Population Health and Medical Home: How do they Align?
Strategies for Title V Programs

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Agenda

- Introduce the National Center for a System of Services for CYSHCN
- Describe how Title V programs measure access to medical home
- Briefly review core tenets of medical home
- Discuss medical home population health approaches

National Center for a System of Services for CYSHCN

Goal: Advance systems of services for CYSHCN through Blueprint implementation.

What We Do

One-on-one technical assistance

Tools

Training

Strategies

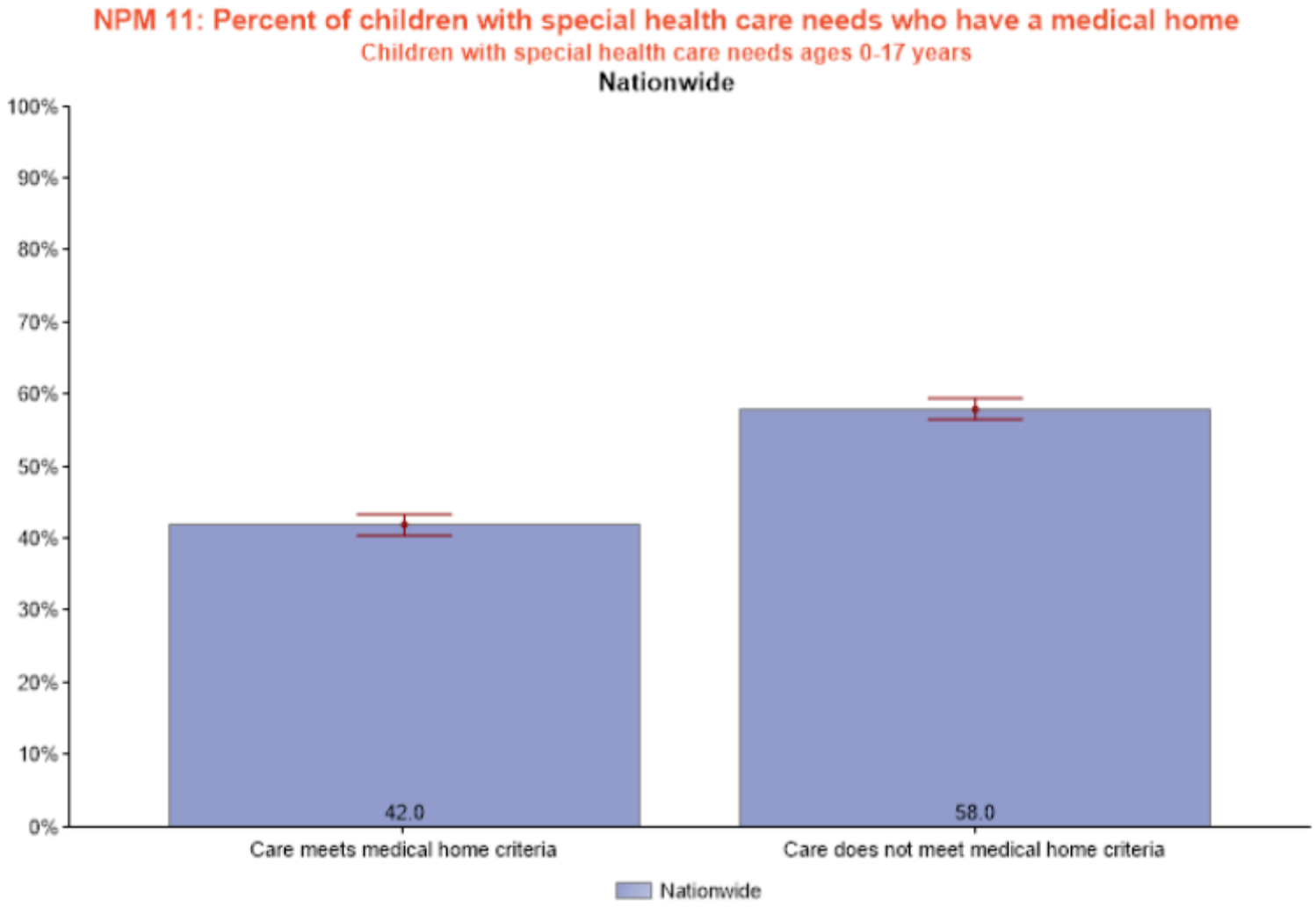
Connections to peers and experts

Why does the medical home matter?

