Home Visiting and the Family-Centered Medical Home: Synergistic Services to Promote Child Health

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Academic Pediatrics 2013;13:3–5

In light of increasing interest and funding of home visiting programs, there has been discussion about the intersection of the family-centered medical home (FCMH) and home visiting programs (HV). This statement discusses the synergistic potential of FCMH and HV services. Guidance is provided on how these programs might partner to better integrate care, what the benefits of that integration would be, and how the coordination between the FCMH and HV should be evaluated.

HV programs and FCMHs provide parents and patients with health, developmental, and safety education; linkage to community services; and social support. Integration of home-based activities into a system of high-quality well-child care, such as the FCMH, has the potential to promote child health and well-being and reduce disparities in health and health care. Integration of HV and FCMH should be supported and encouraged through colocating HV programs with the FCMH to optimize communication and collaboration, and where colocation is not feasible, establishing other mechanisms for bidirectional communication. HV and FCMH providers should have a joint registry of at-risk children and families. Insurance providers that participate in health care exchanges should be required to include HV services in all essential benefits packages. HV and FCMH coordination should be evaluated, and the evaluation should include programmatic, process, and outcome measures. The APA and AAP propose to raise awareness among pediatric primary care clinicians, families, public health programs, and policy makers of the potential synergies between HV and FCMHs and provide recommendations to support HV and FCMH integration.

Contributions of Home Visiting Programs and Family-Centered Medical Homes to the Health of Children

In recognition of the need for improved integration of services for families, the Affordable Care Act of 2010 (ACA) includes support for both FCMH and HV programs. Integration of home-based activities into a system of high-quality well-child care, such as the FCMH, has the potential to promote child health and well-being and reduce disparities in health and health care. A key shared goal of HV programs and the FCMH is to promote the healthy development and well-being of children and their families.[1] This policy statement reviews the synergistic contributions of HV programs and the FCMH and makes recommendations for how to evaluate their coordination.

Home visiting (HV) is an approach to service delivery by paraprofessionals or health care clinicians that support and provide services to families with children. HV programs have roots in health care, child welfare, and education and provide culturally-informed evaluation and support of children and families in their own homes. Categories of HV programs include: maternal, infant, and early childhood HV; HV for children and youth with special health care needs; HV for maltreated and neglected children; HV for at-risk children; HV for children in at-risk families (eg, parent is limited cognitively or emotionally, has a physical limitation, or is socioeconomically disadvantaged); and child care and school-based educational programs. For young children, high-intensity HV programs have been found to be effective for multiple child and family outcomes, including improving child physical and emotional health and development, improving social skills, reducing child maltreatment, and improving parenting skills.[1–8] HV by health care clinicians has been found to strengthen the relationship between the family and provider and enhance trust.[9–13]

The FCMH provides comprehensive, coordinated, family-centered primary care that facilitates partnerships between patients, families, clinicians, and community resources and services. The FCMH aims to deliver optimal health care services to children to maximize health-related outcomes and coordinates the care provided in different venues and by an array of providers. FCMHs vary in regards to structure, resources, and challenges. In addition, different approaches can be taken to measure the FCMH (eg, NCQA, Medical Home Index,[14] CAHPS Clinician and Group PCMH Survey). Research suggests that the

FCMH can decrease barriers to care, improve family satisfaction, and improve child and family outcomes.[15–18]

BENEFITS OF INTEGRATING HV PROGRAMS AND FCMH

HV and FCMH providers have complementary and synergistic skill sets. In some cases, these services have been fully integrated and shown to be effective[19,20] (eg, Healthy Steps). Coordination, communication, and linkage between HV providers and the FCMH, however, are often suboptimal. Many HV programs are supported through state health, welfare, or education departments and do not share any administrative oversight with FCMHs. A qualitative study of parents, HV providers, and child health care clinicians found that there were barriers to communication. However, greater coordination between providers in HV programs and FCMHs could simultaneously enhance HV program effectiveness and help reinforce advice and anticipatory guidance given by primary care clinicians (PCPs).[21]

