Medical Home (a Universal Measure) is one of twenty Maternal and Child Health (MCH) **National Performance Measures (NPMs)** for the Title V MCH Services Block Grant to States Program. This NPM is focused on increasing the percent of children with and without special health care needs, ages 0 through 17, who have a medical home.

For Medical Home (overall measure), there are 10 evidence-based strategies from MCHbest and 22 field-based practices from Innovation Hub. Strategies for the overall NPM start on p. 3.

The **What Works Evidence Accelerators** provide background information and a summary of effective strategies to advance each of the NPM topic areas. This NPM has expanded to include five sub-components: the percent of children with and without special health care needs, ages 0 through 17, who have a personal doctor or nurse; have a usual source of sick care; are provided with family-centered care; receive needed referrals; and receive needed care coordination.

Overview.

The American Academy of Pediatrics (AAP) defines the medical home model as an "approach to providing comprehensive and high quality primary care."[1,2] Studies show that both children with and without special health care needs benefit from care consistent with the model.[3] The pediatric medical home model is capable of addressing preventive, acute, and chronic care from birth through transition to adulthood.[4] It is able to facilitate an integrated health system with an interdisciplinary team of patients and families, primary care physicians, specialists, hospitals and health care facilities, and agencies.[5]

The model helps connect families to specialty care, educational services, out-of-home care, family support, and other public and private community services.[6] It recognizes the family as a constant in a child's life and emphasizes partnership between families and health care professionals.[2] It is not a building or place, but an ideal approach for delivering good care.[6] A medical home should be: accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective.[2]

Data.

This NPM is measured through data collected from the National Survey of Children's Health (NSCH). In 2022, 39.5% of children and youth with special health care needs (CYSHCN) had a medical home[7] and 46.7% of non-CYSHCN had a medical home[8] as reported by their parent/caregiver. For both CYSHCN and non-CYSHCN, the rate of reported medical home attainment was lowest among American Indian/ Alaska Native, non-Hispanic children (29.6% and 37.1%), Hispanic children (30.7% and 34.4%), Black, non-Hispanic children (32.6% and 36.1%), and Asian, non-Hispanic children (33.0% and 36.9%); and it was highest among White, non-Hispanic children (45.6% and 57.1%).[9,10]

Additionally, in 2022, 45.2% of children received coordinated, ongoing, comprehensive care within a medical home.[11] By special health care need status, 39.5% of CYSHCN and 46.7% of non-CYSHCN received coordinated, ongoing, comprehensive care within a medical home.[12] By race and ethnicity of the child, 33.8% of Hispanic children, 35.2% of Black, non-Hispanic children, and 36.5% of Asian, non-Hispanic children received coordinated, ongoing, comprehensive care within a medical home, compared to 54.6% of White, non-Hispanic children.[13]

Social Determinants of Health (SDOH).

The AAP stresses the influence that social risk factors have on children's health, along with the role pediatricians have in improving them.[14] Strategies affecting social risk that have demonstrated effectiveness include:

- Addressing SDOH as a key tenet of clinical guidelines and the medical home model.
- Screening for social needs at medical visits (e.g., unmet material needs such as food, employment).
- Co-locating community-based resources (e.g., WIC) in the medical home.
- Developing "outside the box" multidisciplinary primary care interventions, care teams, and technology-based health education efforts.
- Integrating home visiting with the medical home to assist providers in addressing SDOH.[14,15]

Access additional evidence-based strategies in the MCH Digital Library's SDOH in the Medical Home professional resource brief.

Health Equity. Traditionally marginalized populations of children (diverse racial, ethnic, and cultural groups, non-English speakers, families from low-income backgrounds, and children with multiple disabilities or complex conditions) who experience health inequities in the US have the least access to care consistent with the medical home model.[3,16]

Health equity can be improved by focusing on:

- Equitable collaborations between families and any child-serving system that supports families.
- Mutual trust and respect between families and providers to ensure the best possible care.
- Systems of care that are responsible for moving towards a more equitable distribution of resources to enable all families, especially those who are under-resourced and have CYSHCN, to access needed services and supports regardless of who they are, what they look like, where they live, and what resources they may have.[17]

The AAP maintains a health equity page that includes resources and a logic model to promote a family-centered, equitable, and culturally component medical home.[17]

