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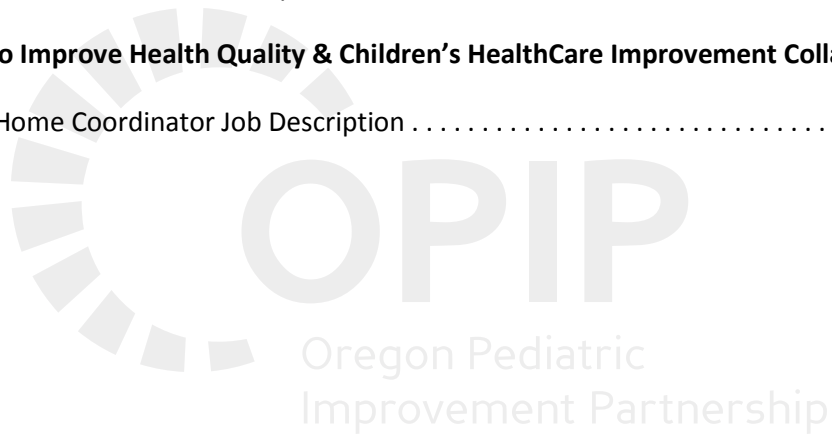
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West Virginia: Health Improvement Institute

Care Coordinator Job Description

Care Coordination in the WV T-CHIC Project

We can be Proactive rather than Reactive, we can:

- Facilitate communication among patients, family members, survivors and healthcare providers
- Coordinate care among providers
- Assist with financial support and assist with paperwork when appropriate
- Arrange transportation and child care
- Ensure that appropriate medical records are available at medical appointments.
- Facilitate follow-up appointments
- Community outreach and build partnership with local agencies and groups
- Decrease anxieties of patients/families of the “unknown”

While there is no set education required for a care coordinator to be successful, a successful care coordinator should be:

- Compassionate, sensitive, culturally attuned to the people and community being served and able to communicate effectively
- Knowledgeable about the environment and healthcare system
- Connected with critical decision makers inside the system, especially financial decision makers

Potential Care Coordination Tasks

Improve Physician Satisfaction

- Make rounds with physicians
- Get reports on the chart before patients arrive
- Improve communication

Administrative

- Completion of paperwork
- Coordinating appointment organization, confirmation or rescheduling and attendance:
 - Reminding patients of appointments
- Organizing transport
- Accessing support for patients who live in rural areas, for example accommodation when referred to treatment centers which are distant to the patients home
- Assistance with work related issues, such as providing letters to employers for patients and/or their family

Clinical Tasks

- Coordinating care through investigation, diagnosis and treatment from multiple providers and across one or more providers
- Ensuring patients are prepared for appointments
- Ensuring patients and families understand their condition, treatment (including medications and therapies such as radiotherapy, chemotherapy and so on) if not bringing it to the attention of the provider

- Track interventions and outcomes to ensure patients are being reviewed in accordance to protocol and have not „fallen through the gaps
- Answering questions that patients and families have
- Coordinate/facilitate communication among all team members, including community resources
- Function in a collaborative and supportive role to care team members

Advocacy

- Advocating or coaching for patients at medical appointments
- Activation is the process of supporting patients to increase their communication skills including developing the ability to ask questions re treatment programs
- Facilitation of communication between healthcare providers and patients/family
- Increasing patient’s experience of and ability to become more involved in their care. For example increasing patients confidence in their own or families abilities to manage situations
- Anticipates, plans and discusses patient’s needs with patient/family, physician, nursing/ancillary staff, payers and other staff
- Demonstrates flexibility and creativity in identifying resources to meet patient/family needs

Education

- Distributing educational resources (written, video, audio and so on) after they have been approved by the provider
- Providing tailored cultural health education resources where indicated
- Socio-cultural
- Ensuring social and family networks exist and are accessed where required
- Assessing health literacy and supporting patients and families where required
- Supporting patients and families in accessing or obtaining care for dependants (children, elderly or other family members) if this is directly affecting a patient’s ability to access or uptake care
- Assistance with housing issues or referral to social services
- Accessing translators where required to ensure patients and families understand the condition and treatment options

Psychosocial support

- Emotional support provision or referral for patient and families
- Reduction of patient fear and anxiety
- Articles also noted „being there’ and reduction of feelings of isolation amongst patients as core to the role
- Spiritual support provision or referral for patient and families
- Cultural Support regarding beliefs and world views

Financial support

- Access assistance
- Knowledge of and support to complete forms for unemployment, sickness, and so on
- Support through the benefit system, for example at appointments with Unemployment

