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

C	**Facilitate continuum of patient plan of** care and service delivery.	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	**Perform utilization management (right care, right reason, right cost).**	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	**Link patient to community resources**	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).

		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.

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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