Medical Homes and Young Children:
State Policy Opportunities to Improve Children’s Healthy Development as Part of Early-Childhood Systems Building

Charles Bruner, BUILD Initiative and Child and Family Policy Center

I. Introduction: Definition of a Medical Home

The American Academy of Pediatrics (AAP) introduced the term “medical home” in 1967 and within a decade it was AAP policy. Initially it was used to describe a single source of medical information about a patient but gradually grew to include a partnership approach with families to provide primary health care that is accessible, family-centered, coordinated, comprehensive, continuous, compassionate, and culturally effective. ... [In 2007] The seven core features of a medical home [were] agreed upon by the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association.

- Robert Graham Center (2007)

A fruitful discussion of medical homes must start with a common definition—one that draws on the significant work of the health community in defining the concept. In addition to use among health practitioners, the term “medical home” (sometimes also referred to as a “patient-centered medical home” or, in an even broader context, as a “community-centered health home”) is increasingly used in the policy world as a reform goal—a vehicle to improve health-care quality and health outcomes and/or to control costs. There is growing evidence that medical homes adhering to the seven core features [Figure 1] can help achieve all these results.

The purpose of this paper is to describe how the experiences in developing medical homes that adhere to the core features can inform how the policy world defines and supports the further development of medical homes—as they apply specifically to very young children and their families. While the core features of a medical home remain the same for patients of any age, the manner in which they are incorporated into practice for the youngest in society

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must recognize the developmental trajectories of young children. Young children are dependent on parents or caregivers to follow through on almost all treatments and responses recommended by the health practitioner.

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**Figure 1**
Core Features of the Medical Home

- **Personal Physician** – each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
- **Physician-Directed Medical Practice** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- **Whole Person Orientation** – the personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals.
- **Care is Coordinated and/or Integrated** – across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, public and private community based services).
- **Quality and Safety** – are hallmarks of the medical home. Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient’s family.
- **Enhanced Access** – to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.
- **Payment Reform** – appropriately recognizes the added value provided to patients who have a patient-centered medical home.


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II. The Medical Home and Young Children – Concepts, Outcomes, and Guidelines

*Children’s health is the extent to which individual children or groups of children are able or enabled to (a) develop and realize their potential, (b) satisfy their needs, and (c) develop the capacities that allow them to interact successfully with their biological, physical, and social environments.*

- Institute of Medicine (2004)⁴

*The Broader Concept of Child Health and Its Implications for Medical Homes*
This definition of children’s health reflects the evolution of the medical system over the last century and a half—from treating infectious diseases and injuries, to addressing chronic health

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conditions and disabilities, to focusing on prevention and health promotion. It recognizes that children require a “life course” approach to health care that takes into account the inter-relationships between social environment, biology, physical environment and behavior [Chart 1].

The emphasis on social and physical environment as well as biology and behavior recognizes the relative impacts of these determinants on children’s health. The Prevention Institute notes there is currently a discrepancy between the factors influencing health and national health expenditures. The latter are focused on medical services and interventions rather than actions that would address environmental and behavioral causes of poor health [Chart 2].

If the health care system is to embrace the definition of child health given above, it is clear that it will have to expand its focus beyond strictly providing medical services, treating infectious diseases and injuries and managing chronic health conditions. That approach is consistent with international strategies that increasingly have described the “social determinants” of health that need to be addressed to improve overall health within populations. The sidebar on the next page briefly describes these social determinants.

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The literature on strengthening “protective factors” to support healthy development and prevent child abuse describes factors that correspond to these “social determinants.” So does the literature on fostering “resiliency.” “Health equity” and “social exclusion” literature emphasize the specific impacts of discrimination and the social gradient that are part of the social determinants. All these areas confirm the need to address social and environmental risks in children’s lives.

Based on this broader concept of child health, the question becomes this: What role should the health practitioner community play in addressing such social determinants, given that most are not bio-medical or predominantly bio-medical in nature?

Clearly, all seven core features of the medical home apply, but the medical home as a “first response” that “coordinates and integrates” care across both health and community support systems is key. This feature requires health practitioners to play a strong role identifying such social determinants, counseling the patient on how to respond, and referring the patient to resources that can help address them.
In short, the definitions of “medical home” and “child health” require practitioners to address social as well as biological determinants of health.