CYSHCN. The need for a medical home and improvements to the system of care is especially important for CYSHCN who often require significant care coordination and care integration.[18] In the US, nearly 1 in 5 children (19.4%) or 14.1 million children under 18 have a special health care need, more than 1 in 4 households with children (28.6%) had at least one CYSHCN, and these children require services from multiple child-serving systems, including health care, public health, education, mental health, and social services.[19] The medical home model is critical for CYSHCN because they use more health care services and have more unmet needs than non-CYSHCN.[3]

CYSHCN have also been described as a population requiring care within the medical home model since they have higher health care expenditures, need prescription medications, require medical specialists and other services, such as therapies, vision, and dental, experience unmet mental health needs, and their families have higher out-of-pocket expenses compared to the medical costs of all children.[20] CYSHCN remain a sizable and diverse population with distinct challenges in accessing a high quality, well-organized system of care that meets their needs.[21]

Key Resources. There is a broad array of research on the beneficial outcomes of the pediatric medical home model including an association between access to and utilization of medical homes to improved health outcomes, improved healthcare quality, decreased unmet needs including those for CYSHCN, increased satisfaction for children and families, increased clinician experience and satisfaction, and decreased cost of care.[18,22]

Search the Established Evidence database for peer-reviewed research articles related to strategies for increasing access to the medical home model.

Find field-based resources focused on increasing access to the medical home model relevant to Title V programs in the MCH Digital Library.

Partnership and the Role of Title V.

According to the AAP, programs such as Title V can provide technical assistance (TA) and support to medical practices implementing the medical home model.[23] Title V programs can also explore their needs assessment data to prioritize which medical home components need to be addressed to make progress on the NPM and its sub-components.[22]

Medicaid agencies and Title V programs are engaged in many collaborative efforts to improve systems of care that serve CYSHCN, integrate health care services and supports, and provide resources for children and families.[24] These efforts can be leveraged to promote family-centered care for CYSHCN. Cross-system collaboration can facilitate alignment between programs and ensure that the unique needs of CYSHCN and the importance of medical home are reflected in health reform efforts.

Strategies to enhance collaboration include:

- Participating on interagency advisory committees or councils to improve care for CYSHCN.
- Leveraging interagency agreements to strengthen the medical home model of care for CYSHCN.
- Establishing data sharing agreements to identify needs and monitor care for children.
- Partnering on health reform efforts to advance delivery systems serving CYSHCN.[24]

Medical Home Strategies.

This page summarizes the latest strategies and practices that have emerged as potential approaches for increasing the percent of children with and without special health care needs, ages 0 through 17, who have a medical home. It provides a framework to identify, understand, and implement "what works" in creating new or strengthening current Evidence-based/informed Strategy Measures (ESMs). Use the links below to access strategy and practice details, approaches, supporting evidence, outcomes, and examples of how Title V agencies are either using these strategies directly or adopting components of the intervention that address this NPM.

Evidence-Based/Informed Strategies. 10 strategies have emerged from studies in the scientific literature as being effective in advancing the NPM. They can be adopted or adapted to meet your program needs. More information on these strategies can be found in the MCH Evidence Center's MCHbest database.

- Dedicated Care Coordinators (2022)
- Policies to Promote Medical Home (2023)
- Provider Alliance and Mid-Level Providers (2022)
- Provider-School Partnerships (2021)
- Shared Care Coordination with Home Visiting (2023)
- Federally Qualified Health Centers (FQHCs) (2023)
- Nurse Practitioner Scope of Practice (2017)
- Patient Navigators (2016)
- Practice Coaches/Facilitators (2019)
- School-Based Health Centers (2023)

Field-Based Practices. 22 practices from state-/community-based programs have emerged as potential approaches for advancing the NPM for specific communities or populations. They can be used as models to meet your program needs. More information can be found in the Association of Maternal and Child Health Program's (AMCHP's) Innovation Hub.

