Family Centered Care
Family-Centered Care assures the health and well-being of children and their families through a respectful family-professional partnership. It honors the strengths, cultures, traditions and expertise that everyone brings to this relationship.

Some principles of this would be:

- Acknowledges the family as the constant in a child’s life.
- Builds on family strengths.
- Supports the child in learning about and participating in his/her care and decision-making.
- Honors cultural diversity and family traditions.
- Recognizes the importance of community-based services.
- Promotes an individual and developmental approach.
- Encourages family-to-family and peer support.
- Supports youth as they transition to adulthood.
- Develops policies, practices, and systems that are family-friendly and family-centered in all settings.

Community Based Care
System of services must be organized so that families know how and where to get the services they need. It is equally important that the services are organized and delivered in culturally effective, family-centered, and accessible settings. Simplifying this process and avoiding duplication should be a goal of community-based systems of services.

Coordinated Care
Care coordination is a central, ongoing component of an effective system of care for children and youth with special health care needs and their families. Care coordination engages families in development of a care plan and links them to health and other services that address the full range of their needs and concerns. Principles of care coordination reflect the central role of families and the prioritization of child and family concerns, strengths and needs in effective care of children with special health care needs. Activities of care coordination may vary from family to family, but start with identification of an individual child and family needs, strengths and concerns, and aims simultaneously at meeting family needs, building family capacity and improving systems of care.

Basic principles are that it is:

- Accessible
- Individualized
- Aligned with the family’s desire/values
- Promotes solutions to systematic problems
Culturally Competent
Individual values, beliefs, and behaviors about health and well-being are shaped by various factors such as race, ethnicity, nationality, language, gender, socioeconomic status, physical and mental ability, sexual orientation, and occupation. Cultural competence in health care is broadly defined as the ability of providers and organizations to understand and integrate these factors into the delivery and structure of the health care system. The goal of culturally competent health care services is to provide the highest quality of care to every patient, regardless of race, ethnicity, cultural background, English proficiency or literacy.

Lots of strategies here:
- Provide interpreter services
- Recruit and retain minority staff
- Provide training to increase cultural awareness, knowledge, and skills
- Coordinate with traditional healers
- Use community health workers
- Incorporate culture-specific attitudes and values into health promotion tools
- Include family and community members in health care decision making
- Locate clinics in geographic areas that are easily accessible for certain populations
- Expand hours of operation
- Provide linguistic competency that extends beyond the clinical encounter to the appointment desk, advice lines, medical billing, and other written materials.

Medical Home
A Medical Home is a model of care delivery that every family should be receiving. It is the end result of parents and health care professionals acting as partners. The belief is “that all children should have a medical home where care is accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective.”

Family Professional Collaboration
Parent/professional collaboration moves a step further than family involvement. To collaborate means to work together in an equal relationship that is based on mutual trust and caring. The move toward collaboration is an effort to improve direct services for families and professionals, identify informal supports, and build communities for people with disabilities that are based on their culture, dreams, goals, priorities, and needs.

Healthcare Transition for Youth with Special Health Care Needs
Children and teens, as developmentally able, need to understand their medical condition, medication, and health insurance. They need to learn how to communicate with their doctors, make appointments, and make informed health decisions. Parents and caregivers need to learn about changes in health care needs, services, and insurance coverage as youth transition into adulthood. Pediatricians and other service providers can play an important role in providing information and direction to youth and families on issues affecting health care and lifestyle choices.