Medical Home: Personal Doctor or Nurse is a component of Medical Home (a Universal Measure), 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 subcomponent is focused on increasing the percent of children with and without special health care needs, ages 0 through 17, who have a personal doctor or nurse.

For Personal Doctor or Nurse, there are 15 evidence-based strategies from MCHbest and 6 field-based practices from Innovation Hub. Strategies for this subcomponent 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. The strategies support greater continuity of care with more children and their families having personal doctors or nurses they know and trust as partners in their health and well-being.

Overview. Ideally, the medical home model of care is delivered within the context of a trusting and collaborative relationship between a child's family and a competent health care professional.[1] A personal doctor or nurse is one of the five components of the composite medical home measure.[2] A child's *"personal doctor or nurse"* could be one or more health care professionals who know the child well and are familiar with the child's health history.[3] A *"health care professional"* is defined as a general doctor, pediatrician, specialist doctor, nurse practitioner, or physician's assistant.[3]

Continuity of care is a key aspect of the patient-centered medical home and improves pediatric outcomes.[4] Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care, are less likely to be hospitalized for preventable conditions, and are more likely to be successfully screened and diagnosed early for chronic or disabling conditions.[5, 6] Continuity influences parental trust, and may also improve quality of care and prevent high-cost encounters, especially for children with chronic conditions.[4]

A child's personal doctor or nurse can deliver individualized care, help the family navigate through a complex health care system to ensure the child receives the care they need and can often limit the need to refer to other specialists,[5] and be an integral part of a multidisciplinary care team to address all the health needs of a child.[7, 8] School-based health centers (SBHCs) can further increase access to care, particularly for children from families that would not have any other option for health care due to cost, lack of health insurance, or systemic inequities.[9]

In the absence of continuous, caring relationships with health care professionals who know the child's medical history, parents or caregivers often report frustration, hypervigilance, and mistrust about the quality of care that their child received.[10] *Continuity of relationships* contributes to caregivers' confidence that their child is receiving the best possible care.[10] The more families are included and involved in all aspects of their child's care, with consistent staff providing coordinated information, the less anxious they are likely to become and the more trusting they may be that staff are providing high quality care.[10]

Data. This NPM is measured through data collected from the National Survey of Children's Health (NSCH). In 2022, 71.5% of all children and adolescents were reported to have one or more persons who were considered their personal doctor or nurse.[11] 77.5% of children and youth with special health care needs (CYSHCN) had a personal doctor or nurse while 69.9% of non-CYSHCN has a personal doctor or nurse.[12] By race and ethnicity, White, non-Hispanic children were the most likely group to have a personal doctor or nurse at 78.3% while Hispanic and Black, non-Hispanic children were the least likely groups to have a personal doctor or nurse at 61.4% and 65.3% respectively.[13]

Social Determinants of Health (SDOH).

CYSHCN, especially those with increased medical complexity, have elevated social needs and risks, and as a result, they often need additional nonclinical supports to thrive.[14] Health care providers can offer support or refer to community-based organizations for non-medical concerns, such as meeting basic needs (e.g., food assistance, supportive housing, personal safety) and dealing with stress, social

problems, and emotional concerns.[15] For example, Family-to-Family Health Information Centers can provide information, education, technical assistance, and peer support to families of CYSHCN and the professionals who serve them. Addressing these social needs can greatly benefit a child's health, mental health, development, and well-being.

A systematic review reports on SDOH screening tools used with children primarily in a doctor's or pediatrician's office with a parent or caregiver to detect risk and inform care.[16] Several brief screening tools can be effective in primary care practices as part of a workflow designed to address social needs with referrals to community-based resources.[17]

Health Equity. With the ever-increasing diversity of the pediatric population, there is a need to diversify the medical workforce and for all providers to practice culturally effective health care (CEHC).[18] Access to care for minority patients is improved when the provider and the patient are racially or ethnically concordant; however, such congruence is infrequent.[19,20] Pediatric workforce diversity can be achieved through recruitment, mentoring, education, organizational support, and financial incentives.[18] Diversity in the workforce includes a wide array of racial, ethnic, cultural, and other attributes, such as customs, language, sexual orientation, religious beliefs, disability status, and socioeconomic status.[18]

