Public Health Nurse Home Visiting
Frequently Asked Questions

When did nurse home visiting begin?

- Home visiting became a national public health strategy to improve the health status of women and children in the late 19th century.

What makes nurse home visiting such a successful strategy?

- Therapeutic nurse-client relationships are built on trust, mutual respect and empowerment.
- Services start prenatally for some programs, which greatly benefits high risk parents and children.
- Nurse home visiting is comprehensive in design, so the multiple needs of families can be addressed in one visit (versus interventions that address more narrow outcomes).
- Research shows that strong home visiting programs that adhere to specific curricula, teaching protocols and vigorous monitoring are consistently successful over time.
- Families involved with nurse home visiting programs have fewer repeat pregnancies; improved maternal mental health and children's cognitive development; reduced unintentional injuries and home safety hazards; and improvement in parenting skills.

At a glance:

Nurse home visiting has been working for over 100 years.

Nurse home visiting is associated with positive outcomes for children and families.

Family needs are complex, and nurse home visitors can help address multiple challenges that families face.

Nurse home visitors can provide assistance for parents, children and youth from pregnancy through 21 years of age, depending on the family's needs.

What are the different public health nurse home visiting programs?

Maternity Case Management (MCM) assists pregnant women in improving birth outcomes for themselves and their babies. Babies First! is a home visiting program for at-risk families with babies and children up to age 5. The CaCoon program serves children and youth with special health needs from birth to age 21 years. Nurse-Family Partnership (NFP) nurses work with low-income young women who are pregnant for the first time, helping these vulnerable young mothers achieve healthier pregnancies and births. Families are visited from pregnancy until the child turns 2 years old.

How can public health nurse home visiting programs help Coordinated Care Organizations in Oregon?

- Compliance with perinatal care standards;
- Care coordination/care management for pregnant women and their children;
- Ongoing health and psychosocial assessments throughout the duration of the intervention;
- Anticipatory guidance and preventive services based on need;
- Early identification of problems and swift intervention;
- Timely patient-centered communication and information exchange.

What are the potential benefits of partnering with public health nurse home visiting programs?

- Improved outcomes for plan members
- Reductions in risk factors that lead to chronic conditions
- Reductions in costs due to ED visits
- Better patient compliance with medical provider's instructions
- Improvements in HEDIS and other quality metrics

"With our nurse, you know she truly, genuinely cares about you and your child." – CaCoon Client

Information provided by: Oregon Health Authority Babies First!; Oregon Center for Children and Youth with Special Needs; National Nurse-Family Partnership

Oregon Health Authority

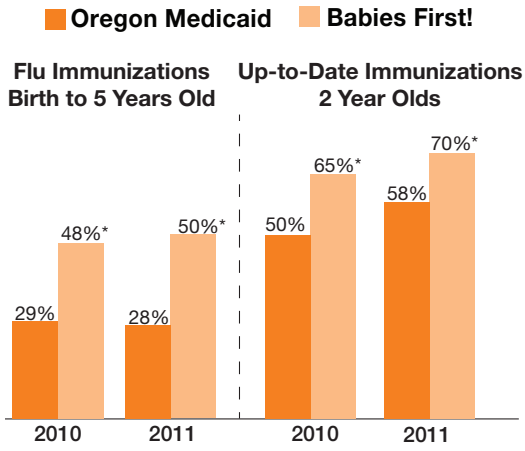
Babies First! Outcomes for High-Risk Children up to Age 5

Babies First! is a statewide public health nurse home visiting program for families with babies and young children up to age 5 years old. The goal is to identify high-risk infants (based on social, emotional and medical risk factors) and improve the health outcomes of these vulnerable children through prevention and early intervention.