Service related tasks

- Recording interventions with patients and families
- Recording meetings with other healthcare providers
- Attending meetings such as multi-disciplinary, care coordination, discharge from hospital and so on

- Reporting (monthly, quarterly, annual and so on)
- Database or spreadsheet maintenance for tracking care coordination interventions for measurement
- Building networks and relationships with other providers both internal to organization and external
- Service development, which may include: Protocols, standards, guidelines and so on (with provider assistance and approval)
- Referral process - into the service (from other health care providers, self-referral and case seeking)
- Service planning and development
- Evaluation of service
- Marketing of service
- Financial management of service (where relevant)

Lack of care coordination is associated with:

- Duplication of services.
- Inappropriate or conflicting care recommendations.
- Medication errors.
- Unavailability of advance care directives across settings.
- Misunderstanding or lack of awareness of warning symptoms.
- Increased costs.
- Increased patient anxiety and distress.

Care Coordinators are clinical extenders that work with the patients, are familiar with the community, and understand the population. Care Coordinators help patients trust the healthcare system better. Care Coordinators are "*Barrier Busters*".

"Care Coordination is the Left Ventricle of the Medical Home", Jennifer Lail, MD, FAAP

West Virginia: Health Improvement Institute

Pediatric Patient Care Coordinator Job Description



PEDIATRIC PATIENT CARE COORDINATOR

ORGANIZATION OVERVIEW

The West Virginia Health Improvement Institute is a statewide collaboration among multiple stakeholders focusing on improving the health and health care of all West Virginians. The goal of the Institute is to improve the health status of all West Virginians through aligned initiatives focusing on improved access, prevention, promotion of wellness and healthy lifestyle choices, and optimal evidence based chronic illness management.

POSITION DESCRIPTION SUMMARY

GENERAL SCOPE OF THE WORK:

A Pediatric Patient Care Coordinator is an unlicensed individual working in an appropriate healthcare setting to assist with client care coordination. The major focus of care coordination is to ensure the client is receiving the most appropriate care to meet both their physical and psychosocial needs. A pediatric patient care coordinator is an advocate who ensures patients are satisfied with their health care. A pediatric patient care coordinator is an individual who serves as one of the most important links between a patient and the team of healthcare providers. They provide services to support families with children and service providers working with such families to assure families are aware of child development/care programs that are affordable, of high quality and meet their needs. The pediatric patient care coordinator works alongside families to build relationships and improve health, outcomes for children and families. The pediatric care coordinator practices responsible, professional care coordination in a team environment in the support and assistance of families with personal, social, health, educational and economic needs; empowers the family to the highest level of self sufficiency; requires little supervision; articulates, supports and applies the high performance practices (continual quality and service improvements, participatory involvement, teamwork, data collection and analysis) of the team.

Partnership for Health Management has exciting position available- A Patient Care Navigator is an unlicensed individual working in an appropriate healthcare setting to assist with client care coordination. The major focus of care coordination is to ensure the client is receiving the most appropriate care to meet both their physical and psychosocial needs.

WORK INCLUDES:

- Create linkage between the client and their Medical Home, community and their licensed healthcare providers while ensuring the healthcare provider has the necessary information regarding the discharge and/or concurrent treatment plan
- Intervene, assist, manage and be a strong advocate for their clients or to promote issues
- Navigate the medical system, then inform, counsel and help their patients and their families understand the results
- Fill out paperwork such as insurance claims
- Keep abreast of current medical laws, rules and policies such as Medicare, Medicaid, CHIP and other companies

KNOWLEDGE, SKILLS AND ABILITIES:

- knowledge of child development, parenting practices and family systems;
- ability to identify social problems and needs and to assess the ability of individual and families to utilize services in problem solving;
- understanding of rights, responsibilities and differences of others;
- ability to read and interpret policies;
- ability to accept and give feedback and to developing oneself with ongoing learning;
- ability to be flexible and to work autonomously;
- ability to mentor, coach, train, and consult with and to others;
- ability to prepare reports and maintain records;
- good interpersonal skills and
- great at dealing with patients, family and clinical staff.
- time-management organizational and problem-solving skills
- confidentiality is of critical importance
- capable of communication with people from various professions, backgrounds, and cultures with tact and diplomacy
- ability to maintain records of family/client contacts and referrals in accordance with state guidelines
- expressive ability to compose minutes, letters, and reports using proper rules of grammar, spelling, and punctuation
- maintain records to document client related and work related activities in accordance with program policy
- document all contacts and attempted contacts with or on behalf of clients
- must have current WV drivers license, reliable transportation, and up to date auto insurance
- attend training sessions, meetings, workshops, etc. relative to this position
- working knowledge of data entry and word processing
- proficient in use of telephone, copier, and calculator
- familiarity with medical terminology is desirable
- perform related duties as required

EDUCATION AND EXPERIENCE

Bachelor's degree from an accredited college or university with major work in social work, psychology, health, child development and three to five years work experience in a healthcare environment.

