td>• Ability to intervene in a crisis (CCMC)</td>
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<td>• Identifies and removes barriers; reduces fragmentation and</td>
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<td>duplication of services (MCCPRN)</td>
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<td></td>
<td>• Utilize creativity in finding new and unique solutions (CMSA)</td>
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<td>• Assist in patient in setting appropriate goals (individual or long</td>
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<td>term) (CMSA)</td>
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<td>• Discuss the potential pros and cons of various treatment options</td>
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<td>with patient and family** (CMSA)</td>
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<td>• General problem solving skills (CMSA)</td>
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<td></td>
<td>• Mobilize the services needed to maximize the client’s physical,</td>
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<td>social, and emotional well-being (NASW)</td>
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<td>• Mobilize the formal and informal resources (NASW)</td>
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<td>• Successfully link patient to needed services (CMSA)</td>
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<td>• Successfully implement and coordinate patient services (CMSA)</td>
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<td>• Intervene at the client level to provide and/or coordinate the</td>
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<td>delivery of direct services to clients and their families (S/P 5</td>
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<tr>
<td></td>
<td>NASW)</td>
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<td>• Provide support to family members who serve as resources to the</td>
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<td>client to avoid overburdening them and inadvertently facilitating</td>
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<td>caregiver burnout (NASW)</td>
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<td></td>
<td>• Ability to advocate on behalf of the elderclient (IA, PA)</td>
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<td>• Ability to problem solve to address client needs (SC)</td>
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<td>• Service counseling with participant and families (SC)</td>
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<td>• Skills in advocacy (VACM)</td>
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<td></td>
<td>• Ability to provide individual, group and marital counseling (VACM)</td>
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<tr>
<td></td>
<td>• Skills in conflict management and mediation (VACM)</td>
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</table>
Communication Skills
The coordinator should be an excellent listener. The coordinator uses different communication styles in interpersonal communication and is able to counsel, manage group dynamics, build relationships, interview, and facilitate understanding and cooperation among interdisciplinary team members. The care coordinator is skilled at passing on information verbally and in writing.

Health and Social Care Related Clinical Skills
Depending on the model and role of the care coordinator, she/he must be able to manage directly or as coordinator of and appropriate professional team a person’s acute or chronic illness from a clinical perspective; and assess the level of care. The care coordinator must be able to manage the care of clients relevant to the disease, condition or circumstance for which she/he is in need of services (e.g. substance use/abuse problems, mental illness and/or dementia, hospice, amongst others).
Program Research and Evaluation

Consistent with level of education, the care coordinator participates in research and evaluation at the program level to improve the quality of care, services and cost effectiveness.

- Evaluates the quality of educational material available on the Internet (MCCPRN)
- Participates in research activities that are appropriate to the case manager’s practice environment and educational preparation (MCCPRN)
- Collect, analyze and synthesize data (CMSA)
- Develop specific markers to track patient progress (CMSA)
- Participate in ongoing quality insurance efforts for the individual client by obtaining timely and accurate information, completion of relevant forms and peer review (NASW)
- Identifies evidence-based interventions substantiated by research that are appropriate to the ongoing care needs of the client and the client’s education, environment, family, and community-support network (MCCPRN)
- Analyzes trends in healthcare and case management services (MCCPRN)
- Uses systematic research methods to evaluate case management practice and study the effectiveness of case management interventions (MCCPRN)
- Contributes to the field of case management through the review and application of research findings to improve and advance case management practice (MCCPRN)
- Analyze the strengths and limitations of environmental systems (NASW)
- Delineate desired outcomes (NASW)
- Select strategies to improve systems (NASW)
- Assess the effectiveness of strategies (NASW)
- Continue to revise, as indicated, desired outcomes and strategies (NASW)
- Collect information and provides feedback on the program modifications, required delivery system changes, quality of provider performance, and effectiveness of the agency’s contracting system (NASW)
- Participate in achieving program improvements and ensuring the equitable allocation of resources at the system level by gathering reliable aggregate data (NASW)
- The social work case manager shall participate in evaluative and quality assurance research activities designed to monitor and appropriateness and effectiveness of both the service delivery systems in which case management operates (S/P 8 NASW)
- Ability to oversee and assure compliance and conduct utilization review activities (ME)

Administrative Skills

The care coordinator must be able to organize, evaluate, and present information clearly both verbally and in written communication; maintain documentation according to agency policy, and keep patient records according to agency policy. She/he must be able to manage a caseload as specified by the agencies or professions guidelines that allows the case manager to effectively plan, provide and evaluate case management tasks related to client and system interventions. Additionally, the coordinator must be knowledgeable about the range of service options, inform the patient/family and monitor service delivery once the care plan is enacted. The care coordinator is fluent and/or able to learn the technology and programs.