Compared to Medicaid, children that received Babies First! Medicaid nurse home visits had significantly* higher rates of:

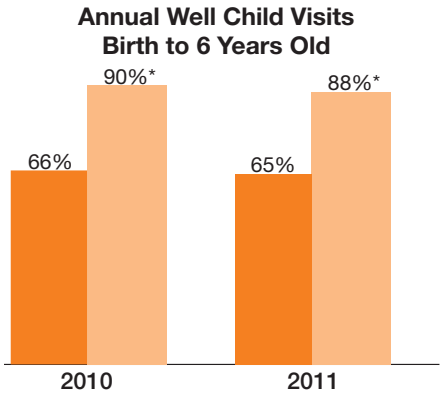
Immunizations

Immunizations save lives and improve quality of life. Babies First! annual flu immunization rates were 69% higher than Medicaid children in 2010 and 78% higher in 2011. For children that turned two years old during the year, Babies First! up-to-date immunization rates were 30% higher than Medicaid in 2010 and 21% higher in 2011.



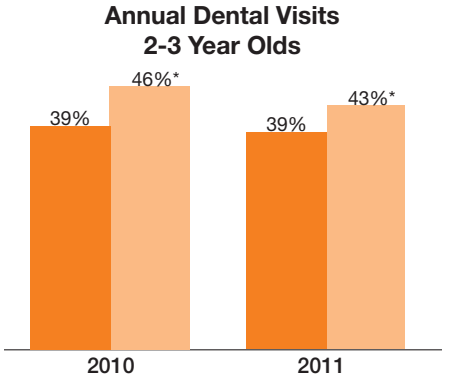
Annual well-child visits

Well-child visits are routinely scheduled preventive visits for children. Well-child visits are essential for maintaining long term positive health for children. Babies First! children were 37% more likely to receive an annual well child visit than other Medicaid children in 2010 and 36% more in 2011.



Annual dental visits

Developing good dental habits and routines early in life is important for long term health. Babies First! clients were 18% more likely to receive an annual dental visit than other Medicaid children in 2010 and 10% more likely in 2011.



*Chi-square significant at .05 or less

Babies First! Potential Medicaid Cost Savings

Immunizations: Immunizations generate significant economic benefits. The Centers for Disease Control and Prevention (CDC) estimates for every dollar spent on immunizations about $6 dollars in direct medical costs are saved. The higher Babies First! immunization rate may therefore result in considerable Medicaid savings.

Medicaid hospital costs: A recent study indicates that Babies First! visits were associated with a 10% reduction in Medicaid hospitalization compared to clients who did not receive nurse home visits. The national average cost of a child's hospital visit is $5,200, indicating substantial potential Medicaid savings.

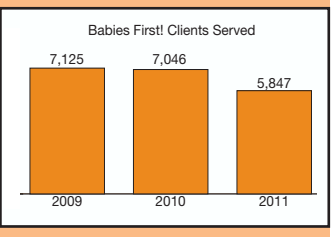
At a glance:

Babies First! clients are more likely than other Medicaid clients to be up-to-date on immunizations.

Children involved with Babies First! access important early dental care.

"Our nurse was the best. She was compassionate, capable, knowledgeable, and caring. I learned so much about parenting, health and safety issues from her."

-Babies First! Client

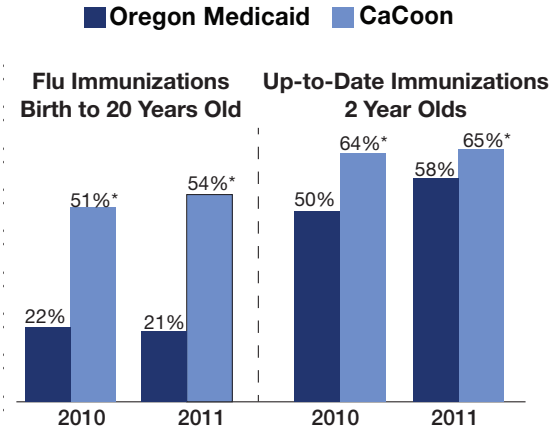


Information provided by:
Oregon Health Authority:
Department of Medical Assistance Programs
Immunization Program
Maternal and Child Health

CaCoon: Evidence-Based Outcomes for Serving Children with Special Health Needs

CaCoon is a statewide public health nurse home visiting program providing care coordination for families with children, birth to 21 years, with special health needs. These children and their families often have very complex health and related needs requiring coordination across multiple systems of care. CaCoon nurses assess family needs and provide interventions and care coordination to improve their health and well-being. The goal is to assure these children access to needed health and related services, spanning multiple systems of care, resulting in optimal health and well-being.

