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.**

<table>
<thead>
<tr>
<th>Case Management</th>
<th>Wrap Facilitator/Care Coordinator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child focused</td>
<td>Family focused</td>
</tr>
<tr>
<td>Has authority within the agency for the care of the child</td>
<td>Can have authority over resources and/or acts as an information hub between agencies/systems</td>
</tr>
<tr>
<td>Develops an agency specific service plan</td>
<td>Coordinates a community-level service plan</td>
</tr>
<tr>
<td>Implements some or all of the crisis plan</td>
<td>Develops the crisis plan</td>
</tr>
<tr>
<td>Focuses on providing services to address specific needs and building specific strengths</td>
<td>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</td>
</tr>
<tr>
<td>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</td>
<td>Visits child/assesses placements regularly regardless of the specific service provider/vendor</td>
</tr>
<tr>
<td>When a child no longer needs services from that agency, the file is closed</td>
<td>The file remains open if any member of the family is receiving any services</td>
</tr>
</tbody>
</table>
– 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!