

CARE COORDINATION
VIRGINIA DEPARTMENT FOR THE AGING
SERVICE STANDARD

Definition

Care Coordination is assistance, either in the form of accessing needed services, benefits, and/or resources or, arranging, in circumstances where the older person and/or their caregivers are experiencing diminished functioning capacities, personal conditions or other characteristics, the needed services by providers.¹ Care Coordination is a distinct and comprehensive service. It entails investigating a person's needs and resources, linking the person to a full range of appropriate services, using all available funding sources and monitoring the care provided over an extended period of time.

Eligible Population

Care Coordination shall be targeted to those older persons, age 60 years and over, who are frail, or have disabilities, or who are at risk of institutional placement. Priority shall be given to older persons who are in the greatest economic or social need and/or residing in rural and geographically isolated areas with particular attention to low-income minority individuals.² Such persons shall also be unable to maintain independent living and self-sufficiency in their community due to the inability to define, locate, secure or retain the necessary resources and services of multiple providers on an on-going basis and shall be dependent in two (2) or more activities of daily living and significant unmet needs which result in substantive limitations in major life activities.

Unlike Medicaid elderly care coordination or Title III care coordination the state-funded Care Coordination for Elderly Virginians Program is not an entitlement program. Care coordination shall be available to the extent that state appropriations allow.

The care coordination team may decide to deny care coordination services if the team determines the client can be better served/more efficiently served in an institutional setting.

Service Delivery Elements

Care Coordination providers must perform all of the following:

Outreach:

Outreach is the proactive seeking of older persons who may be in need of care coordination. It involves defining and identifying a target population, and devising an outreach mechanism for educating this population about the program. Outreach makes the service known to other providers and helps assure proper referrals and coordination of care.

Intake/Screening:

Intake/screening is an initial evaluation of a person's needs for care coordination and/or another service. The purpose is to obtain enough information to determine the person's

¹ National Aging Program Information System Reporting Requirements – State Program Report Definitions

² Older Americans Act of 1965 as amended, Section 306 (a)(4)(A)(i)

likelihood of needing care coordination or another service and whether a full assessment is needed. The information obtained includes the reason for the referral or for the individual seeking help, the informal and formal supports already available, and basic information such as age and income that relates to eligibility for services. Intake/Screening may be provided in the area agency on aging offices, at senior centers and other community facilities, in the older person's residence or by telephone.

Assessment:

The assessment, using the full Uniform Assessment Instrument (UAI), identifies the person's care needs beyond the presenting problem in the areas of physical, cognitive, social and emotional functioning as well as financial and environmental needs. It also includes a detailed review of the person's current support from family, friends and formal service providers. The assessment is conducted prior to provision of any further care coordination services. The assessment interview is conducted with the older person and, if applicable and with the person's permission, his or her caregiver(s). It is conducted in the person's residence. If the person is institutionalized or temporarily in another residence, a home visit is conducted after the person's return to the residence. No longer than fifteen (15) working days shall pass between the time a client is referred for care coordination services and a full Uniform Assessment Instrument is completed.

- A nutritional screening shall be completed on each client.
- Federal Poverty should be determined and documented. The Federal Poverty/VDA form may be used.
- Any fee for service charge to the client shall be determined by the applicable sliding fee scale. (Cost sharing is prohibited in Title III Care Coordination.)

Care Planning:

The care plan is the link from the assessment to the delivery of services. Working with the person and the caregivers, the Care Coordinator develops a plan to address the problems and strengths identified in the assessment; the establishment of desired client-specific goals; the development of a complete list of services to achieve these goals, the responsibilities of the Care Coordinator, client, and informal and formal supports; and the payment sources for services. The client's agreement with the care plan must be documented. The care plan must be developed within fifteen (15) working days of the completion of the full Uniform Assessment Instrument. Written notification of acceptance or denial into care coordination shall be mailed within five (5) working days of completion of the plan of care.

