Strengthening Alaska's Care Coordination Services

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Trust
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AADD
ALASKA ASSOCIATION ON DEVELOPMENTAL DISABILITIES

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Introduction

This report presents findings from an evaluation carried out in response to a significant decrease in the number of care coordination providers in the last seven years, which has impacted individuals' ability to access services through Alaska's HCBS system.

The past seven years (2015-2022) have been difficult for everyone associated with Alaska's home and community-based services (HCBS). Add in a global pandemic and the long-term care system has experienced a historic amount of disruption, uncertainty, and change.[1] Implementation of the federal requirement for conflict-free case management (CFCM)[2] was a turning point in the system. Between the implementation of CFCM in 2016 and 2022, there was a 43%[3] reduction in the total number of coordinators in Alaska. During this same period, two new programs were implemented,[4] adding over 440[5] additional individuals statewide who require a care coordinator to access support. Thus, as the care coordination workforce dropped dramatically, the demand for care coordinators increased. This has resulted in an overburdened system affecting some individuals' ability to access services in a timely manner.

The changes described above have had the following impacts:

1. The Division of Senior and Disabilities Services has been under continuous pressure to respond to federal and state policy and budget shifts, and a global pandemic, while maintaining access to services across Alaska.

2. The system has become increasingly more difficult to enter as a new care coordinator.

3. Provision of care coordination services has become significantly more complex.

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[1] See Appendix A: Historical Background for further information regarding the referenced changes
[2] 7 AAC 130.220(a)(2), requiring the separation of care coordination services from HCBS direct service providers
[3] May 2015, 314 active certified care coordinators; Feb 2022, 179 active certified care coordinators (Source: SDS data request)
[4] The Individualized Supports Waiver (ISW) and the Community First Choice (CFC) program
[5] SDS Continuum of Care, # of service recipients: FY21, ISW = 441

The purpose of the evaluation is to assess the current state of care coordination services in Alaska and propose recommendations for strengthening this critical lynchpin of the HCBS system for Alaskan seniors and individuals who experience developmental and physical disabilities. In recognition of the essential role of care coordinators in the Medicaid HCBS waiver system, this evaluation was envisioned by the Alaska Association on Developmental Disabilities (AADD), funded by the Alaska Mental Health Trust Authority (AMHTA), and embraced by the Department of Health, Division of Senior and Disabilities Services (SDS).

Information in this report is based on input from 73% of the current care coordination workforce.[6] Thus, the researchers believe the findings and data presented in this report accurately describe the experiences, perceptions, and opinions of the current care coordination workforce in Alaska.

The evaluation aims to provide a starting point for further collaboration and action planning, the beginning of the road to a robust care coordination workforce. It will require the collective effort of all stakeholders that support quality services and the realization of Alaska's Shared Vision.[7]

STRUCTURE OF THE REPORT

This report is informed by the shared values of Alaska's HCBS system enshrined in Alaska's Shared Vision statute[8] and provides recommendations in five key areas impacting the care coordination system (not necessarily in order of importance). Appendices with detailed information are referred to throughout the report in footnotes, as they apply to the content. A complete list of recommendations is provided in the Next Steps section of this report.

Section 1: Workforce Development

- Describes skill requirements and responsibilities for care coordination services, and identifies paths to enhance recruitment and onboarding efforts and improve retention of skilled care coordinators.

Section 2: Continuum of Support Gaps

- Identifies areas of unmet needs and gaps in services that recipients are experiencing, the impact on care coordination services, and recommendations to address these service gaps.

Section 3: Compensation

- Describes how current reimbursement rates and methods impact care coordination services and identifies ways to align care coordination services and reimbursement rates.

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[6] N=131 of 179 total certified care coordinators in Alaska
[7] https://health.alaska.gov/gcdse/Pages/ddsharedvision/default.aspx
[8] AS 47.80.130(a)(7)

Section 4: Streamline Processes

- Identifies areas where efforts to streamline processes can increase productivity and enhance outcomes for stakeholders.

Section 5: Communication

- Identifies areas where communication improvements can enhance the system to facilitate collaboration and increase efficiency.

EVALUATION METHODS SUMMARY

The evaluation was completed using data from a variety of primary and secondary sources, including specific data requests to the Alaska Department of Health and Social Services[9] Division of Senior and Disabilities Services. Four in-person focus groups were conducted in January 2022. The purpose of the focus group sessions was to identify themes to explore further through a written survey and individual interviews. Primary data was collected through a written survey distributed online to 100% of the sample/total population of certified care coordinators in Alaska as of February 9, 2022. A total of 131 responses were received, resulting in a 73% response rate for the survey. Additional information came from 19 individual interviews completed in March and April of 2022. Source citations are noted throughout the report. A full description of the evaluation methods can be found in Appendix B: Evaluation Methods.

ALASKA'S SHARED VISION

"Alaskans share a Vision of a flexible system in which each person directs their own supports, based on their strengths and abilities, toward a meaningful life in their home, their job and their community. Our Vision includes supported families, professional staff and services available throughout the state now and into the future."[10]

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[9] Department of Health as of July 1, 2022
[10] https://health.alaska.gov/gcdse/Pages/ddsharedvision/default.aspx

Section One: Workforce Development

> The HCBS system relies on having a skilled, robust care coordination workforce that can navigate a highly complex system. Effective recruitment, efficient onboarding, well-defined responsibilities, and ongoing support are central to a sustainable workforce.

Alaska's HCBS care coordination system assists people to gain access to waivers and other state plan services, as well as other services not funded by Medicaid. As described below, care coordinators must wear many hats: business owner, system navigator, counselor, coach, mentor, facilitator, writer, and the list goes on. The complexities of the care coordination system create a steep learning curve.

> *Being a care coordinator is not an easy job. It's not a glamorous job – it is a job that comes from the heart. It is a job that has tears and sadness. It is a job that little things coming together are a win. It is a job that is worth doing.*
> – Survey Respondent

Areas of responsibility care coordinators manage include:[11]

1. **Certification** – Care coordinators must be individually certified, and either establish or work for a certified HCBS care coordination provider agency. Each has a separate certification process, which must be recertified biannually.

2. **Continuing Education** – Care coordinators must obtain 16 hours of relevant training annually to maintain their individual certification.

3. **Business Management** – Care coordinators must work in or be responsible for a properly set up and managed HCBS certified care coordination provider agency.

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[11] See Care Coordination Service System Map for further information regarding care coordinators' areas of responsibility

4. **Care Coordination Services** – The provision of care coordination services is complex and requires ongoing service coordination with recipients and families, collaboration with a wide range of community programs and resources, facilitating access to services, meeting submission deadlines, and assisting recipients to address unmet needs.

5. **Knowledge Base** – Care coordinators rely on a broad base of experience and skills to provide quality services.

> *It's a big job with a lot of different pieces and it's evolved and changed a lot over the years. So, I think there was never really a comprehensive narrative about what the job entailed or what would be expected or needed. It evolved on the fly.*
> – Interview Respondent

The role and responsibilities of a care coordination provider and individual care coordinators are described in the Care Coordination Services Conditions of Participation (COPs).[12] Throughout this evaluation (during focus groups, in the survey and interview responses), participants identified a lack of clarity in the specifics of what are and are not a care coordinator's responsibilities, especially concerning case management tasks (e.g., medical, financial, social, educational, etc.) as impacting recruitment efforts and retention of skilled care coordinators.

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[12] See Appendix C: Care Coordination Services Conditions of Participation Table

FIGURE 1 Care Coordination Service System Map

Individual Care Coordinator Certification
- DSM
- Conduent
- SDS Training-CC Training
- Backup CC Plan
- SDS Provider certification
- NPI
- Harmony
- AKTC - Basics of CC
- Annual continuing education
- Background Unit

Provider Certification
- DSM
- Conduent
- Insurance requirements
- SDS provider certification
- Develop policies & procedures
- NPI
- Harmony
- Re-certification reporting
- Background Unit

Adhere to PCP Expectations

Care Coordinator Services
- Service documentation
- Coordination with recipients, families, guardians, service providers
- Facilitating access to all needed services
- Ongoing service coordination
- Addressing unmet needs

Addressing unmet needs
- Cost of care issues
- Access, maintaining Medicaid eligibility
- Housing
- Transportation
- Complex behaviors, mental health

Ongoing service coordination
- Required monthly contacts
- Health and safety needs
- Assisting with financial benefits, management as needed
- Monitoring quality, other needs
- Coordinate SME, DME access
- Coordinating travel as needed
- Crisis management
- Connecting with community services

Facilitating access to all needed services
- Emods
- Initial application and renewal
- Coordinating assessments
- Responding to denials, fair hearings
- Support plan development, amendments

Business Management
- Office space, equipment, technology
- Accounting system - bill, audit proof
- Cash flow management
- Labor requirements
- Medicaid self-audits
- Business License

KEY
- All care coordinators and providers
- Only for new care coordinators, new providers
- Upon renewal

Foundational Knowledge
- Community Resources
- Disability and Aging
- Awareness of Best Practices
- Human Services (boundaries, etc.)
- State Resources and Processes
- Professional Skills in Communication and Technology

CARE COORDINATION WORKFORCE CAPACITY

To measure workforce capacity there are a number of factors to consider – caseload size, geographic distribution of the care coordination workforce, whether care coordinators are accepting referrals, the current workforce age distribution, and the stability of the current care coordination workforce

Caseload Size

Caseload sizes reported by survey respondents varied widely despite the majority reporting that they worked full-time (over 37 hours per week). Forty-seven percent reported a caseload between 21-40. However, 31% reported caseloads between 1-20, and 6% percent reported they were not carrying a caseload.[13] For those carrying larger caseloads, 10% reported caseloads between 41-50 and 7% reported caseloads over 50. (*Figure 2*)

FIGURE 2 Distribution of Caseload Sizes
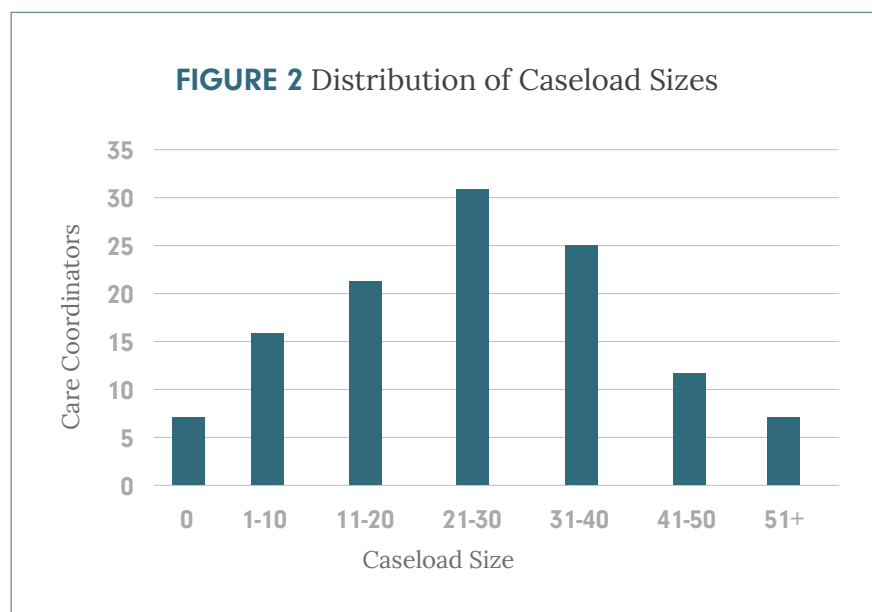
Source: Care Coordination Evaluation Survey, 2022   N=120

The variability of caseload sizes demonstrates that capacity cannot be determined solely through a direct comparison of the number of certified care coordinators[14] to the number of waiver recipients[15] at any given time.

[13] Survey respondents not carrying a caseload self-identified as either program manager/director, new care coordinator/agency, and/or working less than 20 hrs/wk

[14] As of February 2022, there were 179 certified care coordinators providing community-based care coordination services (Source: SDS data request)

[15] In FY2021 there were 4,854 waiver recipients (Source: SDS Continuum of Care, # of Service Recipients)

Geographic Distribution

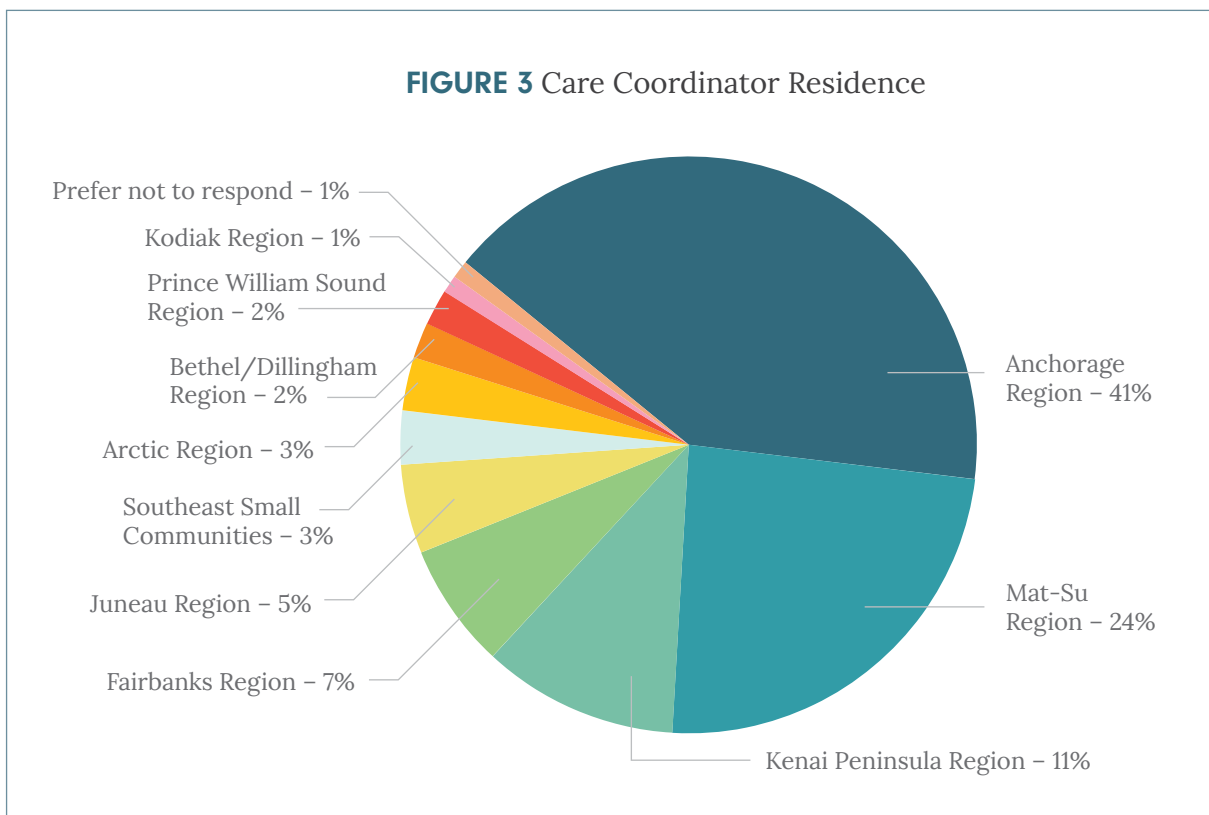The geographic distribution of the care coordination workforce is an important consideration in determining workforce capacity. The majority of care coordinators (84%) who responded to the survey reside on the road system – Fairbanks, Mat-Su, Anchorage, and Kenai Peninsula regions. (*Figure 3*)

Since 2016, when CFCM was implemented in Alaska,[16] SDS has granted agencies exceptions to CFCM in order to assure access to care coordination services in non-urban census areas where the number of conflict-free care coordinators could not meet the capacity[17] for the number of recipients and/or waiver types in the census area. Exceptions to CFCM are granted for three-year periods. For the 2022-2025 exceptions period eight census areas were eligible – Aleutians East, Aleutians West, Bethel, Bristol Bay, Kusilvak, Nome, Northwest Arctic, and Yukon-Koyukuk.[18]

FIGURE 3 Care Coordinator Residence

- Prefer not to respond – 1%
- Kodiak Region – 1%
- Prince William Sound Region – 2%
- Bethel/Dillingham Region – 2%
- Arctic Region – 3%
- Southeast Small Communities – 3%
- Juneau Region – 5%
- Fairbanks Region – 7%
- Anchorage Region – 41%
- Mat-Su Region – 24%
- Kenai Peninsula Region – 11%

Source: Care Coordination Evaluation Survey, 2022   N=116

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[16] https://health.alaska.gov/dsds/Pages/conflictFree.aspx

[17] SDS *Census Area Exceptions, May* 2022: for the purpose of the analysis, SDS defined capacity as 25 individual recipients to one care coordinator

[18] SDS *Analysis of Census Areas to Determine Eligibility for Exceptions to Conflict-Free Care Coordination Requirements, May* 2022

The concentration of the care coordination workforce residing on the road system, along with the continued need for SDS to provide exceptions to CFCM in non-urban census areas, demonstrates the need to increase care coordination capacity in rural/remote regions of Alaska.

Accepting Referrals

Another measurement of the current workforce capacity revolves around whether care coordinators are accepting new referrals. Fifty-two percent of the survey respondents stated that they were accepting referrals, 31% were not accepting referrals, and 17% provided circumstances under which they were accepting referrals. (*Figure 4*) Sixty-nine percent who were accepting referrals at the time of the survey indicated they would only accept initial applications with established long-term care Medicaid and recipients with approved waivers. (*Table 1*) Additional circumstances include taking TEFRA[19] referrals only, evaluating on a case-by-case basis, accepting if the referral was for a family member of a recipient they support, and urgent cases. Thus, the availability of care coordination services is further restricted by where an individual resides (*Figure 5*), whether they have been approved for long-term care Medicaid, and what their support needs are.

FIGURE 4 Accepting Referrals

Other (Please Specify) – 17%

Yes – 52%

No – 31%
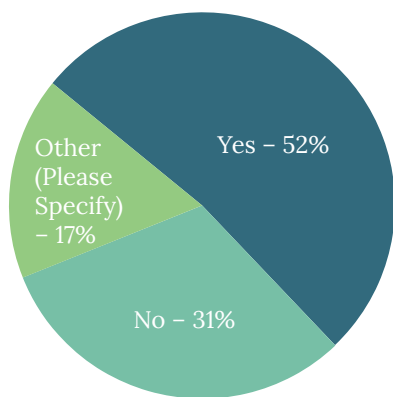
Source: Care Coordination Evaluation Survey, 2022
N=121

TABLE 1 Type of Referrals Accepting

People with an approved HCBS waiver	34%
Initial waiver applications with established Long-Term Care Medicaid	35%
Initial waiver applications without established Long-Term Care Medicaid	22%
Other (please specify)	9%

Source: Care Coordination Evaluation Survey, 2022
categories not mutually exclusive

[19] Tax Equity and Fiscal Responsibility Act, a program for children with disabilities and significant medical, developmental, or psychiatric needs to receive specific Medicaid benefits

FIGURE 5 Regions Accepting Referrals

Regions (y-axis):
- Anchorage Region
- Fairbanks Region
- Parks/Elliott/Steese Highways
- Glenallen Region
- Delta Junction/Tok Region
- Roadless Interior Region
- Mat-Su Region
- Kenai Peninsula Region
- Prince William Sound Region
- Kodiak Region
- Arctic Region
- Bethel/Dillingham Region
- Aleutian Region
- Southwest Small Communities
- Juneau Region
- Ketchikan/Sitka Region
- Southeast Mid-Size Communities
- Southeast Small Communities

Care Coordinators (x-axis): 0, 10, 20, 30, 40, 50, 60
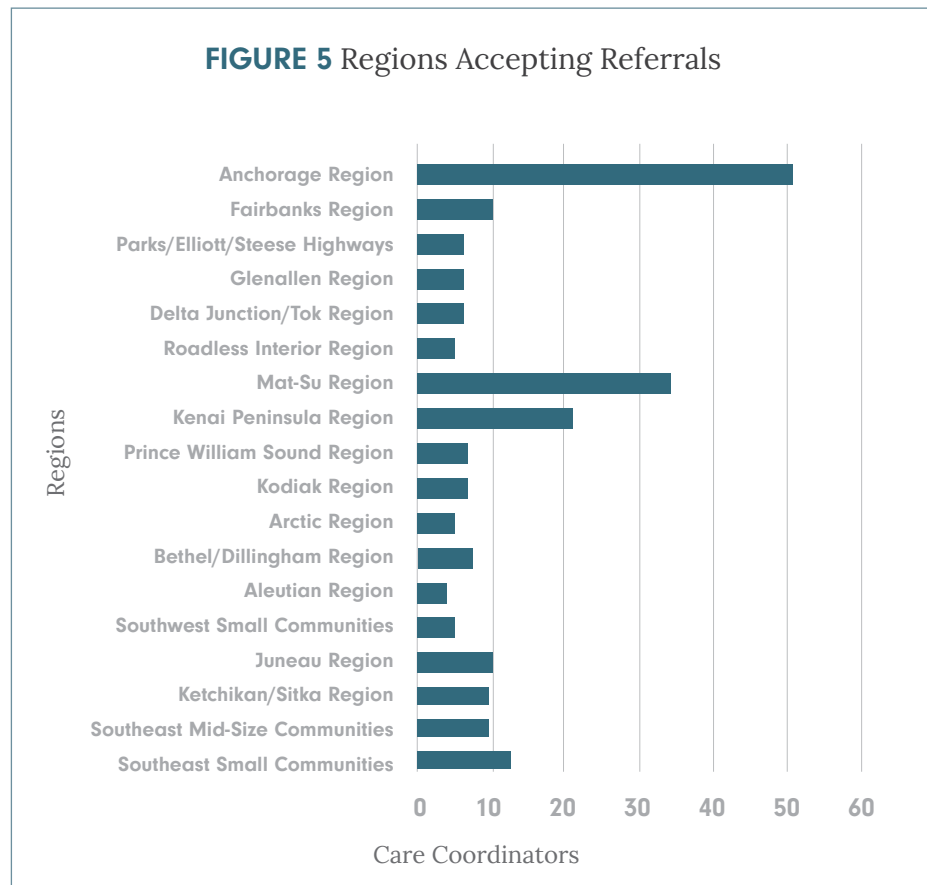
Source: Care Coordination Evaluation Survey, 2022   *categories not mutually exclusive*

