COLORADO HEALTH CARE TRAINING & CONSULTING

Home Care Administrator Training
Care Coordination Standards

Supplement

1/8/2025

CONTENT OF SUPPLEMENTAL WORKBOOK

"We should coordinate care not to save money but because coordinated care is better care. Patients deserve more from the health care system. But to spend less, we need to do less. Providers and payers do not have to convince patients that less is more with complex arguments about iatrogenic harm or incidentalomas. Nobody likes waste. So let's get rid of it."

Cost Containment and the Tale of Care Coordination, **J. Michael McWilliams, M.D., Ph.D., N Engl J Med 2016; 375:2218-2220December 8, 2016 DOI: 10.1056/NEJMp1610821**

http://www.nejm.org/doi/full/10.1056/NEJMp1610821?query=TOC&utm_campaign=KHN%3A+Daily+Health+Policy+Report&utm_source=hs_email&utm_medium=email&utm_content=38997879&_hsenc=p2ANqtz-8vF4yLD2xEYaNqCksFyumG3VvqC9-gYKks8le8xKverwCsASoepUGpHDEmzqmBLoddGtj0VWfAYtLlgdUTUHxqJskUdA&_hsmi=38997879&#t=article

DEFINITIONS

The following terms are provided by the Joint Commission:

• **Effective communication -** The successful joint establishment of meaning wherein patients and health care providers exchange information, enabling patients to participate actively in their care from admission through discharge, and ensuring that the responsibilities of both patients and providers are understood. To be truly effective, communication requires a two-way process (expressive and receptive) in which messages are negotiated until the information is correctly understood by both parties. Successful communication takes place only when providers understand and integrate the information gleaned from patients, and when patients comprehend accurate, timely, complete, and unambiguous messages from providers in a way that enables them to participate responsibly in their care.

• **Cultural competence -** The ability of health care providers and health care organizations to understand and respond effectively to the cultural and language needs brought by the patient to the health care encounter. Cultural competence requires organizations and their personnel to do the following: (1) value diversity; (2) assess themselves; (3) manage the dynamics of difference; (4) acquire and institutionalize cultural knowledge; and (5) adapt to diversity and the cultural contexts of individuals and communities served.

• **Patient- and family-centered care -** An innovative approach to plan, deliver, and evaluate health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families. Patient- and family-centered care applies to patients of all ages, and it may be practiced in any health care setting.

• **Terms used synonymously with care coordination that** reduce fragmentation and improve health care delivery through better coordination:
collaboration, teamwork, continuity of care, disease management, case management, care management, Chronic Care Model, and care or patient navigator.
Source: National Center for Biotechnology Information, https://www.ncbi.nlm.nih.gov/books/NBK44012/#A25396

Pre-Assignment

List three items that you feel are important to Care Coordination in your organization:

1. _____

   _____

2. _____

   _____

3. _____

   _____

Is It Home Care Coordination?

Checklist – how is your agency doing?

1=None, 2=Partial, 3=Fully

What elements are in place? Which require some additional attention? Which answers will you include in your Quality Management Program?

NO / PARTIALLY/ YES	
1) Families know who their care coordinator is and how to access him or her (or their backup)?	1 2 3
2) Values of family-centeredness are known to the caregiver team and drive the development and provision of care coordination?	1 2 3
3) A home care coordination position description is established; roles/activities are clearly articulated and care coordination training and education is available?	1 2 3
4) Administrative leadership helps to develop/support a care coordination service system; protected time allows for CC role development?	1 2 3
5) Identification and assessment of consumer/family needs/unmet needs are completed; care planning is a core Care Coordination home care response?	1 2 3
6) Education and counseling are offered as an essential part of home care coordination?	1 2 3
7) Care coordination includes comprehensive resource information, referrals, and cross agency/organization communication?	1 2 3
8) Consumer/family advocacy is a part of care coordination	1 2 3
9) Families are asked for feedback about their experiences with care coordination?	1 2 3
10) System improvements are implemented simultaneously with the development of care coordination (care coordinator contributes to this quality improvement process)?	1 2 3

Adapted from Medical Home Practice-Based Care Coordination

Care Coordination Quiz: What duties are appropriate at your agency?