- Reviews patient records (MCCPRN)
- Case recording and documentation (CCMC)
- General writing skills (CMSA)
- General verbal communication skills (CMSA)
- Ability to organize, evaluate and present information effectively, both orally and in writing; ability to maintain case records, including documentation of follow-up (AK, IL, OH)
- Locate needed services or community resources for patients (CMSA)
- Monitoring service delivery (NASW)
- Inform the client of the full range of existing choices (NASW)
- Terminate the case (NASW)
- Ability to follow up, monitor, and ensure services are provided as prescribed in the enrolee’s plan of care (IA, ME, NJ, SC)
- Terminate/transfer the case (IL, IA, PA, SC)
- Ability to process claims (ME)
- Excellent computer skills, including the Windows operating systems, MS Word, MS Excel, data entry, and the ability to learn new software applications as needed (OH)
- The social work case manager shall carry a reasonable case load that allows the case manager to effectively plan, provide and evaluate case management tasks related to client and system interventions. (S/P 9 NASW)
- Ensure caseload is maintained (PA)
- Secure the most appropriate services for clients within the legal standards within the scope of practice. (IAECM)
- Documenting termination of services to the client or representative (IAECM S/P 11)
- Maintain files and other documents securely, with provisions for proper destruction of records. (IAECM)
- Verify ethically and to the extent possible the identity of a client, guardian or care management professional. (IAECM)
- Store case-related electronic transmissions in the case file (IAECM)
- Ability to communicate and negotiate with all levels of the organization and community with documented information and recommended solutions. (VACM)
KNOWLEDGE
The areas of knowledge laid out below are needed to effectively perform Essential Functions of a Care Coordinator.

<table>
<thead>
<tr>
<th>Recommendation</th>
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</table>
| **Case Management Theory and Emerging Models of Practice**  
The care coordinator should be familiar with various models of care coordination (e.g. transitional care, case management, gatekeeping, targeted case management, life care planning.) The care coordinator should know the goals and objectives; functions and roles of the care coordinator, and the care coordination model used in the employing organization. |  
- Case management models (CCMC)  
- Case management process and tools (CCMC)  
- Goals and objectives of case management (CCMC)  
- Roles and functions of case managers in various settings (CCMC)  
- Life care planning (CCMC)  
- Quality and performance improvement concepts (CCMC)  
- Process of care management; (MCCPRN)  
- Focusing on an effective treatment or approach for the client (MCCPRN)  
- Knows relevant areas of care coordination practice (MCCPRN)  
- Transitional planning (MCCPRN)  
- Knowledge in the case management process (VACM)  
- Continuum of care (CCMC) |
| **Client Population**  
The care coordinator must know how and be competent in different diagnoses, cultures, and/or other background factors affect the successful delivery of care, and in particular the aging population. |  
- Management of clients with substance use/abuse/addiction (CCMC)  
- Multicultural issues as they relate to health behavior (CCMC)  
- Psychosocial aspects of chronic illness and disability (CCMC)  
- Behavioral health and psychiatric disability concepts (CCMC)  
- Spirituality as it relates to health behavior (CCMC)  
- Concepts related to working with clients who have been abused (emotionally, psychologically, physically, financially) (CCMC)  
- Dementia as it affects client abilities and case manager/carer roles (NASW)  
- A good working knowledge and understanding of issues related to the elderly population (OH)  
- Ability to assess treatment needs of individuals who experience physical and/or intellectual disabilities (AK, IA)  
- Knowledge of population characteristics, to include cultural, ethnic, and religious diversity (VACM)  
- Respect the cultural/ethnic differences of clients, being aware of own biases. (IAECM)  
- Understanding conditions of the assessment/evaluation  
  - Recognizing importance of timely client assessment (e.g., onset of injury/illness)  
  - Release(s) of information  
  - Medical/Mental health status review  
  - Client’s understanding/learning needs related to the diagnosis, treatment, resources, adjustment, and coping mechanisms  
- Family knowledge base and need for education, health status, expectations, support or caregiver potential. (IAECM S/P 3) |
| **Interpersonal and Group Dynamic Theories**  
The care coordinator understands and is knowledgeable about different communication patterns (including conflict) and is aware of family and group dynamics and how they affect service delivery and the client. |  
- Group dynamics (CCMC)  
- Conflict resolution strategies (CCMC)  
- Crisis intervention strategies (CCMC)  
- Family dynamics (CCMC)  
- Different kinds of communication to patient and family: authoritative; prescriptive; informative; confronting; facilitative; cathartic; catalytic; supportive (MCCPRN)  
- Negotiation (MCCPRN)  
- Identify and engage clients (NASW)  
- Knowledge of the individual, family, social systems, and the individuals functioning in the aging process. (OH)  
- Knowledge of family dynamics (VACM) |
| **Health and Wellness**  
The care coordinator is knowledgeable about medical terminology; common symptoms and diseases progression of frequently seen diseases (e.g. CHF, Alzheimer’s) |  
- Wellness and illness prevention concepts and strategies (CCMC)  
- Assistive technology (CCMC)  
- Critical pathways, standards of care, practice guidelines (including average duration of treatment associated with various disabilities) (CCMC)  
- Levels of care (CCMC)  
- Management of medication use (CCMC) |
disease, ALS); and common medications (names and side effects). She/he should be knowledgeable about how to promote wellness and prevent illness from a general sense. The care coordinator should only practice within any professional guidelines of his/her profession/license.