Workforce Age

The current care coordination workforce age distribution is another factor when determining workforce capacity. Survey data indicates an older workforce creating an imbalance tipped toward retirement age. Approximately one-third are over 50 years old, and one-fifth are over 60 years old. Only about one-quarter are under 40 years old. (*Figure 6*)

Workforce Stability

A final factor to consider is the stability of the current care coordination workforce. Over two-thirds of the survey respondents indicated that they were satisfied in their care coordinator job. However, when respondents were asked if they plan to leave the care coordination profession within the next five years, two-thirds either indicated yes or provided a written open-ended (not simple yes/no) response; only one-third of the respondents committed to remaining beyond five years. (*Figure 7*)

FIGURE 6 Care Coordination Workforce Age Distribution
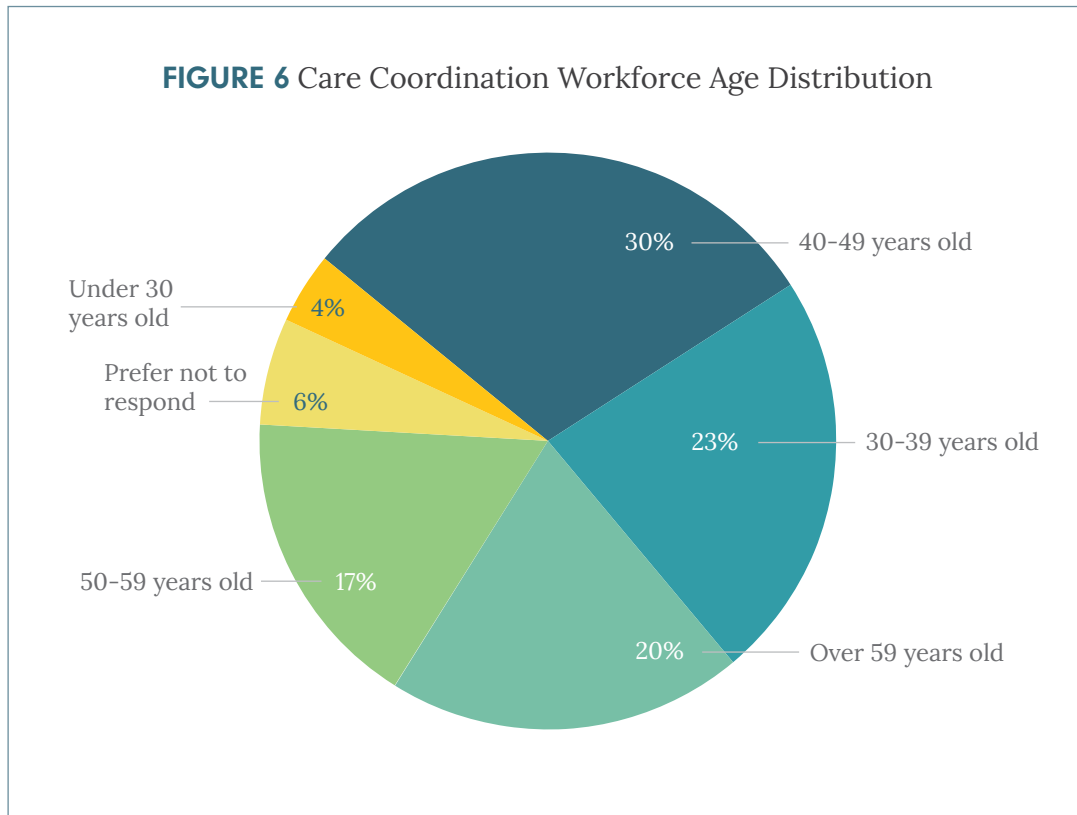
Source: Care Coordination Evaluation Survey, 2022   N=116

FIGURE 7 Plan to leave within 5 years
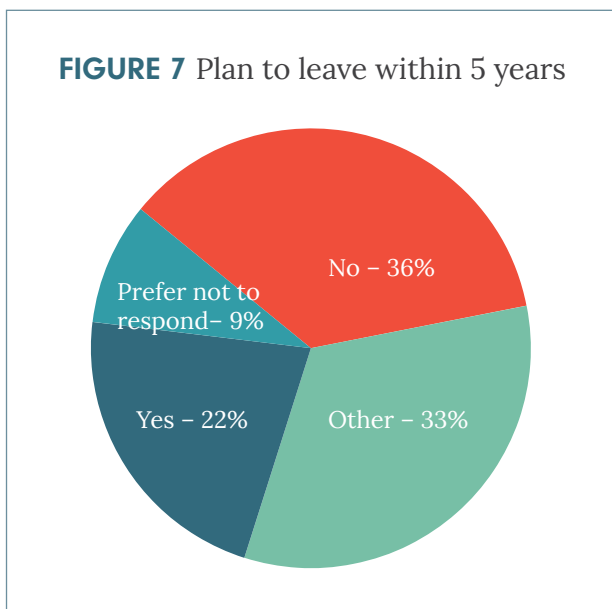
Source: Care Coordination Evaluation Survey, 2022   N=117

Thoughts about leaving the care coordination profession fell into five categories. Some responses noted a combination of factors, including stress from financial challenges and increasing workloads leading to burnout:

1. Increasing workload

2. High level of change occurring in the system

3. Communication difficulties

4. Negative work environment

5. Financial concerns

> *Possibly, the last 2 years with Harmony, CFC and the more administrative duties being added make me question my longevity in the field. I used to LOVE my job. Now I feel defeated and like I'm not actually making a difference.*
> – Survey Respondent

> *My job is rewarding and fulfilling because of those I serve; however, challenging processes, communication deficits, unrealistic expectations and increase in responsibilities continue to make this profession difficult.*
> – Survey Respondent

Upon reviewing the data presented above, the researchers believe that the current care coordination workforce does not adequately meet the level of need for care coordination services, especially in areas outside of the road system. Moreover, due to the age distribution and plans to leave the profession the current capacity of the care coordination workforce is likely to decrease.

> *My intentions are to continue to provide [care coordination] services, however; it is becoming more and more difficult to do my job effectively, and efficiently with all the new Harmony demands, changing regs, and limited salary. It is becoming less than cost effective to own a [care coordination] agency in AK.*
> – Survey Respondent

There is a compelling need to increase the care coordination workforce. Inadequate care coordination capacity resulting from the high degree of change in the past seven years and the increasing complexity of care coordination services is being exacerbated by the factors described above.

Recruitment Challenges and Opportunities

Effective recruitment methods are needed to build capacity. Recruitment efforts are hampered by the lack of awareness regarding the care coordination profession outside of the Medicaid system, along with the challenges less experienced care coordinators face in learning a complex system and building a caseload capable of providing a livable income.

Survey respondents rated the impact of the following statement on their work (rating scale 0-10, from "does not affect my work", to "affects my work somewhat", or "affects my work significantly") – *Within the Home and Community-Based Service system, the role and responsibilities of a certified care coordinator are not widely understood. (Figure 8)*

FIGURE 8 Lack of Awareness of the Care Coordination Profession
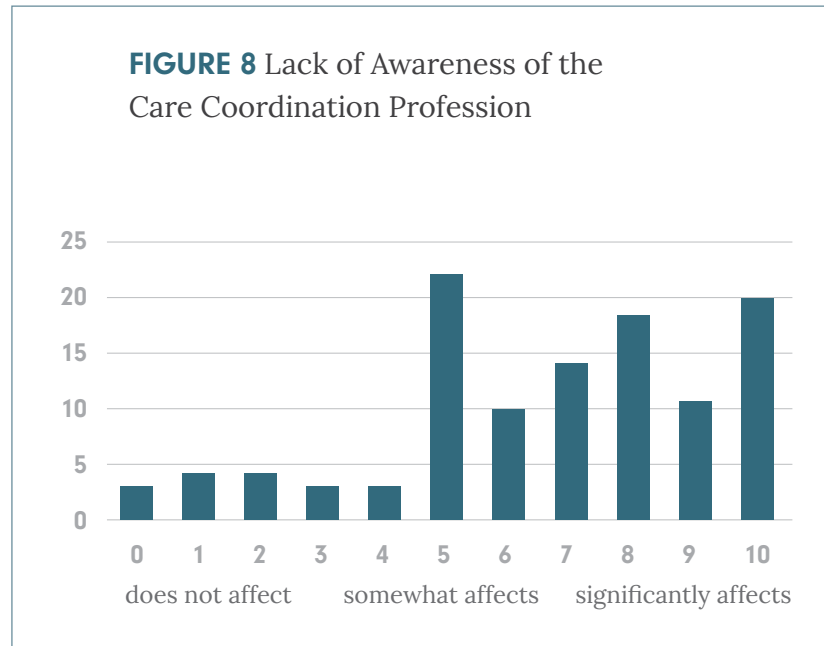
Source: Care Coordination Evaluation Survey, 2022   N=112

Eighty-five percent rated this question between 5-10, indicating a lack of understanding of the care coordination profession within the HCBS system. The researchers suggest that this lack of understanding of the care coordination profession is even more pronounced outside of the HCBS system.

Additionally, for the majority of the workforce, incomes are variable, depending on changes in their caseload, and do not include benefits (e.g., health insurance, paid time off, or retirement). This creates a barrier to recruitment and retention, limiting the attractiveness of the job to people who can weather fluctuations in income and have access to benefits outside their care coordination work.[20]

[There is a need to] increase awareness of what/who a care coordinator is and what they do. Since [care coordinators] are no longer in agencies, there is a limited outlet for potential [care coordinators] to learn about the profession. Better education of the [care coordinator] role will bring awareness to those who would be good candidates to become a [care coordinator]. Improving the available resources to assist folks in learning about and becoming a [care coordinator] would also help. Many are overwhelmed by the process and all of the responsibility involved in becoming a provider. Better compensation would also help.
– Survey Respondent

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20 See the Compensation section of this report for further information concerning care coordinator income and benefits

Potential avenues for increasing awareness of the care coordination profession and stronger recruitment efforts identified by evaluation participants include: collaborating with the University of Alaska Social Work and Human Service degree programs, creating internship/formal mentorship opportunities, and through coordinated marketing efforts at job fairs. Furthermore, evaluation participants emphasized the need to focus these efforts in areas not on the road system, especially rural/remote regions of the state.

> *I feel like the field has lost a significant amount of Care Coordinators since being removed from the provider agencies. When Care Coordinators worked at provider agencies, there were other positions that assisted the Care Coordinator with their responsibilities ... We have to do better at identifying people with Care Coordinator skills and actively recruit so we can increase our numbers to support folks with ALL waiver types. It is a very rewarding job.*
> – Survey Respondent

Supporting Less Experienced Care Coordinators

Beyond effective recruitment measures, retaining less experienced care coordinators is essential to increase care coordination capacity and develop a sustainable workforce. The period between the initial business set up and certification and establishing a caseload that financially supports the new care coordinator is precarious. The start-up phase for new care coordinators is lengthy and involves developing a working understanding of a complex system with limited revenue.

> *Being a new care coordinator is like putting together a puzzle in the dark.*
> – Survey Respondent

Evaluation participants recommended an approach to developing a sustainable workforce that both provides a career path and ongoing support through a system of tiered care coordination roles with increasing skill requirements and responsibilities, and a systematic mentoring program for new care coordinators. This approach could both increase care coordination capacity and allow care coordinators to focus their time and resources on providing high-quality support and advocacy to assist recipients in meeting their needs and achieving their goals.

A system of tiered care coordination roles could create a career path for care coordination by offering an entry-level role for individuals interested in working with vulnerable individuals and case management/coordination work, with opportunities for advancement as they gain the necessary skills and experience required to provide the full spectrum of quality care coordination services. The tiered roles could provide essential services, from providing information and referral services, to supporting initial waiver assessment tasks and person-centered support planning, to assistance with ongoing case management needs. This would involve adapting the care coordination roles and creating a structure for reimbursement associated with the tiered positions.

In a tiered system, a "mentor care coordinator" role provided by highly skilled care coordinators would offer ongoing support and professional development for less experienced care coordinators. Evaluation participants recommended creating a process to identify and financially support experienced care coordinators to serve in mentor roles.

> *Care coordination needs to become a professional career with a career development program. In addition, agencies aren't able to hire care coordinators as we don't get paid unless they have a caseload. The risk of bringing someone on, training them and paying them, and them not staying on is a lot of money to possibly lose. Care coordination agencies cannot afford this cost.*
> – Survey Respondent

Additionally, making the recently created care coordinator liaison position within SDS permanent would provide a dedicated link to SDS for the care coordination workforce and could potentially be a "home base" for the mentoring program. The March 2022 job bulletin described the purpose of this long-term non-permanent position:

> Under the direction of the Health Program Manager 4 (Chief of Programs), the incumbent will work on a variety of goals designed to increase the number of Care Coordinators available within the State of Alaska. The incumbent will work on identifying training needs, monitoring performance and timelines and will work on developing a career path for the Care Coordination sector. The incumbent will also work with a variety of stakeholders and community partners.[21]

This position is funded until June 2023 via a joint funding agreement between SDS and the AMHTA.[22]

> *Mentorship options – allowing [care coordination] agencies to take on new care coordinators with an internship grant so people can be paid as they are learning the job and building clientele.*
> – Survey Respondent

Throughout this evaluation, participants highlighted the need for additional training opportunities, especially for less experienced care coordinators. The topics most commonly mentioned included the dual care coordination certification processes, the Medicaid reimbursement system through the Department of Public Assistance (DPA) and Conduent,[23] the essential elements of data management and quality assurance systems, and the self-audit procedures for care coordination providers. Additional training topics suggested included waiver-specific training that explains the differences between waiver types and provides guidance on best

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[21] See Appendix D: Care Coordination Liaison Job Bulletin

[22] See Appendix E: Care Coordination Liaison Project Performance Measures

[23] The third-party billing entity

practices for working with each waiver population, as well as methods for supporting individuals with highly complex needs.

The Alaska Training Cooperative (AKTC), housed in the University of Alaska Center for Human Development,[24] promotes career development opportunities for the human service workforce. AKTC offers an array of training opportunities that address topics important to the care coordination profession that are affordable, accessible, and relevant. Securing funding for a collaboration project with the AKTC to develop a suite of training opportunities on topics identified by care coordinators would enhance professional development opportunities and could be linked to the career pathways a tiered care coordination system would be able to offer.

Retaining Experienced Care Coordinators

Retention of experienced care coordinators is key to developing a sustainable workforce that can offer recipients choice and meet the needs of recipients throughout the state. A common thread throughout the survey responses was how many care coordinators felt a strong commitment to supporting vulnerable Alaskans and felt they make a positive difference in the lives of the people they support. This element is noted as keeping many in the field despite the current challenges.

> *I think creating a more transparent and team-like environment would help to retain [care coordinators] and attract new [care coordinators].*
> – Survey Respondent

More than any other survey question, responses to the open-ended question of how to retain experienced care coordinators focused on the need for acknowledgment, mutual understanding, and trust of care coordinators by SDS and service providers; this was second in incidence only to calls for higher compensation. Potential approaches to address both of these needs are discussed later in the Compensation and Communication sections of this report.

> *One of the ways to retain experienced care coordinators is for the state departments to have and show us respect and understand that this is not just a job from 9-5. The people on the papers that they read are not just names to us, they are people that we know and want the best for. … We don't need trophies, or medals, we need respect. Respect means that not only are we heard, but the issues we talk about are taken in consideration and then put into action.*
> –Survey Respondent

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[24] https://www.uaa.alaska.edu/academics/college-of-health/departments/center-for-human-development/alaska-training-cooperative

Value us. Treat us as partners with respect, professional courtesy and work with us rather than against us. … our workload has grown significantly with CFC, reapplications and Harmony being an example of this. While our workloads have grown, so have the Conditions of Participation that govern us. We are more intensely regulated than any other Waiver provider. What hasn't grown is our compensation.
– Survey Respondent

Section Two: Continuum of Support Gaps

> Addressing unmet needs and gaps in services is crucial to meet the essential needs of vulnerable Alaskans and alleviate demands on the care coordination workforce outside of their primary role.

Waiver recipients often struggle to meet their basic needs – housing, transportation, and healthcare. In addition, they often need assistance to:

1. Access and maintain public benefits which are required to access HCBS and community support.

2. Find evaluation resources to document their qualifying diagnosis and support needs for waiver services.

3. Access resources for environmental modifications needed to live in the home and community of their choice.

4. Access resources to address their highly complex needs.

Evaluation participants identified the lack of accessible resources to assist and support individuals in addressing the needs described above as frequently requiring the care coordination workforce to fill these gaps. Care coordinators develop long-term, trusting relationships with the people they support, which commonly leads individuals to seek out their assistance. Thus, many care coordinators work long hours to help meet these needs as there are limited resources to refer individuals to.

> *[Care coordinators] are often expected to be case manager, [care coordinator] and Medicaid specialist, with many professionals in our community confused about what it is that we do. With the growing gap in services and resources available, clients new and old are finding that they have no options left in our state.*
> – Survey Respondent

Throughout the HCBS system, Conditions of Participation[25] describe the responsibilities of each provider type. As noted earlier, the lack of understanding of the care coordination profession within the HCBS system (see Figure 8) and the lack of well-defined responsibilities in certain areas of the care coordination COPs impacts the care coordination workforce. The researchers suggest that this lack of clarity extends to the COPs for all HCBS providers. A potential avenue to identifying service gaps affecting waiver recipients could be realized through the clarification of the responsibilities of all HCBS providers.

> *It makes it difficult to work efficiently, when the role of [care coordinator] is misunderstood by recipients, providers and community services alike.*
> – Survey Respondent

> *The amount of work required differs by the client, case, and life circumstances each month. … It's hard to manage and predict workload.*
> – Survey Respondent

Survey respondents reported spending an average of 14% of their time on case management tasks – such as assistance with public benefits, travel, healthcare, housing, employment, and education – and addressing critical needs – such as emergency medical care, hospitalization, behavioral supports, and support/caregiving. This was in addition to the 20% of their time spent on monthly contacts and monitoring tasks.[26] Evaluation participants described how this tends to overburden the workforce, often leading to burnout, care coordinators leaving the workforce, and ultimately decreased care coordination capacity.

> *[I have] two crisis situations going on right now that I am getting contacted daily and one of the individuals being in a crisis for a long time, that's just been a regular thing. I would say that 60% of my time I feel is case management with visits. … having my crisis situations going the extra step and trying to get them connected with appropriate services to help them through whatever it is they're going through.*
> – Survey Respondent

Better Use of Existing Resources

There are existing support entities that can potentially be enhanced to address some of the service gaps. An outcome of this evaluation may be to further explore this possibility and the likely need for additional funding to address gaps in the continuum of support for vulnerable Alaskans.

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[25] https://health.alaska.gov/dsds/Pages/regulationpackage.aspx

[26] See Figure 11: Time Allocation (monthly) for further information on how care coordinators spend their time providing services

For example, the Aging and Disability Resource Centers (ADRC)[27] and the Developmental Disabilities Resource Centers (DDRC)[28] are statewide resources that provide information and referral services for individuals needing long-term services and supports (LTSS). These organizations serve as an entry point to HCBS, assisting individuals to access public and community resources by conducting a Person-Centered Intake (PCI)[29] and/or completing the Developmental Disability Determination Application.[30] The ADRC/DDRC, as resource centers, are ideally situated to assist with issues related to access to public benefits outside of the HCBS waiver. More specifically, ADRC/DDRCs could assist in the initial Medicaid application and possibly assist with coordinating access to medical/behavioral health providers for neuropsychological and other specialized evaluations, which are required to apply for HCBS waivers, in a timely and cost-efficient manner.

Reevaluating the EMOD Support System

Environmental modification projects (EMODs) address the need for physical adaptations to a person's residence to maintain their independence. Care coordinators are responsible for assisting recipients to apply for EMOD waiver services,[31] which involve assisting recipients to determine what modifications are needed, request cost estimates from Medicaid-certified contractors, and complete the application process through SDS.[32] Evaluation participants described their experiences with EMOD projects – they noted that EMODs require a substantial time investment, there are a lack of contractors willing to provide this service, limited resources available outside of Medicaid waiver services, and require skills that fall outside of traditional care coordination services.

> *I made a decision for my own health and well-being to transfer clients out rather than do EMOD or [Specialized Private Duty Nursing] requests.*
> – Survey Respondent

As a result, gaps in the EMOD support system inadequately meet individuals' needs for EMODs tailored to their living environments. A potential outcome of this evaluation is to coordinate an effort to address challenges in the EMOD system.

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[27] https://health.alaska.gov/dsds/Pages/adrc/default.aspx, https://acl.gov/programs/aging-and-disability-networks/aging-and-disability-resource-centers

[28] https://health.alaska.gov/dsds/Pages/grantservices/DDRCmini.aspx

[29] https://health.alaska.gov/dsds/Documents/adrc/PCI_Handbook.pdf

[30] https://health.alaska.gov/dsds/Documents/SDSforms/idd/IDD_Determination_Application.pdf

[31] https://health.alaska.gov/dsds/Pages/emod/default.aspx

[32] See Appendix C: Care Coordination Services Conditions of Participation Table

Specializing in Complex Care

When needs arise, crisis or not, the care coordinator is often asked to assist. For recipients who can advocate for themselves or who have family/guardianship support, these needs may be intermittent or not time-intensive. However, evaluation participants noted that the current system does not account for people with highly complex needs – either intermittent or ongoing. For LTSS recipients, resources are lacking for the numerous case management needs that arise; therefore, the care coordinator becomes the catch-all. The researchers believe that care coordinators have the skills and relationships with people to address complex needs; it makes sense to build on this by creating a way to compensate care coordinators for these increased responsibilities and time commitments.

