CASE MANAGEMENT ASSESSMENT AND COURSE DEVELOPMENT

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A

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Abstract

As health care costs skyrocket, a system of financially responsible health care with a high standard of quality is needed. Case management is a concept conceived over 100 years ago to coordinate care with effective use of services, excellent outcomes and patient satisfaction. This study looked at a needs assessment for a case management/care coordination course at the University of Alaska Anchorage (UAA) by interviewing 10 key informants in the Anchorage area who are actively involved in case management/care coordination or supervision. The participants were enrolled via the snowball method. Assessments of current UAA and online offerings were also conducted looking at present university level offerings in case management/care coordination both at UAA and at universities in the United States. Questions posed to the interviewed participants included the need for a case management/care coordination course, suggested format: graduate school, undergraduate or continuing education and the suggested course content. All participants felt UAA needed a specific course on case management/care coordination. Sixty percent of the participants felt the course should offer continuing education credits, 1 % felt the course would be most effective in graduate school and 4 % felt it would be best utilized as an undergraduate arena. Analysis also found 18 universities with online programs ranging from master degrees to certificates. All participants strongly voiced a need for ongoing information on statewide resources and a need for connections with other case managers/care coordinators.

Table of Contents

Page

Signature Page i

Title Page ii

Abstract iii

Table of Contents v

List of Tables vii

List of Appendices viii

Chapter 1: Introduction and Background 1

Chapter 2: Literature Review 4

2.1 History of Care Coordination/Case Management 4

2.2 Types of Case Management/Case Coordination 9

2.2.1 Case Management 9

2.2.2 Care Management 10

2.2.4 Discharge Planning 11

2.2.5 Disease Management 12

2.3 Similarities and Differences 12

2.4 Healthcare Finances 14

2.5 Quality of Care 17

Chapter 3: Activities and Methods 20

3.1. Methods 21

3.2 Data Collection 22

Page

3.3 Data Analysis 23

Chapter 4: Results 24

4.1 UAA Course Offerings: Case Management and Care Coordination 24

4.2 Online National Offerings in Case Management and Care Coordination 27

4.3. Continuing Education Requirements 28

4.4. Interviews 30

Chapter 5: Discussion 37

Chapter 6: Strengthens and Limitations 40

Chapter 7: Public Health Implications 42

Chapter 8: Conclusions 43

References 44

Appendices 49

List of Tables

Page

Table 1. Key Informant Questions....21

Table 2. Current UAA Offerings versus Proposed Course Content....26

Table 3. Online Case Management Courses....27

Table 4. Certifications, Requirements, and Maintenance....29

Table 5. Results of Interview Questions....34

Appendix G-1. Needs Assessment for CM/CC Course....75

List of Appendices

Appendix A. Institutional Review Board: Proposal Form.....49

Appendix B. Research & Graduate Studies.....66

Appendix C. Collaborative Institutional Training Initiative (CITI Program).....67

Appendix D. Key Informant Interview Questions.....70

Appendix E. Key Informant Informed Consent Form.....71

Appendix F. Course Content Guide.....73

Appendix G-1. Needs Assessment for CM/CC Course.....75

Chapter 1: Introduction and Background

Health care sparks a passionate discussion among Americans. On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA) commonly called the Affordable Care Act (ACA). The goal of the ACA was to make health insurance affordable for all by lowering costs and expanding public and private insurance coverage. The intended result was a reduction in total healthcare costs. Even though the law has undergone scrutiny, it has survived, and affordable health care for all remains a goal of the American public. As health care services expands, controlling health care costs becomes critical. Considering the continued increase in the gross national product (GNP) related to health care expenditures, a desperate need exists to control costs as the number of health care recipients increases (Centers for Disease Control and Prevention [CDC], 2014). Under the ACA, physician groups are encouraged to use case management/care coordination to decrease costs and to participate in an advanced payment model (CDC, 2014). As more Americans have access to health care and costs escalate, a need exists to decrease duplication and target effective care for all individuals. Research has demonstrated that case management/care coordination decreases costs, organizes effective care, and increases patient satisfaction (Fisher et al., 2000; Peter et al., 2011).

In Alaska, where resources are limited, the need for case management/care coordination is even more acute. The cost of a visit to a specialist increases dramatically when travel and lodging is added. The need for families to travel to services also increases the challenges of transition of care. Flow of communication between the

primary care physician and supporting services is critical for patient success. Care coordination/case management can facilitate improved communication and best utilization of resources.

Coordination of care exists on many levels and is most commonly used within the context of the medical model. In Alaska, over 300 people help coordinate supportive services for the elderly and people with disabilities, under the state waiver program (Alaska Department of Senior and Disability Services [AK DSDS], 2015). The state waiver program is a program under Medicaid that provides additional services for those who medically and physically qualify. Care coordinators and case managers coordinate the supportive services. Under the Centers for Medicaid and Medicare Services (CMS) new guidelines, the state is mandated to provide case management without conflict. Per CMS guidelines, clients cannot receive case management and care coordination services from the same service provider as doing so presents a conflict of interest (Alaska Department of Health and Social Services [DHSS], 2015). To ensure such conflict does not arise, the State of Alaska chose to have care coordinators function independently. This decision has taken many care coordinators from under the guidance of a central agency and has limited their access to knowledge, education, and support.

Many terms can be used when discussing case management/care coordination. Care coordination and case management are the two most commonly used terms. For this report, the terms are used interchangeably. While there are clear overlapping responsibilities within the Alaskan healthcare system, case management is most

commonly related to medical management and non-medical management utilizes the term care coordination.

Because of escalating health care costs, more individuals receiving health care, and the limited resources in Alaska, case management/care coordination is an important tool used to decrease costs without compromising care. However, case managers and care coordinators in Alaska have limited educational opportunities. When researching educational opportunities online in Alaska the only local classes offered are the Department of Senior and Disability Services case management waiver training. Most learning opportunities are online, but they do not address Alaskan resources. Therefore, there is an increasing need for a case management/care coordination course within the state. The goal of this project practicum was to assess the need for a course on case management and care coordination by interviewing case managers and care coordinators concerning their interests in such a course and by requesting input on how best to structure a course to meet their needs.

Chapter 2: Literature Review

2.1 History of Care Coordination/Case Management

Referring to history when striving to understand a concept or idea often helps explain how an idea filled a need and expanded over time. Case management and care coordination are concepts with a long history of meeting societal needs. Case management is also a role that continues to evolve as society struggles to use available resources efficiently and effectively.

Case management began in the 19th century. In 1863, an influx of immigrants brought to American shores many people with limited and disjointed resources. Many agencies used a type of case management to organize delivery of patient care. For example, some organizations, such as Hull House in Chicago and Henry Street Settlement Home in New York City (Fero, Herrick, & Hu, 2011), used systems as simple as index cards to keep records of each family's needs and to coordinate services (Kersbergen, 1996). The Hull House and Henry Street Settlement Home helped the poor obtain the resources necessary to improve quality of life. Additionally, the first board of charity, founded in Massachusetts in 1886 promoted coordinated public services using care coordination (Fero et al., 2011). Dr. Stephen Smith founded the American Public Health Association in 1872 with the goal of providing a national health service.

Charity Organization Society, founded in England and active in many east coast cities in the 1880s, aimed to maximize limited reserves of services. To provide resources to the poor, the Charity Organization Society tested innovative programs, such as case management (Kersbergen, 1996). The programs used interdisciplinary teams that tapped

resources from public health, nursing, medicine, and social work to assist their clients. In 1890, Lillian Wald founded the American Public Health Nursing Association (APHNA). The goal of the APHNA was to promote self-health through good choices (Kersbergen, 1996). Lillian Wald believed that public health involved improving the living conditions of the poor, not just treating the sick (Fee & Bu, 2010).

The 1900s saw the beginning of the United States Public Health Service (USPHS), which focused on using community services for environmental issues related to public health (Fero et al., 2011). Public health nurses supported the focus of care coordination with clients as the center of the care model. By 1909, all states had established health departments that have continued to evolve to address public health needs (Kersbergen, 1996).

Health insurance companies become involved in case management in 1909. Lillian Wald encouraged Metropolitan Life Insurance Company to send visiting nurses to patients' homes during periods of illness. The ultimate goal was to decrease the payment of death benefits. By 1925, the visiting nurse program had saved Metropolitan Life Insurance Company over $43 million, and case management and visiting nurses became a tangible asset (Fero et al., 2011).

The Social Security Act of 1935 provided a welfare program for the aged, blind, dependent and crippled children, and mothers and children. This program supported activities related to individualized health care (Amado, McAnnally, & Linz, 1989). One of the oldest programs related to children with special needs is the Title V Maternal and Child Health Program. The Maternal and Child Health Program designated specific

funds to improve the health of women and children (Health Resources and Services Administration [HRSA], n.d.). On the heels of this legislation came the end of World War II and an increased need for healthcare and case management services among the large group of returning veterans (Amado et al., 1989).

The 1960s were highlighted by the civil rights movement and the war on poverty and services continued to be fragmented and uncoordinated. Many clients were forced to take more active roles to navigate the healthcare system. President Kennedy's Panel on Mental Retardation in 1962 proposed a plan—A Proposed Program for National Action to Combat Mental Retardation—to support a continuum of care model that was client focused and multi-organizational. During this time, the number of programs for people with developmental disabilities increased, and providers and other stakeholders highlighted serious attempts to integrate services.

While the federal government attempted to increase resources for families to navigate the complex system of agencies, individual hospitals also helped the poor obtain services. In 1962, St. Paul Medical Center in Minnesota noted overlapping services and initiated a project to develop and evaluate a system of comprehensive medical care directed toward the medically indigent. The goal of the program was to support indigent clients in navigating available services. The team leader was a clinical physician who was assisted by nurses and social workers (Strantz & Miller, 1966).

Several federal initiatives have highlighted the evolution toward the increased use of case management. In 1970, the Department of Health, Education, and Welfare (HEW) Allied Services Act facilitated the integration of services across the continuum of care

(Amado et al., 1989). In 1971, Secretary of HEW, Elliott Richardson, enhanced the act with a memorandum titled "Services Integration: Next Steps," which included four objectives. The first objective was a coordinated delivery of services for the greatest benefit to the people (Amado et al., 1989). In 1971, the Services Integration Targets of Opportunity (SITO) was used to test several service integration systems, including client tracking systems, computerized inventories, and management reorganization projects. While some systems were successful, many were not used following the 3-year grant cycle (Amado et al., 1989).

Adding to the lack of coordinated services for persons with developmental disabilities, the deinstitutionalization of clients with mental disabilities burdened them and their families with the responsibility of seeking resources on their own. To address this issue, Congress passed the first Developmental Disabilities Act in 1974, which identified care coordination or case management as a national priority (Amado et al., 1989). The Developmental Disabilities Assistance and Bill of Rights was enacted ten years later to allocate federal funds to states with the primary purpose of increasing case management and case management education (Amado et al., 1989).

The National Institute of Mental Health developed a framework for community support under the Developmentally Disabled Assistance Act and Bill of Rights Acts of 1975 and 1978. The first bill supported case management services and the second enforced the critical importance of case managers (Fero et al., 2011). While the acts supported case managers, gap in services remained.

The need for case management was also seen in child abuse cases. In 1975, experts in child abuse and case management began assisting in many aspects of these cases. Expert case managers assisted medical teams in identifying cases, assisting practitioners in supporting accurate reporting, managing complex problems requiring multi-disciplinary teams, and assisting with coordinating investigations (Weinbach, 1972).