Addressing the health and psychosocial needs of families requires a range of social, medical and other support services. Some of these are optimally provided in the patient's home. Teamwork, collaboration and integration among service providers are needed. HV programs within an FCMH framework can provide effective care of children and families at the individual patient and population levels. Partnership between HV and FCMH providers can have many benefits.[19,22–25] HV and FCMH providers can share information to identify child and family needs, collaborate in educating families, and "refer" to each other. This partnership can assist families in care coordination and facilitate referrals to community resources (eg, early intervention), medical evaluations (eg, audiology), and community supports (eg, parenting groups, nutrition services, social work). HV providers can validate clinician assessments and identify nutrition and living condition needs and perform environmental and safety assessments. HV and FCMH providers can mutually reinforce advice and anticipatory guidance (eg, injury prevention). Partnership between HV and FCMH providers can improve identification, treatment, and prevention of parental depression. HV providers can assist FCMH clinicians in overseeing complex health care in the home of children with serious ongoing health conditions, identifying needs for equipment for special needs, and implementing prescribed care in the least disruptive manner. Partnership between HV and FCMH providers can improve the identification of community needs that are important in managing population health. Last, this partnership can help to educate medical students and residents in the benefits of HV services.

CONCLUSIONS AND RECOMMENDATIONS

HV programs and FCMHs provide parents and patients with services critical to promoting child health and well-being. Integration of home-based activities into a system of high-quality well-child care, such as the FCMH, has the potential to promote child health and well-being and reduce disparities in health and health care. Changes need to be made to provide the necessary support for HV and FCMH integration. Ongoing evaluation of models integrating home visiting with the FCMH is needed to determine optimal effectiveness (Table 1).

The APA and AAP support and encourage integration of HV and FCMH:

- Colocate HV programs with the FCMH to optimize communication and collaboration; where colocation is

Table 1. Measures for Assessing the Coordination of HV Programs and FCMH

Programmatic measures
• Mission statements and policies that support coordinated or integrated service delivery within communities.
• Partnership among HV workers and FCMHs, formal partnership agreements, HV consent forms, including sharing of child and family information with the child's FCMH and vice versa.
• Integration of HV and FCMH services and specific methods for communication and joint training.
• Reimbursement and payment for services provided.
Process measures
• Administrative coordination.
• Care coordination.
• Communication between HV and FCMH providers.
• Access to care and services.
• Family centeredness.
• Joint monitoring of immunizations, developmental screening, FCMH visits in accordance with Bright Futures guidelines.[26]
• Show rates for HV and FCMH visits.
• Adherence to recommendations/follow-up.
Outcome measures
• Utilization of HV, FCMH, and other community services.
• Health service utilization (eg, hospitalizations, emergency department visits, and office visits).
• Maternal and newborn health (eg, reduction of untreated maternal depression, admission for jaundice, immunizations up to date).
• Child development, including school readiness.
• Child and family health-related outcomes (eg, quality of life).
• Economic impact (eg, work and school days lost).
• Family and child satisfaction and experience of care.

HV = home visiting program; FCMH = family-centered medical home.

not feasible, other mechanisms need to be established for bidirectional communication (eg, monthly team meetings with HV and FCMH providers).

- Educate HV and FCMH providers about each other's roles.
- Build integrated computerized record systems and/or health information exchanges.
- Create a joint registry of at-risk children and families for HV and FCMH providers.
- Require insurance providers that participate in health care exchanges to include HV services in all essential benefits packages.
- Support and encourage the evaluation of HV and FCMH coordination.