CEHC is the delivery of care within the context of appropriate provider knowledge, understanding, and appreciation of all cultural distinctions, leading to optimal health outcomes, quality of life, and family satisfaction.[21] It is a more inclusive term than "cultural competence" because it encompasses the values of competence and focuses on the outcomes of the provider-patient and provider-family interaction.[18]

Significant and pervasive racial and ethnic health and health care disparities persist among children with chronic health conditions.[22] Black and Hispanic parents of CYSHCN report higher dissatisfaction with care and more difficulties navigating services for their children compared to their White counterparts.[23] Addressing disparities requires educational efforts focused on the enhancement of interpersonal and communication skills that are essential to nurturing the provider-child-family relationship.[18]

CYSHCN. CYSHCN remain a sizable and diverse population with distinct challenges in accessing well-functioning systems of care, particularly those with the greatest needs.[24] An approach combining telehealth visits and family-centered care can greatly improve the health care experience for CYSHCN:

- Children and families may feel more relaxed attending virtual visits from their own homes.
- Children and families can have more quality one-on-one time with their providers to discuss medical issues and social and emotional needs.
- The use of telehealth can help strengthen continuity of care with a personal doctor or nurse when transportation options are limited.
- Virtual visits may fit better into the schedule for families of CYSHCN who often juggle many appointments every week.[25]

Key Resources. Lack of a personal health care provider can be driven by larger issues, such as health insurance, socioeconomic status, as well as race and ethnicity. Multifaceted approaches are needed to achieve the goal of a personal health care provider for all children.[26]

Search the Established Evidence database for peer-reviewed research articles related to strategies for increasing care with a personal doctor or nurse.

Find field-based resources focused on increasing care with a personal doctor or nurse relevant to Title V programs in the MCH Digital Library.

Partnership and the Role of Title V. Title V programs can help ensure continuity of care with a personal doctor or nurse by:

- Developing care coordination mechanisms and team-based communication to ensure a single point of contact and provider consistency.[27]
- Expanding telehealth services to connect children with their personal providers whenever needed.[25]
- Addressing barriers to accessing care, such as transportation, language, cultural factors, and health literacy, to help establish a continuous source of health care.[28]
- Supporting the use of a whole child approach to enable the medical home team to work collaboratively to meet the varied and multifaceted needs of the child and family.[15]

Personal Doctor or Nurse 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 personal doctor or nurse. 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. 15 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.

- Culturally Competent Care (2020)
- Health Education and Outreach Programs (2021)
- Health Insurance Coverage (2022)
- Medicaid Managed Care (2018)
- Provider Training and Support (2023)
- Telemedicine and Telehealth Services (2023)
- Home Visiting Programs (2022)
- Care Coordination and Case Management (2021)
- Integrated Care (2022)
- Quality Improvement Initiatives (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. 6 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.

- Connecting Families to Supports through Service Assessments (RI; 2023)
- Family Navigator Network (IA; 2020)
- Health Education, Case Management, and Patient Navigation (NY; 2019)
- Young Parent-Centered Case Management (MA; 2020)
- Community-based Care Coordination Network (National; 2023)
- Community Systems Building Grants for CYSHCN (NC; 2018)

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

1. Enhancements at the clinic or practice level, such as integrated, co-located, and collaborative care models,[29-34] warm hand-offs from colleagues,[35,36] care coordination,[37-39] nurse practitioner-led services,[40,41] inclusive clinical intake forms,[42] patient portal messages to encourage online scheduling and feedback,[43] and continuity clinics[44] can increase access to health care services, strengthen patient-provider relationships, and ensure children receive individualized, continuous, and comprehensive care in a familiar setting.
2. Provider training, mentoring, and support,[45-50] including use of an electronic screening, feedback, and consultation tool to support clinical decision-making,[51,52] enhances the knowledge, skills, confidence, and self-efficacy of providers resulting in improved communication practices, greater disease management, enhanced quality of care, and better health outcomes for children.
3. Alternative settings and modalities to traditional primary care, such as telemedicine and telehealth services,[53-58] school-based health clinics,[59,60] and home visiting programs[61-63] can increase access to care and improve health care utilization, particularly for CYSHCN in underserved areas, as well as reduce burdens on families and address SDOH for families.
4. By expanding health insurance coverage, reducing gaps in coverage, and transitioning to systems like Medicaid Managed Care,[64-67] more children from low-income backgrounds have the opportunity to establish and maintain relationships with care providers leading to better health outcomes.

