

Care Coordinator Works Directly with Family and Care teams via In-Person Visits, Telephone Calls, Home Visits, and by Attending Clinic Appointments with the Family. Activities are customized to identified needs, priorities and goals, and may include:

- Facilitating health transitions and referrals
- Sharing regular progress notes and information across service areas to improve communication
- Linking family to community resources and supports
- Proactively engaging community providers
- Linking with school and other community programs
- Facilitating case conferences for joint care planning
- Family education and coaching to develop self-management and advocacy skills
- Coordinated scheduling of tests and appointments
- Supporting transition to adult care, where applicable



Monitoring Progress and Transition Planning Through Ongoing Assessment of:

- Improvements in family functioning and demonstrated self-management skills
- Attainment of family and care team goals
- Strengthened connections between family, care teams, school, and community providers
- Established linkages to longerterm community resources and family supports
- Strengthened care team functioning, including improved communication and planning across services



Continued
Care
Coordination
or Re-Referral
as Needed

Ready for Discharge Back to Standard of Care