This Broader Conception as Applied to Young Children
For young children (0-5), the social and physical environment is most heavily influenced by home environment and the social, economic and emotional supports that their families—and particularly primary caregivers—offer. While young children may demonstrate challenging behaviors and have bio-medical conditions that affect behavior (such as autism spectral disorder), at a minimum treatment will require information and guidance to parents as part of the care and treatment process. In the case of young children, almost all of what the health practitioner must do to ensure good health involves the family (e.g. the patient in the patient-centered medical home is the family). While families remain critically important for older children and adolescents, the health practitioner increasingly responds to the child and works with the child as an individual (e.g. the patient is the child).

To serve the youngest children, medical homes must have a two-generation focus that responds to children’s health in the context of their families. Medical homes must support parents in being the child’s first nurse, nutritionist, and mental-health specialist – and strengthen the family’s protective factors that support healthy development.

Medical Home Outcomes for Young Children
Pediatricians and other child health practitioners (family practitioners, nurse practitioners and physician assistants) are experts in bio-medicine, able to detect and respond to medical conditions in young children. Typically, however, they have little training in child development, family dynamics, social work, lead abatement, employment and training, or family economic security—knowledge required to respond to concerns regarding many social and environmental determinants of health. Dr. Ed Schor has developed a set of outcomes to which child health practitioners for young children should be held accountable for achieving or contributing to achieving. Many of these outcomes relate to behavioral, environmental and social determinants of health [Chart 3]. These fit into the core features of a medical home, particularly around a whole person focus and coordinated and/or integrated care.

 Particularly in activities related to the chart’s italicized items, child health practitioners must engage in substantial observation, inquiry and surveillance. They must incorporate opportunities to gather information, particularly through developmental screenings and parental reporting, identify risks to be further explored and, where needed, addressed. They must be offer advice (anticipatory guidance) to help families fulfill their critical roles by addressing concerns or simply optimizing opportunities for healthy development.

Bright Futures, developed by the American Academy of Pediatrics, offers evidence-informed guidelines on how to incorporate such actions into well-child visits. Putting them into practice, however, also requires time and the knowledge of local resources in the context of family customs, cultures and languages. One reason a core feature of a medical home is “payment

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Chart 3
Outcomes of Well-Child Care During the First Five Years of Life

<table>
<thead>
<tr>
<th>Domain of Well-Child Care</th>
<th>Outcome at School Entry</th>
</tr>
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<tbody>
<tr>
<td>Child Physical Health and Development</td>
<td>• All vision problems detected and corrected optimally&lt;br&gt;• All hearing problems detected and managed&lt;br&gt;• Management plans in place for all chronic health problems&lt;br&gt;• Immunization complete for age&lt;br&gt;• All congenital anomalies/birth defects detected&lt;br&gt;• All lead poisoning detected&lt;br&gt;• All children free from exposure to tobacco smoke&lt;br&gt;• Good nutritional habits and no obesity; attained appropriate growth and good health&lt;br&gt;• All dental caries treated&lt;br&gt;• Live and travel in physically safe environments</td>
</tr>
<tr>
<td>Child Emotional, Social, and Cognitive Development</td>
<td>• All developmental delays recognized and treated (emotional, social, cognitive, communication)&lt;br&gt;• Child has good self-esteem&lt;br&gt;• Child recognizes relationship between letters and sounds&lt;br&gt;• Child has adaptive skills and positive social behaviors with peers and adults</td>
</tr>
<tr>
<td>Family Capacity and Functioning</td>
<td>• Parents knowledgeable about child’s physical health status and needs&lt;br&gt;• Warning signs of child abuse and neglect detected&lt;br&gt;• Parents feel valued and supported as their child’s primary caregiver and function in partnership with the child health care provider&lt;br&gt;• Maternal depression, family violence, and family substance abuse detected and referral initiated&lt;br&gt;• Parents understand and are able to fully use well-child care services&lt;br&gt;• Parents read regularly to the child&lt;br&gt;• Parents knowledgeable and skilled to anticipate and meet a child’s developmental needs&lt;br&gt;• Parents have access to consistent sources of emotional support&lt;br&gt;• Parents linked to all appropriate community services</td>
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Note: regular font bullets are those outcomes for which child health care providers should be held accountable for achieving. Italicized bullets are those outcomes to which child health care providers should contribute by educating parents, identifying potential strengths and problems and making appropriate referrals, but for which they are not independently responsible. Bold-faced bullets have particular implications for healthy mental development.

reform” is that providing such care may require substantially more time and resources – particularly for the provision of primary, preventive, and developmental health services – than are compensated for by most health insurers today, and certainly will require different types of accountability. As the health care system further identifies core outcomes for primary practice, it will be essential to establish metrics that cover the full range of outcomes and where medical homes achieve their goals and where gaps remain.