As a care coordinator for a local agency, imagine your job duties then answer these questions:

1. Identify any barriers or possible barriers to care.	True	False
2. Streamline appointments and paperwork.	True	False
3. Get involved with direct "hands-on" medical care.	True	False
4. Assist with obtaining financial counseling and services and other resources as needed.	True	False
5. Keep communication open with providers, caregivers and patients in order to coordinate services.	True	False
6. Offer opinions about a diagnosis or health care services.	True	False
7. Provide recommendations or opinions on physicians.	True	False
8. Link patients, caregivers and families with needed follow-up services.	True	False
9. Provide therapy.	True	False
10. Make phone calls to clients to assess their need for non-medical services such as food, transportation and housing.	True	False

Adapted from Colonoscopy Patient Navigator Program Orientation Manual, page 9, NYCDOHMH in the Care Coordination student exercise book.

Worksheet One: Care Coordination need assessment

You are doing a Supervisory visit (of PCW or C.N.A.) to the home of a client. Your HCA goal with this client is trying to control the blood pressure or blood sugar of an elderly lady.
This elderly lady has been to the Emergency department three times in 90 days. You pull her medical record and read it before going to the home. There is an emergency contact documented but missing from the chart is whether the client lives alone or with others.

After 20 minutes in the home you learn that a grandson, who is on drugs, lives with the patient and adds enormous stress to the patientôs ñgolden years.ò You know that whether a person lives in social isolation, or in a nurturing social environment is critical to the plan of care and treatment plan.

As a group, identify the main issue(s) in the scenario. After identifying the issue(s), brainstorm, discuss and decide how staff members providing care coordination can approach and resolve barriers faced by the patient. There usually is more than one way to eliminate or reduce barriers faced by a patient. What other concern(s) can be identified that affect patient care quality and safety?

SAMPLE CARE COORDINATION POLICY (SKILLED HCA)

PURPOSE:

- To ensure effective and appropriate coordination and continuity of care, treatment and/or services to promote positive patient outcomes.
- To uphold patient rights.
- To support the goals and objectives outlined in the plan of care.
- To prevent duplication and conflict of care, treatment and/or services.

POLICY:

- Care, treatment and/or services are provided by _____ HHA in an interdisciplinary, collaborative manner as appropriate to the needs of the patient and the HHA's scope of service.
- All HHA staff, including providers under contractual arrangement, providing care, treatment and/or services to _____ HHA patients maintain liaison with other healthcare team members to ensure effective coordination of efforts and to support the goals and objectives outlined in the plan of care.
- The clinical services provided by _____ HHA staff and/or providers under contractual arrangement with _____ HHA shall complement one another and shall be coordinated by _____ HHA to assure quality patient care/services and to promote positive patient outcomes.
- Whenever possible, the patient's care, treatment and/or services are provided by a limited number and consistent team of HHA staff.
- When the patient is receiving care, treatment and/or services from other organizations/ providers, _____ HHA ensures that the responsibilities of the HHA and other organizations/providers are collaborative and exclusive.
- Communication is maintained between those providing services regarding changes in the patient's needs, services or care to be provided or goals that impact the overall care, treatment and/or services.
- The plan of care is reviewed in its entirety by the attending physician and _____ HHA as often as the severity and/or instability of the patient's condition requires, but at least every 60 days or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a change in the case-mix assignment; or a discharge and return to _____ HHA during the 60-day episode.
- A written summary report for each patient shall be sent to the attending physician every 60 days.
- Case conferences are held at least bimonthly or more often if necessary, to facilitate multidisciplinary coordination and communication of patient care. Case conference also occur spontaneously/informally between healthcare team members and are documented in the patient's medical record and communicated to the Clinical Supervisor.

- When the patient is referred to another provider, the patient/family shall be informed of any financial benefit to the referring organization.

- The individual designated to coordinate the services provided by _____ HHA is qualified through education, training and/or experience and is one who:

    - Understands the scope and types of services which are provided

    - Understands the required staff standards and knows which staff within _____ HHA meet the criteria

    - Understands the relationships among staff providing services and the responsibilities of each party involved

    - Understands the needs of the patient population served by _____ HHA

PROCEDURE:

- The individualized plan of care should be available to all appropriate staff.

