

**VHA PROSTHETIC CLINICAL MANAGEMENT PROGRAM (PCMP)  
CLINICAL PRACTICE RECOMMENDATIONS  
FOR THE ORDERING OF CARE COORDINATION AND TELEHEALTH  
DEVICES FOR VETERAN PATIENTS**

**I. PURPOSE**

The purpose of these clinical practice recommendations (CPRs) is to assist VHA practitioners in determining the appropriate technology to use for care coordination home telehealth and at the same time to standardize the technology, thereby optimizing the delivery of quality patient care and promoting safe, timely and cost-effective use of emerging health care technologies. These CPRs address the routine use of technology in clinical practice but not research applications.

**II. BACKGROUND**

VHA's Prosthetic and Sensory Aids Service Strategic Healthcare Group (PSAS SHG) was directed by the Under Secretary for Health to establish a Prosthetic Clinical Management Program (PCMP). The objectives are to coordinate the development of clinical practice recommendations for prosthetic prescription practices and contracting opportunities to assure technology uniformity and ease of access to prosthetic prescriptions and patient care that will lead to valid outcome measures.

The VHA Office of Care Coordination (OCC) was charged in FY 2003 and FY 2004 to implement care coordination programs in all 21 VISNs. Care coordination programs exist in VISNs 1, 2, 8, 11 and 17. Further expansion of care coordination programs will take place using existing staff and the OCC is providing home telehealth technologies of a value up to \$1 Million per VISN to enable programs to be established. VISNs 1, 2, 8, 11, 17 have already received such funding and the remaining 16 VISNs will be funded under one of two Requests For Proposals (RFP). The first Information Letter 10-2003-004 was issued in August 2003 and is funding six more VISNs 9, 10, 15, 18, 19 and 23. The remaining VISNs will receive funding under another RFP which will go out between December 2003 and February 2004.

Delays in contracting for equipment when developing previous programs, lack of standardization of equipment and variations in prices and discounts available from VISN to VISN have encouraged OCC to develop national contracts for care coordination technologies. Since there is an existing process to develop national contracts, purchase from vendors, distribute equipment and enable clinicians to order technologies for patients within the PSAS SHG, OCC is collaborating with PSAS SHG to use their system. The other purpose in developing national contracts

is to use this purchasing leverage to encourage vendors to integrate these technologies with the VHA's Computerized Patient Record System (CPRS).

This Clinical Practice Recommendation has been prepared with input from selected clinicians and staff from OCC and the PSAS SHG.

### III. BUDGETARY SYSTEMS

It is important to note that during FY 2004 care coordination and home telehealth devices will be purchased via the PCMP but not from the VISN Prosthetics budget. In determining how the equipment is ordered, it is important that VISNs understand whether they are:

- A. Ordering care coordination or home telehealth technologies under a VACO care coordination expansion program**, e.g., Information Letter 10-2003-004 *or* the subsequent RFP that will be issued between December 2003 and February 2004 and therefore, excludes VISNs 1, 2, 8,11 and 17 because they have already received this funding.

VISNs that have VACO centralized funding under an RFP will establish a local VISN Prosthetics account specifically for this purpose. The \$1 million will be placed in this account and programs within the VISN can draw down on this account to order equipment up to the value of the account. This funding cannot be used for other non-care coordination/home telehealth equipment purchases.

- B. Ordering equipment outside a VACO care coordination expansion program irrespective of whether they are also receiving funding under an RFP such as Information Letter 10-2003-004 or the subsequent RFP that will be issued between October 2003 and January 2004.** For example, some VISNs have determined that they will use funds from their own VISN in addition to any centralized funding to expand care coordination or purchase home telehealth equipment.
- C.** Regardless of your particular funding source, the facility is required to use Cost Center 8272 and Budget Object Code 3131 to purchase the devices. The devices will be purchased by Prosthetic and Sensory Aids Service through the Prosthetic Software Package.

Ordering care coordination or home telehealth technologies in situations other than under a VACO care coordination expansion program.

Again, it is important to reiterate that currently care coordination and home telehealth equipment is not funded through the Prosthetics budget. The arrangement with Prosthetics is to take advantage of mechanisms for contracting equipment, supplies, and tracking of equipment. Therefore, if a VISN wishes to purchase care coordination/home telehealth equipment, General Purpose funding needs to be

placed into an account within Prosthetics from which the required equipment purchases can be funded.

When practitioners within VISN programs are ordering equipment they need to have a process in place that makes sure that equipment is ordered from the correct account if this is an issue for the VISN.

