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Collaboration in Home Visiting

Case Study: Urban Health System, Mid-Atlantic 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 with substance use treatment providers 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 urban geography and implementation of the program through a health system. The case study was informed by 15 qualitative interviews: 9 conducted with members of the two local NFP teams, 3 with NFP graduates or current clients, and 3 with community partners working in public health and social services in the winter of 2021 to spring 2022.

Context

The NFP program has been implemented by a teaching health system since 2001 under the women's and pediatric services line along with obstetrics and gynecology, pediatrics, the Centering program, family planning, a Medicaid home visitation program, and a substance use program for mothers affected by substance use. The NFP teams are composed of two nurse supervisors, an administrator, twelve nurse home visitors (NHV), and an administrative assistant. The team is funded to serve 290 clients, with blended funding from the state child development department, an opioid use disorder grant, and expansion dollars from the state human services department.

Community and Population Served

This site serves the sixth-most populous county in the state with urban areas, suburban areas, and rural/agricultural surrounding areas. The NFP team visits clients who are White, Black, or Hispanic/Latin-X as well as refugee populations from Nepal, Burma, Congo, Afghanistan, and Africa. Other client characteristics include being undocumented, adolescents, having high mental health needs, substance use and misuse (opioid and methamphetamine use), lack of housing, lack of social support, intimate partner violence, and physical health risks. Most NFP clients receive their healthcare from local federally qualified health centers (FQHC) and deliver at the hospital that is a part of the health system implementing the NFP program.

Integration and Coordination with Health Care Providers

The NFP office is physically located a half block away from the medical campus, and NHVs have badge access to the hospital. NFP and the health system being part of the same organization allows for sharing of information once consent forms and releases of information are signed. The health system has a shared electronic medical record (EMR) system that allows all providers within the department (including NFP and other home visiting programs) to see if a visit was made. NHVs chart in and have full access to the shared EMR with the health system and other home visiting programs for referrals and to view clinic notes and send messages within the system.

NHVs in this site also had strong coordination with women's care providers both within and outside the health system. Many NHVs had personal relationships with the health system's women's care providers and other home visiting programs which facilitate program referrals and care coordination. In addition to the health system providers, there are seven FQHCs in the county which have providers who have full privileges to deliver babies at their hospital and full access to the shared EMR. One of the providers from the FQHC has long-standing personal relationships with several of the NFP NHVs and freely offers her cell phone number to communicate with her. NFP further shares goals with women's care providers within and outside the health system in promoting healthy pregnancies and babies.

In general, NHVs reported less coordination with pediatric providers. While NFP and pediatric providers share the same goal of ensuring the health and wellbeing of the baby, most pediatricians in this community do not know about NFP and what NHVs offer to their families. Limited care coordination has occurred to address infant weight gain or with breastfeeding.

Coordination with Other Home Visiting Programs

Within the health system, all pregnant people are screened for eligibility for home visiting services at their first prenatal appointment. The Medicaid home visitation program at the health system receives these referrals and outreaches to the referrals, conducts a full assessment including mental health needs, and then refers them to either the NFP program, the substance use home visiting program or retains them in the Medicaid home visiting program. These referrals account for 85% of the referrals that NFP receives. If the person enrolls in NFP, the social worker from the Medicaid home visiting program continues to work alongside the NFP NHV to coordinate care. The NFP administrator also oversees the three home visitation programs within the health system which allows for greater cohesion where the programs are in constant communication.

Coordination with Substance Use Programs

Coordination with substance use providers primarily refers to coordination regarding clients who are dually enrolled in both NFP and the substance use home visiting program offered through their health system; though NHVs have collaborated with recovery homes to support their clients in recovery. NFP shares the same administrator with the substance use home visiting program and is co-located in the same office space. Both programs share the same EMR and can send referrals, communicate, and view notes through the system. Despite the opportunity for care coordination, most clients are not dually enrolled in both programs though they share the same goal in supporting mothers to be the best parent. The substance use program offers mothers community support through engagement with others with similar lived experiences, and NFP provides individualized support to address family needs.

Best Practices

Effective cross-sector collaboration in this NFP site is facilitated by several factors. First, there are three sister home visiting programs offered within the health system, where one administrator manages all three programs. There are shared goals and mission to support mothers and babies, shared office space, and a shared EMR system. These aspects allow for ease of information to flow, ease of communication, and knowledge of one another's programs. In addition, the Medicaid home visitation program serves as the major referral source for NFP and provides support in the way of access to community resources and easier access to women's care providers within the health system.

Providers within the health system and those who have delivering privileges at the major hospital share an EMR system with NFP nurses. This integration allows NFP nurses to access their clients' records and health notes, message providers when concerns arise, and facilitate overall care coordination as needed. At the interpersonal level, one of the local FQHCs where referrals to NFP are made has an NFP program champion. This champion also facilitates care coordination by connecting nurses to other providers in the clinic. Having knowledge of NFP, previous experiences of coordination, and personal relationships facilitate communications to address clients' health needs.

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