Evaluation participants recommended establishing a care coordination acuity rate for recipients with complex needs requiring a significant time investment to support, and reimbursement resources for care coordinators providing essential support when natural or guardianship support is unavailable – including healthcare coordination (medical, specialists, evaluations, equipment), behavioral health and complex needs coordination, etc.

Section Three: Compensation

Competitive compensation is a key component of supporting a skilled, robust care coordination workforce that can navigate the highly complex HCBS system.

Care coordinators participating in this evaluation expressed concern regarding the level of compensation in relation to the work they are required to complete. Upon review, it is clear to the researchers that care coordination reimbursement – both the rate of reimbursement and the process for determining rates – needs revision. A robust care coordination workforce hinges on providing competitive compensation.

Survey respondents rated the impact of the following statement on their work (rating scale 0-10, from "does not affect my work", to "affects my work somewhat", or "affects my work significantly") – *Compensation levels are too low, given the work requirements. (Figure 9)*

FIGURE 9 Compensation Levels
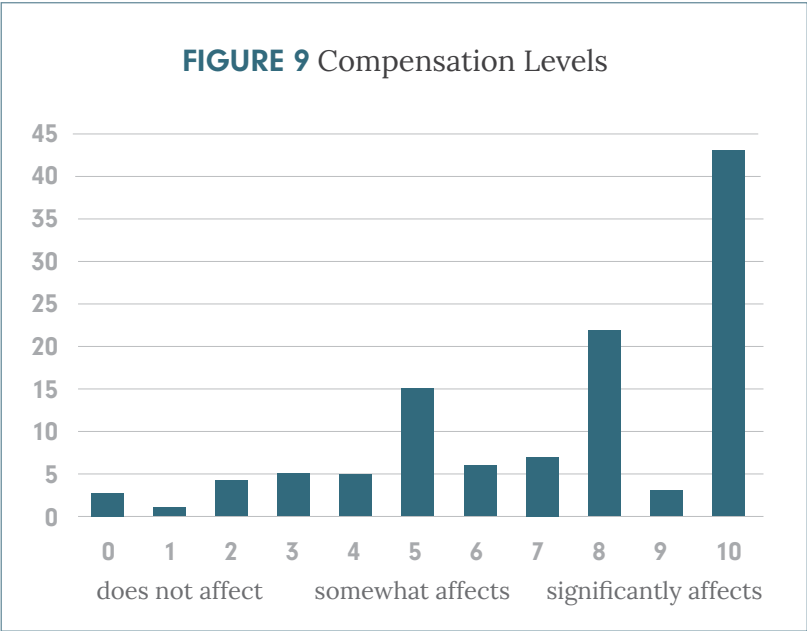
Forty-six percent rated this question between 5-9 and 38% rated a 10, indicating that low compensation levels are significantly impacting the workforce.

Rating		
0	does not affect	
5	somewhat affects	
10	significantly affects	

Source: Care Coordination Evaluation Survey, 2022   N=114

> *[We need] a livable wage so we could have a smaller caseload, ensuring our clients receive the care and attention they need. We are tired.*
> – Survey Respondent
>
> *A lot of a [care coordinator's] work is unpaid, i.e., the weeks/months it takes helping the person get Medicaid eligibility determined, submitting a Waiver application, attending their assessment and hoping they meet [level of care]. Writing an initial [support plan], waiting for approval and then finally being able to bill for your services/time.*
> – Survey Respondent
>
> *The workload is not sustainable. Challenges with initial [level of care] are numerous often resulting in denials and not being reimbursed for your time/efforts. Reimbursement of services don't accurately reflect services provided/time.*
> – Survey Respondent

The care coordination reimbursement base rates have not changed since 2011[33] and therefore do not capture increased time and expenses related to regulatory changes including the transition to CFCM, the increase in continuing education requirements,[34] the introduction of the Community First Choice (CFC) and Individualized Supports Waiver (ISW) programs, and the requirement to work in Harmony.[35] Furthermore, because of the extended time without a rate rebasing, the value of the rate has declined over time due to increasing costs.

According to current regulations, the care coordination service rates are set to be re-established at least every four years. Regulations describe a modeled rate methodology based on salaries, fringe benefits, administrative/general, and caseload size.[36] This methodology is no longer relevant to how care coordination services are provided as it does not capture the actual costs and level of expertise required to provide the service.

The care coordination delivery system has changed substantially since CFCM was implemented. The majority of care coordination providers are independent or work collaboratively in small care coordination-only agencies,[37] with associated business and administrative costs borne by them as service providers. Findings from the survey indicate that four out of five care coordinators do not have employee benefits. (*Figure 10*) Additionally, the majority of evaluation participants reported working well over 40 hours a week, including evenings, weekends, and holidays.

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[33] See Appendix F: Care Coordination Services Medicaid Reimbursement Procedure Codes and Rates Table

[34] See Appendix C: Care Coordination Services Conditions of Participation Table

[35] Harmony is the secure web-based data management system SDS uses to administer programs, services, and provider certification; July 1, 2021, care coordinators required to submit materials and monitor their caseload in Harmony

[36] 7 AAC 145.520, Home and Community-Based Waiver Services Payment Rates

[37] Of the 179 certified care coordinators at the time of this evaluation, 42% are independent, 37% work in a care coordination-only agency, and 21% work for multi-service organizations. (Source: Care Coordination Evaluation Survey, 2022)

FIGURE 10 Benefits
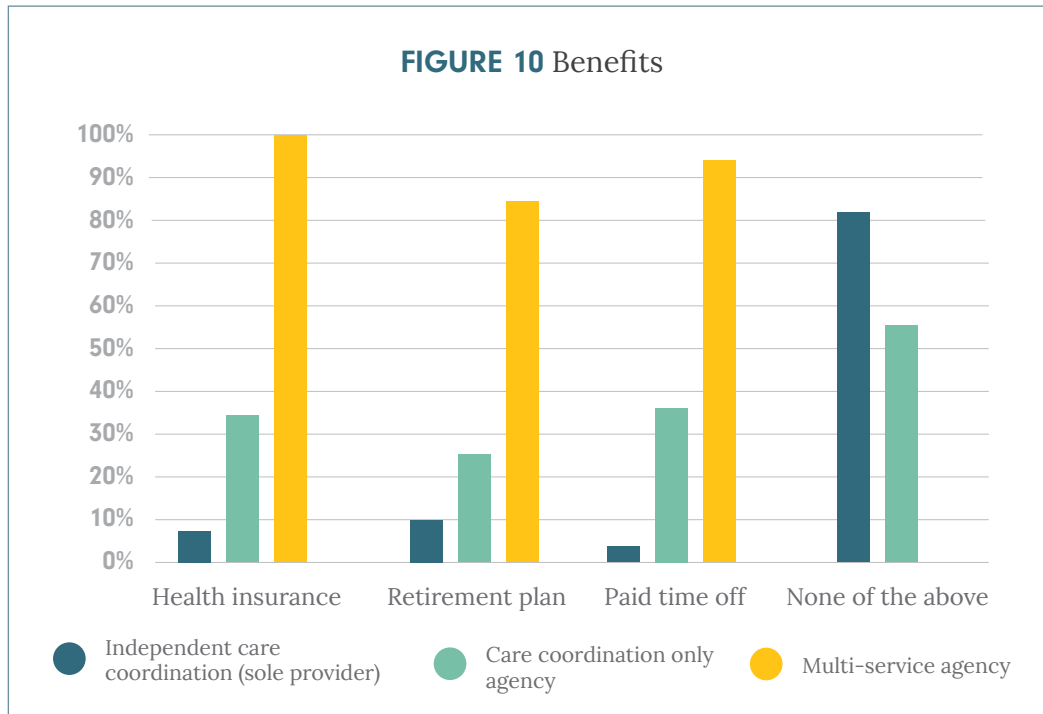
Source: Care Coordination Evaluation Survey, 2022   N=114

> *I accept phone calls between 9:00 and 5:00 Monday through Friday. However, I'm usually in the office a couple hours before and several hours after, and then on Saturday. I haven't counted the hours in a long time because it's just what we do. You just have to get it done so you just make it happen. My husband would probably say 50 to 60 hours a week, if not more.*
> – Interview Participant

> *More like work 50 plus hours a week. People need more help than what Medicaid allows and more than what Care Coordinators get paid for.*
> – Survey Respondent

> *Probably 50 to 60 [hours a week] for me. But none of it is 9 to 5, none of it...*
> – Interview Participant

Survey respondents were asked to indicate the percentage of their time they spend in a typical month providing the array of care coordination services and meeting the needs of the people they support. Figure 11 shows the percentages reported for each category and Table 2 illustrates how many hours a care coordinator spends in each category correlated to the hours worked per week.

FIGURE 11 Time Allocation (monthly)

Required Monthly Contacts/ Monitoring – 20%

Requests for Reimbursement/ Billing – 4%

Tasks Related to Running a Business **Enter 0 if you are employed by an agency – 4%

Required Training for Certification – 5%

Initial Applications for HCBS Waiver Programs – 5%

Amendments to Support Plan – 6%

Inital Support Plan Development – 6%

Case notes/ Documentation – 13%

Renewal Support Plan Development – 13%

Renewal Applications for HCBS Waiver Programs – 9%

Case Management such as assistance with benefits, travel, healthcare, housing, employment, education, etc. – 8%

Addressing Critical Needs such as emergency medical care, hospitalization, behavioral supports, support/caregiving, etc. – 7%

Source: Care Coordination Evaluation Survey, 2022   *categories not mutually exclusive*

TABLE 2 Monthly Hours Spent Providing Care Coordination Services

Task	Hours per month		
	40 hr/wk	50 hr/wk	60 hr/wk
Initial Applications for HCBS Waiver Programs	9	11	13
Initial Support Plan Development	10	12	14
Renewal Applications for HCBS Waiver Programs	16	20	24
Renewal Support Plan Development	22	27	32
Amendments to Support Plans	11	14	16
Required Monthly Contacts & Monitoring	35	44	53
Case Notes & Documentation	23	29	35
Case Management: assistance with benefits, travel, healthcare, housing, employment, education, etc.	14	17	20
Addressing Critical Needs: emergency medical care, hospitalization, behavioral support, support/caregiving, etc.	11	14	17
Requests for Reimbursement & Billing	7	8	10
Required Training for Certification	9	11	14
Tasks Related to Running a Business	8	10	11
Total Hours Work per Month	**173**	**217**	**260**

Source: Care Coordination Evaluation Survey, 2022   *categories not mutually exclusive*

It was difficult to come up with the allotment of time for the various tasks on the previous page because the reality is, I work far more than 40 hours a week as there is not enough a time in the day to complete what is expected of us as [care coordinators]. My priority is ensuring the participants I work with needs are met and often times, paperwork gets pushed to evenings or weekends. It hasn't always been this way but . . . the paperwork requirements have increased tremendously.
– Survey Respondent

The percentages above are not really telling. For instance, a good initial support plan takes me a solid week to write with little to no interruptions. This past week I had no time to work on the [support plan] due by Monday. I will have to work this weekend to complete it.
– Survey Respondent

A list of keywords was created related to 14 types of tasks the interview participants identified as requiring a significant amount of time to complete in relation to current reimbursement rates. Many of the tasks identified relate to the lack of accessible resources to assist and support individuals in addressing unmet needs described in the Continuum of Support Gaps section of this report. The Word Cloud illustration below was created using the total incidence of each keyword across the interview transcripts.
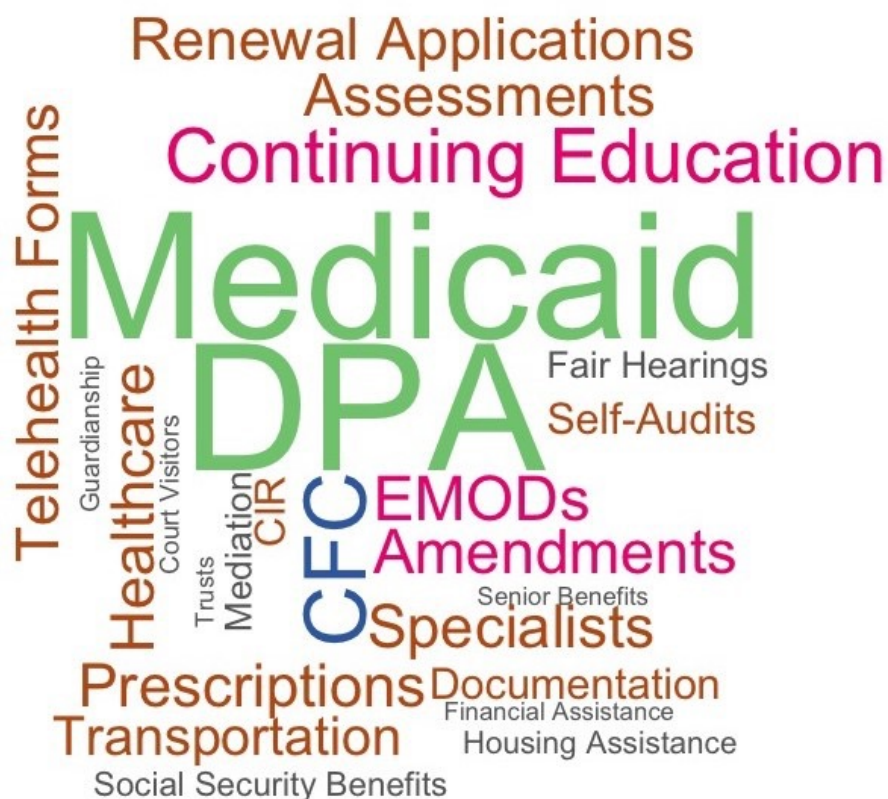
Source: Care Coordination Evaluation Interview Transcripts, 2022

> *[Medicaid has] been a huge drag on my time, but it's necessary to maintain paying people's waivers and maintain their Medicaid eligibility. And navigating these systems has become harder because I can't adequately instruct parents on how to do it anymore.*
> – Interview Participant

An additional expense category not captured in the current rate methodology concerns travel when serving rural areas. These costs are borne by the care coordination provider and for much of the year, inclement weather commonly adds to this expense. Currently, the care coordination reimbursement rates are adjusted to reflect regional differences in the cost of doing business *based on the region in which the provider is located.* As discussed in the Geographic Distribution section of this report, the majority of survey respondents (84%) reside on the road system – Fairbanks, Mat-Su, Anchorage, and Kenai Peninsula regions.

Consequently, the majority of the care coordination workforce is not able to access the additional reimbursement for providing services in a more costly region.[38]

An important consideration when reviewing the reimbursement rate structure is that revenue is tied to the number of recipients on a caseload. There currently are no guidelines regarding caseload size. Care coordinators report that they need to maintain enough people to make the job financially viable as well as have a degree of cushion in the event a recipient's circumstances changed.[39]

> *Most of us must keep very high caseloads just to survive because so much of our work is unbillable, a client passes away, or moves or the claims just do not pay out. That is life. We get paid less than minimum wage often times yet have to keep very expensive insurances, offices and a host of other things just to make ends meet.*
> – Survey Respondent

In addition to inadequate reimbursement rates, several billing challenges consistently impact compensation. Many evaluation participants report having difficulty being reimbursed for initial applications (screenings), as well as collecting compensation for CFC Targeted Case Management (TCM), due to a difference in understanding of the requirements for reimbursement between SDS and Conduent.

> *Billing for screening is so hard. I have not been able to bill for a single client since I started.*
> – Survey Respondent

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[38] Table I-1 of the Alaska Geographic Differential Study, dated April 30, 2009

[39] See the Caseload Size section of this report for further information

> *You never really know when they'll allow you to bill [for an initial application], if it's the date that they give you the screening coupon, if it's the month they give you the screening coupon. What if you don't have a screening coupon? Then I was billing for the date that I submitted it, but then that's not approved if the assessment is done in the same month because that's the start date of the support plan. ... It just wasn't worth the 90 bucks to try and get it.*
> – Interview Participant

> *My client whose CFC only has case management for CFC, which is what I'm supposed to be paid monthly and it doesn't pay right now. SDS is convinced that it does not need a service authorization. Conduent is convinced that it does, and they are not talking to each other. And it's more cost effective for me to just not provide the service as an agency than to chase down $140 every month.*
> – Interview Participant

Evaluation participants recommended exploring other systemic issues that impact compensation, including addressing barriers to reimbursement for work performed and submitted on behalf of a recipient before their death, and the disparity in reimbursement rates between waiver applications and TEFRA[40] applications. Although HCBS waiver programs[41] and TEFRA[42] have similar eligibility requirements they are administered by different programs[43] and have substantially different reimbursement rates.

Upon reviewing findings from this evaluation, the researchers believe that the reimbursement rate methodology described above no longer reflects the reality of the care coordination workforce and does not capture the true costs of providing care coordination services.

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[40] Tax Equity and Fiscal Responsibility Act, a program for children with disabilities and significant medical, developmental, or psychiatric needs to receive specific Medicaid benefits

[41] HCBS waiver programs, https://health.alaska.gov/dsds/Pages/HCBWprogram.aspx

[42] TEFRA program, http://dpaweb.hss.state.ak.us/e-forms/pdf/MED-15.pdf

[43] Waiver applications are administered by SDS and Conduent; TEFRA applications are administered by DPA and Comagine Health (third-party billing entity) https://comagine.org/program/alaska-medicaid-tefra/patients-families

Section Four: Streamline Processes

> Increasing efficiency within the system allows everyone to work smarter, not harder, improving outcomes for individuals.

The HCBS system is highly complex and governed by federal and state regulations. SDS is charged with administering Alaska's HCBS with oversight provided by the Centers for Medicare & Medicaid Services (CMS) and Alaska's policymakers. SDS is tasked with being responsive to this oversight while maintaining access to services provided by public and private entities throughout Alaska. This places SDS in the challenging position of providing guidance and support while being accountable for quality assurance and responsible resource management.

In 2009, CMS placed a moratorium on new waivers in Alaska as a result of findings from a federal audit.[44] SDS's current Quality Improvement System (QIS), described in the state's waiver applications,[45] which CMS approves, was originally developed as part of a corrective action plan in response to the moratorium. It is essential that SDS maintain Alaska's compliance in order to ensure continuous access to HCBS services.

Care coordinators fill an essential role in the provision of HCBS. Survey respondents identified three primary areas within the system that make this difficult job more challenging – redundancies, inconsistent guidance, and a lack of clear expectations.

> *Processes can be redundant, expectations / requests by reviewers are not consistent and since the implementation of Harmony, communication between SDS employees is strained; thereby, creating undue stress for the care coordinators seeking guidance to meet deadlines.*
> – Survey Respondent

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[44] https://dhss.alaska.gov/health/News/Pages/2009/cms_benchmark101609.aspx

[45] https://health.alaska.gov/dsds/Pages/AK-HCBS-waivers.aspx

Survey respondents rated the impact of the following statement on their work (rating scale 0-10, from "does not affect my work", to "affects my work somewhat", or "affects my work significantly") – *The Home and Community-Based Service system is fragmented and inefficient, making it difficult to navigate and secure needed support for recipients of waiver services.* (*Figure 12*)

Seventy-seven percent rated this question between 5-10, indicating that fragmentation and inefficiencies within the HCBS system are impacting the workforce.

FIGURE 12 Fragmentation and Inefficiencies
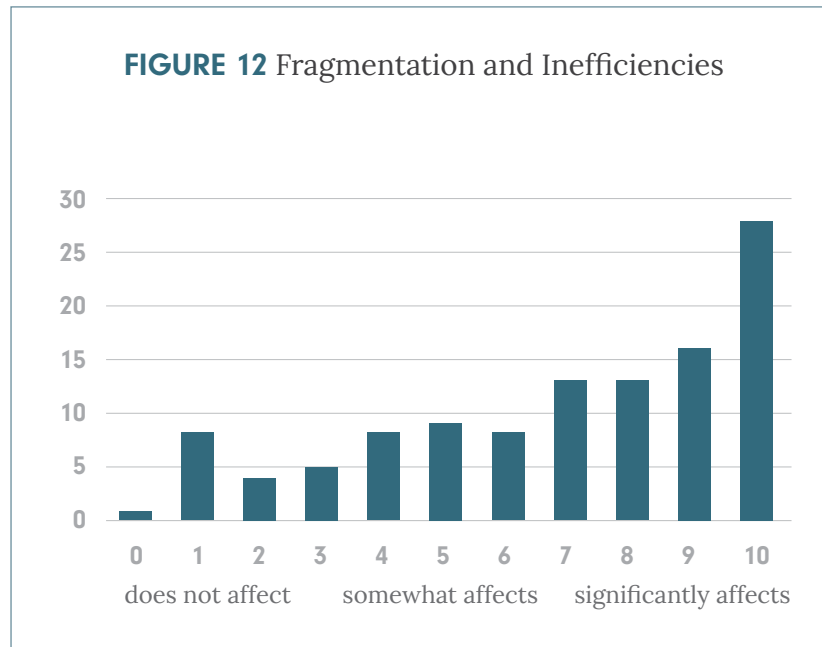
Source: Care Coordination Evaluation Survey, 2022   N=113

Survey respondents rated the impact of the following statement on their work (rating scale 0-10, from "does not affect my work", to "affects my work somewhat", or "affects my work significantly") – *The waiver application and support plan requirements are applied inconsistently, with differing interpretations of regulations and care coordinator expectations within the Division of Senior and Disabilities Services.* (*Figure 13*)

Eighty-five percent rated this question between 5-10, indicating that inconsistencies within SDS are impacting the workforce.