- Standard of care for all children, including CYSHCN
- Key driver of comprehensive system of services for CYSHCN
- Proposed universal national performance measure (NPM) for Title V Programs
  - Focus on access and quality of primary and preventive care
  - Intended to drive improvement in CYSHCN systems of care national outcome measure

NPM 11: Medical Home (Proposed Universal Measure)

- % of children with and without special health care needs, ages 0 through 17, who have a medical home
- Composite measure based on five components constructed from a total of 16 survey items.
  - Personal doctor or nurse
  - Usual source of sick care
  - Family-centered care
  - Problems getting needed referrals
  - Effective Care Coordination when needed
- **Blueprint for Change efforts can fall within the medical home NPM**

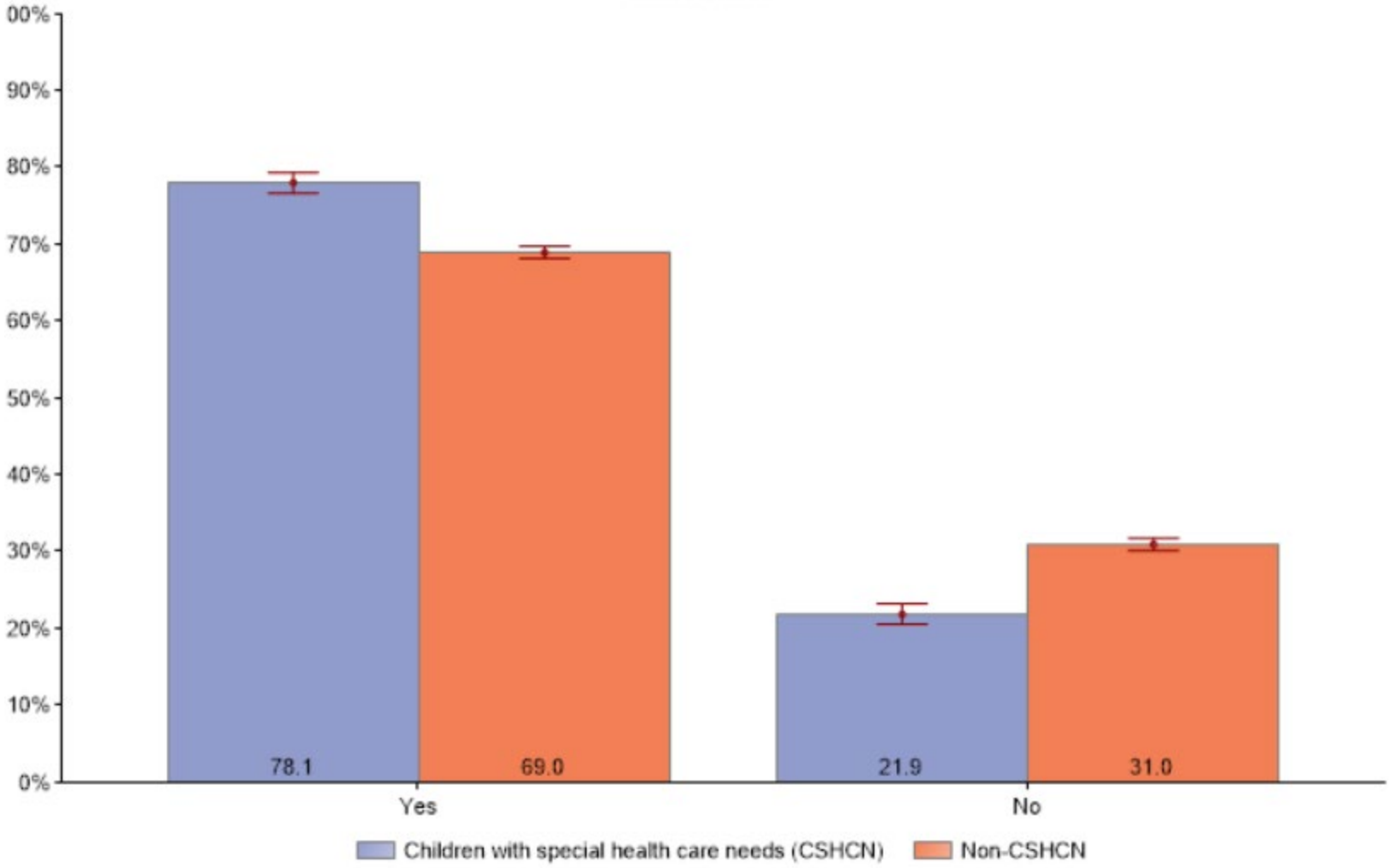


Source: 2020-2021 National Survey of Children's Health;
Data Resource Center for Child and Adolescent Health