Healthcare costs escalated rapidly in the 1980s. In 1984, Diagnosis Related Group (DRG) changed reimbursements to hospitals to standard lengths of stay for each medical condition. Therefore, hospitals began looking acutely at case management to find tools to ensure timely discharge and decreased lengths of stay (Kersbergen, 1996). Also in 1984, in response to a landmark study on children's mental health, the Child and Adolescent Service System Program (CASSP) was funded. The purpose of the program was to encourage states to fund systems of care for children with severe mental health problems. One of the 10 guiding principles of the program stated, "Case management is fundamental to service coordination and integration of services" (Behan & Blodgett, 2003, p. 7). Currently, care coordination is addressed in the Affordable Care Act and grants are available to fund interdisciplinary primary care teams to integrate clinical and community preventive services that support healthy lifestyles (Thorpe & Ogden, 2010).

The concept of case management/care coordination has been around for more than 150 years. The terminology often changes with the times and circumstances surrounding the practice. Common terminology used in relation to case management/care coordination include case management, care management, case

management/care coordination, care coordination, case coordination, continuity coordination, service integration, service coordination, discharge planning, and disease management. The two most used types in Alaska are care coordination and case management. This literature review centers on the five most common types of case management/care coordination, all practiced in Alaska under various titles.

2.2 Types of Case Management/Case Coordination

2.2.1 Case Management

Of the five types of case management/care coordination, the two discussed most in peer-reviewed journal articles are case management and care coordination. Case management "is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes" (Case Management Society of America [CMSA], n.d., para. 3). Because of health care laws, regulations, and reimbursements, case management is continually evolving (Robinson, 2010). Case managers must be current in these areas to be effective for their clients. One method to standardize the level of expertise is certification. Internet searches of case management revealed extensive opportunities for certification within various disciplines, including nursing, social work, disability, chronic care, and case management/care coordination. Certification requirements vary regarding mandatory hours, testing, and required hours of annual study (Commission for Case Management Certification [CCMC], n.d.). Certification verifies that case managers possess the education, skills, knowledge, and experience required to

render appropriate services according to sound principles of practice (CCMC, n.d., para. 5). Requirements for certification also vary from employer to employer.

As professional training for case managers has evolved, many have argued whether the role of case manager should be the primary physician, nurse, social worker, or adjunct support services personal. Liptak and Revell (1989) examined who should provide case management by posing the question to physicians and parents. The authors found that 59% of physicians surveyed believed they should provide case management for children with chronic illnesses, but only 41% of children actually received case management from their physicians. Tahan and Campagna (2010) examined 6,909 case managers whose professional backgrounds ranged from nursing (88.5%), social work (1.7%), vocational rehab (1.6%), and others (8.2%). The other disciplines included addiction counselors, health coaches, medical doctors, nurse practitioners, occupational therapists, clinical nurses, and university educators.

2.2.2 Care Management

According to the Office of Quality and Care Management (OQCM, 2008), care management applies systems, incentives, science, and information to "improve medical practice and assist consumers and their support system to become engaged in a collaborative process designed to manage medical/social/mental health conditions more effectively" (p. 1). The goal is to coordinate cost effective, non-replicated optimal services. Care managers assess clients for greatest improvements in health outcomes, tailor interventions based on individual needs, and evaluate interventions. Care plans must be aligned within the financial and insurance restrictions of each individual.

Care coordination involves deliberately organizing patient care activities and sharing information will all stakeholders concerned with a patient's care to achieve safer and more effective care. Such facilitation means that the patient's needs and preferences are assessed initially and communicated at the right time to the right people. This information is also used to provide patients with safe, appropriate, and effective care (Agency for Healthcare Research and Quality [AHRQ], 2015, para. 1).

Care coordination encompasses planning, monitoring outcomes, coordinating visits, organizing care to avoid replication, sharing information among professionals, training caregivers, and engaging in ongoing reassessment and refinement. The three common models of care coordination include social, medical, and integrated. Medicaid programs with the elderly often use social models. Medical models are often used for chronic disease management and discharge care, while integrated care models are used to address both social and medical needs.

2.2.4 Discharge Planning

Discharge planning is "a process used to decide what a patient needs for a smooth move from one level of care to another" (CMS, 2012, p. 4). Discharge planners meet patients and families early in the hospitalization process, collect data on previous functioning levels, and asses the effects of hospitalization on care needs. Discharge planners formulate plans of care after discharge with their patients and other interdisciplinary team members, such as social workers, physical therapists, nurses, and physicians. These plans consider the medical condition, necessary home therapies, and available resources within the family. The goal of this process focuses on all aspects of

the patient's life to address acute care needs and solutions. Successful discharge is critical, especially after the 2013 Medicare regulation that limits or denies reimbursement for hospitalizations less than 30 days after discharge (Thorpe & Ogden, 2010). The two largest hospitals in Anchorage use discharge planners and discharge care coordinators.

2.2.5 Disease Management

The term disease management refers to the "multidisciplinary efforts to improve the quality and cost-effectiveness of care for select patients with chronic illness" (Faxon et al., 2004, p. 2651). Disease management has arisen from case management/care coordination to reduce the financial burden of chronic illness. Tools used may include assessment tools, clinical guidelines, wellness programs, best practices, formularies, and other systems and protocols.

2.3 Similarities and Differences

Discharge planning and disease management encompass specific entities within the scope of a patient's life. Care management, care coordination, and case management have similar goals, policies, and procedures. It is important to note that case management, care coordination, and case management/care coordination have overlapping definitions, roles, and responsibilities. Stanford University (2007) searched for a common definition of care coordination and found over 40 different definitions. The researchers also found much confusion in distinguishing between case management and care coordination (Stanford University, 2007).

Tahan, Downey, and Huber (2006) examined common worksites of case management/care coordination activities, such as hospitals, independent case

management companies, health insurance companies, case management/care coordination organizations, worker's compensation agencies, and rehabilitation and workers' compensation groups. The goal of the study was to clarify essential knowledge and skills of case management activities. The researchers looked at the job titles of over 6,900 participants and found titles including care coordinator, care manager, case manager, and discharge planner. The researchers also assessed participants by their associations on a case management website; approximately half were certified case managers. However, Tahan et al. (2006) found a definite lack of standardization in roles and many activities were used by all the disciplines. These activities included assessment, resource acquisition, referrals, communication, and documentation, building relationships with referral resources, vocational and professional resources, ongoing interviews and evaluations, adherence to standards of practice and the law, and maintaining patient safety. Even with the common activities, different professions had different foci, with nursing and social work having similar focus.

Care coordinators and case managers are instrumental in decreasing medical costs, increasing frugal use of services and educating families in health promotion and available resources. These types of case management/care coordination services are valuable for the continued health of people with complex medical and developmental problems. The United States healthcare system has become increasingly complex and difficult to navigate. Resources come and go depending on the political climate and funding allocations. The term case manager may be over 50 years old, but the need for a "navigator of health" continues today (Robinson, 2010).

2.4 Healthcare Finances

Healthcare costs have escalated at an increase of 6.3% over the last 20 years. Americans now spend $2.7 trillion per year on health care or $8,680 for every man, women, and child (Wilson, 2013). Of the $2.7 trillion spent on health care, about 75% is spent on chronic illness. According to the CDC (2010) from 2001 to 2010, the number of people with chronic conditions (a condition lasting more than 1 year) increases to one in every two Americans. Additionally, 26% of those with chronic illnesses experience some type of lifestyle change (Ward, Schiller, & Goodman 2014).

Healthcare costs in the United States are more than twice that of any other industrialized nation. America spends 17% of its gross domestic product (GDP) on health care (Appleby, 2012). Unfortunately, this expenditure has not resulted in improved health and the United States ranks 169th in infant mortality, 136th in maternal mortality, and 42nd worldwide in life expectancy (Central Intelligence Agency [CIA], n.d.). In 2003, the Institute of Medicine (IOM) identified a national goal to increase the use of case management for better access to healthcare resources (Institute of Medicine [IOM], 2013). Health care in the United States is transitioning from the traditional acute care to chronic care as more individuals with chronic illnesses are living longer. In Alaska, the population of those with chronic illnesses (heart disease, diabetes, and asthma) increased in 4 years from 17.4% to 18.9%, which equates to an increase of over 10,000 people with new chronic illnesses (Robert Wood Johnson Foundation [RWJF], 2012).

In addition to the increase in healthcare costs, the U.S. population is aging. According to the CDC (2003), the population of individuals older than 65 years is expected to increase from 12.4% to 19.6% within the US by the year 2030. Older adults greatly influence healthcare costs. Chronic disease among older adults has increased the need for healthcare services and long-term care costs. According to Ward et al. (2014), the number of people with three or more chronic medical conditions more than doubled from the 45-64 age range (13.8%) to those older than 65 years of age (33.2%).

At the other end of the age spectrum, the number of children with chronic medical needs has also increased, as have their in-hospital care needs. Simon et al. (2010) examined retrospective data of children hospitalized in 1997, 2000, 2003, and 2006. Their findings demonstrated an increase in both number and proportion of complex pediatric hospitalizations nationally. According to the American Academy of Pediatrics (AAP), children with special health care needs are defined as those "who have or are at risk for chronic physical, developmental, behavioral or emotional condition and required health and related services of a type of an amount beyond that required by children generally" (Council on Children with Disabilities, 2005, p. 1238).

Children with multiple chronic illnesses have more physician contacts and are more likely to be hospitalized. In fact, 80% of all healthcare costs are related to 20% of children (Simon et al., 2010). Burns et al. (2010) also found increases in the hospitalization rates for children with renal disease, cardiovascular disease, and other congenital defects and genetic disorders. Because of the increased risk of hospitalizations and number of specialized physicians needed, the IOM identified care

coordination as a priority for national action to transform the health care system (Robinson, 2010).

Researchers have documented the significant effect that care coordination can produce in conserving healthcare costs (Fisher et al., 2000; Peter et al., 2011). Peter et al. (2011) targeted children in Western Australia who had complex medical conditions. Responding to an increase in hospitalization of children with chronic medical needs, the hospital enrolled 101 children with complex care conditions who frequently used hospital services. These children were offered integrated care coordination services that were available 24/7. The care coordinators intervened in several key areas, including around the clock triage and interventions with the emergency department concerning impending admission, integrated healthcare plans with comprehensive summaries of medical history that was available to the medical teams and families, monthly monitoring of patients' healthcare statuses, and participation by care coordinators of inpatient and outpatient visits.

Overall, the results demonstrated significant savings over the short-term among those who received the care coordination services (Peter et al., 2011). Specifically, over 10 months, the hospital yielded a significant savings of over $1.9 million based on inpatient healthcare dollars. In addition to the monetary savings were positive results in other areas, including increased patient satisfaction and feeling a part of a partnership. The program also helped identify barriers common to families of children with complex medical needs. Unfortunately, actual case studies that examine cost savings are rare.

Fisher et al. (2000) also demonstrated a cost savings with the advent of a case manager in an HMO program with care related to asthma, diabetes mellitus, and congestive heart failure. The researchers enrolled over 295,000 people and collected data for 1 year. The savings to the organization was over $5.4 million in decreased healthcare costs.

2.5 Quality of Care

The healthcare delivery system in the United States is uncoordinated and fragmented and the current focus is on acute care needs. The CDC (2010) reported over 1 million doctor visits nationwide annually; however, only 55.5% of physician visits is to primary care physicians (CDC, 2010). The remainder of these 1 million plus doctor visits is to emergency rooms, local clinics, and other facilities. This lack of flow of care causes replication of services and difficulty in planning preventive health care.

In addition to the underuse of primary physicians is the increased use of specialty providers because of the increase in chronic diseases. Increasing the number of physicians involved with a particular patient adds the burden of coordination of medications and disease planning (National Quality Forum [NQF], 2012). According to the NQF (2012), “Care coordination is essential to reducing medical errors, wasteful spending, and unnecessary pain and procedures for patient” (para. 2). By coordinating patients’ plans of care, care coordinators can help reduce costs and improve quality of care.