#### **IV. ORDERING EQUIPMENT**

**Care coordination/home telehealth technologies** have been available to veteran users since the 1990s. Over the years, these have become a commonly used device for all manner of healthcare problem management and monitoring. In July of 2003, the Under Secretary for Health created the Office of Care Coordination whose mission is to assist VHA staff in the deploying these technologies with the specific aim of ensuring that veteran patients received the right care in the right place at the right time. Care coordination enables disease management and home telehealth technologies to supplement care management and case management in a range of conditions to make this mission successful. Care coordination, therefore, involves instituting safe, effective and cost-effective ways to interface the clinical, technical and managerial aspects of home telehealth and disease management technologies into routine care. For this reason, the title "Care Coordination" is preferred to "Home Telehealth" because it implicitly requires these safe, effective and cost-effective processes to be instituted. Therefore, in the remainder of this document the term "Care Coordination/Home Telehealth" will be used.

##### **What Are Care Coordination Technologies?**

Care coordination technologies are home telehealth technologies that are suitable to use in managing the care of patients using care coordination and that have been selected through a competitive bidding process to become part of a national contract that has been negotiated by the VHA National Acquisition Center (NAC). Details of the solicitation under which these technologies were selected are available from the VA Business Opportunities Web Page <http://www.va.gov/osdbu/opps/busops.htm>

These technologies consist of:

- a) Computers and Software
- b) Wound care cameras
- c) Videophones
- d) Disease messaging devices
- e) Home telemonitors
- f) Medication dispensers and reminders

### How to order care coordination technologies?

The ordering of care coordination technologies will be considered under the following elements:

1. What are the care coordination technologies?
2. Technology Inventory in a care coordination program.
3. Who can select a care coordination technology for a patient?
4. How is a particular technology selected for a patient?
5. How is a particular technology provided for a specific patient?
6. How is a technology ordered for a specific patient?
7. How to refurbish technologies after use (where applicable).
8. How to deal with defective equipment.

### Technology Inventory in a Care Coordination Program

It is sometimes necessary for a VHA Care Coordinator to travel long distances to deliver home telehealth equipment and although the technology algorithm that is described below may suggest one technology to use when a home assessment takes place, it may sometimes lead to choosing another technology instead. For this reason, and in case of equipment malfunction, it is therefore recommended that two items of each technology that a patient is likely to use be in the Care Coordinator's possession when visiting the patient at home. Sometimes equipment is defective or idiosyncrasies relating to the baud rates of telephones mean that a piece of equipment will not work. For this reason, it is recommended that each program should keep a 30 day supply inventory of equipment. For care coordination programs just starting out with the expectation of less than 50 patients, four pieces of each supply inventory equipment is recommended. For programs enrolling 150 patients or greater, 12 pieces of each supply inventory of equipment is recommended.

### Who Can Select a Care Coordination Technology for a Particular Patient?

Licensed practitioners involved in care coordination can order care coordination technologies. These practitioners may be full time Care Coordinators or other licensed practitioners who have care coordination skills and competencies. The care coordination competencies these licensed practitioners should have include:

- a) Assessment Skills
- b) Ability to use technology and an understanding of how disease management tools offer a population-based approach to deliver care.

These skills and competencies are further defined in attached Appendices. If a practitioner is not a full time Care Coordinator but another licensed practitioner and undertaking a Care Coordinator function, the appropriate elements from the Appendices should be added to their functional statement/position description. Both full time Care Coordinators and licensed practitioners with coordinator skills and

competencies will be referred to as "Care Coordinators" throughout the remainder of this document.

How is a particular technology selected for a patient?

For each patient that is being assessed for his/her suitability to be cared for in a care coordination program, specific inclusion/exclusion criteria developed by local programs must be used. If a patient meets the inclusion criteria, then the correct technology to use should be selected using the Care Coordination Technology Algorithm provided in Appendix G and the Care Coordination process outlined in Appendix H.

How is a particular technology provided for a specific patient?

The Care Coordinator visiting the patient in his/her home should carry two items of each technology that the patient may be suitable to use; in the event one piece of technology malfunctions. The Care Coordinator will assess the patient's ability to use the technology, using the suggested technology algorithm. In order to provide the selected technology to the patient, it is necessary to educate the patient and/or home care giver on the use of the equipment and fill in the following forms that need to be developed by local programs:

- a. The Patient Consent Document
- b. Written Patient Acceptance of Receipt of Technology

The serial number of the device must be recorded on a copy of the "Patient Acceptance of Receipt of the Technology Form" so that the electronic Prosthetic consult can be made.