REFERENCES

1. American Academy of Pediatrics, Council on Community Pediatrics. The role of preschool home-visiting programs in improving children's developmental and health outcomes. *Pediatrics*. 2009;123:598–603.
2. Kahn J, Moore KA. What works for home visiting programs: lessons from experimental evaluations of programs and interventions. *Child trends fact sheet*. July 2010:1–33. Available at: http://www.childtrends.org/Files/Child_Trends-2010_7_1_FS_WWHomeVisitpdf.pdf. Accessed November 9, 2012.
3. MacMillan HL, Wathen CD, Barlow J, et al. Interventions to prevent child maltreatment and associated impairment. *Lancet*. 2009;373(9659):250–266.
4. Department of Health and Human Services. Home visiting evidence of effectiveness. 2012. Available at: http://homvee.acf.hhs.gov/. Accessed July 22, 2012.
5. Duggan AK, McFarlane E, Fuddy L, et al. Randomized trial of a statewide home visiting program: Impact in preventing child abuse and neglect. *Child Abuse Neglect*. 2004;28:597–622.
6. Caldera D, Burrell L, Rodriguez K, et al. Impact of a statewide home visiting program on parenting and on child health and development. *Child Abuse Neglect*. 2007;31:829–852.
7. McFarlane E, Burrell L, Crowne SL, et al. Maternal relationship secuirty as a moderator of home visiting impacts on maternal psychosocial functioning. *Prev Sci*. 2012 Oct 27. [Epub ahead of print]
8. Postma J, Karr C, Kieckhefer G. Community health workers and environmental interventions for children with asthma: a systematic review. *J Asthma*. 2009;46:564–576.
9. Eckenrode J, Ganzel B, Henderson CR, et al. Preventing child abuse and neglect with a program of nurse home visitation: the limiting effects of domestic violence. *JAMA*. 2000;284:1385–1391.
10. Olds DL, Robinson J, O'Brien R, et al. Home visiting by paraprofessionals and by nurses: a randomized, controlled trial. *Pediatrics*. 2002;110:486–496.
11. Olds DL, Kitzman H, Cole R, et al. Effects of nurse home-visiting on maternal life course and child development: age 6 follow-up results of a randomized trial. *Pediatrics*. 2004;114:1550–1559.
12. Olds DL, Kitzman H, Hanks C, et al. Effects of nurse home visiting on maternal and child functioning: age-9 follow-up of a randomized trial. *Pediatrics*. 2007;120:e832–e845.
13. Gomby DS, Culross PL, Behrman RE. Home visiting: recent program evaluations: analysis and recommendations. *Future Child*. 1999;9:4–26.
14. Cooley WC, McAllister JW, Sherrieb K, et al. The Medical Home Index: development and validation of a new practice-level measure of implementation of the medical home model. *Ambul Pediatr*. 2003;3:173–180.
15. Hardy JB, Streett R. Family support and parenting education in the home: an effective extension of clinic based preventive health care services for poor children. *J Pediatr*. 1989;115:927–931.
16. Duggan AK, McFarlane EC, Windham AM, et al. Evaluation of Hawaii's Healthy Start program. *Future Child*. 1999;9:66–90.
17. Homer CJ, Klatka K, Romm D, et al. A review of the evidence for the medical home for children with special health care needs. *Pediatrics*. 2008;122:e922–e937.
18. Toomey SL, Chan E, Ratner JA, et al. The patient-centered medical home, practice patterns, and functional outcomes for children with attention deficit/hyperactivity disorder. *Acad Pediatr*. 2011;11:500–507.
19. Minkovitz CS, Hughart N, Stobino D, et al. A practice-based intervention to enhance quality of care in the first three years of life: results from the Healthy Steps for Young Children program. *JAMA*. 2003;290:3081–3091.
20. Minkovitz CS, Stobino D, Mistry KB, et al. Healthy Steps for Young Children: sustained results at 5.5 years. *Pediatrics*. 2007;120:e658–e668.
21. Nelson CS, Tandon SD, Duggan AK, et al. Communication between key stakeholders within a medical home: a qualitative study. *Clin Pediatr (Phila)*. 2009;48:252–262.
22. National Research Council, Institute of Medicine, Committee on Depression, Parenting Practices, and the Healthy Development of Children. Board on Children, Youth, and Families. *Depression in Parents, Parenting, and Children: Opportunities to Improve Identification, Treatment, and Prevention*. Washington, DC: National Academies Press; 2009.
23. Wheeler BK, Powelson S, Kim JH. Interdisciplinary clinical education: implementing a gerontological home visiting program. *Nurse Educ*. 2007;32:136–140.
24. Sharma N, Lalinde PS, Brosco JP. What do residents learn by meeting with families of children with disabilities? A qualitative study of an experiential learning module. *Pediatr Rehabil*. 2006;9:185–189.
25. Lawson K, Bloom SR, Sadof M, et al. Care coordination for children with special health care needs: evaluation of a state experiment. *Matern Child Health J*. 2011;15:993–1000.
26. Hagan JF, Shaw JS, Duncan P, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 3rd ed. Elk Grove Village, Ill: American Academy of Pediatrics; 2008.