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ADULT AND CHILD CENTER FOR OUTCOMES RESEARCH AND DELIVERY SCIENCE
UNIVERSITY OF COLORADO
CHILDREN'S HOSPITAL COLORADO

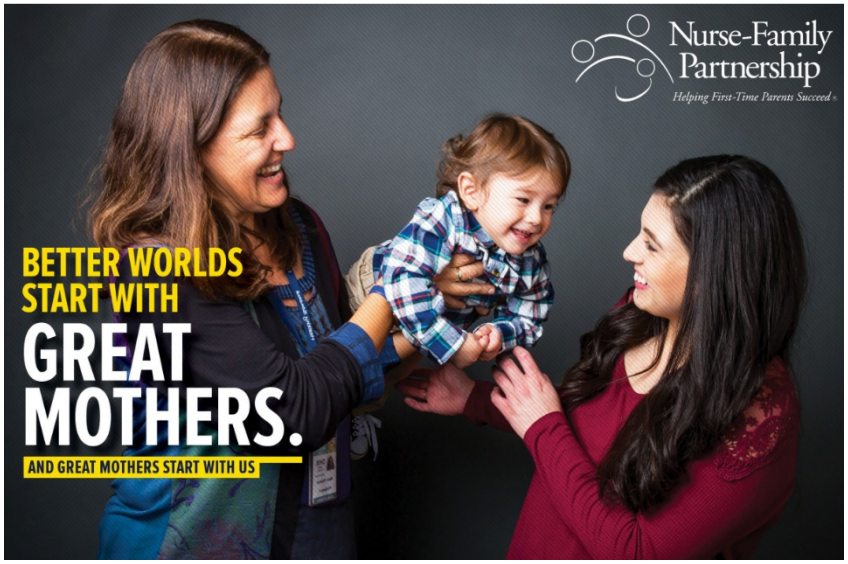
Collaboration in Home Visiting

Case Study: Rural Health Department, Western United States

Background

The goal of our research was to understand factors that lead to high-functioning cross-sector collaboration (defined as relational coordination and structural integration) among highly collaborative Nurse-Family Partnership (NFP) implementing agencies across the United States. NFP is an evidence-based, voluntary, nurse home visitation program designed to improve the health and development of first-time mothers and their children experiencing economic, health and/or social adversities. In a series of randomized-controlled trials, the NFP program showed consistent effects in improving prenatal health, child health and development, and maternal life-course, as well as decreasing childhood injuries and the incidence of child abuse and neglect. NFP was designed to be implemented with community commitment and collaboration; however, there is variation in the extent to which community leaders and services support program implementation across the country.

For the purpose of this case study, we define collaboration to occur across multiple sectors of public health, healthcare, and social services. Collaboration is a function of relational coordination (shared goals, shared knowledge, mutual respect, and high quality communications) and structural integration (shared policies or agreements, physical space, data or information systems, and financial alignment).



Methods

This case study focused on a team of NFP nurses who reported high levels of relational coordination and structural integration with women's care and pediatric providers in the NFP Collaboration Survey administered by the University of Colorado Prevention Research Center for Family and Child Health in 2020. This NFP team was also selected because of their mostly rural geography (located in Western United States), and implementation of the program through a local health department (LHD). The case study was informed by 19 qualitative interviews: 9 with the local NFP team, 3 with NFP graduates or current clients, and 7 with community partners working in the sectors of public health (i.e. supplemental nutritional program), health care (i.e. health alliance supervisor), and social services (i.e. United Way) from summer to fall of 2021, observations from a site visit and Community Advisory Board (CAB) meeting, and CAB meeting minutes.

Context

In this site, the NFP program has been implemented by the LHD since 2001 under the Clinical and Community Health Division, alongside a program for children with special healthcare needs and a family planning clinic. The NFP team is composed of the nurse supervisor, an administrator, and six nurse home visitors (NHV). The team is funded by the state to serve 150 clients. The LHD's family planning clinic, alongside local federally qualified health centers (FQHCs), the university health system, and behavioral health centers offer the majority of medical care services for NFP clients and their children.

Community and Population Served

This site serves the third-largest county in the state by area with an urban center and primarily rural/agricultural surrounding areas. The county has the highest incidence of child maltreatment in the state. The NFP team visits clients who are White or Hispanic/Latin-X, as well as refugee populations from Somalia and Burma. Other client characteristics include lower income, adolescents, substance use disorder and misuse, mental illness, and low educational attainment.

Integration with Women's Care

This community has a regional health alliance that includes the LHD, local FQHCs, and the local behavioral health center. The alliance shares an electronic medical record (EMR) system that allows providers to communicate with one another by "flagging" patient charts for scheduling appointments and/or requesting follow-up communications. Providers' ability to exchange referrals through the EMR allows for efficient exchange of referrals for clients who need to receive care from any of the entities and services that are part of the alliance. NFP is also located in the same building as the family planning clinic located at the LHD. This co-location and close proximity mean NHVs can access the clinic via their keycard and walk into clinic rooms to see a client when needed. The NFP program is less integrated with women's care providers from the university health system and a different FQHC system, where a release of information is necessary for NHVs to communicate with their providers about mutual clients.