    - The designated _____ HHA staff member should initiate/maintain communication with appropriate parties and individuals involved by:

        - Meeting or telephoning pertinent staff

        - Initiating telephone or onsite conferences with involved parties

        - Participating in patient case conferences

- Coordination of service activities is documented in the patient's home care record. Each record shall contain up-to-date information regarding:

    - The services that are being provided

    - The responsibilities of each service/discipline

    - The interventions provided along with the patient/family response

    - Communication between involved parties

- Case conferences are documented in the patient record.

- _____ HHA staff promptly contacts the physician:

    - When there are changes in the patient's condition

    - With results of relevant laboratory tests

    - When there are changes in the patient's expected response to treatment and/or medications

- When changes occur in family support or the environment
- When _____ HHA can no longer adequately meet the patient's medical, nursing, and/or social needs in the patient's place of residence

- A written report for each patient is sent to the attending physician at least every 60 days. The report provides a summary of the patient's response to care, treatment and/or services as well as the patient's progress toward identified goals and achievement of outcomes.

SAMPLE CARE COORDINATION POLICY (NON-MEDICAL HCA)

PURPOSE:

To ensure coordination of services for each consumer and support the goals and objectives outlined in the plan of care.

POLICY:

All staff providing services, including those working under arrangement, will maintain liaison, internally and externally, to ensure their efforts are coordinated effectively and support the objectives outlined in the plan of care and as delineated through outside home care services.

PROCEDURE:

Effective interchange and reporting, as well as coordination of care will occur between the disciplines providing care. Communication regarding the consumer's progress may occur through a formal case conference and/or it may include informal verbal and written communication among all staff members providing care.

1. Documentation of all communication will be included in the consumer record on a communication note, case conference summary or clinical visit note.

    - Documentation will include: the date and time the communication occurred, individuals involved in the communication, information discussed and the outcome of the communication.
2. Care coordination shall be demonstrated for each consumer at least every 30 days for cases where there is more than one agency sharing the provision of the same home health services.

    - The minutes of these case conferences shall reflect discussion and input by all the disciplines providing care to the consumer.
3. The agency will coordinate with other known organizations providing care and services to the same consumer. This includes organizations providing medical equipment, hospice services, other home care services, outpatient clinics, etc.

    - Documentation of this coordination will be maintained in the consumer record. If the consumer refuses coordination with external home care agencies, this refusal will be documented in the consumer record.
4. The agency will monitor, evaluate and report to the consumer's authorized representative, as appropriate, regarding the consumer's progress toward achieving goals established on the plan of care.

Care Coordination Conference Form

Client Name: _____ Case Manager: _____

Chart #:_____ Case Conference Date: _____

Participant	Position/Title	Phone/Contact Info	Face-to-face or by Phone?
Consumer			
MD			
Nursing			
SW			
PT			
OT			
ST			
Family			
Chaplain			

Client Present: Yes No Primary Diagnosis: _____

Is there a signed release for all agencies present? Yes No

Purpose of case conference: _____

Client Story:
Health Care Directive/Special Concerns/Why was conference initiated (pain, mental health issues,)

Care /Treatment Options:
Consumer/Family Needs (spouses, dependents):

