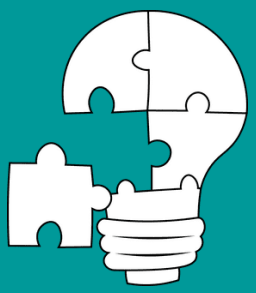
Empowering families and connecting dots



What is care coordination?

Connecticut Children's Center for Care Coordination (the Center) empowers families to advocate for their children and connects families to appropriate medical, behavioral, educational, legal and social services.

Care coordination is a team-based approach designed to meet the needs of children while also strengthening the caregiving capabilities of families through the Protective Factors Framework. It addresses the medical, social, developmental, behavioral, educational and financial needs of families to achieve optimal health, development and well-being for children.

How does care coordination support our patients and their families?

The Center strives to facilitate comprehensive care to meet the medical, social, and mental health needs of children and their families. Our team is available to help bridge the gap between families and the services they need to stay healthy. In an effort to connect all families to supports across our hospital's care continuum, the Center also leads our inpatient nurse case management team who support families discharging from an inpatient hospitalization, as well as our clinical social work teams who provide support, evaluation and care as families receive care in our emergency, inpatient and outpatient settings.

Through grants from the Department of Public Health, community care coordination services through the Center are complimentary for children and youth birth to 21 years of age (21+ for some patient populations). Our community care team is focused on patients and families looking for support, including those with medical, developmental or behavioral conditions and those needing help with basic supports

What services do care coordinators provide?

- Global needs assessment (medical, behavioral, educational, basic needs, developmental, etc.)
- Review and support around discharge recommendations
- Benefit review and coordination
- Linkage to community resources (after school programs, job training, social supports)
- Connection with local behavioral health resources
- Referrals to state and local programs
- Communication between care providers
- Transitional planning into adulthood (medical, educational, vocational, community)
- Legal and educational advocacy

How do care coordinators support community pediatricians?

The Center works with pediatricians across the state to ensure their patients are well supported within their community, so providers can focus on patient care.

The Center is proud to be the home of several innovations including the Care Coordination Collaborative Model. The Model brings together care coordinators from various child-serving sectors to increase the efficiency and effectiveness of their work within a comprehensive child health system, decrease the duplication of services and unnecessary visits, and to advocate for policy level solutions to ensure families have access to beneficial services. Additionally, the Center has published on the benefits of Care Coordination in a behavioral health emergency department setting and been building our behavioral health coordination expertise in recent years.

Today, our care coordinators participate in a range of community collaboratives as well as host an annual Care Coordination Forum to ensure that our team is ready to lead through best practices.

What impact does the Center for Care Coordination have in Hartford?

- In the past year, 319 Hartford families were referred and 263 enrolled in care coordination services
- 89% of those enrolled families rely on HUSKY
- Needs identified for enrolled families included:
  - Basic needs (88)
  - Behavioral health (82)
  - Medical/dental services (46)
  - Education (39)
  - Social connections (37)