

# Communication Between Key Stakeholders Within a Medical Home: A Qualitative Study

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The objective of this study was to determine perceived benefits, detriments, and barriers to communication between pediatric providers and home visitors. The authors performed a cross-sectional, qualitative study consisting of 3 focus groups with paraprofessional home visitors ( $n = 12$ ), 6 with parents receiving home visiting ( $n = 33$ ), and 4 with pediatric providers whose patients received home visiting ( $n = 19$ ). Emerging themes were generated by an inductive analytic approach. Perceived benefits included home visitors assisting parents with communication, giving providers family information, and reinforcing providers' guidance.

Detriments included parental concern of sharing confidential information and providers becoming aware of family issues for which they are unprepared to act. Barriers included parental consent, logistics of home visitor-provider communication, and providers' lack of knowledge about home visitor programs/roles. Greater coordination between home visitation programs and pediatric providers may strengthen home visiting services and reinforce advice and anticipatory guidance given by providers.

**Keywords:** home visitors; communication; medical home

The medical home is the centerpiece of pediatric primary care and consists of accessible, family-centered, comprehensive, continuous, coordinated, culturally effective, and compassionate care.<sup>1</sup> The medical home concept is relevant for children with special health care needs, including children with environmental, social, and economic risk factors, such as poverty and poor social support.<sup>2,3</sup>

Home visitation programs for impoverished families, developed more than 100 years ago, have similar

goals as pediatric primary care, to promote the health and development of children<sup>4-6</sup> and to develop a longitudinal, trusting relationship with parents.<sup>7-9</sup> Home visitation program models involve regular home visits by a paraprofessional or nurse/social worker. Paraprofessionals are lay individuals who receive training and work under professional supervision,<sup>10</sup> and community health workers (CHWs) have become increasingly used as the overarching label for these frontline health workers.

To provide optimal care to children and families within the medical home, pediatric primary care providers (PCPs) need to partner with community agencies and resources,<sup>11-14</sup> such as home visitation programs. One barrier to quality care is inadequate communication and coordination with these CHWs.<sup>15</sup> Whereas no studies to our knowledge have examined pediatric PCP and home visitor (HV) communication, several studies have examined pediatric PCP and subspecialist communication<sup>16-18</sup> within the medical home. Pediatric PCPs and subspecialists feel that improved intercommunication would allow the provision of more timely patient care, enhance parent

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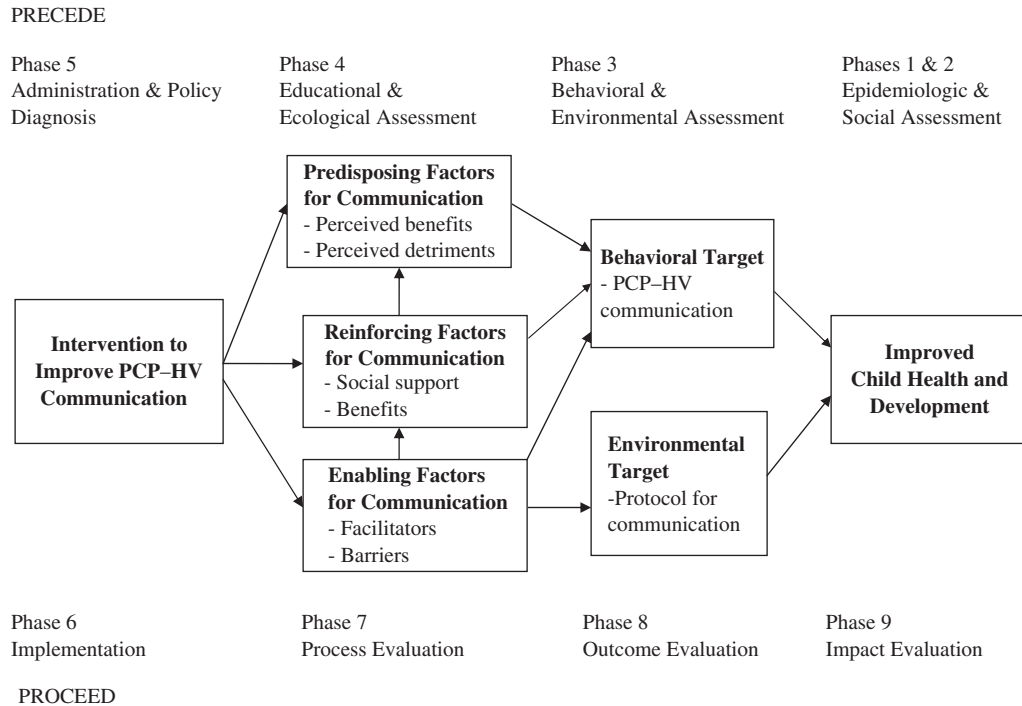