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:

- Deploying mobile health clinics to underserved communities to increase provider availability.[68-70]
- Empowering parents and caregivers to navigate the health care system and to establish strong provider connections.[71]
- Collaborating with community organizations, schools, and local stakeholders to establish referral networks enabling more children to be cared for by trusted providers.[72,73]

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

- Primary Care Assessment Tools (Johns Hopkins). Tools to measure care over time, coordination, comprehensiveness, community orientation, family-centeredness, and cultural competence.
- Patient-Doctor Depth of Relationship Tool (University of Bristol). This scale measures the depth of the patient-doctor relationship in primary care from the patient's perspective.

Partnership. The following organizations focus efforts on enhancing patient-provider relationships:

- American Academy of Pediatrics (AAP) Medical Home Resources. Highlights medical home resources for families and caregivers to support partnerships with their child's health professionals.
- Family-to-Family Health Information Centers. Helps families of CYSHCN and the health professionals who serve them.

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, Watson K, Richards J. *Medical Home-Personal Doctor or Nurse: 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.

References

[1] Strengthen the Evidence for Maternal and Child Health Programs. Georgetown University. (n.d.). Evidence Tools: Medical Home. Retrieved from NPM 11 | MCH Evidence

[2] Lichstein, J. C., Ghandour, R. M., & Mann, M. Y. (2018). Access to the Medical Home Among Children With and Without Special Health Care Needs. *Pediatrics*, *142*(6).

[3] Retrieved from NSCH Interactive Data Query (2022 - present) - Data Resource Center for Child and Adolescent Health (childhealthdata.org)

[4] Enlow, E., Passarella, M., & Lorch, S. A. (2017). Continuity of Care in Infancy and Early Childhood Health Outcomes. *Pediatrics*, *140*(1), e20170339.

[5] Nationwide Children's. The Importance of Having a Relationship with Your Child's Pediatrician (2020). 700 Children's Blog.

[6] Retrieved from Title V Block Grant Technical Assistance Resources (hrsa.gov)

[7] Katkin, J. P., Kressly, S. J., Edwards, A. R., Perrin, J. M., Kraft, C. A., Richerson, J. E., Tieder, J. S., Wall, L., & TASK FORCE ON PEDIATRIC PRACTICE CHANGE (2017). Guiding Principles for Team-Based Pediatric Care. *Pediatrics*, *140*(2).

[8] Boudreau, A., Hamling, A., et al. (2022). Pediatric Primary Health Care: The Central Role of Pediatricians in Maintaining Children's Health in Evolving Health Care Models. *Pediatrics*, *149*(2).

[9] School-Based Health Alliance. (2024). Toolkit to increase well-child visits and vaccinations in school-aged youth. Retrieved from Merck Toolkit: Home – SBHA Toolkits (sbh4all.org)

[10] Heller, K. S., Solomon, M. Z., & Initiative for Pediatric Palliative Care (IPPC) Investigator Team (2005). Continuity of care and caring: what matters to parents of children with life-threatening conditions. *Journal of pediatric nursing*, *20*(5), 335–346.

