A comprehensive medical home is considered the foundation of quality primary care services for all children, particularly for those with special health care needs (SHCN).1,2 In the article “Access to the Medical Home Among Children With and Without Special Health Care Needs,”3 the authors describe results from the 2016 National Survey of Children’s Health, which revealed that children with special health care needs (CSHCN) were less likely than non-CSHCN to receive care that meets the medical home criteria3 of having a usual source of care, having a personal doctor or nurse, receiving necessary referrals, receiving needed care coordination, and receiving family-centered care.4 In addition, CSHCN with more qualifiers for SHCN status (a marker of higher medical complexity) are less likely to have access to a medical home than children with fewer SHCN qualifiers. However, CSHCN were more likely than non-CSHCN to have a usual source of care or personal doctor or nurse.3

Because less than half of the children surveyed had access to care in a medical home, it is clear that there are barriers within the current health care system preventing all children from accessing medical homes. With finite resources, it may be necessary to prioritize who gets access to care within a comprehensive medical home. Clearly, CSHCN benefit from a medical home,1,5–7 but in their article, Lichstein et al3 question whether having a personal doctor or nurse (and thus meeting the full definition of access to a medical home) is essential for non-CSHCN, given that they are typically healthy.

However, what if SHCN is being considered too narrowly? Many of these so-called non-CSHCN may in fact have social complexities that make their care needs reflect those of CSHCN. Social complexity, such as poverty, limited English proficiency, insurance discontinuity, or caregiver illness,8 may necessitate many of the elements of a comprehensive medical home and make the health care needs care for these children closer to that of CSHCN than non-CSHCN.

There is a growing body of literature revealing the short- and long-term effects of social determinants of health.9,10 In their analysis, Lichstein et al3 found that social determinants predicted access to a medical home as well as to specific subcomponents but that the association varied between CSHCN and non-CSHCN. The authors posit that because CSHCN have been the targets of medical home models for so long, the sociodemographic disparities have dissipated for this population. For non-CSHCN, nonwhite race is associated with a lower likelihood of receiving family-centered care, having a usual source of care, or having a personal doctor or nurse.3 It is possible that in the absence of a mediating framework, such as the medical home, nonwhite, non-CSHCN’s healthcare is more likely to display the more typical patterns of health inequities that we see as a result of poor health care access, unconscious bias, and systemic racism.11,12 Non-CSHCN with private insurance are more likely than those with public or

no insurance to receive effective care coordination and have a usual source of care. This is concerning because the literature shows that children with public insurance have fewer options for where to receive care and have longer wait times for care than those with private insurance, meaning that they might be more likely to benefit from effective care coordination and the usual sources of care of a medical home.

If social complexity and multiple negative social determinants of health are to be considered indicators of needing a medical home model, then measuring social complexity or the social determinants of health in the clinical setting will be necessary. The American Academy of Family Physicians has launched The EveryONE Project, which includes short- and long-form social determinants of health screeners, and the Institute of Medicine has a measure of social and behavioral determinants of health that is feasible to implement within a primary care clinic. State administrative data have also been used to identify patients with social complexity factors who are insured by Medicaid.

Once children who are at risk for poor health outcomes due to a higher burden of negative social determinants of health are identified, efforts should be made to provide their health care within a medical home model. The components of a comprehensive medical home interact to better meet the needs of children with social complexity. Having a usual source of care is expected to increase the likelihood of having a personal doctor or nurse. A provider who has an established relationship with a child and family will be better positioned to understand the family’s values and needs to partner with the family in the child’s care, key components of family-centered care. Care coordination could facilitate access to care by ensuring the receipt of needed referrals, including to programs in which social needs are addressed. Strategies to reduce the burden of social determinants of health at the patient, practice, and community level and an individualized patient action plan could be implemented within a medical home in response to the social determinants of health.

ABBREVIATIONS
CSHCN: children with special health care needs
SHCN: special health care needs

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