Figure 1. Adapted from PRECEDE–PROCEED planning model.<sup>19</sup>

understanding and comfort,<sup>17</sup> and enhance their ability to provide optimal patient care.<sup>16</sup> However, when parents are intermediaries in communication between PCP and subspecialists, both physicians and parents feel uncomfortable with this role.<sup>18</sup>

The American Academy of Pediatrics has suggested that partnership and communication between paraprofessional HV and pediatric PCP could improve care and strengthen support provided to families.<sup>5</sup> As we are aware of no studies examining this, we chose to study the following objectives: (a) to determine the perceived benefits and detriments of communication between pediatric PCPs and HVs and (b) to determine the methods of and barriers to communication.

## Methods

### Study Design

We used the PRECEDE–PROCEED planning model<sup>19</sup> as a framework for our study (Figure 1). This study concentrated on the educational and ecological assessment phase of this model. To capture

viewpoints of multiple stakeholders on this complex topic, we employed a qualitative approach.<sup>20,21</sup>

This cross-sectional, community-based qualitative study consisted of separate focus groups with 3 key stakeholders to elicit their perspectives on communication: (a) HVs and their program supervisors, (b) parents who received home visiting from these HVs, and (c) the pediatric PCPs of the home visited families.

### Study Community and Participants

East Baltimore, the site of the study, is an impoverished, urban community.<sup>22-24</sup> Healthy Start East is the agency that provides paraprofessional home visitation in East Baltimore and uses the national Healthy Start home visitation model.<sup>25</sup> Inclusion criteria for voluntary family enrollment included any expectant mother and mothers with children less than 6 months of age who live in the 16 census tracts served by the agency. Recruitment occurred through comprehensive, door-to-door canvassing and referrals to Healthy Start by outside agencies and providers, such as social workers in obstetric clinics, newborn nurseries, or neonatal intensive care units.

## Recruitment

*Home visitors.* The 10 HVs and 3 program supervisors employed by Healthy Start at the time of the study were invited by letter to participate in focus groups. Two focus groups were held with 9 HVs and 1 focus group was held with 3 program supervisors at the Healthy Start office in July 2004.

*Parents.* Parents receiving home visiting services from participating HVs were recruited for the study. A total of 362 families were enrolled at the time this study began (G. Hicks, personal communication, July 9, 2004). HVs distributed written invitations for focus groups during their home visits with families. Thirty-three parents participated in 6 focus groups that were held at the Healthy Start office from August to November 2004.

*Pediatric primary care providers.* At the end of each parent focus group, parents completed a brief exit survey that included the name of their child's PCP. The principal investigator (CSN) called the pediatric offices of providers who had at least 2 patients actively receiving home visiting services from Healthy Start and invited all members of the medical home with whom a HV might have contact or communication to participate in a focus group. This included physicians, nurses, social workers, and office staff. We conducted 4 focus groups with 19 participants (16 providers and 3 office staff; Table 1), and the focus groups were held at the participants' individual practices from November 2004 to January 2005. In summary, we conducted 13 focus groups with a total of 64 participants (Table 1).

Focus groups were conducted until thematic saturation was reached as determined by the consensus of the study team. HVs received \$10 grocery store gift cards, parents received \$30 cash, and providers received \$10 cash, and food was served for all. Transportation and child care were provided for parents by the Healthy Start program.

## Data Collection Procedures

A topic guide was developed by the study team to lead discussion in each focus group (Table 2). The same topic guide was used for all key stakeholder focus groups with slight wording variations and was piloted with 3 mothers from the East Baltimore community prior to use.

