CARE COORDINATOR
(Time-Based)

APPENDIX A

O*NET-SOC CODE 29-2099.08

A Care Coordinator manages and organizes patient/client care between two or more participants involved in a person's care (such as healthcare providers, social service providers, payers) and communicates information with/to everyone involved – including the patient/client - to help ensure safe, appropriate, and effective care.

This training outline is a minimum standard for Work Processes and Related Instruction. Changes in technology and regulations may result in the need for additional on-the-job or classroom training.

WORK PROCESSES

Approximate Hours

A. Introduction to the Care Coordinator Role and Orientation to the Work Environment **320**

1. Orientation to the role of the Care Coordinator (customized to employer and population served.
    a. Adhere to rules and regulations established by government agencies (such as the New York State Department of Health).
    b. Learn job description and requirements.
    c. Uphold Organization's mission and core values, policies, procedures, business ethic codes, information security policies, and Health Insurance Portability and Accountability Act (HIPAA) and Americans with Disabilities Act (ADA) requirements/guidelines.
    d. Demonstrate an understanding of the Care Coordinator's role within the organization and the care team.
    e. Understand and respect relationships between co-worker(s), mentor(s), and supervisors.
    f. Utilize access to mentors, supervisors, employee assistance programs, and resources.
    g. Understand and uphold the professional relationships and boundaries with clients/patients, and their family members.

h. Demonstrate effective organizational skills, time management, attention to detail, and ability to prioritize and manage multiple and competing demands.

i. Demonstrate professional work habits including dependability, responsibility, the ability to work both independently and as part of a team, and the ability to maintain confidentiality in accordance with HIPAA regulations.

2. Specialized and technical knowledge unique to the work environment.

   a. Learn characteristics of the individual(s) and population(s) served.

   b. Demonstrate knowledge and understanding of medical terminology.

   c. Have familiarity with patient/client entitlements, such as Supplemental Security Income (SSI) and Medicaid, sources of potential funding, and eligibility requirements for services to patients/clients.

   d. Proficiently utilize computers and technology necessary for the work environment, such as electronic medical records, databases, videoconferencing, telehealth, and Microsoft applications.

   e. Maintain accurate, clear, and timely documentation of client/patient interactions and progress within multiple concurrent platforms.

   f. Secure all health records and other protected information with the highest regard to confidentiality and HIPAA laws and regulations.

   g. Acquire and utilize knowledge of community-based resources related to housing, transportation, nutrition, disability supports, financial assistance, etc. (based on population served and/or work environment).

3. Employee and individuals' safety in any environment in which care/services are provided (based on employment location)

   a. Practice effective universal precautions/infection control.

   b. Employ CPR/Basic First Aid (if/when necessary)

   c. Understand health, safety, and medical concerns unique to the work environment.

d. Exercise safety precautions in all service delivery settings.

e. Understand and follow employer's procedure(s) for emergencies, if/when necessary.

f. Understand and utilize crisis intervention, if/when necessary, in accordance with employer policies and procedures.

B. Development of Community-based Networking and Advocacy (customized for specific region and employer) 815

1. Community Networking

   a. Develop and maintain effective relationships and communication with external organizations, such as hospitals, external specialty providers, and social service agencies, to facilitate service coordination, referrals, and a positive outcome for clients/patients.

2. Advocacy, and Supporting Empowerment

   a. Promote empowerment and self-confidence of clients/patients/responsible party to help them work toward problem solving, self-advocacy, and self-management skills.

   b. Identify and address gaps in care and/or services to provide relevant community and/or health care resources.

   c. Help client/patient/responsible party to understand and access available services and supports.

3. Outreach and Education (customized to employer and population served)

   a. Provide outreach, information, guidance, and education to the client/patient and/or family, and other members of the care team for appropriate healthcare utilization, chronic disease (e.g., diabetes, hypertension) self-management skills, effective care transitions, assessment, and elimination of barriers, including socio-economic barriers, quality of care, and cost control.

   b. Provide coaching, information, and referral services to clients/patients to promote wellness, preventive care, and to manage various chronic and/or behavioral health conditions.

   c. Elicit, respect, and actively support client/patient/responsible party choices and preferences.

4. Communication
    a. Choose and use effective and appropriate written, verbal, and interpersonal communication skills; demonstrate good listening skills and a willingness to be helpful, flexible, and patient.
    b. Facilitate basic group communication.
    c. Ability to develop and maintain trust with the population(s) and community served.
    d. Effectively engage people in the care coordination process.
    e. Learn and utilize health literacy and health equity principles for clear and inclusive communication.
    f. Maintain ongoing communication between the client/patient/responsible party and the care team.
    g. Use alternative communication devises and technologies, as applicable.
    h. Obtain and appropriately use interpreters when needed.
    i. Address and resolve conflict in a professional and ethical manner.

C. Interdisciplinary/Multidisciplinary Teamwork and Collaboration **125**

1. Demonstrate an understanding of the role and scope of practice of all members of the care team, including nurses [e.g., licensed practical nurses (LPN), registered nurses (RN)]; providers [e.g., physicians, nurse practitioners (NPs), physician assistants (PAs)]; social workers [e.g., licensed clinical social worker (LCSW)], mental/behavioral health providers, etc. Recognize the client/patient as a contributing member of the care team.
2. Work closely and collaboratively with the care team and build effective and positive relationships among care team members to support positive outcomes for clients/patients.
3. Attend and actively participate in individual, group, and team meetings.

D. Assess and Identify Client Strengths, Needs, Concerns, and Preferences **350**

1. Screen potential clients for care coordination needs to determine the appropriateness of and eligibility for services.

