**Care Coordination and the Medical Home Approach**

* The Medical Home Approach

The Medical Home is a team approach to healthcare that focuses on providing comprehensive and cost-effective patient- and family-centered care. It ensures that care is organized across systems using open and proficient communication with the patient/family, providers, and other individuals supporting the patient’s/family’s welfare.

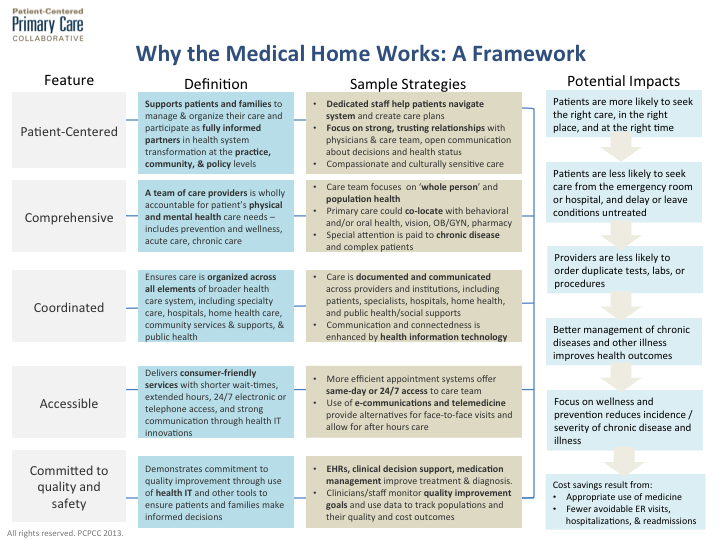
* Care Coordination

According to Antonelli, McAllister, and Popp (2009), developers of the “Framework for High-Performing Pediatric Care Coordination,” the defining characteristics of care coordination are as follows:

* **Patient- and family-centered**
* **Proactive, planned, and comprehensive**
* **Promotes self-care skills and independence**
* **Emphasizes cross-organizational relationships**

Furthermore, several care coordination competencies are recommended, including the **development of partnerships**, **integration of resource knowledge**, and **management/tracking of tests, referrals, and outcomes** (Antonelli, McAllister, and Popp, 2009).

* Strategies and Benefits of Implementing Care Coordination and the Medical Home Approach



Patient-Centered Primary Care Collaborative, 2013