Experience working with young children & families experiencing specialized needs or risk factors through Head Start, or other high quality early care and education settings preferred; experience providing professional development, technical assistance, coaching and/or mentoring, and consultation to staff working with young children and families a plus.

Vermont Child Health Improvement Program

Pediatric Care Coordinator Job Description



Pediatric Care Coordinator Job Description

The care coordination position at *Insert Practice Name* is designed to assist our parents, patients, and caregivers with:

- Referrals to specialists and other care providers
- Communication between the child's primary care physician, service providers and subspecialty physicians
- Support for parental concerns
- Problem solving to promote the patients' well being

Additionally, the care coordinators' work will serve to afford physicians more time in direct clinical care, and patients a more direct portal of entry to having needs met at *Insert Practice Name*. In accordance with the American Academy of Pediatrics, care delivered by the care coordinator(s) should be accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective.

For purposes of our pilot we use the federal Maternal and Child Health Bureau definition of children with special health care needs (CSHCN) as:

*“those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally”*¹¹ Specifically, this definition **includes** children with mental/behavioral health concerns and psychosocial challenges.

Job Responsibilities

Broadly defined, the Care Coordinator (CC) will:

- A) Maintain the registry of children with special health care needs (CSHCN)
- B) Pre-visit Planning (PVP) prior to physicals of children identified in our CSHCN registry.
- C) Be available to assist with physician directed quality improvement projects using the CSHN registry (improving Asthma care outcomes, for example)
- D) Assist with and anticipate health care transition steps from adolescence to adulthood
- E) Improve communication between families, the practice, community services and health care providers

More specifically defined, the Care Coordinator role includes:

A) CSHN registry management:

- Request to MD for diagnoses, complexity score and need for PVP
- Assist with down-regulating or up-regulating “need level” of CSHN registry families
- Entry of complexity score in registry and update of diagnoses
- Assurance of adequate time for visit, and of Special Designation

^{1 1} McPherson M, Arango P, Fox H, et al. “A new definition of children with special health care needs”, *Pediatrics*, 1998; 102: 137-140.

- Develop assessment-based tools for who needs CC

B) Pre-visit Planning:

- Completion of PVP phone call to parent and team members if required
- Completion of PVP log
- Initiation of parent survey re: PVP value q 6 months
- Gathering lab work results, discharge summaries, recent MD correspondence, latest family concerns if known, for physician to review prior to visit

C) Quality Improvement Projects and Liason with Community Health Team:

- Be available to assist with physician directed improvement projects using the CSHN registry (improving Asthma care outcomes, for example)
- Assist with development of protocols for care plan completion for group home patients (such as Lund Family Center, AllenBrook, foster family communication tools)
- Report to CHT and meets other care coordinators within the CHT network to support, train and liason with community resources, cross-pollinate ideas and share experience
- Identify children who need financial assistance and refer them to local agencies for help
- Collate eligibility criteria for public health service
- Share info with parents on appropriate diagnosis-based topics (support groups, studies, educational speakers)
- Assist with parent education sessions
- Assist with patient satisfaction surveys.
- Help MD's identify parents for parent-to-parent (Vermont Family Network)support opportunities
- Continue to educate self, CHT, and clinicians about local/state resources; encourage interface with university and state support agencies
- Present CC work at educational meetings on Medical Home.
- Maintain data base that tracks clients served, categories of activities and time spent, for review and planning purposes.
- Create Annual report of activities and complete an evaluation process for supervision/development, strategic planning, and quality improvement.
- Attend an annual pediatric state care coordinator meeting along with AAP chapter meeting

D) Health Care Transition

Assist with and anticipate health care transition steps from adolescence to adulthood in accordance with AAP's recent guidelines as presented in "Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home"² and by the Center for Medical Home Improvement

² "Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home," American Academy of Pediatrics, American Academy of Family Physicians, and American College of Physicians, Transitions Clinical Report Authoring Group Pediatrics 2011;128;182; originally published online June 27, 2011; DOI: 10.1542/peds.2011-0969