- Cultural Brokering (Virginia)
- School Nurse Education (Missouri)
- Telehealth Lending Library (Utah)
- Family-Centered Care Coordination (Virginia | Iowa)
- LEND Training (Tennessee)
- Medical Home for Foster Care (Florida)
- Primary Care Provider Training (Tennessee)
- Publicly Financed Palliative Care Model (Florida)
- Virtual Autism Diagnostic Clinic (Pennsylvania)
- Community-based Care Coordination (Oregon)
- County System Care Coordination (California)
- Integrated Mental Health Services (New York)
- Community Team (Pennsylvania)
- Statewide Leadership Initiative (Washington)
- Telehealth Autism Screening (Tennessee)
- Youth Advocacy (National | Wisconsin)
- Culturally Competent Community Health Workers (South Carolina)
- Early Childhood Mental Health Care (Massachusetts)
- Family Connects Model (National)
- Family-Driven Systems Change (North Carolina)
- Teen Educator Program (Wisconsin)
- Telemedicine (New York)

Key Findings. The following are key findings emerging from the literature:

1. There is limited rigorous evidence about effective interventions to increase access to a medical home for children with and without special health care needs.[25]
2. The identified interventions for this NPM overall were focused on all children with no strategy specifically targeting CYSHCN.[25]
3. The studies identified partnerships and care coordination as mechanisms to improve access to care within the medical home model.[26]
4. Use of community collaborators, such as School-Based Health Centers (SBHCs) and outreach via community care coordinators, resulted in more children receiving care within the medical home model. More specifically, collaborations with SBHCs, home visiting programs, or use of enhanced care coordination in underserved, urban neighborhoods or with children in foster care led to positive outcomes. These impacts include increased contact with the medical home model for well-child visits, access to specialty care, better adherence with disease management, and dental care.[27]
5. A shift in policy was found to increase access to a medical home for children receiving Medicaid. Moving from a traditional fee-for-service model of health care financing and delivery to a primary care case management model by a Medicaid program resulted in more targeted identification and support for children and their families to enter into a medical home model of care.[28]

Discussion: Research, Practice, Partnership.

Research. Multiple strategies are emerging as potential approaches to advance this NPM, but they have not been studied with enough rigor to be included in the evidence-based continuum. Additional research is needed to verify outcomes, but initial studies have shown promise of these strategies in MCH settings:

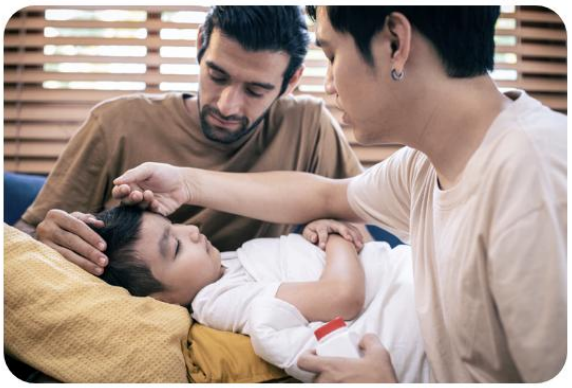
- Developing robust, comprehensive telehealth coverage to expand the reach of the medical home, reduce inequities, and improve the health and well-being of children, particularly CYSHCN and children without access to high-quality care.[29]
- Offering innovative education and training, such as using a parent-led curriculum for interprofessional students to build the knowledge and skills necessary for establishing a medical home in the future.[30]

Practice. The following tools can be used to translate evidence to action to advance this NPM:

- Fostering Partnership and Teamwork in the Pediatric Medical Home (AAP). This video series shows pediatric practices how to build a stronger medical home through collaboration.
- The Medical Home Index: Pediatric (Center for Medical Home Improvement). This tool is designed to translate the broad indicators defining the medical home into observable, tangible behaviors and processes of care.

Partnership. The following organizations focus efforts on supporting the medical home model:

- AAP Medical Home Resources. Provides tools and resources to assist families, practices, and others with pediatric medical home implementation.
- Primary Care Collaborative. Focuses on advancing an effective health system built on a strong foundation of primary care and the medical home.



Frameworks and Tools for "What Works."

Use this accelerator to strengthen current or new programs that align with multiple MCH frameworks across domains and settings. Access toolkits related to these frameworks for additional resources:

- MCH Evidence Framework
- Blueprint for Change for CYSHCN
- Maternal Health Toolkit
- Life Course and Social Determinants Brief

Need More Help? Contact us for training and technical assistance customized to your needs.

Cite As. Le L, Zeeck E, Watson K, Richards J. *Medical Home: What Works Evidence Accelerator. Summarizing Effective Strategies for MCH.* Strengthen the Evidence for MCH Programs. National Center for Education in Maternal and Child Health, Georgetown University, Washington DC. May 2024.

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This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U02MC31613, MCH Advanced Education Policy, $3.5 M. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.