Medical Home: Usual Source of Sick Care 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 number of children with and without special health care needs, ages 0 through 17, who have a usual source of sick care.

For Usual Source of Sick Care, there are 18 evidence-based strategies from MCHbest and 10 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 increased capacity to promote a usual source of care and policies to support access to consistent and comprehensive sick and preventive care for children.

Overview. Children need a consistent and reliable source of health care – for sick and preventive care – to grow up strong and healthy.[1] A *"usual source of sick care"* refers to a regular point of contact or health care provider that a child usually goes to first when they need medical attention due to illness or a parent or caregiver needs advice about their child's health.[1,2] A usual provider could be a primary care physician such as a pediatrician or a nurse practitioner and a usual place could be a doctor's office, clinic or health center, urgent care center,* hospital outpatient department, or school nurse's office.[1,2] Emergency rooms are excluded given the focus on emergency care and lack of continuity.[1,2]

A usual source of sick care is one of the components of the composite medical home measure.[3] It is an important indicator when examining health care access for children.[4] Children with a usual source of care are more likely than those without to have seen a physician during the last year, have received preventive health counseling, and have lower levels of unmet need.[5] Overall, having a usual source of care has been shown to increase quality of care, boost access to preventive services, enhance provider-family partnerships, improve health outcomes, and reduce health care costs.[4,5,6,7]

A usual source of care ensures that children and their families have a trusted and familiar place to seek timely medical advice, diagnoses, treatment, and ongoing health care services, promoting continuity and quality of care.[8] This could mean that usual sources of care have office hours at night, on weekends, or both and it is not difficult to contact them by phone or after hours.[9] It is important to schedule regular appointments with a child's health care provider, even during periods of wellness, to maintain continuity of care and allow for early detection of emerging health issues.[10]

Research highlights the need for children to have both health insurance coverage and a usual source of care – or financial and structural access to health care services – to maximize the delivery of high quality and effective care.[11,12] Policies are needed to ensure an adequate supply of pediatric health care providers.[12] To successfully implement pediatric medical homes, new Medicaid beneficiaries should be connected to primary care providers to encourage the establishment of a usual source of care.[13,14] Team-based care involving medical providers and community partners may help extend the foundation of the medical home to better meet the needs of children and families.[15] The COVID-19 pandemic demonstrated that equitable access to telehealth may enhance use of health care services for children with a usual source of care, including children with chronic medical conditions.[16,17]

Data. This NPM is measured through data collected through the National Survey of Children's Health (NSCH). In 2022, 75.4% of children and youth have a place that they usually go to first when they are sick or a caregiver needs advice about their health.[18] In terms of health status, 81.6% of children and youth with special health care needs (CYSHCN) and 73.7% of non-CYSHCN have usual sources for sick care.[19] With regards to racial and ethnic make-up, the rate of usual source of sick care attainment was lowest among non-Hispanic Asian children (63.5%), followed by Hispanic children (64.6%), and non-Hispanic Black children (64.7%).[20] It was highest among non-Hispanic White children (84.6%).[20]

Social Determinants of Health (SDOH).

Variable access to care is based on race, ethnicity, age, sex, socioeconomic status, disability status, sexual orientation, gender identity, and residential location due to systemic issues such as racism, classism, and ableism.[21,22] Lacking a usual source of care is more common for low-income, uninsured, and non-white children.[23] Further, significant demographic risk factors for reporting an emergency department as a usual source of sick care include being Black, living in a single-parent family, being from a lower income background, and living in an urban setting.[24]

Access to primary care is a SDOH with primary care providers offering a usual source of care, early detection and treatment of disease, chronic disease management, and preventive care.[22] Obstacles to accessing primary care include lack of insurance, language-related barriers, disabilities, inability to take time off work for appointments, geographic and transportation-related barriers, and a shortage of primary care providers.[22] Emerging evidence indicates that improving health insurance coverage may promote equity and reduce disparities in access to care by reducing out-of-pocket costs.[21]

Health Equity. Efforts to promote health equity involve ensuring that all children have access to and utilize a usual source of care for their medical needs. Children who are poor, minoritized children, and CYSHCN are more commonly covered by Medicaid, and can be crowded out from getting appointments to see their pediatricians.[25] They are also less likely to receive needed medical home services to manage their health.[3,24,26] These issues are compounded when explicit and implicit biases hinder the ability of providers to establish a safe and stable usual source of care.[25]

Opportunities to improve access and equity include:

- Creating a single point of service entry, determining services based on need instead of diagnosis, and emphasizing service continuity, transition, and a place-based approach to preventive and sick care.[27]
- Using performance and outcome measures to help track adherence to nondiscriminatory equitable service delivery.[25]
- Providing culturally responsive care within the medical home to ensure high-quality, ongoing care for the most vulnerable children.[22,25]

CYSHCN. Although CYSHCN are more likely to have a usual source of care compared to non-CYSHCN, they can have greater difficulty in getting appointments, care, and referrals and receive poorer quality of care.[11] It is significantly more difficult for children with 3-5 special health care needs to receive necessary care or get illness care and referrals to specialists compared to children with none.[11] Like all CYSHCN, children with a behavioral health diagnosis have challenges getting routine appointments and referrals to specialists, compared to children with no behavioral health diagnosis.[11] The entities serving CYSHCN need to be equitably designed to create a well-functioning system for CYSHCN.[25,28]

Key Resources. Research shows that children with a usual source of care have more consistent access to health care services, which likely contributes to better overall health outcomes.[29-35] Multi-level strategies are needed to promote usual sources of care for children and their families.

Search the Established Evidence database for peer-reviewed research articles related to strategies for increasing access to usual sources of care.