Hospitals also use case management to decrease inefficiency. Hospitals from Illinois to South Carolina have used the team approach with clinicians and case managers

to address problems of delayed discharges, to improve effective and accurate billing, to increase appropriate documentation, and to decrease length of stay (Baguhn, 2011). Baguhn (2011) found that case managers provided a unique bridge between clinical and financial realms of health care, served to decrease lengths of stay from 6.5 days to 5.2 days, and saved over $2 million (Baguhn, 2011).

Toomey, Chien, Elliott, Ratner, and Schuster (2013) conducted phone surveys with participation nationwide. Caretakers were asked about types and number of chronic conditions. Parents of children with special healthcare needs reported having unmet care coordination needs significantly more often than those without special needs do. In fact, Toomey et al. found that 72% of parents with children with chronic conditions identified a need for care coordination.

Lawson, Bloom, Sadof, Stille, and Perrin (2010) explored parental perceptions of case management in the Boston area. Parents perceived case management as helping them access many community supports, including better use of their regular and specialized physicians. The parents also believed their contacts with specialists were enhanced with case management and they reported a high level of satisfaction with these services (Lawson et al., 2010).

One important comprehensive study conducted by CMS yielded mixed results. Peikes, Chen, Schore, and Brown (2009) reported results from the 2000 Center for Medicaid and Medicare project that included 15 programs that were required to select a target population, establish exclusion criteria and design interventions for patients with one or more chronic condition. The programs were initially authorized for 4 years. The

number of patients in each program ranged from less than 115 to more than 1,150 patients, and the majority of programs enrolled 400-750 patients.

The design of care coordination was agency specific. Fourteen of the 15 programs educated patients to improved adherence to diet, exercise, and medications, and to improve care coordination by educating individuals or providing timely information on care needs (Peikes et al., 2009). The data revealed that the treatment groups did not decrease Medicare expenditures for enrollees with chronic illnesses. While enrollees were more likely to recall received education, they did not alter their habits in relation to diet, exercise, and education. Two programs were successful in decreasing Medicaid expenditures. Aspects of these successful programs were screening to identify the most severe cases, an average of one in-person contact per month, teaching patients how to take their medicines, and working with local hospitals to manage transitions and reduce readmissions (Peikes et al., 2009).

Case management is not restricted to nursing. Case managers also are used in the visiting program for children younger than 3 years of age, commonly known as infant learning or early childhood development. Children are enrolled in these programs if they demonstrate greater than a 50% delay in physical, emotional, social, or cognitive development. In one Ohio study, parents indicated their desire for more parenting support and family interventions (Allen, 2007).

Chapter 3 Activities and Methods

The primary goal of this practicum was to complete a needs assessment for a course on case management and care coordination for the UAA Office of Health Program Development. The specific objectives included the following:

- Assess current UAA course offerings for case management and care coordination content within established courses.
- Assess current online national offerings in case management and care coordination.
- Survey 5-10 local leaders in case management and care coordination
- Submit a proposed course offering to the UAA Office of Health Program Development that incorporates recommendations on level of education, type of offering, length of offering, and syllabus.
- Review continuing education requirements for personnel in various case management and care coordination roles and certificate requirements and develop a table of certifications in case management, care coordination, and CEU requirements..

The additional information was added after the participants referred to certification needs in relation to education. Questions for the interview were formulated with the goal of categorizing participant's job titles, reviewing job duties, obtaining information about educational opportunities and needs within the work place and professional needs (see Table 1). The final questions related to the participants recommendations on course content, format of course and length of course. The

community partner reviewed the posed interview questions to facilitate acquisition of knowledge necessary to move forward with the plan to implement a case management class if the data supported such a recommendation.

Table 1

Key Informant Questions

1. What type of organization do you work for: hospital, impendent case management, health insurance company, mental health, worker's compensation, disability organization
2. How many case managers employed at the agency?
3. Are you a supervisor?
4. What are alternative titles for case managers employed here?
5. What are the job duties of the case managers?
6. What are required certifications within organizations and educational requirements?
7. Would there be interest in UAA course?
8. Any suggestions for course content, length, cost?

3.1. Methods

The researcher conducted qualitative interviews between May 20 and July 24, 2015. The UAA Institutional Review Board IRB)) determined this project did not meet the definition of human subject research under the purview of the IRB according to federal regulations (see Appendices A, B, and E).

The researcher began recruiting participants following IRB determination in April 2015. The goal of participant selection was 5-10 employees who actively functioned as case managers or care coordinators or who supervised case managers and care coordinators in hospitals, independent case management companies, case management/care coordination organizations, primary care settings, and state agencies. On recommendations of the community partner the participants were limited to agencies within the Anchorage bowl. The researcher made initial contacts by phone or email from known participants within the case management/care coordination role. Additional interviewees were solicited using the snowball method with the goal of diversity of job setting. In addition, unsolicited contacts were made at four health care agencies with known case managers, of those contacted two declined. At the end of interviews, the researcher asked participants for recommendations of others who might be willing to participate in the study. Using a snowball sampling method a group of more than 20 potential interviewees were identified; however, because of time constraints and the goal of diversity, the researcher only interviewed 12 individuals. Of note, 10 interviewees met the criteria for direct case management or care coordination exposure. The other two interviewed were in state positions that had no direct case management/care coordination but functioned in administrative capacity related to care coordination. This resulted in 10 interviewers being utilized for content.

3.2 Data Collection

Each interview lasted between 30-60 minutes. The researcher conducted 12 interviews, and 10 are included in this report.

The researcher conducted three interviews by phone per the request of the interviewees; nine interviews were conducted in person. Prior to the interviews, all participants received an introductory letter, interview questions, and informed consent via email. All were offered a copy of their signed consents; some declined. The interviews were digitally recorded with participants' verbal approval. The researcher did not request any identifying information for confidentiality; however, many interviewees shared identifying information during their interviews. The interviews were transcribed for accuracy, and the digital recordings will be erased at the end of the project.

3.3 Data Analysis

Participants' responses are presented in table form under the results section to facilitate ease in comparing the results. The analysis searched for common themes within the responses. The first five questions sought basic information of participants. The remaining three questions specifically investigated educational requirements, opportunities and interest in a UAA course delving into recommendations from the participants for course content, length and cost.

Chapter 4: Results

The goal of this project was to complete a needs assessment for a course on case management and care coordination for the University of Alaska-Anchorage (UAA) Office of Health Programs Development. To achieve this goal, the researcher assessed current UAA and national course offerings for case management and care coordination content within established courses, reviewed continuing education requirements for case management and care coordination, and surveyed 10 professionals in case management and care coordination and two administrators. Online search was conducted using a standard google search engine for national case management/care coordination courses and within the UAA website reviewing offerings in the schools of human services, social work, and nursing and health services. Certification information was researched after discussion with the interviewees who referred to the requirements of certification related to educational needs.

4.1 UAA Course Offerings: Case Management and Care Coordination

Case management and case coordination courses offered at UAA per the course catalog description include the following:

Human Services A322: Service Coordination in Human Services Practice. Employing a blend of readings and skill development activities, the course focuses upon theory and application associated with service delivery, client assessment, treatment planning, implementation, evaluation and ethical decision-making.

Human Services A405: Children's Mental Health Interdisciplinary Seminar. Examines strategies for optimal interdisciplinary collaboration by mental health

professionals working with children and their families, including techniques for building successful teams, strengthening family-professional partnerships, and introducing effective communication/conflict management. Cultural competence and the promotion of professional resilience are also covered.

Human Services A414: Advanced Case Management for Human Services Professionals. Broadens the perspective of the advanced student in defining and implementing case management concepts. Examines the relatedness of human services delivery programs. Skills linking client assessment, treatment planning and evaluation are presented.

Disability and Long Term Support A204: Person-Centered Planning. Fundamentals of the person-centered planning process, including tools and facilitation techniques. Emphasizes Wrap-Around Supports as applied to families and children.

Human Services A414 was limited to undergraduate students in the human service professionals program. The other three included descriptions of the components critical to the process of case management and care coordination. These components include wrap-around support, assessment, treatment planning and evaluation, building successful teams, and strengthening family and professional partnerships.

Table 2 benchmarks the course content against the recommendations of the participants. As can be seen the content recommended by the participants spans content of all four course offerings at UAA. Additional topics not covered can be viewed to the left. While the current course offerings can meet some of the needs of the participants' additional information is clearly desired.

Table 2

Current UAA Offerings versus Proposed Course Content

UAA Course Content Offerings	Proposed Content Offerings	Other Proposed Content
DLS 204		Holistic approach
Person centered planning	Person centered planning	Navigate system
Team building strategies	Interdisciplinary teams, role of SW, PT, OT, speech	Connect resources
Ethics		Motivational interviewing
Conflict Resolution	Conflict resolution	Training for certification standards
Assessing Effectiveness		Conflict free case management
HUMS 322		Waiver information
Service Coordination: history, definitions, models of care	Introductory Course	Specialty/medical care
Cultural diversity	Cultural competency	Trauma informed care
Effective communication	Establishing rapport	Understanding medical diagnosis
Client Assessment		Self-advocacy
Service Planning	Connecting resources, resources within the life span	
Monitoring Services		
HUMS A405		
Professional roles & guidelines	Developing boundaries	
Interdisciplinary teams	Interdisciplinary teams	
Cultural competence		
Self-help for professionals		
HUMS A414		
Foundations for Critical Thinking		
Theoretical Orientations		
Legal & Ethical Issues		
Communication Skills		
Working with a Diverse Population	Alcoholism, culture of homelessness, meeting people where they are, mental health, behavioral challenges, geriatrics, pediatrics	
Client Assessment & Plan		

4.2 Online National Offerings in Case Management and Care Coordination

The search was conducted via a Google online search engine seeking out US universities that offer courses in case management, care coordination or a similar topic. Eighteen US universities have online programs that offered certificates or advance degrees related to case management, care coordination, and population health management (see Table 3).

Table 3 *Online Case Management Courses*

Site	Requirement	Degree/Certificate/CEU
University of Phoenix	Bachelor	Certificate CM
University of CA Riverside	RN, PT, OT, SW 1-2 yrs. health exp.	Certificate CM
University of S Indiana	RN, health professional	Certificate CM
University of S. Indiana	**AD, clinical expert., license, 1-2 yrs. SW exper.**	**Certificate in CCC**
American Sentinel University	nursing	MSN in CM
UC San Diego	RN, MD, RT, SW	Certificate CM
Rutgers School of SW	health professionals	Certificate CM
Davenport University	BS, human services experience	Certificate CMt
McNeese State University LA	RN	Certificate CM
University of Alabama	RN	MS in Nursing CM
University of Wisconsin-Milwaukee	health professionals	Certificate CM
Grantham, KS	RN	MSN in CM
Umass Medical School	**RN, SW, Med assistants**	**Certificate ICMD**
Duke University School of NSG	**RN**	**PCC Certificate**
Boston University School of SW	**SW, health service practitioners**	**Certificate CM**
Capella University	**RN**	**Post BSN certificate care coord. specialist**
Boise State University	**Bachelor**	**4 classes care coord. and resource**
Villanova University	**RN, SW**	**CC in a Fragmented System: PHM**
St. Peters University-New Jersey	RN	MSN CM

Note. CC-Coordinating Care; CCC-Community Care Coordination; CM-Case Management; ICMD-integrated care management/didactic; PCC-Population Care Coordinator; PHM-Population Health Management.

