Strengthen the Evidence for MCH Programs: Environmental Scan of Strategies

National Performance Measure (NPM) #11: Medical Home

Percent of children with and without special health care needs having a medical home

Introduction

This environmental scan identifies collections of strategies to advance performance for NPM #11, Medical Home. The information provided in this document focuses on strategies to achieve the NPM, not on the content of care or specified health outcomes. Please note that the quality of the evidence in this compilation has not been evaluated, and that data sources describing a single strategy, rather than a collection of strategies, have been excluded.

This compilation includes the following sections:

- **Reviews and Compilations:** Identifies existing compilations for strategies that intend to improve performance for each measure
- **Frameworks and Landmark Initiatives:** Frameworks includes conceptual models underlying strategy implementation; Landmark Initiatives include seminal programs/policies related to the NPM
- **Data Sources:** Indicates sources, search criteria, links to search strategy and selected organizational websites
- **Inclusion and Exclusion Criteria**: Denotes types of studies, setting, populations of interest and exclusion criteria

Technical assistance for State Title V MCH programs related to using evidence to inform State Action Plans, selection of strategies, and development of evidence-based or evidence-informed Strategy Measures may be requested at http://www.semch.org/technical-assistance.html

Table of Contents

Reviews and Compilations……………………………………………………………………2
Frameworks and Landmark Initiatives…………………………………………………………7
Data Sources……………………………………………………………………………15
Inclusion and Exclusion Criteria………………………………………………………………16

Strengthen the Evidence Base for MCH Programs is a collaborative initiative of the Women's and Children's Health Policy Center at Johns Hopkins University, AMCHP, and Welch Medical Library. 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 U02MC28257, MCH Advanced Education Policy, $1.65 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.

Reviews and Compilations

Review/Compilation	Summary	Web Link

Buxbaum. (2010). Making Connections: Medicaid, Chip, and Title V Working Together on State Medical Home Initiatives. *National Academy for State Health Policy*. [Target: B,C,H]	• Summarizes discussion on interagency collaboration among Medicaid, Children's Health Insurance Program (CHIP), and Title V agencies in 6 states (Colorado, Illinois, Iowa, Minnesota, Pennsylvania, and Texas
	• Overarching theme of "collaborative medical home building" to strengthen initiatives
	• Discusses key policy considerations and actions for four areas:
	  o Foundations for partnership
	  o Patient and family engagement
	  o Health care provider and practice engagement
	  o Building systems of care
		http://nashp.org/sites/default/files/Medicaid_Collaboration-FINAL.pdf

Hanlon, C. (2012). Supporting Healthy Child Development Through Medical Homes: Strategies from ABCD III States. *National Academy for State Health Policy.* *[*Target*:* C,D,E,G]	• The Assuring Better Child Health and Development (ABCD III) learning collaborative has supported five states in creating and piloting models to ultimately strengthen care coordination for children with/at risk of developmental delay; the medical home has been a driving factor in these efforts
	• Describes four strategies used to promote healthy development through medical homes
	  o Include pediatric criteria in standards that define primary care sites as medical homes
	  o Create learning collaboratives for providers of medical homes
	• Assist and engage non-medical providers in understanding PCMH
		http://www.nashp.org/sites/default/files/child.development.medical.home_.abcd_.III_.pd

Peikes et al. (2011). The Patient-Centered Medical Home: Strategies to Put Patients at the Center of Primary Care. *Agency for Healthcare Research and Quality* [Target: C,H]	• Outlines how decisionmakers can encourage a patient-centerd medical home (PCMH)model of care that is truly patient-centered
	• Involving patients in the medical home at three levels
	  o Involvement in their own care
	  o Quality improvement in the primary care practice
	  o Policy and research development and implementation
	• Evidence of the importance of patient engagement
		https://pcmh.ahrq.gov/sites/default/files/attachments/Strategies%20to%20Put%20Patients%20at%20the%20Center%20of%20Primary%20Care.pdf

	○ Available evidence mainly describes benefits of engaging patients in their own care ○ More research is warranted to identify ways to apply these approaches to primary care settings • Strategy options to put patients at the center of PCMH ○ Require practices to actively demonstrate patient and family engagement ○ Utilize payment strategies ○ Provide practices with technical assistance and other resources ○ Ensure meaningful use of health IT ○ Collect patient input at every stage in the design and implementation of the PCMH ○ Proactively support additional research on patient-engagement strategies	