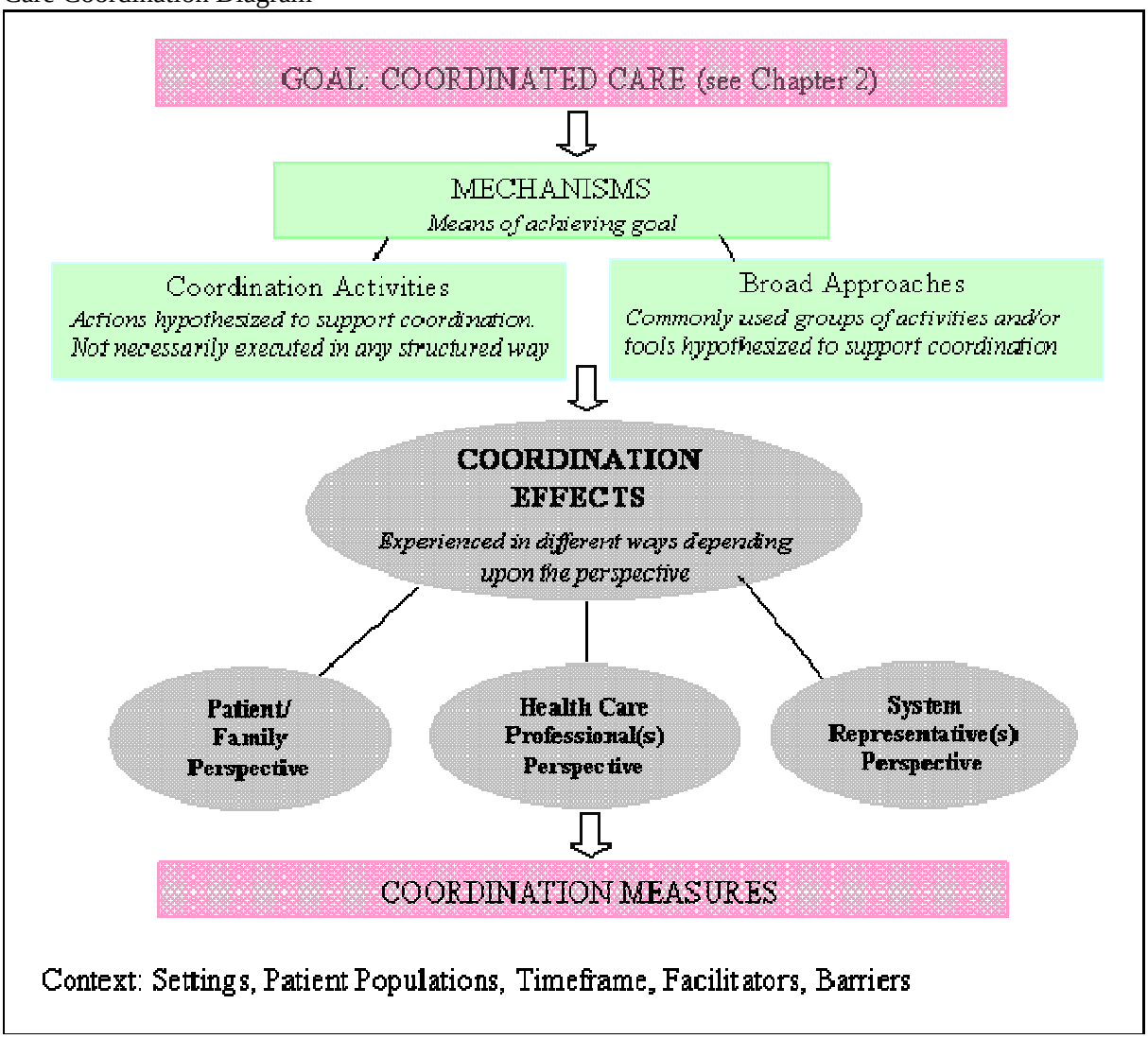
Plan of Care / Goals: (e.g., remain in residence, communication, care plan change, education, etc.)

Discharge Plan: (None at this time, Home, Hospice, Nursing Home, Assisted Living)

SIGNATURE _____

TITLE / DISCIPLINE _____

Care Coordination Diagram



Source: Agency for Health Care Research and Quality, https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/atlas2014/chapter3.html#fig2

Worksheet Two: Care Coordination need assessment

What level of care coordination is needed –

High, medium or low?

The level of care coordination need will increase with greater system fragmentation (e.g., wider gaps between circles), greater clinical complexity (e.g., greater number of circles on ring), and decreased patient capacity for participating effectively in coordinating one's own care, as illustrated by the following scenarios. The level of need is not fixed in time, nor by patient. Assessment of level of care coordination is likely important to tailor interventions appropriately and to evaluate their effectiveness.