**Table 1.** Characteristics of Focus Groups

Paraprofessional home visitors (N = 12)	
Duration employed by program (years), mean (range)	4.6 (0.04-10)
Female, n (%)	12 (100)
Ethnicity, n (%)	
Black	12 (100)
Parents (N = 33)	
Age (years), mean (range)	25 (17-44)
Duration program enrollment (months), mean (range)	17 (3-132)
Number of children, mean (range)	2 (0-7)
Currently pregnant, n (%)	7 (21)
Ethnicity, n (%)	
Black	31 (94)
Latino	2 (6)
Pediatric primary care providers (N = 19)	
Duration provider in Baltimore City (years), mean (range)	11.5 (1.5-35)
Patients in practice site receiving public medical assistance, % (range)	80 (70-85)
Type of provider, n (%)	
Pediatrician	14 (74)
Social worker	2 (10)
Pediatric nurse practitioner	1 (5)
Nurse	1 (5)
Pediatric resident	1 (5)
Ethnicity, n (%)	
Black	5 (26)
White	12 (63)
Asian	2 (11)

Focus groups were moderated by the principal investigator using accepted techniques.<sup>26</sup> A research assistant was present at HV and parent focus groups to assist with audio-recording and to take notes. At the end of each focus group, member checking was performed by summarizing the discussion orally to the participants based on notes taken during each session. If any member disagreed with the content clarification, corrections were obtained. All focus groups were digitally audio-recorded and transcribed verbatim by a research assistant. To promote accuracy and completeness of transcripts, each transcribed focus group was subsequently checked by the principal investigator by listening to the audiotapes, comparing it with the transcript, and revising the transcript if needed based on her comparison.

The Johns Hopkins School of Medicine Institutional Review Board approved the study, and all participants provided written informed consent.

**Table 2.** Focus Group Topic Guide

Topic	Specific Focus Group Question <sup>a</sup>
Past experiences, challenges, and barriers to communication	Think about your child's primary care doctor. Do you think your child's primary care doctor knows that you are receiving home visiting from this program? Do you know if your home visitor and your child's primary care doctor have ever communicated with each other?
Content of communication	What is your opinion about them sharing information? To improve children's health, what information do you think home visitors <i>should give</i> children's primary care doctors? To improve children's health, what information do you think children's primary care doctors should give home visitors?
Methods of communication	In your opinion, is there any information that home visitors should not give primary care providers? Why? In your opinion, is there any information that primary care providers should not give home visitors? Why? How do you think home visitors and children's primary care doctors should communicate with each other?

a. Wording for parent focus group questions are shown. For home visitors, wording was changed to obtain their perspectives on communication with pediatric providers. For pediatric providers, wording was changed to obtain their perspectives on communication with paraprofessional home visitor.

## Data Analysis

Focus group transcripts were analyzed using an inductive analytic approach.<sup>27</sup> The principal investigator (CSN) and one of the coinvestigators (JRS) reviewed the transcripts and created a codebook that listed code names and operational definitions of each code. The codebook, containing 69 codes, was reviewed for clarity by another coinvestigator (SDT). Two research assistants, who were not involved in study design and data collection, independently coded transcripts using the codebook developed by the study investigators. Initially, each research assistant independently coded transcripts of 1 HV, 1 parent, and 1 provider. Interrater reliability for each of these transcripts was calculated and found to have a Cohen's  $\kappa$  of  $>.70$  for each transcript, demonstrating good interrater reliability of the coding process.<sup>28,29</sup> Once this was established, the research assistants subsequently independently coded the 10 remaining transcripts (each coding 5 transcripts).

Descriptive statistics of demographic data were calculated using SPSS, version 11.0.

## Results

Three thematic domains emerged from key stakeholders regarding communication between HV and pediatric PCP: (a) perceived benefits of communication,

(b) perceived detriments of communication, and (c) barriers to communication. Table 3 lists the themes in each domain and indicates the stakeholder focus groups in which they were presented.

### Benefits of Communication

Themes and sample quotes from focus group participants are described in Table 4. All stakeholder groups felt that HV involvement with parents during or prior to office visits with the PCP could improve communication between parent and PCP (benefit theme 1). Parents expressed that HVs could be particularly helpful when there is a disagreement between parent and PCP, when parents are having trouble communicating with PCPs by telephone about health problems or making appointments, and when parents expressed low self-efficacy for communicating with the PCP or interpreting what the PCP is saying.