[11] Child and Adolescent Health Measurement Initiative. 2022 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved [04/11/2024] from [www.childhealthdata.org]. NSCH 2022: Medical Home Component: Children with a personal doctor or nurse, Nationwide (childhealthdata.org)

[12] Child and Adolescent Health Measurement Initiative. 2022 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved [04/11/2024] from [www.childhealthdata.org]. NSCH 2022: Medical Home Component: Children with a personal doctor or nurse, Nationwide, Special health care needs status (childhealthdata.org)

[13] Child and Adolescent Health Measurement Initiative. 2022 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved [04/11/2024] from [www.childhealthdata.org]. NSCH 2022: Medical Home Component: Children with a personal doctor or nurse, Nationwide, Race/ethnicity of child -- with Asian (childhealthdata.org)

[14] McLellan SE, Mann MY, Scott JA, Brown TW. A Blueprint for Change: Guiding Principles for a System of Services for Children and Youth With Special Health Care Needs and Their Families. Pediatrics. 2022;149(Suppl 7).

[15] Retrieved from Special Health Needs: Non-Medical Necessities Matter, Too - HealthyChildren.org.

[16] Sokol, R., Austin, A., et al. (2019). Screening Children for Social Determinants of Health: A Systematic Review. *Pediatrics*, *144*(4).

[17] O'Gurek, D. T., & Henke, C. (2018). A Practical Approach to Screening for Social Determinants of Health. *Family practice management*, *25*(3), 7–12.

[18] Committee on Pediatric Workforce, Pletcher, B. A., Rimsza, M. E., Basco, W. T., Hotaling, A. J., Sigrest, T. D., & Simon, F. A. (2013). Enhancing pediatric workforce diversity and providing culturally effective pediatric care: implications for practice, education, and policy making. *Pediatrics*, *132*(4), e1105-e1116.

[19] Toomey, S. L., Chien, A. T., Elliott, M. N., Ratner, J., & Schuster, M. A. (2013). Disparities in unmet need for care coordination: the national survey of children's health. *Pediatrics*, *131*(2), 217-224.

[20] Collins, K. S., Hughes, D. L., Doty, M. M., Ives, B. L., Edwards, J. N., & Tenney, K. (2002). *Diverse communities, common concerns: assessing health care quality for minority Americans* (p. 523). New York: Commonwealth Fund.

[21] Britton, C.V.; Committee on Pediatric Workforce. (2004). Ensuring culturally effective pediatric care: implications for education and health policy. *Pediatrics*, *114*(6), 1677-1685.

[22] Berry, J. G., Bloom, S., Foley, S., & Palfrey, J. S. (2010). Health inequity in children and youth with chronic health conditions. *Pediatrics*, *126*(Supplement_3), S111-S119.

[23] Ngui, E. M., & Flores, G. (2006). Satisfaction with care and ease of using health care services among parents of children with special health care needs: the roles of race/ethnicity, insurance, language, and adequacy of family-centered care. *Pediatrics*, *117*(4), 1184-1196.

[24] Ghandour, R. M., Hirai, A. H., & Kenney, M. K. (2022). Children and Youth With Special Health Care Needs: A Profile. *Pediatrics*, *149*(Suppl 7).

