Effective Expansion and Sustainability of Home Visiting Services Requires Integration Across Systems

Family & Community Health

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Evidence-based home visiting services partner nurses or other trained professionals with pregnant persons and their young families to provide voluntary, home-based parent education and support and, ultimately, promote child health, well-being, learning and development. The benefits to families of evidence-based home visiting models have been well-documented and include improved maternal and child health indicators, school readiness, parenting satisfaction and connection to social services. As such, there's been a growing movement to expand home visiting services to ensure more families can access them, and at a time when health systems are being called upon to improve social determinants of health, home visitors hold the power to help us truly transform care delivery through meaningful, effective strategies.

To understand the role of home visitors more deeply, as well as learn from families how systems-level barriers interfere with them effectively meeting their family's needs, I shadowed a nurse home visitor and family from 2014-2016. I saw this opportunity as an incredible privilege—I was humbled that this family graciously welcomed me into their home. During this time, I watched care being delivered and listened to the family's challenges and concerns. It was through this experience that I witnessed firsthand the incredibly profound relationship a home visitor develops with a family and how that relationship empowered this family to overcome incredible odds.

At the same time, I observed that a home visitor is a siloed member of the health care team and that family-serving systems (including health care) were being asked to do more and more. I was frustrated that it was so difficult to communicate across systems and believed that if we could just work more seamlessly together, we could more effectively (and efficiently) provide better care and support to families.

My Journey With Home Visiting Work

Before coming to PolicyLab, I served as a regional business development manager for 12 years for the Nurse-Family Partnership National Service Office, a well-known evidence-based home visiting model with over 40 years of data validating the investment and support in it. In this capacity, I was a registered lobbyist, working to grow and sustain services across a multi-state region. For many of these years, I was charged with the development of a health care integration strategy—a strategy that, while well-received by many, proved to be considerably challenging. As support for home visiting grew, I witnessed (and was part of) the implementation of countless efforts to expand services to more families, as well as policies designed to leverage nurse home visiting services to address a multitude of public health issues.

Well-intentioned, and at times initially effective, these policies were often not coordinated with other family-serving systems, creating duplication of services and increased expectations of home visitors. This in turn

undermined quality and burdened already under-resourced community providers. With increased expectations but level public funding, sustainability of quality services gradually became more difficult. Although the benefits of evidence-based home visiting were well known, it was clear that alone, these services cannot succeed without a robust safety net of health and social services in communities.

Program models, policymakers and state administrators have explored multiple strategies to address these challenges, particularly integrating home visiting with health care given their shared goal of preventive care. While maternal and child health leadership have called for uniting these services, actual efforts to meaningfully re-envision service delivery to communities have been limited.

Connecting Systems to Enhance the Delivery of Home Visiting Services

In 2017, I joined PolicyLab to lead the Community Clinical Systems Integration Initiative (CCSI), an initiative aiming to eliminate siloes by building an integrated model of care delivery through which community-based nurse home visitors work seamlessly alongside the pediatric primary care medical team. By identifying areas of alignment between home visiting and pediatric well-child care, CCSI seeks to improve patient outcomes by creating consistent communication between the nurse home visitor, families and the child's pediatric provider. With the intentional integration of these services, our objective for providers is to create efficiencies and reduce burden, enhance care coordination, and ultimately improve the sustainability of quality services.

Lessons learned and progress made during CCSI's early implementation have revealed 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 while simultaneously increasing efficiencies in care. Through interviews with some of the families we've served, we learned they hold in high value the trusted relationship that exists with their nurse home visitor, and they see a critical role for their home visitor to serve as a member of their own, as well as their child's, clinical care team.

CCSI has built a strong business model that maintains home visitors' employment with their community-based organization, ensuring this model can be replicated across communities and health systems. We have also identified areas of alignment in care delivery models that have become foundational for our model of integration, as well as provided nurses read and write access to patient electronic health records. This arrangement has facilitated the opportunity for home visitor care to directly influence well-child care delivered in the doctor's office. Communication about patient care has become less burdensome, too, between providers, with messaging options directly available within patient medical records.

Opportunities to Further Refine & Replicate Our Model

While CCSI has experienced significant progress, full integration of home visitor care within the clinical care setting rests on the ability to avoid duplicative services and documentation and reallocate resources in ways that provide the best care for families. As we have worked to enhance coordination across systems, we acknowledge that we have merged two cultures with very distinct approaches to patient care. Many providers are not aware of what evidence-based home visiting is and home visitors are not accustomed to operating in a care team; we must work to educate all parties involved as well as build trust across this new virtual care team.

To effectively replicate this model, CCSI must ultimately create 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 further develop this experience, continued engagement with patients and families will be critical. Hearing from families will ensure that as we create systems-level change, the recipients of care feel that they too have benefited.

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