AMCHP Innovation Station [Target: D, E, G]	• Oregon Care COOrdinatioN Program (CaCoon) ○ Location: Oregon ○ Community-based coordination program administered by the Oregon Center for Children with Special Health Care Needs and Oregon's Title V program. ○ Serves all 36 Oregon counties and Oregon children 0-17 years with special needs. ○ Employs Public Health Nurses (PHN) to deliver home visiting and care coordination services	http://www.amchp.org/programsandtopics/BestPractices/InnovationStation/ISDocs/Cacoon_2015.pdf
	• Pediatric Practice Enhancement Project (PPEP) ○ Location: Rhode Island ○ Statewide project developed in 2003 with 3 objectives: ▪ Reduce the number of families with CYSHCN reporting system barriers ▪ Provide all CYSHCN with access to a "Medical Home" by 2010 ▪ Implement a system that is both accessible and navigable, to improve health outcomes ○ Utilizes paraprofessionals - trained Parent Educators- in	http://www.amchp.org/programsandtopics/BestPractices/InnovationStation/ISDocs/PPEP_2015.pdf

	clinical settings to "create linkages between the family, pediatric practice, and the community as a whole"	
National Center for Medical Home Implementation (NCMHI) [Target: B, C, G, H]	• National & State Initiatives o National initiatives: information on national programs, policies, and initiatives that advance the pediatric medical home model o All state initiatives: collection of state-by-state pediatric medical home announcements, state activities, partners and stakeholders within the state, and additional resources for pediatric medical home model o Medicaid and CHIP state profiles: profiles that highlight how Medicaid and CHIP in specific states (AL, CO, CT, IA, MI, MO, NY, OR, VT) are implementing and advancing the pediatric medical home model o State pediatric Medicaid and CHIP medical home initiatives: at-a-glance table: overview of pediatric medical home initiatives occurring through Medicaid programs and the CHIP	https://medicalhomeinfo.aap.org/national-state-initiatives/Pages/default.aspx
	• "For Practices": collection of tools and resources for pediatric practices interested in learning more about the pediatric medical home o Medical home implementation, family-centered care, care coordination, care planning culturally competent care, team-based care, measuring and paying for medical homes, online implementation guides for pediatric practices and professionals	https://medicalhomeinfo.aap.org/tools-resources/Pages/For-Practices.aspx
	• "For Families and Caregivers": tools, resources, and links to information that will assist families in successfully partnering with their child's medical home o Building care notebooks, Affordable Care Act facts sheets, medical home videos, tools and resources for families partnering with child health professionals	https://medicalhomeinfo.aap.org/tools-resources/Pages/For-Families.aspx

	• Promising Practices o Innovative and replicable state-based practices in pediatric medical home implementation	https://medicalhomeinfo.aap.org/practices/Pages/default.aspx

	• Health System Transformation Efforts
	  o General information on state health care system transformation
	  o Information on the Centers for Medicare and Medicaid Innovation (CMMI)
	  o Many resources include focus on State Innovation Models (SIM), some of which have pediatric components
		https://www.aap.org/en-us/advocacy-and-policy/state-advocacy/Pages/State-Health-Care-System-Transformation.aspx

	• Strategies to Enhance Care for Hispanic Children, Youth and Families
	  o For practices and clinicians:
	    ▪ Support family readiness
	    ▪ Use cultural brokers
	    ▪ Avoid jargon
	    ▪ Use patient education tools and resources that take culture into consideration
	    ▪ Offer accessible resources
	    ▪ Encourage team-based care
	    ▪ Refer to peer supports
	• Strategies for Implementing Pediatric Medical Home Projects for Hispanic Communities
	  o For state and community-based organizations
	    ▪ Build relationships first
	    ▪ Ask “what’s in it for them?”
	    ▪ Find motivated community members
	    ▪ Engage the neighborhood
	    ▪ Provide incentives
	    ▪ Avoid jargon
	    ▪ Offer and acknowledge professional development
	    ▪ Use tools and resources that take culture into
		https://medicalhomeinfo.aap.org/tools-resources/Documents/RI%20FactSheet.pdf

	consideration ▪ Offer accessible resources ▪ Proactively seek family and community feedback	
National Academy for State Health Policy (NASHP) [Target: C,D,E,G,H]	• Independent academy of state health policymakers • Committed to helping states in health policy and practice • Resources on a broad range of health-related topics (e.g. children's health, insurance exchanges, Medicaid, primary care and medical homes)	http://nashp.org/
	• Medical Homes & Patient-Centered Care Maps o Medical Home activities since 2006 o Multi-payer initiatives o 2703 Health Homes o Qualification standards o Shared support • State Medical Home Strategies o Form partnerships o Define & recognize medical homes o Align reimbursement & purchasing o Support practices o Measure results	http://nashp.org/medical-homes-map/

