**Care Coordinator Sample Position Description**

**Medical Home (Practice Based) Care Coordination - Position Description**

The care coordinator works within the context of a primary care medical home, from a team approach, and in continuous partnership with families and physicians to promote: timely access to needed care, comprehension and continuity of care, and the enhancement of child and family well-being.

Care Coordination Qualifications: The care coordinator shall have:

􀂌Bachelor’s preparation as a nurse, social worker, or the equivalent with appropriate past experience in health care

􀂌Three years relevant experience, or the equivalent, in community based pediatrics or primary care, particularly in the care and service of vulnerable populations such as children/youth with special health care needs (CYSHCN)

􀂌Essential leadership, advocacy, communication, education and counseling, and resource research skills

􀂌Core philosophy or values consistent with a family-centered approach to care

􀂌Culturally effective capabilities demonstrating a sensitivity and responsiveness to varying cultural characteristics and beliefs

Medical Home Care Coordination Responsibilities The care coordinator will:

1) Demonstrate and apply knowledge of the philosophy/ principles of comprehensive, community based, family-centered, developmentally appropriate, culturally sensitive care coordination services

2) Facilitate family access to medical home providers, staff and resources

3) Assist with or promote the identification of patients in the practice with special health care needs (such as CYSHCN); add to registry and use to plan and monitor care

4) Assess child/patient and family needs and unmet needs, strengths and assets

5) Initiate family contacts; create ongoing processes for families to determine and request the level of care coordination support they desire for their child/youth or family member at any given point in time

6) Build care relationships among family and team; support the primary care-giving role of the family

7) Develop care plan with family/youth/team (emergency plan, medical summary and action plan as appropriate)

8) Carry out care plans, evaluate effectiveness, monitor in a timely way and effect changes as needed; use age appropriate transition timetables for interventions within care plans

9) Serve as the contact point, advocate and informational resource for family and community partners / payers

10) Research, find, and link resources, services and supports with/for the family

11) Educate, counsel, and support; provide developmentally appropriate anticipatory guidance; in a crisis, intervene or facilitate referrals appropriately

12) Cultivate and support primary care & subspecialty co-management with timely communication, inquiry, follow up and integration of information into the care plan

13) Coordinate inter-organizationally among family, medical home, and involved agencies; facilitate “wrap around” meetings or team conferences and attend community/school meetings with family as needed and prudent; offer outreach to the community related to the population of CYSHCN

14) Serve as a medical home quality improvement team member; help to measure quality and to identify, test, refine and implement practice improvements

15) Coordinate efforts to gain family/youth feedback regarding their experiences of health care (focus groups, surveys, other means); participate in interventions which address family/youth articulated needs