The University of Southern Indiana offers certificates in case management and community care coordination. All programs require some type of healthcare affiliation, nursing or social work backgrounds for enrollment. Two courses are housed within an undergraduate program. Schools that are bolded offer certificates or degrees in non-case management areas. Only the undergraduate program at the University of Phoenix is a single class, the remainders of the certificate programs offer multiple classes to receive a certification.

4.3. Continuing Education Requirements

During the interview, 60% of the participants recommended some type of continuing education needs in relation to their employment. Certifications were also required or recommended in 50% of the interviewees. Because of the interest in certification, the researcher investigated the continuing education requirements for common certifications related to case management and care coordination. Table 4 includes a list of national certifications related to case management and care coordination. The majority of national certifications are directed toward healthcare workers, specifically RNs (registered nurses) and social workers. Certification renewal ranges from 3-5 years with 25-80 continuing education hours. Within the certifications listed below the Nationally Certified Case Management did not specify its renewal criteria, and the Qualified Professional Case Management certification is geared toward entry-level case managers and encourages members to obtain certificates in case management within a 3-year period.

Table 4

Certifications, Requirements, and Certification Maintenance

Title of Certification	Entry Requirements	Maintenance
ACM-Accredited CM	Hospital-level CM, RN, SW	4yrs/40CEU in hospital CM
CCM-Commission of CM Certification	License, bachelor or masters health field	5yrs/80 CEU in focus area
CDMS-Certified Disability Management Specialist	Bachelor, RN, 12 mos. disability management	5yrs/80 CEU or exam
CPDM-Certified Professional Disability Management	No testing/3 completed courses	15 CEU annually in disability
CMCN-Certified Managed Care Nurse	RN must purchase home study	3yrs/25 CDU
C-SWCM Certified SW CM	SW	3yrs/ 4,500 hours
NCCM-Nationally Certified CM	CM for addictions. No requirements listed	Online training program
NACCM-National Academy of Certified CM	Associate Degree to Masters with experience	3yrs/45 CEU
RN-BC Registered Nurse-Board Certified	RN	1000hrs/5yrs/75 CEU
QPCM-Qualified Professional CM	Entry-level case managers	3yrs/28 CEU/Certificate in CM

Alaska does not require certifications for licensure or practice except for care coordinators functioning under the Department of Senior and Disability Services (DSDS) waiver program. This program provides its own training program and testing for certification. Within the state, some, but not all, organizations require national certifications. Outside of Alaska, an increasing number of employers are requiring some type of certification for entry-level positions in case management and care coordination. Renewals for all but one certification have a requirement for continuing education in case management or care coordination. Limited opportunities exist in Anchorage for

continuing education other than online courses. Further, the cost of traveling outside Alaska for education can make it prohibitive to many. A course at UAA that may additionally offer continuing education credits along with college credits would add additional appeal.

4.4. Interviews

Participants were from a variety of organizations, including hospitals, primary care, private physician offices, private non-profits, workers' compensation, waivered agencies, and state and for-profit case management agencies. The goal of participant diversity was achieved. The number of case managers and care coordinators per agency ranged from two to over 100. Most participants were not supervisors because of their limited availability for the interview process. While the primary care agency also covered mental health needs one agency interviewed focused on substance abuse and mental health needs. . Six participants had the title of case manager and four were called care coordinators. Five agencies required an RN license and all agencies referred to their employees as case managers. One question asked about alternative titles for case manager like jobs. Alternative job titles included patient navigator and behavioral health manager. These were titles, which existed within the agencies but titles that were not held by the interviewees. Since research has demonstrated varying titles for similar responsibilities, the goal was to document additional titles used in Alaska.

Two positions associated with the state waiver program required the state care coordination waiver course on a biannual basis. This is a care coordination course, administered by the Department of Senior and Disability Services that is required by care

coordinators who work with clients under the state waiver program. Two agencies with RN case managers required a national certification after employment, and three agencies both recommended and supported the attainment of certifications for their employees.

The majority of positions required undergraduate degrees for employment or a minimum of 2 years of experience. All but one participant had an undergraduate degree. Job duties were similar and included communication among providers, care plan development, transition of care, assistance with referrals, data collection, and monitoring services. Along with these duties, RN case managers were responsible for reviewing medications, coordinating medical needs, and discharge planning.

Job duties were similar and reflected assessment, planning and implementation of resources. All agencies represented encouraged continuing education and offered access to continuing education thru their agency. One agency, a hospital, had an educator specifically for case managers and social workers. Three of the ten agencies required an undergraduate degree for initial employment and five required an RN. Sixty percent of the interviewees had jobs that required or highly recommended some type of national certification. RN licensed in Alaska are required 30 units of continuing education for relicensure. Due to the ongoing continuing education requirements needed for certifications this topic will be addressed later in this report. All of the participants agreed with the value of a case management course. Fifty percent of the participants felt it would best fit in an undergraduate curriculum, only one recommended the course be on a graduate level but 60% felt continuing education credits were important.

Content recommendations included basic concepts in case management/care coordination, establishing rapport with clients, resources available in Alaska, interdisciplinary teams, motivational interviewing, person centered planning, the culture of homelessness, mental illness and behavioral challenges. One participant, who was hospital based specifically spoke to the need for information specifically related to requirements for certification while three others specifically requested additional training in disease specific information. One theme, which was conveyed by the majority of participants, was a need for knowledge of resources within the state and a need to connect to other case managers to tap a larger knowledge base. It is ironical that case managers/care coordinators within the state, who function by connecting clients to resources, feel isolated. This is especially important when acknowledging that these case managers were primarily Anchorage based. The data demonstrates a desire for a course but more participants felt continuing education units and connection with other case managers would be important.

All participants advocated for support of a case management or care coordination course at UAA. The recommended structure ranged from a course within the context of an undergraduate or master program (one participant), to online or webinar offerings, to a proposed hybrid class with some online and some face-to-face classroom instruction. Many participants highly recommended some form of hybrid class because interpersonal relationships within the case management/care coordination community are important. The following lists specifics of the recommendations for course content from most

frequent to least frequent (the numbers reflect the number of participants who recommended this format):

- Type of Course: Continuing education hours(6), undergraduates(4), master's program(1), Hybrid (5)
- Length: Semester, 4-6 weeks (1), 6-8 weeks (1), or 10 weeks (1), semester (2)
- The proposed content guide, seen on page 26, benchmarks the recommendations of the participants against the current UAA offerings. The recommended content from the participants covers topics from all four current course offerings that would make any one specific course inadequate to meet the recommendations of the interviewees.

Table 5

Results of Interview Questions

Questions	A	B	C	D	E	F	G	H	I	J
Type of Organization	Primary care clinic	State	Hospital	Physician owned practice	Private, statewide, nonprofit	Private, not-for-profit	Workers' comp cm	Non-profit, disease specific	For profit	For profit
# of CM/CC	90-100	2	16	1 CC 2 CM	2	11 CC 15 CM	2	7 FTE	15 CM/CC	10+
Supervisor	No	No	No	No	No	Yes	No	Yes	No	Formally
Alternative titles	CC	NA	Support techs, patient navigators	NA	NA	Behavioral health	vocational CM	NA	NA	nonclinical CM CC-Behave health
Job duties	Nurse care via phone Patient, chart review, psychosocial Assess, education, screening, telephone triage, document treatment, population based care, med. manage. prospect planning	Communicate with providers, care plan develop, outreach/ community partnership	Transition care, discharge planning, support specific units and cross cover	CC-monitor outgoing referrals, review referrals, lead for schedule apt. CM-medical focused	Service plans, client apt, assist in meeting goals	CC-plan of care, contact client 2x/mos. billing CM-staffing for plan	Based on insurance company assess., attend apt	Collect info., needs assess., develop plan of care, connect people to community resources, monitor services	Develop plan of care, assess, work plan of care with patient, reach out to physician review meds. Monthly	Develop care plan, assess., recommend

Table 5. Continued

Questions	A	B	C	D	E	F	G	H	I	J
Required Recommend certifications	RN required, CM recommend and supported by org.	Bachelor required for job, no cert. recommended	RN required. Cert. thru ACM model, hospital oriented	UAA peds course	Bachelor and 5 yrs. exper., recommended. chemical counsel.	State CC training for cert.	BSN required, recommend CM cert.	CC training from the state waiver program	2 yrs. exper. or BSN. CCM requ. 2 years employ	RN or CMC, prefer cert.in specialty
Interest in UAA course	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Course Suggestions	CEU Length 6-8 weeks,	Undergrad 10wks	Undergrad or grad semester long, face to face	Undergrad & CEU	CEU, semester long	Face-to-face possible hybrid course	CEU, hybrid course-online and in person 4-6 weeks, course	Online access but in person preferred,	Undergrad, college credit, CEU,	CEU, hybrid model, face to face

Table 5. Continued

Questions	A	B	C	D	E	F	G	H	I	J
Content	Approach people holistically, Navigate system, Connect resources, Intro course, Interdiscip. teams, relationship based care. add critical conversation, motivational interviewing Develop boundaries	Resource within life span, vignettes or stories, , Appeal to waiver CC, measures	ACM-CM training required by ACM cert. Org. support, Use ACM or CCM models, qualify. to sit for national exam, A&P,	On-boarding staff, parents, conflict free CM, community resources, specialty care & prerequ. motivation interview, cultural comp. care spectrums -SW, PT, OT, speech.	Confident. trauma informed care, establishing rapport, diagnosis, , mental illness, elderly, cultural comp. boundary, alcoholism, culture of homelessness, meeting people where they are.	Person centered plans, self-advocacy helpful to develop relations	Basic CM training exam, theories in CM, medical specifics of condition-head injuries.	Community knowledge, mental illness, behavioral challenges	ethics, complex disease specific-transplant, peds, video or webcast	Holistic looks at family, geriatric and elderly increase

Chapter 5: Discussion

Case management and care coordination is an expanding field. The majority of participants interviewed discussed the isolation they felt at their particular agencies in relation to awareness of available statewide resources. Participants verbalized a definite need for a central location or class where connections could be made and resources shared. Many participants struggled with lack of support because of limited personnel in their agencies. All participants expressed the desire to provide their clients with the best resources available in the state; however, they felt limited and needed guidance on ways to make that happen. Of note, the case managers interviewed were all from the Anchorage area; therefore, one could only imagine the isolation those in rural Alaska might feel.

The majority of participants had undergraduate degrees in the health services field. Most desired continuing education credits as opposed to college credits, and several voiced interest in both. All participants worked for organizations that offered some type of continuing education, and one agency had an educator specifically assigned to the department. Even with these supports in place, participants verbalized the need for additional information.

Alaska does have two specialized case management classes. A course in pediatric case management has been developed through the All Alaska Pediatric Partnership in collaboration with UAA. This course is specifically for pediatrics. Additionally, the state of Alaska frequently provides a free 3-day care coordination course on the waiver process in Alaska. While basic education exists in online classes, participants expressed

a desire for an Alaskan course. Therefore, connecting with the Alaskan community is paramount for success. One of the most requested aspects of a course was the opportunity to develop relationships between case managers.

Based on the review of the UAA course catalog, the university offers three courses in case management and related topics. However, the requested content by the participants was spread among all the courses. Participants also voiced a desire for a hybrid course with CEU options and interconnections with others. Critical pieces for a new course should include personal connections with others in the field and knowledge of Alaska resources. Without these pieces, UAA would be competing against online courses that are accessible to all.

As budget cuts put pressure on agencies, many outsource their education to other vendors. Leaders from two large agencies voiced interest in a course aimed to provide basic knowledge of case management, especially to new employees. The State of Alaska offers a free care coordination course and recertification specifically attached to the waiver. Participants who have attended this course in the past voiced frustration and desire for more information on the topics discussed. This would be another opportunity for additional students.

