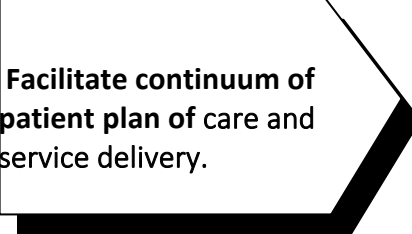
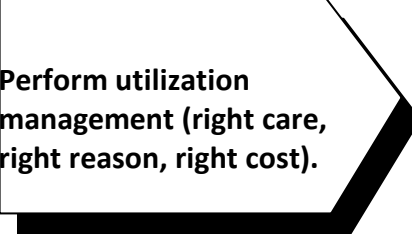



DACUM Competency Profile for Case Manager/Care Coordinator

The Case Manager/Care Coordinator is one who provides a holistic approach to the overall care practice and provides deliberate organization of patient care activities, and sharing information to achieve the highest quality for a safe and effective plan of care.

| | Duties | ← Tasks | | | | | | |
|---|---|---|---|---|--|--|--|--|
| A | <p>Insure patient care is provided in compliance with rules & regulations.</p> | <p>A-1 Determine decision maker for health care needs (e.g. advance directive, self, conservator, CPS).</p> | <p>A-2 Ensure appropriate documentation per regulations.</p> | <p>A-3 Inform patient and caregivers of health care options.</p> | <p>A-4 Comply with state and federal regulations (e.g. notification; MOON, SBIRT, IM).</p> | <p>A-5 Mitigate patient healthcare concerns (e.g. physicians, legal, and risk management).</p> | <p>A-6 Mitigate organizational risk and liability.</p> | <p>A-7 Evaluate the potential of abuse and/or neglect.</p> |
| | | <p>A-8 Mitigate patient risk for safety and liability.</p> | <p>A-9 Comply with law enforcement mandates.</p> | <p>A-10 Communicate with patient/ caregiver regarding current regulations (e.g. SBIRT, SOGI).</p> | | | | |
| B | <p>Identify need for case management.</p> | <p>B-1 Prioritize patients based on needs, services and/or eligibility.</p> | <p>B-2 Assess patient's current resources (e.g. income, equipment).</p> | <p>B-3 Update patient caseload.</p> | <p>B-4 Conduct telephonic case management and utilization reviews.</p> | <p>B-5 Identify patient's healthcare providers (e.g. physician, consultant).</p> | <p>B-6 Screen for appropriate needs and services.</p> | <p>B-7 Categorize patients by needs and services.</p> |
| | | <p>B-8 Delegate patient assignments to appropriate staff.</p> | <p>B-9 Review patient assignments and update as needed.</p> | <p>B-10 Reassess patient needs throughout continuum of care.</p> | <p>B-11 Promote seamless communication among health care team.</p> | <p>B-12 Provide plan of care status updates (e.g. court, payer).</p> | <p>B-13 Supervise support staff (e.g. discharge planner, medical assistant).</p> | |

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| C |  <p>Facilitate continuum of patient plan of care and service delivery.</p> | C-1 Evaluate patient's physical & psychosocial baseline status. | C-2 Evaluate patient for psychiatric needs. | C-3 Evaluate patient for psychological/ neuropsychological needs. | C-4 Determine appropriate level of care (e.g. observation vs. inpatient, acuity). | C-5 Confirm care and service delivery. | C-6 Facilitate engagement of patient and caregiver with plan of care. | C-7 Promote patient/caregiver health management goal (e.g. smoking cessation, harm reduction). |
| | | C-8 Facilitate multi-disciplinary team meeting. | C-9 Communicate patient short term status (e.g. discharge readiness). | C-10 Serve as a resource to health care team. | C-11 Refer to appropriate care & services (e.g. diabetic management). | C-12 Address palliative, respite, hospice care, and end of life care issues. | C-13 Facilitate resources for the decedent. | |
| D |  <p>Perform utilization management (right care, right reason, right cost).</p> | D-1 Identify payer source (e.g. Medicare Medicaid, private insurance, worker's comp., self-pay). | D-2 Determine eligibility for specialty services. | D-3 Obtain authorization for appropriate level of care from payer source. | D-4 Confirm benefits and reimbursement from payer source. | D-5 Refer patient to financial services/ counselor (e.g. eligibility worker). | D-6 Obtain external medical records. | D-7 Obtain authorization for referrals (e.g. TAR). |
| | | D-8 Negotiate with payer for authorization of extended services. | D-9 Initiate appeal process on receipt of denial of service. | D-10 Facilitate peer to peer review (e.g. physician to physician advisor). | D-11 Evaluate for appropriate vs. over utilization of resources. | | | |
| E |  <p>Link patient to community resources</p> | E-1 Identify patients who require complex discharge planning. | E-2 Identify community resources and partners (e.g. shelter, clothing, food bank). | E-3 Assess anticipated needs for next level of care. | E-4 Evaluate home environment and living conditions. | E-5 Assess caregiver's ability to provide care. | E-6 Initiate procurement of patient medication and related supplies. | E-7 Initiate procurement of patient Durable Medical Equipment (e.g. walker wheelchair). |

