Exploring Integration of a Home Visiting Public Health Nurse Into a Pediatric Medical Home

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Background

There is mounting evidence that home visiting programs can decrease health disparities; reduce hospitalizations and ED visits and increase access to care. Experts in pediatrics, public health and early childhood development have discussed the integration of home visiting nurses and the medical home to optimize communication, collaboration and continuity of care.

Purpose

The aim of this pilot quality improvement project was to explore a new model of care that enhances the pediatric medical home model by incorporating a home visiting Public Health Nurse (PHN) into the existing medical home team.

The goal is to improve client access to medical care and continuity of care between the clinic and the home.

Methods and Measures

"The PHN had time to listen to me. She called to check in with me."

Project Activities

- Established group norms, case load, team expectations and 8 month length for project.
- Met regularly for case conferencing and program discussion.
- Created safety education chart for coordination of education and messaging.
- Team members shadowed each other for a clear understanding of each others roles.

"You gain so much insight about the patient when doing a home visit. I wish I could do one home visit for my patients." MD after shadowing the PHN

Project Methods

- Chart review
- Patient interviews
- Employee focus group
- Theme analysis of meeting minutes

Participants

- 7 infants
- 6 mothers
- 5 languages spoken: English, Laotian, Amharic, Vietnamese, and Spanish
- First home visit occurred between 2 days to 20 days after birth
- All 7 infants are male
- 5 team members including; Pediatrician, Registered Nurse, Medical Assistant, Public Health Nurse, and Supervisor

Outcomes

Patient Perspective

- Received excellent care.
- PHN has more time for each visit so is able to educate and assist with care (breastfeeding).
- Appreciated infant weight checks at home so didn't have to take baby to clinic.
- Improved communication by having PHN available to assist with questions or follow-up.
- PHN was able to improve access to care through home visits prior to well child checkup.

Team Perspective

Strengths

- Patient access to medical appointments and follow-up from appointments was improved with PHN home visiting.
- Decreased duplication of services.
- Improved all providers community resources knowledge.
- Improved ability to contact client by PHN's understanding of living environment.
- PHN's home visit prevented unnecessary office visits and/or significant health issues were identified (financial benefit).
- PHN/MD overcame communication barriers by establishing texting as the optimal communication tool for urgent/time sensitive issues.

Barriers

- Different electronic health records created barriers to continuity of care.
- Trust between team members needs to be established which takes time and energy.
- Offices in different locations creates communication barriers.

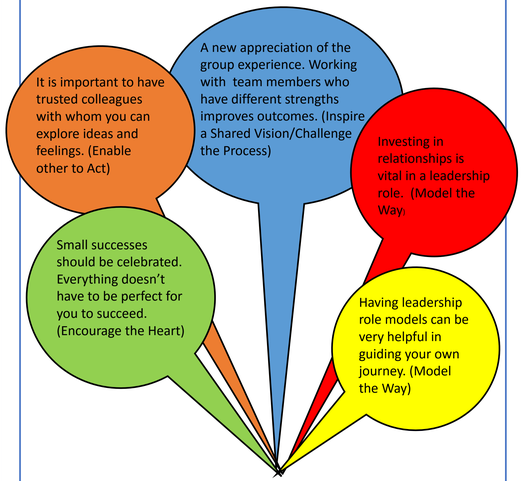
Discussion

- Developing trust between team members was a critical element for success in this project and not found in the literature review.
- A home visiting nurse who had time to listen was a key finding for patient/family satisfaction. This finding was not identified in any of the literature reviews of similar teams.
- Expansion of the team with a PHN increases access to the right care, creativity to care and improved time efficiencies.
- Strength based approach by PHN impacted confidence in parent decision making skills.

Next Steps

- Expand model to other providers within office and other community partner sites.
- Orient medical residents to PHN home visiting through shadowing experience.
- Plan shadowing for all team members to all roles.
- Request "view only" access to Electronic Health Record for partnering organizations.

STTI MCH Leadership Journey



Lessons Learned

References

Shah, P. E. (2010). Maximizing Partnerships With Parents and Pediatricians; The Role of Early Childhood Specialists; *Zero to Three, 30,* 29-35.

Tschudy, M. M., Toomey, S. L., & Cheng, T. L. (2013). Merging Systems: Integrating Home Visitation and the Family-Centered Medical Home. *Pediatrics*, Volume 132, S74-S81.

Willis, D. W. (2013). Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV); Building Health and Early Development with the Pediatric Family-Centered Medical Home. *Zero to Three, 34,* 51-58.

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