The Children's Institute
Amazing Kids. Amazing Place.

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Care Coordination Tip Sheet

Does CYF have to have an open/active case for the family to receive Care Coordination services?

No, the child/family must reside in Allegheny County in order to be eligible for Care Coordination services, an active CYF case is not an eligibility requirement.

Does the child have to be listed as having medical complexities to be referred to Care Coordination?

No, children/families can be referred due to having a need in any of the following areas: healthcare coverage, basic needs, physical health, mental/emotional health, childcare, family, education, employment, legal status, social life skills and trauma.

What does Care Coordination have to offer that a Blended Case Manager does not?

Care Coordination can work with every member of the household, not just the individual listed on the referral.

How does Care Coordination benefit the child/family?

Through participating in Care Coordination, the family receives unprejudiced assistance to support them during times of crisis. As Care Coordination is a voluntary, telephonic service, families can discuss their needs openly, ultimately allowing the Care Support Coordinator to dissect the barrier(s) and work with the family to develop their Care Plan to address the challenges and work towards self-sufficiency.

How does Care Coordination support and promote the client through self-sufficiency?

Upon receiving a referral and identifying goals for the service, the Care Support Coordinator will provide a task to the family to complete. If the family member does not complete this task after a few days, the Care Support Coordinator follows up to determine if there's a barrier associated with the failure to complete the task. If this family requires more support to complete a task, and this is not a lack of interest, the Care Support Coordinator will work with the family member on a step-by-step procedure to assist them in completing the task independently.

How is Care Coordination different from an in-home provider/case manager?

As Care Coordination is a telephonic service, the Care Support Coordinators have greater availability as they are not traveling throughout the day and can take calls more easily. Additionally, Care Support Coordinators have great success in collaborating with agency workers and in-home workers with regard to high risk cases, sharing information and discussing the ever changing needs of the family as it relates to health, safety and well-being. We've had experience in working with a Service Coordinator who elected to focus on the behavioral health needs of the family while our Care Support Coordinator focused on addressing the physical health needs.

What sets Care Coordination apart from other similar services:

As a remote service, our Care Support Coordinators have found that the families we serve share their worries and needs more freely, as they do not have to make eye contact with our team. We have often found ourselves able to share information with the county agency that they had not been made aware of previously; ultimately creating a strong collaborative team whose goal is to support the family.

What are the aspects of Care Coordination that can assist the agency worker?

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Often times families are in need of being connected to community resources to eliminate barriers, or a family may need assistance in connecting to medical providers, scheduling necessary appointments, and setting up medical transportation. Care Coordination is able to take on some of the more tedious tasks that agencies get bogged down with, while making sure safety is assured. Monthly reports are submitted to the county worker and coordinators maintain weekly contact with the county agency.