FIGURE 13 Inconsistencies
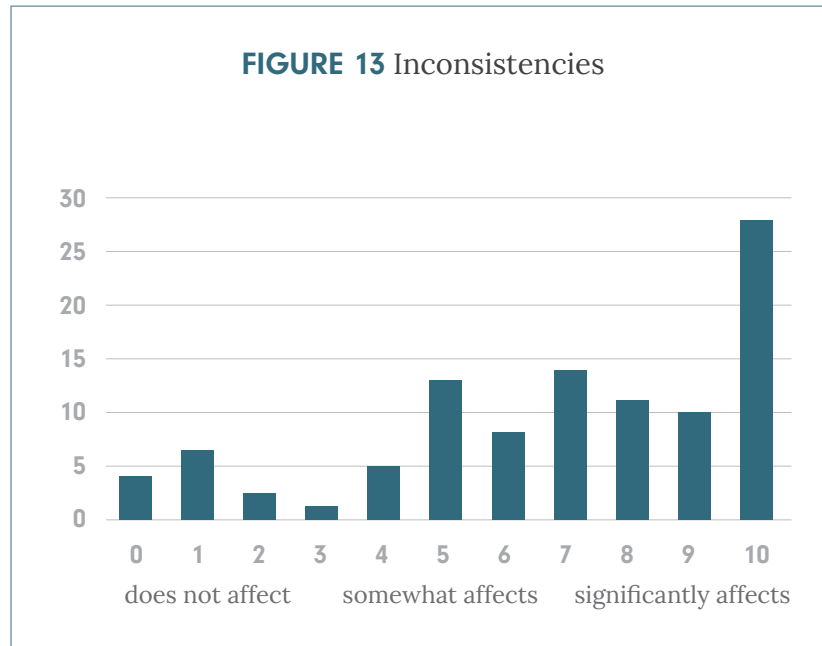
Source: Care Coordination Evaluation Survey, 2022   N=117

Due to the high degree of change over the past seven years, the system has increased in complexity without sufficient time and resources allotted to SDS by regulatory entities with which to streamline processes. This has resulted in numerous redundancies as old processes have had to be updated to accommodate changes in regulations and data management systems. Furthermore, the ability of SDS to provide consistent guidance and establish clear expectations has been strained.

Care coordinators participating in this evaluation identified redundancies within the processes for submitting required documentation to establish and maintain individuals' waiver services. As regulations have changed and new data management systems adopted, the required paperwork and submission paths have had to be revised, often on the fly without adequate time for SDS personnel, care coordinators, and service providers to adapt to these changes.

> *Streamline expectations and responsibilities. Simplify and reduce paperwork so we can direct our attention to the people we support.*
> – Survey Respondent

> *The duplication of work requested by DSDS is increasing. The new application form requires a medication list, but so does Harmony and care coordinators have to update both with the same information. Assessors requesting additional records from the same providers whose records are in Harmony and current.*
> – Survey Respondent

The complexities inherent in the HCBS system, with its many moving parts, have made it difficult for SDS to provide consistent guidance and clear expectations regarding these regulation and process changes. Having to continuously adapt during this period of change while continuing to provide services has created a working environment characterized by disruptions and uncertainty, causing strain on the HCBS workforce, and pushing it past its ability to respond effectively.

> *There are a lot of complications about our system and questions are answered differently depending on who you ask.*
> – Survey Respondent

> *Regarding application and support plan requirements being applied inconsistently, this is a huge problem. I can complete the same document in the same way on any given day and it may or may not be accepted. There is no consistency and yet it is my time being taken to try and determine the issue or re-submit documents.*
> – Survey Respondent

> *The difference between reviewers is very large and has become impersonal. It's frustrating, sometimes even soul-crushing, to spend a minimum of 6 hours up to 14 hours to enter a plan in Harmony to have a reviewer write something like "what about dental?" on a meticulously detailed plan about complex medical issues; or "this is similar to last year" on a plan when someone has autism and is extremely scripted and regimented in their daily life – although you did your best to re-word it and mix it up a bit. It also makes us look bad … when this document goes to agencies, guardians, and families. Very little positive feedback is seen.*
> – Survey Respondent

Other areas for potential improvements identified by survey respondents include the alignment of the level of care, CFC, and waiver plan dates to streamline the application and support plan development processes, and coordinate joint processes between relevant state departments/programs and outside entities – SDS, Background Check Program, Health Care Services, Public Assistance, and Conduent.

> *We need better collaboration with DPA. Working with them is crucial in many cases but it is so difficult.*
> – Survey Respondent

This evaluation highlights an opportunity to strengthen the partnership between care coordinators, direct service providers, and SDS through a collaborative effort to streamline processes within the system. The researchers recommend this be accomplished through a review of current waiver processes with a focus on removing redundancies, addressing inconsistencies, and clarifying expectations.

Section Five: Communication

Collaborative working relationships are key to creating a supportive environment that sets the HCBS workforce up for success.

Effective communication throughout the HCBS system is a key component of strengthening the partnership between care coordinators, direct service providers, and SDS – fostering a collaborative working relationship built on mutual understanding and trust.

A consistent theme throughout this evaluation's findings was the need to improve lines of communication between SDS, care coordinators, and direct service providers. It is worth noting that the care coordinator liaison position had not been in place at the time of this evaluation.

Better communication. The SDS E-Alerts are inconsistent. Information isn't always sent. Many of us are confused about things often. We need some forum or space to go for support and answers.
- Survey Respondent

Survey respondents rated the impact of the following statement on their work (rating scale 0-10, from "does not affect my work", to "affects my work somewhat", or "affects my work significantly") – *Lack of good communication among those involved in the Home and Community-Based Service system makes it hard to meet deadlines and is time consuming.* (Figure 14)

Seventy-five percent rated this question between 5-10, indicating that communication challenges are impacting the workforce.

FIGURE 14 Lack of Communication

Source: Care Coordination Evaluation Survey, 2022   N=114
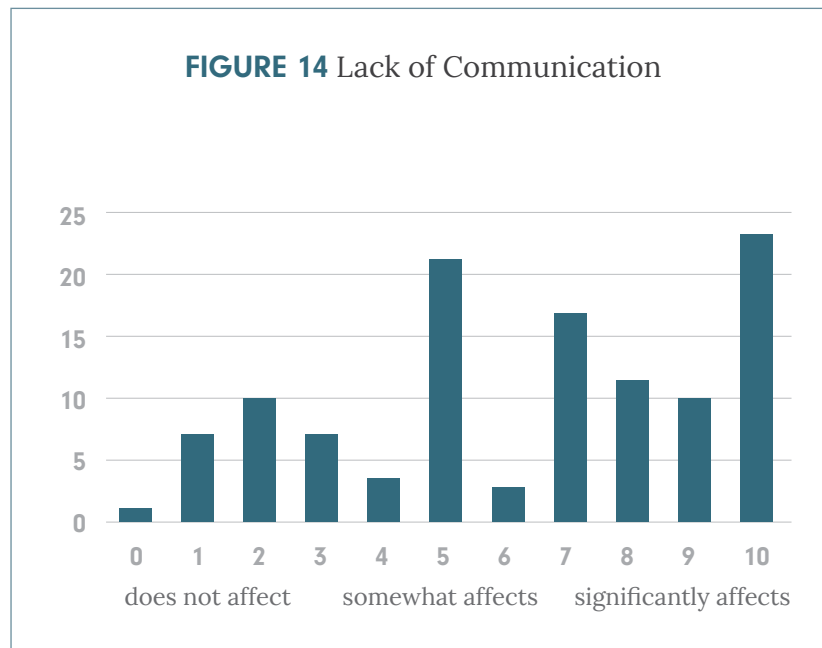
Evaluation participants identified two primary communication areas within the system needing improvement:

1. Increase the frequency of personal communication between care coordinators and SDS team members. Currently, scripted responses are the most frequent approach to exchanges. While scripted responses do increase consistency, they also decrease partnership and shared problem-solving.

2. Enhance communication protocols between state departments/programs and outside entities – SDS, Background Check Program, Health Care Services, Public Assistance, and Conduent – to increase efficiency and address concerns timely.

> *It's difficult to have communications with SDS folks, and a lot of times it's only by emails or a note that they leave you in Harmony, where they're basically talking at you. There's no dialogue. It's not like we can just call them up.*
> – Interview Participant

> *Communication with Medicaid/DPA is very frustrating and time consuming. If we could even be provided with the caseworker's name and due date of each client's Medicaid renewal each year, it would make a HUGE difference and prevent many difficulties.*
> – Survey Respondent

> *It is also incredibly frustrating that SDS doesn't talk to DPA who definitely doesn't communicate with anyone else.*
> – Survey Respondent

The evaluation findings, as discussed throughout this report, indicate the impacts of change on the HCBS working environment are numerous, making effective communication within this complex system all the more challenging. In addition, challenges of high turnover and difficulties in recruitment are impacting all of the players within the system.

As described in the Streamline Processes section, the degree of change and limited time and resources to adjust to these changes have also impacted the lines of communication. As new processes and systems have been implemented many of the old modes of communication have been discontinued. Additionally, the understaffed workforce is stressed, leading to breakdowns in communication.

A supportive working environment creates the capacity for stakeholders to work collaboratively and address these challenges. Key components of effective communication include having a clear purpose, being focused on results, using commonly understood terminology, being considerate and responsive, requiring active listening, and including an open feedback loop.

The researchers suggest that a collaborative approach to strengthening lines of communication throughout the HCBS system would acknowledge each other's challenges and focus on the key components of effective communication outlined above. Using personalized methods of communication, reducing reliance on scripted responses, and strengthening communication protocols would support clear, results-focused interactions that are responsive, considerate, and outcome-based. Active listening and ongoing feedback are supported when individuals can engage directly with each other, which leads to building collaborative working relationships.

Next Steps

> The purpose of this evaluation is to provide a starting point for further action planning. With this goal in mind, the researchers propose the creation of a facilitated working group of care coordinators and SDS team members that use this report to create an action plan guided by the evaluation findings and recommendations.

The researchers also want to note that the care coordination liaison position, if made permanent, would add capacity to SDS that could be used to manage elements of the action plan within SDS and coordinate efforts with outside entities.

Through a facilitated process, the researchers see an opportunity for stakeholders to take a collective breath and work collaboratively to structure the HCBS system in Alaska to withstand regulatory and budgetary shifts while staying true to Alaska's Shared Vision of a responsive, flexible system providing opportunities for people to live the life they choose with the support they direct.

RECOMMENDATIONS LIST

The researchers recognize that the implementation of improvements in the care coordination system is dependent on available resources, subject to Federal and State oversight, and will take time to realize. The following list of recommendations was presented throughout the narrative of this report and is provided as a starting guide for further action planning.

Section 1: Workforce Development

1. Increase clarity regarding the role of care coordinators in the HCBS system.

2. Create avenues to increase awareness of the care coordination profession and improve recruitment efforts through the creation of internships for UA students as well as develop a marketing campaign for job fairs.

3. Develop a clear career path through a system of tiered care coordination roles, including a mentoring program for less experienced care coordinators.

4. Make the care coordination liaison position at SDS permanent.

5. Collaborate with the AKTC to provide additional training opportunities.

Section 2: Continuum of Support Gaps

1. Increase clarity of the roles of all HCBS providers with the intent of identifying service gaps.

2. Explore the potential of existing support entities to address service gaps and the need for additional funding to build this capacity.

3. Coordinate an effort to address challenges in the EMOD support system.

4. Establish a care coordination acuity rate and reimbursement methods for providing essential support to recipients with highly complex needs.

Section 3: Compensation

1. Revise the care coordination rate methodology to capture the actual costs and level of expertise required (including costs associated with providing service in rural/ remote areas), and establish rates based on the revised methodology.

2. Address billing challenges related to reimbursement for initial applications and CFC TCM.

3. Investigate additional system issues impacting compensation: reimbursement for services provided before an individual's death, and disparity in reimbursement between the waiver application and the TEFRA application.

Section 4: Streamline Processes

1. Review current waiver processes with a focus on removing redundancies, addressing inconsistencies, and clarifying expectations.

2. Implement procedural improvements: align the level of care, CFC, and waiver plan dates, and coordinate joint processes between state departments/programs and outside entities.

Section 5: Communication

1. Increase the frequency of personal communication while decreasing the use of scripted responses.

2. Enhance communication protocols between state departments/programs and outside entities.

Appendix A – Historical Background

The years 2015-2022 have been a period of significant systems change within HCBS. Three major events occurred during this period.

1. The passage in March 2014 of the Centers for Medicare & Medicaid Services (CMS) published final rules for 1915(c) waivers requiring the separation of care coordination from Medicaid HCBS direct service providers, and increased requirements for person-centered planning.
2. Implementation of two new programs requiring care coordination services: the Community First Choice (CFC) program and the Individualized Supports Waiver (ISW).
3. SDS implemented a new data management system, Harmony.

Implementation of Conflict-Free Case Management

Before the passage of the 2014 Final Rule, the majority of care coordinators were employed by organizations that provided HCBS direct services. The service provider organization that employed care coordinators provided administrative support, training, and supervision, and managed the billing and quality assurance processes. In December of 2014, 58% of Alaskan waiver recipients (2,527 individuals) were being served by care coordinators employed by agencies that provided HCBS direct services.[1] On July 1, 2016, once Alaska fully implemented CFCM[2], certified care coordinators wanting to continue providing care coordination services had to terminate their employment relationship with providers. Three employment options emerged for care coordinators:

1. Independent care coordination agency – A care coordinator operates as a sole provider and assumes the responsibilities of the business owner, the certified care coordination program administrator, and the certified care coordinator.

2. Care coordination-only agency – A care coordinator provides care coordination services within a care coordination-only agency, working as part of a group of care coordinators. The owner or co-owner assumes the responsibilities as the business owner(s), the program administrator, and a certified care coordinator with the option of employing additional certified care coordinators.

3. Multi-service organization – Either a non-Medicaid HCBS direct service organization or a Medicaid HCBS direct service organization, granted an exclusion from CFCM by SDS. Care coordinators choosing to provide services within a multi-service organization are employees.

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[1] SDS data request: ConflictFreeCareCoordination_12_16_2014
[2] 7 AAC 130.220(a)(2), requiring the separation of care coordination services from HCBS direct service providers

Evolution of Care Coordinator Role and Responsibilities

Conditions of Participation for Care Coordination

The HCBS care coordination provider and individual care coordinator regulatory responsibilities are described in the Care Coordination Services Conditions of Participation (COPs). Multiple revisions to the COPs in response to federal and state regulatory shifts have expanded care coordination services[3]. A major shift began in the fiscal year 2018 with the inclusion of the federally mandated person-centered planning (PCP) requirements.

Additionally, the continuing education requirements for care coordinators increased from enrollment in at least one SDS care coordination training course to requiring an additional 16 hours annually of relevant continuing education.

The COPs were revised again in the fiscal year 2019 to further define PCP requirements, and include Alaska's Shared Vision[4] values, targeted case management (TCM), and CFC and ISW requirements for care coordination services. Knowledge and abilities in PCP were added to the care coordinator qualification requirements.

Implementation of the Harmony Data System

A major shift in how care coordinators meet their regulatory responsibilities, submit documentation, and interact with SDS came with the implementation of the SDS Harmony Data System (Harmony). Harmony is a secure web-based data management system that SDS uses to administer programs, services, and provider certification. Effective July 1, 2021, care coordinators were required to submit materials and monitor their caseload in Harmony.

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[3] See Appendix C: Care Coordination Services Conditions of Participation Table
[4] AS 47.80.130(a)(7), https://health.alaska.gov/gcdse/Pages/ddsharedvision/default.aspx

Appendix B - Evaluation Methods

The evaluation was completed using data from a variety of primary and secondary sources, including specific data requests to The Alaska Department of Health and Social Services[1] Division of Senior and Disabilities Services. Source citations are noted throughout the report. Primary data collection methods are described below.

Four in-person focus groups were conducted in January 2022. The purpose of the focus group sessions was to identify themes to explore further through a written survey and individual interviews.

The written survey was distributed online, using the SurveyMonkey[2] platform. The survey was sent to 100% of the sample/total population of certified care coordinators in Alaska as of February 9, 2022.

Nineteen interviews were conducted over the Zoom[3] video conference platform. The interviews were completed in March and April of 2022, drawn from the sample/total population of certified care coordinators in Alaska as of February 9, 2022.

Research Team

The research team included Kimberly Adkison, principal consultant for the evaluation, Kim Champney, co-principal consultant for the evaluation, and Elizabeth Figus, social science statistician for the evaluation.

Ms. Adkison has a master's degree in social work and over 30 years of experience providing direct service, supervision, program management, and evaluation in human services in Alaska. She has worked 11 years in disability and senior services, six of those years in program management, evaluation, and supervision while continuing to provide direct services. She has a deep understanding of the Medicaid waiver system, as well as experience coordinating community-based services for individuals with complex needs, including navigating transitions from institutions back to community settings.

Ms. Champney has a master's degree in social work and over 25 years of experience in the field of developmental disabilities. She has 20 years of experience in Medicaid HCBS waiver direct services and served as adjunct faculty with the University of Alaska providing instruction in LTSS. As a consultant she guided the development and implementation of the Shared Vision, a statewide systems change project.

Ms. Figus has a doctorate in fisheries with a focus on policy and management and extensive qualitative analysis experience. Her expertise includes survey construction and analysis for

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[1] Department of Health as of July 1, 2022
[2] https://www.surveymonkey.com/
[3] https://zoom.us/

human dimensions and policy research. She has 12 years of interdisciplinary research experience and nine years of project management experience including grant writing.

Sample Population

Certified care coordinators removed from the sample included those:
- Serving Tax Equity and Fiscal Responsibility Act (TEFRA) only recipients and employed by HCBS direct service providers = 3
- Employed by the State of Alaska Division of Senior and Disabilities Services = 2
- Not yet approved to provide care coordination services = 1

Total certified care coordinators included in the sample population: 179

Total community types included in the sample population: 24
- Urban = 8
- Rural (on the road system) = 10
- Remote Rural = 6

Total business types included in the sample population: 103
- Independent (sole provider) = 75
- Care Coordination-Only Agency = 21
- Multi-Service Organization = 7

Stratified Sample

The research sample was stratified to better understand the representativeness of the responses, but the research team allowed all members of the sample population to participate. The stratification allowed the research team to determine the relative likelihood that the 73% written survey response rate was in fact representative of business type and community type.

The sample population was divided into two strata, by community type and business type, each with three subgroupings. (Table 1 and Table 2) Therefore, in this evaluation, 'representativeness' is defined as being representative across those strata. Representativeness across other strata (e.g., gender, age, years of experience, etc.) was not attempted, though future studies may benefit from doing so. Multiple methods were used to target participants, including emailing invitations to all care coordinators current at the time this work started (in late 2021) and snowball sampling. Additional outreach for volunteers was made through the Care Coordination Network Facebook group, the AADD Care Coordinator Task Force, the SDS E-Alert system, and the SDS Training Unit care coordinator email distribution list.

Table 1: Breakdown of the total certified care coordinators by community type

Community Type	Number of Communities	Number of Care Coordinators
Urban	8	139
Rural (on the road system)	10	27
Remote Rural	6	13

Table 2: Breakdown of the total certified care coordinators by business type

Business Type	Number of Certified Care Coordination Provider Agencies	Number of Certified Care Coordinators
Independent (sole provider)	75	75
Care Coordination-Only Agency	21	66
Multi-Service Organization	7	38

Stakeholder Engagement

Focus groups

Four in-person focus group sessions were conducted in four different communities from January 11-13, 2022. This timeframe was selected due to evaluation timeline considerations and the research team's availability. The four communities were chosen based on ease of access for the research team, cost and time factors due to budget and evaluation timeline constraints, and availability of care coordinators from a variety of care coordination providers. The meeting space was selected based on the ease of access for participants and the research team, COVID mitigation protocols, and cost.

Participants were certified care coordinators with varied levels of experience, representing all waiver types and business models. Participants were not a random sample because the purpose of the focus group sessions was to use the information gathered to develop themes to explore further through a written survey and individual interviews.

Table 3: Focus group sessions communities, meeting space, and number of participants

Community	Date	Location	Number of Participants
Fairbanks	Jan 11, 2022	Fairbanks Resource Agency	4
Mat-Su	Jan 12, 2022	Mat-Su Health Foundation	5
Anchorage	Jan 12, 2022	Center for Child Loss	9
Kenai	Jan 13, 2022	HOPE Kenai Community Center	8

The research team noted the following observations throughout the focus groups sessions:

- All attendees were eager to participate, and they seemed to enjoy the post-it note exercise
- The format worked well for getting the discussion moving and focused
- The session timeframes worked to capture the comments thoroughly
- All attendees voiced appreciation for the opportunity to gather in person and have a facilitated group discussion regarding challenges the care coordination workforce is experiencing
- There was more alignment than expected, the cluster of comments was quite similar in all locations
- Due to the SDS E-Alert: *Proposed Changes to Third Party Liability (TPL) and Processing of Medicaid Claims*, released on January 4, 2022, a week before the focus group sessions, the tone was more negative than expected, all participants shared information indicating low morale among currently certified care coordinators
- All four groups brought up concerns regarding systems outside care coordination services, i.e., Direct Support Professional workforce shortages, The Department of Corrections, DHSS Division of Behavioral Health, Division of Health Care Services Background Check Program, and the Division of Public Assistance, etc.

Through the focus group sessions 12 work-related challenges were identified to further explore through the planned written survey and individual interviews:

1. Care Coordination Certification
2. Care Coordinator Capacity
3. Care Coordinator Role and Responsibilities
4. Communication
5. Community First Choice Program
6. Compensation
7. Harmony Data System
8. Alaska's Home and Community Based Service System
9. Person-Centered Services
10. Reimbursement
11. Care Coordinator Training
12. Waiver Application and Support Plan Procedures

Written Survey

The written survey was conducted through the web-based SurveyMonkey platform. The survey was initially distributed through a SurveyMonkey email invitation to the 179 certified care coordinators identified in the sample/total population. Survey announcements were made through the Care Coordination Network Facebook group, the AADD Care Coordinator Task Force, and the SDS E-Alert system. Survey reminder emails were sent automatically through

SurveyMonkey. A second survey distribution was done through a survey web link emailed to the respondents who had not completed the survey as of March 3, 2022. The response period was from February 14 through April 4, 2022, extended from the original closure date of March 7, 2022, to provide additional time for respondents to complete the survey. A total of 131 responses were received, resulting in a 73% response rate for the survey.

