

**– Care Coordination/Case Manager –
?? What’s the Difference ??**

The *care coordinator* serves as a guide who is responsible for overseeing the community-level team process and takes the lead on cross-system/agency collaboration, pooled resources, collective mandates, family voice and choice, and consensus building. This person also acts as a single point of entry to the whole service system, serves a family rather than a specific child, and follows the family as long as they are receiving any services from any system.

The distinction between a *care coordinator* and a *case manager* is the coordinator works with, and guides, the team process and tasks while building collaboration with all parties at the table. The agency-specific case manager works with and guides the service needs of the client specific to that agency.

Clearly defining roles is critical.

Case Management	Wrap Facilitator/Care Coordinator
Child focused	Family focused
Has authority within the agency for the care of the child	Can have authority over resources and/or acts as an information hub between agencies/systems
Develops an agency specific service plan	Coordinates a community-level service plan
Implements some or all of the crisis plan	Develops the crisis plan
Focuses on providing services to address specific needs and building specific strengths	Focuses on understanding needs in the context of strengths, and connecting families/children with appropriate services, ensures multidisciplinary coordination and planning with inclusion of community and natural supports
May be minimally actively involved when a child is not being provided services by the case manager’s agency and/or the child is in a residential placement	Visits child/assesses placements regularly regardless of the specific service provider/vendor
When a child no longer needs services from that agency, the file is closed	The file remains open if any member of the family is receiving any services

– *Child Specific Team* –
?? How Does it Work ??

- ✓ The Care Coordinator orients the family to the process and conducts an initial strengths-based assessment.
- ✓ The Care Coordinator helps the family develop a child-specific team, including all necessary service providers, other support persons important to the family, and a family advocate
- ✓ **Core values and beliefs are maintained.**
- ✓ CSA policy and procedures are ensured.
- ✓ Roles and responsibilities of the Team members are negotiated.
- ✓ Full partnership and collaboration of all Team members (including the youth/family) is facilitated.
- ✓ All background information is gathered; information is routinely shared.
- ✓ Consensus is the goal.
- ✓ The Team develops the strengths-based family assessment to better understand the *whole* family and to identify youth and family needs.
- ✓ The Team develops innovative and responsive service, crisis, and transition plans.
- ✓ The plans are implemented.
- ✓ Service providers report progress back to the Team, typically via the Care Coordinator.
- ✓ The Team meets regularly to monitor and record progress, to problem solve difficulties and obstacles, and to adjust the plans as needed.
- ✓ Outcome data is gathered and reported.
- ✓ The Team works to leverage new resources as needed.
- ✓ The Team is responsive to the changing strengths and needs of the child and family, with Team membership, service/crisis/transition plans, and service providers changing as necessary.
- ✓ Successes are celebrated!