All stakeholder groups felt that HVs could give PCPs important information about families' lives (benefit theme 2). Examples included sharing information about the home environment (including physical environment and safety issues, family structure, evidence of substance abuse, family violence, child abuse), family health, child behavior at home, and specifically about the well-being of children who have missed office visits. Parents expressed that

**Table 3.** Domains and Themes Articulated by Stakeholder Groups

Domains	Themes	View of Key Stakeholder Groups		
		Home Visitors	Parents	Pediatric Providers
Benefits of communication	1. HVs could assist parents in communicating with PCPs	×	×	×
	2. HVs could give PCPs information about families	×	×	×
	3. HVs could learn and reinforce the specific advice and anticipatory guidance that PCPs give families	×	×	×
	4. HVs could learn about children's health and families	×	×	
	5. HVs could help parents understand about children's health	×	×	
	6. HVs could verify information that parents say is from PCPs	×		
Detriments of communication	7. Parents may not want confidential information communicated to PCP or HV; loss of trust with provider or HV with communication	×	×	×
	8. PCPs may become aware of family issues for which they are unprepared to act			×
Barriers to communication	9. PCPs and HVs need to obtain consent from parents for communication	×	×	×
	10. Communication between PCPs and HVs may waste time, be disruptive, or be difficult to achieve	×		×
	11. PCPs do not know about home visitation program and role of HV		×	

Note: HV = home visitor; PCP = primary care provider.

they wanted HVs to share this information with PCPs so that PCPs would then refer them to appropriate services.

All stakeholders felt that HVs should reinforce the advice and anticipatory guidance that providers give families during office visits (benefit theme 3). PCPs discussed how HVs could help parents implement guidance, such as demonstrate positive reinforcement with discipline or portion sizes for meals.

Parents and HVs thought that HVs could learn about children's health and family from PCPs (benefit theme 4). Some parents expressed difficulty explaining their children's health conditions and treatment to HVs and felt that HVs would better understand if told directly by medical providers.

HVs and parents thought that HVs could help parents better understand their children's health problems (benefit theme 5). HVs gave examples of reinforcing health information that PCPs give parents and using their longitudinal relationship with parents to do so. Parents noted that HVs could help parents identify symptoms of illness that occur at home.

HVs felt that communication with PCPs could verify information that parents tell them the doctor said (benefit theme 6). HVs discussed situations when parents tell them either there are no concerns with their child or that the PCP gave them guidance that HVs feel may be harmful to the child

or may have been misunderstood by parents. They expressed a desire to directly verify this information with PCPs.

### Detriments of Communication

Although there was general support among participants for communication, as discussion in focus groups deepened, perceived detriments of communication were identified (Table 4).

All stakeholders discussed that parents may not want confidential information communicated to either the PCP or the HV and that this disclosure could affect parents' trust in either the HV or the PCP (detriment theme 7). PCPs wondered whether information about families would remain confidential with HVs who are generally from the parents' community. Parents expressed concerns about information being shared from HV to PCP and from PCP to HV, suggesting that some parents have a stronger relationship with and therefore may trust one more than the other. PCPs discussed concerns about HVs keeping information confidential, but this concern was not raised by parents or HVs.

PCPs expressed concern that they may become aware of information through communication with the HV for which they are unprepared to act, that is, parental substance use (detriment theme 8).

