



## Attestation of Performance Activity Completion

**Organization Name:**

**Performance Activity ID:** PA\_046

I hereby attest to the best of my knowledge that my organization has completed the performance activity listed below by its CNYCC prescribed completion date. I am authorized to attest on behalf of my organization.

PA ID	Performance Activity	Prescribed Completion Date
PA_010	75% of indicated staff complete Care Coordination training as specified by CNYCC by <b>March 31, 2018</b> .	04/16/18

**At a minimum, a Care Coordination course must meet the following objectives (approved by CNYCC's Workforce Committee) to be at least equivalent to CNYCC's Care Coordination 101 course and must have been delivered to at least 75% of staff on or after 4/1/15:**

- 1) Understand the activities associated with care coordination/care management.
- 2) Understand the levels of care coordination/care management and the benefits of each.
- 3) Understand the purpose of care coordination/care management and its correlation to patient outcomes.

\_\_\_\_\_  
Authorized Signatory Name

\_\_\_\_\_  
Authorized Signatory Title

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date