Arranging for Service Delivery:

Service delivery is the process through which the Care Coordinator arranges and/or authorizes services to implement the care plan. This may involve arranging for services to be provided by outside agencies through collaboration, formal request, or the use of purchase-of-service agreements; coordinating help given by family, friends, and volunteers; and requesting services provided directly by the care coordination agency.

Monitoring:

Monitoring is the maintenance of regular contact with the person, informal caregivers, and other providers of service. The purpose is to evaluate whether the services are appropriate, of high quality, and are meeting the individual's current needs. Monitoring includes the function of verifying whether a service has been delivered and altering the care plan as the individual's needs change. Contact must be made monthly with the client for purposes of monitoring the implementation of the care plan.

Reassessment:

Reassessment is the formal review of the client's status to determine whether the person's situation and functioning have changed in relation to the goals established in the initial care plan. Again, service is reviewed for quality and appropriateness. If the person's needs have changed, the care plan is adjusted. This review is done at least every six months or with any significant change in the person's condition or services. The reassessment interview is conducted with the person in their home and, if applicable and with the person's permission, his or her caregiver(s). Reassessments must be completed at least every six months. If a change is needed on the care plan prior to the six months reassessment, it can be facilitated with a phone call to the client. The change should be noted on the care plan and in the care coordination progress notes. The Care Coordinator should make two copies of the revised care plan, mailing one to the client and retaining the other in the client's file.

- Federal Poverty should be determined and documented. The Federal Poverty/VDA form may be used.
- Any fee for service charge to the client shall be determined by the applicable sliding fee scale.

Termination:

Care Coordination services can be terminated at the discretion of the service provider. Written notification of termination of care coordination services shall be mailed to the client 10 business days in advance of the date the action is to become effective.

Administrative Elements

A qualified Care Coordinator must possess a combination of relevant work experience in human services or health care and relevant education that indicates the individual possesses the following knowledge, skills, and abilities at entry level. These must be documented on the Care Coordinator's job application form or supporting documentation, or observable in the job or promotion interview.

Staff Qualifications:

- **Knowledge:** Care Coordinators should have a knowledge of aging and/or the impact of disabilities and illness on aging; conducting client assessments (including psychosocial, health and functional factors) and their uses in care planning; interviewing techniques; consumers' rights; local human and health service delivery systems, including support services and public benefits eligibility requirements; the principles of human behavior and interpersonal relationships; effective oral, written,

and interpersonal communication principles and techniques; general principles of file documentation, and service planning process and the major components of a service plan.

- Skills: Care Coordinators should have skills in negotiating with consumers and service providers; observing, filling and reporting behaviors; identifying and documenting a consumer's needs for resources, services and other assistance; identifying services within the established services system to meet the consumer's needs; coordinating the provision of services by diverse public and private providers; analyzing and planning for the service needs of elderly and/or disabled persons, and assessing individuals using the Uniform Assessment Instrument (UAI).
- Ability: Care Coordinators should have the ability to demonstrate a positive regard for consumers and their families; be persistent and remain objective; work as a team member, maintaining effective inter-and intra-agency working relationships; work independently, performing position duties under general supervision; communicate effectively, verbally and in writing; develop a rapport and to communicate with different types of persons from diverse cultural backgrounds, and interview.

It is required that an individual complete training on the UAI prior to performing care coordination.

Individuals meeting all the above qualifications shall be considered a qualified Care Coordinator; however, it is preferred that the Care Coordinator will possess a minimum of an undergraduate degree in a human service field, or be a licensed nurse. In addition it is preferable that the Care Coordinator will have two years of satisfactory experience in the human services field working with the aged or disabled.

Job Description: For each paid and volunteer position an Area Agency on Aging shall maintain:

- A current and complete job description which shall cover the scope of each position-holder's duties and responsibilities and which shall be updated as often as required, and
- A current description of the minimum entry-level standards of performance for each job.