Medical Home Component: Children with a personal doctor or nurse

Children age 0-17 years

Nationwide



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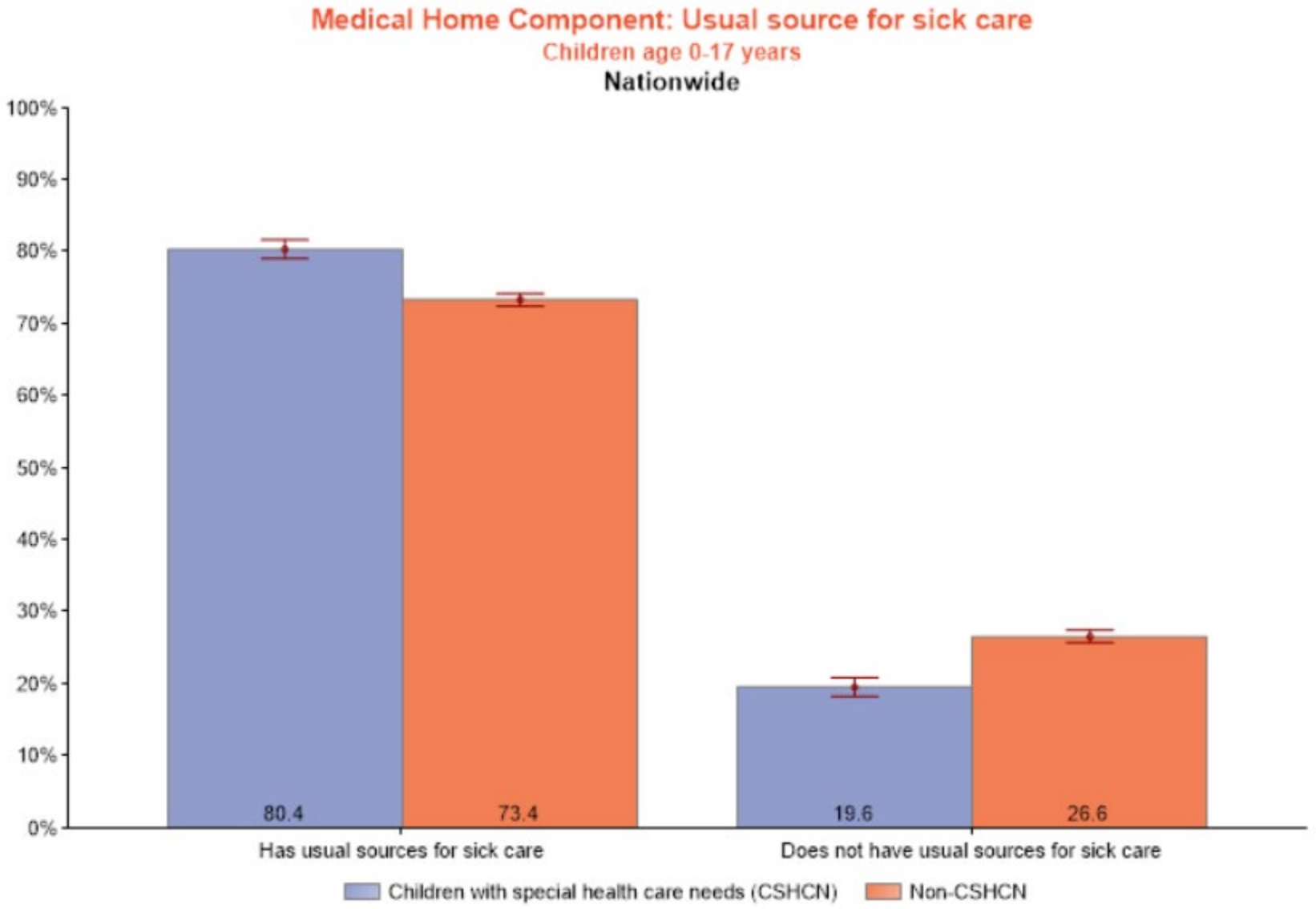