For medical homes to achieve the outcomes described in Chart 3, a whole child focus that coordinates or integrates care with both subspecialty services and community supports is needed. This also requires that payment and outcome monitoring systems be structured and attention given to developing an overall community system to provide them.
Guidelines for Medical Home Practice

Conceptually, fulfilling expectations for medical homes for young children requires them to be part of a larger system of community services and supports. The Early Childhood Systems Working Group has developed a framework describing an interconnected, early-childhood “system of systems” to ensure children start school healthy and equipped for success. Health is one of the core components of that system. Some actions can be taken within the medical home itself, but others rely on effective referrals to other parts of the system, with communication back on what transpires [Chart 4].

Guidelines for constructing effective medical homes in this systemic framework include ensuring:

- **Coverage**: Providing a medical home for children (outreach, engagement, health coverage and/or provision through a safety-net provider, providing continuity in response in movement from one medical home to another)
- **Clinical care**: Directly providing needed services to identify and address child health outcomes (surveillance and screening, biomedical treatments, anticipatory guidance to child/family)
- **Coordination**: Providing effective referrals to subspecialty and community services (care coordination, resource identification and provider relationship development/collaboration)
- **Consultation**: Providing additional guidance to other providers on clinical-care needs and responses so they can be effective care/treatment agents
- **Community health**: Promoting community responses to social and environmental health issues and concerns by sharing needs and opportunities as identified from practice and experience

Clearly, the medical home itself has different responsibilities in each of these areas. The medical home is not necessarily responsible for securing health coverage for patients (although it has some responsibility to direct families to a source of coverage), but it does have responsibility for engaging them and ensuring continuity of care over time.
The medical home is responsible for clinical care, broadly defined to include developmental screening and surveillance and anticipatory guidance for social and biological determinants of health. Further, the medical home should play some role in coordinating and providing effective referrals. The medical home clearly has the primary responsibility for ensuring connections to subspeciality health services.

Each medical home is not necessarily directly responsible for identifying and accessing all community resources children and families could use to address child health – but it does have a responsibility to assist in that navigation, generally through directly providing or referring to care coordination. This care coordination function may be developed on a community-wide basis (and is increasingly thought of as a community health utility). Medical homes have the responsibility for making appropriate referrals to that care coordination and participating in an overall system that supports those referrals. In some instances, this extends to consultation with community providers related to the child’s health needs.

Medical homes also can contribute to broad community health initiatives, in particular by providing insights into opportunities for promoting health on a community-wide basis and addressing gaps in services.

**In short, medical homes should be expected to play some roles in all these areas, with guidelines developed that delineate those expectations and additional community resources or utilities created to ensure coordination and consultation.**

### III. The Medical Home and Young Children – From Concept to Effective Practice

A mother brings her one-year-old in for a check-up and it’s clear that the mom is stressed, if not depressed, and shows little sign of responding to the child’s cues for attention. While the child isn’t “diagnosable” today, if things proceed as the health practitioner expects, in two years there will be significant indicators of developmental delay and likely social and emotional problems, including a DSM-IV diagnosis. The provider does not want to wait two years to take action and the mom seems receptive to receiving help. At this point, it is not clear what the family most needs and the degree to which the issues involve clinical care for the mother, social supports and community connections for the family, or both. Determining a best course of action likely will require additional screening or testing, certainly some greater understanding of the family’s situation, and some extended time connecting her and her child to resources within the community. The medical home provider also knows that simply pointing out problems without offering help is not a solution and could be considered malpractice.

- Bruner (2011)¹¹

This vignette is one that challenges child health practitioners and medical homes to engage in multiple levels of activity – contact, clinical care, coordination, consultation and community health. It extends beyond the specific medical training the practitioner likely has received and requires responses to social determinants of health.

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While this is a constructed vignette, child health practitioners, particularly those in poorer neighborhoods and communities, will regard it as a common situation and a fundamental source of concern.