**Table 4.** Themes and Quotes

Stakeholder	Sample Quotes
<b>Benefit theme 1: HVs could assist parents in communicating with providers</b>	
Home visitor	“If the parent has a medical concern, we could either communicate to the provider for them or encourage the parent to do it themselves.”
Parent	“I think they [home visitors and pediatric providers] should communicate because maybe they [home visitors] can talk to the doctors better than we could. You know the doctors will probably understand them instead of, well we have a problem with one of our kids and we go to the doctor they might take it the wrong way . . . But if we got somebody like [the home visitor] that on our side maybe they [providers] will listen to them much better. Because I mean because sometimes you get hard ways to go with these doctors.”
Provider	“They [home visitors] could also interpret later, what we have said that may not have [been] fully absorbed.”
<b>Benefit theme 2: HVs could give providers information about families</b>	
Home visitor	“Their environment sometimes has a lot to do with their . . . health risks . . . child may have asthma . . . they might have a lot of dust, dirt, rugs. You know, anything could be a health risk or a health hazard to the asthmatic child.”
Home visitor	“I would let . . . the physician know that she [mother] has a substance abuse problem. You know doctors may have a better chance of getting her in the door somewhere quicker [for substance abuse treatment] than me giving her a referral.”
Parent	“If they [providers] knew about family violence [because home visitor told provider], and it was affecting the child . . . they might could get (sic) him into counseling . . . or try to get them out of the situation.”
Provider	“I guess information that this is an at-risk family that they are dealing with . . . if they are seeing that it is a chaotic environment, if they are seeing signs of domestic violence, things that are not going to be easily revealed at a pediatric visit.”
Provider	“If there is any concern that they [home visitors] have with safety of the child . . . Identify that this kid may be at risk for abuse or neglect or poor nutrition . . . it would be nice to know if there is something you should be concerned about.”
<b>Benefit theme 3: HVs could learn and reinforce the specific advice and anticipatory guidance that providers give families</b>	
Home visitor	“It helped [accompanying a family to a provider visit] . . . It helped me to you know if the situation ever come up again then I would know what to say to the client.”
Parent	“The advocate [home visitor] calls the doctor and gives the doctor questions about that situation and then the doctor gives the advocate, you know what she should, what she should know . . . The advocate does her job and tells me, you know put it into detail what I should do.”
Provider	“I think that one of the things I come up against all the time . . . is that families . . . of infants . . . are not making formula correctly. So, it would be very helpful for me to speak to someone else who is in the home so I could review with them so I would be sure that they would understand how to mix it up so that I would know the infant is getting the correct mixture.”
Provider	“It [home visitor escorting parent to doctor’s visit] provides another set of ears that can have the same information that you give and can lead to reinforcement with the medication doses and safety information. If the family is comfortable with that, I think it is a wonderful idea if they are going to have a proponent that works with the family and it works both ways they can bring information to the family.”
<b>Benefit theme 4: HVs could learn about children’s health and families</b>	
Home visitor	“They [provider] told me [that] my client had a history of depression after she had the baby.”
Parent	“I think that my doctor, my children’s doctor, and my advocate [home visitor] should talk because my son, he’s three, and he’s just learning to walk because he was born early, and my advocate don’t know that . . . there’s certain different health problems that the advocate don’t know so . . . it would help if they would talk because she don’t know what’s up with the children.”
<b>Benefit theme 5: HVs could help parents understand about children’s health</b>	
Home visitor	“Over the course of the parent being a participant in the program we were able to develop a pretty good relationship with the pediatrician to get the information and pretty much help the parent understand the challenges that her child was facing.”
Parent	“Yeah, you’ll [home visitor] have more information on like symptoms . . . you tell the doctor about.”