**Community Resources**
The care coordinator is familiar with the continuum of care concept and the functions and roles of various health and long term care providers. The care coordinator is knowledgeable about a wide range of public and private community resources, services and other forms of support available to the client.

| Community resources (e.g. elder services, fraternal/religious organizations, governmental resources, Meals on Wheels) (CCMC) |
| Support programs (e.g. support groups or resources provided by professional organizations such as the American Heart Association) (CCMC) |
| Management of complementary alternative medicine (CAM) practices (CCMC) |
| Continuum of care (CCMC) |
| Roles and functions of other providers (CCMC) |
| Healthcare providers (including vendors available in the community) (CCMC) |
| Knowledge of available local and statewide resources (AK, ME, OH, PA, SC) |
| The social work case manager shall be knowledgeable about resource availability, service costs, and budgetary parameters and be fiscally responsible in carrying out all case management functions and activities (SP 7, NASW) |
| Definition of role to other practitioners (NAPGCM) |

**Organizational Knowledge**
The care coordinator should be knowledgeable about the policies/procedures and organizational structure of his/her own organization. She/he should also be knowledgeable and respectful of any organization she/he works with in the course of coordinating a person’s care and services.

| Institutional/ agency operations (MCCPRN) |
| System processes (MCCPRN) |
| Policies and procedures (MCCPRN) |
| Organizational support/authority (MCCPRN) |
| Knowledge base: collect information and provide feedback on the program modifications, required delivery system changes, quality of provider performance and effectiveness of the agency’s contracting system. (NASW) |

**Financing and Payment Options**
From a conceptual place, the care coordinator should be knowledgeable about managed care, health insurance, cost containment, revenue management, and gatekeeping. The care coordinator should be knowledgeable about reimbursement policies related to eligibility guidelines for the program that the client is enrolled in or to be enrolled in. The care coordinator should be familiar with budgeting, particularly with low income clients.