The growing body of research on the impacts of adverse childhood experiences, early childhood adversity, and what these can produce in “toxic stress” is clearly relevant here. Young children in families like the one in the vignette are at high risk of very negative health outcomes. Infants and toddlers are particularly vulnerable to toxic stress and its impact on neural development and lifelong patterns of behavior, and toxic stress itself is almost entirely a function of social determinants that they themselves become wired into bio-neurological ones. The role of the child health practitioner is, at a minimum, one of screener and first responder to such high-risk situations. Particularly when children are very young, the role of the child health practitioner as a first responder is critical. Almost nine in 10 young children see a health practitioner for a check-up when they are very young, but fewer than three in 10 come into contact with any other formal child-serving system.

Until children start school, their most universal contact with professional systems is with the health practitioner, which makes the role of the medical home as first responder so critical.

Prevalence and Consequences of the Challenge
One could offer many vignettes describing a child who presents his or her health practitioner with concerns transcending traditional bio-medical care. In most instances, not only is that child vulnerable to poorer physical and mental health, but also is less likely to succeed educationally.

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or socially. Research suggests that, while most American children proceed through early childhood healthy and equipped for success, a large proportion does not. At least 20 percent can be identified as at substantial risk or displaying significantly suboptimal development, as shown in the sidebar.

It is this approximately 20 percent of young children for whom medical homes must play a significant role in developing more preventive, developmental and community-based responses that address social as well as biological determinants of health.

Exemplary Practices to Develop Effective Medical Homes for Young Children

There have been many innovations in child health practice which have shown great promise in improving young child health and development. While not necessarily described as medical homes or fully encompassing the medical home definition, they provide insights into how to develop medical homes and ensure medical homes incorporate all core features into practice.

The following describes current exemplary and cutting-edge practices which can inform how medical homes are developed and operate to meet young children’s health needs.

Coverage: Establish a medical home for all children

The first step is to ensure that medical homes for young children exist and that young children and their families use them. Several states (Iowa, Washington, Colorado and Minnesota) have defined a patient-centered medical home for children within statute. Iowa, among others, has established EPSDT outreach workers within Medicaid to contact the families of all newly enrolled children and get them connected to a medical home. Other exemplary efforts include direct outreach through community organizations and health navigators to ensure that young children and their families access medical homes and, in some instances, to expand the number of providers operating as medical homes. Some practices have developed strong linkages between prenatal-care providers and primary infant- and child-health practitioners.

Some Facts about the Health and Well-Being of Our Youngest Children (0-6)

- 30 percent will be born into families where two or more of the following “risk factors” apply: single mother, adolescent mother, mother without a high school diploma, household living in poverty, household living in a poor neighborhood, depressed parent
- 16 percent of 2- to 5-year-olds will have a diagnosable mental health condition
- 13 percent of 6-month-olds to 2-year-olds will have a diagnosable developmental delay
- 20 percent of 3-year-olds will have vocabularies of less than 200 words
- 10 percent of 4-year-olds will have BMIs indicating they are obese and 30 percent will have BMIs indicating they are obese or moving in that direction
- 20 percent of 5- to 6-year-olds will start school significantly behind in at least two of three areas (health, cognition, social and emotional development) and require substantial remediation if they are to catch up with their peers (and at least half won’t)
- 30 percent will experience two or more adverse childhood experiences (ACEs) and be vulnerable to toxic stress by the time they are five

Clinical care: Directly provide services and anticipatory guidance to identify and address child health outcomes

Ideally, medical home practice fully follows the *Bright Futures* guidelines for well-child care. For the last decade, the Commonwealth Fund’s Assuring Better Child Health and Development (ABCD) Initiative has supported state efforts to expand developmental health services to children under Medicaid. With technical assistance from the National Academy for State Health Policy, in some states the ABCD Initiative has supported cutting-edge efforts, drawing on *Bright Futures*, to incorporate more comprehensive screening and surveillance in well child-care settings. Some states are developing and using screening tools that identify social determinants as a routine part of well-child visits. These may include the use of developmental screening instruments like Ages and Stages or screenings for maternal depression. Many practices have adopted Reach Out and Read as a form of anticipatory guidance supporting children’s overall development and emerging literacy. Increasingly, practices are incorporating nutrition and exercise anticipatory guidance into their visits with young children. With both Reach Out and Read and infant and toddler exercise and eating programs, medical homes can provide books and resources that enable parents to model practices in their own homes.