How is a technology ordered for a specific patient?

Once the Care Coordinator has returned to the VAMC, an electronic Prosthetic consult must be entered into CPRS, ordering the selected Care Coordination/Home Telehealth technology(ies) with each serial number and Health Care Financing Administration Common Procedures Coding System (HCPCS) code included for the patient. The correct PSAS HCPCS code to be selected and entered on the electronic Prosthetic consult will be:

- TM100 Telemed Home Computer/Equipment
- TM101 Telemed Video Monitor
- TM102 Telemed Home Equipment
- TM103 Telemed Message./Monitoring
- TM104 Telemed Audio/Video
- TM105 Telemed Wound Care

Once the Care Coordinator has signed off electronically on the Prosthetic consult, it will automatically print in the Prosthetic activity location. The Prosthetic activity will then order a replacement home telehealth technology(ies) for the Care Coordinator's

inventory and notify the Care Coordinator of its arrival.

#### How to refurbish technologies after use (where applicable)?

After a patient has finished with a telehealth equipment that has been used to care coordinate his/her care, the Care Coordinator will make arrangements to retrieve the equipment. The Care Coordinator will then provide a receipt for the equipment to the patient and contact the local Prosthetics activity so that the serial number of the equipment can be detached from the patient it was originally assigned to and reassigned to Biomedical Engineering Department (in-house) or sent to the equipment vendor for refurbishing, calibration check, and sterilization. Biomedical Engineering will inform Prosthetics of the equipments location throughout the refurbishing process.

The Biomedical Engineering Department will determine whether the equipment needs to be refurbished in-house or sent to the equipment vendor. If the equipment can to be refurbished in-house, the Biomedical Engineering Department will do this. When the equipment has been refurbished it will be sent back to the local Care Coordination office where it will be stocked in inventory and Prosthetics contacted to record this reassignment.

If the equipment is re-furbished by the equipment vendor, Biomedical Engineering Department will arrange at VHA's expense for the shipping of the equipment to the vendor. Details of the addresses to which the various technologies need to be sent will be provided to the Biomedical Engineering Department. Prosthetics will be contacted to inform them that the equipment has been sent for refurbishment.

After refurbishment, the equipment will be returned to the Biomedical Engineering Department at the equipment vendor's expense and checked by Biomedical Engineering Department prior to return to the local Care Coordination inventory. Prosthetics will be informed of the equipment whereabouts.

#### How to deal with defective equipment?

In the event that equipment is found to be defective when issued to a patient (either new or refurbished), it will be taken to Biomedical Engineering Department for return to the equipment vendor for replacement. Prosthetics will be contacted to provide information for equipment tracking purposes and also to keep a tally of defective products for contract monitoring purposes.

## **V. QUALITY STANDARDS**

The following quality standards must be met for technology provision to all care coordination patients:

- A. Use of the device must have been determined by a licensed professional (physician, advanced practice nurse, registered nurse, social worker,

rehab therapist, dietitian or pharmacist) to meet clinical, functional, and resource utilization enrollment criteria set by a Care Coordination program. This means that health care professionals, within the scope of their position description, must have the ability to access patients using home health technologies and react satisfactory to associated disease management information.

- B. The patient must complete a training session on the device to determine competency and safety of use and have agreed through informed consent to have the device installed in their place of residence. The training session and safety review will evaluate the veteran's ability to benefit from the device or devices installed.
- C. There must be a stated plan in the patient's chart that incorporates the use of a device.
- D. The patient must express an interest in using the device as recommended to accomplish goal(s).
- E. The patient must demonstrate the ability to independently and safely use the device to effectively meet the stated goal(s). See Appendix A.

#### **VI. INTERNAL VHA CONDITIONS OF PARTICIPATION FOR CARE COORDINATION PROGRAMS: PROPOSED STANDARDS RELATING TO EQUIPMENT ORDERING**

The Care Coordination program staff may provide a home telehealth technology on an outpatient or inpatient care basis such as, but not limited to, i.e., Community Care Coordination Program (CCCS), Case Management Program, Primary Care Clinic, Geriatric Care Clinic, Mental Health Clinic, SCI Program or Home-based Primary Care Program. In whatever setting, the following criteria must be in place to ensure VA issuance of care coordination and telehealth devices is safe and appropriate. The outpatient or inpatient program must therefore have:

- A Care Coordinator and a clearly defined Care Coordination and Telehealth Program, including a policy and procedure manual that outlines procedures for evaluation and training on care coordination and telehealth devices and a performance improvement plan.
- Documented evidence of an ongoing program of quality assurance in order to maintain the highest level of care.
- Appropriate documentation in the medical record that clearly identifies the training provided and the veteran's ability to achieve the stated goal(s).