Recently, the state implicated a “conflict free case management” ruling in relation to waivered services (Department of Health and Social Services [DHSS], 2015). Due to this new policy over 300 care coordinators will function independently and no longer be employed by disability agencies. This is an opportunity for UAA to provide multiple

levels of education in case management. This course could be used to expand the existing advanced case management class.

Chapter 6: Strengthens and Limitations

Conducting the interviews at this critical time in the nation's healthcare history lent importance to the study. Health care is expanding with added enrollees, but Americans desperately need to streamline health services to provide high-quality cost-effective care. The interviews gave providers a voice for effective education and the needs and resources of Alaskans. The interviews were limited because of time constraints and participant availability. Further, there was limited involvement by mental health in the interviews. The mental health community is an arena where there is an increased need for case management. A larger sample size could have added more diversity and include mental health. The snowball sampling method was effective in securing a large sample, but not necessarily a diverse sample.

Interviews were limited to agencies within the Anchorage bowl for several reasons. Medical care has its hub in Anchorage and there is the best offering of services and diversity within the Anchorage bowl. Anchorage is also the primary site where many insurance companies, disability organizations and case managers are located. The goal of the study was a prompt assessment of the need for a course. This project would have been enhanced by expanding the questionnaire to the rural community.

Two interviews were not included because of a lack of direct case management; however, they exposed the researcher to additional areas to be explored in case management/care coordination. The Alaska Mental Health Trust formulates policies for the future needs of Alaskans who struggle with mental health. Case managers can advocate with this agency to address unmet needs in the community. Additionally, a

need exists for case managers to become actively involved with state agencies to advocate for gaps in the system and to support effective programs.

Financing this course/certification will be challenging in this economically conservative time. Two major hospitals in Anchorage have recently limited educational reimbursement for their employees. However most professionals seek out opportunities for growth even at self-cost. The state of Alaska DSDS currently offers its care coordination-training program at no cost. With 300 coordinators listed on their roster this is a huge economic burden for the state. As budgets become tighter, outsourcing education to other venues could be a win-win situation. There has also been a movement in the state for providing the training within Alaska for an educated workforce for economic growth. Many insurance companies hire case managers/care coordinators across the country as much of the work is done remotely. By combining a new course along with an established course this could increase revenue thru increased utilization.

Because a case management course exists within the university system, expanding on the current offering would be the most cost effective way to proceed. There was a definite need to let the community know of the courses that currently exist at UAA. Conducting research allowed the researcher to offer recommendations to enhance the current offering. When the voices of the community are heard, leaders can enhance the state education system.

Chapter 7: Public Health Implications

Among the Ten Essential Public Health Services from the Core Public Health Function Steering Committee (2014), the new University of Alaska Anchorage course will address the following:

- Inform, educate, and empower people about health issues.
- Mobilize community partnerships and actions to identify and solve health problems.
- Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
- Assure a competent public and personal health care workforce.
- Research new insights and innovative solutions to health problems.

The new course could be a helpful adjunct for the medical community and the state. Within the Affordable Care Act, the medical-centered home advocates for care coordination. The enhanced course will address the critical aspect of linking people to personal health services and assure a competent workforce in Alaska.

Chapter 8: Conclusions

Alaska may be largest state in size but it has the fourth smallest population (United States Census Bureau, 2009). This large land mass with low population density limits resources and increases costs. As state leaders scrutinize expenditures, the participants verbalized a desire to use the available resources wisely and advocate for additional resources. The healthcare community in Alaska is small and, by connecting and supporting each other, healthcare providers can maximize resources. Alaskans deserve the best health care available and a collaborative team can make that happen.

References

Agency for Healthcare Research and Quality. (2015, May). *Care coordination*. Retrieved from http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html

Alaska Department of Senior and Disability Services. (2015). Provider List. Retrieved from http://dhss.alaska.gov/dsds/Documents/pdfs/sds_providerlist.pdf

Allen, S. (2007, April). Parent's perspectives: An evaluation of case management intervention in home visiting programs for young children. *Children & Schools, 29*, 75-85. doi:10.1093/cs/29.2.75

Amado, A. N., McAnnally, P. L., & Linz, M. H. (1989). History and effectiveness of case management in the United States. In M. H. Linz, P. L. McAnnally, & Wieck, C. (Ed.), *Case management: Historical current & future perspectives* (pp. 1-20). Retrieved from http://mn.gov/mnddc/learning/document/GT062.PDF

Appleby, J. (2012, October 24). Seven factors driving up your health care costs [Review of the television program *PBS news hour*, 2012]. Retrieved from http://www.pbs.org/newshour/rundown/seven-factors-driving-your-health-care-costs/

Baguhn, B. (2011, December). The case for case management. *Healthcare Financial Management, 65*(12), 40-43.

Behan, K., & Blodgett, C. (2003). *Children's mental health promising practices: A review of the literature*. Retrieved from http://www.dshs.wa.gov/pdf/dbhr/mh/resource guide/Bestpracerport.pdf

Burns, K. H., Casey, P. H., Lyle, R. E., Bird, T. M., Fussell, J. J., & Robbins, J. M. (2010, October). Increasing prevalence of medically complex children in US hospitals. *Pediatrics, 126*, 638-646. doi:10.1542/peds.2009-1658

Case Management Society of America. (n.d.). *About CMSA*. Retrieved from http://www.cmsa.org/2012AnnualConferenceExpoSanFranciscoCA/ExhibitorInformation/AboutCMSACaseManagers/tabid/714/Default.aspx#.VesFLfZVhBc

Center for Medicare and Medicaid Services. (2012). *Discharge planning* (8184). Washington, DC: Government Printing Office.

Centers for Disease Control and Prevention. (2003). *Public health and aging: trends in aging—United States and worldwide* (MMWR52). Washington, DC: Government Printing Office.

Centers for Disease Control and Prevention. (2010). *National ambulatory medical care survey*. Washington, DC: Government Printing Office. Centers for Disease Control and Prevention. (2014). *Gross domestic product, national health expenditures, per capita amounts, percent distribution, and average annual percent change United States, selected years 1960–2013*. Retrieved from http://www.cdc.gov/nchs/data/hus/2014/102.pdf

Central Intelligence Agency. (n.d.). *The world fact book*. Retrieved from https://www.cia.gov/library/publications/the-world-factbook/geos/us.html

Commission for Case Management Certification. (n.d.). *Professional case manager.* Retrieved from http://ccmcertification.org/case-managers/professional-case-manager

Commission for Case Manager Certification. (2010). *Philosophy of case management.* Retrieved from http://www.nursingcenter.com/lnc/cearticle?tid=1067978

Council on Children with Disabilities. (2005, November). Care coordination in the medical home: Integrating health and related systems of care for children with special health care needs [Policy Revision]. *Pediatrics, 116*, 1238-1244. doi:10.1542/peds.2005-2070

Department of Health and Social Services. (2015, March 12). *The state of Alaska: Senior and disabilities services* [Press Release]. Retrieved from http://dhss.alaska.gov /dsds/Documents/docs/CFCMSummary.pdf

Faxon, D. P., Schwamm, L. H., Pasternak, R. C., Peterson, E. D., McNeil, B. J., Bufalino, V.,...& Shine, K. (2004). Improving quality of care through disease management: Principles and recommendations for the American Heart Association's expert panel on disease management. *Circulation, 109*, 2651-2654. doi:10.116/01.CIR .0000128373.90851.7B

Fee, E., & Bu, L. (2010, July). . *The origins of public health nursing: The Henry Street visiting nurse service, 1000*, 1206-1207. doi:10.2105/AJPH2009.186049

Fero, L. J., Herrick, C. A., & Hu, J. (2011). *Introduction to nursing case management.* Sudbury, MA: Jones & Bartlett Learning.

Fisher, F. J., Sidorov, J., Fox, G., Girolami, S., Dobeck, L., Donmoyer, C., & Wolke, O. (2000). PCV28: Savings achieved in an HMO sponsored primary care based disease management and case imitative. *Value in Health, 3*(5), 320. doi:10.1016 /S1098-3015(11)0681-7

Health Resources and Service Administration. (n.d.). *Maternal and child health bureau fact sheet.* Washington, DC: Government Printing Office.

HHS.gov. (2015). http://www.hhs.gov/healthcare/about-the-law/read-the-law/index.html

Kersbergen, A. L. (1996, July/August). Case management: A rich history of coordinating care to control costs. *Nursing Outlook, 44,* 169-172.

Lawson, K. A., Bloom, S. R., Sadof, M., Stille, C., & Perrin, J. M. (2012). Care coordination for children with special health care needs: Evaluation of a state experiment. *Maternal and Child Health Journal.* doi:10.1007/s10995-010-0660-1

Liptak, G. S., & Revell, G. M. (1989). Community physician's role in case management of children with chronic illnesses. *Pediatrics, 84,* 465-471.

National Quality Forum. (2012, August 10). *NQF endorses care coordination measures* [Press Release]. Retrieved from http://www.qualityforum.org/News_And _Resources/Press_Releases/2012/NQF_Endorses_Care_Coordination_Measures.a spx

Office of Quality and Care Management. (2008). *Operation definition of care management* [Policy Brief]. Retrieved from http://www.hca.wa.gov/medicaid/healthyoptions/documents/ccm_finalopdef.pdf

Peikes, D., Chen, A., Schore, J., & Brown, R. (2009, February 11). Effects of care coordination on hospitalization, quality of care, and health care expenditures among Medicare beneficiaries. *JAMA, 301,* 603-618. Retrieved from http://jama.jamanetwork.com/article.aspx?articleid=183370&resultclick=1

Peter, S., Chaney, G., Zappia, T., Van Veldhuisen, C., Pereira, S., & Santamaria, N. (2011, September 23). Care coordination for children with complex care needs significantly reduces hospital utilization. *Journal for Specialists of Pediatric Nursing, 16,* 305-312. http://dx.doi.org/10.1111/j.1744-6155.2011.00303.x

Robert Wood Johnson Foundation. (2012). *National data hub: Prevalence of diabetes, CVD and asthma in adults* [Data file]. Retrieved from http://www.rwjf.org/en /research-publications/research-features/rwjf-datahub/national.html#q/scope/national/ind/10/dist/0/char/0/time/23/viz/map/cmp /brkd

Robinson, K. M. (2010, April 29, 2011). Care coordination: A priority for health reform. *Policy, Politics & Nursing Practice, 11,* 266-274. doi:10.1177 /1527154410396572

Simon, T. D., Berry, J., Feudtner, C., Stone, B. L., Sheng, X., Bratton, S. L.,...& Srivastava, R. (2010). Children with complex chronic conditions in inpatient hospital setting in the United States. *Pediatrics, 126,* 647-655. doi:10.1542/peds .2009-3266

Stanford University. (2007). *Closing the quality gap: A critical analysis of quality improvement strategies.* Retrieved from http://www.ahrq.gov/research/findings /evidence-based-reports/caregaptp .html

Strantz, I. H., & Miller, W. R. (1966). Development of interagency coordination in a program of comprehensive medical care. *American Journal of Public Health, 56,* 785-796.

Social Security Act Pub. L. 89-97, 79 Stat. 286. (1935)

Tahan, H. A., & Campagna, V. (2010). Case management roles and functions across various settings and professional disciplines. *Professional Case Management, 15,* 245-277. doi:10.1097/NCM.0b013e3181e94452

Tahan, H. A., Downey, W. T., & Huber, D. L. (2006). Case manager's roles and functions: Commission for case manager certification's 2004, part II. *Lippincott's Case Management, 11*(2), 71-87.