[25] Retrieved from Can I use telehealth for my child with special health care needs? | Telehealth.HHS.gov
[26] Zeni, M. B., Sappenfield, W., Thompson, D., & Chen, H. (2007). Factors associated with not having a personal health care provider for children in Florida. *Pediatrics*, *119 Suppl 1*, S61–S67.
[27] Randi, O., Gould, Z, Honsberger, K. (2022). National Care Coordination Standards for Children and Youth with Special Health Care Needs (CYSHCN) Implementation Guide - NASHP.
[28] Children's Health Fund. November 2016. Unfinished business: More than 20 million children still lack sufficient access to essential health care.
[29] Cole, M. B., Qin, Q., Sheldrick, R. C., Morley, D. S., & Bair-Merritt, M. H. (2019). The effects of integrating behavioral health into primary care for low-income children. Health services research, 54(6), 1203–1213. https://doi.org/10.1111/1475-6773.13230
[30] Kolko, D. J., Hart, J. A., et al. (2020). Effects of Collaborative Care for Comorbid Attention Deficit Hyperactivity Disorder Among Children With Behavior Problems in Pediatric Primary Care. Clinical pediatrics, 59(8), 787–800.
[31] Valleley, R. J., Leja, A., et al. (2019). Promoting Earlier Access to Pediatric Behavioral Health Services with Colocated Care. Journal of developmental and behavioral pediatrics: JDBP, 40(4), 240–248.
[32] Rickwood, D., Paraskakis, M., Quin, D., Hobbs, N., Ryall, V., Trethowan, J., & McGorry, P. (2019). Australia's innovation in youth mental health care: The headspace centre model. Early intervention in psychiatry, 13(1), 159-166.
[33] Arora, B. K., Klein, M. J., Yousif, C., Khacheryan, A., & Walter, H. J. (2023). Virtual Collaborative Behavioral Health Model in a Community Pediatric Network: Two-Year Outcomes. Clinical pediatrics, 62(11), 1414–1425.
[34] Hoff, A., Hughes-Reid, C., Sood, E., & Lines, M. (2020). Utilization of Integrated and Colocated Behavioral Health Models in Pediatric Primary Care. Clinical pediatrics, 59(14), 1225–1232.
[35] Sheldrick, R. C., Bair-Merritt, M. H., Durham, M. P., Rosenberg, J., Tamene, M., Bonacci, C., Daftary, G., Tang, M. H., Sengupta, N., Morris, A., & Feinberg, E. (2022). Integrating Pediatric Universal Behavioral Health Care at Federally Qualified Health Centers. Pediatrics, 149(4), e2021051822.
[36] Sanderson, D., Braganza, S., Philips, K., Chodon, T., Whiskey, R., Bernard, P., ... & Fiori, K. (2021). Increasing warm handoffs: optimizing community based referrals in primary care using QI methodology. Journal of Primary Care & Community Health, 12.
[37] SaSadof, M., Carlin, S., Brandt, S., & Maypole, J. (2019). A step-by-step guide to building a complex care coordination program in a small setting. Clinical pediatrics, 58(8), 897-902.
[38] Matiz, L. A., Kostacos, C., Robbins-Milne, L., Chang, S. J., Rausch, J. C., & Tariq, A. (2021). Integrating Nurse Care Managers in the Medical Home of Children with Special Health Care needs to Improve their Care Coordination and Impact Health Care Utilization. Journal of pediatric nursing, 59, 32–36.
[39] Looman, W. S., Hullsiek, R. L., et al. (2018). Health-Related Quality of Life Outcomes of a Telehealth Care Coordination Intervention for Children With Medical Complexity: A Randomized Controlled Trial. Journal of pediatric health care, 32(1), 63–75.