- The care coordination and telehealth device should be evaluated in conjunction with other traditional care management approaches that may also achieve the stated goal(s).
- When the veteran presents with a healthcare, functional or social issue requiring management that cannot be adequately addressed with the care coordination and telehealth device, then the appropriate alternative may be evaluated.
- When the veteran's goals necessitate intensive monitoring and management, issuance of more than one type of care coordination and telehealth device may be justified.
- Veterans with a demonstrated need for an audio-video telehealth device and an in-home messaging or camera device may be issued all devices.

#### V. REFERENCES

1. VHA Directive # 2002-042 The Credentialing and Privileging of VHA Health Care Providers Remotely Delivering Health Care to Patients at Home, In Vet Centers, and In Non-health Care Settings via Telemedicine and/or Telehealth. <http://www.va.gov/publ/direc/health/direct/12002042.pdf>
2. Information Letter 10-2003-004 Request for Proposals (RFP) for Care Coordination Implementation Projects. <http://www.va.gov/publ/direc/health/infolet/10200304.pdf>

APPROVED/DISAPPROVED:



Robert H. Roswell, M.D.  
Under Secretary for Health

Date: **MAR 09 2004**



## Appendix A. Draft Patient Training Outcomes

At the conclusion of training, the veteran must be able to demonstrate the ability to independently and safely operate the care coordination and telehealth device to achieve the stated goal(s) for his treatment plan. Outcomes may include the following:

1. Ability to understand power and phone connections.
2. Ability to turn device on and off.
3. Ability to appropriately adjust device settings as instructed for viewing information, images or other objects.
4. Ability to clean, care for, maintain and trouble shoot the device as instructed and when appropriate to do so.
5. Understanding the potential uses of the device, and when the device will be ineffectual or inappropriate.
6. Ability to properly position materials or objects to maintain proper focus when appropriate.
7. Understands procedure for when and how to contact VA staff for any problems related to the device.
8. Understands procedure for returning equipment upon discharge from the program

**APPENDIX B:**  
**Draft Memo to Chief of Staff on Prescribing Authority**

TO: Chief of Staff (medical center name and mailing symbol)  
FROM: Care Coordination Program name/Service Chief  
RE: Prescription for Care Coordination and Telehealth Devices through  
Prosthetics Service  
Date:

1. The (program name) staff are requesting designation as prescribing authorities for care coordination and telehealth devices through the use of the electronic Prosthetics consult.

**Staff names and titles:**

- a. (list all licensed and competent staff and position titles here)
  - b.
2. These individuals are licensed and have had the necessary competencies to install and educate patients on these devices.
  3. The Prosthetics Clinical management Program Memo (see attached) outlines specifics related to this request.

Thank you for your time and consideration in this matter.

**APPENDIX C  
DRAFT IMPLEMENTATION PROCESS  
CARE COORDINATION & TELEHEALTH DEVICES**

PROCESS STEP	RESPONSIBLE PARTY
1. Care Coordination/Telehealth Program is authorized to prescribe equipment (Care Coordination /Telehealth Program meets the Conditions of Participation for use of Telehealth Devices) .	OCC QM in collaboration with local program manager/staff.
2. Memo to Chief of Staff at local medical center or satellite is initiated to identify authorized clinicians for consult ordering of devices.	Local program manager and staff to initiate memo.
3. Training for electronic consult ordering and option in CPRS menu for all appropriate staff not already trained.	Local program manager alerts Information Services to schedule training or provide consult ordering in CPRS menu option.
4. Chief of Staff memo maintained to identify authorized clinicians	Prosthetics Service designee
5. Set-up an inventory of equipment to include a minimum of (12) for large programs (150 or > patient total) and a minimum of (5) for smaller programs (< 150 patients). This will allow for less than a 24-hour turnaround for patient enrollment if needed and also allow staff to bring multiple types of equipment to the patient's home to assess appropriate level of technology needed.	Prosthetics Service to set up inventory and ensure delivery of equipment to local program staff.  Local program staff to designate storage space for inventory and make assessment on appropriate type of equipment is given to patient.
6. Equipment is delivered to patient's home or given to patient in clinic for potential installation. Once installed the patient is educated on the equipment, patient rights and responsibilities related to equipment, and who and when to call for equipment-related issues.	Local program staff
7. Progress note detailing patient encounter, informed consent, assessment, education, and installation of equipment is entered into CPRS.	Local program staff
8. Consult completed to Prosthetics for each individual patient with device type, serial numbers and any other pertinent data for tracking.	Authorized local program clinicians
9. Pick-up and return of equipment from a discharged patient.	Local program staff to send to Biomedical Engineering Service for disinfection and recalibration if appropriate and return to Prosthetics to return to inventory for reuse.
10. Pick-up and return of malfunctioning equipment from a patient.	Local program staff to trouble-shoot with vendor, if unsuccessful equipment will be returned to Biomedical Engineering Service for mailing back to vendor.