Thorpe, K. E., & Ogden, L. L. (2010, June). Analysis & commentary: The foundation that health reform lays for improved payment, care coordination and prevention. *Health Affairs, 29,* 1183-1187. doi:10.1377/hlthaff.2010.0415

Toomey, S. L., Chien, A. T., Elliott, M. N., Ratner, J., & Schuster, M. A. (2013). Disparities in unmet need for care coordination: the national survey of children's health. *Pediatrics, 131,* 217-224. doi:10.1542/peds.2012-1535

United States Census Bureau. (2009, December). *Resident population—July 2009.* Retrieved from http://www.census.gov/compendia/statab/2012/ranks/rank01.html

Ward, B. W., Schiller, J. S., & Goodman, R. A. (2014, April 17). Multiple chronic conditions among US adults: A 2012 update. *Preventing Chronic Disease, 11, 1-*4. doi:10.5888/pcd11.130389

Weinbach, R. W. (1972, September). Notes for practice: case management of child abuse. *Social Work, 20*(5), 396-397. Retrieved from http://sw.oxfordjournals.org /content/20/5/396.extract

Wilson, K. B. (2013). *Health care costs 101.* Retrieved from http://www.chcf.org/chart-cart/presentations/health-care-costs-101

Appendix A

Institutional Review Board: Proposal Form

Do not change the text in the shaded areas of the form. Your responses to each question/section should be written where it says <<Overwrite Here>>; please keep your response in the same blue 10 pt Arial font.

1. Application Information

Title of Proposal	Case Management Assessment and Course Development
Principal Investigator(s) and Degree(s)	Arlene Patuc RN BSN
Principal Investigator(s) UAA Department	Master of Public Health
PI(s) UAA phone number	907-786-6536
PI(s) Home or cell phone number	907-243-5415
Other Project Personnel and Contact Information	apatuc@gci.net

Date Submitted	<<Overwrite Here>>
Proposed Start Date	May 1, 2015
Anticipated Completion Date	October 31, 2015

Indicate which review category for our application by placing an "X" in the first column on the left. See the IRBNet Library for the IRB Review Categories document. Note that the final determination of review category is made by the IRB Chair.

	Review Requested	Explanation (if needed)
	Exempt	<<Overwrite Here>>
	Expedited	It is a research activity that presents no more than minimal risk to human subjects.
	Full Review	<<Overwrite Here>>

	Place an "X" in the left column to indicate that you have included Certificates of IRB Training for all PIs and Researchers. Please attach the certificates separately.

Principal Investigator Assurance Statement

By submitting this protocol application and signing the IRBNet package electronically, I certify that the information provided is true and complete. I agree to and will comply with the following statements:

1. I will abide by all regulations, policies and procedures applicable to research involving human subjects.
2. I will accept responsibility for the scientific and ethical conduct of this research.
3. I will accept responsibility for providing personnel (collaborators, staff, graduate students, undergraduate students, and volunteers) with the appropriate training and mentoring to conduct their duties as part of this research.
4. If this IRB Protocol Application is for student research, I certify that the student's graduate advisory committee has reviewed and approved this research protocol.
5. I will obtain approval from the IRB prior to amending or altering the research protocol, consent/assent forms or initiating further correspondence with the research subjects.
6. I will report immediately to the Office of Research Compliance (907-786-1099) any complaints from participants or others, any adverse events associated with research participation, and/or any unanticipated problems or issues related to this study.
7. I will report the death or life threatening event of a participant that is possibly, probably or definitely associated with study procedures to the IRB immediately by submitting an IRB Adverse Event Report on IRBNet.
8. I will comply in a timely manner with requests of the IRB regarding Continuing/Final Review.

I realize that failure to comply with the above provisions may result in suspension or termination of this project by the IRB and, if appropriate, restricted access to funding and notification of sponsor, and referral to the appropriate UAA administrative official(s) for disciplinary action.

2. Funding Information

Funding Type	Brief Description
Have you applied for external funding?	No If yes, include a copy of the funding proposal in the IRBNet package.
If yes, list the Agency	NA
Proposal Number	NA
Have you applied for internal funding?	No If yes, include a copy of the funding proposal in the IRBNet package.

3. Project Classification

Type of Project	Brief Description
Faculty Research	<<Overwrite Here>>
Doctoral or Master's Student – Thesis Research*	<<Overwrite Here>>
Doctoral or Master's Student – Other Research*	Arlene Patuc BSN, MPH Program, apatuc@gci.net, 907-243-5415
Bachelor Student – Thesis Research*	
Bachelor Student – Other Research*	<<Overwrite Here>>
Other	<<Overwrite Here>>

***** In the brief description, provide the Research Supervisor's name, UAA department, and contact information.

4. Other Human Subject Review Information

Information	Response (if applicable)
Is this proposal being reviewed by another ethics committee?	No
Name of Committee	<<Overwrite Here>>
Institution	<<Overwrite Here>>
Contact Person	<<Overwrite Here>>
Email Address	
Phone Number	

Place an "X" in the first column to indicate the status of review of this project by another ethics committee.

	Review Status	Explanation (if required)
	Application has not been submitted.	NA
	Application is currently under review.	NA
	Application has been approved.	NA Please include a copy of the approval document in the IRBNet package.
	Other	<<Overwrite Here>>

5. Abstract

Explain the research project in **lay language** that can be easily understood by someone who is not an expert in your field. The abstract must include: 1) A brief summary of the research question; and 2) a brief description of the procedure. **Maximum 150 words.**

Abstract

The goal of this project is to complete a needs assessment within the Anchorage community on the need for a managed care course in Alaska. If the research supports the interest and need for a course, a course syllabus will be produced. The ultimate goal is to produce a syllabus which meets the needs of the Alaska community for case management or care coordination if the assessment supports the need for a course. Qualitative in-person or telephone needs assessment surveys will be conducted with 5-10 content experts in case management/care coordination roles from multiple organizations and multiple specialties in the Anchorage area. The participants will be selected using a snowball method utilizing community partner recommendations. The content experts surveyed will be knowledgeable to the job and educational requirements of the employees functioning as case managers and selected in collaboration with community partners.

6. Brief rationale and objectives

(Maximum 500 words for all three responses)

Required Information
Rationale for study grounded in peer reviewed literature in your discipline:
As health care costs skyrocket, our nation is searching for a system of financially responsible utilization of health services which delivers excellent care. Managed care is a concept conceived over one hundred years which has demonstrated the ability to coordinate care with good utilization of services and excellent outcomes and patient satisfaction. Case management, care coordination and disease management are just a few of the terms used in relation to this concept. Multiple disciplines utilize the practices known as case management, care coordination, discharge planning, managed care nurse, disability management specialist and others. An increasing number of national agencies and government organizations have supported this systematic approach to health care. Also influencing health care costs, the aging population and increased use of specialized care contributes to increased fragmentation and costs. Statistics continue to show that a small minority of patients are utilizing a large percentage of health care dollars. Case management involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient (Agency for Healthcare Research and Quality [AHRQ], n.d., para. 1). Care coordination includes planning, monitoring outcomes, coordinating visits, organizing care to avoid replication, sharing information among professionals, training of caregivers and ongoing reassessment and refinement. Case management can positively increase patient satisfaction, improve utilization of resources and decrease health care costs. The Institute for Healthcare Improvement recommends case management to more effectively allocate resources (Eby & Whittington, 2011). The new Affordable Care Act adds many clients to the role of healthcare consumers. Alaska, while a large state geographically has a small health care community which is challenged by vast distances and limited resources. Alaska currently has one course on pediatric case management available through the All Alaska Pediatric Partnership. Infrequent stand-alone courses through private companies are offered on an inconsistent basis. Online courses are available, but do not address the complexities of health care in Alaska. As part of this proposed project, online classes will be researched for the availability, cost, and content.

Agency for Healthcare Research and Quality. (n.d). *Care coordination*. Retrieved from http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html Eby, C. C., & Whittington, D. (2011). *Care coordination model: better care at lower cost for people with multiple health and social needs.* [White paper]. Retrieved from http://www.ihi.org: http://www.ihi.org/resources/Pages/IHIWhitePapers/IHICareCoordinationModelWhitePaper.aspx	
State your research question and hypotheses	Conducting a needs assessment in the Anchorage community for a case management course
Explain your research design/approach (e.g., quantitative, qualitative, experimental, survey, focus group, etc.). If applicable, respond to the following questions: a) How many groups are you collecting data from? b) Is there random assignment to the groups? c) Is there an experimental manipulation? If yes, explain why. A description of the stimulus or the manipulation can be explained in the summary of procedures.	Qualitative in-person or telephone needs assessment surveys will be conducted with 5-10 content experts in the Anchorage area in case management/care coordination roles from multiple organizations and multiple specialties in the Anchorage area. The participants will be selected using a snowball method. The key people surveyed will be knowledgeable to the job and educational requirements of the employees functioning as case managers and will be selected with the collaboration of the community partner.

7. Research Methodology(Detailed description of Procedures)

Required Information	
Provide a brief summary of procedures in **lay language** (no more than 500 words):	
Qualitative in-person or telephone needs assessment surveys will be conducted with 5-10 content experts in case management/care coordination roles from multiple organizations and multiple specialties in the Anchorage area. The participants will be selected using a snowball method. The key people surveyed will be knowledgeable to the job and educational requirements of the employees functioning as case managers. The surveys will be semi-structured with 8 standard questions, will last 30-60 minutes and can be shortened or lengthened as needed. The surveys will be digitally taped, with the participant's approval, and will not contain any identifiable information on the participant. Only the principle investigator, the committee chair and the community partner will have access to the identifying data. The completed project will be available to community partners, presented in a public presentation and is part of the UAA library but will be password protected. The questions and consent will be provided to the participant one week before the interview.	
Description of the location where the research will be conducted	As a graduate student in the MPH program, I intend to conduct the research online via key informant interviews either in person or by telephone. Utilizing technology allows the researcher to not have to be on campus or at a specific location in order to conduct the research. Thereby, authorization at any specific location is not required.

Research Methods and Tools Check all that apply with an "X". Include in your IRBNet package all questionnaire(s), interview guides, and focus group questions.

	Data Collection Methods or Instruments
	Questionnaires
	Interviews
	Observations
	Focus Groups
	Archival Data/Records Review: If your project utilizes academic, medical, or other records, please describe the data, provide documentation of official permission allowing you access to the data in your IRBNet package.
	Apparatus/Measuring Equipment or Device

Archival Data/Records Review	Response (if applicable)
If you are utilizing archival or existing data, indicate the dates the data were collected. These data must exist at the time of your IRBNet submission.	<<Overwrite Here>> If the data are from a survey or questionnaire, provide a copy of the original instrument and a copy of the consent form in your IRBNet package. If the data records are from an experiment, provide a detailed description of the manipulation and measures and a copy of the consent form.
If the data are records based (e.g., medical records, legal documents), provide a list of the variables being extracted from the data.	<<Overwrite Here>>
If consent form is not available or if consent was not needed for the original data collection, please provide a brief explanation.	<<Overwrite Here>>

8. Subject Selection and Recruitment:

Required Information	Response
a. Maximum number of research participants and a brief rationale for that number	Five to ten participants will be included in the study. Goal is for a representative sample in a limited cohort of individuals utilizing case management.
b. Description of participants, rationale for their participation, and inclusion criteria. (Indicate age range, gender, cultural background or if specific populations will be chosen, e.g., prisoners, pregnant women, Alaska Natives)	Goal is to recruit participants involved in case management without regard to sex, race or national origins.
c. Description of groups or types of individuals that you are intentionally excluding, rationale for exclusion, and exclusion criteria	This study will survey 5-10 healthcare employees who actively function as case managers or supervise case managers in hospitals, independent case management companies, health insurance companies, managed care organizations, worker's compensation agencies, or rehabilitation and worker's compensation groups' base in the Anchorage area.
d. Description of recruitment process and recruitment materials	Utilizing verbal description of project and consent form for the participants. Participants would be recruited using snowball sampling technique. Please submit a copy of recruitment materials and messages in your IRBNet package.
e. Explanation of how recruitment is not burdensome or coercive to participants	Participation will be voluntary with the ultimate goal of providing additional educational opportunities within Alaska for case management
f. Description of plans (if any) to encourage the recruitment of minorities and women	Goal is to recruit participants involved in case management without regard to sex, race or national origins.