Coordination: Provide effective referrals to subspecialty and community services

Medical homes that are comprehensive in scope, following *Bright Futures* guidelines, will identify needs that require responses beyond the scope of the primary medical-home practitioner and, in most instances, the practitioner’s overall practice setting.

Subspecialty coordination

For children with special health-care needs, this may involve a team of professionals and subspecialists. In fact, medical homes are likely to have their biggest immediate impact on care and costs when they serve children with complex medical conditions. One of the strengths of a medical home in these instances is its ability to support the family by providing ongoing care and coordination. Young children with developmental or behavioral/mental conditions may require the expertise of child development or mental health specialists. In the case of the former, some medical homes have developed exemplary practices in accessing special education services through early intervention (Part C services under the Individuals with Disabilities Education Act) services for infants and toddlers and special education services (Part B under IDEA) for 3- to 6-year-olds. Most states face shortages in mental health specialists for young children, particularly infants and toddlers, often extending the time between initial screening for a mental health concern (e.g. autism spectral disorder) and diagnosis and development of a treatment plan. Again, some states have employed mental health consultants and telemedicine in order to provide more timely responses in both establishing diagnoses and subsequent treatment planning. Exemplary actions also have created professionally facilitated support groups and group pediatric visits to accommodate group learning and peer support among parents.

Coordination with community services

Medical homes also will experience families like the one described in the vignette, where there are reasons for substantial concern about the child’s growth and development, but not a biomedical diagnosis. In some instances the major concern may be that the family is under economic or social stress, which, in turn, is limiting the nurturing the child receives. In these instances, someone needs to spend additional time to get a fuller picture of the family’s situation,
and then to connect that family to supports that strengthen its capacity to care for the child. This typically is referred to as “care coordination,” although it also can be referred to as “case management” or other terms. There are exemplary pediatric practices, particularly those within federal qualified community health centers and other large clinics, where care coordination and even some community services are offered within the practice setting—usually through social workers or child development specialists. In other instances, however, care coordination is viewed more as a health utility supported at a community or state level and accessible to all medical homes, including those that are not in large clinics or FQHCs. The national Help Me Grow replication project is seeking to extend care coordination, coupled with ongoing community liaison work to identify and coordinate with community resources, according to this utility model [Chart 6].

The experiences of exemplary programs tell us that “care coordination” often takes extensive time – time engaging with families, understanding their particular needs, identifying resources (and moving beyond referrals to actually scheduling appointments) and following up to learn what actions were taken. Care coordinators need specialized skills to be effective. These skills need to be enumerated, supported through training and supervision and regularly monitored. In establishing effective care coordination, as with other elements of effective medical home practice, the devil is in the details.

**Consultation:** Provide additional guidance to community providers on clinical care needs and responses so they can be effective care/treatment agents

Non-clinical providers working with children with special biomedical or behavioral conditions often require additional training themselves to respond to those children’s needs. Child care providers are a prime example. Providers may be able to meet the special feeding needs of children in their care if provided the right support. They also may be able to address behavioral and mental health issues more effectively (and better aligned with an overall treatment plan), if they have expert consultation. For children with complex clinical conditions, these providers may actually become part of the medical home team. In other instances, medical homes may provide more general consultation to equip providers with information and skills. Several states...
have developed mental health consultants to help strengthen the capacity of early care and education providers to respond to children with challenging behaviors or mental health concerns. States also have developed training programs to equip these providers with more skills in this area. Where this has occurred, it affords the medical home an additional resource in the community.

**Community health: Promote community responses to social and environmental health issues**

Medical home practitioners can serve as community health leaders. Particularly when embedded in a larger health practice with a community focus, such as a federally qualified health center or a hospital, they can be a locus for broad community activities to improve child health. In addition to supporting facilitated or group sessions for families with young children as part of practice, these facilities can promote parent and family leadership in addressing young children’s needs, which can extend to public education campaigns, development of additional recreational spaces and programs, and efforts to address neighborhood safety issues. Individual medical home practitioners can promote community actions to strengthen the environment in which young children and their families live, work and play. Medical home practitioners may have unique insights into what young children and their families are facing and can contribute to community planning efforts addressing them.

Exemplary actions within medical home practices across the country show the promise of taking on all these roles. One of the great challenges – and opportunities – for state policy makers is to encourage and promote expansion and diffusion of such practices, recognizing that only in rare instances will child health practitioners as medical home providers be able to take on *all* such roles. Transformation will require time, intentionality and supports that do not simply impose new requirements while holding time and money constant.

