S4A
Systems for Action

Research-in-Progress Webinar
Aligning Health & Social Systems to Expand Evidence-Based Home-Visiting

Q&A Presentation with Venice Williams, PhD, Greg Tung, PhD & Mandy Allison, MD, and David Olds, PhD

Can you share more details about data sharing across different systems? It seems that there are a lot of barriers of data linkage and data sharing due to HIPPA?
Yes, there can be barriers across systems and we need to work across various partners on agreements and how sharing can work. One area where we see success is where NFP is implemented as part of health system where the NFP nurses use the electronic health records of the system and can share and coordinate with other providers and services within the system without the need for additional patient consent or data sharing agreements. In situations where there is not shared EMRs, NFP programs have consent forms with their clients to allow NFP nurses to talk and share information with other service providers. There is a lot of variability across the United States.

Can you talk more about the coordination with WIC, as well as any other intersections with public benefit programs?
We measured coordination in the same way as any other service provider type. Typically coordination with WIC is related to getting clients engaged with a breastfeeding consultant, or discussing nutritional needs if the client has gestational diabetes.

Do you know what percentage of families could benefit from connection to substance use support? or housing? Interesting to know what the opportunity would be if collaboration were improved ? What percent of the families would benefit?
Our program data suggests that 8.5% of clients use substances of any kind and a portion of these families; about 8% of clients are ever referred to substance use support/treatment. Regarding housing, 1.35% of clients report being homeless at intake; while 25% of clients are ever referred for housing resources. So yes, I think that from the housing standpoint, for sure better collaboration could support these at least a quarter of our clients in accessing housing resources. However, the bigger challenge is the availability of these services especially for mothers with young children. With regards to substances, we suspect that 8% is an underreport and hope to improve the collection of this data moving forward.

I serve as a health care navigator for the perinatal community in Central Oregon, our office shares a physical location with WIC, the behavioral health dept and a primary care clinic. While this proximity seems to help with access and communication to WIC especially, oftentimes families prefer telehealth and do not benefit from the close proximity of our services. Do you think telehealth has infringed on access to care coordination, while increasing convenience?
This is a great question and we don't really know and is area that deserves further research. From our existing qualitative work, we have definitely see less care coordination between physically co-located services during COVID; but this has since picked up over the last year.

What's the theory behind using these three types of data?
Program data was used as that is how ongoing NFP implementation data is collected. Survey data was used because that is how we measured collaboration for this project. County/neighborhood level data were used to control for population characteristics. All align with our conceptual model.

Do you measure or collect data about infant safe sleep?
There are 3 questions re safe sleep that are asked on the Infant Health Care Form at ages 6 and 12 months: 1) How often do you place your infant to sleep on their back? 2) How often do you bed share with your infant?, and 3) How often does your infant sleep with soft bedding? The responses for all 3 questions are Always, Sometimes, and Never

In the vein of funding alignment, do you think your evidence base supports a 'business case' for providers to implement (and thus fund) the NFP model and structure a value-based payment contract with payers responsible for low-income pregnancies and child health outcomes?
Both implementation within health systems and funding from healthcare payers, specifically Medicaid and managed care, are areas we are exploring. There is alignment between NFP goals and outcomes and the interests and goals of health systems and of managed care. Additionally, the structure of the payment, for example, pay per visit or paying per member per month and value based arrangements and what works best for achieving outcomes are something we are interested in and actively researching. We are also interested in whether NFP home-visitation could replace some clinic-based well child care visits and whether collaboration/communication between NFP nurses and pediatric primary care providers could be incentivized by a value-based payment system.

Is high retention necessarily "good" and low retention "bad"? Could it be that lower retention for more collaborative or integrated services mean that clients received the services they needed and completed HV earlier than others?
From our perspective, retention in the program is necessary to see the full benefits. Also, the NFP program is intended for, and research indicates that the program is the most effective for, clients at risk for poor outcomes. So clients dropping out of the program early because they have received the services they need likely is an indication of not reaching the target population.

In terms of collaboration's impact on birth outcomes, is there sufficient time in the program before birth?
This is a good point and from past research, we would expect there to be enough time as clients are enrolled before 28 weeks. That said, perhaps collaboration is less salient or necessary for these outcomes, largely driven by physical health risk factors.

One reason for the negative associations may be the challenge faced by clients who have multiple community care coordinators. We at the Pathways Community HUB Institute have seen clients with as many as 10 community care coordinators which is ineffective and wastes resources. It is ideal for each client to have one community care coordinator who helps clients reach needed service providers.
Yes, that is a good point. Most often times, the NFP nurse serves as the care coordinator for clients and they do not have another care coordinator in the community. The intention for care coordination is to reduce duplication of services.

What do you think of nursing students delivering the program with the support of their supervisors (either in person or behind the scenes)? What would be the minimum length of time for a student involvement?
This would be better answered by the NSO nursing leadership, but we know they've been considering a model like this as a way to recruit nurses from under-represented minority backgrounds and a way to help with nurse hiring in areas experiencing the worst nursing shortages.

Most Medicaid is now going into MCOs and thus will have pretty short term ROI needs. NFP has very powerful long term ROI, beyond the 2-4 years the MCOs want. What to do?
NFP in community replication has been shown to also improve short term health outcomes like increased breastfeeding and immunization rates, reduced preterm birth, increased employment and educational attainment after 1 year, etc.

Really important to look for return on investment OUTSIDE of the health payors as well. child welfare, courts
We believe this is evident in the child maltreatment outcomes that NFP has been shown to prevent entry into the child welfare system and we are researching whether NFP improves reunification.