| Healthcare insurance principles (CCMC) |
| Managed care reimbursement concepts (CCMC) |
| Managed care concepts (CCMC) |
| Cost containment principles (CCMC) |
| Cost/benefit analysis (CCMC) |
| Accreditation standards and requirements (CCMC) |
| Prospective payment system (CCMC) |
| Risk management(CCMC) |
| Knows clinical, reimbursement and eligibility guidelines (MCCPRN) |
| Insurance benefits and reimbursement (MCCPRN) |
| Allocation and utilization of resources (MCCPRN) |
| Gatekeeping of services (MCCPRN) |
| Reimbursement and performance review (MCCPRN) |
| Management including revenue management (MCCPRN) |
| Account for costs, establish and charge fees for services rendered, and obtain reimbursement for professional services through direct program support, third- party payments, fees for service, and other financing mechanisms. (NASW) |
Federal, State and Local Laws and Policies related to delivery systems, resources and benefits as well as law and ethical standards related to client autonomy

The care coordinator must have current knowledge about the laws and regulations that regulate the delivery of health and social services for the population in which she/he works. The care coordinator must be familiar with the various systems in which services are delivered (e.g. healthcare, social service, rehabilitation, vocational rehabilitation). The care coordinator must have fluency in public (SSI, SSDI, Medicare, Medicaid, VA) and private programs. (e.g. pharmacy benefits management, indemnity, employer sponsored health coverage, individual-purchased insurance, home care benefits) benefit programs.

- Healthcare and disability related legislation (e.g. ADA, HIPAA) (CCMC)
- Legal and regulatory requirements (CCMC)
- Healthcare delivery systems (CCMC)
- Rehabilitation service delivery systems (CCMC)
- Private benefit programs (e.g. pharmacy benefits management, indemnity, employer sponsored health coverage, individual-purchased insurance, home care benefits) (CCMC)
- Public benefit programs (e.g. SSI, SSDI, Medicare, Medicaid) (CCMC)
- Know health plan benefits and services (CMSA)
- Disability compensation systems (e.g. workers' compensation, auto insurance, short term disability, accident and health) (CCMC)
- Workers' compensation principles (CCMC)
- Knowledge of requirements for HCBS Waiver Care Coordination Services and the care coordination process (AK, PA)
- Changing care delivery systems (MCCPRN)
- Knowledge of employment laws (NAPGCM S/P 8)
- Fiduciary principles (NAPGCM S/P 9)
- Issues relating to advocacy, experimental treatments and protocols, end of life, refusal of treatment/services, benefit limits, professional conduct (CMCC)
- Stay informed about emerging legislation trends and issues within the field. (IAECM)
- Knowledge of current VA and non-VA entitlements and benefits (VACM)
# ATTITUDES AND VALUES

The attitudes and values laid out below are needed to effectively perform Essential Functions of a Care Coordinator.

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Source</th>
</tr>
</thead>
</table>
| **Respectful Communication**  
Care coordinators treat colleagues (inter and intra agency), clients and other involved parties with respect and in a culturally competent way. | • Treat colleagues respectfully as a prerequisite for effective communication and cooperation among professionals (NASW)  
• Have a spirit of respect and caring in the social worker-client relationship. (NASW) |
| **Confidentiality and Ethical Practice**  
The care coordinator works to safeguard the interests and rights of clients when releasing information (verbal, in writing or electronically) by gaining permission from the client, legal guardian, or appointed surrogate. The coordinator safeguards the client’s right to privacy and interviews the client privately. The care coordinator abides by the ethical standards of his/her profession or organization. | • Safeguard the interests and rights of the client when the case manager must act on behalf of a client who has been judged incompetent (NASW)  
• The social work case manager shall ensure the client’s right to privacy and ensure appropriate confidentiality when information about the client is released to others (S/P 4, NASW)  
• Release information to other professionals and agencies only with the written permission of the client or his or her guardian, detailing what information is to be disclosed, to whom, and in what time frame. (NASW)  
• Interview clients privately and offer them the opportunity to be interviewed alone. (NASW)  
• Safeguard right to privacy (NAPGCM S/P 3) |
| **Client Self-Determination and Family Involvement**  
The care coordinator maximizes client self-determination and decision-making at all stages of the process, making the client’s goals, choices and needs a priority. The care coordinator safeguards the interests/rights of the client when it is necessary to act on behalf of a client who has been judged incompetent and appropriately assists family when a client has dementia or other cognitive deficits. Family and other informal caregivers are involved in the decision making when the client chooses or when the client’s mental or physical condition makes self-determination and self-management impossible. Self-management services are available to maximize client and family knowledge and skills. | • Ability to engage and mobilize patient and family coping strengths and community resources (VACM)  
• The care coordinator will help the recipient manage his/her care to the maximum extent possible. (AGSP S/P 10) |
| **Disclosure and Conflicts of Interest**  
The care coordinator discloses to client and family (prior to accessing and coordinating services) any fees related to the service, professional fees she/he may charge, any known aspects or limitations of resources/benefits/services being recommended, and the extent of his/her own qualifications. The care coordinator avoids or discloses all conflicts of interest. | • Obtain necessary written authorizations from client and make sure client is aware from the onset if service delivery is being monitored (IAECM)  
• Provide client with a professional disclosure statement and document in case file. (IAECM)  
• Maintain files and other documents securely, with provisions for proper destruction of records. (IAECM)  
• Fully disclose to clients all aspects and limitations of available resources (NASW)  
• Account for costs, establish and charge fees for services rendered, and obtain reimbursement for professional services through direct program support, third- party payments, fees for service, and other financing mechanisms (NASW)  
• Safeguard information obtained in the course of practice, disclosing only what is necessary, relevant, and verifiable to referral sources and other professionals. (IAECM) |
APPENDIX B: Case Manager Educational and Training Requirements for Select States