Find field-based resources focused on increasing access to usual sources of care relevant to Title V programs in the MCH Digital Library.

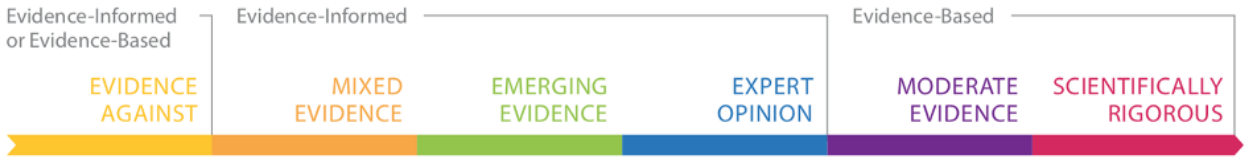
Partnership and the Role of Title V. Title V agencies can build capacity to promote usual sources of care for children and their families by:

- Partnering with other child-serving entities to disseminate information about where and how children can access preventive and sick care.[13,22]
- Supporting the use of School-Based Health Centers (SBHCs) to increase access to care.[36]
- Reducing financial barriers to care for families by offering subsidies, expanding insurance coverage, or creating sliding-scale payment options.[37,38]
- Encouraging pediatric practices to use resources such as enhanced access scheduling, extended hours, and expanded telehealth services to promote a usual source of care.[16,17,39]

Usual Source of Sick Care 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 usual source of sick care. 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. 18 strategies have emerged from studies in the scientific literature as being effective in advancing this 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.



- Care Transition Support (2018)
- Quality Improvement Initiatives (2022)
- Care Coordination (2019)
- Culturally Competent Care and Language Services (2021)
- Expanded Telehealth Services (2023)
- Health Literacy and Parental Engagement (2022)
- Retail Clinics (2020)
- Promotion of Social Determinants of Health (2022)
- Enhanced Access to Healthcare (2022)
- Expanded Health Insurance Coverage (2021)
- Patient-Centered Care (2018)
- Medical Home Model Promotion (2023)
- Care Coordination Infrastructure (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. 10 practices from state-/community-based programs have emerged as potential approaches for advancing this 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.

- Family-Centered Shared Care Planning Assessment (OR; 2023)
- Directory of Relevant Service Providers and Resources (Multiple States; 2023)
- Family-Centered Care Coordination (VA; 2018 | IA; 2020)
- Parent Leadership Curriculum (NC; 2023)
- Primary Care Provider Training (TN; 2022)
- Community-based Care Coordination (OR; 2009)
- Culturally Competent Community Health Workers (SC; 2019)
- Family Connects Model (NC; 2021)
- Family-Driven Systems Change (NC; 2018)

Key Findings.

The following are key findings emerging from the literature:

1. Strategies such as increasing hours of availability, providing outreach efforts to address transportation issues, and integrating mental health services can facilitate the establishment of a usual source of care.[40,41]
2. Racial and ethnic disparities and perceived discrimination in healthcare settings may create barriers to establishing a usual source of sick care for children, as factors like language barriers can impact equitable access to quality healthcare services.[40,42]
3. Health insurance coverage gaps diminish access to healthcare for children, including a greater likelihood of lacking a usual source of care, delaying care, and reporting unmet healthcare needs.[41,43,44,45,46,47]
4. Continuity of primary care, one factor in ensuring children have usual sources of sick care, results in lower healthcare costs, improved health outcomes and reduced undesirable use.[45,48,49,50]
5. School-based health centers (SBHCs) can improve health equity through increased access to care, and there is the potential for improvement in the range and availability of services provided for children who usually receive care from a school-based provider.[46]

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 for these strategies in MCH settings:

- Improving care coordination efforts through innovative solutions such as patient-facing mobile apps.[51,52]
- Expanding healthcare coverage and increasing access to primary care providers, particularly for racial and ethnic minority groups and CYSHCN.[53]
- Enhancing equitable access to telemedicine by sustaining payment for telemedicine and addressing barriers to access in non-metropolitan practices and communities.[54]
- Equipping healthcare professionals with the resources and training necessary to maintain ongoing relationships with patients.[55,56,57]
- Understanding factors that have led to increased utilization of urgent care centers and retail health clinics for parents seeking care for their children.[58]

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

- How to Find Affordable Health Care (Nemours). This page provides guidance on sources to access and pay for preventive and sick care.
- MEPS Topics: Usual Source of Care (AHRQ). A portal to statistical briefs, research findings, and chartbooks.

Partnership. The following organizations focus efforts on advancing usual sources of sick care:

- Healthy Start TA & Support Center. The center provides resources to support Healthy Start Benchmarks, including Usual Source of Medical Care.
- Using a Health Equity Lens (CDC). This page provides public health strategies to reduce disparities to increase equal access to care.

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.

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* Note. Acute care entities are listed as a usual source of sick care in the National Survey of Children's Health (NSCH): "Having a usual place for sick care (K4Q01) that is categorized in K4Q02_R as a doctor's office, hospital outpatient department, clinic or health center, retail store clinic or "Minute clinic," school (nurse's office, athletic trainer's office), urgent care center, or some other place."[2] Given inclusion of acute care entities in the Indicator, these are included as options for a usual place of sick care for children in this document. Note that The American Academy of Pediatrics (AAP) considers acute care entities including urgent care centers, retail-based clinics or "Minute clinics," and commercial telemedicine services to be outside of the medical home.[39] Children and families use these services because there is perceived or real benefit related to accessibility, convenience, or cost of care. Patients "medical neighborhoods" may include providers of acute care services outside the medical home.

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