The Connecticut Medical Home System of Care for Children & Youth with Special Health Care Needs

Medical Home & HP 2010 Goals

By achieving the (6) performance outcomes, you ensure that CYSHCN have access to a medical home.

1) Children are screened early and continuously for special health care needs:

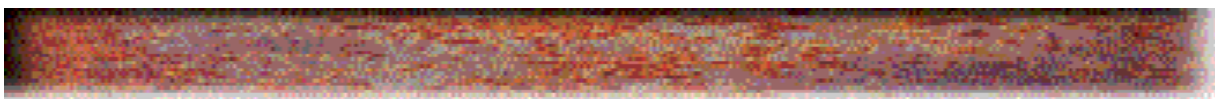
- **Coordinated, Continuous, Comprehensive Care**
  - **Medical home professionals can help ensure timely & appropriate follow-up for patients who screen positive**
  - **Children identified through screening can have their care coordinated through one central location**
  - **Children with special needs can receive ongoing monitoring for secondary conditions**

2) Families participate in decision-making at all levels & are satisfied with the services they receive:

- **Family-Centered Care**
  - **Medical home physician is knowledgeable about the CYSHCN & family and needs**
  - **Mutual responsibility & trust exists between patient, family & medical home physician**
  - **Family is recognized as principal caregiver & center of strength & support for child, as well as the expert**
  - **Clear, unbiased & complete information & options are shared on an ongoing basis with family**
  - **Families & youth are supported to play a central role in care coordination & share responsibility in decision making**

3) Children receive regular ongoing comprehensive care within a Medical Home:

- **Accessible, Family-Centered, Comprehensive, Continuous, Coordinated, Compassionate & Culturally-Effective**
  - **Physician & family share responsibility**



4) Families have adequate private and/or public insurance to pay for needed services:

- **Accessible**
  - **All insurance, including Medicaid, is accepted**
  - **Changes in insurance are accommodated**
- **Comprehensive**
  - **Information is made available about private insurance & public resources**

5) Services for children & families are organized & easy to use:

- **Accessible**
  - **Care is provided in the CYSHCN's community**
  - **Practice is accessible by public transportation, where available**
- **Coordinated**
  - **Families are linked to support & advocacy groups, parent-to-parent groups & other family resources**
- **Culturally-Effective**
  - **CYSHCN's & family's cultural background, including beliefs, rituals & customs are recognized, valued, respected & incorporated into care plan**

6) Youth with special health care needs receive services necessary to make appropriate transitions to all aspects of adult life, including adult health care, work & independence:

- **Accessible**
  - **Families & youth are able to speak directly to the physician when needed**
- **Family-Centered**
  - **Families & youth are supported to play a central role in care coordination & share responsibility in decision-making**
- **Continuous**
  - **Assistance with transitions, in the form of developmentally-appropriate health assessments & counseling, is available to the CYSHCN & family**