The programs described below are all associated with 1915(c) or 1115 Medicaid Waiver Programs.

<table>
<thead>
<tr>
<th>State</th>
<th>Education</th>
<th>Preferred</th>
<th>Waiver</th>
<th>Licensure or Certificate Related to Degree</th>
<th>Experience</th>
<th>State Training and/or Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>Social work care manager Master’s in social work, nursing, psychology, counseling, rehabilitation, gerontology, sociology, or a BA in same fields</td>
<td>None</td>
<td>Nurse must pass federal nursing exam and hold a current license within the state</td>
<td>One year with master’s degree or Two years with bachelor’s degree or Three years for a nurse case manager title</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Nurse care manager</td>
<td>BSN in public health, health education, health administration, gerontology</td>
<td></td>
<td>Social workers are not required to be licensed or certified</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Illinois</td>
<td>An RN or a BSN, or a BA/BBS degree in social science, social work, or related field; or be a licensed practical nurse (LPN) (experience required for LPN)</td>
<td>One year of program experience, which is defined as assessment, provision, and/or authorization of formal services for the elderly; may replace one year of college education up to and including four years of experience replacing a bachelor’s degree</td>
<td>Nurse must pass federal nursing exam and hold a current license within the state</td>
<td>LPNs must have one year of program experience (as defined earlier)</td>
<td>Prior to performing CCP eligibility determinations and developing plans of care, each case manager and each supervisor acting as a case manager shall successfully complete: Department-sponsored three-day CCP training on the DON, eligibility determination, care planning, nursing home prescreening, and OBRA-1 (Level I ID Screen). Successful completion of the above training shall be established by preliminary certification, which shall expire six months from completion of training. At the end of the three-day training, there is an exam. The new case manager must pass the exam to obtain case manager certification. The Illinois Department on Aging is the certifying agency.</td>
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</tr>
<tr>
<td>Case Coordination Units for CCP Program</td>
<td>Persons hired/serving in this capacity prior to December 13, 1991, may be waived</td>
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<tr>
<td>Ohio</td>
<td>Bachelor’s degree in nursing or bachelor’s degree in social work</td>
<td>None</td>
<td>Nurse must pass federal nursing exam and hold a current license within the state</td>
<td>At least one year of prior experience in medical social work and/or geriatrics</td>
<td>Case managers and AAA coordinators must receive six hours of LTC or aging-related training per year. CEU training required for maintenance of licensure can be used to meet the CMPFE training requirement; there are approval guidelines. To fulfill the training requirements of this section, any training course or event must be approved by the CMPFE program manager unless the course or event is: ■ A conference sponsored by the DEA, such as the Governor’s Conference on Aging ■ Caregiver or Elder Rights Conference ■ Conferences sponsored by N4A, NCOA, ASA, AOA, or the Alzheimer’s Association ■ Training sponsored by the DHS ■ A conference sponsored by a university, college, community college, or state agency other than the DEA if the conference content is related to aging</td>
<td></td>
</tr>
<tr>
<td>Passport</td>
<td></td>
<td></td>
<td>Social workers must be licensed</td>
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</tbody>
</table>