*(continued)*

**Table 4.** (continued)

Stakeholder	Sample Quotes
<b>Benefit theme 6: HVs could verify information that parents say is from providers</b>	
Home visitor	"I'm going to call the doctor anyway when I get back to the center just to verify because they [parents] will tell you anything so if its something like I think its going to do some kind of harm to the baby [I will call doctor]."
<b>Detriment theme 7: Parents may not want confidential information communicated to provider or HV</b>	
Home visitor	"A lot of our clients don't want them [providers] to know and they only confide in us because they see us and if we was (sic) to ever tell it then they won't be confiding in us anymore because we put it out there."
Parent	"The advocate [home visitor] should not give the doctor stuff that you tell them . . . because you might confide in them."
Parent	"You're still putting all my medical information out there . . . All your information . . . You wouldn't want somebody just letting people know your business."
Parent	"The provider or the doctor like once again I'll say if you done sat there and confided in something with the doctor that you don't want everybody to know then, no, you [provider] don't run back and tell the home visitor nothing like that."
Provider	"I mean, I would want to know confidentiality issues. I want to know . . . I mean these are people in the community . . . there is that risk of, I assume, that people [home visitors and parents] are matched . . . [and are] not relatives, not knowing each other, but this is a relatively small community. We always have families meeting each other in the halls saying 'what are you here for?' So I would be worried about the gossip and lack of confidentiality for some of the relatively sensitive information."
Provider	"Would communications from these home visitors be appropriate for the medical record? When it is communicated to the physician, is that going to compromise the relationship if they request records or that sort of stuff?"
<b>Detriment theme 8: Providers may become aware of family issues for which they are unprepared to act</b>	
Provider	"You [home visitor] are the agency out in the home. You identify substance abuse, you should not give that information to someone [pediatric provider] who isn't really an expert in that in terms that they may or may not do anything."
<b>Barrier theme 9: Providers and HVs need to obtain consent from parents for communication</b>	
Home visitor	"Actually we can't call the pediatrician and get information unless we fax over a pediatric release form they won't give us information so even if they ask us basically we would have to go to the client [parent]."
Parent	"I think that I do have a right to know exactly what type of information they [home visitors and providers] would be sharing with anybody."
Provider	"If you're going to do this, you need the consent of the parent. Those that need the (sic) most help are probably not going to consent."
<b>Barrier theme 10: Communication between providers and HVs may waste time, be disruptive, or be difficult to achieve</b>	
Home visitor	"Most of the time the professional staff [providers] they're just not readily available to us . . . it was a struggle . . . a difficulty getting to know the pediatricians you know because they aren't readily available."
Provider	"And we are busy so we don't just want to be disrupted in the midst of patient visits."
<b>Barrier theme 11: Providers do not know about home visitation program and role of HV</b>	
Provider	"I'm not really sure what . . . why we would have to communicate . . . not really sure what they [home visitors] have to offer."
Provider	"I think the problem is that these are laypeople and to ask them to give us feedback about anything of a clinical nature is inappropriate . . . I think judging the home environment is dependent upon the skill of the person doing the judging. How much training they've had and how well they are able to judge, for example, the safety."

Note: HV = home visitor.

## Barriers to Communication

All stakeholder groups felt that HVs and PCPs need to obtain signed parental consent prior to communicating and sharing information with one another (barrier theme 9, Table 4). PCPs felt the need to follow Health Insurance and Portability and Accountability Act regulations.

Both PCPs and HVs felt that communication may be disruptive, waste of time, or be difficult to achieve (barrier theme 10). Both HVs and PCPs expressed that PCPs are difficult to reach and that contacting them would disrupt their time with patients. HVs felt that their own caseloads and job duties may limit their ability to contact PCPs.

PCPs discussed that they were not knowledgeable about the home visitation program, unsure what role the HV could play in promoting child and family health (barrier theme 11), expressed concern over the adequacy of HV training, and whether HVs would understand medical conditions and be able to assess child well-being in the home environment. Table 3 displays similarities and differences of themes among stakeholders.

## Discussion

This is the first study, to our knowledge, to elicit perspectives of HVs, home visited parents, and pediatric PCPs on communication between HVs and PCPs. The strengths include the use of qualitative methods to obtain a detailed understanding of these 3 stakeholder groups' perspectives. To improve the reliability and validity of our qualitative approach, we conducted member checking, used multiple coders, and established interrater reliability of the coding process.

We found that all 3 stakeholder groups support communication between HVs and PCPs to improve parent–provider communication and to share information about children's health. However, each stakeholder group also highlighted detriments and barriers to communication. Although most emerging themes were endorsed by all 3 stakeholder groups, there were also notable differences in the endorsement of themes.

Many community-based interventions have increasingly relied on CHWs to work collaboratively with health professionals to promote health outcomes for both adult and pediatric patients, including improved detection of breast and cervical cancer,

hypertension control, timely childhood immunizations, smoking cessation, and use of child mental health services.<sup>10</sup> Although paraprofessional home visiting programs, such as Healthy Start, specify the importance of communicating with health professionals such as PCPs,<sup>25</sup> we are unaware of previous research examining whether and how this communication occurs. A randomized controlled trial examined emergency department personnel's communication with lay home health visitors about emergency room visits for child injuries.<sup>30</sup> Informing HVs about child injuries was associated with more home visits after the information about the injuries was obtained, although the study investigators did not investigate the impact of these postinjury home visits on future child outcomes.