[40] Sivertsen, N., Parry, Y., et al. (2022). Aboriginal children and family connections to primary health care whilst homeless and in high housing mobility: observations from a Nurse Practitioner-led service. Primary Health Care Research & Development, 23, e16.
[41] Wall, S., & Medina, R. (2022). Creating an academic-practice partnership in a primary care pediatric clinic. Journal of professional nursing: official journal of the American Association of Colleges of Nursing, 41, 176–180. https://doi.org/10.1016/j.profnurs.2022.05.009
[42] Guss, C. E., Eiduson, R., et al. (2020). "It'd Be Great to Have the Options There": A Mixed-Methods Study of Gender Identity Questions on Clinic Forms in a Primary Care Setting. Journal of Adolescent Health, 67(4), 590-596.
[43] Snyder, D. A., Schuller, J., Ameen, Z., Toth, C., & Kemper, A. R. (2022). Improving Patient-Provider Continuity in a Large Urban Academic Primary Care Network. Academic pediatrics, 22(2), 305–312.
[44] Kiger, M. E., Bautista, E., Bertagnoli, T. M., Hammond, C. E., Meyer, H. S., Varpio, L., & Dong, T. (2021). Defragmenting the Day: The Effect of Full-Day Continuity Clinics on Continuity of Care and Perceptions of Clinic. Teaching and learning in medicine, 33(5), 546–553.
[45] Cinko, C., Thrasher, A., Sawyer, C., Kramer, K., West, S., & Harris, E. (2023). Using the Project ECHO Model to Increase Pediatric Primary Care Provider Confidence to Independently Treat Adolescent Depression. Academic psychiatry: the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, 47(4), 360–367.
[46] Addala, A., Filipp, S. L., et al. (2022). Tele-education model for primary care providers to advance diabetes equity: Findings from Project ECHO Diabetes. Frontiers in endocrinology, 13, 1066521.
[47] Chokshi, B., Chen, K. D., & Beers, L. (2020). Interactive Case-Based Childhood Adversity and Trauma-Informed Care Electronic Modules for Pediatric Primary Care. MedEdPORTAL : the journal of teaching and learning resources, 16, 10990.
[48] Jones, M. R., Dadiz, R., Baldwin, C. D., Alpert-Gillis, L., & Jee, S. H. (2022). Integrated behavioral health education using simulated patients for pediatric residents engaged in a primary care community of practice. Families, systems & health, 40(4), 472–483.
[49] Patel, M. R., Song, P. X. K., et al. (2019). Does cross-cultural communication training for physicians improve pediatric asthma outcomes? A randomized trial. The Journal of asthma, 56(3), 273–284.
[50] Mazurek, M. O., Stobbe, G., et al. (2020). ECHO Autism Transition: Enhancing healthcare for adolescents and young adults with autism spectrum disorder. Autism: the international journal of research and practice, 24(3), 633–644.
[51] McCarty, C. A., Parker, E., Zhou, C., Katzman, K., Stout, J., & Richardson, L. P. (2022). Electronic Screening, Feedback, and Clinician Training in Adolescent Primary Care: A Stepped-Wedge Cluster Randomized Trial. The Journal of adolescent health, 70(2), 234–240.
[52] Rea, C. J., Wenren, L. M., Tran, K. D., Zwemer, E., Mallon, D., Bernson-Leung, M., Samuels, R. C., & Toomey, S. L. (2018). Shared Care: Using an Electronic Consult Form to Facilitate Primary Care Provider-Specialty Care Coordination. Academic pediatrics, 18(7), 797–804.