Scenario 1. Mrs. Jones is a healthy 55-year-old woman. She visits her primary care provider, Dr. I. Care, once a year for a routine physical. Dr. Care practices in a primary care clinic with an electronic medical record (EMR) system and on-site laboratory and radiology services. At Mrs. Jones' annual physical, Dr. Care ordered several blood tests to evaluate her cholesterol and triglyceride levels. Mrs. Jones also mentioned that she is having lingering pain in her ankle after a previous sprain. Dr. Care ordered an x-ray. After receiving the blood test results via the electronic medical record system, Dr. Care sees that Mrs. Jones' cholesterol is high and prescribes a medication. She submits the prescription directly to the pharmacy via a link from the EMR. She receives electronic notification that the x-ray does not show any fracture. She calls Mrs. Jones to refer her to a nearby physical therapy practice. Mrs. Jones picks up her medication from the pharmacy and calls the physical therapist to schedule an appointment.

Scenario 1. Visual

Complexity: _____

Fragmentation: _____

Patient Capacity: _____

Care Coordination Need: _____

Scenario 2. Mr. Andrews is a 70-year-old man with congestive heart failure and diabetes. He uses a cane when walking and recently has had some mild memory problems. His primary care physician, Dr. Busy, is part of a small group physician practice focused on primary care. The primary care clinic includes a laboratory, but they refer their radiology tests to a nearby radiology center. Mr. Andrews also sees Dr. Kidney, a nephrologist, and Dr. Love, a cardiologist. Both specialists are part of a specialty group practice that is not affiliated with Dr. Busy's clinic. Their specialty practice includes an on-site laboratory, radiology clinic, and pharmacy. Mr. Andrews has prescriptions filled at the specialty clinic pharmacy after his appointments with Drs. Kidney and Love and picks up medications prescribed by Dr. Busy at a pharmacy near his home. Mr. Andrews has a daughter who lives nearby but works full time. Because he has trouble getting to the grocery store to do his shopping, he receives meals at his home 5 days a week through a meals-on-wheels senior support service. His daughter has hired a caregiver to help Mr. Andrews with household tasks for two hours three days a week.

During a recent meal delivery, the program staffer noticed that Mr. Andrews seemed very ill. He called an ambulance, and Mr. Andrews was taken to the emergency department. There he was diagnosed with a congestive heart failure exacerbation and was admitted. During his initial evaluation, the admitting physician asked Mr. Andrews about which medications he was taking, but the patient could not recall what they were or the doses. The physician on the hospital team contacted Dr. Busy, who provided a medical history and general list of medications. Dr. Busy noted that Mr. Andrews may have had dosing changes after a recent appointment with Dr. Love. In addition, Dr. Busy noted that Mr. Andrews may be missing medication doses because of his

forgetfulness. He provided the hospital team with contact information for Drs. Love and Kidney. He also asked that a record of Mr. Andrews' hospital stay be sent to his office upon his discharge.

Mr. Andrews was discharged from the hospital one week later. Before going home, the nurse reviewed important information with him and his daughter, who was taking him home. They went over several new prescriptions and details of a low-salt diet. She told him to schedule a follow-up appointment with his primary care physician within 2 days and to see his cardiologist in the next 2 weeks. Mr. Andrews was very tired so his daughter picked up the prescriptions from a pharmacy near the hospital, rather than the one Mr. Andrews usually uses.

Scenario 2. Visual

Complexity: _____

Fragmentation: _____

Patient Capacity: _____

Care Coordination Need: _____

Answers to Worksheet Two:

Scenario 1. Visual
Complexity: Low
Fragmentation: Low
Patient Capacity: High
Care Coordination Need: Minimal

Scenario 2. Visual
Complexity: High
Fragmentation: Moderate
Patient Capacity: Low
Care Coordination Need: Extensive

4 **Scripts to help verify medications a home care patient is taking during Medication reconciliation**

1. In addition to the medications ordered by your doctor are you taking any other pills, vitamins or minerals?
2. Do you have any other pills or other medications in your:
   - Kitchen
   - Bedroom
   - Bathroom
   - Pantry or linen closet
   - Anywhere else?