Communication between PCPs and HVs also requires that PCPs are aware of such programs and embrace the concept of collaboration. Our findings suggest that PCPs need to be informed when their patients are participating in these programs and increase their awareness of what services are provided and the contributions of home visiting programs. Recent policy statements by the American Academy of Pediatrics recommend that PCPs practice community pediatrics by becoming involved with and referring patients to community services and family support programs.<sup>12,13</sup>

A recent survey of pediatric residency program directors found that nearly half of residency programs required training in working at home visiting programs.<sup>31</sup> Although such training likely facilitates pediatric providers' awareness and understanding of home visiting programs, the extent to which this training promotes communication is unclear. Our results are similar to a qualitative study by Stille et al,<sup>17</sup> who found that common barriers to pediatric PCP–subspecialist communication included the method and timing of communication, inadequate content of communication, and organizational/systems issues.

Our finding that parents experience problems communicating with PCPs adds to a growing literature on disparities in patient–provider communication. Considerable research has shown that physicians engage in less total and less informative communication with patients of lower socioeconomic status when compared with patients from higher social classes.<sup>32,33</sup> Our finding that home visited parents had difficulty understanding what providers say to them and communicating concerns to providers may be a

function of providers' low expectations for what parents can understand about their child's health. Future interventions need to address this.

### Study Implications

We believe there are several implications for future research and practice. First, better relationships need to be established between home visiting programs and pediatric PCPs. Both stakeholder groups need to become better informed about the other and also be more confident that their families' needs can be helped by the other stakeholder group.

Second, HVs and pediatric PCPs need to establish specific methods for communicating with one another about the families they mutually serve. These methods must be feasible to both stakeholder groups, easily integrated into existing protocols, and not time consuming. One potential approach would be to have HVs contact the pediatric PCP when a family enters a home visiting program. For pregnant women, this could serve as an opportunity to link a family with a medical home for their soon to be born infant. A preferred method of and desired frequency of communication could be established a priori (eg, e-mail, phone, fax). This approach is consistent with the description of Cooley and McAllister<sup>34</sup> of a community-based medical home, in which medical providers coordinate relationships with early intervention programs such as home visiting programs.

Third, we recommend that home visiting programs incorporate in their goals the preparation of parents for upcoming pediatric appointments. Because our study findings showed that many parents do not feel comfortable asking their pediatrician questions about their child's health, we believe that the preparation of families for upcoming pediatric appointments is an important role for HVs to undertake. For HVs to coach families in this preparation, they will need training as well as ongoing guidance from their supervisors. Training could be conducted by pediatric residents or postdoctoral fellows, thereby increasing pediatric trainees' exposure to home visiting programs. Hardy and Streett<sup>35</sup> demonstrated the effectiveness of a similar model of linking HVs and pediatric PCPs, as home visits conducted 2 to 3 weeks before well child visits were associated with fewer missed well child visits, fewer sick or acute care visits, and decreased hospitalization, neglect, and abuse.

Fourth, we recommend that home visiting consent forms include consent for sharing of child and family information with the child's PCP. In Baltimore City, such language is being adopted to facilitate home visiting programs' communication with prenatal clinics and pediatric, mental health, and social services providers.

There are several study limitations that must be considered. This study involves a single community, so findings may not be generalized to other settings. Because our study enrolled parents who were actively receiving home visiting services, the most at-risk families who refuse services or who may be difficult to retain in home visitation were not included. Parents who volunteered to participate may represent either those parents who are most satisfied with the home visitation program or, conversely, those who were less satisfied and thus wanted to have their opinions noted. The lack of endorsement for a particular theme may have been influenced by varied levels of discussion across focus groups. Although each stakeholder group discussed the same overarching set of questions, probing questions varied across focus groups and certain themes may have surfaced among certain stakeholder groups.

### Conclusions

Recent years have seen a rapid growth in the number of paraprofessional home visitation programs. This study suggests that home visiting programs and health care providers may not be taking full advantage of each other as a resource. Greater coordination between home visitation programs and pediatric PCPs may simultaneously enhance home visiting program effectiveness and may help reinforce advice and anticipatory guidance given by pediatric providers. Future research should build on these findings to understand how to promote HV-PCP collaboration, best communication practices, and to examine the effectiveness of such collaborations in promoting maternal and child health and true establishment of the medical home.

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