[1] Target specifies Target Audience for the strategies mentioned in each Review/Compilation: A = Hospital Inpatient (includes physical, mental, and oral health); B = Hospital Outpatient (includes physical, mental, and oral health); C = Non-Hospital Outpatient Providers (e.g. community health centers, private medical groups, health maintenance organizations); D = Community Organizations (e.g. WIC, advocacy organizations, child care providers, home visiting services); E = Social Service Organizations (e.g. Head Start, child welfare); F = Schools and School Systems; G = Consumers/Families; H = Other

Frameworks and Landmark Initiatives

Framework/Initiative	Summary	Web Link
American Academy of Pediatrics.(2002). Policy Statement: Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children	• AAP Policy Statement containing an expanded definition and interpretation of a Medical Home • Describes 7 desirable characteristics of a Medical Home: Accessible, Family-centered, Continuous, Comprehensive, Coordinated, Compassionate, Culturally effective	http://pediatrics.aappublications.org/content/pediatrics/110/1/184.full.pdf
American Academy of Pediatrics Council on Children with Disabilities and Medical Home Implementation Project Advisory Committee. (2014). Policy Statement. Patient- and Family-Centered Care Coordination: A Framework for Integrating Care for Children and Youth Across Multiple Systems	• Describes care coordination, an integral element of the medical home • Statement includes care coordination definition and defining characteristics, as well as new developments, benefits of care coordination, and recommendations for implementation	http://pediatrics.aappublications.org/content/133/5/e1451.full

Agency for Healthcare Research and Quality (AHRQ) Patient Centered Medical Home (PCMH) Resource Center	• Evidence-based resources on the PCMH model, including tools for engaging primary care practices in implementing the PCMH
	• Tools and resources available according to the 5 key domains of the PCMH, and its 3 foundational supports:
	  ○ Domains:
	    ▪ Comprehensive care
	    ▪ Patient-centered care
	    ▪ Coordinated care
	    ▪ Accessible services
	    ▪ Quality and safety
		https://pcmh.ahrq.gov/

	o Foundational supports ▪ Health IT ▪ Workforce ▪ Finance	
Child and Adolescent Heath Measurement Initiative (CAHMI) Data Resource Center (DRC) – Medical Home State Data Pages	• Data by state on the provision of care for children and youth within medical homes • Resources regarding measurement of the medical home and application of data	http://www.childhealthdata.org/browse/medicalhome
CHIPRA Quality Demonstration Grant Program – *Evaluation Highlights*	• 2010: Centers for Medicare & Medicaid Services (CMS) funded 18 states to implement 52 total projects, with the overarching goal of improving the quality of healthcare for children enrolled in Medicaid and the Children's Health Insurance Program (CHIP) • A series of issue briefs were produced by the national evaluation team to highlight the most relevant findings	http://www.ahrq.gov/policymakers/chipra/demoeval/what-we-learned/index.html
	"How are States and evaluators measuring medical homeness in the CHIPRA Quality Demonstration Grant Program?" • 12 states (Alaska, Florida, Idaho, Illinois, Maine, Massachusetts, North Carolina, Oregon, South Carolina, Utah, Vermont, and West Virginia) used funding to establish PCMHs for pediatric and family practices, and for Federally Qualified Health Centers (FQHCs) • Delves into the approaches used and barriers associated with measuring medical-homeness in these practices • Describes the Medical Home Index-Revised Short Form (MHI-RSF) for use in evaluating the projects	http://www.ahrq.gov/sites/default/files/wysiwyg/policymakers/chipra/demoeval/what-we-learned/highlight02.pdf
	"CHIPRA quality demonstration States help school-based health centers strengthen their medical home features" • Evaluation of 2 states' projects (Colorado and New Mexico) who chose to incorporate the patient-centered medical home (PCMH) into school based health centers (SBHC) • Total of 16 CHIPRA quality demonstration SBHCs in place by	http://www.ahrq.gov/sites/default/files/wysiwyg/policymakers/chipra/demoeval/what-we-learned/highlight08.pdf