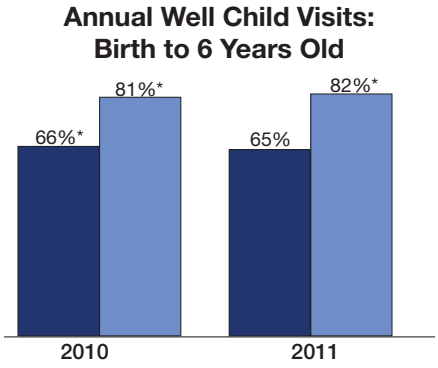
CaCoon children have complex needs. About 27% of CaCoon children have multiple chronic medical diagnoses, compared to only 2% of Medicaid children not served by CaCoon. CaCoon diagnoses include cleft palate, developmental delay, Down syndrome, epilepsy, failure to thrive, hearing loss, heart and brain disorders, cerebral palsy, spina bifida, and cystic fibrosis, among other rare and complex conditions.



Compared to Medicaid, children and youth that receive CaCoon nurse home visits had significantly higher rates of:*

Immunizations

The CaCoon annual flu immunization rate was 137% higher than Medicaid children in 2010 and 159% higher in 2011. For children that turned two years old during the year, the CaCoon up-to-date immunization rate was 28% higher than Medicaid children in 2010 and 12% higher in 2011.

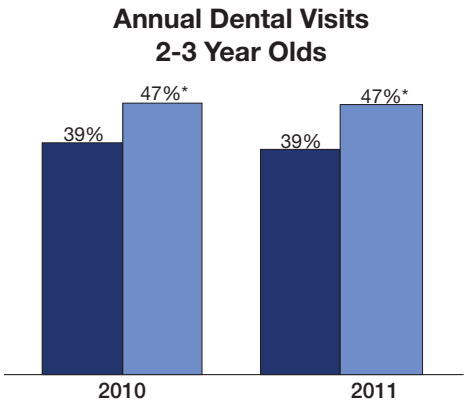


Annual well-child visits

The CaCoon annual well child care visit rate was 23% higher than Medicaid children in 2010 and 26% more in 2011.

Annual dental care visits

The CaCoon annual dental care visit rate was 21% higher than Medicaid children in 2010 and 2011.



Chi-square significant at .05 or less

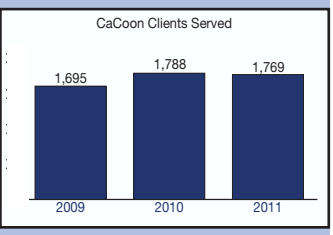
CaCoon Potential Medicaid Cost Savings

Immunizations generate significant economic benefits. The Centers for Disease Control and Prevention (CDC) estimates for every dollar spent on immunizations about $6 dollars in direct medical costs are saved. The higher CaCoon immunization rate results in considerable Medicaid savings.

At a glance:

CaCoon clients have higher immunization rates, well child visits, primary care visits, and dental care than Medicaid clients not served by CaCoon

"I don't think my son would be here if the CaCoon nurse hadn't linked me to the services needed to help him."
– CaCoon Client



Information provided by:
Oregon Health Authority
Department of Medical Assistance Program
Immunization Program
Oregon Center for Children and Youth with Special Health Needs

Oregon Center for Children and Youth with Special Health Needs
503-494-8303 www.occyshn.org

Evidence-Based Home Visiting and Nurse-Family Partnership: A Critical Component to Achieving the "Triple Aim" for At-Risk Women and Children

February 22, 2013

What it is: Nurse-Family Partnership (NFP) is an evidence-based, community health home visiting program for first-time, low-income moms and their babies with over 30 years of randomized controlled-trial research proving its effectiveness. Through ongoing home visits from registered nurses, NFP clients receive the care and support they need to have a healthy pregnancy, provide responsible and competent care for their children, and become more economically self-sufficient. From pregnancy until the child turns two years old, NFP Nurse Home Visitors form a much-needed, trusting relationship with the first-time moms, instilling confidence and empowering them to achieve a better life for their children – and themselves.