****

1. Do you take any vitamin or mineral supplements?
2. Do you take any herbal remedies like Sleepy Time Tea?
3. Do you regularly take an over-the-counter medication for:
   - Constipation
   - Diarrhea
   - Pain like a headache, arthritis, muscle aches
   - Sleep
   - Heartburn
   - Upset stomach
   - Skin problems

****

1. Do you take any other pills on a regular or occasional basis other than what your doctors have ordered?
2. Any other over the counter medications such as pain relievers or laxatives?
3. Do you take any vitamins or herbal supplements?

****

1. What prescription medications are you currently taking?
2. What other non-prescription medications do you take?

If response is none/nothing:

Verify: Any herbals, vitamins, over-the-counter pain medicine like Tylenol, Ibuprofen? Any laxatives?

Source: CHAMP:http://champ-program.org/

Hint: Many elderly people take 81mg aspirin a day, Tylenol PM at bedtime, laxative & supplements (multivitamin, iron)

PATIENT DISCHARGE INSTRUCTIONS
INSTRUCCIONES AL SER DADO DE ALTA

Source: _____ Date: _____ Patient Identification: _____

The physician who has taken care of you strongly recommends that you receive follow-up care as indicated below.
(El médico que lo atendió c considera de suma importancia que reciba usted los cuidados complementarios señaldos a continuacion.)

❑ A. Appointments *(Citas)*

	1.	2.
Date/Time *(Fecha/Hora)*	_____	_____
Clinic/Phone *(Clinica/Teléfono)*	_____	_____
Location *(Ubicación)*	_____	_____
Physician *(Médico)*	_____	_____

❑ B. An appointment has NOT been made for you. Call your personal physician or make an appointment at the clinic(s) below:
NO se ha hecho cita a su nombre. Llame a su médico familiar o concierte una cita en la clinica que aparece a continuación.

Clinic *(Clinica)*	_____	Clinic *(Clinica)*	_____
Phone *(Teléfono)*	_____	Phone *(Teléfono)*	_____

Medications ***(Medicamentos)***	**Dose** ***(Dosis)***	**Times To Be Taken** ***(Horario De Administración)***	**Special Instructions** ***(Instrucciones Especiales)***

Activities ***(Actividades)***

❑ As tolerated *(Las que resulten cómodas)*
❑ Restrictions as listed *(Limitaciones)*:

Diet ***(Dieta)***
Your diet will be _____
(Su dieta será) _____
Restrictions *(Limitaciones)*:

Special Instructions (i.e., wound care, treatments)
Instrucciones Especiales (cuidado de la herida, tratamientos, etc.)

I acknowledge receiving the above instructions.
(*Confirmo haber recibido las instrucciones anteriores.)*

_____ _____
Signature (if signed by other than patient, give relationship) Date
Firma (si no firma el paciente mismo, indique parentesco) *(Fecha)*

_____
Name of nurse/therapist giving instructions

_____
Date

DISCHARGE SUMMARY PLAN/TRANSFER FORM

Patient Name: _____ MR#: _____

Physician(s) Name: _____ Physician Phone: _____

Start of Care Date: _____ Discharge/Transfer Date: _____

Physician Notified: ❑ Yes ❑ No

Advance Directives Executed: ❑ Yes ❑ No DNR: ❑ Yes ❑ No

Languages Spoken/Understood: ❑ English ❑ Spanish ❑ Other: _____

Services Rendered at Home: ❑ RN ❑ PT ❑ SLP ❑ OT ❑ MSW ❑ Aide ❑ Other: _____

Summary of Course and Significant Events (include social or emotional factors): _____

Services	Admission Date	# of Visits Made	Discharge Date
❑ Skilled Nurse			
❑ Home Health Aide			
❑ Physical Therapy			
❑ Occupational Therapy			
❑ Speech Therapy			
❑ Social Worker			
❑ Other: _____			

Medical Diagnoses: _____

Patient Problem	Goal Reached	Goal Not Reached	Goal Partially Met	Comments

Patient Medications	Reason	Dosage	Time

Diet/Fluids: _____ Allergies: _____

Current Height: _____ Weight: _____ ❑ Gained ❑ Lost ❑ Unchanged

PATIENT'S STATUS:

Vital Signs at Last Visit: T: _____ P: _____ R: _____ B/P: _____/_____

Mental Status: ❑ Alert ❑ Oriented ❑ Disoriented ❑ Confused
❑ Cooperative ❑ Comatose ❑ Depressed ❑ Agitated ❑ Forgetful
❑ Other (please specify): _____

Physical Status: ❑ Stable ❑ Improved ❑ Strong ❑ Weak ❑ Varies
❑ Other (please specify): _____

Activity Level: ❑ Homebound ❑ Ambulates Independently ❑ Bedridden ❑ As Tolerated
❑ Out of Bed with Assistance ❑ Exercise as Prescribed ❑ Ambulates with Assistance
❑ Other (please specify): _____

Functional Limits: ❑ Amputation ❑ Paralysis ❑ Legally Blind ❑ Bowel/Bladder ❑ Endurance
❑ Contracture ❑ Speech ❑ Hearing ❑ _____ with Minimal Exertion
❑ Other (please specify): _____

Adaptation: ❑ Cane ❑ Walker ❑ Wheelchair ❑ Crutches ❑ Hospital Bed
❑ Oxygen ❑ Bedside Commode ❑ Other: _____

REASON FOR DISCHARGE:

❑ Maximum HHA benefit received
❑ Patient has moved out of geographic area
❑ Patient, family or physician request services terminated
❑ Patient transferred to another home health agency
❑ Patient admitted to: _____ (name/type of facility)
❑ Patient expired
❑ Not homebound
❑ Patient refusing defined treatment
❑ No medical supervision

Services are continuing by ❑ RN ❑ PT ❑ SLP ❑ OT ❑ Aide ❑ None

The patient was instructed to continue under your medical supervision. Continuing needs will be assumed by:

❑ Self care ❑ Family ❑ Private caregiver ❑ Instructions: ☐ Verbal ☐ Written and left in home

Community resources referral for continuing needs: ❑ Yes ❑ No ❑ NA

Follow-up healthcare appointments: _____

Transfer to: _____

ADDITIONAL COMMENTS: _____

_____

_____

Patient/Legal Representative Signature: _____ Date: _____

HHA Representative Signature: _____ Date: _____

Care Coordination Training Actionable Form

Training Takeaway	Objective	Training Activities	Completion Status
Establish Clear Communication Protocols	Ensure all staff follow a standardized process for timely and accurate communication.	Conduct a role-play exercise to simulate clear communication scenarios.	Not Started
Maintain Accurate and Updated Client Records	Keep client records up-to-date to reflect changes in condition and care plans.	Review sample client records and conduct a mock audit.	Not Started
Foster Interdisciplinary Collaboration	Break down silos and encourage collaboration among all care team members.	Facilitate a team-building workshop focused on collaborative care planning.	Not Started
Prioritize Client-Centric Care	Align services with client needs, preferences, and goals.	Engage staff in a brainstorming session to define client goals.	Not Started
Develop Policies for Care Coordination	Formalize processes to guide care coordination practices.	Review and discuss agency care coordination policies with staff.	Not Started
Monitor and Evaluate Care Coordination Effectiveness	Track and assess the effectiveness of coordination activities.	Use metrics and case studies to identify and improve weak points in coordination.	Not Started
Train and Empower Staff	Equip staff with skills and knowledge to excel in their roles.	Organize training sessions on documentation and communication best practices.	Not Started
Prepare for Regulatory Compliance	Ensure care coordination practices comply with regulations.	Conduct compliance workshops to review relevant regulations and standards.	Not Started
Address Barriers to Coordination	Identify and resolve communication and coordination barriers.	Hold discussions to identify barriers and brainstorm solutions as a team.	Not Started
Document Changes	Maintain thorough	Provide templates	Not Started

and Outcomes	documentation for all client updates and progress.	and examples of proper documentation processes.	
Promote Accountability	Clarify roles and responsibilities to foster a culture of accountability.	Use real-life examples to discuss the importance of accountability in care coordination.	Not Started