E) Improving Family Communication/Continuity and Care Coordination:

- Perform nurse screening role for CSHCN registry patients when they come for their visits, allowing for face to face clinical interactions whenever possible (institution of health maintenance check lists)
- Interact with school nurses, health departments and other community agencies, including the Department of Health Access

- Coordinate specialty referrals, which involves:
 - Arranging appointments if parent desires.
 - Assuring appropriate records are forwarded
 - Send appropriate chart records to specialist
 - Assure referral was completed
 - Access records of referral visit and direct referring MD
 - Maintain referral log
- Coordinate procedure schedule and home care services
- Communicate with parents/hospitals around hospitalizations and new diagnoses
- Make daily call to hospitalized children/families (not on our service)
- Communicate the status of hospitalized patients (not on our service) to on call MD, and enter note in pt. chart
- Attend community meetings involving the CSHCN, IEP, hospital d/c meetings, NFI d/c meetings, Act 264 mtgs. etc.
- Attend Care Conferences
- For patients with extended stays, greater than 1 week (not on our service) (ex. Premies), make weekly calls to parents.
- Arrange follow-up care with hospitals; assure discharge summaries/data are available.
- Take verbal reports on patients being discharged from hospital and direct info to physician who will see patient
- Work to identify/integrate children who come only for episodic care; encourage PE's, immunization update, and developmental/lead/TB/anemia screening for such patients.
- Template and write letters authorizing service and equipment for patients.
- Help maintain printed or online directory of consultants for CSHCN
- Log each CC call to assist with continuity of care, and ultimately, billing for CC
- Begin to develop parent email directory
- Perform other duties related to Medical Home as assigned.

Preparation and Training

Registered nurse with training in medical home and knowledge of current medical home, preferably with established connections with and knowledge of medical home families. Must have appropriate training in business machines, spreadsheets, Medical Manager

software, work processing and Windows computer skills. Kind and assertive interactional skills, excellent listening skills and careful record-keeping are requisites for this position. Clinical knowledge of children's chronic medical condition and medical terminology are a definite asset for this position.

Experience:

With the above preparation and training, it will take approximately 6-12 months to become proficient in the CC role, and in the policies and procedures of Insert Practice Name. Experience with parents of CSHCN, and/or knowledge of local/state services would be a specific asset.

Independent Judgement and Professional Behavior:

While the care coordinator will have the general supervision of the primary care provider assigned to the family they are working with, personal judgment is essential to identify when to involve a physician. Any questionable cases should be discussed with the physician most familiar with that patient, or his/her team member. Individuals who require the assistance of the care coordinator may be stressed by their child's condition, and will require a calm, professional approach to best help them. Because the CC will represent Insert Practice Name to the greater community, tact, good manners and a cooperative attitude are mandatory.

Working Conditions:

Most of the work is performed under usual working office conditions. The position has some exposure to communicable diseases by virtue of working with sick children. The position requires the physical ability to obtain charts from medical records, and occasionally to lift children or push wheelchairs. The care coordinator will assist physicians and nurse practitioners at Hagan, Rinehart & Connolly Pediatricians offices, and will be primarily located in the this office. Some travel between office and community based schools or services may be needed.

Mental Demand:

Duties require normal mental and visual attention with manual dexterity for data entry. Must be able to communicate by telephone, so normal or corrected hearing and vision are *required*.

Phoenix Pediatrics

Care Coordinator Job Description



What is Care Coordination?

Care Coordination is a process that links children with special health care needs and their families to services and resources in a coordinated effort to maximize the potential of the children and provide them with optimal health care. Care Coordination often is complicated because there is no single entry point to multiple systems of care, and complex criteria determine the availability of funding and services among public and private payors. Economic and sociocultural barriers to coordination of care exist and affect families and health care professionals. In their important role of providing a medical home for all children, primary care pediatricians have a vital role in the process of care coordination, in concert with the family. (Courtesy of American Academy of Pediatrics, Volume 104, No. 4, October 1999, pp.978-981.)

Care Coordination is complex and can take many different directions. To effectively coordinate the coordinator must have knowledge of how the state agencies function. He/She must also know the eligibility criteria for the multiple agencies and how they compliment each other. Resources within the state are extremely important to families. Being able to put yourself in the family's situations without judgment. Being respectful of cultural differences even if you do not share that value. Being organized and efficient. The Clinical Care Coordinator works first and foremost for the patient. He/She does not represent the insurance company or any other agency. Being a strong advocate is a requirement. Being able to think outside the box and find unique ways to solve problems. There are no restrictions to how effectively you manage your patients.

