**Care Coordination Roles and Responsibilities**

The practice is responsible for the care coordination activities as outlined below. Practice may hire or designate staff for care coordination including, but not limited to a nurse care manager, behavioral health provider, parent consultant, or peer navigator. CTC has an interest in implementing a systematized approach to care management and coordination. PCMH-Kids facilitators will assist practices with standardizing workflows, creating assessment templates, and streamlining the referral processes. PCMH-Kids will define methods for identifying high-risk patients. The practice will adhere to the guidance set forth by these standardized procedures.

General Definition: Pediatric care coordination is a patient- and family-centered, assessment driven, team-based activity designed to meet the needs of children and youth while enhancing the caregiving capabilities of families. Care coordination addresses medical, social, developmental, behavioral, educational, and financial needs to achieve optimal health and wellness.

Key Characteristics of Effective Pediatric Care Coordination

1. Patient- and Family-Centered
2. Proactive, Planned, and Comprehensive
   1. Supports proactive, continuous, and longitudinal care
   2. Builds on family strengths and is guided by a comprehensive, standardized assessment of needs
   3. Supports and relies on team care
   4. Facilitates the care-planning process including consultation, referral, testing, goals

(jointly developed and shared), monitoring, and follow-up

* 1. Plans for the transition of youth from pediatric to adult systems of care

1. Promotes Self-Care Skills and Independence
   1. Ensures the provision of patient/family education to build self-management skills
   2. Equips families with the skills needed to navigate a complex health care system
2. Emphasizes Cross-Organizational Relationships
   1. Builds relationships throughout the community that support integration of care and patient/youth/family self-management skills
   2. Ensures effective communication and collaboration along the continuum of care

# Key Responsibilities

The care coordinator links patients and families to systems of services available within health care, education, early child care, and family support. An important component of care coordination is the creation of individualized care plans, informed by a comprehensive needs assessment and including clear goals, roles and responsibilities and expected outcomes. *The level of care coordination required to implement the care plan will vary and is determined by a stratification model. based on the needs of the patient and family.*  *The care plan is continuously monitored and updated..* *To be most effective, care planning must be supported by team-based care.*

# Key Care Coordination Activities

1. Establish relationships with children, youth, and families through introductory visits, like a warm hand-off, dedicated to setting expectations for care coordination.
2. Promote communication with families and among professional partners and establish frequency of communication.
3. Complete a child/youth and family assessment *that includes family status and home environment assessment (i.e., assessment of medical/behavioral/dental health status; social supports of family and friends; financial needs; family demands, relationships, and functioning; cultural beliefs and values of family; strengths/assets of child, youth, family/caregivers, and current goals of child, youth and family) and growth and development assessment (i.e., assessment of child/youth developmental progress/status; child/youth strengths/assets; school performance/needs, and emotional/behavioral strengths and needs).*
4. Working with the family, develop a written care plan, including a medical summary, action plan, and, if needed, an emergency plan, that reflects mutual goals. *Update the written care plan on a regular basis.*
5. Ensure the set up and coordination of *all medical, developmental, behavioral health, and social* referrals, and track referrals and test results. *Examples of care coordinator activities include working with the patient or parent/family member to schedule a referral appointment; contacting the school to obtain information on support services; contacting a government agency, such as SSI, to determine service eligibility; scheduling appointments with a hospital or clinic, clarifying coverage with a payer; arranging for participation in vocational or training programs and providing medication reconciliation. Additional examples include conferring with the PCP; doing a chart review, or doing patient-focused research.*
6. Provide condition-specific and related medical, financial, educational, and social supportive resource information, while promoting health-management skills and self-care skills.
7. Ensure the health care team integrates multiple sources of health care information; provide the *patient/caregiver with a summary of this information*, thereby building caregiver skills and fostering relationships between the health care team and families.
8. Coordinate care with and referrals to the state-designated community health team, if available in your area.
9. Support and facilitate all care transitions, including to and from hospital and emergency rooms, practice to practice and pediatric to adult systems of care.
10. Coordinate family-centered team meetings, across organizations as needed.
11. Use health information technology to effectively deliver and continually monitor care coordination and the effectiveness of service delivery.