	2012
	• Three basic strategies to strengthen SBHCs' PCMH features
	  o Utilize practice facilitators to collaborate with SBHCs on data-driven quality improvement
	  o Encourage SBHCs to engage with students and families
	  o Support communication and collaboration between SBHCs and other providers	

	"How are CHIPRA quality demonstration States supporting the use of care coordinators?"
	• Evaluation focuses on the 6 states (Alaska, Idaho, Massachusetts, Oregon, Utah, and West Virginia) who chose to use grant funds to support the work of the care coordinator's role in the PCMH model
	• Key findings include:
	  o States used very different approaches to ensure effective care coordination
	  o Care coordinators' roles varied between states, though all performed an extensive set of functions
	  o It is important for practices to be involved in hiring the care coordinators
	  o States supported the integration of care coordinators by providing them with resources
	  o States and practices reported that care coordinators were associated with improved health quality
	  o Many states plan on funding care coordinators beyond the demonstration
		http://www.ahrq.gov/sites/default/files/wysiwyg/policymakers/chipra/demoeval/what-we-learned/highlight09.pdf

	"How did CHIPRA quality demonstration States employ learning collaboratives to improve children's health quality?"
	• Evaluation of 9 states (Alaska, Florida, Idaho, Maine, Massachusetts, North Carolina, Oregon, Utah, and West Virginia) who implemented learning collaboratives to improve medical home capacity and health care quality
	• Strategies utilized by learning collaboratives to engage practices:
	  o A combination of didactic and interactive instruction
	  o Peer networking
		http://www.ahrq.gov/sites/default/files/wysiwyg/policymakers/chipra/demoeval/what-we-learned/highlight13.pdf

	○ Modification of collaborative depending on practices' needs ○ Designation of reputable physician as faculty ○ Demonstrations	
Cooley & McAllister. (2004). Building Medical Homes: Improvement Strategies in Primary Care for Children with Special Health Care Needs. Pediatrics.	• Describes the Center for Medical Home Improvement (CMHI) method to be implemented within primary care practices to best serve CSHCN; includes both quality improvement strategies as well as measurement • Four-steps guide the CMHI change process ○ Baseline measurement ○ Team formation ○ Learning medical home quality improvement structure and process implementation ○ Collaborative learning	http://pediatrics.aappublications.org/content/113/Supplement_4/1499.full.pdf
Joint Principles of the Patient-Centered Medical Home	• Principles developed by the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA) that describe the characteristics of the PCMH: ○ Personal physician ○ Physician directed medical practice ○ Whole person orientation ○ Care is coordinated and/or integrated ○ Quality and safety ○ Enhanced access ○ Payment	http://www.aafp.org/dam/AAFP/documents/practice_management/pcmh/initiatives/PCMHJoint.pdf
Kaye et. al. (2011). Building Medical Homes: Lessons from Eight States with Emerging Programs. *National Academy for State Health Policy*.	• NASHP developed a framework that other states can follow to implement medical home programs. Framework consists of five broad steps: ○ Strategically engage partners ○ Set performance expectations and implement a process to identify practices to meet expectations ○ Compensate/motivate practices through enhanced	http://nashp.org/sites/default/files/building.medical.homes_.emerging.states.pdf

	payment ○ Help practices meet expectations and improve performance ○ Evaluate program performance	
Malouin. (2013). Positioning the Family and Patient at the Center: A Guide to Family and Patient Partnership in the Medical Home	• History and relevance of family-centered care • Case studies of best practices in family-centered care • Describes the processes within a medical home that relate to family-centered care • Implications for research, practice, and policy	http://medicalhomeinfo.org/about/medical_home/literature.aspx
McAllister et al. (2013). Medical Home Transformation in Pediatric Primary Care – What Drives Change? *Annals of Family Medicine.*	• At 6-7 years after participating in a national medical home learning collaborative, the 12 primary care practice teams with the highest Medical Home Index (MHI) were evaluated. • Essential factors in medical home transformation emerged: ○ Culture of quality improvement ○ Family-centered care ○ Team-based care ○ Care coordination	http://dx.doi.org/10.1370/afm.1528
Medical Home Portal	• Articles and recommendations written by parents and family members of CYSCHN • Tools for health care professionals on implementing a medical home, screening and prevention, medical technology, etc. • Instrumental resources written to assist the primary care team in caring, assessing, and managing children with any of 45 conditions • Guides and recommendations for responding to positive newborn screening tests • Searchable database of local provide information; over 250 categories	http://medicalhomeportal.org/