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|----------|--|---|---|---|--|--|---|--|
| | | E-8 Initiate procurement of care and treatment supplies (e.g. wound care, dialysis). | E-9 Arrange for follow up care as indicated (e.g. surgery, specialty application, labs). | E-10 Coordinate care and service delivery (e.g. home health, physical therapy) | E-11 Facilitate appropriate placement (e.g., board and care, skilled nursing care, shelter) | E-12 Coordinate transportation. | E-13 Provide follow-up patient education and care delivery. | E-14 Collaborate with provider regarding the need for palliative and/or hospice care. |
| F | Support delivery of patient centered care | F-1 Serve as patient/ caregiver advocate. | F-2 Integrate cultural competency into delivery of care. | F-3 Educate patient/ caregiver on plan of care and care delivery. | F-4 Conduct patient/ caregiver education (e.g. disease and medication management) | F-5 Provide budgetary counselling. | F-6 Refer patient/ caregiver to legal services (e.g. immigration). | F-7 Navigate patient/ caregiver through legal and judicial system. |
| | | F-8 Serve as a resource to patient/ care giver. | F-9 Encourage patient/ caregiver adherence to plan of care. | F-10 Promote patient's rights (e.g. ombudsman). | F-11 Respond to patient/ caregiver complaints. | | | |
| G | Assess effectiveness of care and service delivery | G-1 Collaborate with interdisciplinary team. | G-2 Identify barriers to continuum of care and discharge. | G-3 Communicate to healthcare providers regarding barriers to continuum of care and discharge. | G-4 Manage barriers to continuum of care and discharge. | G-5 Collaborate with external case management (e.g. IPA, HMO) | G-6 Develop a contingency plan of care. | G-7 Coordinate transition to next level of care. |
| H | Participate in continuous quality improvement | H-1 Identify trends (e.g. infections, unexpected events) | H-2 Analyze causative factors. | H-3 Identify patient at high risk for readmission. | H-4 Monitor medical necessity for length of stay/ treatment. | H-5 Promote patient satisfaction. | H-6 Participate in process improvement. | H-7 Participate in professional development. |

DACUM Competency Profile for

Case Manager Care Coordinator

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HWI LOGO

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Acronyms Used

| | |
|--------|--|
| 5150 | 24 Hour Psychiatric Hold |
| 5152 | 72 Hour Psychiatric Hold |
| ACA | Affordable Care Act |
| ACM | Accredited Case Manager |
| AD | Advance Directives |
| APS | Adult Protective Services |
| BSN | Bachelor of Science in Nursing |
| CCS | California Children Services |
| CCRN-K | Acute/Critical Care Registered Nurse - Knowledge |
| CG | Caregiver |
| COC | Continuum of Care |
| CPS | Child Protective Services |
| CQI | Continuous Quality Improvement |
| DC | Discharge |
| DME | Durable Medical Equipment |
| DMV | Department of Motor Vehicles |
| DRG | Diagnostics Related Group |
| FFS | Fee for Service |
| FQHC | Federally Qualified Health Center |
| HEDIS | Healthcare Effectiveness Data and Information Set |
| HINN | Hospital-Issued Notices of Non-coverage |
| HIPPA | Health Insurance Portability and Accountability Act |
| HMO | Health Maintenance Organization |
| IM | Important Message from Medicare |
| IPA | Independent Practice Association |
| LCSW | Licensed Clinical Social Worker |
| LOS | Length of Stay |
| MPA | Masters of Public Administration |
| MD | Medical Doctor |
| MOON | Medicare Outpatient Observation Notice |
| MSN | Master of Science in Nursing |
| MSN-Ed | Master of Science in Nursing Education |
| NCQA | National Committee for Quality Assurance |
| ON | Observation Notice (State Required) |
| OON | Out of Network |
| P4P | Pay for Performance |
| PA | Physician Assistant/ Physician Advisor |
| PHN | Public Health Nurse |
| RN | Registered Nurse |
| SBIRT | Screening, Brief Intervention, and Referral to Treatment |
| SOGI | Sexual Orientation Gender Identification |
| SNF | Skilled Nursing Facility |
| SPD | Seniors and Persons with Disabilities |
| TAR | Treatment Authorization Request |
| Tb | Tuberculosis |

Worker Characteristics and Behaviors

- Ability to Multi-task
- Caring
- Collaborative
- Compassionate
- Cultural sensitivity
- Customer service
- Diplomatic
- Efficient performance
- Empathetic
- Ethical
- Flexible
- Model empowerment and advocacy
- Non-biased/non-judgmental
- Persistence
- Professionalism
- Resilient
- Resourceful
- Respectful
- Strong negotiator
- Teamwork

Future Trends/Concerns

- ACA – replacement/ modification
- Aging population
- Care team
- Certification
- Congregate care
- Cyber security of EHR
- Educational level
- Homelessness
- Immigration issues
- Nursing shortage
- P4P – Pay for Performance
- Recuperative care
- Technologic innovations

Tools, Equipment, Supplies, and Materials

- Computer/ tablet
- Data & Information Set
- Facsimile
- Health Care Effectiveness Measures (eg. NCQA, HEDIS)
- Printer/peripherals
- Readmission Tool (e.g. late red boost)
- Research methodologies

- Smartphone
- Telephone/ cellphone
- Utilization review tools (e.g. InterQual, Milliman)

General Knowledge and Skills

- Awareness and knowledge of the law
- Clinical pathways
- Community resources
- Computer literacy
- Computer literacy
- Cultures
- Delegation
- Disability claims
- DMV referrals
- Dyad model
- Federal guidelines
- Federal/state information regulations
- Financial literacy
- General office procedures
- Healthcare assessment
- Healthcare experience
- Healthcare system
- HIPPA compliance
- Immigration
- Insurance (e.g. plans, carriers)
- Mandated reporter
- Mandated reporting
- Mental Health
- Multilingual (Spanish, Korean, etc.)
- PUB4C health referrals
- Regulations
- Special population (e.g. high risk, homeless, incarcerated, abused/neglected)
- Supervisory skills
- Time management
- Transition of care model
- Triad model
- Written and verbal communication