## **APPENDIX D**

### **Office of Care Coordination Suggested Care Coordinator Title 38: Generic Functional Statement**

#### **ROLE DEFINITION:**

A Care Coordinator is a professional who coordinates care for a panel of patients throughout the continuum of care to assure that care is timely, appropriate, of high quality and cost effective. A Care Coordinator works closely with the primary care provider (or providers) and other healthcare professionals and team members, other clinics, internal or external services and community agencies.

He/she provides professional assessment, coordination and planning of multiple health care services; acts on behalf of the veteran to assure that necessary clinical services are received and that progress is being made. In addition the Care Coordinator provides ongoing evaluation of care management services.

#### **B. QUALIFICATIONS:**

1. Meets all the basic requirements for Title 38 appointment in the Veterans Health Administration.
2. Educationally prepared at the baccalaureate level or higher. Masters Degree Preferred.
3. Minimum of three years of successful clinical practice.
4. Demonstrated ability in the areas of interpersonal relations, critical thinking, and problem-solving and conflict resolution.

#### **FUNCTIONS AND RESPONSIBILITIES:**

##### **1. Clinical Practice**

- a) Provides initial and ongoing assessment of patients to identify needs issues, care goals and appropriate resources necessary for care management.
- b) Provides leadership in application of the nursing process and identifies resources and critical factors for achieving desired outcomes for discharge, post hospitalization recovery and health maintenance/improvement.
- c) Sets clinical care goals, short and long term, in collaboration with patient, provider(s), and family members.
- d) Functions as a systems coordinator for the plan of care; monitors progress through the expected hospital course and intervenes as appropriate to facilitate achieving patient outcomes within anticipated timeframes. Coordinates care and discharge planning with the patient's primary care provider and team.

- e) Collaborates with patient and care providers in any and all settings where care is being provided to evaluate and update changes in the therapeutic plan of care and patient management.
- f) Recognizes complex situations that impact patient care and intervenes, using sound judgment, professional attitude and appropriate channels.
- g) Recognizes impact of age-specific care needs and incorporates this into the assessment process. Also, incorporates these age-specific needs into care as reflected by modification of treatment plans.
- h) Maintains a working Knowledge of resources available in the community
- i) Appropriately documents own interventions and oversee appropriate health team documentation of patient care.
- j.) Assesses patients for use of appropriate telehealth devices, follows procedures for ordering through Prosthetics Service, documents installation and education in computerized medical record.

## **2. Quality of Care**

- a) Develops and leads interdisciplinary teams to improve organizational performance.
- b) Participates in performance improvement activities related to the service line quality improvement process.
- c) Evaluates need and initiates interdisciplinary ad hoc committees/process action teams for constructive problem solving.
- d) Tracks and trends issues related to care delivery and role implementation.

## **3. Performance**

- a) Develops and implements interdisciplinary standards of practice and care at the station level for the Care Coordinator role.
- b) Participates in VISN-wide standards development for the role.

## **4. Education/Career Development**

- a) Identifies personal learning needs and assumes responsibility for own professional growth.
- b) Develops and implements an educational plan to enhance program development and professional performance.

- c) Develops coordinates and presents educational programs toward improving productivity, patient outcomes and treatment modalities.
- d) Serves as a preceptor for students seeking learning experiences on a graduate level and evaluates outcomes.

#### **5. Collegiality**

- a) Leads and works collaboratively with interdisciplinary groups in a cohesive manner.
- b) Communicates effectively with patients, families/significant others and the health team members.
- c) Facilitates open dialogue among peers, supervisors and staff.

#### **Ethics**

- a) Conducts self in a professional manner in many clinical and administrative settings.
- b) Provides leadership to the interdisciplinary team in identification and addressing of ethical issues surrounding care management and professional practice.
- c) Participates in ethics consultations in clinical settings across the continuum.