Care Coordination is a truly unique position and benefit to the families that must continually fight to have their needs met. Please utilize the lists below as a baseline for Care Coordination duties. Remembering that all Children with Special Health Care Needs have very different needs, never try to put the definition of Care Coordination into a square box and expect it to fit.

POSITION DESCRIPTION

Phoenix
Pediatrics

TITLE OF POSITION Care Coordinator	DEPARTMENT Clinical	DATE 2008
REPORTS TO Management and Physician Partners	NON-EXEMPT <input type="checkbox"/>	APPROVED BY:
<p>GENERAL PURPOSE: Coordinates and maintains the integrity and consistency of Long Term Care patient resources.</p> <p>RESPONSIBILITIES:</p> <ol style="list-style-type: none"> 1. Coordinate, research and assist long term care patients and families access to community resources. 2. Act as a liaison and advocate for long term care patients with outside agencies. 3. Prepare necessary paperwork and documents to obtain outside services for long term care patients with the physician's approval. 4. Maintain good relationships and strong communications with outside agencies and affiliates to ensure continuity of care for long term care patients. 5. Monitors and maintains supplies and equipment necessary for job function. 6. Is polite, helpful and courteous to patients at all times 7. Maintains strictest confidentiality. 8. Other duties as assigned. <p>KNOWLEDGE, SKILLS & ABILITIES: Knowledge of medical office procedures, community resources, medical terminology and managed care regulations. Ability to recognize and solve problems. Ability to establish and maintain effective working relationship with patients, employees and the public.</p> <p>EDUCATION/EXPERIENCE: BS/BA in relevant area of study. Experience in advocating and interacting with community resources in a medical environment.</p> <p>PHYSICAL REQUIREMENTS: Work may require sitting or mobility for long periods, also may require stooping, bending and stretching. Occasional lifting up to 30 pounds. Requires manual dexterity sufficient to operate medical equipment, keyboard, calculator, telephone, copier and such other office equipment as necessary. It is necessary to view and type on a computer for long periods.</p>		

<p>TYPICAL WORKING CONDITIONS: Work is performed in an office environment. Involves frequent telephone contact with, patients, outside agencies and other medical staff. Work may be stressful at times. Interaction with others is constant and interruptive. Contact may involve exposure to illness.</p>
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Baseline Duties of a Care Coordinator

Role of Care Coordinator

- Link CSHCN with services and resources in coordinated effort to maximize potential of the children and provide them with optimal health care
- Be an advocate for the family and child
- Respect: Remember that you are not dealing with the same stressors as the family and that the parents know their child best
- Think outside of the box: Recognize the highly individualized needs of the families and children you care for

Responsibilities of Care Coordinator

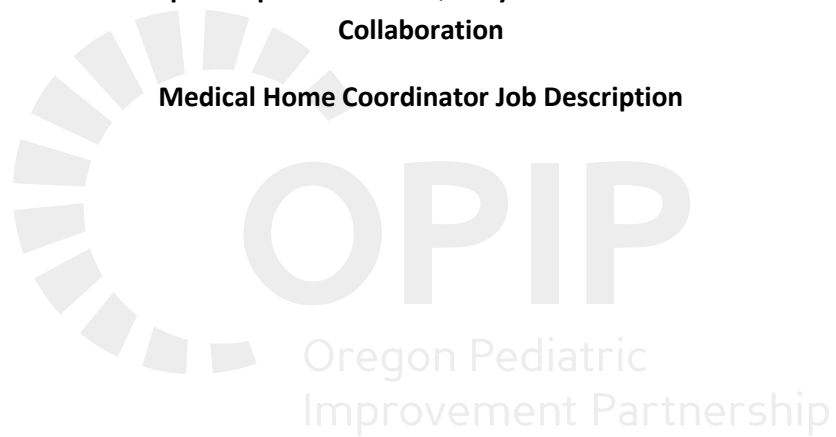
- Family/Community resource liaison: help families find resources
- Conflict resolution between families, insurance companies, schools, community organizations, etc
- Letters of medical necessity to obtain equipment or services: Assist community professionals in writing letters to ensure that clear medical necessity is proven
- Write prescriptions for DME, formula and related equipment, therapies (OT, PT, ST, etc,) all prescriptions must be reviewed and signed by doctors
- Work with community professionals (case managers, therapists, etc) to preserve continuity of care, coordinate all aspects to ensure goals are met, introduce yourself and care coordinator's role in patient care, gain understanding of how community agencies work and how you can work efficiently with them, i.e. their systems, paperwork, policies, establish a good working relationship by making personal contacts
- Assist families in filing grievance and appeal process for services or equipment that has been denied

