Community Clinical Systems Integration Initiative – Home Visiting

Statement of Problem

A growing body of research links social and environmental factors facing communities directly to a multitude of health inequities. Fragmented and siloed community supports and health delivery systems further complicate and add to the complexities that families face when navigating services. Integrating health care with that of community maternal and child home visiting services is a promising strategy to re-envision preventive care in a way that holistically and intentionally approaches a family's care and improves health outcomes across diverse populations. The benefits of evidence-based home visiting have been well-documented and include improvements in parenting approaches, family well-being, preventive health care engagement and connection to social resources.

Despite increasing interest by policymakers in deploying home visiting solutions for families of young children, realizing the maximum potential of these services requires systems-level change to bridge these community-based preventive services with care provided in a clinical setting. While a call for uniting these services has been raised by maternal and child health leadership, actual efforts to meaningfully re-envision service delivery to communities have been limited.

Description

Effective equity-focused population health strategies must include a response to social determinants of health while meaningfully connecting health systems to community services. In 2018, with the generous support of the Vanguard Strong Start for Kids initiative, PolicyLab developed and began to pilot Community Clinical Systems Integration (CCSI), an initiative recognizing that current fragmentation contributes not only to system inefficiencies but, more importantly, structural barriers to the receipt of quality, trusted care for families across all family-serving systems.

We launched the CCSI home visiting integration strategy—a model that utilizes evidence-based nurse-led home visiting services as part of the clinical care team—within Children's Hospital of Philadelphia's (CHOP) pediatric primary care network. The goal of this strategy is to create a transformative, sustainable model that centers public health nurse home visitors as a bridge between preventive care delivery systems in home and clinical settings using a shared staffing model.

By identifying areas of alignment between providers, our efforts aim to improve patient care by creating consistent communication between the nurse home visitor, families and the child's pediatric provider. Through the intentional integration of these services, we seek to create efficiencies and reduce burden, enhance coordination of care for patients, improve the sustainability of quality services and, most importantly, improve health outcomes for families served.

Early implementation of this strategy reveals that a stronger, more coordinated care team that extends the health system's reach into the communities it serves offers tremendous opportunity to move the needle on

complex public health issues. Over the last few years, CCSI has:

- built a strong business model that maintains a home visitor's employment with their community-based organization, ensuring replicability across health systems and community-based providers
- integrated nurse home visitor documentation of critical points of care delivered into the patient's electronic health care record
- conducted a robust evaluation of these efforts

Preliminary research findings underscore the value of team-based care with impacts on patient outcomes such as well-child visit adherence and immunization compliance as well as patient and provider satisfaction.

Next Steps

While we have experienced considerable progress, full integration of home visitor care within the clinical care setting rests on the ability to avoid duplicative services and reallocate resources in ways that provide the best care for families. CCSI continues to work towards the creation of an uninterrupted primary care experience for families with fluid communication between all parties (including the patient), as well as aligned billing, documentation, finances and workflows.

As we continue to develop this integrated model of care, we aim to:

- Continue to refine the staffing model shared between family home visiting programs and pediatric primary care and expand to a second community-based provider to serve more children in the Philadelphia community.
- Improve efficiencies in documentation and communication workflows to enhance patient and provider experience and outcomes.
- Continue to evaluate the incremental value of this integrated staffing model on child health outcomes and utilization.
- Disseminate research findings and best practice recommendations for home visitor integration of community practice and primary care.
- Collaborate with other health systems to identify opportunities that support replication of the model beyond one health system.
- Investigate and develop a financial model that generates a sustainable path for CCSI efforts.

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A Qualitative Exploration of Co-location as an Intervention to Strengthen Home Visiting Implementation in Addressing Maternal Child Health
Article
Feb 2018

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Nov 14, 2024

Effective Expansion and Sustainability of Home Visiting Services Requires Integration Across Systems
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Mar 28, 2022

Meeting Families Where They Are: Child Care Navigation Supports Through Primary Care
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Pennsylvania Department of Human Services Request for Public Comment: Subsidized Child Care Eligibility Requirements
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Oct 2021
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