<table>
<tr>
<td rowspan="2">National Center for Medical Home Implementation (NCMHI)</td>
<td>The NCMHI is a cooperative agreement between the Maternal and Child Health Bureau and the American Academy of Pediatrics
The center is focused on ensuring that all children and youth receive care within, and have access to, a medical home
Provides tools and resources to assist families, practices, and others with pediatric medical home implementation and related efforts to enhance collaboration between professionals and families; information on state and national projects, initiatives, and policies focused on advancing the pediatric medical home model; and innovative and promising practices in pediatric medical home implementation
Links to the National Center for Care Coordination Technical Assistance</td>
<td>https://medicalhomeinfo.aap.org/Pages/default.aspx</td>
</tr>
<tr>
<td>“Measuring Medical Homes: Tools to Evaluate the Pediatric Patient- and Family-Centered Medical Home”
Describes various available tools to “identify, recognize, and evaluate a practice as a pediatric medical home”</td>
<td>https://medicalhomeinfo.aap.org/tools-resources/Documents/Monograph_FINAL_Sept2010.pdf</td>
</tr>
<tr>
<td>National Standards for Systems of Care for Children and Youth with Special Health Care Needs: A Product of the National Consensus Framework for Systems of Care for Children and Youth with Special Health Care Needs Project (2014).</td>
<td>Based on research and national consensus by a diverse group of partners with expertise in systems of care for CYSHCN
Intended for: state Title V CYSCHN programs, health plans, state Medicaid and CHIP agencies, physicians and other pediatric provider organizations, hospitals, insurers, researchers, and families/consumers
Describes key components of “the structure and process of an effective system of care for CYSHCN”
Includes systems standards for Medical Home (10 overall standards, 9 for pediatric preventive and primary care, 3 for care coordination, 7 for pediatric specialty care)
Supported by AMCHP and Lucille Packard Foundation</td>
<td>http://www.amchp.org/AboutTitleV/Resources/Documents/Standards%20Charts%20FINAL.pdf</td>
</tr>
</table>

Nielsen et. al. (2012). Benefits of Implementing the Primary Care Patient-Centered Medical Home: A Review of Cost & Quality Results. *Patient-Centered Primary Care Collaborative*	• Section I: Lists state/agency specific patient-centered medical home (PCMH) initiatives as well as health care cost and service outcomes • Section II: Key features and outcomes of state/agency specific PCMH • Appendix A details selected PCMH pilots	https://www.pcpcc.org/sites/default/files/media/benefits_of_implementing_the_primary_care_pcmh.pdf
Safety Net Medical Home Initiative	• Five-year initiative to enhance PCMH performance in 65 primary care safety net sites • Resulted in many resources and tools to assist practices in implementing the PCMH Model of Care	http://www.safetynetmedicalhome.org

	• "Change Concepts for Practice Transformation"
	  ○ Framework for PCMH transformation developed by the Safety Net Medical Home Initiative
	  ○ Intended to support primary care practices
	  ○ Change Concepts include:
	    ▪ Laying the foundation
	    ▪ Building relationships
	    ▪ Changing care delivery
	    ▪ Reducing barriers to care
		http://www.safetynetmedicalhome.org/sites/default/files/Change-Concepts-Overview.pdf

Townley & Takach. (2012). Developing and Implementing the Section 2703 Health Home State Option: State Strategies to Address Key Issues. *National Academy for State Health Policy.*	• Section 2703 of Affordable Care Act established the "State Option to Provide Coordinated Care through a Health Home for Individuals with Chronic Conditions," changes delivery of care.
	  ○ ACA provides funding for a two-year enhanced (90 percent) federal match for health home services for eligible Medicaid enrollees
	• 5 issue areas states likely face when implementing a health home state plan amendment (SPA) and possible strategies to address these problems:
	  ○ Coordinating with existing programs
	    ▪ Example strategies to address issue:
	    ▪ Modify managed care contracts with clear guidelines for which services are the responsibility of the health home vs. the managed care plan
		http://nashp.org/sites/default/files/health.home_.state_.option.strategies.section.2703.pdf