Units of Service:

Units of service must be reported in AIM for each client receiving the service. Service Units can be reported on a daily basis, but not aggregated (summarized) more than beyond one calendar month.

- Hours (All hours relating to care coordination services, including travel time for Care Coordination for Elderly Virginians Program clients Assessment time is included in hours, if this process leads to care coordination. An hour or part of an hour in 15 minute increments is a unit of service.)

- Persons served (unduplicated)

Program Reports:

- Aging Monthly Report (AMR) to VDA by the twelfth (12th) of the following month. If the area agency on aging provides this service, this report must be updated and submitted even if no expenditures or units of service occurred.
- AIM client level data transmitted to VDA by the last day of the following month.

Organizational Structure:

Care Coordination Services are separate and discreet services of an area agency on aging. Care Coordinators must be organizationally separate from management of services provided by the agency and which the care coordination clients might receive.

Consumer Contributions/Program Income:

The Area Agency on Aging shall formally adopt written policies and procedures, approved by the governing board, regarding the collection, disposition, and accounting for program income.

- Cost Sharing/Fee for Service: Cost sharing/fee for service is prohibited in Title III Care Coordination.³
- Cost Sharing/Fee for Service: Cost sharing/fee for service is permitted for Care Coordination for Elderly Virginians Program Clients.

And/Or

- Voluntary Contributions: Voluntary contributions shall be allowed and may be solicited for this service provided that the method of solicitation is non-coercive.⁴

Quality Assurance:

Criminal Background Checks:

- VDA strongly recommends that the agency and its contractors protect their vulnerable older clients by conducting criminal background checks for staff providing any service where they go to or into a client's home.

Staff Training:

- All new staff must receive an in-depth orientation on policies and procedures; client's rights' characteristics and resources of the community; and techniques for conducting the assessment, care planning, service arrangement, and monitoring.
- Each staff person must participate in a ten (10) hour in-service training per year. Content should be based on the Care Coordinator's need for professional growth and upgrading of skills.

³ Older Americans Act of 1965 as amended, Section 315(a)

⁴ Older Americans Act of 1965 as amended, Section 315(b)

Caseload Size:

The ratio of clients to Care Coordinator must be reviewed annually and is dependent on the following:

- characteristics of the target population served (e.g., very frail, disoriented, without family support);
- complexity of the care plan;
- geographical size of the area covered, taking transportation difficulties into account;
- availability of community-based services; and the extent of responsibility and control over funds that is exercised by the Care Coordinator.

Supervision/Case Review:

Consultation, supervision and case review shall be available to all staff providing the service.

Program Evaluation:

The area agency on aging should conduct a regular systematic analysis of the persons served and the impact of the service. Service providers shall be monitored annually.

Complaint and Appeals:

Care Coordination agencies shall have in place a written Complaint Procedures and Appeals Procedures.

Client Bill of Rights:

Care Coordination agencies shall make a bill of rights available to all clients. This is a statement of the rights of the person receiving care coordination services and includes basic tenets that should be followed in providing the service. Clients should receive copies of the bill of rights on commencement of care coordination and, sign and date a copy to be kept in the client's file.

Client Records:

Records must be maintained for all recipients of services. Care Coordination for Elderly Virginians Program (CCEVP) participants must use forms recommended in the CCEVP Policies and Procedures Manual. Such records must contain the following:

- Intake instrument(s)
- Full Uniform Assessment Instrument
- Determine Your Nutritional Health Nutritional Checklist
- Federal Poverty documentation and Fee for Service calculations must be part of the client record. Federal Poverty/VDA Sliding Fee Scale form may be used. (Cost Sharing is prohibited in Title III Care Coordination.)
- Original Care Plan
- Monthly Progress Notes
- Case Coordination Fee Form
- Purchase of Gap-Filling Services Form

- Acceptance/Denial Notice
- Care Coordination Outcome Report
- Client Bill of Rights
- Consent to Exchange Information Form