### IV. State Policy Roles in Medical Home Development for Young Children

*Understanding innovations and their diffusion is now more important than ever. ... We need to know more about the spatial and temporal diffusion of major public health–influencing innovations because that information will tell us how innovators deal with the diversity of norms, values, laws, religions, ideologies, and political issues that can influence the adoption and long-term prognosis of a public health–related innovation.*

- Greenberg (2006)\textsuperscript{16}

Medical home practices are developing for all sorts of patients and in all sorts of settings. At the practice and community level, there are growing numbers of very intentional efforts to reform practices along the lines described above. Some are supported with foundation funding, others with federal or state demonstration funding, community grants or simply the time and energy medical home advocates have themselves committed. There are growing efforts to promote innovation through “plan, do, study, act” (PDSA) processes, where individual practices and practitioners try out new approaches quickly and without initially undertaking complex changes to their entire practices.

There also is a growing body of literature describing the manner and speed at which innovation is diffused through a system. That literature draws attention to the intentional actions that can be taken to speed the diffusion of innovation and to ensure fidelity to the model as it occurs. This has extended to a discussion of how public policies themselves are diffused across states, and how state policies can promote diffusion of innovations. The “diffusion of innovation” literature suggests that there are stages of diffusion and a process for that diffusion, and that reaching a “tipping point” of adopters often is needed to produce the systemic changes that convert exemplary into routine practice.

State policy actions can affect the speed, spread and depth of diffusion in multiple ways. First, state policies can focus on areas where there is a need for innovation, support the initial work and planning to promote such innovation and highlight innovations that already show signs of success. Second, state policy can foster the spread of innovations through demonstration programs and practice diffusion infrastructures that usually involve peer training and technical assistance for early adopters. Third, state policy can be explicit in using the experiences of exemplary practices in identifying how rules, procedures and reimbursement systems are structured to make such practices the routine, rather than exceptional, way of doing business. Fourth, state policy can establish monitoring and regulatory requirements to make standard the innovative practices that have developed sufficient evidence to no longer be considered innovative. While state policy makers often see their role primarily at this fourth level, their actions may do more to hasten or delay diffusion of effective innovations in the first three areas.

**Focus attention**

With respect to medical homes, some states have shown their support for innovation and change by adopting “medical home” definitions within their codes, along with some structure to promote their adoption. Washington, Minnesota, Colorado and Iowa all have established medical home statutes that, in effect, focus attention on the value of expanding medical practices to be more patient-centered and comprehensive. They also have begun to establish infrastructures which can serve as a locus for identifying innovations and promoting them to the field. This is a way to ensure that both inventors and respected peer/early adopters become lead partners in the diffusion process.

**Foster early adoption and spread**

States also have supported specific demonstration programs to promote comprehensive medical homes, or incorporated medical home practitioners in other reform efforts. Both the Help Me Grow national replication project supported by the Kellogg Foundation and the National Improvement Partnership Network (NIPN) supported by the Commonwealth Fund are examples of efforts to diffuse child health innovations through state and community systems. Project LAUNCH is a federal initiative around young child healthy development that promotes similar practice-level and policy-level changes. A federal demonstration program through federally qualified health centers is underway to promote medical homes within FQHCs. While not all of these initiatives have an explicit focus on building medical homes in the full definition of the term, they all, in effect, require that child health practitioners take on at least some important elements of a medical home as it applies to young children—and most offer significant technical assistance and incentives for practitioners to do so. They are building an additional core of early adopters which enable practices to provide medical homes even where the existing finance and
management structure does not itself provide the incentives needed to implement changes. They also help establish an understanding of how existing financing, monitoring and management structures need to change to diffuse innovations.

**Foster adoption within standard practice**

States with the policy infrastructure and the evidence from effective innovations can use this knowledge and credibility to make financing, monitoring and management changes to further convert exemplary medical home practices into mainstream practice. The Commonwealth Fund’s Assuring Better Child Health and Development Initiative has been very successful in many states in reforming Medicaid financing of primary practice to include developmental surveillance and screening and, in some instances, to finance care coordination that expands practitioners’ ability to connect families to community and subspecialty services. Across the country, states have made changes to their Medicaid and CHIP systems based on experiences of medical home innovators and the discoveries of what they need to do that currently is outside existing financing but should covered within it. Since Medicaid and CHIP together cover approximately 40 percent of all U.S. children birth to five, and a much larger share of those most likely to benefit from comprehensive medical homes, Medicaid financing clearly plays a huge role in promoting change.