2 This table can also be found in the Appendix of the original report Towards the Development of Care Coordination Standards: An Analysis of Care Coordination in Programs for Older Adults.
<table>
<thead>
<tr>
<th>State</th>
<th>Education</th>
<th>Licensure or Certificate Related to Degree</th>
<th>Experience</th>
<th>State Training and/or Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pennsylvania PA Independence Waiver</td>
<td>Bachelor’s degree in social work, social science, or related field</td>
<td>Person with a physical disability with a high school diploma who has successfully transitioned to living independently</td>
<td>None required</td>
<td>Person with a disability must have one year of experience working with individuals with disabilities in a home- and community-based setting</td>
</tr>
<tr>
<td></td>
<td>Person with a physical disability with a high school diploma who has successfully transitioned to living independently</td>
<td>Person with a disability must have one year of experience working with individuals with disabilities in a home- and community-based setting</td>
<td>Person with a disability must pass an oral and/or written review</td>
<td>All supports coordinators must complete CORE, service, and annual training requirements</td>
</tr>
<tr>
<td>Utah Medicaid Waiver for Individuals Aged Sixty-Five and Over</td>
<td>Bachelor’s degree in nursing or bachelor’s degree in social work</td>
<td>Case manager certification from the National Academy of Certified Care Managers</td>
<td>Nurse must pass federal nursing exam and hold a current license within the state</td>
<td>Case managers must have a minimum of one year of experience working with the aging population before they can be hired to work with waiver clients</td>
</tr>
<tr>
<td></td>
<td>Case manager certification from the National Academy of Certified Care Managers</td>
<td>Case manager certification from the National Academy of Certified Care Managers</td>
<td>Case managers must have a minimum of one year of experience working with the aging population before they can be hired to work with waiver clients</td>
<td>Prior to performing case management services, each case manager is trained on the requirements necessary to perform this service for the Aging Waiver</td>
</tr>
<tr>
<td>New Jersey CCPED</td>
<td>Bachelor’s degree in nursing or bachelor’s degree in social work</td>
<td>Certified case manager—must be certified through an exam and must take training (see training requirements)</td>
<td>Certified social worker (BSW and passing ASWB bachelor’s-level exam) Nurse must pass federal nursing exam and hold a current license within the state</td>
<td>None noted</td>
</tr>
<tr>
<td>State</td>
<td>Community Care</td>
<td>Education</td>
<td>Licensure or Certificate related to degree</td>
<td>Experience</td>
</tr>
<tr>
<td>-------</td>
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</tr>
<tr>
<td>South Carolina</td>
<td>Community Care</td>
<td>Bachelor’s degree in social work or nursing</td>
<td>An individual who is not a licensed social worker, BSW/MSW with experience, RN, or LPC, but was enrolled and active or hired through a provider agency prior to July 1, 2007. All individuals enrolled or hired through a provider agency on or after July 1, 2007, must be an LSW, BSW/MSW with experience, RN, or LPC</td>
<td>BSW/MSW; must be licensed</td>
</tr>
<tr>
<td>Iowa</td>
<td>Case Management Program for the Frail Elderly (CMPFE)</td>
<td>Bachelor’s degree in a human service field or bachelor’s degree in nursing</td>
<td>The case manager may substitute up to two years’ full-time equivalent work experience in a human services field involving direct contact with people in overcoming social, economic, psychological, or health problems for two years of the educational requirement</td>
<td>Nurse must pass federal nursing exam and hold a current license within the state</td>
</tr>
<tr>
<td>Vermont</td>
<td>Choices for Care</td>
<td>Bachelor’s degree in arts or science</td>
<td>At least two years experience in human services or nursing or At least three years’ experience working with elders or adults with disabilities or On a case-by-case basis, the Department may approve staff to provide services when they have an equivalent combination of education, experience, and skill specific to working with elders with functional limitations or individuals with disabilities</td>
<td>None noted</td>
</tr>
</tbody>
</table>
APPENDIX C: Selected State Based Care Coordinator Competencies & Responsibilities

These competencies and responsibilities of care coordinators were obtained from the programs found in Appendix B. Information on competencies/responsibilities of Care Coordinators in Vermont, California, and Utah was not available. We included the competencies/responsibilities of Care Coordinators in Alaska’s Older Alaskan’s Waiver, Maine’s Elder Independence of Maine, and Texas’ Star+Plus program for comparison.

