



Care Coordination in the Medical Home

Care coordination connects children to the services and supports that are needed to ensure optimal health and development. Some of these services are within the health care system (subspecialists, labs, pharmacies), and others require contacts beyond health care to education, family support, and social services. Families, children, and pediatric providers, too, benefit when care is coordinated through a medical home. Research shows that parents miss fewer days from work; children make fewer visits to the emergency department and are hospitalized less; and practices have more time for patient visits and spend less time tracking down services for families.

Challenges to providing care coordination in the medical home include finding time, awareness of community resources and programs, communication among providers, and reimbursement.

These challenges are addressed in the *Care Coordination in the Medical Home* module provided through the Educating Practices in the Community (EPIC) program in partnership with the Connecticut Department of Public Health. A professional trainer will visit your practice at a time that is convenient for you and provide a brief presentation to you and your entire staff.

Presentation Objectives

- Learn the benefits of care coordination for families and the practice, the care coordination process and tasks, and individual and practice roles
- Learn how to implement care coordination in your practice
- Learn how to use available local supports to coordinate care for your patients

EPIC provides:

- Resource Materials
- Lunch or snack



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The Care Coordination in the Medical Home module was developed by Richard Antonelli, MD, Connecticut Children's Medical Center and Jill Popp, consultant, specifically for use in community practice as part of the EPIC initiative. We acknowledge the partnership and contribution of our family partners, Connecticut Family Voices and Family Support Network to this module.