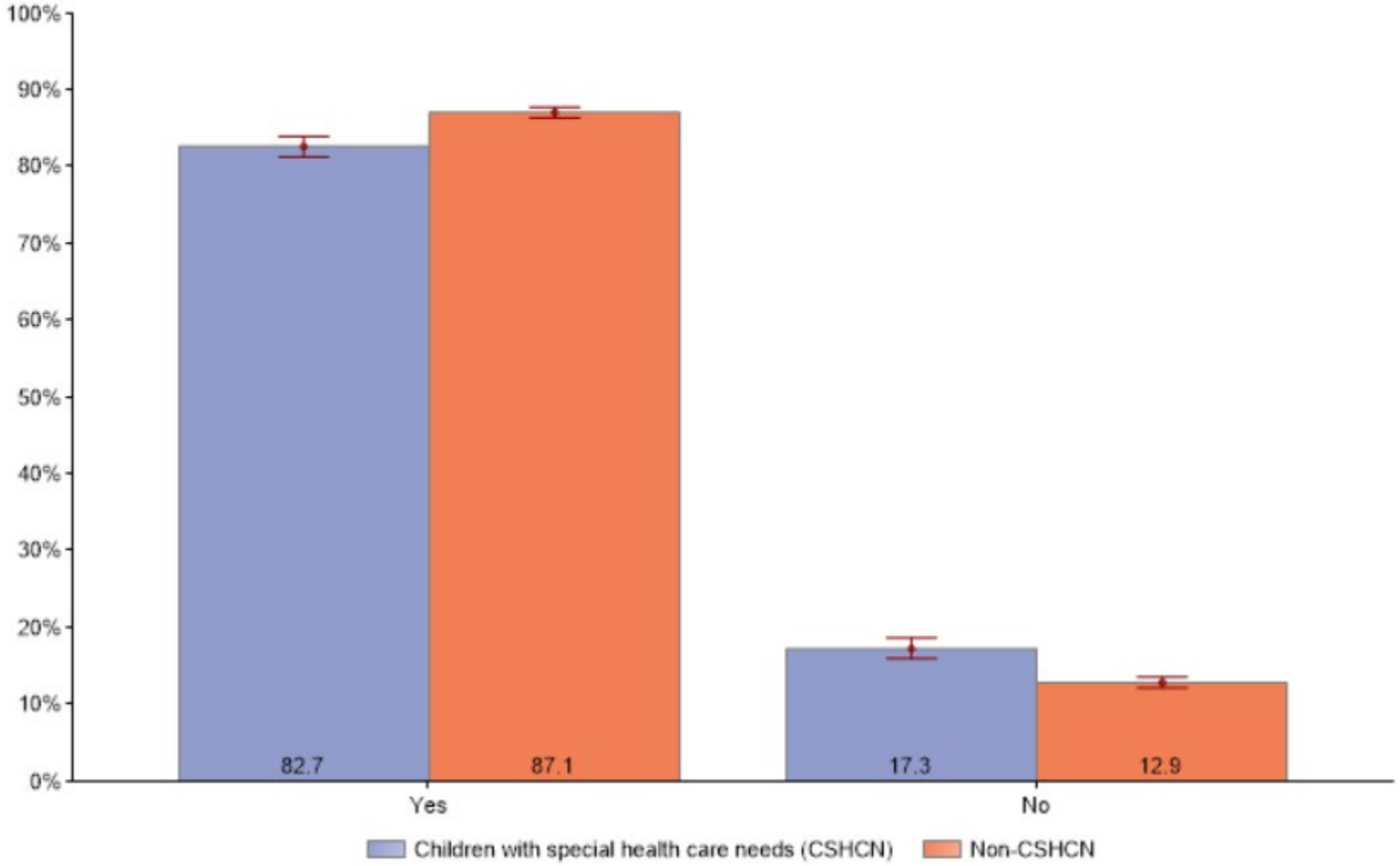


Source: 2020-2021 National Survey of Children's Health;
Data Resource Center for Child and Adolescent Health

