

VCHIP has identified several commonly used terms and definitions related to care coordination functions and activities. The project team has synthesized existing definitions to establish a set of shared definitions that will be used throughout the project.

Care Coordination involves patient and family-centered, assessment-driven, team-based activities designed to meet the needs of children and youth. Care coordination provides culturally sensitive and culturally safe care and education that address interrelated medical, social, developmental, behavioral, educational, and financial needs of the patient and family to achieve optimal health and wellness outcomes and ensure the efficient delivery of health-related services and resources both within and across systems. Care Coordination includes non-clinical functions and can be performed by nurses, social workers, or other identified care team members. (1,2,3,4,5)

Care Coordinator is an identified individual who can assist patients, families, and caregivers with referrals to specialists and other care providers, communication between the child's primary care physician, service providers and specialty physicians, support for family concerns and problem solving to promote the patient's well-being. (5)

A **Care Conference** is a multidisciplinary meeting, initiated by a medically based team, that brings together the care team, including the family, to work together to solve a patient's clinical or social concerns, address care planning needs, develop shared plans of care, and communicate changes in patient care with the entire care team. This activity may drive the development of a Shared Plan of Care and is medically focused.

Care Management refers to the more intensive clinical management provided by a specifically skilled registered nurse or other licensed health worker to an identified high risk patient population. (4,6)

A **Care Manager** is an identified individual, usually a specifically skilled registered nurse or other licensed health worker, providing more intensive clinical management to an identified high-risk patient. (4,6)

Case Management addresses utilization of resources and supports insurance, payment issues, and health resources needed for care transitions (i.e. discharge from hospitalization or similar transitions). This service provides episodic support rather than ongoing support. (7)

The **Care Team** describes the multidisciplinary group functioning as part of an expanded medical home in which the family is an equal partner. The team may include members from multiple health care settings (primary and specialty care) and may even include community organizations or education systems. (5)

Children and Youth with Special Health Care Needs (CYSHN) are children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions who also require health and related services of a type or amount beyond that is generally required by children. (8, 5)

Children with Health Complexities refer to a subset of the CYSHN population having medical and/or behavioral conditions associated with medical fragility, substantial functional limitations, increased need for support with medical care, behavioral health care, or health related social needs, and increased health care costs. (9,10,11)

Children with Special Health Needs (CSHN) Care Consultants in Vermont provide information and support to families, care teams, and community providers to help access resources and reduce barriers to care. CSHN Care Consultants are distributed across the state and partners with care coordinators in primary care and home health, as well as case managers in designated agencies and educational settings. Care Consultants are knowledgeable about complex medical conditions and developmental disabilities, Vermont Medicaid, healthcare transitions, and access to higher-levels of care – including out of state treatment. The team supports care providers to implement team-based care and shared plans of care for children with complex care needs.

An **element** of the Shared Plan of Care refers to a specific component or category found within the Shared Plan of Care. Each element includes specific patient level data to help guide care.

An **Emergency Care Plan** is a condition or specialty specific plan of care that provides care teams or caregivers with information and instructions for managing a specific condition or event. Examples include Asthma Action Plans, Seizure Action Plans, Metabolic Plans, etc. An Emergency Care Plan can be a component within a Shared Plan of Care, but for the purposes of our pilot, it is not considered a true Shared Plan of Care.

A **High-Risk Patient** may be determined by several variables including (6):

- High utilizer of health care services;
- Specific diagnosis or condition;
- Medical and/or social complexity;
- Involvement with programs such as foster care or DCF;
- Behavioral health concerns;
- Health related social needs;
- Patient or family self-identification; or
- Care team identified.

A **Medical Home** is a primary care practice that delivers comprehensive care that facilitates partnerships between patients, clinicians, medical staff, behavioral health professionals, care coordinators, families, and professionals from social services and education systems. (10)

A **Needs Assessment** refers to a specific, comprehensive activity, completed by a member of the care team documenting the identified needs, beliefs and goals of the family and child and how they can be best addressed by the health care system. This activity is usually completed annually, or at another period defined by the organization and may drive the development of a Shared Plan of Care and may include identifying the team that surrounds the family, building an Ecomap, and identifying care gaps. (5,12)

A **Shared Plan of Care (SPoC)** is a concise yet comprehensive, integrated, and user-friendly compilation of child and family specific information and goals that guides care and facilitates its coordination among the family and their lead clinical team in concert with the appropriate “constellation” of subspecialists and community resource providers. This document is reviewed and updated at regular intervals. (12)

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