9. Benefits, Incentives and Compensation, Costs, and Risks

Note: Consent forms should reflect any risks or compensation described below.

Question	Response
a. Describe potential benefits (e.g., therapeutic or unique self knowledge) that individuals may receive from participating in this research	Benefit of research would be additional knowledge shared with participants of about similar case management roles, responsibilities, and educational requirements within Anchorage. If data supports needs ultimate benefit would be case management course which addresses the need of case managers in Alaska.
b. Describe what new information may be learned from this research	Assessment of case manager's roles, responsibilities and educational needs within Anchorage.
c. Describe incentives to encourage individuals to participate in this research (including monetary or other compensation, thank you gifts, course or other academic credit, lotteries, etc.)	There are no financial incentives. Incentives would be reward for advancing profession within Alaska, verbal and written thank you and if needs assessment occurs during meal hours paid lunch or dinner.
d. Describe costs (time, monetary or other) for participants in this research	No monetary cost would be involved. Time cost would be 30-60 minutes of participant's time. The surveys will be semi-structured with 8 standard questions, will last 30-60 minutes and can be shortened or lengthened as needed. The questions will be emailed along with the consent one week prior to the interview for the review of the participants.
e. Describe potential harms or discomforts (physical, psychological, social) for participants in this research	Time cost may be challenging for some participants.
f. Describe what you will do to minimize potential harms or discomforts to participants in this research	Accommodate scheduling needs of participants.
g. Describe any potential harms to the culture or society that is the subject of this research	None noted
h. Describe what you will do to	No harm anticipated.

minimize potential harms to the culture or society that is the subject of this research	

10. Participant Consent / Assent

Unless a waiver is requested and granted, all participants should be fully informed about the research (purpose, benefits and potential harms from participation, procedures, duration of participation, and special accommodations for language or comprehension), informed consent shall be documented by a written and signed consent form and the participant shall be given a copy of the signed form. The recommended reading level for consent documents is the 8th grade. Guidelines and examples for consent/assent forms can be found at http://www.uaa.alaska.edu/research/ric/irb/documents.cfm. A copy of the consent documents must be included in the IRBNet package. Please submit these documents as a Word document or text file.

Consent	Description
Describe the process of obtaining consent to participate in this research	After receiving verbal consent to participate in the study, a emailed consent will be sent one week prior to the interview so the participant may have adequate time to review the consent and ask questions.
If the participants are minors, describe the process of obtaining assent to participate in this research	NA
Describe how you will communicate to potential participants that their participation is voluntary and that they may withdraw from the research at any time without penalty	After receiving verbal permission for the participant's participation and setting up a meeting time, the participants will receive an emailed consent form one week prior to the agreed meeting time. The researcher will be available to answer any questions before, during and after the interview. The participants may withdraw consent at any time prior to conclusion of the research.
Describe if there was any deception involved in the generation of archival data, or if there is any deception involved in the consent process prior to data collection	None

Place an "X" in the first column if you requesting special accommodations to consent for this research.

	Request for Special Consent Procedures	Justification
	a. Elements of informed consent are presented orally and documented through a short written consent form; the process shall be documented by a witness	<<Overwrite Here>> In your IRBNet package, provide a written summary of what is to be said to the potential participant and a short form written consent document
	b. Electronic acknowledgement of informed consent (e.g., SurveyMonkey)	<<Overwrite Here>> In your IRBNet package, include the language from the online survey which indicates acknowledgment of informed consent.
	c. Waiver of the requirement for documentation (written, audio or video) of informed consent	<<Overwrite Here>>
	d. Waiver of some or all of the elements of consent	<<Overwrite Here>>
	e. Approval of reading level greater than 8th grade in consent documents	<<Overwrite Here>>
	f. Approval for inclusion of participants whose primary language is not English	<<Overwrite Here>>
	g. Approval for inclusion of adults with diminished cognitive capacity	<<Overwrite Here>>

11. Data Storage and Retention

Required Information	Description
a. Describe how the data will be collected or recorded (e.g., *paper instruments, electronic records, field notes, audio/video recordings, notes, etc.)*	The data will be collected using electronic recordings and then transcribed to a computer. The data will then be transferred to a jump drive for storage in a locked drawer. No identifiers will be attached to the transcribed data.

b. Describe who will have access to the data	Only the researcher and the committee chair will have access to the identifying data. The content will be shared with the community partners, committee members and accessible under the UAA password protected system.
c. Describe how you will maintain confidentiality of the data	No identifiers will be used in the transcription. After the digital recordings are transcribed they will be erased to maintain confidentiality.
d. Do you have a federal Certificate of Confidentiality for this research?	No
e. Describe your plans for retention of data, where it will be stored, how long it will be stored, who will be responsible for maintaining and securing it, how it will be destroyed and when it will be destroyed	The researcher will store the data in a locked drawer until completion of the research and then the transcripts will be destroyed.
f. Describe your plans for using the data you collect (e.g., published in journal or equivalent, non- published written report, presented at conference or equivalent, archive only)	The data will be used for this researcher's project practicum for partial fulfillment of the requirements for the degree in public health. The data will also be shared with the community partner-UAA Office of Health Program Development.
g. Describe your plans for sharing the data and results with the community or population from whom the data were collected	Upon request the completed research project will be available to the participants.
h. Describe how you will transfer, communicate and share data among research team members, including description of encryption or security protocols	Only the researcher and committee chair will have access to the identifying data. After completion of the project the committee member will also be offered a copy of the completed needs assessment if desired.
i. Describe where and how consent documents will be stored	The consents will be scanned in to an electronic data base along with the transcribed data.

12. Special Participants and Data Considerations:

a. PRINCIPLES FOR THE CONDUCT OF RESEARCH IN THE ARCTIC

In the table below, explain how your research proposal is responsive to the NSF Principles for the Conduct of Research in the Arctic (if applicable – see http://www.nsf.gov/od/opp/arctic/conduct.jsp).

b. HIPAA

If your research project involves the use of restricted private health information, please view IPAA information at http://www.uaa.alaska.edu/research/ric/irb/Resources.cfm, and explain in the table below below how your proposal is responsive to these requirements.

c. REQUIRED REPORTING OF ABUSE OR NEGLECT OF CHILDREN AND/OR VULNERABLE ADULTS

If your research has the potential to uncover actual or suspected cases of abuse or neglect of children or vulnerable adults, please consult the appropriate Alaska statute (47.17 Child Protection) to determine requirements for reporting such information at http://www.legis.state.ak.us. Please indicate in the table below how you will explain those requirements for reporting to potential participants.

d. FERPA

Family Educational Rights and Privacy Act, FERPA, (Title 34, Part 99 of the CFR). The regulations provide that educational agencies and institutions that receive funding under a program administered by the U.S. Department of Education must provide students with access to their educational records, an opportunity to seek to have the records amended, and some control over the disclosure of information from the records. With several exceptions, schools must have a student's consent prior to the disclosure of educational records. In the table below, explain how your research is responsive to FERPA provisions.

e. SPECIAL PROTECTIONS FOR VULNERABLE POPULATIONS.

When applicable, researchers must document that additional protections of subpart B (Additional Protections for Pregnant Women, Human Fetuses and Neonates Involved in Research), subpart C (Additional Protections Pertaining to Biomedical and Behavioral Research Involving Prisoners as Subjects), or subpart D (Additional Protections for Children Involved as Subjects in Research) of 45 CFR part 46 have been met.

Place an "X" in the first column to indicate all of the following that are applicable to this research

To Consider	Response
a. Principles for the Conduct of Research in the Arctic	Please explain how your research proposal is responsive
b. HIPAA	<<Overwrite Here>>
c. Required reporting of abuse or neglect for children or vulnerable adults	<<Overwrite Here>>
d. FERPA	<<Overwrite Here>>
e. Special protections for vulnerable populations	<<Overwrite Here>>

Appendix B

Research & Graduate Studies

UNIVERSITY *of* ALASKA ANCHORAGE
3211 Providence Drive
Anchorage, Alaska 99508-4614
T 907.786.1099, F 907.786.1791
www.uaa.alaska.edu/research/ric

DATE: April 29, 2015
TO: Arlene Patuc
FROM: University of Alaska Anchorage IRB
PROJECT TITLE: [741907-1] Case Management Assessment and Course Development
SUBMISSION TYPE: New Project
ACTION: DETERMINATION OF NOT RESEARCH
DECISION DATE: April 28, 2015

Thank you for your submission of New Project materials for this research study. The University of Alaska Anchorage IRB has determined this project does not meet the definition of human subject research under the purview of the IRB according to federal regulations. We will retain a copy of this correspondence within our records. If you have any questions, please contact Sharilyn Mumaw at (907) 786-1099 or simumaw@uaa.alaska.edu. Please include your project title and reference number in all correspondence with this office.

Sharilyn Mumaw, M.P.A.
Research Integrity & Compliance Officer

Appendix C

Collaborative Institutional Training Initiative (CITI Program)

COURSEWORK REQUIREMENTS REPORT*

* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details.

See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

- **Name:** Arlene Patuc (ID: 2647419)
- **Email:** apatuc@anthc.org
- **Institution Affiliation:** University of Alaska Anchorage (ID: 537)
- **Institution Unit:** MPH student
- **Phone:** 9077291075
- **Curriculum Group:** Basic/Refresher Course in Human Subjects Research
- **Course Learner Group:** University of Alaska Anchorage Faculty, Staff and Students
- **Stage:** Stage 2 - Refresher Course
- **Report ID:** 14473735
- **Completion Date:** 01/05/2015
- **Expiration Date:** 01/04/2018
- **Minimum Passing:** 80
- **Reported Score*:** 94

REQUIRED AND ELECTIVE MODULES ONLY DATE COMPLETED SCORE

Biomed Refresher 2 - Instructions 12/21/14 No Quiz

Biomed Refresher 2 – History and Ethical Principles 12/21/14 3/3 (100%)

Biomed Refresher 2 – Regulations and Process 12/22/14 2/2 (100%)

Biomed Refresher 2 – Informed Consent 12/22/14 3/3 (100%)

Biomed Refresher 2 – SBR Methodologies in Biomedical Research 12/22/14 4/4 (100%)

Biomed Refresher 2 – Genetics Research 12/22/14 2/2 (100%)

Biomed Refresher 2 – Records-Based Research 12/22/14 3/3 (100%)

Biomed Refresher 2 - Populations in Research Requiring Additional Considerations and/or Protections 12/31/14 1/1 (100%)

Biomed Refresher 2 – Vulnerable Subjects – Prisoners 12/31/14 2/2 (100%)

Biomed Refresher 2 – Vulnerable Subjects – Children 12/31/14 3/3 (100%)

Biomed Refresher 2 – Vulnerable Subjects – Pregnant Women, Human Fetuses, Neonates 12/31/14 2/2 (100%)

Biomed Refresher 2 – HIPAA and Human Subjects Research 12/31/14 3/5 (60%)

Biomed Refresher 2 – Conflicts of Interest in Research Involving Human Subjects 01/05/15 3/3 (100%)

How to Complete the CITI Refresher Course and Receive a Completion Report 01/05/15 No Quiz

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

CITI Program
Email: citisupport@miami.edu
Phone: 305-243-7970
Web: https://www.citiprogram.org

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COURSEWORK TRANSCRIPT REPORT**

** NOTE: Scores on this Transcript Report reflect the most current quiz completions, including quizzes on optional (supplemental) elements of the course. See list below for details. See separate Requirements Report for the reported scores at the time all requirements for the course were met.