Medical Home Component: Family-centered care

Children age 0-17 years who had a health care visit in the past 12 months

Nationwide

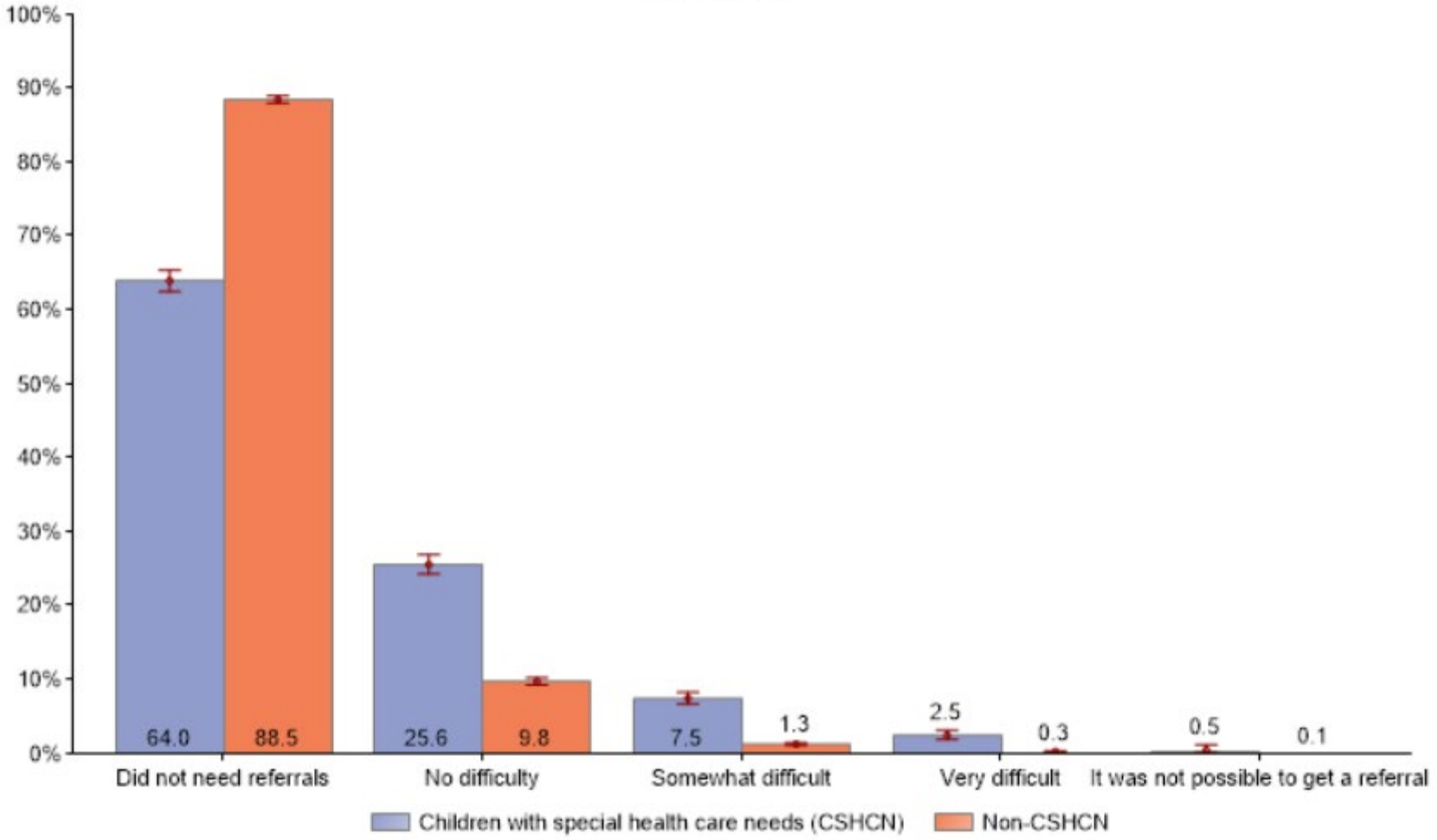


Source: 2020-2021 National Survey of Children's Health;
Data Resource Center for Child and Adolescent Health

Medical Home Component: Difficulties getting referrals to see any doctors or receive any services