2. Ensure informed consent and appropriate disclosures (e.g., explain to the client/responsible party the role of the care coordinator, the scope of services provided, costs (if any) for care coordination services, and the client's/responsible party's rights and responsibilities).
3. Conduct a comprehensive assessment of client/patient and family's unmet health and social needs using standardized assessment tools provided and/or recommended by the organization.
    a. Assess the client's ability to participate in developing the care plan and identify alternative decision makers if client has limited ability or lacks decisional capacity.
    b. Collect additional information and data by contacting relevant sources, e.g., physician(s), other care providers, and social support systems.
    c. Synthesize and interpret information and data.

E. Establish Goals and a Plan of Care **700**

1. Collaborate with client/responsible party to develop individualized, goal-oriented, client/patient-centered care plans that promote positive outcomes and address physical health, mental health, and socio-economic barriers.
2. Identify options and resources that address the areas identified for intervention and provide appropriate information and referrals.
3. Discuss with the client/responsible party the advantages, disadvantages, and costs of available, and appropriate options and resources.
4. Develop and prioritize action steps with the client/responsible party to achieve the agreed upon care plan goals.

F. Implement, Manage, and Monitor Ongoing Progress and Outcomes of Care Plan **450**

1. Coordinate and facilitate services and interventions.
2. Communicate goals of the care plan with the client's support system and the care team.
3. Monitor service delivery and interventions.
4. Monitor client's/patient's adherence to their care plan and their progress toward goals in a timely fashion, and facilitate changes as needed.

5. Cultivate and support care coordination with patient care team through timely communication, inquiry, follow-up, and integration of information into the care plan regarding transitions in care and referrals.
6. Maintain an ongoing responsibility for assigned caseload by prioritizing referrals and activities according to intensity, needs, and required follow-up.
7. Evaluate client satisfaction with services.
8. Develop a process for termination and/or tapering of services.

G. Maintain Ethical and Professional Practice Standards **290**

1. Promote client autonomy and right to self-determination.
2. Recognize and respect diversity with respect to factors such as culture, religion, race, ethnicity, national origin, age, disability, gender, gender identity, sexual orientation, and socioeconomic status, to uphold the client's value system, preferences, and choices.
3. Identify and work to resolve ethical dilemmas using consultation and supervision when appropriate.
4. Document professionally relevant information about the client/client system (e.g., assessments, care plans, services and supports provided, communications with the client and other parties, referrals made, outcomes, reasons for the termination of services).
5. Evaluate service quality and effectiveness.
6. Practice self-assessment and accountability for job performance; accept appraisal of performance and accept and incorporate constructive feedback.

H. Provide Crisis Management and Conflict Management **200**

1. Ability to effectively address and manage crisis situations, in accordance with organization policies.
2. Utilize de-escalation strategies and techniques to reduce agitation and/or aggression in the community care setting.

Approximate Total Hours **3250**

Apprenticeship work processes are applicable only to training curricula for apprentices in approved programs. Apprenticeship work processes have no impact on classification determinations under Article 8 or 9 of the Labor Law. For guidance regarding classification for purposes of Article 8 or 9 of the Labor Law, please refer to https://dol.ny.gov/public-work-and-prevailing-wage

CARE COORDINATOR

APPENDIX B

RELATED INSTRUCTION

Safety, Health, and the Workplace

1. Government-specific Laws, Codes, and Regulations
2. Organizational Onboarding
3. First Aid and CPR (6.5 hours every 3 years)
4. Opioid Overdose Prevention
5. Sexual Harassment Prevention Training – must comply with Section 201-g of the labor law.
6. HIPAA and Confidentiality
7. Technology, Documentation, Confidentiality, Privacy and Security, and Electronic Health Records
8. Mental Health First Aid/Suicide Prevention Training
9. Mandated Reporter Training
10. Professionalism and Ethics
11. Safety in the Field

Occupational Theory and Science

1. Introduction to Care Coordination (defining the care coordinator roles, tasks, and key responsibilities).
2. Value-based Care
3. Managing Chronic Disease
4. Patient-centered Medical Home Concepts
5. Patient-centered Care Planning
6. Trauma Informed Care
7. Boundaries and Dual Relationships
8. Social Determinants of Health (SDOH) and Impact on Social Care Networks
9. Health Behavior Change (factors relating to why clients/patients change or do not change).
10. Quality, Accountability, Performance and Process Improvement, and Evidence-Based Practice

Occupational Skills

1. Cultural Competency and Health Literacy
2. Diversity, Equity, Inclusion, and Accessibility (DEIA) Training
3. Teamwork, Communication, and Collaboration; Interdisciplinary Teams
4. Assessments: How to Conduct Them and Which Ones Are Important
5. How to Develop and Implement a Care Plan
6. How to Access and Use Regional Clinical Data Resources (e.g., Hixny).
7. SDOH Screening and Referral; training on Social Care Network Health Related Social Needs Services (HRSN)
8. Documentation: How to Write Effective Progress Notes; Objective Documentation
9. Motivational Interviewing
10. Health Coaching
11. Verbal De-escalation, Crisis Intervention, Safe Environment and Conflict Management
12. Medication Management Training for Care Manager
13. Networking and Knowledge of Community Resources
14. Payment Systems (e.g., value-based payments, insurance plans)

Topics Specific to Work Setting

For Example:

a. Understanding the Dynamics that Cause and Maintain Poverty (such as “Bridges Out of Poverty”)
b. Specific Chronic Diseases/Conditions
c. Screening, Brief Intervention, and Referral to Treatment (SBIRT) Training
d. NARCAN Training
e. Self-Care
f. Addressing Burnout
g. Workplace/Career Wellbeing
h. Complex and Comprehensive Care Transition Codes
i. Billing and Coding

Additional Topics as Required

A minimum of 144 hours of Related Instruction is required for each Apprentice each year.

Appendix B topics are approved by New York State Education Department.