#### **6. Research**

- a) Bases practice on current knowledge/technological advances and/or research findings.
- b) Participates in interdisciplinary research-related activities as appropriate.

#### **7. Collaboration**

- a) Develops and leads interdisciplinary groups as appropriate.
- b) Establishes ongoing relationships with professional/health related groups within the community.
- c) Fosters good public relations when interpreting philosophy, policies/procedures, goals and objectives to staff, patients and the public.

#### **8. Resource Utilization**

- a) Advocates fiscal responsibility in the management of patient care through effective utilization of resources.
- b) Demonstrates effective program resource management skills (including documenting and reporting

#### **Evaluation and Supervision:**

- a) The Care Coordinator is programmatically responsible to the designated program oversight for the local medical center in accordance with station level assignment.
- b) He/She participates regularly in peer review activities.
- c) Annual performance evaluation will be a collaborative effort between the employee and the station level supervisor with additional input from the VISN Community Care Coordination Service (CCCS) Clinical Program Manager as appropriate.

## APPENDIX E

### **Office of Care Coordination Suggested Care Coordinator Generic Social Worker Title V Position Description**

- A. Care Management is a process that increases the likelihood that a patient will receive easily accessible, coordinated, continuous, high quality health care across all settings, including home. Care Management uses evidence-based medicine and best practices, technology, health education materials, nursing and other clinical disciplines' expertise, to manage the health care process and limit the inappropriate use of health care services.
- B. A Care Coordinator is a professional who coordinates care for a panel of patients throughout the continuum of care to assure that care is timely, appropriate, of high quality and cost effective. A Care Coordinator works closely with the primary care provider (or providers) and other healthcare professionals and team members, other clinics, internal or external services and community agencies. He/she provides professional assessment, coordination and planning of multiple health care services; acts on behalf of the veteran to assure that necessary clinical services are received and that progress is being made. In addition the Care Coordinator provides ongoing evaluation of care management services.

#### **Major Duties:**

- 1 The incumbent provides professional assessment to an adult population of predominantly older, male patients.
2. The individual must demonstrate the knowledge of age-related factors, changes associated with aging and possess the ability to provide care as noted in age-specific competencies described in network and station policies and procedures. The Care Coordinator especially focuses on the patient in the context of family, home and community by integrating an assessment of living conditions, individual, family dynamics, and cultural background into the patient's plan of care.
3. The Care Coordinator is responsible for coordinating the appropriate intensity of care management for his/her panel. It is recognized that manageable panel sizes will vary depending on the case-mix of the panel. Care management is focused primarily on providing more coordinated and higher quality care to complex clinical cases with a goal of reducing the cost.
4. The Care Coordinator provides and coordinates services by assessing the needs of the client and the client's family. When appropriate, arranges, coordinates, monitors, evaluates,, and advocates for a package of multiple services to meet the specific client's complex needs.
5. Care Management Services are carried out in full accordance with the broad program goals of the VA health care system. Within these broad categorizations, the Care Coordinator must



assess and tailor patient care/support services. Through assessment of each veteran's needs, he/she then facilitate the delivery of services that are most responsive to the concerns of individual patients to the extent possible.

6. The Care Coordinator establishes methods for tracking patients' progress, evaluating effectiveness of care, and maintains appropriate documentation of each patient's care and progress within the plan.
7. Assesses patients for use of appropriate telehealth devices, follows procedures for ordering through Prosthetics Service, documents installation and education in computerized medical record.

**Factor 1. Knowledge required by the Position**

- A. The employee must be able to demonstrate the knowledge and skills necessary to provide care appropriate to the age and complexity of the patients served in his/her assigned service area.
- B. The individual must demonstrate knowledge of the changes associated with aging and the principles of growth and development relevant to the adult and geriatric patient group. Incumbent must have knowledge and the ability to apply developmental theory and age specific issues.
- C. He or she must be able to access and interpret data about the patient's social, emotional, mental health, medical needs and coordinate the care/services needed.
- D. The incumbent must have knowledge of the vast array of VA, federal, state and local community agencies and resources and how to access and coordinate those services.
- E. The incumbent must be able to demonstrate the knowledge and skills as identified in the Competency Assessment Checklist developed for this position.
- F. The incumbent must demonstrate knowledge and skills in interpersonal relations. This includes the ability to appropriately, professionally and courteously relate to internal and external customers.
- G. The incumbent must demonstrate the knowledge and skills to complete job assignments and safely and correctly operate equipment necessary to complete the duties of the position.
- H. The incumbent is required to meet minimum OPM Qualification Standards for General Schedule Positions and/or VA Qualification Standards, MP-5, Part 1, Chapter 338.
- I. The incumbent has knowledge of population characteristics including cultural, ethnic, gender, and religious diversity. He/she must have knowledge of family dynamics, psychotherapy, developmental theory and interpersonal relationships and systems approach to clinical care.

