

From Medical Home to Health Neighborhood: Transforming the Medical Home into a Community-Based Health Neighborhood

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Social Determinants and the Medical Home

Social issues such as poor housing conditions, homelessness, and food insecurity powerfully shape children's development and physical well-being¹⁻⁸ and contribute to the physiological and psychological stress that can harm health throughout the life course.⁹ The American Academy of Pediatrics' medical home model promotes primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective.¹⁰ Less discussed, but critical for addressing social determinants of health, is the American Academy of Pediatrics' recognition that the medical home also includes "interaction with early intervention programs, schools, early childhood education and child care programs, and other public and private community agencies to be certain that the special needs of the child and family are addressed."¹⁰ We believe that effectively addressing families' unmet social needs will require much greater attention to developing connections between the medical home and community-based services. Although this approach is not new and is embedded in the Community Health Center movement and other initiatives, such as the collaborative mental health care model,¹¹ health care reform, with its emphasis on linking outcomes with payment, provides a timely opportunity to create a more effective, integrated health services system.

To date, suggested refinements to the medical home model include the concepts of a "health home" to promote community-oriented care and a "medical neighborhood" to better coordinate care in various healthcare providers.^{12,13} However, a gap still exists as to how best to connect the medical home with community-based services.

A Health Neighborhood Service System

We recommend a "health neighborhood," to include community-based, non-medical services that promote the health of patients and families. Developing a high-performance health neighborhood will require these components: identification of basic needs and facilitation of referrals, care coordination, co-location, and centralization of services.

ACOs Accountable care organizations

Identifying Basic Needs and Facilitating Referrals at Pediatric Visits

Currently, basic needs of families too often go unidentified,^{14,15} and providers often struggle to connect patients to community-based resources.¹⁶ Universal screening for basic needs at low-income children's health supervision visits should be adopted. To ensure efficiency, screening can be performed before the visit, or screening questions can be incorporated in the health record for use.^{17,18}

Identification of needs should be closely linked to referrals to available community-based services. Referrals for basic needs should be similar to referrals for subspecialty consultation and include transfer of information and accountability.¹⁹ The concept of virtual specialty consultations (ie, e-consults),²⁰ typically involving electronic communication of medical information between physicians,²¹ could be adapted for the referral of high-risk families to community agencies. Two-way informed consent for information transfer between the primary care practice and community agency may facilitate this process. Innovative practice-based models that promote screening and facilitate referrals within an integrated referral system should be implemented in medical homes.²² Measuring successful referrals and developing quality improvement activities are likely necessary to develop an effective service system.

Care Coordination

Care coordination is necessary to improve families' access to services in the community and facilitate communication.²³ We suggest that a patient navigator,²⁴ an expert in local resources who is primarily responsible for assisting families in contacting resources, coordinating services, and, when necessary, helping families' submit applications (eg, Women, Infants, Children Program enrollment, unemployment benefits, Section 8 vouchers), who is based in the medical home may be helpful. This type of approach can improve

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Editor's Note: H. Dele Davies, M.D., MSc (Michigan State University), served as Guest Editor for this report. The authors declare no conflicts of interest.

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enrollment of children in such services as Head Start programs.²⁵ A “transitions of care” coordinator could also maintain registries of the highest-risk children to ensure that successful links to services are accomplished.

Co-location of Services

Many child health clinics have social workers, Women, Infants, Children Program nutritionists, and behavioral health clinicians on site.²⁶ More recently, legal services (ie, Medical-Legal Partnership) have been embedded within the health care setting to address the legal needs of families.¹⁸ Co-location leads to greater patient satisfaction and more appropriate use of services.²⁶⁻²⁸ Opportunities exist to expand the types of community-based services and public health interventions offered on site to improve families’ access, communication, and coordination.

Centralized Community Services

Barriers of time, transportation, paperwork, and access prevent many families from using services. A centralized, coordinated, local or state-wide infrastructure with a universal point of access to services is needed. Help Me Grow, a state-wide program in Connecticut that is currently being replicated in other states, has proven to be effective at linking children at risk for developmental and behavioral problems and their families to community-based programs through a centralized access point via a Child Development Infoline.^{29,30}

Financial Incentives

Innovative reimbursement strategies are necessary for a health neighborhood to come to fruition. To date, some state Medicaid programs, such as Community Care of North Carolina,³¹ have demonstrated the beneficial impact an integrated care model that emphasizes care coordination can have on both health and fiscal outcomes. Accountable care organizations (ACOs) provide a special and new opportunity for enhancing access to community-based services. Within ACOs, funding could be directed to pay for not only care coordination, but also for the co-location of services. ACOs will emphasize population health and high-value care, which means that spending money to address social issues in an effort to reduce illness will likely be necessary for the system to prosper.¹⁹ The return on investment of such strategies (eg, reduced hospitalization and emergency department visits) could be critical outcomes for ACO evaluation.

In this era of health care reform, we believe that a unique opportunity exists to ameliorate the social determinants of health by expanding the medical home, in full partnership with community-based resources, to a “health neighborhood.” ■

We would like to thank Michael Silverstein MD, MPH, and Priya Sinha Garg, MD, for their feedback and comments on the manuscript draft.

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