Care Coordination

What is care coordination?
Care coordination is a generic term used for the integration of health and social care services for a particular person.

Components of Care Coordination:

1. Working with an individual and his/her carer(s) to ensure that a high-level, integrated and personalized care plan is implemented.
2. Monitoring services to ensure they are delivered effectively on time and achieve their objectives.
3. Facilitating communication between multiple agencies and professionals, and overseeing discussions/meetings as appropriate.
4. Maintaining contact with the individual during hospital stay and arranging for discharge.
5. Ensuring that reviews of care are undertaken.

Values and Principles of a Care Coordinator:

- Working in partnership
- Respecting diversity
- Practicing ethically
- Challenging inequality
- Promoting recovery
- Identifying people's needs and strengths
- Providing service user centered care
- Making a difference
- Promoting safety and positive risk taking
- Personal development and learning.

Key Functions of a Care Coordinator?

1. Works in partnership with people who have complex medical, mental health and social care needs, and those supporting them.

2. Strives to empower people using services to have choices and make decisions to determine their wellbeing and recovery.

3. Integrates and coordinates a person's journey through all parts of the health and social care system.

4. Enables each person to have a personalized care plan based on his/her needs, preferences and choices.

5. Ensures that the person receives the least restrictive care in the setting most appropriate for that person.

6. Supports the person to attain wellbeing and recovery.

7. Ensures that the needs of carers/families are addressed;

8. Brokers partnerships with health and social care agencies and networks which can respond to, and help to meet the needs of the person who is experiencing medical, mental health or social problems.

Care coordination is predicated on the principle that people, however vulnerable, should share in decision-making; that they are knowledgeable about themselves and the effect their conditions may have on their lives; and that they should be empowered and enabled to inform their own recovery.

Call to Action:

1. We would like to ensure that you are incorporating the Components of Care Coordination and performing the Key Functions of a Care Coordinator in your day to day functions. Whereas many of the Community Based Organizations are already performing many of these functions, the Care Coordinator role is a new role for the primary care setting. We would like all of our care coordinators within our region to utilize these components to provide the best care for the individuals we serve and to improve communications between all providers in each individual's care. At each meeting, we would like to incorporate the above areas into our communications and ask that you are all prepared to discuss how you are incorporating them into your daily work.

2. Each care collaborative meeting will consist of an educational component. Based off the topic of the education, we are expecting each Care Manager/Coordinator to:
    - Apply what you have learned during the collaborative meetings to your everyday work

    AND

    - Be prepared to share how you are incorporating what you've learned at the next Care Coordination Collaborative Meeting (whether it be through referrals, completion of health care proxy, etc.).