

COORDINATION BETWEEN HOME VISITING PROGRAMS AND MEDICAL HOMES

The first few years after the birth of a child can be a challenging time for families. Coordination between home visiting programs and medical homes that both care for these families may enhance the support families receive¹. These services share many of the same goals, such as healthy child development and increased parenting skills².

***MEDICAL HOMES** deliver primary care that is “organized and delivered” and apply to both adults and children. They focus on patient-centeredness, coordinated care, and have a systems-based approach³.*

Home visiting program members of the Home Visiting Applied Research Collaborative (HARC) participated in a mixed method study to answer three research questions:

1. What is the **current extent of coordination** between home visiting programs and medical homes?
2. What **factors are associated with coordination** between these services?
3. What are the **barriers and facilitators for coordination** between these services?

METHODS

The study included a web-based survey of 80 HARC home visiting program staff members and key informant phone interviews with 12 of these staff. For additional information, contact Amanda Belknap at aebelknap@jhu.edu

EXTENT OF COORDINATION

Overall, home visiting programs reported limited coordination with the medical homes:

- About two thirds of programs interviewed contact providers only if a problem arises or the family requests that they make contact.
- One third of programs have a memorandum of understanding (MOU) with providers.
- For half of programs interviewed, the only formal documentation they have for coordination is consent forms to obtain child immunization records.
- Survey respondents reported the highest level of regular communication with pediatric medical providers (38%) followed by prenatal providers (25%) and adult primary care providers (18%).

However, home visiting programs identified benefits to coordination with medical homes:

- Eighty percent of respondents highlighted communication with medical homes as a key tool to increase the number of referrals they receive from providers into their program. Many provided educational materials to medical practices in order to facilitate the referral process.
- Additional benefits include increased awareness of poor health outcomes, updating immunization records, and increasing the knowledge in the community about the role of home visiting programs.

“If mom is maybe struggling with alcohol or drugs... we let [providers] know what ... we’re working on. We also will contact the providers if we see a concern. If it seems that mom isn’t maybe following up with her prenatal visits, or if we have a concern about drugs or alcohol, we will for sure talk with the provider.”

“Our relationships with hospitals and clinics helps us to ensure that kids are getting immunized. Kids are getting in for their well-baby checks.”

FACTORS ASSOCIATED WITH COORDINATION

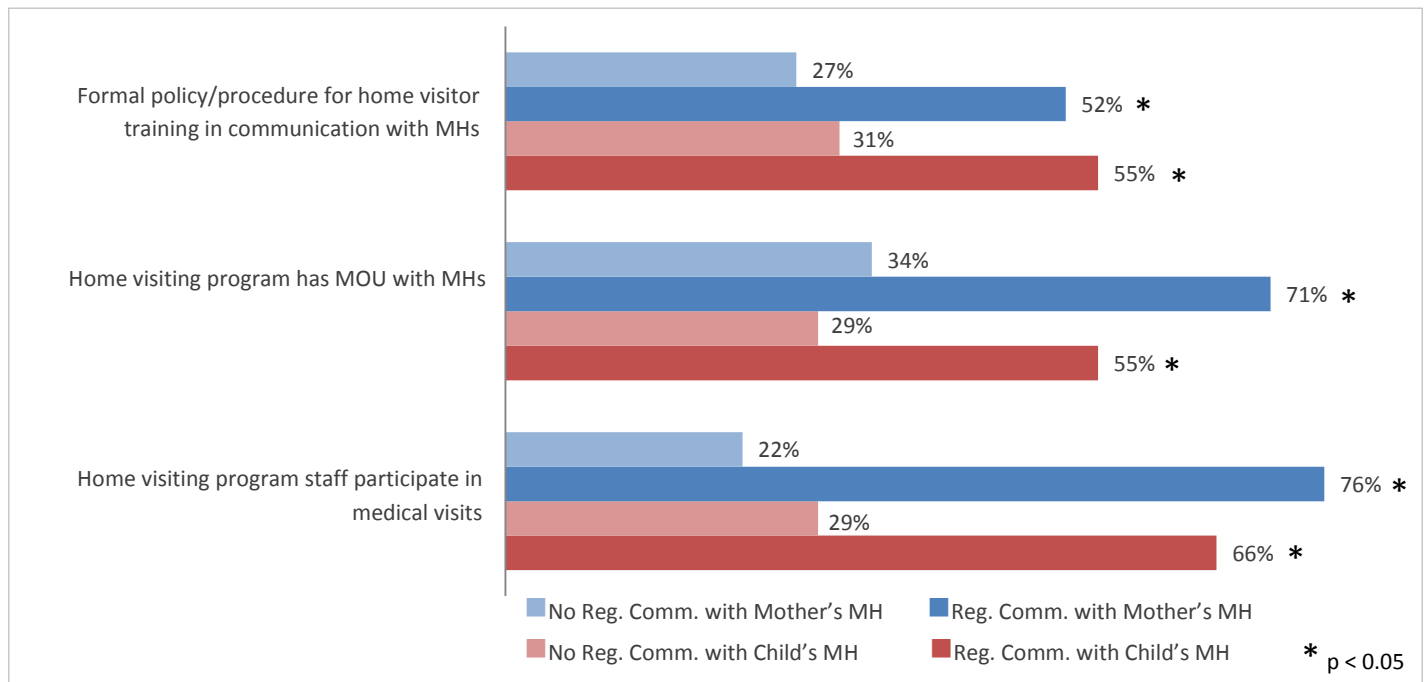
The figure identifies key factors that are associated with regular communication with medical homes. These include having an MOU, attending visits and having formal policies or procedures in training home visitors to communication to the medical home. All were significant predictors of regular communication with providers for both mothers and children.