Helping families find resources

- Legal: advocacy issues
- Respite (work with state case management agency to help find respite providers)
- DME providers, families must start and maintain relationships with the agencies that provide equipment and supplies to their children. Give families contact names and phone numbers to call at these agencies.
- Support groups
- Brainstorming for alternative resources to obtain services or monies for equipment

**Utah Pediatric Partnership to Improve Health Quality & Children’s Healthcare Improvement
Collaboration**

Medical Home Coordinator Job Description



Medical Home Coordinator

Job Description

Job Summary

The Utah Pediatric Partnership to Improve Healthcare Quality (UPIQ), www.upiq.org, and the Children's Healthcare Improvement Collaboration (CHIC), a CHIPRA Quality Demonstration grant will provide several pediatric primary care and sub-specialty practices with substantial support to implement and evaluate the medical home model* of care over the next four years.

The Medical Home Coordinator (MHC) will play a key role in the demonstration by working with practice teams and families in building systems, (re)designing processes, leveraging health information technology and collaborating across practices to improve the quality, equity and outcomes of care. There are four immediate openings for this position. Each MHC will work with two or three assigned practices to provide support in implementing a medical home model of care through the use of quality improvement techniques. In addition, the MHC will provide care coordination, hands-on as well as facilitating the provision of care coordination activities by members of the practice team.

* The "medical home" model describes an approach to enhancing, particularly, primary care that focuses on patient- and/or family-centered care, improving the quality of and access to care, and coordinating care and collaborating across specialties and disciplines.

Responsibilities

1. Support assigned practice teams and their Family Partners in defining, implementing and continuously improving medical homes within their practices utilizing tools and resources such as electronic medical records (EMR's), patient portals, patient registries, assessment and screening tools, practice guidelines, care and action plans, referral tracking logs and patient education resources.
2. Provide hands-on care coordination for high acuity complex patients/families by:
 - a. Assessing, planning, facilitating and advocating for the health needs, including those of an ethical and cultural nature of the patient/family
 - b. Collaborating with patient/family, physician(s), other healthcare providers, community resources and funding sources including insurers/payers to meet the health needs of the patient/family
3. Facilitate provision of appropriate care coordination activities by designated members of the practice team for their high acuity complex patients/families.
4. Support the assigned practice teams in defining and implementing population-based care strategies (guidelines for care, interventions and outcome measures) and systems for target populations.
5. Support the Practice Coach in training and mentoring the assigned practice teams and Family Partners in the use of quality improvement techniques and tools to:
 - a. Identify relevant improvement opportunities
 - b. Design and implement improvements
 - c. Measure their impact
 - d. Hold the gains
 - e. Seek opportunities to continuously improve

6. In collaboration with the practices' Family Partners, develop a parent advisory system within each practice to provide advice into policy and clinical decision-making processes.
7. Work with demonstration project team and peer MHC's to:
 - a. Participate in joint planning sessions
 - b. Share lessons learned
 - c. Design and conduct training sessions for practice teams and Family Partners
 - d. Coordinate data collection, analysis and reporting for practice performance feedback and evaluation of overall demonstration
8. Seek opportunities for professional development to continually improve necessary skills.

Qualifications

Minimum Education and/or Experience Requirements:

- Current licensure to practice as a Registered Nurse in the State of Utah.
- 3+ years of pediatric nursing experience.
- PC/Windows literate with working knowledge of the following Microsoft applications: Outlook, Word and Excel.
- Strong analytical, organizational and leadership skills.
- Demonstrated human relations and effective communication skills.

Preferred Experience:

- Bachelor's Degree in Nursing.
- Acute care and case and/or care management work experience.
- Working knowledge of quality improvement methodologies, tools and techniques.
- Project team facilitation and mentoring preferably using QI methods (i.e., PDSA).
- Familiarity with electronic medical record (EMR) applications.
- Bilingual: English and Spanish.

Other Skills and Abilities:

- Ability to effectively manage and prioritize multiple tasks.
- Demonstrated ability to function effectively as a member of a team and successfully promote change.
- Proven ability to proactively identify issues, diplomatically resolve problems and effectively manage conflict.
- Must be self-directed, proactive and resourceful.

Position requires travel to multiple Wasatch Front locations; candidates must provide own transportation.