NewYork-Presbyterian
Queens

Document Title:	Care Coordination Team Project 3.b.i
Approving Committee:	Informational only
Approval Date:	NA
Document Objective/Summary:	This document serves to outline general responsibilities the care coordination team for addressing chronic conditions for the cardiovascular project

In order to engage a patient, with chronic conditions, in developing self-management goals, interdisciplinary teams may need to be included in the care planning process.

The PPS will outline the roles of some of the members of the interdisciplinary team that will be engaged in developing self-management goals with the appropriate patients.

Care Coordination Team Roster

Team Member	Role	When to engage
Patient	The patient is the center of the development of self-management goals	Throughout the care planning/ care coordination process
Provider	along with the patient, the provider will engage the patient in developing self-management goals addressing the physical symptoms	Throughout the care planning/ care coordination process
Registered Nurse	provides and coordinates patient care, educates patients and is the patient advocate	To reinforce and educate
Dietician	the assigned site dietician will be engaged to provide weight/nutritional goals setting guidance	To provided education on nutrition goals
Social Worker	the assigned site social worker will develop goals that address social needs such securing community resources (housing, food, medication)	For counselling and to secure entitlements
Health Home Care Manager:	patients that meet the criteria and are enrolled in a health home will have the health home care manager engaged when developing self-management goals	When a patient meets the health home criteria