¹ Nelson C, Tandon S, Duggan A, Serwint J. Communication between key stakeholders within a medical home: a qualitative study. *Clinical Pediatrics* 2009;48(3):252-262.

² Toomey S, Cheng T. Home visiting and the family-centered medical home: synergistic services to promote child health. *Academic Pediatrics* 2013;13(1):3-5.

³ Agency for Healthcare Research and Quality. What is the PCMH? Available at: <http://www.pcmh.ahrq.gov/page/what-pcmh>.

Figure: Respondents with and without Regular Communication with Medical Homes (MHs)



BARRIERS AND FACILITATORS TO COORDINATION

Regardless of geographic location, home visiting programs interviewed cited lack of time and availability of health care staff as major barriers to communication. Some home visiting programs found that having a ‘champion’ at the front desk or making unscheduled visits to the medical practice helped to overcome these barriers. However, a quarter of the programs perceived medical providers who were not receptive to communication or did not appreciate the value of home visiting services.

For programs with established relationships with medical providers, various facilitators kept the relationship strong. The ability to converse in-person with medical providers was named as a strength for many of the programs and many also had pediatricians who would call the home visiting team to provide updates on the child and family. One program in particular had such strong ties with their medical homes in the community that this relationship kept them afloat during hard times.

“In [the past few years] we were hit with a huge budget crunch. Many of our services were going to be cut. It was the community, the providers in the community that knew of the strength of our programs that came out into community forums, and spoke highly of us. That kept us surviving.”

SUMMARY AND IMPLICATIONS

While communication occurs between some home visiting programs and medical homes, it is not a priority for many. More strategies are needed to enhance communication, including:

- Increasing medical provider knowledge of the purpose of home visiting; and
- Reinforcing that benefits of communication extend beyond a growth in referrals for home visiting programs.

Selected efforts to improve coordination have been piloted through the Illinois Chapter of the American Academy of Pediatrics⁴, the New Jersey MIECHV program expansion⁵, and the Oregon Health and Science University CaCoon program⁶.

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⁴American Academy of Pediatrics. Home Visiting. 2014; Available at: <http://illinoisAAP.org/projects/early-childhood-development-initiatives/home-visiting/>.

⁵The Center for Law and Social Policy and the Center for American Progress. New Jersey: Maternal, infant, and early childhood home visiting program. 2015. Available at: https://cdn.americanprogress.org/wp-content/uploads/2015/02/NJ_HomeVisiting-factsheet.pdf.

⁶Oregon Center for Children and Youth with Special Health Needs. Care coordination (CACOON). Oregon Health and Science University. 2015. Available at <http://www.ohsu.edu/xd/outreach/occyshn/programs-projects/cacoon.cfm>.