Coordination with Women's Care

NHVs from this site primarily coordinate with women's care providers from three main entities: the LHD family planning clinic, local FQHCs, and the local behavioral health center. NHVs coordinate with the family planning clinic for NFP program referrals where they can be contacted directly by clinic via phone during a client's visit to the clinic, typically to confirm a pregnancy. With the local FQHCs, NFP share a common vision to serve low-income first-time parents. Most FQHC staff and providers are aware of NFP, though many have only a basic understanding of the purpose of the program and how they serve pregnant people and their children. There is leadership support for coordination, and the obstetrics case manager is a champion of the NFP program who regularly communicates with the NFP nurse supervisor. FQHC providers were described as very responsive to NHV questions or concerns regarding mutual clients, especially regarding physical or mental health needs.

NHVs can attend prenatal appointments with their clients, view appointments in the shared EMR, and "flag" providers in the EMR for requests or concerns. NHVs also have a direct contact person at the local behavioral health center. They coordinate with the maternal mental health specialist who participates in monthly NFP case conferences where they determine if a client's mental health concerns are specifically related to maternal or postpartum needs, such as concerns over bonding with a newborn, or if there are general mental health needs, such as working through a traumatic experience.

Community Advisory Board and Other Collaborations

Beyond strong coordination with women's care providers, this NFP site has strong coordination with other program and supports including the LHD social worker for client resources, Supplemental nutrition program for Women, Infants, and Children (WIC; which is not implemented by the LHD) for clients' nutritional needs, United Way for client items (like diapers, wipes, car seats), the local library, and a local university reading program. These relationships were highly evident based on these organizations' eagerness to be interviewed for the case study and their engagement in the site's CAB, which was described to be effective in meeting the needs of the NFP program.

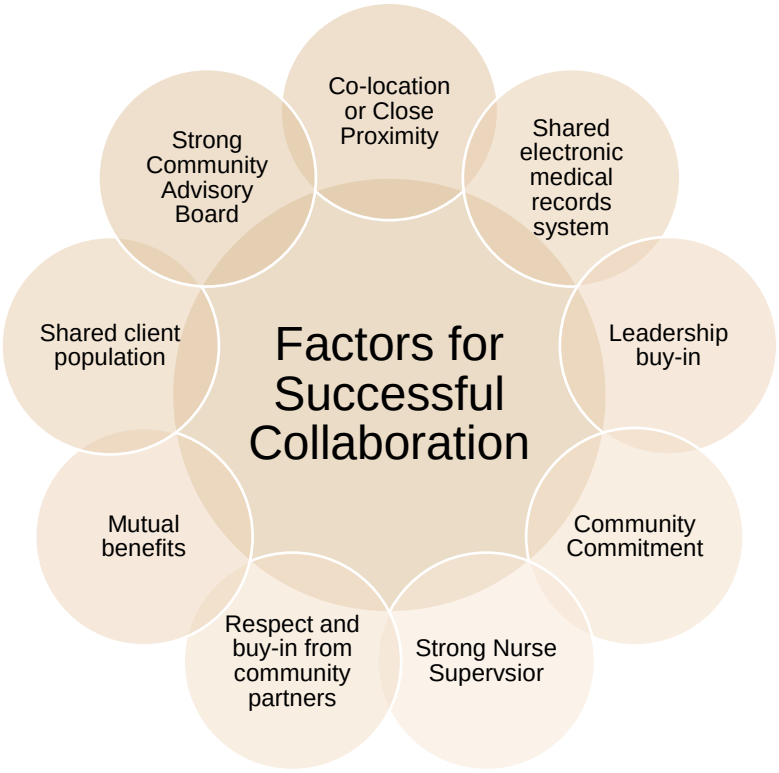
The CAB meets quarterly via video conferencing and is chaired by the NFP nurse supervisor. All CAB members stated that there is a shared commitment to provide excellent care to the population that they serve and a desire to stay connected. Serving on the CAB was described to be beneficial for all members because it helps to bridge the gap between families with needs and programs. CAB meetings help to facilitate communication between the programs regarding resources and events relevant for a common client population. The CAB invites NFP clients to participate in the final meeting of the year which boosts morale, motivates members, and reminds them of "why they do the work they do".

Best Practices

Cross-sector collaboration in this NFP site is facilitated by several factors. Notably, the program has had a long history of community buy-in and support for the program initiated by an NFP champion with a long-standing presence in the community. Support from a respected figure in the healthcare and public health sectors paved the way for the respect and recognition of NFP. The advocacy from a physician champion led to the implementation of NFP through the LHD and ensured access to a shared EMR, which further facilitated their ability to coordinate care with partners within the PHD and the local FQHCs. Integration with these entities reinforced the coordination, by enabling providers within the FHQC to engage with NFP in an efficient and accessible way. Proximity with programs within the LHD allows for regular and reliable communication between nurses and public health staff, making it easy for NFP clients to access care and resources with very few barriers.

Reliable referrals into the NFP program are facilitated by a prominent champion within the FQHC system who serves as an OB Case Manager and serving the high-risk clients that would most benefit from programs such as NFP. Her knowledge of the program, the streamlined process in sending referrals, and her ability to reach out to prospective clients when NFP nurses are having problems further ensures that clients are able to access services.

The community's desire to work together and passion for serving the people of the county are at the forefront of the collaborative relationships. Indeed, fostering relationships in a "small" community, where they know they need to rely on each other, promotes their continued engagement, particularly in the context of the CAB. The CAB serves as a way to engage these partners, where the NFP nurse supervisor creates an environment of shared mission and purpose to meet families' needs.



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