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Collaboration in Home Visiting

Case Study: Urban Health System, South Central 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 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 (located in South Central United States), and implementation of the program through a hospital/health system. The case study was informed by 15 qualitative interviews: 10 with the local NFP team, 3 with NFP graduates or current clients, and 2 with community partners working in health care from summer 2021 to summer 2022.

Context

In this site, the NFP program has been implemented by an academic health system since 2008, under the women's services line along with obstetrics and gynecology, the CenteringPregnancy program (patient-centered prenatal group care), adolescent health, lactation, and a substance use program for mothers on methadone. The NFP team consists of the nurse supervisor, an administrator, eight Nurse Home Visitors (NHV), and a data entry clerk. The team is funded to serve 200 clients through the federal Medicaid block grant. The organization, at time of interviews, has 12 satellite ambulatory clinics, of which 10 offer women's care and pediatric services where NFP clients and their children receive medical care. A medical insurance navigator is available to enroll patients, and obstetrics patient navigator welcomes patients into the system, bridging the gap between clients and resources.

Community and Population Served

This site serves the second-largest city in the state, in terms of area and population, in an urban-suburban core within 25-mile radius of the NFP office. The city has the highest rate of domestic violence and child maltreatment in the state. Twenty percent of NFP clients are monolingual Spanish-speaking, and 10-15% are undocumented or refugees. All clients are Medicaid-eligible or uninsured. Other client characteristics include having mental health challenges, substance use, physical health risks, and housing instability.

Integration with Women's Care

The NFP office is located on the medical campus, across from the women's health facility that is the organization's largest satellite ambulatory clinic. This co-location means that NHVs have badge access to the hospital and clinics where NFP clients receive their care.

Because NFP and the health system are part of the same organization, it allows for sharing of information once consent forms and release of information are signed. NHVs have read-only access to the shared electronic medical record (EMR) to view clinic notes and send messages, while the nurse supervisor has full access. NHVs use the EMR to look up patient appointments and review patient weights and visit notes from providers.

Coordination with Women's Care

NFP is part of the women's health service line at the health system. NFP and women's care providers share goals of compassion, collaboration, and education for patients as well as shared outcomes of healthy pregnancies and deliveries. The NFP nurse supervisor is also included in management meetings within the same service line, which allows for exposure of NFP to other programs within the women's health service line. The NFP program receives the majority of their referrals from the obstetrics patient navigators based within the ambulatory clinics. Beyond referrals, NHVs coordinate with patient navigators to "track down" clients who may have missed appointments.

There were multiple individuals from the largest clinic who were identified as NFP champions, including the obstetrics clinic supervisor, physician assistant, and a patient navigator, who tell patients about the program, submit referrals, and help to coordinate care. Many NHVs have personal relationships with the clinic front-line staff, which facilitate communications, and NHVs are able to support clients to navigate the health system. At the same time, the NFP nurse supervisor and the clinic supervisor coordinate regularly via phone and email. In general, there is less coordination with pediatric care providers. Interactions with pediatric care providers centers around scheduling well-child visits or referrals to early intervention. The pediatric patient navigators are situated within the hospital rather than the clinic, and no NHVs described communicating with these navigators.

Community Advisory Board

This NFP site shares a CAB with two other NFP sites located in the same community. All three NFP sites are represented on the CAB and aligned to serve the community, which helps to minimize the number of meetings for individuals who would otherwise participate in independent CABs for each NFP site. CAB members represent medical care, social work, education, social services, Medicaid, juvenile detention, and early childcare. The three NFP sites each see value in sharing a CAB because they can compare and contrast performance measures among sites to address why one site may be having a problem with a particular measure. Other successes include the use of virtual meetings, which has

increased member participation and formal written bylaws and goals that helped form a legislative strategic plan to sustain the NFP program.

Best Practices

Cross-sector collaboration in this NFP site is facilitated by several factors. Notably, the program is embedded within a health system where NHVs have badge access to the hospital and ambulatory clinics, as well as read-only access to clients' EMRs. Integration within the health system allows providers to engage with NFP and for NHVs to support clients in navigating the health system. Patient navigators further serve as champions to the NFP program and provide the majority of referrals the program. The CAB also creates opportunities for multiple NFP programs to work together to increase awareness of the program in an urban community and minimize burden on service providers to participate in multiple boards that have the same purpose.

Acknowledgements

The research team would like to acknowledge the NFP nurses, supervisor, administrator, and community partners for participating in the interviews. Thank you for being an excellent research partner and helping us learn from you, but most importantly, thank you for all you do in serving families in your community.

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