Definition of Care Coordination

Care coordination is a central ongoing component of an effective system of care for seniors or individuals with special health care needs and their families. Care coordination engages families in the development of a care plan, and links them to the proper healthcare and other social services that address the full range of their needs and concerns. Principles of care coordination reflect the central role of families and the prioritization of the senior or individual and the family concerns. It strengthens and supports the needs in effective care of the chronically ill and/or disabled person with special health care needs. Activities of care coordination may vary from family to family, but start with identification of individual senior/individual and family needs, strengths and concerns, and aims simultaneously at meeting family needs, building family capacity and improving systems of care.

Scope
(The way that the position contributes to and impacts the organization/family)

The Care Coordinator (CC) provides and coordinates individualized care and resources to elders, disabled, and others, so that they may continue to live in their homes and/or a designated community. Home Care may include transportation, house cleaning, personal hygiene, providing meals, and other health and wellness related activities, and may be provided by the CC or other coordinated individual, perhaps even family. The Care Coordinator is also responsible for managing and administering the Care Program. The Coordinator will maintain confidential client files, including, budget and program information. The Coordinator will prepare and present reports and information as required. The CC will manage and distribute resources effectively, and will ensure that all care is provided in a caring and respectful way in keeping with all relevant policies and procedures. The CC will liaise with other community services and resources to ensure that other resources are involved, if required. The Coordinator will also provide information and education to individuals and groups in the community, as required and as requested. Failure to provide adequate services may put elders and others at risk and/or force elders to move from their homes or community before they are prepared to do so, or want or need to for that matter. Financial decisions will be ascertained and coordinated with advisor regarding budgetary constraints that are brought to CC's attention that may negatively impact the originally developed action plan.

Principles of Care Coordination

Accessibility

- understand universal resources; available/accessible for all seniors
- Continuous across service systems and across transitions; relevant to the family's needs
- Ability to be housed within family home, rather than the general “as client relationship”
- Integrated with community resources to assure access for all linguistic and cultural groups

Individualization

(based on family circumstances, needs and strengths)

- Maximizes family care-giving capacity
- Looks to family to define needs, rather than offering family what the system happens to provide.
- Builds, and builds on, family strengths
- Provides anticipatory guidance to prepare family and senior for future
- Respects and engages with family culture and customs

Aligned with the family

(in its interactions with broader community)

- Promotes inclusion of senior in all settings; in transition phases and generalities
- Promotes autonomy of senior towards and through transition
- Serves as advocate for family when systems with challenging or unresponsive sources persist.
- Elevates status of family and legitimizes family concerns to align with broader community concerted effort.

Promotes solution of systemic problems

(through a network of relationships guided by clear standards and ethics, i.e. no conflicts of interest)

- Ties individual CC to broader network for quality assurance, accountability and support
- Draws on knowledge base and resources of multiple disciplines, while not focused on providing any one specific therapeutic or curative service
- Promotes appropriate use of services and resources (from family and system perspectives) based on needs of senior, family and system
- Reduces fragmentation and connects services across systems
- Identifies and tracks systemic gaps and barriers

Outcomes of Care Coordination

- Satisfaction, well-being and autonomy of senior
- Satisfaction and well-being of family
- Satisfaction and capacity of providers
- Effectiveness and efficiency of system(s)

Stages of Care Coordination Process and Associated Activities

The following activities are components of an effective care coordination process.

1. Conduct and update community and conduct environmental scans
    a. Develop census of community programs and agencies
    b. Acquire or develop community resource guide
    c. Gather written and electronic program descriptions and application(s) maintained date centric
    d. Establish person-to-person contact with agency staff
    e. Join or initiate community coalition
2. Enhance capacity for early and ongoing screening and identification
    a. Collect and synthesize screening tools reflective of different conditions, needs, cultures, personalities, and systems with barriers

b. Establish mechanisms for referral including self-referral by families
c. Conduct outreach and education regarding availability of CC services

3. In-depth needs assessment
    a. Interview family to determine full array of needs related to care of senior
    b. Identify family strengths and resources
    c. Review family circumstances, needs and concerns on an ongoing basis
    d. Conduct home and/or community visit as setting for needs assessment
4. Development of individualized family support plan
    a. Review needs, concerns and strengths with family
    b. Define priority issues
    c. Identify resources, programs, and benefits to address priority issues
    d. Provide or carry out referrals to relevant services and programs
    e. Intercede with or for family when systems fail to respond
5. Implementation and monitoring of care plan
    a. Carry out activities with or for family as prioritized
        i. Identify family versus CC tasks incorporated in plan
        ii. Contact referrals
        iii. Initiate meetings as needed
        iv. Send information to family
        v. Identify resources to meet specific family needs
        vi. Follow-up with services and family as needed
        vii. Act as proxy/advocate for family as needed
6. Review and revision or completion of plan as needed
    a. Conduct regular, periodic global review of plan with family
    b. Revise plan as needed and return to stages 4 and 5
7. Link information on unmet needs and continuing barriers to system level assessment and planning efforts

Specific Responsibilities

1. Administer the Care Program in order to ensure that the program is delivered in an appropriate, caring and respectful manner

Main Activities
- Ensure that care is provided according to all relevant policies, procedures and regulations
- Ensure that Home Care Workers are trained to administer the required care
- Monitor and evaluate all tasks of the Home Care Worker and the program
- Monitor supplies and resources
- Identify persons requiring home care and client needs
- Make recommendations for changes and improvements to the program, as required
- Schedule work assignments with regard to Home Care Worker training and experience
- Act on client's behalf to correct problems with caregivers, including residential facilities, to maximize provision of high quality care

