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Home Visiting: Strategies and Outcomes

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In a study released recently in *Pediatrics*, Drs. Rebecca Kilburn and Jill Cannon (10.1542/peds.2016-1274) from the Rand Corporation in Santa Monica, California report on a randomized clinical trial to evaluate a home visiting program that employed a nurse-parent educator team during the first year of life. Home visiting has received attention as an evidence-based strategy that successfully improves early childhood outcomes.

Since it is necessarily expensive to send trained and licensed health professionals into the community and into the home, this unique program looked at the possibility of partnering a registered nurse with a trained lay educator, specifically a parent, to deliver the intervention. The project enrolled first-time families, preferably during pregnancy, and intended to provide 40 visits in the first year of life. The population served was just over 50% Hispanic, just over 50% Medicaid insured, and was predominantly urban with some rural participants, with more than 50% of mothers having achieved a high school education.

Certainly the overall study conduct and results are important and well worth your full read. Strengths and limitations of the project are well described. I was intrigued that the authors presented the nurse-parent educator team utilized in their program as a novel option without comparison to Community Health Worker home visiting as an alternative.

Community Health Workers (CHWs), presumably like the parent educators, are persons from the same community, with shared social values, and of similar background, race and ethnicity as those whom they visit and serve. This unique connection “sets the table” for providing health and medical advice in a more personalized and culturally competent manner. The authors describe 200 hours of training for parent educators, and a broad health-based manualized curriculum that utilizes “a 3-pronged approach” with family education, identification of family challenges, followed by referrals and referral coordination; this sounds like a lot like the CHW approach.

A comparison of the nurse-parent educator team with CHW home visiting with respect to time in training, total cost and maternal and child outcomes might be instructive, especially since several federally funded initiatives including National Healthy Start employ CHWs for home visiting. For those unfamiliar, the federal Healthy Start Initiative has a 20+ year record of effective use of home visitation models to serve marginalized and underserved communities, both rural and urban, throughout the US, with core services provided by CHWs (for more information see http://www.nationalhealthystart.org/site/assets/docs/NHSA_WhitePaper.pdf).

Another area of interest for me was the outcome measures for the study. It makes sense that Emergency Room (ER) visit number is an excellent outcome, since "inappropriate ER use" represents a terrific potential target for reducing health care costs and improving the quality of health care for individual families and children. As a secondary outcome measure, however, reducing the number of primary care office visits seems to me less clearly a valuable goal. Many other health initiatives are actually focused on increasing visits to primary care physicians so that immunizations and basic care can be delivered. If the AAP recommends 7 well care visits between the time the child is a newborn and one year of age, and if a child is ill a couple of times in their first year of life, then 9 total visits in the first year would seem pretty reasonable as a minimum.

Yet in this home visiting program treatment group children (who received the intervention) "…were 41% less likely to have visited a primary care provider nine or more times…$p<0.001$)." If the parent educator-nurse team is able to beautifully answer questions about growth and development so the infant can skip any visit at which a vaccine is not delivered, perhaps we can rationalize fewer visits, but this should be carefully delineated as a strategy, and the families' pediatricians/health providers should be in agreement with this plan and potentially partner as collaborators or technical advisors to the home visiting program. This type of team work might be our next step in integrating services, and could ultimately potentially strengthen pediatric care for high-risk families who benefit most from home visiting.

Further Reading

- Risk Factors for Sleep-Related Infant Deaths in In-Home and Out-of-Home Settings
- Back to the Future of Home Visits?
- Home Visits: Advancing Pediatric Training by Preserving Past Traditions
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