**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 will provide practices with standardized workflows, assessment templates, and 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 interrelated medical, social, developmental, behavioral, educational, and financial needs to achieve optimal health and wellness outcomes.

Key Characteristics of an Effective Pediatric Care Coordination Function

1. Patient- and Family-Centered
2. Links patients and families to an accessible, community-based primary care medical home
3. Proactive, Planned, and Comprehensive
	1. Supports anticipatory, 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
	5. Plans for the transition of youth from pediatric to adult systems of care
4. 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
5. Emphasizes Cross-Organizational Relationships
	1. Builds strategic relationships across a 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

In its most robust form, care coordination provides linkages to systems of services available within health care, education, early child care, and family support sectors. An important component of care coordination is the creation of individualized care plans, informed by a comprehensive needs assessment and including a clear delineation of 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 assessed level of need of the family, taking into account the requirements for carrying out care plans and the resources available to the family.* *The care plan is continuously monitored and updated with new assessments, goal setting, and care planning.* *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 dedicated to setting expectations for care coordination.
2. Promote communication with families and among professional partners, and define minimal intervals between communications.
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. Arrange for, set up, and coordinate *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 being provided; contacting a governmental agency, such as SSI, to determine service eligibility; scheduling appointments with the hospital or clinic, clarifying coverage with a payer; arranging for participation in vocational or training programs and refilling a prescription with the pharmacy. Additional examples of other activities that may be undertaken to meet this responsibility 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 coaching for the transfer of health-management skills supportive of partnerships with families to care for their children and youth.
7. Ensure the health care team integrates multiple sources of health care information; communicate this summary *to the patient/caregiver*, 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
9. Support and facilitate all care transitions from practice to practice and from the 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.