**EXHIBIT A**

**Practice Care Coordination Responsibilities**

* Conduct thorough chart review of targeted UPMCFY members and identify subspecialists involved in each Member’s care.
* Contact subspecialists as the lead care coordinator.
* Conduct comprehensive assessments that include the medical, behavioral, pharmacy, and social needs of the Member, and identify gaps in care based on clinical standards of care.
* Collaborate with UPMCFY related to resources to assist in Members’ needs including behavioral health and social work services.
* Engage PCP, subspecialists and Member to develop an individualized plan of care to promote healthy lifestyles, close gaps in care, reduce unnecessary ER utilization and hospital readmissions.  Involve community agencies and other staff to support the individualized plan of care based on identified needs of the member.
* Follow-up with the Members/families to monitor their status, evaluate the effectiveness of the individualized plan of care, and identify new needs.  Modify the individualized plan of care or case status based on the status of the Member.
* Provide Member education on prevention, early intervention, and self-management of identified conditions.
* Access UPMCFY tools that provide patient profile information that could assist in the assessment and development of the individualized plan of care.
* Document all activities in the Member’s electronic medical record, and identify trends and opportunities for improvement based on information obtained from interaction with Members and subspecialists.
* Assist UPMCFY and the Practice in the development and implementation of efficient work flow processes that can better support care coordination and education.
* Maintain contact with Members/families and provide reminders when assisting with and encouraging home self-care measures.
* Triage telephone calls and provide accurate consultation.  Maintain accessibility between all care coordination team members.
* Provide pre-visit consultation to establish concerns and needs prior to appointment in clinic and to determine the level of care coordination support the family desires for the patient at any given point in time.
* Coordinate care team conferences held by video, telephone or a combination of video and telephone.  Care team conferences can include, but may not be limited to, members/families, PCP, subspecialists, physician office staff, UPMCFY staff and community provider organizations.
* Communicate with the Member and/or family related to the UPMC High Value Care for Kids project.  Assist UPMCFY in enrolling Members/families into a consumer directed account program that will be created, funded and managed by UPMCFY.

UPMCFY contract for care coordination