The survey tool consisted of ordered data (multiple choice, Likert scale, dropdown, demographic, etc.) and open-ended questions. The research team developed the survey tool to gather information from currently certified care coordinators to describe the current care coordination workforce and working conditions, and to expand on themes identified in the focus group sessions. The survey consisted of 13 sections with a total of 62 questions.

The survey tool was tested by two groups for clarity, length, and accessibility. Group 1 consisted of individuals not in the field and focused on the overall survey experience. Group 2 consisted of individuals experienced in the field, but not currently certified care coordinators, and focused on content, clarity, and length.

Open-Ended Survey Responses

Text analysis was used to explore, analyze, and summarize data from the written survey open-ended responses. Survey responses to 11 open-ended questions were individually analyzed in the NVivo text analysis software program using inductive coding (Bernard, 2011). Ms. Figus inductively coded answers to 11 open-ended survey responses. All text in each of the responses was assigned at least one of the codes, with some text assigned to multiple codes. Inductive codes were subsequently analyzed for incidence and qualitative characteristics in the NVivo software program. Ms. Adkison reviewed the inductive codes to determine qualitative trends, which were then grouped into broad themes (described in the body of the report).

Coding results were visualized using NVivo software. Selected quotes were also chosen from the survey responses to aid in descriptions throughout the paper.

Individual Interviews

Nineteen individual interviews were completed in March and April 2022, conducted over the Zoom video conference platform. The interview participants were drawn from the sample/total population of certified care coordinators in Alaska as of February 9, 2022, and based on the criteria identified in the stratified sample.

Total individual interviews by community type:
- Urban = 14
- Rural (on the road system) = 2
- Remote Rural = 3

Total individual interviews by business type:
- Independent (sole provider) = 12

- Care Coordination-Only Agency = 4
- Multi-Service Organization = 3

Participants were certified care coordinators with varied levels of experience, representing all waiver types and business models. Participants were not a random sample, though a randomized sample was determined to not be critical because the purpose of the interviews was exploratory. The interviews were conducted by Ms. Adkison; none of the interview participants had a previous professional relationship with Ms. Adkison.

The interview tool was semi-structured, consisting of ordered data (multiple choice, Likert scale, dropdown, demographic, etc.), prompts, and open-ended questions. The research team developed the interview tool to gather more in-depth information from currently certified care coordinators on business operations, working conditions, and themes identified in the focus group sessions. The interview tool was tested with individuals not in the field, and focused on clarity, length, and the overall interview experience.

The interviews were recorded through the Zoom video conference platform and transcribed using Rev[4], a web-based transcription service company.

Interview Transcripts

Text analysis was used to explore, analyze, and summarize data from the interview transcripts. Interview transcripts were analyzed in Microsoft Word and the NVivo text analysis software program (QSR International Pty Ltd., 2020) using both deductive and inductive coding (Bernard, 2011). Lead, Ms. Adkison, deductively coded themes from interviews. The Lead developed a list of topics (deductive codes) based on the interview questions that explored the primary evaluation questions regarding the care coordination workforce. Based on that list, the Lead read each transcript and highlighted select sections where the interviewee provided content related to the list of each deductive code.

The entirety of interview transcripts was not coded, and codes did not overlap one another except in a few occurrences (e.g., of 'Support Plans' occasionally being coded as both 'Support habilitative' and 'Support non-habilitative'). Transcripts were coded in order of interview date. Codes started separated by a paragraph in each transcript but began including multiple paragraphs partway through (around 0315), after which there was an overall trend to fewer codes per interview transcript, and therefore an expectation of coding saturation was evident by 0317. Incidence of codes is not especially useful for this approach, other than addressing major differences in incidence (e.g., which were the top 5).

A list of keywords was created related to 14 types of tasks care coordinators identified as requiring a significant amount of time to complete in relation to current reimbursement rates. Ms. Figus conducted a keyword in context (KWIC) coding exercise (Bernard, 2011) to determine

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[4] https://www.rev.com/

the total incidence of each keyword across the interview transcripts, as well as the context of use. The five words before and following each incident of each keyword were reviewed.

References

QSR International Pty Ltd. (2020). NVivo software.

Bernard, H. R. (2011). *Research Methods in Anthropology: Qualitative and Quantitative Approaches*. 5th ed. Rowman Altamira.

Supplemental Information

Care Coordination Evaluation Focus Group Consent Agreement

Care Coordination Evaluation Project
Consent to take part in research

You are being asked to take part in a study about Alaska's Home and Community-Based Medicaid Waiver Care Coordination services. This is a project of the Alaska Association on Developmental Disabilities, funded by the Alaska Mental Health Trust Authority.

The goal of this study is to ensure every eligible beneficiary is able to access a care coordinator and the care coordination workforce has the capacity to provide high quality support and services. You are being asked to take part in this study because of your care coordination experience. You are invited to ask any questions at any time during your participation.

If you decide to take part, you will be asked to participate in a Focus Group lasting about 90 minutes. The Focus Group will be done in-person with 6-8 other participants. The discussion will focus on your experiences and opinions about the provision of care coordination services and Alaska's care coordination service system.

We do not expect any risks to you if you take part in this study. Possible benefits to you if you choose to take part in this study include having your experiences and opinions contribute to a greater understanding of care coordination services in Alaska and future service system enhancements. Due to the group nature of your participation, **confidentiality cannot be guaranteed**. During the Focus Group, other people will be able to connect your statements to your name. However, the research team will ask participants to respect each other's privacy. **Your name will not be used in reports, presentations, or publications**. Any summary Focus Group content, or direct quotations from the Focus Group, will be anonymized so that you cannot be identified.

Your decision to take part in the study is voluntary. If you decide to take part, you can stop at any time. You may change your mind and ask to be removed from the study. You may also skip any questions. If you have questions, feel free to ask. If you have questions about this study,

you may contact the primary consultant, Kimberly Adkison, at
kimberly@adkisonconsulting.com or (907) 328-8632.

STATEMENT OF CONSENT: I understand everything described above. My questions have been answered to my satisfaction, and I agree to participate in this study. I am 18 years old or older. I have been provided a copy of this form.

_____   _____

Signature   Date

_____

Printed Name

Care Coordination Evaluation Focus Group COVID-19 Protocols

The research team is following the actions below to help slow the spread of COVID-19 virus:

1. Wear a face covering (mask) over your nose and mouth while participating in focus group sessions, regardless of vaccination status.

2. Practice social distancing by keeping six feet away from others where possible.

3. Practice good hygiene including washing hands and/or use of alcohol-based hand sanitizer.

4. Persons with symptoms consistent with the COVID-19 virus may not participate in the focus group sessions.

    a. Most common symptoms include: fever, dry cough, and tiredness.

    b. Serious symptoms include: difficulty breathing or shortness of breath, chest pain or pressure, loss of speech or movement.

    c. https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html

ANY PERSON WITH SYMPTOMS CONSISTENT WITH COVID-19, PENDING A COVID-19 TEST, AND/OR UNDER AN ISOLATION OR QUARANTINE ORDER MAY NOT PARTICIPATE IN THE FOCUS GROUP SESSIONS

Care Coordination Evaluation Focus Group Session Agenda

	FAIRBANKS	ANCHORAGE	MAT-SU	KENAI
Date	Tue, Jan 11	Wed, Jan 12	Wed, Jan 12	Thu, Jan 13
Time	2:30-4:00 p.m.	3:00-4:30 p.m.	10:00-11:30 a.m.	10:30-12:00 p.m.
Location	Fairbanks Resource Agency	Center for Child Loss	Mat-Su Health Foundation	HOPE Kenai Community Center
Address	805 Airport Way	5631 Silverado Way #F-102	777 N Crusey St	47202 Princeton Avenue, 2nd Building

Agenda

1. Facilitator Introductions
   a. Our background
   b. Project Overview (Kimberly)
      i. Purpose of Focus Groups
   c. Discussion Guidelines (Kim)
      i. Do not disclose PHI
      ii. Confidential discussion, respect each other's privacy
      iii. Equal time
      iv. Productive discussion, not a venting session
   d. Consent Agreement review and signatures
2. Care Coordinator Introductions
   a. Name
   b. How long been a care coordinator?
   c. Primary population served
   d. Ice breaker
      i. What is one thing that is working in the care coordination service system
3. Prompt
   a. What are the challenges in the care coordination service system?
   b. Write 5-10 challenges on post-it notes
   c. Kimberly goes around room having participants reading one challenge each time
   d. Kim organizes challenges on Poster Post-its
   e. Retain Post-it notes and take a picture
4. Discussion
   a. As time permits
   b. Final thought, as each participant
      i. What would you be asking stakeholders?
5. Participant Gifts
   a. Purchase local $20 gift cards after session (know how many to purchase)
   b. Mail gift cards to participants with a thank you card

Care Coordination Evaluation Interview Consent Agreement

Care Coordination Evaluation Project
Consent to take part in research

You are being invited to take part in a study about Alaska's Home and Community-Based Medicaid Waiver Care Coordination services. This is a project of the Alaska Association on Developmental Disabilities, funded by the Alaska Mental Health Trust Authority.

The goal of this study is to ensure every eligible beneficiary is able to access a care coordinator and the care coordination workforce has the capacity to provide high quality support and services. You are being asked to take part in this study because of your care coordination experience. You are invited to ask any questions at any time during your participation.

If you decide to take part, you will be asked to participate in an interview lasting 60-90 minutes. The interview will be done using the Zoom video conferencing platform. Topics covered will include information about your background and experience, what communities and waiver types you serve, caseload size, and business model. Other questions will focus on your experiences and opinions about the provision of care coordination services and Alaska's care coordination service system. **The interview will be recorded, and a transcript produced**. You may ask for the voice recorder to be turned off at any time.

We do not expect any risks to you if you take part in this study. Possible benefits to you if you choose to take part in this study include having your experiences and opinions contribute to a greater understanding of care coordination services in Alaska and future service system enhancements. **Information we get about you from the interview will be kept confidential**. Information with your name attached will not be shared with anyone outside the research team. We will code your information with a number so no one can trace your answers to your name. **Your name will not be used in reports, presentations, or publications**. Any summary interview content, or direct quotations from the interview, will be anonymized so that you cannot be identified. **The actual recording will be destroyed at the conclusion of the study**.

Your decision to take part in the study is voluntary. If you decide to take part, you can stop at any time. You may change your mind and ask to be removed from the study. You may also skip any questions. If you have questions, feel free to ask. If you have questions about this study, you may contact the primary consultant, Kimberly Adkison, at kimberly@adkisonconsulting.com or (907) 328-8632.

STATEMENT OF CONSENT: I understand everything described above. My questions have been answered to my satisfaction, and I agree to participate in this study. I am 18 years old or older. I have been provided a copy of this form.

You will provide your verbal consent at the beginning of the interview.

Care Coordination Evaluation Interview Plan

Introduction

Thank you for meeting with me today to discuss your care coordination experiences and thoughts about Alaska's care coordination service system. This interview covers five topic areas: your business operations, your caseload, the time you spend providing services, your potential work-related challenges, and your ideas about recruitment and retention in care coordination. It is okay if your responses relate to more than one of these topics at a time, but I just want you to know that my questions fall into those five categories.

The interview will likely last between 60 and 90 minutes, depending on the degree of detail you wish to provide. I will try to pause a few seconds after you stop speaking to make sure you have completed your thoughts, so I hope you don't feel awkward when there is a brief silence. I may ask follow-up or clarification questions prior to moving to the next topic area. I will be taking some notes during our conversation, so if I am looking away from my screen that is why. Please feel free to ask me questions at any time during this interview.

Once I start the recording, Zoom will request your consent to be recorded. You will need to click the "Got It" button to proceed.

I will summarize the consent agreement I emailed you prior to this interview. Afterward, I will ask you to verbally agree to participate. Then we will jump into the interview conversation.

Are you ready to proceed?

BEGIN RECORDING

Before we begin, I am going to read the consent agreement and ask for your verbal agreement to participate in this study. A copy of the consent agreement was emailed to you prior to this interview for your records.

Consent Summary

SHOW POWERPOINT SLIDE

You are being invited to take part in a study about Alaska's Home and Community-Based Medicaid Waiver Care Coordination services. This is a project of the Alaska Association on Developmental Disabilities, funded by the Alaska Mental Health Trust Authority.

Your decision to take part in the study is voluntary. You are invited to ask any questions at any time during your participation. The interview will be recorded, and a transcript produced. You may ask for the Zoom recording to be paused or turned off at any time.

Information we get about you from the interview will be kept confidential. Information with your name attached will not be shared with anyone outside the research team. We will code your information with a number so no one can trace your answers to your name. Your name will not be used in reports, presentations, or publications. Any summary interview content, or

direct quotations from the interview, will be anonymized so that you cannot be identified. The actual recording will be destroyed at the conclusion of the study.

Do you agree to participate in this study?

Topics and Guiding Questions

Part 1: Business Operations

Let's start our discussion with questions about your provider agency and how you make decisions related to the business operations.

1.1 First, what type of provider agency are you currently associated with: independent, care coordination only, or multi-service?

1.2 Have you ever worked as a care coordinator for a different business type?

Independent Care Coordinator

1.3 What factors did you consider when deciding to be an independent care coordinator?

1.4 What was the startup process like for you when you started your independent care coordination business?

1.5 From when you began taking steps to start your business, until the time you began providing care coordination services, how long did it take?

1.6 What types of business planning and operation resources have you found most helpful?

a. Are there areas where resources for business planning and operation are lacking? If so, please tell me more about what resources are lacking.

1.7 As an independent care coordinator, what types of business-related expenses do you have? *(examples: DSM, internet, phone, fax, liability insurance, health insurance, computer, software, utilities, transportation, rent, outsourced services, and other business-related expenses?)*

1.8 As an independent care coordinator, do you complete all the business operation tasks yourself, or do you use supports?

a. What types of business operation tasks do you use supports to complete?

b. Do you employ staff to perform these tasks, or do you contract for these services?

c. How much time in any given month does it "typically" take to complete your business operation tasks?

Care Coordination Only Agency

    1.9   What is your relationship/role with your care coordination-only agency?

    1.10   What factors did you consider when deciding to work as a care coordinator in a care coordination-only agency?

    1.11   Were you involved in starting your care coordination-only agency? If so, please describe your experience.

        a.   About how long did it take to complete the business start-up process and begin to provide care coordination services?

        b.   What was the process like to get the agency started?

        c.   What types of business planning and operation resources have you found most helpful?

        d.   Are there areas where resources for business planning and operation are lacking? If so, please tell me more about what resources are lacking.

    1.12   If you are familiar with the business operations, what types of business-related expenses does your agency have? *(examples: DSM, internet, phone, fax, liability insurance, health insurance, computer, software, utilities, transportation, rent, outsource services, employment-related benefits (paid time off, retirement), other business-related expenses?)*

    1.13   If you are familiar with the business operations, are all the business operation tasks completed in-house, or does your agency contract for these services?

        a.   If these tasks are completed in-house, do you employ staff to perform these tasks? What types of business operation tasks do support staff complete? How much time in any given month does it "typically" take to complete these tasks?

        b.   If your agency contracts for these services, what types of business operation tasks do you use contractors to complete?

Multi-Service Agency

    1.14   What is your relationship/role with your multi-service agency?

    1.15   What factors did you consider when deciding to work as a care coordinator for a multi-service agency?

    1.16   If you are familiar with the business operations at your agency, what types of business-related expenses does your agency have? *(examples: DSM, internet, phone, fax, liability insurance, health insurance, computer, software, utilities,*

transportation, rent, outsource services, employment-related benefits (paid time off, retirement), other business-related expenses?)

1.17 If you are familiar with the business operations, are all the business operation tasks completed in-house, or does your agency contract for these services?

   a. [*If these tasks are completed in-house*], do you employ staff to perform these tasks? What types of business operation tasks do support staff complete? How much time in any given month does it "typically" take to complete these tasks?

   b. [*If your agency contracts for these services*], what types of business operation tasks do you use contractors to complete?

Part 2: Caseloads

Now I'd like to shift to a discussion about how you make service decisions and manage your caseload.

2.1 Please describe your process for determining which individuals to serve. How do you go about that?

   a. What factors do you consider when deciding whether to accept a new referral?

   b. How do you receive new referrals?

   c. Do you advertise your availability? If so, how?

2.2 How would you describe a manageable caseload?

   a. Do you find a difference in the time it takes to provide services for different waiver types? If so, how?

   b. Do these time requirements influence your decisions about who you serve? If so, how?

   c. Do you ever feel the necessity to carry a caseload larger than you feel is manageable? If so, why?

2.3 I know you live and work primarily in [*town*], right? In the context of your business, how do you determine what areas/regions to serve?

   a. What challenges do you experience in regard to providing services in rural and remote areas?

Part 3: Time Spent Providing Services

Now I'd like to talk about how you spend your time while providing care coordination services. I realize that the ebb and flow of your work varies greatly, but if you can, try to consider a "typical" month when thinking about how you spend your time. For clarity, I have organized our discussion to first focus on Medicaid reimbursable tasks and then talk about other tasks.

3.1   First, I'd like you to focus on the amount of time you spend engaged in Medicaid reimbursable tasks. When you think about the time you spend on:

SHOW POWERPOINT SLIDE

- Care Coordination Monthly Case Management: T2022, T2022 CG, T2022 TS
- Application for Waiver or Community First Choice Services: T1023 SE
- Support Plan Development: T2024 SE

a.   How much time does it "typically" take to complete each of these tasks?

b.   Are there other types of reimbursable tasks you typically do in any given month? If so, what are they? How much time do they typically take to complete?

c.   Are there any outlying factors that can increase the amount of time required to complete any of these tasks? If so, please describe them for me.

3.2   Now, I'd like you to focus on other tasks.

a.   What types of other tasks do you typically do in any given month? How much time do these tasks "typically" take to complete?

b.   Are any of these tasks required by the State of Alaska as a certified care coordinator? If so, which ones? Why do you consider them to be required tasks?

c.   Are any of these tasks necessary, though not required, in order to provide care coordination services? If so, which ones? Why do you consider them to be necessary in order to provide care coordination services?

Part 4: Work-Related Challenges

Next, I want to give you the opportunity to discuss the work-related challenges you experience as a care coordinator.

SHOW POWERPOINT SLIDE

These are work-related challenges identified by certified care coordinators I met with in January 2022. If you took the online survey, this same list was a part of it. There are 12 of them, so I will

pause to give you time to read them, and if they are hard to see on the screen, I can read them if you'd like:

1) The care coordination certification process is vague and time consuming. (Requirements for initial/renewal, length of time to complete, number of steps to become certified)

2) The lack of support for new care coordinators entering a very complex system make it difficult to increase care coordination capacity. (Recruitment of people to the care coordination profession)

3) Within the Home and Community-Based Service system, the role and responsibilities of a certified care coordinator are not widely understood. (By recipients, families/natural supports, guardians, DSPs, service providers, state employees)

4) The lack of good communication among those involved in the Home and Community-Based Service system makes it hard to meet deadlines and is time consuming. (Lack of responsive, accurate, professional, communication by state employees and providers)

5) The Community First Choice (CFC) program is not well understood and requires duplication of work. (Lacks clear understanding of roles and expectations for care coordinators and service providers)

6) Compensation levels are too low, given the work requirements. (Available reimbursement codes and rate levels for care coordination services)

7) Working within the Harmony data system is time consuming and restrictive. (Database requirements for workflow, submission, communication and approval processes)

8) The Home and Community-Based Service system is fragmented and inefficient, making it difficult to navigate and secure needed supports for recipients of waiver services. (Involving federal and state agencies and contractors: CMS, SSA, SDS, DPA, HCS, Conduent, etc.)

9) The Home and Community-Based Service system is becoming less person-centered due to increased regulations/restrictions and less flexibility in how services are accessed and used. (Supporting people to make decisions about their life, based on their preferences, interests and goals)

10) The reimbursement system for care coordination is time consuming with payments frequently delayed and denied. (Process involving SDS, DPA, Conduent)

11) The Senior and Disabilities Services Training Unit does not adequately meet care coordinator training and ongoing support needs. (Required certification training and ongoing support within SDS for care coordinators)

12) The waiver application and support plan requirements are applied inconsistently, with differing interpretations of regulations and care coordinator expectations within the Division of Senior and Disabilities Services. (Lack of standardized definitions of submission and approval requirements and procedures)

<u>Interviewees who took the online survey</u>

4.1   When you took the online survey, you had the opportunity to share your thoughts about these 12 work-related challenges. I have pulled up your responses from the survey, which are on the screen now. I am interested to learn a bit more about your thoughts.

4.2   When you took the online survey, you had the opportunity to share your thoughts about work-related challenges not listed above that impact your work as a care coordinator. I have pulled up your responses from the survey, which are on the screen now. I am interested to learn a bit more about your thoughts.

<u>Interviewees who did not take the online survey</u>

4.3   What thoughts do you have about the 12 work-related challenges listed on the screen?

4.4   What are some work-related challenges, not listed on the screen that impact your work as a care coordinator?

<u>Part 5: Recruitment and Retention</u>

Finally, I'd like to talk about the recruitment of new people to the care coordination profession, and the retention of experienced care coordinators.

<u>Interviewees who took the online survey</u>

Again, I have pulled up your responses from the survey, which are on the screen now. I am interested to learn a bit more about your thoughts.

5.1   What ideas do you have about ways to attract and support new people to the care coordination profession?

5.2   What ideas do you have about ways to retain experienced care coordinators?

<u>Interviewees who did not take the online survey</u>

5.3   What ideas do you have about ways to attract and support new people to the care coordination profession?

5.4   What ideas do you have about ways to retain experienced care coordinators?

Part 6: Closing

Wonderful. Thank you for taking the time to share with me today. That is all I have to ask you about.

6.1   Do you have any additional thoughts or information you would like to share that hasn't been captured in the online survey or this interview?

6.2   Do you have any questions for me?

Okay, I will stop the recording now unless you have any more to add.

