Co-funded by the Erasmus+ Programme of the European Union	**BeWell – Digital Care Coordinator matrix**		BeWell.
EQF Level	**5-6**	**ESCO**	Coordinate Care (skill)[1] Provide nursing care in community settings (skill)[2] Communicate in specialised nursing care (skill)[3]
Aggregated Units of Learning Outcomes	**BeWell – NEOP 1**		**Digital Care Coordinator**

Co-funded by the Erasmus+ Programme of the European Union		BeWell.
Generic Title of the Training programme:	**NEOP 1 – Digital Care Coordinator**	
Description:	**This Training programme equips learners with the competencies to manage and coordinate care effectively across multidisciplinary teams. It focuses on patient-**	

[1] **Description:** Coordinate care for patient groups, being able to manage a number of patients within a given amount of time and provide optimum health services.

[2] **Description:** Provide nursing care in community settings such as schools, home settings, assisted living facilities, correctional facilities and hospice, and outside the hospital system.

[3] **Description:** Formulate and communicate complex clinical issues to patients, relatives and other health professionals.

<table>
<tr><td colspan="2"></td><td colspan="2">centred approaches, interdisciplinary collaboration, communication strategies, and the role of care coordination in improving health and care outcomes, reducing costs, and enhancing the patient experience. Additionally, learners will develop skills in managing chronic health conditions, ensuring seamless transitions of care, and optimising patient-provider communication.</td></tr>
<tr><td colspan="2">EQF Level:</td><td colspan="2">6</td></tr>
<tr><td colspan="4">Learning Outcomes</td></tr>
<tr><td rowspan="2">NEOP 1 – Digital Care Coordinator</td><td rowspan="2">Training Module # in MOOC</td><td colspan="2">Competence (Autonomy and responsibility)</td></tr>
<tr><td>Knowledge</td><td>Skills</td></tr>
<tr><td rowspan="4">1.1 Applying Care Coordination Principles for Better Patient Outcomes</td><td rowspan="4">Module 1</td><td colspan="2">Is able to implement care coordination strategies to enhance patient outcomes and improve health and care systems efficiency.</td></tr>
<tr><td rowspan="3">Knows the role of care coordination in reducing health and care costs and improving patient experience.</td><td>Assesses the impact of care coordination on patient safety, quality of care, and hospital readmissions.</td></tr>
<tr><td>Implements strategies to enhance interdisciplinary collaboration and care continuity.</td></tr>
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		Understands the key responsibilities of nursing care coordinators in facilitating communication between patients and health and care professionals.	Identifies team roles and responsibilities to optimise collaboration.
			Develops communication frameworks to improve patient-provider interactions.
			Utilises digital tools to streamline care documentation and patient follow-ups.
1.2 Facilitating Care Coordination in Community Health Settings	Module 2	Is able to facilitate care coordination activities in community health and care settings, ensuring effective communication and resource utilisation.	
		Knows the responsibilities of nurse care coordinators in bridging communication between patients and health and care teams.	Develops structured approaches for patient follow-up and support.
			Implements community outreach initiatives to improve care accessibility.
		Understands the role of nurse leaders in fostering	Facilitates teamwork among health and care professionals to enhance service delivery.

		interprofessional collaboration to streamline care processes.	Uses digital tools and technologies to support community-based care coordination.
			Establishes interdisciplinary protocols to improve patient care pathways.
		Knows how to manage chronic health problems within a coordinated care approach.	Develops long-term management plans for chronic disease patients.
			Monitors patient progress to prevent complications and hospital readmissions.
			Engages with patients and caregivers to promote self-management strategies.
1.3 Managing Complex Cases through Specialised Care Coordination	Module 3	Is able to coordinate patient-centred care strategies for complex and specialised health conditions, ensuring seamless transitions between hospitals, primary health and care, and specialised care settings.	
		Knows the essential functions and responsibilities of care	Assesses patient needs and develops tailored care plans.

		coordinators in various specialised clinical settings.	Implements evidence-based interventions for high-risk patients.
			Coordinates with specialists to ensure continuity of care.
		Understands best practices for effective communication and collaboration among health and care providers.	Applies structured communication methods to enhance care transitions.
			Ensures continuity of care through integrated service models.
			Facilitates case discussions and collaborative decision-making among multidisciplinary teams.
		Knows how to assess the effectiveness of care coordination activities in optimising health services and reducing hospital readmissions.	Uses quality metrics and patient feedback to improve care strategies.
			Evaluates health and care resource utilisation and makes recommendations for efficiency improvements.

		Understands the principles of facilitating seamless transitions of care between different health and care settings.	Coordinates discharge planning and follow-up care to support patient recovery.
			Engages multidisciplinary teams to ensure smooth patient transitions and reduce readmissions.
			Implements early intervention strategies to minimise patient deterioration post-discharge.