<table>
<thead>
<tr>
<th>Competency/Responsibility</th>
<th>AK</th>
<th>IL</th>
<th>IA</th>
<th>ME</th>
<th>NJ</th>
<th>OH</th>
<th>PA</th>
<th>SC</th>
<th>TX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to develop a care and/or service plan</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Ability to organize/coordinate medical, social, and educational services that are and that are not covered by Medicaid and make appropriate referrals</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Knowledge of available local and statewide resources</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Knowledge of requirements for HCBS Waiver Care Coordination Services and the care coordination process</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td>✓</td>
</tr>
<tr>
<td>Knowledge of the medical, behavioral, habilitative, and rehabilitative conditions</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Knowledge of laws, rules, regulations, and precedents, including IDEA (Act) and the ADA; terminology used in ADA; terminology used in the work</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>A good working knowledge and understanding of issues related to the elderly population</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Knowledge of the individual, family, social systems, and the individuals functioning in the aging process.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Ability to follow up, monitor, and ensure services are provided as prescribed in the enrollee’s plan of care</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Ability to authorize services</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Ability to reassess, evaluate outcomes and terminate/transfer; ability to assess level of care review</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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</tr>
<tr>
<td>Ability to work with professional and support staff in an interdisciplinary team</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td>✓</td>
</tr>
<tr>
<td>Ability to organize, evaluate and present information effectively, both orally and in writing; ability to maintain case records, including documentation of follow-up</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td>✓</td>
</tr>
<tr>
<td>Ability to organize, evaluate and present information effectively, both orally and in writing; ability to maintain case records, including documentation of follow-up</td>
<td>✓</td>
<td>✓</td>
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</tr>
<tr>
<td>Ability to assess treatment needs of individuals who experience physical and/or intellectual disabilities</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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</tr>
<tr>
<td>Administration of the appropriate intake form, including a comprehensive needs assessment</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td>✓</td>
</tr>
<tr>
<td>Ability to guide enrollees through the health care system</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td>✓</td>
<td>✓</td>
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</tr>
<tr>
<td>Ability to advocate on behalf of the elder/client</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td>✓</td>
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<tr>
<td>Ability to conduct skills training</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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</tr>
<tr>
<td>Ability to process claims</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Ability to oversee and assure compliance and conduct; utilization review activities</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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</tr>
<tr>
<td>Ability to provide good customer service</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Good interpersonal communication skills</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Ability to adapt to frequent change</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td>✓</td>
</tr>
<tr>
<td>Excellent computer skills, including the Windows operating systems, MS Word, MS Excel, data entry, and the ability to learn new software applications as needed</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Provide ongoing monthly monitoring of the provision of services included in the participant’s ISP and any risk agreements negotiated by the participant to assure the health and welfare of the participant</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Ensure caseload is maintained</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Ability to problem solve to address client needs</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Service counseling with participant and families</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Willing to try new approaches</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Tolerant, empathetic, good interviewing capability</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Respect the cultural, spiritual, racial, ethnic beliefs of others</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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</tbody>
</table>

This table can also be found in the Appendix of the original report Towards the Development of Care Coordination Standards: An Analysis of Care Coordination in Programs for Older Adults.
APPENDIX D: NY State Survey of Programs on Care Coordinator Education, Training and Function

Purpose
After submitting a Human Subjects Protocol proposal to the New York Academy of Medicine’s Institutional Review Board for this research and subsequently receiving an exemption, Social Work Leadership Institute staff members interviewed administrators of state programs suggested by NYSDOH and NYSOFA to determine the way in which case management was being conducted. A goal was to understand the qualifications and standards of practice currently being used by NY programs for care coordination.