Children age 0-17 years

Nationwide

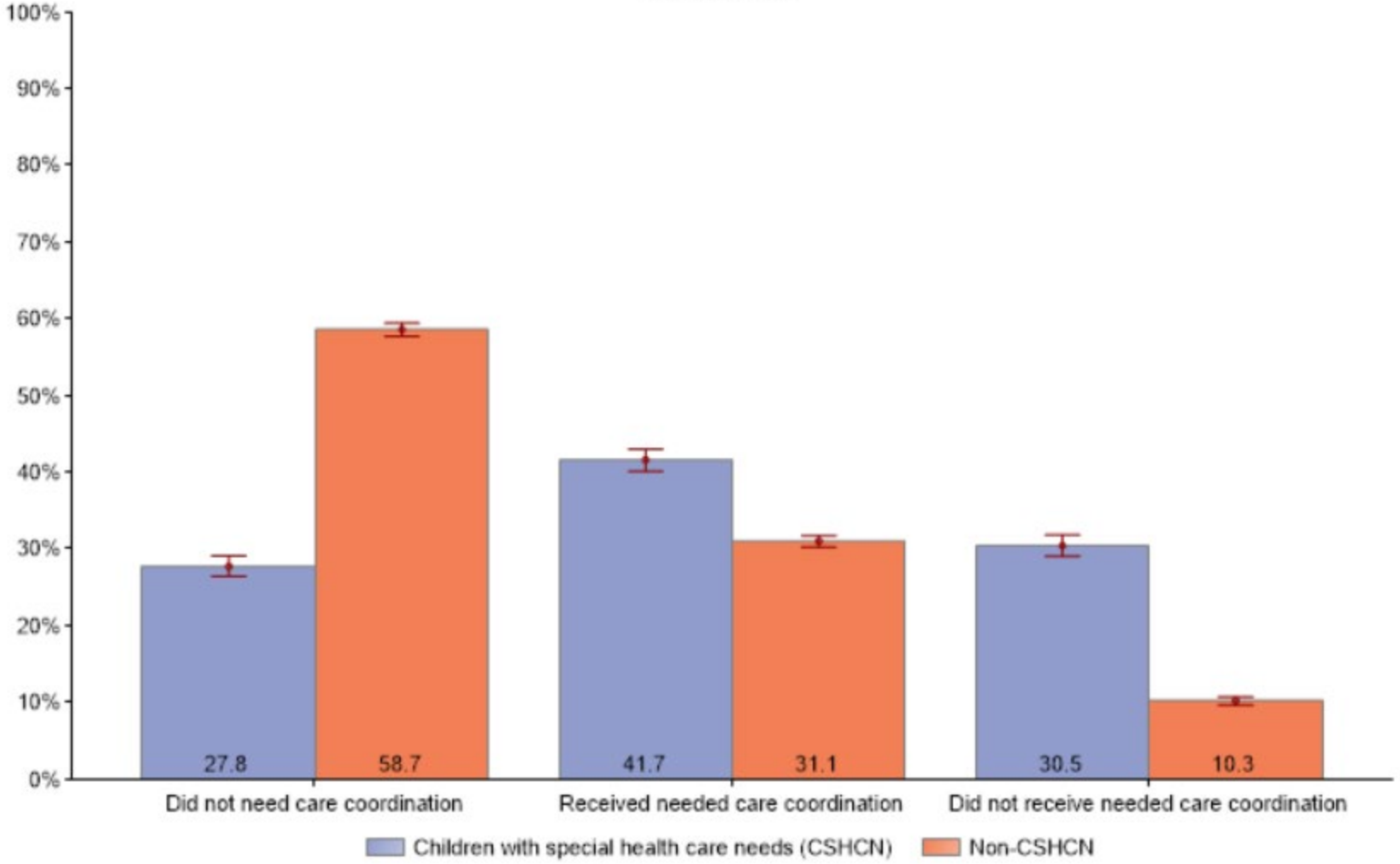


Source: 2020-2021 National Survey of Children's Health;
Data Resource Center for Child and Adolescent Health