- J. Incumbent maintain knowledge about disease processes, disabilities, medications and their clinical sequelae.
- K. Incumbent participates in regular peer review and performance improvement activities.
- L. Incumbent may serve as a preceptor or field instructor for students at the undergraduate, graduate or doctoral level.
- M. Incumbent must have knowledge of current VA and non-VA entitlements and benefits. Must have knowledge of terminal illness and end of life planning processes.
- N. Incumbent must have knowledge of medical, legal and ethical issues.

**Factor 2. Supervisory Controls**

A. Supervision is of a consultative nature and is usually arranged at the Care Coordinator's request to seek assistance with unusually complicated direct service work and for clarification of administrative issues. In the performance of the majority of activities, the incumbent exercises independent professional judgment working in the context of a multidisciplinary or interdisciplinary team. This ability is required to make independent decisions when working with the primary care team/provider while remaining an advocate for the patient/family.

B. The Care Coordinator is programmatically responsible to the designated program oversight for the local medical center in accordance with station level assignment.

C. Annual performance evaluation will be a collaborative effort between the employee and the station level supervisor with additional input from the VISN Community Care Coordination Service (CCCS) Clinical Program Manager as appropriate.

**Factor 3. Guidelines**

Incumbent is guided by VA Headquarters' directives, centralized network product line policies, bulletins, procedures, and supervisory instructions.

Highly developed professional skills, flexibility, mature professional judgment, and knowledge of a variety of advanced treatment modalities are required to make assessments and to intervene in complex and emergent case situations.

**Factor 4. Complexity**

In performing his/her duties, the incumbent works with clients whose socioeconomic and health-related problems vary in complexity. Because the level of difficulty frequently cannot be determined prior to the Care Coordinator's involvement in individual cases, the incumbent must independently make sound treatment decisions based on assessments, sometimes utilizing standardized assessment tools, and skillfully execute interventions for the most difficult cases.

In all cases, the Care Coordinator must make accurate and ongoing assessments of the patient's clinical and social problems and needs, and be aware of procedures to support the veteran physically and financially in the community. The incumbent must be able to effectively work with clients and families. The Care Coordinator provides assistance, information and support to patients/families in coping with emotional, practical and lifestyle issues, which accompany advancing age and physical, sensory, and cognitive impairments. He/she assists with development of processes to coordinate care along the continuum encouraging exploration of creative alternatives for care, enhancing communication with others, and helps to screen for problems that should be brought to the attention of the primary care provider. Assessment skills are appropriately utilized while articulating to members of the primary care team the needs of the patient. Initiative is taken to monitor appropriate level of care and length of stay in acute care to ensure cost effective care. While cost is a consideration, the overall goal of the Care Coordinator is to assure that the patient has the appropriate level of care and services to meet the social and health care needs. The incumbent may also perform a variety of mediating roles in promoting effective and efficient use of treatment services and the health care system.

**Factor 5. Scope and Effect**

The Care Coordinator is responsible for coordinating the development and implementing of the biopsychosocial treatment plan in collaboration with the primary care team/provider, across all settings, including the home. This responsibility requires considerable expertise and skill, as well as maintenance of an effective balance between the needs of the patients and families and the priorities of the Medical Center, the Sunshine Network and the VA health care system. The challenge of this assignment lies in skillfully developing an effective biopsychosocial treatment plan for patients who are seriously compromised by chronic illness, mental health, social, financial and other related conditions. The consequences of the actions taken may be serious because the veteran may be in an especially vulnerable position due to cognitive, sensory and functional impairments.

**Factor 6. Personal Contacts**

The incumbent must continually relate in a professional manner to primary care providers, members of the interdisciplinary team, as well as to patients, family members, students in training, representatives of various community agencies, and other medical center administrators and employees. In those contacts and in every-day decisions, the incumbent is expected to perform effectively in the absence of immediate access to a supervisor.

**Factor 7. Purpose of Contacts**

The Care Coordinator must assess the provision of individual, family and group treatment; consult and plan with the interdisciplinary team; provide information to community agencies and inform supervisory staff of patient care activities. He/she also supervises/evaluates aspects of care provided by non-VA providers.