[53] Hylén, M., Nilsson, S., et al. (2022). Access to health care perceived by parents caring for their child at home supported by eHealth—a directed approach introducing aperture. BMC Health Services Research, 22(1), 1008.
[54] Gilkey, M. B., Kong, W. Y., et al. (2021). Using Telehealth to Deliver Primary Care to Adolescents During and After the COVID-19 Pandemic: National Survey Study of US Primary Care Professionals. Journal of medical Internet research, 23(9), e31240.
[55] Watson, L., Woods, C. W., Cutler, A., DiPalazzo, J., & Craig, A. K. (2023). Telemedicine Improves Rate of Successful First Visit to NICU Follow-up Clinic. Hospital pediatrics, 13(1), 3–8.
[56] Mosquera, R. A., Avritscher, E. B. C., Pedroza, C., Lee, K. H., Ramanathan, S., Harris, T. S., Eapen, J. C., Yadav, A., Caldas-Vasquez, M., Poe, M., Martinez Castillo, D. J., Harting, M. T., Ottosen, M. J., Gonzalez, T., & Tyson, J. E. (2021). Telemedicine for Children With Medical Complexity: A Randomized Clinical Trial. Pediatrics, 148(3), e2021050400.
[57] Jamison, S., Zheng, Y., Nguyen, L., Khan, F. A., Tumin, D., & Simeonsson, K. (2023). Telemedicine and Disparities in Visit Attendance at a Rural Pediatric Primary Care Clinic During the COVID-19 Pandemic. Journal of health care for the poor and underserved, 34(2), 535–548.
[58] Hooshmand, M., & Foronda, C. (2018). Comparison of Telemedicine to Traditional Face-to-Face Care for Children with Special Needs: A Quasiexperimental Study. Telemedicine journal and e-health, 24(6), 433–441.
[59] Jones, D., Ballard, J., Dyson, R., Macbeth, P., Lyle, D., Sunny, P., ... & Sharma, I. (2019). A community engaged primary healthcare strategy to address rural school student inequities: a descriptive paper. Primary Health Care Research & Development, 20, e26.
[60] Pradhan, T., Six-Workman, E. A., & Law, K. B. (2019). An innovative approach to care: Integrating mental health services through telemedicine in rural school-based health centers. Psychiatric Services, 70(3), 239-242.
[61] Barboza, M., Kulane, A., et al. (2018). A better start for health equity? Qualitative content analysis of implementation of extended postnatal home visiting in a disadvantaged area in Sweden. International journal for equity in health, 17(1), 1-9.
[62] Williams, V. N., Lopez, C. C., Tung, G. J., Olds, D. L., & Allison, M. A. (2022). A case study of care co-ordination between primary care providers and nurse home visitors to serve young families experiencing adversity in the Northwestern United States. Health & Social Care in the Community, 30(4), 1400-1411.
[63] Lin, E., Scharbach, K., Liu, B., Braun, M., Tannis, C., Wilson, K., & Truglio, J. (2020). A multidisciplinary home visiting program for children with medical complexity. Hospital Pediatrics, 10(11), 925-931.
[64] Chen, A., Lo Sasso, A. T., & Richards, M. R. (2018). Supply-side effects from public insurance expansions: Evidence from physician labor markets. Health economics, 27(4), 690–708.
[65] Cousineau, M. R., Kim, S. E., Hamilton, A. S., Miller, K. A., & Milam, J. (2019). Insurance Coverage, and Having a Regular Provider, and Utilization of Cancer Follow-up and Noncancer Health Care Among Childhood Cancer Survivors. Inquiry: a journal of medical care organization, provision and financing, 56, 46958018817996.
[66] Brantley, E., & Ku, L. (2022). Continuous Eligibility for Medicaid Associated With Improved Child Health Outcomes. Medical care research and review: MCRR, 79(3), 404–413.
[67] Bright, M. A., Kleinman, L., Vogel, B., & Shenkman, E. (2018). Visits to Primary Care and Emergency Department Reliance for Foster Youth: Impact of Medicaid Managed Care. Academic pediatrics, 18(4), 397–404.
[68] Singh, S. P., Baig, F., & Singh, S. (2022). Mobile Health Clinics as a Healthcare Delivery Model to Address Community Disparities. *Kansas journal of medicine*, *15*, 259–261.
[69] Yu, S. W. Y., Hill, C., Ricks, M. L., Bennet, J., & Oriol, N. E. (2017). The scope and impact of mobile health clinics in the United States: a literature review. *International journal for equity in health*, *16*(1), 178.
[70] Malone, N. C., Williams, M. M., Smith Fawzi, M. C., Bennet, J., Hill, C., Katz, J. N., & Oriol, N. E. (2020). Mobile health clinics in the United States. *International journal for equity in health*, *19*(1), 40.
[71] Ashcraft, L. E., Asato, M., Houtrow, A. J., Kavalieratos, D., Miller, E., & Ray, K. N. (2019). Parent Empowerment in Pediatric Healthcare Settings: A Systematic Review of Observational Studies. *The patient*, *12*(2), 199–212.
[72] Castillo, E. G., Ijadi-Maghsoodi, R., Shadravan, S., Moore, E., Mensah, M. O., 3rd, Docherty, M., Aguilera Nunez, M. G., Barcelo, N., Goodsmith, N., Halpin, L. E., Morton, I., Mango, J., Montero, A. E., Rahmanian Koushkaki, S., Bromley, E., Chung, B., Jones, F., Gabrielian, S., Gelberg, L., Greenberg, J. M., … Wells, K. B. (2019). Community Interventions to Promote Mental Health and Social Equity. *Current psychiatry reports*, *21*(5), 35.
[73] Alderwick, H., Hutchings, A., Briggs, A., & Mays, N. (2021). The impacts of collaboration between local health care and non-health care organizations and factors shaping how they work: a systematic review of reviews. *BMC Public Health*, *21*, 1-16.

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.