Medical Home Component: Effective care coordination

Children age 0-17 years

Nationwide

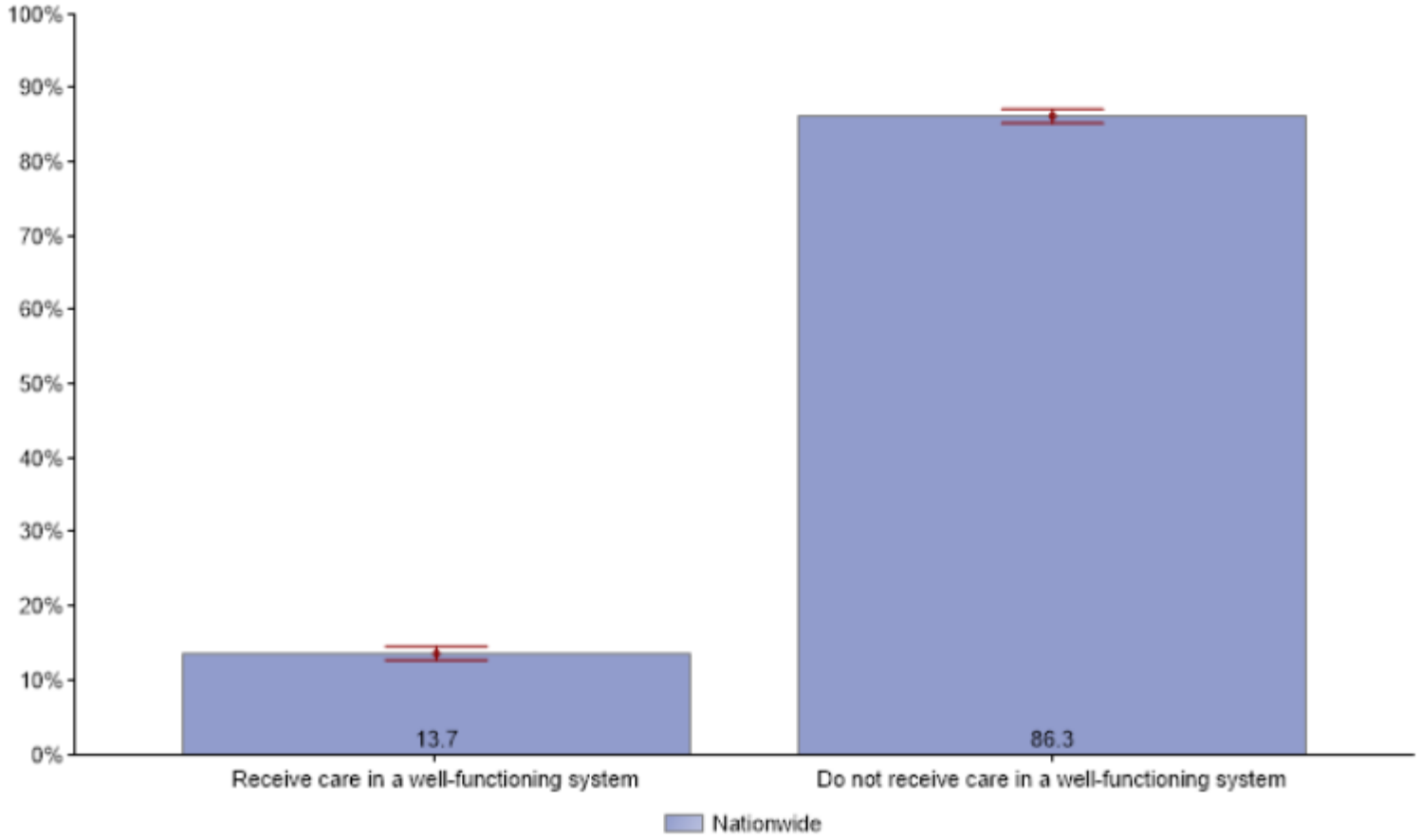


Source: 2020-2021 National Survey of Children's Health;
Data Resource Center for Child and Adolescent Health

NOM 17.2: Percent of children with special health care needs who receive care in a well-functioning system