**Set and enforce new standards of practice**

Eventually, medical home practices no longer should be considered innovations but instead should be expectations for practice. In particular, medical homes must be supported consistently across health care reimbursement systems. While Medicaid clearly is the largest and most important insurer of young children and their families, private health insurance also needs to appropriately support medical homes. With provisions within the Affordable Care Act, including the establishment of health exchanges and new requirements for all policies to cover preventive health services, there are opportunities to further incorporate robust medical home financing within health insurance coverage.

States very likely will take different policy steps in these directions, but hopefully can draw from one another as they do so. The sidebar below provides some specific and discrete ideas states might consider as they move forward with development of medical homes for young children and their families.
V. Establishing Medical Homes as Key Component of Early Childhood Systems Building and School Readiness

Over the last decade, there have been focused state-level efforts to expand public preschool programs, develop home visiting services and improve the quality of early childhood programs generally. Those involved in early childhood systems building have increasingly emphasized the need to incorporate child health services into early childhood systems building as both a

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<tr>
<th>State Policy Opportunities for Promoting Medical Homes for Young Children</th>
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<tbody>
<tr>
<td><strong>Definition and Engagement:</strong> Develop a statutory definition of a medical home and a center, advisory committee, task force, division or other locus for promoting medical home development as it applies specifically to young children, involving champions from the child health practitioner community.</td>
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<tr>
<td><strong>Infrastructure for Spreading Effective Practice:</strong> Establish sufficient staffing and support for identifying exemplary and innovative practices within the states and communities and providing for opportunities for training, technical assistance, peer networking, and other activities to spread those practices and the lessons learned from them.</td>
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<td><strong>Financing under Medicaid:</strong> Based on exemplary practices and their experiences, ensure that Medicaid provides sufficient reimbursement and support for the practices desired in medical homes, including reimbursement for developmental surveillance and screening and for care coordination and community health liaison activity.</td>
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<tr>
<td><strong>Linkages to Other Publicly-Funded Services for Young Children:</strong> Embed medical home expectations and supports within other early childhood programs, including how medical homes need to connect with home visiting, preschool programs, Part B and C services, and other publicly-funded programs and initiatives for young children and their families.</td>
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<tr>
<td><strong>FQHC’s and Place-Based Health Activities:</strong> Build on the work and experiences of Federally Qualified Health Centers in serving young children and their families within underserved communities and support their work to establish comprehensive medical homes as a core approach to providing those services.</td>
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<tr>
<td><strong>Health Insurance Regulation and Requirements for all Payers:</strong> Develop appropriate requirements within health exchanges and for private health insurers to provide adequate financial coverage to maintain and support medical homes for young children that interface with those provided under Medicaid and CHIP.</td>
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<td><strong>Providing Consultation and Support to Early Childhood Programs:</strong> Explore how to make use of medical home practitioners, as well as staff who engage in care coordination or social services, as consultants to early childhood providers and other programs serving families with young children, that can be mutually beneficial in linking children to medical homes and equipping providers with greater health care knowledge.</td>
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<tr>
<td><strong>Promoting Community Health:</strong> Ensure that medical home providers for young children are recruited and their knowledge and expertise enlisted in broader community health initiatives, particularly those focused on young children and their families.</td>
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fundamental and better interconnected element of the early childhood system. Great advances have been made in providing publicly-financed health coverage for young children and their families, through state and federal actions to expand Medicaid and the Child Health Insurance Program (CHIP). As coverage has expanded, so has attention to the content of that coverage and care, with an increased recognition of the value of medical homes and the need to provide developmental health services that respond to social as well as biomedical determinants of health.

Still, developments in early childhood systems building and those in health often are only minimally linked at the state policy level. If they are to become better linked, it will require that there be intentionality in including medical home providers as part of broader early childhood systems development groups—and ensuring that all strategies being developed consider how medical homes can play a role and what resources and supports will be needed to enable them to do so. Every state has champions for medical homes who can bring that perspective into early childhood systems planning, whether it is around home visiting, early learning standards development, QRIS or developmental screening in health practitioners’ offices. The more these champions are included and informed about other early childhood systems building work, the more states will benefit from the synergy between efforts to expand medical homes and those to improve the quality of other early childhood services.