STOP RECORDING

The final report will be available at the conclusion of the study. If you'd like to be placed on the distribution list, I can do so now.

Thank you for your time and willingness to share your thoughts and experiences with me. Please feel free to reach out if you have any questions or wish to share additional information.

Appendix C - Conditions of Participation for Care Coordination Services

FY15	FY18	FY21
Care Coordination Services Conditions of Participation	Care Coordination Services Conditions of Participation	Care Coordination Services **and Long Term Services and Supports Targeted Case Management** Conditions of Participation
COP-02 (Rev 3/21/2014)	COP-02 (Rev 09/05/2017)	COP-02 (Rev 08/02/2018)
Care coordination services are provided for every recipient. Care coordinators assist individuals to gain access to waiver and other state plan services with funding sources other than Medicaid. For recipients, care coordinators manage the process of planning for services, developing a plan of care, on-going monitoring of services, and renewing the plan of care annually. Throughout the year, care coordinators remain in contact with recipients in a manner, and with a frequency, appropriate to the needs of the recipients.	Care coordination services are provided for every recipient **of home and community-based waiver services. By means of a person-centered process led by the recipient and the planning team of his or her choosing,** care coordinators assist individuals to gain access to waiver and other state plan services, as well as medical, social, educational, and other services with funding sources other than Medicaid. For recipients, care coordinators **facilitate** the process of planning for services, developing a plan of care, on-going monitoring of services, and renewing the plan of care annually. Throughout the year, care coordinators remain in contact with recipients in a manner, and with a frequency, appropriate to the needs of the recipients **and as required.**	Care coordinators **assist individuals to gain access to** home and community-based waiver services **under 7 AAC 130; Community First Choice services under 7 AAC 127;** and other state plan services, as well as medical, social, educational, and other services with funding sources other than Medicaid. **Care coordinators do this through** a person-centered process led by the recipient and the planning team of **the recipient's** choosing.
		Care coordinators also perform targeted case management services, which include helping recipients to complete an application and then submitting the application for home and community-based waiver services, Community First Choice services, or both. Once an applicant is determined eligible, care coordinators assist applicants with identifying goals, planning for services and selecting service providers. Care coordinators then assist the recipient-directed team to develop an initial support plan. Finally, care coordinators assist recipients to direct the team in reviewing goals and renewing the support plan annually.
		On-going care coordination is a home and community-based waiver service that includes monthly monitoring of services in the support plan. Care coordinators remain in contact with the recipient throughout the support plan year, in manner and with a frequency appropriate to the needs of the plan year.
		For a recipient receiving only Community First Choice services, a care coordinator provides case management services during the recipient's support plan year.
The provider who chooses to offer care coordination services must be certified as a provider of care coordination services under 7 AAC 130.220 (b)(2), meet with the requirements of 7 AAC 130.240, and operate in compliance with the Provider Conditions of Participation and the following standards.	The provider who chooses to offer care coordination services must be certified as a provider of care coordination services under 7 AAC 130.220 **(a)(2),** meet with the requirements of 7 AAC 130.240, and operate in compliance with the Provider Conditions of Participation and the following standards.	**To offer care coordination services, a provider** must be certified as a provider of care coordination services under 7 AAC 130.220 (a)(2); meet the requirements of **7 AAC 130. 238 and 7 AAC 130.240;** and operate in compliance with the **Home and Community-based Waiver Services** Provider Conditions of Participation. **To offer long term services and supports targeted case management, the provider must be certified under 7 AAC 128.010(b), and comply with** the following standards:
I. Program Administration	I. Program Administration	I. Program Administration
A. Personnel	A. Personnel	A. Personnel
1. Care coordination service program administrator	1. Care coordination services program administrator	1. Care coordination services/**targeted case management** program administrator
2. Care coordinators	2. Care coordinators	**2. Care coordinators**
		i. The care coordination knowledge base must include:
		(A) an understanding of person-centered planning, including how this applies not only to the development of the support plan but also to the on-going monitoring of services;
		v. The care coordination skill set must include:
		(A) the ability to support a recipient in directing the development of a support plan, based on his/her strengths and abilities, that leads to a meaningful life at home, at work, and in the community;
		(B) the ability to effectively assist the recipient in communicating the recipient's choices and decisions and collaborating with supporters such as family members, guardians, or other decision-making assistants;

Appendix C - Conditions of Participation for Care Coordination Services

FY15	FY18	FY21
B. Training	B. Training	B. Training
	ii. 16 hours annually of continuing education that is relevant to a care coordinator's job responsibilities; and	
	b. when submitting an application for recertification, provide proof of successful completion of the Senior and Disabilities Services training course and 16 hours annually of continuing education.	
	3. The provider agency must document attendance and successful completion by a care coordinator of 16 hours of continuing education annually in the care coordinator's personnel file; the provider agency's in-service training may qualify as continuing education if	
	a. the training increases the knowledge, abilities, or skills of the care coordinator and	
	b. the content of the in-service training, date, and time in attendance is documented.	
II. Program Operations	II. Program Operations	II. Program Operations
A. Quality management	A. Quality management	**A. Quality management**
		1. The provider agency must develop a system to monitor support plan development and implementation to ensure that support plans for recipients
		a. are developed and implemented as directed by the recipient;
III. Recipient relationships		
A. Conflicts of interest	B. Billing for services	B. Billing for services
B. Backup care coordinator	C. Conflicts of interest	C. Conflicts of interest
C. Billing for services	D. Backup care coordination	D. Backup care coordination/**targeted case management**
D. Ending care coordinator associations with the provider agency	1. The provider agency must	
	a. develop a plan for back-up care coordination services in collaboration with the recipient, and give a copy of the plan to the recipient; and	
	b. ensure that any care coordinator identified as a backup care coordinator is currently certified by SDS and associated with a care coordination agency in accordance with 7 AAC 10.900 (b).	
	2. The back-up plan must include	
	a. the extent to which the primary care coordinator or the recipient is responsible for obtaining care coordination services if the primary care coordinator will be unavailable for a period that exceeds 72 hours;	
	b. a contingency plan that defines the primary care coordinator's responsibilities to educate the recipient regarding a plan of action to ensure the health, safety, and welfare of the recipient if the primary care coordinator will be unavailable for a period that exceeds 30 days; and	
	c. information about the potentials risks involved if back-up care coordination services are not secured.	
B. Recipient contacts	E. Care coordinator appointment and transfer	E. Care coordinator appointment and transfer
	F. Care coordinator communications	
	All certified care coordinators must individually subscribe to and review SDS electronic email, http://list.state.ak.us/mailman/listinfo/sds-e-news.	
IV. The care coordination process	III. The care coordination process	III. The care coordination/**targeted case management** process
A. Care coordination goals	A. Care coordination goals	**A. Care coordination goals**
		The provider must operate its care coordination services **and targeted case management** program for the following purposes:
		1. to assist the recipient in accessing and directing the support needed to live the life that the recipient chooses at home, at work, and in the community;
		3. to encourage the development of meaningful relationships and natural (unpaid) supports;
		4. to assist the recipient with access to community-based services as directed by the recipient;

Appendix C - Conditions of Participation for Care Coordination Services

FY15	FY18	FY21
B. Plan of care development	B. Person-centered planning process	B. Person-centered planning process
1. Recipient orientation	1. Recipient orientation	1. Recipient orientation. The care coordinator must
	b. advise the recipient of, and support, the recipient's right to lead the planning process where possible and to define the role of other individuals he or she chooses for participation in the process;	a. ensure the planning process is timely and at a time and in a place determined by the recipient;
		d. provide information about **home and community-based service settings and options for medical, social, educational, employment, and other services;**
		f. discuss conflict-of-interest guidelines and develop strategies for resolving disagreements amongplanning participants; and
		g. if providing targeted case management for Community First Choice recipients, discuss the right of the recipient to contact the care coordinator when the recipient feels contact is necessary, and a method for such contact.
	2. Comprehensive needs assessment. The care coordinator must complete a comprehensive needs assessment that includes	2. Comprehensive needs assessment
2. Planning team	a. the recipient's history;	3. Planning Team
	b. the recipient's strengths, preferences, goals, and interests; and	
	c. identification and documentation of each need of the recipient.	
	3. Planning Team	
	a. The care coordination must	
	i. facilitate the recipient's role as the leader of the planning process to the maximum extent possible;	
	ii. with direction from the recipient, identify, meet with, and consult each member of the planning team for purposes of developing an individualized, person-centered plan of care; and	
	iii. cultural considerations to be included in the planning process;	
	iv. the overarching purpose of the plan of care; and	
	v. strategies for solving disagreements during the planning process.	
	b. The planning team must identify	
	i. risk factors and measures to minimize those risks;	
3. Integrated program of services	4. Integration of program of services	4. Integration of program of services
4. The care coordinator must deliver	5. Approved plan of care	
	The care coordintor must deliver a copy of the **approved** plan of care to the recipient and to each provider of sevices for the recipient, within 10 business days of receiving the plan of care from Senior and Disabilities Services.	
C. Plan of care implementation	C. Plan of care implementation	C. Support plan implementation. The care coordinator must
D. Service monitoring	D. Service monitoring	5. if necessary, write and submit an amendment to the support plan.
E. Care coordinator appointment and transfer	1. Recipient contacts	D. Recipient and provider contacts
		1. Recipient contacts for the ALI Waiver, CCMC Waiver, APDD Waiver, and the People with IDD Waiver: The care coordinator must
		a. contact each wavier recipient in person at least once a month, and contact the recipient or the recipient's representative in person or by phone at least once a month and as frequently as necessary, to evaluate whether
		2. Recipient contacts: Individualized Support Waiver
		The care coordinator must
		a. contact the waiver recipient in person at least once every three months, and contact the recipient by telephone at least once in each month in which in-person contact is not made, to evaluate whether
		i. services are furnished in accordance with the support plan and in a timely manner;
		ii. services are delivered in a manner that protects the recipient's health, safety, and welfare;
		iii. services are adequate to meet the recipient's identified need; and

Appendix C - Conditions of Participation for Care Coordination Services

FY15	FY18	FY21
		iv. changes in the needs or status of the recipient require adjustments to the support plan or to arrangements with providers;
		b. ensure that at least one of the in-person contacts made according to 2(a) above is accomplished in one of the settings where Individualized Supports Waiver services are provided; and
		c. document the content of each contact with the recipient as required in this subsection, including:
		i. the method used to make that contact meaningful in terms of monitoring the health, safety, and welfare of the recipient;
		ii. a summary of the meeting and the names of those in attendance;
		iii. whether services are adequate, delivered safely, respectfully, and acceptably to the recipient; and
		iv. whether the support plan should be amended.
		3. Recipient contacts: Community First Choice.
		The care coordinator providing targeted case management must provide the following:
		a. assistance with an individual's Community First Choice application;
		b. pre-enrollment counseling to discuss the range of services and supports available to the individual;
		c. with the recipient and planning team, development of an initial support plan and annual renewal support plan;
		d. monitoring the recipient and services received by the recipient on a schedule that is approved in the support plan; monitoring may occur more frequently when requested by the recipient or when an issue is identified by the care coordinator, a service provider, or the state.
	2. Provider contacts	4. Provider contacts: All Waivers and Community First Choice
	V. Environmental modification projects	V. Environmental modification projects
	A. Evironmental modification evaluation	A. Environmental modification evaluation
	B. Requests for cost estimates	B. Requests for cost estimates
	C. Selection of the project provider	C. Selection of the project provider
	D. Collaboration with interested parties	D. Collaboration with interested parties

Appendix D - Care Coordination Liaison Job Bulletin

STATE OF ALASKA
invites applications for the position of:

Health Program Manager 2 (06N22076)

Job Code: 33610	**Job Title:** Health Program Manager 2 (06N22076)
Open Date: 03/04/22	**Closing Date:** 03/15/22 05:00 PM
Position Open To: Alaska Residents Only	**Job Type:** Long Term Nonperm
Range: 19	**Salary:** $2,481.75 Biweekly
Department: Health & Social Services	**Division**: Senior and Disabilities Services
Location: Anchorage	**Bargaining Unit**: General Government

JOB DESCRIPTION:

**This position is open to Alaska Residents only.
Please check our residency definition to determine if you qualify**.

Alaska Department of Health and Social Services
Senior and Disabilities Services

What you will be doing:
Under the direction of the Health Program Manager 4 (Chief of Programs), the incumbent will work on a variety of goals designed to increase the number of Care Coordinators available within the State of Alaska. Care Coordinators assist applicants and recipients to access home and community based services. The incumbent will work on identifying training needs, monitoring performance and timelines and will work on developing a career path for the Care Coordination sector. The incumbent will also work with a variety of stakeholders and community partners.

Our organization, mission, and culture:
This position is located in Anchorage. Senior and Disabilities Services (SDS) promotes health, well being and safety for individuals with disabilities, seniors and vulnerable adults by facilitating access to quality services and supports that foster independence, personal choice and dignity. SDS and its partners are responsible and accountable for the efficient and effective management of services, and foster an environment of fairness, equality, integrity and honesty. SDS and its partners provide quality services designed and delivered to build communities where all members are included, respected and valued.

The benefits of joining our team:
We offer a vibrant and dynamic work environment. The work our team does positively impacts the lives of hundreds of Alaskan by facilitating access to quality and safe services for individuals with disabilities, seniors and vulnerable adults, while giving them the opportunity to live in their community of choice. We are guided by our mission, which foster dignity, independence, and personal choice. The work of this position will promote continuous learning, and growth among the care coordinator sector.

The working environment you can expect:
The office is located in Northeast Anchorage (1831 Bragaw Street). It is near Costco, East High School, and various restaurants and a coffee shop. Parking is readily available at the office. The incumbent will work closely with the Chief of Programs, the Training Unit and all SDS certified care coordinators. The position also involves regular travel throughout the state.

Who we are looking for:
We are looking for someone with the following competencies:

Adaptability: adjusts planned work by gathering relevant information and applying critical thinking to address multiple demands and competing priorities in a changing environment.

Interpersonal Skills: Shows understanding, friendliness, courtesy, tact, empathy, concern, and politeness to others; develops and maintains effective relationships with others; may include effectively dealing with individuals who are difficult, hostile, or distressed; relates well to people from varied backgrounds and different situations; is sensitive to cultural diversity, race, gender, disabilities, and other individual differences.

Oral Communication: Expresses information (for example, ideas or facts) to individuals or groups effectively, taking into account the audience and nature of the information (for example, technical, sensitive, controversial); makes clear and convincing oral presentations; listens to others, attends to nonverbal cues, and responds appropriately.

Technical Competence: Uses knowledge that is acquired through formal training or extensive on-the-job experience to perform one's job; works with, understands, and evaluates technical information related to the job; advises others on technical issues.

Self-Management: Sets well-defined and realistic personal goals; displays a high level of initiative, effort, and commitment towards completing assignments in a timely manner; works with minimal supervision; is motivated to achieve; demonstrates responsible behavior

A cover letter is NOT required for this position.** **Your complete application, including supplemental questions will be used to determine which applicants will advance to the interview phase of the recruitment and selection process.

To view the general description and example of duties for a** Health Program Manager 2**, please go to the following link: https://www.governmentjobs.com/careers/Alaska/classspecs

MINIMUM QUALIFICATIONS:

Any combination of education and/or experience that provides the applicant with the competencies in
- **Analysis and Assessment:** Uses information technology in accessing, collecting, analyzing, maintaining, and disseminating data and information**.**
- **Writing:** Recognizes or uses correct English grammar, punctuation, and spelling; communicates information (e.g., facts, ideas, or messages) in a succinct and organized manner; produces written information, which may include technical material and information that is appropriate for the intended audience.
- **Community Dimensions of Practice:** Distinguishes the roles and responsibilities of governmental and non-governmental organizations in providing programs and services to improve the health of a community.
- **Partnering:** Develops networks and builds alliances; collaborates across boundaries to build strategic relationships and achieve common goals.
- **Public Health:** Applies knowledge of the concepts, principles, theories, methods, and tools associated with protecting and improving the health of people and their communities, including promoting healthy lifestyles, researching disease and injury prevention, and detecting, preventing, and responding to infectious diseases.

Equivalent to those typically gained by:

A Bachelor's degree from an accredited college in biological, health or behavioral science; health practice; education; public, healthcare, or business administration; or a closely related field;

AND/OR

Progressively responsible professional experience performing health program planning, development, coordination, evaluation, or implementation; providing technical health care assistance and consultation; conducting health care utilization or quality assurance examinations; and/or delivering health care.

Special Note: Agencies employing Health Program Managers are responsible for administering a wide range of medical, behavioral, and social health insurance programs for children and adults. Positions typically focus on a particular health area. Where licensure is required, the job vacancy announcement will identify the type of license necessary to apply for that specific position. The essential functions of some positions may involve exposure to infectious disease and/or biohazards. Travel may be required.

"Professional experience" means work that is creative, analytical, evaluative, and interpretive; requires a range and depth of specialized knowledge of the profession's principles, concepts, theories, and practices; and is performed with the power or right to decide or act according to one's own judgment.

"Progressively responsible" means indicating growth and/or advancement in complexity, difficulty, or level of responsibility.

ADDITIONAL REQUIRED INFORMATION:

At time of interview applicant(s) are requested to submit:
- Current Resume
- List of three current references (One must be a direct supervisor)
- The most recent performance evaluation (If Available)

Please read the below information carefully. This applies to your application submission

Requires frequent travel within the State of Alaska to urban and rural regions. Must be comfortable being transported on small planes, boats, snow machines and four wheelers.

SUPPLEMENTAL QUESTIONS
For your application to be evaluated you must answer the Supplemental Questions. Be specific in your answers and tell us how you acquired the relevant experience. Please use complete sentences and proof-read your submissions when answering the supplemental questions. Your responses will be considered a writing sample and will be used to determine which applicants will advance to the interview phase of the recruitment process.

EDUCATION
To verify education being used to meet the required minimum qualifications, you must fill in the Education section of the application. If you have not obtained a degree, please indicate the number of units completed. Copies of transcripts are required to verify educational credentials being used to meet the minimum qualifications for a position and are required with each application. (Unofficial are okay, please ensure that the institution/URL name is listed on the transcripts). Transcripts can be attached at the time of application, provided at the time of interview or if not provided, transcripts will be required prior to appointment.

SPECIAL INSTRUCTIONS FOR FOREIGN EDUCATION
Education completed in foreign colleges or universities may be used to meet the above requirements, if applicable. If utilizing this education you must show that the education credentials have been submitted to a private organization that specializes in interpretation of foreign educational credentials and that such education has been deemed to be at least equivalent to that gained in conventional U.S. education programs; or an accredited U.S. state

university reports the other institution as one whose transcript is given full value, or full value is given in subject areas applicable to the curricula at the state university. It is your responsibility to provide such evidence when applying. *Omission of required documentation listed will result in an incomplete application and you will not receive further consideration.*

WORK EXPERIENCE
When using work experience not already documented in your application, please provide the employer name, your job title, dates of employment, and whether full-or part-time. Applications will be reviewed to determine if the responses are supported and minimum qualifications are clearly met. Work experience needed to meet the minimum qualifications must be documented in the application. If the application does not support minimum qualifications, the applicant may not advance to the interview and selection phase of the recruitment. A resume will not be used to determine that minimum qualifications have been met for the position in which you are applying.

If you are currently or previously been appointed to a flexibly staffed position please ensure your work experience within a flexibly staffed position indicates the actual dates employed at each level. Ensure your time and any subsequent flex promotion(s) are documented as a separate position. This is required as there are minimum qualifications that require experience at a particular level in which the lower level may not be considered. If this information is not accurately reflected in your application this may cause the processing of your application for consideration to be delayed.

NOTE: Attaching a resume or curriculum vitae is not an alternative to filling out the application in its entirety. Noting "see resume or CV" or any similar response on any portion of your application may lead to a determination your application is incomplete and removal from consideration for this job posting.

The State of Alaska does not provide VISA Employer sponsorships.

RECRUITMENT SCOPE
This position is open to Alaska Residents only. Please check ou**r residency definition** to determine if you qualify.

MULTIPLE VACANCIES
This recruitment may be used for more than one (1) vacancy. The applicant pool acquired during this recruitment may be used for future vacancies for up to ninety (90) days after this recruitment closes. Interested applicants are encouraged to apply to each recruitment notice to ensure consideration for all vacancies.

APPLICATION NOTICE
You can ONLY apply for this position through the Workplace Alaska website or via hardcopy application. If you accessed this recruitment bulletin through a job search portal such as AlaskaJobs or any other database, you MUST use a Workplace Alaska online or hardcopy application to successfully apply. Instructions on how to apply with Workplace Alaska may be found on the Workplace Alaska "How to Apply" webpage, found here:
http://doa.alaska.gov/dop/workplace/help/

NOTICE
Questions regarding the application process can be directed to the Workplace Alaska hotline at 800-587-0430 (toll free) or (907) 465- 4095. If you choose to be contacted by email, please ensure your email address is correct on your application and that the spam filter will permit email from the 'govermentjobs.com' domains. For information on allowing emails from the 'governmentjobs.com' domains, visit the Lost Password Help page located at https://www.governmentjobs.com/OnlineApplication/User/ResetPassword.

EEO STATEMENT
The State of Alaska complies with Title I of the Americans with Disabilities Act (ADA). Individuals with disabilities, who require accommodation, auxiliary aides or services, or alternative communication formats, please call 1-800-587-4095 in Juneau or TTY: Alaska Relay 711 or 1-800-770-8973 or correspond with the Division of Personnel & Labor Relations at: P. O. Box 110201, Juneau, AK 99811-0201. The State of Alaska is an equal opportunity employer.

CONTACT INFORMATION:

WORKPLACE ALASKA APPLICATION QUESTIONS & ASSISTANCE
Questions regarding application submission or system operation errors should be directed to the Workplace Alaska hotline at 1-800-587-0430 (toll free) or (907) 465-4095 if you are located in the Juneau area. Requests for information may also be emailed to recruitment.services@alaska.gov.

