

## MHVI FY19 Access to Care

Home Visiting initiative		<b>Primary Drivers</b>	Secondary Drivers	Specific Ideas to Test
Aim Statement:  By September 1, 2019, the MHVI Connecting Home Visiting to the Health Care System Collaborative will increase the % of mothers and children who received recommended prenatal visits, postnatal visits, and well child visits in the past month from xx% to xx%.		PD1: Home visiting program has effective policies & procedures for tracking & monitoring prenatal, postpartum, & well-child care	<ol> <li>Home visiting program has policies and procedures to support early and often prenatal care</li> <li>Home visiting program has policies and procedures to support postpartum care as an ongoing process, versus a single, isolated visit</li> <li>Home visiting program has policies and procedures to support ongoing well-child, preventive healthcare</li> </ol>	<ul> <li>Develop a protocol for postpartum care planning and reproductive life planning w/ clients</li> <li>Develop and revisit postpartum care plans with mother and support revisions after birth</li> <li>Develop and revisit reproductive life plan (including desire for &amp; timing of any future pregnancies) with the mother</li> <li>Educate clients about the purpose of and what they can expect from prenatal, postpartum, and/or well-child visits</li> <li>Support clients in navigating barriers to accessing prenatal, postpartum, &amp; well-child visits, and they advocate for clients when needed</li> <li>Develop protocol to support families in accessing prenatal, postpartum, &amp; well-child care</li> <li>Support families in planning for and accessing prenatal, postpartum, and/or well-child preventative care</li> <li>Support mothers in scheduling and completing prenatal &amp; postpartum visits and/or families in scheduling &amp; completing well-child visits</li> <li>Support timely prenatal, postpartum, and/or well child visits by providing customized calendars w/ the schedule &amp; description of visits</li> <li>Use a reminder system for clients with upcoming prenatal, postpartum, and well-child visits</li> <li>Use a data collection process and system for capturing and tracking prenatal, postpartum, and well-child visits</li> <li>Support clients with accessing and maintaining continuous health insurance coverage</li> </ul>
	•	PD2: Home visitors have knowledge & support to connect clients to health care	<ol> <li>Home visitors understand prenatal, postpartum, and well-child visit recommendations &amp; schedules.</li> <li>Home visitors know how to keep track of clients' well-child visits.</li> <li>Home visitors know how to keep track of clients' prenatal and postpartum visits.</li> <li>Home visitors understand how to develop and support client with postpartum care plan and reproductive life plan</li> </ol>	<ul> <li>Provide training to home visitors on prenatal, postpartum, and well-child care</li> <li>Home visitors understand AAP Guidelines for well-child care</li> <li>Home visitors understand how to track prenatal, postpartum, and well-child visits</li> <li>Provide training to home visitors on postpartum care and reproductive life plans</li> <li>Home visitors are knowledgeable about OB and pediatric care providers in their community</li> <li>Provide training to home visitors on navigating the local healthcare system and barriers to accessing care</li> <li>Home visitors are knowledgeable about the signs and symptoms of trouble during postpartum period</li> <li>Educate home visitors on Medicaid coverage post pregnancy including coverage of birth control options (LARCs)</li> <li>Develop a protocol for prenatal, postpartum, and well-child care education that is consistently delivered by all home visitors, begins in the prenatal period, and includes ACOG &amp; AAP recommendations</li> </ul>
	•	PD3: Home visitors establish connections with prenatal/postpartum & pediatric care providers	<ol> <li>Home visitors establish &amp; maintain strong relationships between home visiting and prenatal and postpartum care providers</li> <li>Home visitors establish &amp; maintain strong relationship between home visiting and pediatric care providers</li> <li>Home visitors and providers establish clear communication pathways and closed loop referral systems</li> </ol>	<ul> <li>Distribute home visiting brochures/promotional materials to local prenatal and postpartum &amp; pediatric care providers practices</li> <li>Facilitate one-on-one introductory meetings with local health care providers</li> <li>Assign home visitors to specific provider offices to strengthen relationships and streamline exchange of information</li> <li>Use an inventory of local providers that can be made available to both caregivers and home visiting staff</li> <li>Hold 1-night home visiting event to educate providers on home visit practice</li> <li>Have a reference list for home visitor to use referring child to appropriate provider</li> <li>Create a document summarizing available local providers for home visitor to use when seeking care</li> <li>Develop a tracking sheet to track referrals to specific providers</li> <li>Maintain a referral tracking system to assure 'closed loop' (i.e. that caregiver makes appointment and that child receives care)</li> <li>Support clients in connecting with pediatric care providers prior to birth</li> <li>Promote connections to community resources, outreach, and education to support the value of the well-child visit</li> <li>Identify &amp; address barriers healthcare providers face when collaborating with home visiting programs</li> <li>Adapt procedures to the needs and preferences of specific providers</li> </ul>
	•	PD4: Home visiting program has agreements in place to share health information to support	<ol> <li>Home visiting program has policies and procedures in place for effective care coordination with healthcare providers</li> <li>Home visiting program maintains agreements to share health information with healthcare</li> </ol>	<ul> <li>Establish clear policies for exchanging referral information with healthcare providers that allow for closed loop referral processes</li> <li>Establish policies and procedures for sharing health information about clients with healthcare providers</li> <li>Create and implement Care Coordination Form (or similar) to gain client permission to access information from healthcare providers</li> <li>Orient home visitors to care coordination expectations and processes</li> <li>Educate clients about the importance of being able to share information between healthcare providers and home visiting program</li> </ul>

• Gain access to Michigan Care Improvement Registry and use the registry to understand client needs

providers at the agency and individual level

care coordination