How Home Visiting Can Impact Health Outcomes:

- Nurse home visiting programs are a long-standing, well known prevention strategy used by states and communities to improve the health and well- being of women, children and families, particularly those who are at risk.
- NFP is a cost-effective prevention program that stands on the weight and power of over thirty years of scientific evidence demonstrating its effectiveness in helping to improve the health and well-being of low income, first time mothers and their children. NFP's primary goals are to improve birth outcomes, child health and development and parental economic self-sufficiency.
- Results from one or more randomized controlled trials demonstrates that NFP can result in:
    - 35% fewer cases of pregnancy-induced hypertension;
    - 79% reduction in preterm delivery among women who smoke;
    - Fewer subsequent births on Medicaid
    - 31% reduction in very closely spaced (<6 months) subsequent pregnancies;
    - 39% fewer health care encounters for injuries or ingestions in the first two years of life among mothers with low psychological resources;
    - 48% reduction in state-verified reports of child abuse and neglect by child age 15;
    - 56% reduction in emergency room visits for accidents and poisoning at age 2;
    - 50% reduction in language delays by child age 21 months; and
    - 67% reduction in behavioral and emotional problems at child age 6. (to name a few)
- NFP is cost effective. Independent studies have also confirmed that NFP saves scarce public resources.
    - Rand Corporation found that for every $1 invested in NFP to serve high risk families, communities can see up to $5.70 in return due to savings in social, medical and criminal justice expenditures.

The Case for Integrating Home Visiting in to a Coordinated Care Organization Model:

In Oregon, we believe that NFP can help Coordinated Care Organizations with :

- Compliance with perinatal care standards;
- Care coordination /care management for first-time pregnant women and their children ;

- Ongoing health and psychosocial assessments throughout the duration of the intervention;
- Anticipatory guidance and preventive services based on need;
- Early identification of problems and swift intervention;
- Referral to and coordination of other care and services as needed; and
- Timely patient-centered communication and information exchange.

As with new CCOs, evidence -based home visiting programs like NFP measure, monitor and analyze metrics and use such data to drive improvements. NFP monitors many of the same quality and outcome measures that CCOs will be accountable for including those used prescribed by HEDIS, CHIPRA and NCQA's criteria for Patient Centered Medical Homes.

Quality Measures	**NFP/MIECHV**	**HEDIS**	**CHIPRA**	**NCQA-PCMH**
ED utilization	X		X	X
Access to primary care	X	X	X	X
Access to behavioral/mental health	X	X	X	
Developmental screening	X		X	
Well child visits in first 15 months	X	X	X	
Birth weight < 2500 grams	X		X	
Preterm Births <39 weeks	X		X	
Timeliness and frequency of prenatal care	X	X	X	
Postpartum care	X		X	
Immunization status	X	X	X	
Depression screening	X		X	
Lead screening	X			
BMI Assessment	X	X	X	
Connection to community resources	X		X	X
Culturally/linguistically appropriate care	X			X

From this important perspective, it is evident that priorities for evidence-based home visiting program are well aligned with those of the new CCOS, making us natural partners going forward.

We think that the potential benefits of partnering with evidence based home visiting programs like NFP would include:

- Improved access to home visiting services for plan members;
- Improved outcomes for plan members
- Reductions in risk factors that lead to chronic conditions;
- Reductions in costs due to ED visits;
- Better patient compliance with medical provider's instructions;
- Improvements in HEDIS and other quality metrics;
- Improved opportunities to take advantage of pay for performance and other quality incentives;
- Less member churning;
- Competitive advantage in the market place.

Strategies for Taking NFP to Scale Within Medicaid and Health Care Reform:

- Statewide Strategies:
    - Include Medicaid coverage and reimbursement for evidence- based MCH home visiting services as part of Oregon Health Plan's Benefit Package
    - Develop policies that support integration of evidence based MCH home- visiting programs within new CCOs;
    - Create incentives for CCOs to contract with evidence- based MCH home visiting programs to provide services to those who might benefit most from them;
    - Evaluate the effectiveness of evidence- based home visiting services in improving maternal and child health outcomes and the experience of care as well as cost offsets to Medicaid over time.
- Community-level Strategies:
    - Work with local CCO's to integrate NFP in to continuum of maternal and child health services