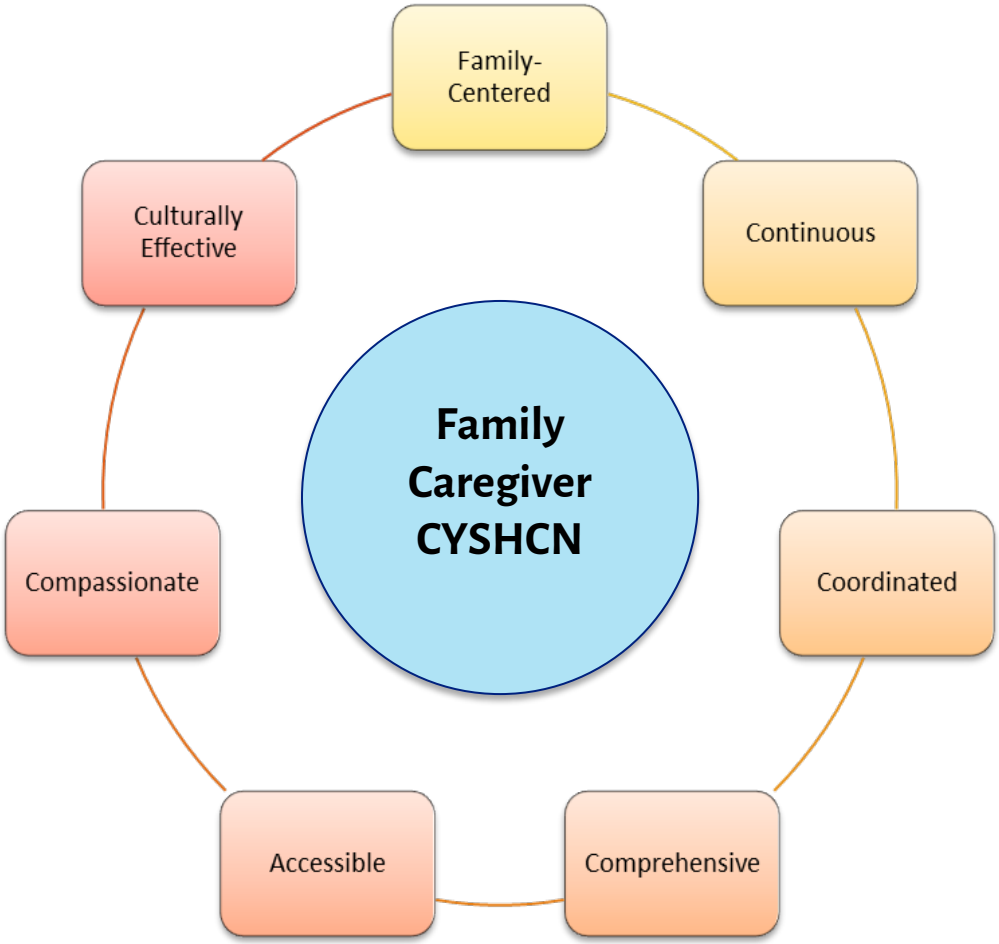
Children with special health care needs ages 0-17 years

Nationwide



Source: 2020-2021 National Survey of Children's Health; Data Resource Center for Child and Adolescent Health

Core Tenets of the Medical Home Model



Medical Home Implementation Advances the Blueprint for Change

- A Title V program educates families/caregivers on how to access non-emergency medical transportation through Medicaid for CYSHCN medical appointments.
  - Blueprint: Access to care, financing, equity
  - Medical home: Accessible, family-centered care, coordinated
- A Title V program provides training for pediatric providers on disability justice and anti-ableism.
  - Blueprint: Access to care, equity, quality of life
  - Medical home: culturally effective, accessible, family-centered

Population Health Strategies for CYSHCN

- **Definition:** Population health strategy for CYSHCN intends to improve the health and well-being of an entire group or subgroup. These strategies occur at the policy or systems level and are measurable over time. They are designed to improve health equity and often focus on social and environmental factors.

Medical Home and Population Health

- Community health workers
- Connections to peer supports/lived expertise organizations
- Advisory groups/steering committees at the state level
- Collaborating with Medicaid
- Non-emergency medical transportation access
- Language access
- Workforce development

Medical Home and Population Health

- Community referral system for families and providers
- Statewide registry to track screening
- Educational campaigns for providers, health systems, families
  - Particularly around emerging public health needs (example: COVID-19, Medicaid Unwinding, immunizations, etc.)
- **Our National Center can help Title V programs with medical home population health approaches. What support would be helpful to you?**

We Can Help!

- National Center for a System of Services for CYSHCN
- Blueprint4CYSHCN@aap.org
- No wrong door – feel free to contact us or any of our Consortium partners:
  - AAP
  - Family Voices
  - Got Transition
  - Catalyst Center