- **Name:** Arlene Patuc (ID: 2647419)
- **Email:** apatuc@anthc.org
- **Institution Affiliation:** University of Alaska Anchorage (ID: 537)
- **Institution Unit:** MPH student
- **Phone:** 9077291075
- **Curriculum Group:** Basic/Refresher Course in Human Subjects Research
- **Course Learner Group:** University of Alaska Anchorage Faculty, Staff and Students
- **Stage:** Stage 2 - Refresher Course
- **Report ID:** 14473735
- **Report Date:** 01/05/2015
- **Current Score**:** 94

REQUIRED, ELECTIVE, AND SUPPLEMENTAL MODULES MOST RECENT SCORE

Biomed Refresher 2 - Instructions 12/21/14 No Quiz
Biomed Refresher 2 – History and Ethical Principles 12/21/14 3/3 (100%)
Biomed Refresher 2 – Regulations and Process 12/22/14 2/2 (100%)
Biomed Refresher 2 – Informed Consent 12/22/14 3/3 (100%)
Biomed Refresher 2 – SBR Methodologies in Biomedical Research 12/22/14 4/4 (100%)
Biomed Refresher 2 – Records-Based Research 12/22/14 3/3 (100%)
Biomed Refresher 2 – Genetics Research 12/22/14 2/2 (100%)
Biomed Refresher 2 - Populations in Research Requiring Additional Considerations and/or Protections 12/31/14 1/1 (100%)
Biomed Refresher 2 – Vulnerable Subjects – Prisoners 12/31/14 2/2 (100%)
Biomed Refresher 2 – Vulnerable Subjects – Children 12/31/14 3/3 (100%)
Biomed Refresher 2 – Vulnerable Subjects – Pregnant Women, Human Fetuses, Neonates 12/31/14 2/2 (100%)
Biomed Refresher 2 – HIPAA and Human Subjects Research 12/31/14 3/5 (60%)

Biomed Refresher 2 – Conflicts of Interest in Research Involving Human Subjects 01/05/15 3/3 (100%)

How to Complete the CITI Refresher Course and Receive a Completion Report 01/05/15 No Quiz

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution

identified above or have been a paid Independent Learner.

CITI Program

Email: citisupport@miami.edu

Phone: 305-243-7970

Web: https://www.citiprogram.org

Appendix D

Key Informant Interview Questions

1. What type of organization do you work for: hospital, impendent case management, health insurance company, mental health, worker's compensation, disability organization
2. How many case managers employed at the agency?
3. Are you a supervisor: Yes or no
4. What are alternative titles for case managers employed here?
5. What are the job duties of the case managers?
6. What are required certifications within organizations and educational requirements?
7. Would there be interest in UAA course?
8. Any suggestions for course content, length, cost?

Appendix E

Key Informant Informed Consent Form

PRINCIPAL INVESTIGATOR
Arlene Patuc
Master in Public Health student
University of Alaska Anchorage
907-729-8895 (work)

RESEARCH SUPERVISOR
Dr. Jenny Miller DrPH, MS, MPH
Assistant Professor Public Health
University of Alaska Anchorage
907-786-6588

DESCRIPTION: I am a graduate student in the Masters of Public Health Program at UAA. For my final project I am researching the need for a course on case management at UAA. I am interested in the thoughts and opinions of health professionals who may be interested in taking the course or may utilize the course for their employees. My research will include one interview with you lasting approximately 30 to 60 minutes. The interview will be taped and the information typed into transcripts. The taped interviews will then be erased. The questions will include:

1. General information about your organization including number of personnel functioning as case managers/care coordinators and their job duties.
2. Educational requirements for employees, educational opportunities at the organization, certifications held or desired by staff, unmet educational needs in relation to case management/care coordination.
3. Your opinion on needed educational opportunities, structure of those opportunities and topics which need to be included in the offering.

Question guidelines will be provided prior to the interview for review by the participant but the interviews is not restricted to those guidelines.

VOLUNTARY PARTICIPATION: Your participation is completely voluntary and you may withdrawal at any time without penalty.

CONFIDENTIALITY: Your name or organization will not be attached to your interview responses. Any identifiers will be kept in a locked file only accessible to me or my committee chair. Any published information from this study will not identify you or your organization by name.

POTENTIAL BENEFITS AND RISKS: Your participation only requires your time and there are no foreseeable risks or benefits to you personally with respect to your personal or professional status from participation in this study. However, your willingness to share your experiences and knowledge may provide valuable insights into a gap in educational opportunities within Alaska.

CONTACT PEOPLE: If you have any questions about this research, please contact the Principal Investigator at the phone number listed above. If you have any questions about your rights as a research subject, please contact Sharilyn Mumaw, Compliance Officer, Office of Research Integrity & Compliance, (907) 786-1099 or simumaw@uaa.alaska.edu

SIGNATURE: By signing this consent form, it means you fully understand the above study, what is being asked of you in this study, and that you are signing voluntarily. If you have any questions, please ask them now or at any time during this study.

SIGNATURE_____ DATE_____

A copy of this form will be given to you to keep.

Appendix F

Course Content Guide

I. Date of Initiation: January 2016

II. Curriculum Action Request

A. College: UAA, College of Health School of Allied Health
B. Number of Credits/Contac Hours: 24 CEU, based on full attendance, less available with decreased attendance
C. Contact Time: Web/Teleconference, Final 1.5 day conference
D. Course Title: Coordinating Health Resources thru the Continuum of Life
E. Grading Basis: attendance. Continuing education credits will be based on course participation on a weekly basis, inability to attend and participate will forfeit credits for session.
F. Course Description: Managed care is designed to prepare care coordinator/case manager to work effectively within Alaska. The course will provide an overview of important concepts of managed care in relation to various periods during the life span. The course will end with a 1.5 day conference to facilitate developing interpersonal relationships between the participants.

G. Course Fees: as set by standards of the university

II. Course Goals

A. Students will recognize the role of the case manager/care coordination in working collaboratively with the patient and family to develop a plan of care for the patient's needs.
B. Students will verbalize how to access resources within Alaska.

III. Course Outline

A. **Session 1 : Introduction/Overview of Care Coordination & Case Management 2 hours**
   a. Identify key components of a care coordination, case management and implications within Alaska.
   b. Identify impact of Affordable Care Act on CC/CM

B. **Session 2: Care Resources in Alaska 2 hours**
   a. Discuss Alaska 's waiver services
   b. Highlight challenges and unique benefits within Alaska

C. Session 3: Understanding Relationship Based Care 2 hours
   a. Defining components of relationship based care
   c. Motivational Interviewing
   d. Person centered Planning

D. Session 4: The World of Children 2 hours

e. Discuss developmental disabilities in relation to children
f. Discuss ACE study, epigenetics and lifelong implications

E. Session 5: Advocating for the Elderly 2 hours

a. Discuss implications of health on the elderly
b. Highlight common disease conditions in the elderly and implications for care
c. Supporting the family of the elderly

F. Session 6: The Challenge of Mental Illness and Developmental Disabilities-2 hours

a. Discuss common mental health conditions and implications for case management

G. Session 7: The conference: 1.5 day conference -12 hours

a. Understanding the medical diseases and implications for coordination
b. Cultural understanding of family dynamics
c. Rural vs urban challenges
d. Ethics
e. Supporting the clients right to choose
f. Establishing boundaries
g. Evaluating success for the patient and family
h. Discussing complex cases, options used, roads not taken
i. Evaluation of program discussion/room for improvement

V. Bibliography and Resources

a. Readings to be determined
b. Utilization of content experts for guest lectures on specialized subject matter

VI. Assignment

a. Readings required prior to each topic to be determined by subject matter.
b. Students are required to participate in discussion, if attending by delayed webinar must post responses to discussion questions addressed within webinar.
c. Certificates will be issued with completed continuing education units.
d. Recommendation; each student be requested to present, during final conference most complex patient (no identifying demographics) to foster closing discussions resources and alternative conclusions.

Appendix G-1

Needs Assessment for CM/CC Course

Questions Interviewee	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**
Type of Organization	Primary care clinic	State	Hospital	Physician owned practice	Private, statewide, nonprofit	Private, not-for-profit	Workers' comp cm	Non-profit, disease specific	For profit	For profit
# of CM/CC	90-100	2	16	1 CC 2 CM	2	11 CC 15 CM	2	7 FTE	15 CM/CC	10+
Supervisor: yes/no	No	No	No	No	No	Yes	No	Yes	No	Formally
Alternative titles	Clinical coordinators	NA	Support techs, patient navigators	NA	NA	Behavioral health	vocational CM	NA	NA	nonclinical CM CC-Behavioral health

Table G-1. Continued

Questions Interviewee	A	B	C	D	E	F	G	H	I	J
Job duties	Nursing care via phone, assess patient, chart review, psychosocial. assessment, education, screening, telephone triage, document treatment, population based care, medication management, prospective planning for patient care	Communicate with providers, care plan development, outreach and community partnership	Transition care, discharge planning, support specific units and cross cover	CC-monitor outgoing referrals, review referrals, lead for appts. CM-medical focused	Service plans, client appts, assist in meeting goals	CC-plan of care, contact client 2x/mos.billing CM-staffing for plan	Based on insurance company, assess., attend appts	Collect info., needs assess., develop plan of care, connect people to community resources, monitor services	Develop plan of care, assess work plan of care with patient, reach out to physician review meds. monthly	Develop plan of care, assess., recommend
Required recommended certification	CM recommend and supported by organization	Bachelor required for job, no cert. recommended	Encourage cert. thru the ACM model, hospital oriented	UAA peds course	Bachelor and 5 yrs. exper. recommend chemical counsel-or	State CC training for cert.	BSN required, recommend CM cert.	CC training from the state waiver program	2 yrs. exper. or BSN. CCM req. 2 years employ	RN or CMC, prefer cert.in specialty
Interest in UAA course	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Table G-1. Continued

Questions Interviewee	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**
Suggestions Length Cost	Approach people holistically, Navigate system, Connect resources, Intro course, Interdiscip. teams, relationship based care. Length 6-8 weeks, add critical conversation, motivational interviewing, Develop boundaries	Resource within life span, vignettes or stories, 10wks, undergrad, Appeal to waiver CC, measures	ACM-CM training required by ACM cert. Org. support, Use ACM or CCM models, qualify to sit for national exam, undergrad or grad, A&P, semester long, face to face	On-boarding staff, parents, conflict free CM, community resources, specialty care & prereq. motivation interview, cultural competence care spectrums-SW, PT, OT, speech. ND CEU and college credits	Trauma informed care, establishing rapport, diagnosis, CEU, semester long, mental illness, elderly, cultural competent. boundary, alcoholism, culture of homelessness, meeting people where they are.	Person centered plans, self-advocacy Online class, face to face helpful to develop relations possible hybrid course	Basic CM training, 4-6 weeks, course exam, theories in CM, medical specifics of condition -head injuries. CEU, hybrid course-online and in person	Community knowledge, online access but in person preferred, mental illness, behavioral challenges	undergrad, ethics, college credit, CEU, complex disease specific-transplant, peds, video or webcast	Holistic looks at family, geriatrics and elderly increased CEU, hybrid model, face to face