For applicant password assistance please visit: https://www.governmentjobs.com/OnlineApplication/User/ResetPassword

For specific information in reference to the position please contact the hiring manager at:

Name: Caroline Hogan, Health Program Manager 4
Phone: (907) 269-3681
Email: caroline.hogan@alaska.gov

APPLICATIONS MAY BE FILED ONLINE AT:
http://workplace.alaska.gov/

PO Box 110201
Juneau, AK 99811
(800) 587-0430 (Statewide toll-free number)
(907) 465-4095 (Juneau and out-of-state callers)

recruitment.services@alaska.gov

Position #33610
HEALTH PROGRAM MANAGER 2 (06N22076)
BB

Health Program Manager 2 (06N22076) Supplemental Questionnaire

* 1. I acknowledge I understand the education and/or experience being used to meet the minimum qualifications for this position must be adequately documented in this application in order to be considered.

    ☐ I acknowledge and I understand this requirement

* 2. Describe your work experience with care coordination, case management or other related work.

* 3. Describe what organizational skills you utilize in the workplace to help you meet department timelines independently.

* 4. Describe your proficiency with using Microsoft Suite (Excel, PowerPoint, Word and Outlook) and how you have used this is previous workplaces.

* 5. Describe your ability to deal calmly and effectively with high stress situations (e.g., tight deadlines, hostile individuals, emergency situations).

Appendix E - Care Coordination Liaison Project Performance Measures

Performance Measure #1: Increase the number of care coordinators certified by SDS, therefore allowing applicants and recipients increased choice.

Performance Measure #2: Increase the number of care coordinators who serve rural areas.

Performance Measure #3: Increase ease of access to the Harmony database.

Performance Measure #4: Increase timeliness of applications and support plans submitted by care coordinators to SDS.

Performance Measure #5: Increase the knowledge base of care coordinators so they are aware of all opportunities to support recipients (not just those within the Medicaid system).

Performance Measure #6: Work with partners to develop a care coordination career path to attract and retain care coordinators.

Performance Measure #7: Ensure care coordinators have knowledge of and promote all opportunities for increased recipient independence including supported employment, independent living, access to Section 1115 behavioral health waiver services, environmental modifications, assistive technology and socialization.[1]

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[1] Email exchange between Kimberly Adkison, consultant, and Caroline Hogan, SDS Chief of Programs

Appendix F - Care Coordination Services Medicaid Reimbursement Procedure Codes and Rates

FY15	FY18	FY21
Effective Jul 1, 2014 with 2.4% inflation	Effective Jul 1, 2016	Effective 01/01/2021 with 2.5% inflation effective 07/01/2020
Waiver Programs ALI: Alaskans Living Independently APDD: Adults with Physical & Developmental Disabilities CCMC: Children with Complex Medical Conditions IDD: Intellectual & Developmental Disabilities	Waiver Programs ALI: Alaskans Living Independently APDD: Adults with Physical & Developmental Disabilities CCMC: Children with Complex Medical Conditions IDD: Intellectual & Developmental Disabilities	Waiver Programs ALI: Alaskans Living Independently APDD: Adults with Physical & Developmental Disabilities CCMC: Children with Complex Medical Conditions IDD: Intellectual & Developmental Disabilities **Added waiver IDD-ISW:** Intellectual & Developmental Disabilities – Individualized Supports Waiver
Care Coordination 7 AAC 130.240	Care Coordination 7 AAC 130.240	Care Coordination 7 AAC 130.240 **Added:** 7 AAC 145.520
Case Management Procedure code: T2022 Waiver program: ALI, APDD, CCMC, IDD Service unit: Per month Service rate: $240.77	Case Management Procedure code: T2022 Waiver program: ALI, APDD, CCMC, IDD Service unit: Per month Service rate: $240.77	**Changed service title from Case Management to:** Care Coordination On-Going Procedure code: T2022 Waiver program: ALI, APDD, CCMC, IDD Service unit: Per month **Increased service rate: $252.96**
Not Applicable	Not Applicable	**Added new waiver:** Care Coordination On-Going **Added procedure code:** T2022 CG **Added waiver program:** IDD-ISW Service unit: Per month Service rate: $156.28
Not Applicable	Not Applicable	**Add a new service:** Case Management (Community First Choice Only) **Added procedure code:** T2022 TS Service unit: Per month Service rate: $125.03
Not Applicable	Not Applicable	**Changed service funding category from Waiver Services to:** Medicaid payment rates for Long Term Services and Supports Targeted Case Management Services 7 AAC 128.010 7 AAC 145.290
Screening	Screening	**Changed service title from Screening to:** Application for Waiver Services or and added a new service: Community First Choice Services
Procedure code: T1023 Waiver program: ALI, APDD, CCMC Service unit: 1 initial (1 additional as approved) Service rate: $90.33	Procedure code: T1023 Waiver program: ALI, APDD, CCMC Service unit: 1 initial (1 additional as approved) Service rate: $90.33	**Changed procedure code:** T1023 SE Waiver program: ALI, APDD, CCMC Service unit: 1 initial (1 additional as approved) **Increased service rate: $94.90**
Not Applicable	Not Applicable	**Changed service title to:** Initial Support Plan and Annual Renewal of Support Plan for Waiver or and added a new service: Community First Choice
Plan of Care Development Procedure Code: T2024 U2 Waiver Program: ALI, APDD, CCMC, IDD Service Unit: 1 annually Service Rate: $384.81	Plan of Care Development Procedure Code: T2024 U2 Waiver Program: ALI, APDD, CCMC, IDD Service Unit: 1 annually Service Rate: $384.81	**Changed procedure code:** T2024 SE **Add New Waiver Program:** ALI, APDD, CCMC, IDD, ISW Service Unit: 1 annually **Increased service rate: $404.29**
Regional rate adjustments Table I-1 *Alaska Geographic Differential Study*, April 30, 2009	Regional rate adjustments Table I-1 *Alaska Geographic Differential Study*, April 30, 2010	Regional rate adjustments Table I-1 *Alaska Geographic Differential Study*, April 30, 2011
Anchorage Region no adj (1.00) Fairbanks 3% (1.03) Parks/Elliott/Steese Highways no adj (1.00) Glennallen Region no adj (1.00) Delta Junction/Tok Region 4% (1.04) Roadless Interior 31% (1.31) Mat-Su no adj (1.00) Kenai Peninsula 1% (1.01) Prince William Sound 8% (1.08)	Anchorage Region no adj (1.00) Fairbanks 3% (1.03) Parks/Elliott/Steese Highways no adj (1.00) Glennallen Region no adj (1.00) Delta Junction/Tok Region 4% (1.04) Roadless Interior 31% (1.31) Mat-Su no adj (1.00) Kenai Peninsula 1% (1.01) Prince William Sound 8% (1.08)	Anchorage Region no adj (1.00) Fairbanks 3% (1.03) Parks/Elliott/Steese Highways no adj (1.00) Glennallen Region no adj (1.00) Delta Junction/Tok Region 4% (1.04) Roadless Interior 31% (1.31) Mat-Su no adj (1.00) Kenai Peninsula 1% (1.01) Prince William Sound 8% (1.08)

Appendix F - Care Coordination Services Medicaid Reimbursement Procedure Codes and Rates

FY15	FY18	FY21
Kodiak 12% (1.12) Arctic Region 48% (1.48) Bethel/Dillingham 49% (1.49) Aleutian Region 50% (1.50) Southwest Small Communities 44% (1.44) Southeast Communities 9% (1.09) References https://health.alaska.gov/dsds/Pages/info/costsurvey.aspx https://health.alaska.gov/dsds/Documents/pca/PCA-service%20-waiver-rates201407.pdf	Kodiak 12% (1.12) Arctic Region 48% (1.48) Bethel/Dillingham 49% (1.49) Aleutian Region 50% (1.50) Southwest Small Communities 44% (1.44) Southeast Communities 9% (1.09) References https://health.alaska.gov/dsds/Pages/info/costsurvey.aspx https://health.alaska.gov/dsds/Documents/pca/PCA-waiver-service-rates201607.pdf	Kodiak 12% (1.12) Arctic Region 48% (1.48) Bethel/Dillingham 49% (1.49) Aleutian Region 50% (1.50) Southwest Small Communities 44% (1.44) Southeast Communities 9% (1.09) References https://health.alaska.gov/dsds/Pages/info/costsurvey.aspx https://health.alaska.gov/dsds/Documents/pca/pdfs/ChartofWaiverServicesRates.pdf https://health.alaska.gov/dsds/Documents/pca/LTSS-TCM-Rate-Chart-FY21.pdf

Appendix G - Care Coordination Evaluation Survey Data

This written survey was distributed online using the SurveyMonkey platform. This appendix displays both the questions as they appeared for the participants taking the survey and the responses to each categorical or continuous response question. Responses to the open-ended questions are not provided to maintain the anonymity of the respondents.

Care Coordination Evaluation Project

Introduction

We are inviting you to take part in this study because you are a currently certified care coordinator in Alaska. Our goal is to gather information needed to:

- **ensure every eligible beneficiary is able to access a care coordinator**
- **ensure the care coordination workforce has the capacity to provide high quality support and services**

This survey has 13 sections. It is easiest to complete the survey on a laptop/desktop. The survey may take 30 to 45 minutes to complete. Your responses will be confidential, and you can skip questions or select 'prefer not to respond' if you choose.

The survey will be open through March 7, 2022. You can complete the survey in several sessions if necessary. The survey will remain available until you click 'submit'.

Thank you for taking the time to complete this survey. Your participation in this study is greatly appreciated.

Care Coordination Evaluation Project

Consent to take part in research

This is a study about Alaska's Home and Community-Based Medicaid Waiver Care Coordination services. This is a project of the Alaska Association on Developmental Disabilities, funded by a grant from the Alaska Mental Health Trust Authority.

We do not expect any risks to you if you take part in this study. Possible benefits to you if you choose to take part in this study include having your experiences and opinions contribute to a greater understanding of care coordination services in Alaska and potential future service system enhancements.

Information we get about you from the survey will be kept confidential. Information with your name attached will not be shared with anyone outside the research team. We will code your information with a number so no one can trace your answers to your name. Your name will not be used in reports, presentations, or publications. Any summary survey content, or direct quotations from the survey, will be anonymized so that you cannot be identified. Copies of the final report will be made available at the conclusion of the study.

Your decision to take part in the study is voluntary. If you decide to take part, you can stop at any time. You may change your mind and ask to be removed from the study. You may also skip any question.

If you have questions about this study, you may contact the primary consultant, Kimberly Adkison, at kimberly@adkisonconsulting.com or (907) 328-8632.

* 1. **STATEMENT OF CONSENT**: I am 18 years old or older. I understand everything described above. Any questions have been answered to my satisfaction, and I agree to participate in this study.

◯ Yes

◯ No

Care Coordination Evaluation Project

Instructions

Please answer questions as they apply to you on the day you are completing this survey, unless otherwise directed. Additional information is provided whenever a phrase has a dotted line underneath. Access the information by hovering the cursor over the phrase.

Care Coordination Evaluation Project

Section 1

Please provide information about your care coordination experience.

1. What year were you **initially** certified as a care coordinator in Alaska? (enter a 4-digit year)

Number of Respondents	Year Certified
1	1993
0	1994
0	1995
2	1996
0	1997
2	1998
2	1999
3	2000
0	2001
3	2002
4	2003
2	2004
1	2005
2	2006
9	2007
4	2008
6	2009
6	2010
6	2011
3	2012
6	2013
7	2014
12	2015
6	2016
9	2017
4	2018
11	2019
6	2020
11	2021
1	2022

N=129

2. How many **total years** have you maintained your care coordination certification in Alaska?
(does not need to be concurrently, please enter a number)

Number of Respondents	Total Years Certified
12	1
6	2
11	3
9	4
4	5
11	6
11	7
10	8
2	9
3	10
6	11
8	12
5	13
3	14
9	15
2	16
0	17
3	18
2	19
2	20
3	21
1	22
2	23
2	24
0	25
1	26

N=128

3. How many years of paid work experience in a human services field do you have outside of care coordination? (please enter a number)

Number of Respondents	Years Human Service Experience
5	2
4	3
5	4
8	5
6	6
2	7
4	8
1	9
7	10
6	11
7	12
5	13
6	14
5	15
3	16
1	17
1	18
0	19
10	20
5	21
6	22
1	23
2	24
6	25
1	26
0	27
3	28
2	29
4	30
1	31
0	32
0	33
2	34
5	35

N=124

4. In which area(s) of disability and vulnerable adult services do you have expertise/specialize in? (check all that apply)

☐ Children (0-15 years old) with intellectual, physical and developmental disabilities

☐ Young people (16-25 years old) with intellectual, physical and developmental disabilities

☐ Adults (26+ years old) with intellectual, physical and developmental disabilities

☐ Children and young people who experience complex medical conditions

☐ Seniors/elders with age related disabilities

☐ People with Alzheimer's and other Related Dementias

☐ Other (please specify)

☐ Prefer not to respond

Specialties	Percentage of Respondents
Children (0-15 years old) with intellectual, physical and developmental disabilities	67%
Young people (16-25 years old) with intellectual, physical and developmental disabilities	79%
Adults (26+ years old) with intellectual, physical and developmental disabilities	83%
Children and young people who experience complex medical conditions	51%
Seniors / elders with age related disabilities	66%
People with Alzheimer's and other Related Dementias	56%
Other (please specify)	23%
Prefer not to respond	2%
Categories not mutually exclusive	

Care Coordination Evaluation Project

Section 2

Please provide information about the certified care coordination provider you are associated with.

* 1. What type of care coordination provider are you associated with?

○ Independent care coordination (sole provider)

○ Care coordination only agency

○ Multi-service agency

○ Prefer not to respond

Business Type	Number of Respondents
Independent care coordination (sole provider)	55
Care coordination-only agency	56
Multi-service agency	18

N=129

Care Coordination Evaluation Project

Section 2.1

Independent care coordination (sole-provider) specific question.

1. Do you use <u>administrative supports?</u> (check all that apply)

☐ I employ administrative staff

☐ I contract for support services

☐ Other (please specify)

☐ Prefer not to respond

Administrative Supports	Number of Responses
I employ administrative staff	8
I contract for support services	6
Other (please specify)	39
Prefer not to respond	6
Categories not mutually exclusive	

Care Coordination Evaluation Project

Section 2.2

Care coordination only agency specific questions.

1. What is your relationship to your care coordination only agency?

○ Owner

○ Partner

○ Employee

○ Contractor

○ Prefer not to respond

Role	Number of Respondents
Owner	11
Partner	10
Employee	33
Contractor	3

N=57

2. How many individually certified care coordinators are associated with your care coordination only agency?

○ 1 to 5

○ 6 to 10

○ 11 to 15

○ 16 to 20

○ More than 20

○ I don't know

○ Prefer not to respond

Care Coordinators	Number of Responses
1 to 5	31
6 to 10	8
11 to 15	2
16 to 20	8
More than 20	2
I don't know	3

N=54

3. Does your care coordination only agency use administrative supports? (check all that apply)

☐ Employ administrative staff

☐ Contract for support services

☐ I don't know

☐ Other (please specify)

☐ Prefer not to respond

Administrative Supports	Number of Responses
Employ administrative staff	29
Contract for support services	6
I don't know	9
Other (please specify)	8
Prefer not to respond	5

Categories not mutually exclusive

Care Coordination Evaluation Project

Section 2.3

Multi-service agency specific questions.

1. What is your role within your multi-service agency?

○ Care coordination program manager

○ Frontline supervisor

○ Care coordination staff

○ Other (please specify)

Role	Number of Respondents
Care coordination program manager	3
Frontline supervisor	1
Care coordination staff	11
Other (please specify)	3

N=18

○ Prefer not to respond

2. How many individually certified care coordinators are employed by your multi-service agency?

○ 1 to 5

○ 6 to 10

○ 11 to 15

○ 16 to 20

○ More than 20

○ I don't know

○ Prefer not to respond

Care Coordinators	Number of Responses
1 to 5	8
6 to 10	3
11 to 15	2
16 to 20	5

N=18

3. Does your multi-service agency use <u>administrative supports?</u> (check all that apply)

☐ Employ administrative staff

☐ Contract for support services

☐ I don't know

☐ Other (please specify)

Administrative Supports	Number of Responses
Employ administrative staff	17
Contract for support services	2
I don't know	0
Other (please specify)	2

Categories not mutually exclusive

☐ Prefer not to respond

Care Coordination Evaluation Project

Section 3

Please provide information about your care coordination employment.

1. What is your care coordination employment status?

　◯ Work full-time (37 or more hours per week)

　◯ Work part-time (20 to 36 hours per week)

　◯ Work part-time (less than 20 hours per week)

　◯ Other (please specify)

　◯ Prefer not to respond

Employment Status	Number of Respondents
Work full-time (37 or more hours per week)	106
Work part-time (20 to 36 hours per week)	8
Work part-time (less than 20 hours per week)	5
Other (please specify)	8

N=127

2. Which of these describes your **care coordination** gross income last year?

　◯ Less than $35,000

　◯ $35,000 to $49,999

　◯ $50,000 to $74,999

　◯ $75,000 to $99,999

　◯ Over $100,000

　◯ Prefer not to respond

Number of Respondents	Income	Independent care coordination (sole provider)	Care coordination-only agency	Multi-service agency
15	Less than $35,000	9	5	1
30	$35,000 to $49,999	8	16	6
30	$50,000 to $74,999	9	15	6
12	$75,000 to $99,999	7	3	2
20	Over $100,000	16	4	0
21	Prefer not to respond	6	12	3

N=128

3. What type of employment benefits do you have access to as a care coordinator? (check all that apply)

☐ Health insurance

☐ Retirement plan

☐ Paid time off

☐ None of the above

☐ Other (please specify)

[text box]

☐ Prefer not to respond

Percentage of Respondents	Employment Benefit	Independent care coordination (sole provider)	Care coordination-only agency	Multi-service agency
31%	Health insurance	7%	34%	100%
27%	Retirement plan	11%	25%	83%
30%	Paid time off	4%	36%	94%
58%	None of the above	82%	55%	0%
2%	Other (please specify)	0%	4%	0%

Categories not mutually exclusive

Care Coordination Evaluation Project

Section 4

As a reminder, please answer questions as they apply to you on the day you are completing this survey, unless otherwise directed.

Please provide information about your Home and Community-Based Services (HCBS) waiver caseload.

1. How many people with approved HCBS waivers are you the **assigned care coordinator** for? (please enter a number)

Number of Respondents	Caseload Size	Independent care coordination (sole provider)	Care coordination-only agency	Multi-service agency
11	no response	2	6	1
20	0 to 9	7	10	3
22	10 to 19	14	5	3
29	20 to 29	8	14	7
28	30 to 39	12	13	3
11	40 to 49	6	4	1
10	50 or more	6	4	0

N=120

2. How many of each type of waiver are you the **assigned care coordinator** for? (please enter a number)

IDD
People with Intellectual & Developmental Disabilities

ISW
Individualized Supports Waiver

CCMC
Children with Complex Medical Conditions

APDD
Adults with Physical & Developmental Disabilities

ALI
Alaskans Living Independently

CFC plus Waiver
Community First Choice

CFC Only
Community First Choice

TEFRA
Tax Equity and Fiscal Responsibility Act

Type of Waiver Caseload	Number of Responses		
	zeros	median	max
IDD	17	8	49
ISW	47	1	26
CCMC	63	0	19
APDD	73	0	5
ALI	34	4	57
CFC + Waiver	60	0	35
CFC Only	117	0	1
TEFRA	99	0	100

Categories not mutually exclusive

3. In which geographic region(s) do the people you are the **assigned care coordinator** for reside? (check all that apply)

☐	Anchorage Region	☐	Arctic Region
☐	Fairbanks Region	☐	Bethel / Dillingham Region
☐	Parks / Elliott / Steese Highways	☐	Aleutian Region
☐	Glennallen Region	☐	Southwest Small Communities
☐	Delta Junction / Tok Region	☐	Juneau Region
☐	Roadless Interior Region	☐	Ketchikan / Sitka Region
☐	Mat-Su Region	☐	Southeast Mid-Size Communities
☐	Kenai Peninsula Region	☐	Southeast Small Communities
☐	Prince William Sound Region		
☐	Kodiak Region		
☐	Other (please specify)		

☐ Prefer not to respond

Geographic Region Caseload Resides	Number of Responses
Anchorage Region	81
Mat-Su Region	58
Kenai Peninsula Region	30
Fairbanks Region	17
Juneau Region	13
Bethel / Dillingham Region	12
Southeast Small Communities	12
Kodiak Region	10
Ketchikan / Sitka Region	10
Glennallen Region	8
Delta Junction / Tok Region	8
Southeast Mid-Size Communities	8
Prince William Sound Region	6
Arctic Region	6
Aleutian Region	5
Parks / Elliott / Steese Highways	4
Southwest Small Communities	4
Roadless Interior Region	2
Prefer not to respond	2

Categories not mutually exclusive

* 4. Are you currently accepting new referrals?

◯ Yes

◯ No

◯ Other (please specify)

[text field]

◯ Prefer not to respond

Accepting Referrals	Number of Respondents
No	37
Yes	63
Other (please specify)	21
Prefer not to respond	5

N=121

Care Coordination Evaluation Project

Section 4.1

Questions about the new referrals you are currently accepting.