2. Coordinate Case Management

Main Activities
- Ensure that all clients needing care are identified

- Coordinate appropriate care and equipment including other community resources, as required

- Establish and maintain a current, accurate, confidential client reporting system
- Provide information to other health care professionals, as required
- Consult with family members and other support systems to ensure that care is on-Going and that all client needs are identified and met

3. Provide individualized home care

Main Activities
- Arrange for in-home services such as Medicare home health, medication and durable medical equipment delivery, and safety devices as indicated
- Arrange services including general housekeeping, personal hygiene and Meals-on-Wheels
- Arrange transport Home Care clients to appointments and activities
- Assist with exercises, physiotherapy and other medical plans
- Monitor blood pressure and other physical conditions, as required
- Assist with medications management as ordered by physician
- Organize time and resources based on the individual needs of clients and family constraints
- Manage any unanticipated events or unstable situations

4. Coordinate community resources and supports

Main Activities
- Encourage clients and families to be involved in care, if appropriate
- Encourage clients and families to take responsibility for care, if appropriate
- Liase with all family, medical and other resources, as required
- Advocate on behalf of clients for additional service and resources, as required
- Establish and maintain current, accurate, confidential files for each client
- Educate clients, families and support systems about the our Care Program – what can be provided and when to access other resources

•Screen, arrange, and monitor in-home help and services
•Provide ongoing support to client and family as client's needs change, adjusting the plan as necessary

KNOWLEDGE, SKILLS AND ABILITIES

(The knowledge, skills and attitudes required for satisfactory job performance)

Knowledge

The Care Coordinator requires knowledge of:

- Client assessment
- Proper home care techniques; Including house cleaning, feeding, and personal hygiene
- Appropriate Home Care interventions
- Services and resources in the community
- Staff and program management and evaluation
- The culture traditions, and ideological idiosyncrasies of each
- All relevant legislation, policies and practices
- First aid and CPR

Skills
The CC must demonstrate the following skills:

- Team building skills
- Supervisory skills
- Analytical and problem solving skills
- Decision making skills
- Effective verbal and listening communications skills
- Stress management skills
- Time management skills
- Financial management skills
- Human resources management skills
- Administrative skills
- Strong interpersonal skills
- Conflict resolution skills
- Well developed organizational skills
- Excellent communication skills
- Demonstrate good decision making in dealing with safety and other medical issues

Personal Attributes
The CC must maintain strict confidentiality in performing the duties of Care Worker. The CC must also demonstrate the following personal attributes:

- Possess cultural awareness and sensitivity
- Demonstrate sound work ethics
- Be consistent and fair
- Be compassionate and understanding (everyone's stressors are different)
- Be flexible, adaptable and able to work effectively in a variety of settings
- Respect cultural differences
- Work independently with little supervision
- Work effectively as a member of a team

WORKING CONDITIONS

(The unavoidable, externally imposed conditions under which the work must be performed and which create hardship for the family care giver including the frequency and duration of occurrence of time demands, environmental conditions of home settings, demands on one's senses and mental demands.)

Physical Demands
(The nature of physical effort leading to physical fatigue)

The Care Coordinator will <u>not</u> be required to lift and move clients, nor will it be their responsibility to bathe and /or clean clients. The Coordinator's responsibility will be to coordinate the administration of interventions and treatments to the client. The Coordinator will often work in the client's home and must practice clean, safe care to eliminate the possibility of infection or cross contamination between clients, family members and/or themselves.

Environmental Conditions
(The nature of adverse environmental conditions affecting the CC)

The Care Coordinator spends some time in the office, and some time in client homes, or senior living communities. The Coordinator may be dealing with patients with potentially infectious conditions. They must be extremely careful to ensure that all medications, treatments and activities are completed safely so as to ensure the safety of all clients, families, the community, and themselves. The Care Coordinator may be required to drive in various conditions and make visits during periods of varying weather conditions.

Sensory Demands
(The nature of demands on the CC's senses)

The Care Coordinator will be exposed to sights and sounds associated with clients who are ill and injured. They may also find a variety of conditions and circumstances as they visit clients in their homes. The CC will be exposed to unpleasant odors in providing health care. The incumbent must make acute use of the senses in assessing health care needs such as hearing (listening for heart, lung and abdominal sounds), visual to look for symptoms of illness, touch in palpitation of clients and manual dexterity and smell to detect unusual odors from wounds and physical surroundings.

Mental Demands
(Conditions that may lead to mental or emotional fatigue)

The Care Coordinator is faced with stress from dealing with clients and family members who may be stressed and difficult to work with. Stress is caused by the fact that the Coordinator must work independently in unfamiliar and uncontrolled situations. There is significant emotional stress in providing care for clients who are dying and providing support for their families. Stress is also caused by the need to manage and evaluate staff and program issues.

Certification of Understanding

_____ _____
Commitment by (CC) Signature Date

_____ ____ I certify that I reviewed and
Printed Name initial understand the responsibilities associated with this position.

_____ _____
Patient, Resident, Advocate, Health Care Proxy, Guardian Date

_____ ____ I certify that I have depicted to the
Printed Name initial best of my ability an accurate description of the responsibilities assigned to the CC position.

The above outline and statements are intended to describe the general nature and level of work being prescribed of this job. They are not intended to be an exhaustive list of all responsibilities and activities required of the position.