	▪ Use of health home planning grants offered by the ACA o Financing and payment ▪ Strategies: ▪ Consider implementing financing for practice education and training ▪ Provide group practice training for providers o Integrating behavioral and physical health ▪ Strategies: ▪ Employ behavioral health consultants to screen and evaluate patients in primary care settings ▪ Involve primary care providers in behavioral treatment planning o Sharing health data ▪ Strategies: ▪ Use of health information technology (e.g. health information exchanges) to coordinate across systems o Evaluating health home programs ▪ Strategies: ▪ Provide access to electronic web portals for easy data reporting	
Williams et al. (2012). The Patient-Centered Medical Home. Closing the Quality Gap: Revisiting the State of Science. *Agency for Healthcare Research and Quality*.	• Systematic review intended to "identify completed and ongoing efforts to evaluate the comprehensive Patient Centered Medical Home (PCMH) model, summarize current evidence for this model, and identify gaps in the evidence." • Foci of review addressed through Key Questions: o What are the effects of the PCMH on patients/staff, process of care, health outcomes, and economic outcomes? (published studies only) o What PCMH components have been implemented in primary-care based evaluations of PCMH interventions? (published studies only) o What financial models and implementation strategies to support uptake have been used in primary-care based evaluations of PCMH interventions? (published studies	http://www.effectivehealthcare.ahrq.gov/ehc/products/391/1178/EvidReport208_CQGPatientCenteredMedicalHome_FinalReport_20120703.pdf

	only) ▪ Note: See Table 20, pg. 54 for financial models, organizational learning strategies, and implementation strategies o What are the study designs, PCMCH components, comparators, settings, financial models, and outcomes currently being evaluated in PCMH interventions? (refers to unpublished comparative studies currently in progress)	

Data Sources

Data Source*	Search Criteria	Web Link
Cochrane Library	Search Term: children medical home	http://onlinelibrary.wiley.com/cochranelibrary/search
	Search Term: children special needs medical home	
Campbell Systematic Reviews	Search Term: children medical home	http://www.campbellcollaboration.org/lib/?go=monograph&search=children+medical+home&search_criteria=title
PubMed	Search Term: children medical home	http://www-ncbi-nlm-nih-gov.ezp.welch.jhmi.edu/pubmed
	Search Term: children special needs medical home	http://www-ncbi-nlm-nih-gov.ezp.welch.jhmi.edu/pubmed/?term=children+special+needs+medical+home
Google Scholar	Search Term: children medical home	https://scholar.google.com/scholar?hl=en&q=children+medical+home&btnG=&as_sdt=1%2C21&as_sdtp=
CINAHL Plus	Search Term: children AND medical home	N/A
	Search Term: children AND medical home AND review	
AMCHP Innovation Station	Search Term: medical home	http://www.amchp.org/programsandtopics/BestPractices/InnovationStation/Pages/default.aspx

Georgetown Knowledge Base	MCH Knowledge Base and Library Collection → Professional Resource Guides and Briefs → Medical Homes	http://ncemch.org/evidence/NPM-11-medical-home.php
Healthy People 2020	Maternal, Infant and Child Health: Health Services • MICH-30.1: Increase the proportion of children who have access to a medical home • MICH-30.2 Increase the proportion of children with special health care needs who have access to a medical home	http://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health/objectives
The Child and Adolescent Health Measurement Initiative (CAHMI) – Data Resource Center (DRC)	Search Term: medical home	http://www.childhealthdata.org/
National Academy for State Health Policy	• Medical Homes & Patient-Centered Care	http://www.nashp.org/medical-homes-map/
National Center for Medical Home	• What is a Family-Centered Medical Home?	http://www.medicalhomeinfo.org
Patient Centered Medical Home Resource Center	• Affiliate of U.S. Department of Health & Human Services and Agency for Healthcare Research and Quality	http://pcmh.ahrq.gov
Patient-Centered Primary Care Collaborative	• Non-profit advocating effective and efficient primary care and patient-centered medical home.	https://www.pcpcc.org

**The Strengthen the Evidence Team of Experts and selected HRSA discretionary grantees contributed to the identification of data sources*

Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
• Types of studies: reviews of studies, scholarly websites, programs focused on medical homes utilized by children ages 0-17 years in the US • Language: English • Populations of interest: children between ages 0-17 years with or without special health care needs	• Articles describing single strategy or recommendation not part of a larger review or compilation • Non-applicable medical settings in international studies • Adult populations or children 18 years and older