Programs identified as having care coordination:

<table>
<thead>
<tr>
<th>Program/Plan</th>
<th>Total # of Programs</th>
<th>Sample</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care At Home (I, II, IV, &amp; VI)</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Bridges to Health</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Nursing Home Transition and Diversion Program</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>NY Long Term Home Health Care Program (Lombardi)</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>NY Traumatic Brain Injury Waiver</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>NY State Education Department Waiver (SED)</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Expanded In-Home Services for the Elderly (EISEP)</td>
<td>60</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>Western NY Care Coordination Program</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>NY Partnership Plans</td>
<td>6</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Medicaid Managed Care Plans</td>
<td>18</td>
<td>18</td>
<td>8</td>
</tr>
<tr>
<td>NY Connects</td>
<td>54</td>
<td>5</td>
<td>2</td>
</tr>
</tbody>
</table>

Total surveys proposed 35
Total surveys completed 15*

Response rate 43%

*The respondents represented a mix of waiver providers, SOFA providers, Medicaid Managed Care Programs and the majority of respondents primarily served the older adult population.

We intended to obtain information from the administration of each of the eleven. However, we found that NY Partnership Plan, NY Connects, EISEP, and the Medicaid Managed Care programs had limited oversight at the state level regarding case management qualifications for their providers. In order to fully understand how care coordination was being carried out, we needed to survey the actual providers of these services. Therefore, we identified a purposive sample of nine individual providers for these programs. Participants were free to not answer questions and were also informed that no identifying information related to their specific responses would be shared, thus our findings will maintain that confidentiality.

The survey consisted of the following questions:

1. How many and what type of agencies administer the care coordination program/waiver?
2. How many people are served in this program and is there a waiting list? If yes, how long is the waiting list?
3. Roughly, how many care coordinators are there in this program?
4. What title is used for the care coordinators in your program (e.g. case manager)?
5. Is there a central job description for these positions?
6. Can you estimate the turnover amongst care coordinators?
7. What are the educational and professional requirements for care coordinators?
What is the starting and/or average salary for a care coordinator?

Are there set caseload sizes for care coordinators?

Is a team approach mandated, required or encouraged?

What changes do you foresee in the program in the coming months/years?

What are the challenges to implementing a care coordination program?

Findings
The findings related to educational background and training have been discussed in the body of this paper.

The Title of the Care Coordinator
Care coordinators have many titles in NY programs. These include:
- Clinical Resource Manager
- RN Case Manager
- Nurse Care Manager
- Nurse Health Partner
- Health Coordinator
- Community Nurse
- Care Manager
- Health Care Integrator (HCI)
- Service Coordinator
- Individualized Care Coordinator (ICC)
- Care Coordinator

A handful of participants were able to provide information about salary of care coordinators. For those who did respond, the salary of care coordinators ranged from $46,000 to $76,000. The lower end salaries seemed to be associated with social work/social service degrees (MSW, BA, MPA) while the higher end salaries were related to nursing degrees (RN, BSN).

For training and functions, our findings are reflected in the recommendations section of this document. Many participants mentioned ‘ongoing training’ as a standard of practice but did not stipulate a set number of hours.

Challenges and Barriers
Several participants took the time to share challenges faced in coordinating care within their programs. Many shared that it was challenging to manage the constant and complex changes in the regulatory environment in which they worked. There are often multiple regulatory bodies governing a single program or practice within a program and no clear or integrated standards between them. Others shared that the high volume of patient turnover posed unique challenges to their systems.

One respondent stated: “(There is a) lack of acknowledgement /understanding of the level of complexity of health and social service needs of population and the need for professional experience and expertise in all phases of care management process but particularly in assessment which must be constant. Given the above, the inadequate (and recently reduced) reimbursement for care management (is challenging). Varying definitions of the terminology leading to confusion of what is really being provided to clients…”

Turning to recruitment, respondents stated that recruiting qualified staff members who want to do field work was very difficult and the experience required is not often there. Respondents shared what they felt were deterrents to taking a care coordination position: high job stress; fear; discomfort in working with older adults; discomfort in working with people in their homes; and salary/no overtime in this kind of work.
Two of the respondents shared that a lack of technology, or low quality technology, hindered the efficiency of the care coordination process. Despite the challenges, many respondents spoke about their programs and innovative practices with a high degree of enthusiasm.