**Factor 8. Physical Demands**

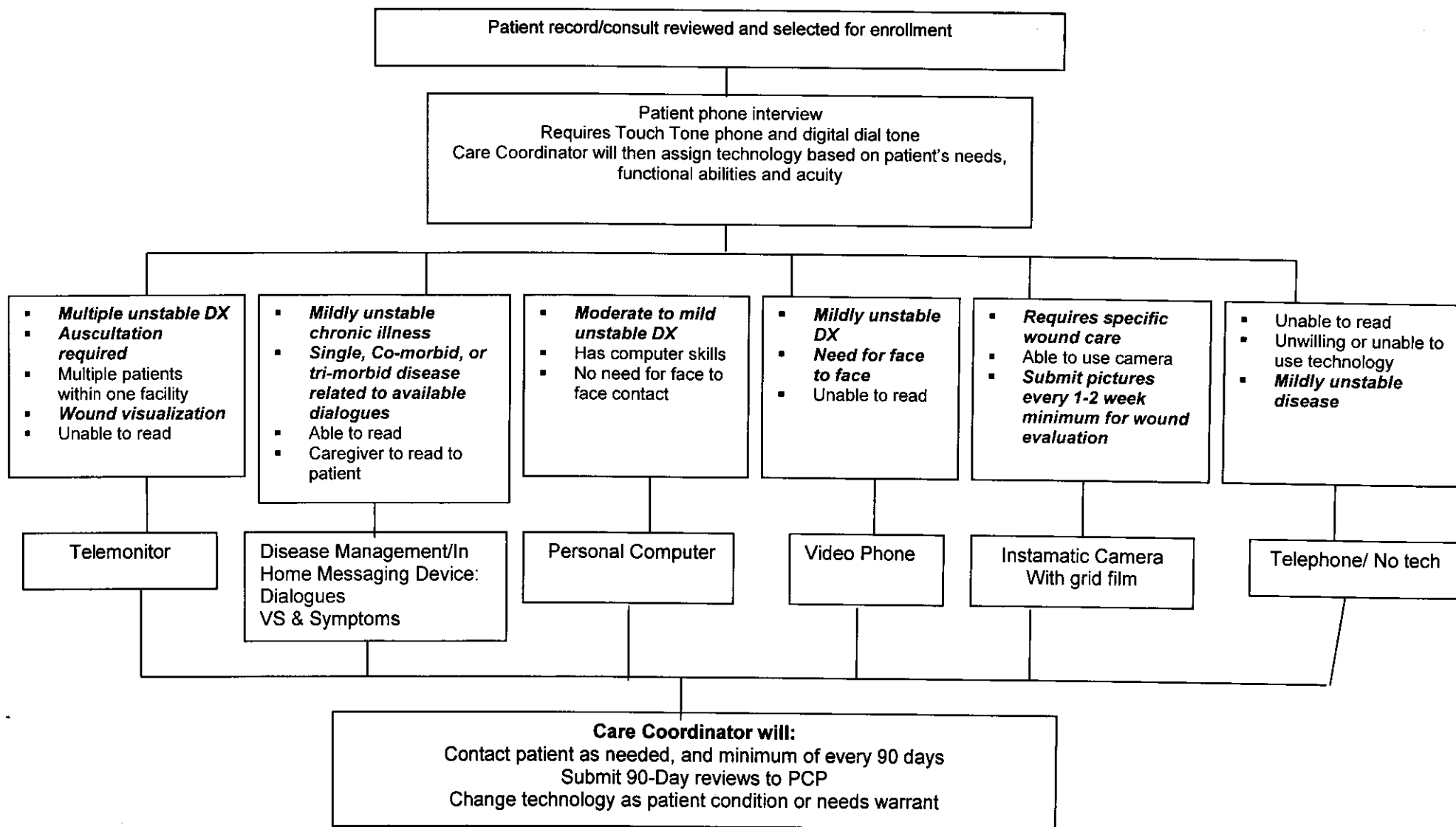
The work requires some walking, standing, bending, and carrying of light items such as books,

papers and laptop computers. Community visits will require the ability to drive a vehicle.

**Factor 9. Work Environment**

The incumbent will see veterans in a variety of treatment settings, such as group therapy rooms, inpatient wards, outpatient treatment rooms, and patients' own homes. The Incumbent abides by VA safety rules and regulations, and promotes safe behavior within the work environment and among co-workers. Position will require travel outside the Medical Center.

## APPENDIX F Care Coordination Technology Assignment Algorithm



Bold Italics denotes clinical

12/31/02

**APPENDIX G**