1. What type of referrals are you currently accepting? (check all that apply)

☐ People with an approved HCBS waiver

☐ Initial waiver applications **with** established Long-Term Care Medicaid

☐ Initial waiver applications **without** established Long-Term Care Medicaid

☐ Other (please specify)

☐ Prefer not to respond

Type of Referral Accepting	Number of Responses
People **with** an approved HCBS waiver	59
Initial waiver applications **with** established Long-Term Care Medicaid	61
Initial waiver applications **without** established Long-Term Care Medicaid	39
Other (please specify)	16
Categories not mutually exclusive	

2. What waiver types are you currently accepting new referrals for? (check all that apply)

☐ IDD
People with Intellectual & Developmental Disabilities

☐ ISW
Individualized Supports Waiver

☐ CCMC
Children with Complex Medical Conditions

☐ APDD
Adults with Physical & Developmental Disabilities

☐ ALI
Alaskans Living Independently

☐ CFC plus Waiver
Community First Choice

☐ CFC Only
Community First Choice

☐ TEFRA
Tax Equity and Fiscal Responsibility Act

☐ Prefer not to respond

Waiver Type Accepting	Number of Responses
IDD	54
ISW	36
CCMC	41
APDD	44
ALI	56
CFC + Waiver	26
CFC Only	7
TEFRA	18
Prefer not to respond	6

Categories not mutually exclusive

3. In what geographic region(s) are you currently accepting new referrals? (check all that apply)

☐ Anchorage Region   ☐ Arctic Region

☐ Fairbanks Region   ☐ Bethel / Dillingham Region

☐ Parks / Elliott / Steese Highways   ☐ Aleutian Region

☐ Glennallen Region   ☐ Southwest Small Communities

☐ Delta Junction / Tok Region   ☐ Juneau Region

☐ Roadless Interior Region   ☐ Ketchikan / Sitka Region

☐ Mat-Su Region   ☐ Southeast Mid-Size Communities

☐ Kenai Peninsula Region   ☐ Southeast Small

☐ Communities Prince William Sound Region

☐ Kodiak Region

☐ Other (please specify)

☐ Prefer not to respond

Geographic Region Accepting Referrals	Number of Responses
Anchorage Region	51
Mat-Su Region	35
Kenai Peninsula Region	21
Southeast Small Communities	12
Fairbanks Region	10
Juneau Region	10
Ketchikan / Sitka Region	9
Southeast Mid-Size Communities	9
Other (please specify)	9
Bethel / Dillingham Region	7
Parks / Elliott / Steese Highways	6
Glennallen Region	6
Delta Junction / Tok Region	6
Prince William Sound Region	6
Kodiak Region	6
Roadless Interior Region	5
Arctic Region	5
Southwest Small Communities	5
Aleutian Region	4
Prefer not to respond	1

Categories not mutually exclusive

Care Coordination Evaluation Project

Section 4.2

Question about the impact of the Appendix K flexibilities on your caseload size.

The Division of Senior and Disabilities Services (SDS) has approval from the Centers for Medicare and Medicaid Services (CMS) to continue Appendix K flexibilities until six months after the federal Public Health Emergency ends. The current end date for the federal public health emergency has been extended to April 16, 2022. Appendix K flexibilities would end in early October 2022, if the federal Public Health Emergency is not extended again.

* 1. When the flexibilities approved through the COVID-19 Appendix K amendment to the HCBS waivers end, will you decrease your caseload?

◯ Yes

◯ No

◯ Other (please specify)

◯ Prefer not to respond

Decrease Caseload Appendix K Ends	Number of Respondents
No	75
Yes	17
Other (please specify)	30
Prefer not to respond	3

N=125

Care Coordination Evaluation Project

Section 4.3

Questions about decreasing your caseload when the Appendix-K flexibilities end.

1. How many people will you need to stop serving when the Appendix K flexibilities end? (please enter a number)

Number Recipients Stop Serving Appendix K Ends	
Average	**Total**
8.8	247

N=41

2. What method(s) will you use to decrease your caseload when the Appendix K flexibilities end? (check all that apply)

☐ By sending 30-day termination of service notice(s)

☐ Through natural attrition

☐ Other (please specify)

☐ Prefer not to respond

Method Decrease Caseload Appendix K End	Number of Responses
By sending 30-day termination of service notice(s)	21
Through natural attrition	15
Other (please specify)	15
Prefer not to respond	6
Categories not mutually exclusive	

Care Coordination Evaluation Project

Section 5

Please provide information about how you spend your time while providing care coordination services.

1. When thinking about how you spend your time in a typical month, what percentage of your time goes to the following tasks? (please enter a number, no decimals or symbols, the **total must add up to 100**)

Initial Applications for HCBS Waiver Programs

Initial Support Plan Development

Renewal Applications for HCBS Waiver Programs

Renewal Support Plan Development

Amendments to Support Plans

Required Monthly Contacts/Monitoring

Case Notes/Documentation

Case Management
such as, assistance with benefits, travel, healthcare, housing, employment, education, etc.

Addressing Critical Needs
such as, emergency medical care, hospitalization, behavioral supports, support/caregiving, etc.

Requests for Reimbursement/Billing

Required Training for Certification

Tasks Related to Running a Business*
*enter zero if you are employed by an agency

Care Coordination Service Tasks	Percentage of Time
Initial Applications for HCBS Waiver Programs	5%
Initial Support Plan Development	5%
Renewal Applications for HCBS Waiver Programs	9%
Renewal Support Plan Development	12%
Amendments to Support Plans	6%
Required Monthly Contacts/Monitoring	20%
Case Notes/Documentation	13%
Case Management *such as, assistance with benefits, travel, healthcare, housing, employment, education, etc.*	8%
Addressing Critical Needs *such as, emergency medical care, hospitalization, behavioral supports, support/caregiving, etc.*	6%
Requests for Reimbursement/Billing	4%
Required Training for Certification	5%
Tasks Related to Running a Business* **enter zero if you are employed by an agency*	4%
Categories not mutually exclusive	

2. When thinking about the **past 12 months**, how many recipients did you assist with the following tasks. (please provide the number of individual recipients per task)

Fair hearing requests and supports

EMODs
environmental modification waiver services

Care Coordination Service Task	Average Recipients
Fair hearing requests and supports	2.0
EMODs	0.8

N=110

Care Coordination Evaluation Project

Section 6

Listed below are 12 work-related challenges identified by certified care coordinators in January 2022.

Please use the sliders to rate how each affects your work as a care coordinator, on a scale of 0 to 10.

1. The care coordination certification process is vague and time consuming.

Does not affect my work | Affects my work somewhat | Affects my work significantly

Rating Scale	0	1	2	3	4	5	6	7	8	9	10
Responses	4	8	4	11	8	28	11	6	13	6	18

N=117

2. ack of support for new care coordinators makes it difficult to increase care coordination capacity.

Does not affect my work | Affects my work somewhat | Affects my work significantly

Rating Scale	0	1	2	3	4	5	6	7	8	9	10
Responses	10	12	10	9	7	13	8	8	7	4	20

N=108

3. Within the Home and Community-Based Service system, the role and responsibilities of a certified care coordinator are <u>not widely understood</u>.

<table>
<tr><td></td><td></td><td>Affects my work
somewhat</td><td></td><td>Affects my work
significantly</td><td></td></tr>
<tr><td>Does not affect my work</td><td></td><td></td><td></td><td></td><td></td></tr>
</table>
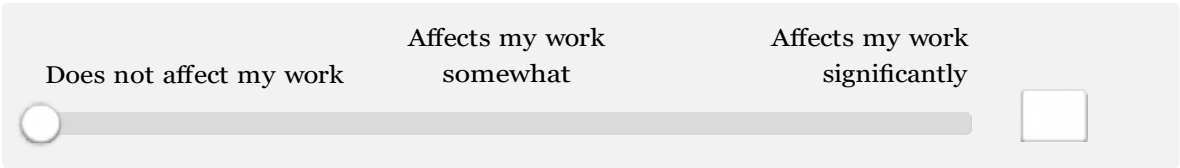
Rating Scale	0	1	2	3	4	5	6	7	8	9	10
Responses	3	4	4	3	3	22	10	14	18	11	20

N=112

4. Lack of <u>good communication</u> among those involved in the Home and Community-Based Service system makes it hard to meet deadlines and is time consuming.

<table>
<tr><td></td><td></td><td>Affects my work
somewhat</td><td></td><td>Affects my work
significantly</td><td></td></tr>
<tr><td>Does not affect my work</td><td></td><td></td><td></td><td></td><td></td></tr>
</table>
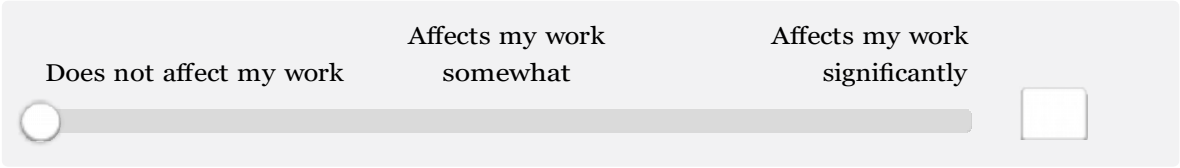
Rating Scale	0	1	2	3	4	5	6	7	8	9	10
Responses	1	7	10	6	4	21	3	17	12	10	23

N=114

5. The Community First Choice (CFC) program is not well understood and requires duplication of work.

	Does not affect my work	Affects my work somewhat	Affects my work significantly	
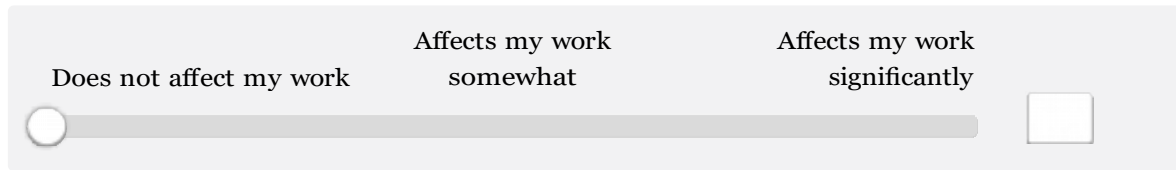
Rating Scale	0	1	2	3	4	5	6	7	8	9	10
Responses	2	3	2	3	2	15	5	7	18	9	47

N=113

6. Compensation levels are too low, given the work requirements.

	Does not affect my work	Affects my work somewhat	Affects my work significantly	
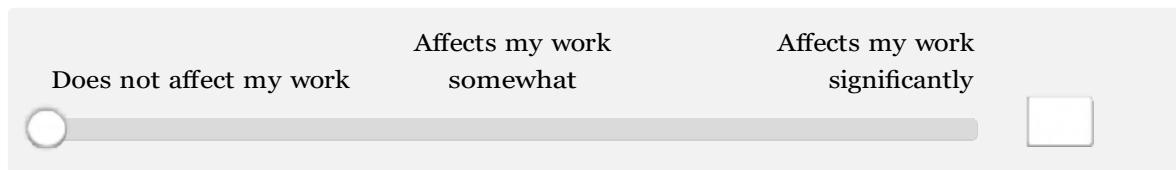
Rating Scale	0	1	2	3	4	5	6	7	8	9	10
Responses	3	1	4	5	5	15	6	7	22	3	43

N=114

7. Working within the Harmony data system is time consuming and restrictive.

	Does not affect my work	Affects my work somewhat	Affects my work significantly	
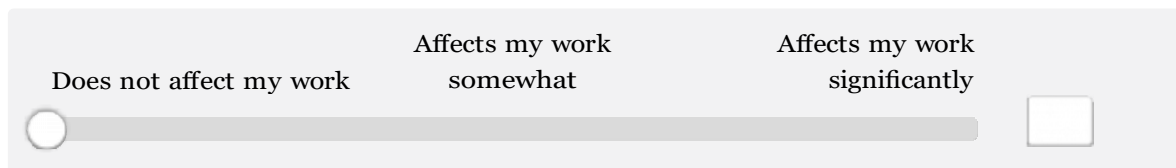
Rating Scale	0	1	2	3	4	5	6	7	8	9	10
Responses	5	10	3	5	4	17	4	10	7	13	37

N=115

8. The Home and Community-Based Service system is fragmented and inefficient, making it difficult to navigate and secure needed support for recipients of waiver services.

Does not affect my work	Affects my work somewhat	Affects my work significantly
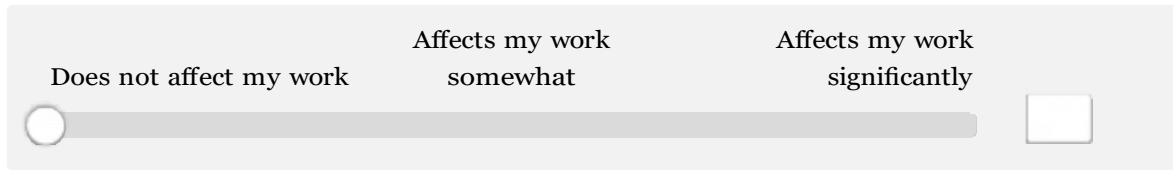
Rating Scale	0	1	2	3	4	5	6	7	8	9	10
Responses	1	8	4	5	8	9	8	13	13	16	28

N=113

9. The Home and Community-Based Service system is becoming less person-centered due to increased regulations/restrictions and less flexibility in how services are accessed and used.
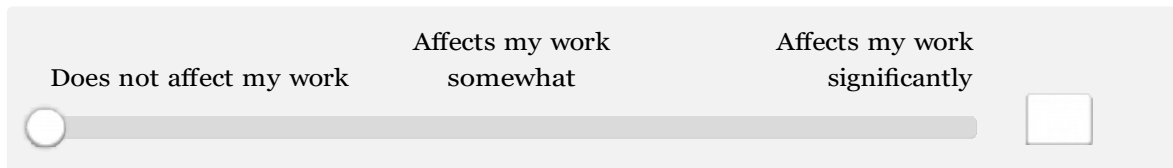
Does not affect my work	Affects my work somewhat	Affects my work significantly

Rating Scale	0	1	2	3	4	5	6	7	8	9	10
Responses	3	6	5	4	2	10	2	9	18	13	44

N=116

10. The reimbursement system for care coordination is time consuming with payments frequently delayed and denied.

Does not affect my work	Affects my work somewhat	Affects my work significantly

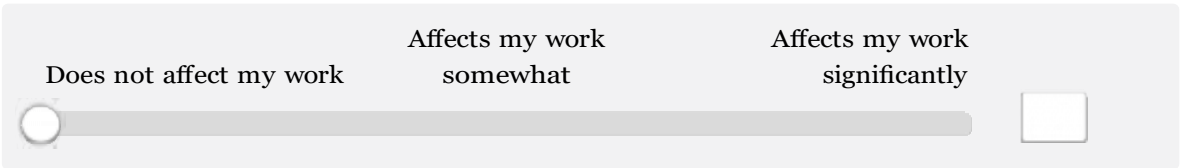| Rating Scale	0	1	2	3	4	5	6	7	8	9	10
Responses	14	12	5	6	6	26	3	7	6	7	13

N=105

11. The Senior and Disabilities Services Training Unit does not adequately meet care coordinator training or ongoing support needs.

Does not affect my work   Affects my work somewhat   Affects my work significantly
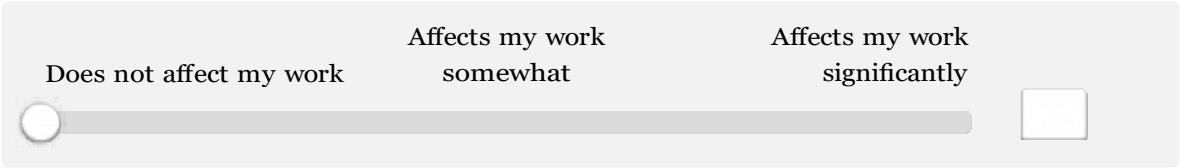
Rating Scale	0	1	2	3	4	5	6	7	8	9	10
Responses	10	14	5	13	5	24	12	6	10	3	11

N=113

12. The waiver application and support plan requirements are applied inconsistently, with differing interpretations of regulations and care coordinator expectations within the Division of Senior and Disabilities Services.

Does not affect my work   Affects my work somewhat   Affects my work significantly

Rating Scale	0	1	2	3	4	5	6	7	8	9	10
Responses	4	6	2	1	5	18	8	19	16	10	28

N=117

13. If you would like to provide additional information about how the challenges listed above affect your care coordination work, please use the box below.

14. If you would you like to provide information about other challenges affecting your care coordination work that are not listed above, please use the box below.

Care Coordination Evaluation Project

Section 7

Please provide information about the effectiveness of the Division of Senior and Disabilities Services (SDS) Training Unit.

1. Please use the slider to rate how effective the SDS Training Unit is at assisting you to meet your care coordination responsibilities, on a scale of 0 to 10.

Not Helpful   Helpful   Very Helpful

Rating Scale	0	1	2	3	4	5	6	7	8	9	10
Responses	2	5	10	11	8	23	11	14	9	7	17

N=117

2. How can the SDS Training Unit improve their training and support for certified care coordinators?

3. How can the SDS Training Unit improve their training and support for people new to the care coordination profession?

Care Coordination Evaluation Project

Section 8

Please provide information about the effectiveness of the Division of Senior and Disabilities Services (SDS) Certification Unit.

1. Please use the slider to rate how effective the SDS Certification Unit was at assisting you to **become** a certified care coordinator, on a scale of 0 to 10.

Not Helpful   Helpful   Very Helpful

Rating Scale	0	1	2	3	4	5	6	7	8	9	10
Responses	9	9	15	7	5	24	6	8	6	4	16

N=109

2. Please use the slider to rate how effective the SDS Certification Unit is at assisting you to **maintain** your care coordination certification, on a scale of 0 to 10.

Not Helpful   Helpful   Very Helpful

Rating Scale	0	1	2	3	4	5	6	7	8	9	10
Responses	7	17	13	7	2	25	7	10	6	6	12

N=112

3. How can the SDS Certification Unit improve their assistance with the initial/renewal certification process?

Care Coordination Evaluation Project

Section 9

Please provide information about the effectiveness of the Division of Senior and Disabilities Services (SDS) IDD Waiver Unit.

1. Please use the slider to rate how effective the SDS IDD Waiver Unit is at assisting you to meet your care coordination responsibilities, on a scale of 0 to 10.

Not Helpful	Helpful	Very Helpful

Rating Scale	0	1	2	3	4	5	6	7	8	9	10
Responses	1	8	3	8	8	29	12	7	15	8	11

N=110

2. How can the SDS IDD Waiver Unit improve their overall effectiveness?

Care Coordination Evaluation Project

Section 10

Please provide information about the effectiveness of the Division of Senior and Disabilities Services (SDS) NFLOC Waiver Unit.

1. Please use the slider to rate how effective the SDS NFLOC Waiver Unit is at assisting you to meet your care coordination responsibilities, on a scale of 0 to 10.

Not Helpful   Helpful   Very Helpful

Rating Scale	0	1	2	3	4	5	6	7	8	9	10
Responses	3	16	14	10	9	24	10	8	5	2	6

N=107

2. How can the SDS NFLOC Waiver Unit improve their overall effectiveness?

Care Coordination Evaluation Project

Section 11

Please provide suggestions for ways to increase the number of certified care coordinators in Alaska.

1. Ways to recruit people to the care coordination profession:

2. Ways the Division of Senior and Disabilities Services can support people new to the care coordination profession:

3. Ways to retain experienced care coordinators:

Care Coordination Evaluation Project

Section 12

You're almost done!

Please provide information about your satisfaction with the care coordination profession.

1. Thinking about how you feel today, please use the slider to rate your overall job satisfaction as a certified care coordinator in Alaska, on a scale of 0 to 10.

Not Satisfied   Satisfied   Very Satisfied

Rating Scale	0	1	2	3	4	5	6	7	8	9	10
Responses	4	4	5	4	15	30	9	10	15	10	11

N=117

2. Do you plan to leave the care coordination profession within the next five years?

◯ Yes

◯ No

◯ Other (please specify)

◯ Prefer not to respond

Plan to Leave within 5 Years	Number of Respondents
Yes	26
No	42
Other (please specify)	39
Prefer not to respond	10

N=117

Care Coordination Evaluation Project

Section 13

Last section! Just a few questions about your demographics.

1. What is your gender identify?

   ○ Woman

   ○ Man

   ○ Non-binary

   ○ Prefer to self-describe:

   [   ]

   ○ Prefer not to respond

Gender Identity	Number of Respondents
Woman	91
Man	19
Prefer to self-describe	2
Prefer not to respond	4

N=116

2. What is your age?

   ○ Under 30 years old

   ○ 30 to 39 years old

   ○ 40 to 49 years old

   ○ 50 to 59 years old

   ○ Over 59 years old

   ○ Prefer not to respond

Age	Number of Respondents
Under 30 years old	5
30 to 39 years old	27
40 to 49 years old	35
50 to 59 years old	19
Over 59 years old	23
Prefer not to respond	7

N=116

3. Please specify your ethnicity. (check all that apply)

☐ White or Caucasian ☐ Hispanic or Latino

☐ Alaska Native ☐ Asian or Asian American

☐ Black or African American ☐ Native Hawaiian or other Pacific Islander

☐ Native American

☐ Other (please specify)

[ ]

☐ Prefer not to respond

Ethnicity	Number of Respondents
White or Caucasian	85
Alaska Native	11
Black or African American	4
Native American	4
Hispanic or Latino	4
Asian or Asian American	8
Native Hawaiian or other Pacific Islander	0
Other (please specify)	1
Prefer not to respond	12

Categories not mutually exclusive

4. In what geographic region do you reside?

[▲▼]

[ ]

Geographic Region Reside	Number of Respondents
Anchorage Region	48
Mat-Su Region	28
Kenai Peninsula Region	13
Fairbanks Region	8
Juneau Region	6
Arctic Region	4
Southeast Small Communities	4
Bethel / Dillingham Region	2
Prince William Sound Region	2
Kodiak Region	1
Prefer not to respond	1

N=116

5. What is the highest degree or level of education you have completed?

	▲▼

Highest Degree or Level Education Completed	Number of Respondents
High School or equivalent (e.g., GED)	4
Vocational degree (e.g., certificate, diploma, apprenticeship)	4
Some college, no degree	22
Associate degree (e.g., AA, AS)	14
Bachelor's degree (e.g., BA, BS)	49
Master's degree (e.g., MA, MS, MEd, MSW)	19
Prefer not to respond	5

N=117

Care Coordination Evaluation Project

You made it!

Thank you for taking the time to complete this survey. Your participation is greatly appreciated.

After you click 'submit' you will receive a confirmation email with a copy of your survey responses.