Home Visiting Programs: What the Primary Care Clinician Should Know

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Responsibilities for primary care clinicians are rapidly expanding ascomplexities in families' lives create increased disparities in health and developmental outcomes for young children. Despite the demands on primary care clinicians to promote health in the context of complex family and community factors, most primary care clinicians are operating in an environment of limited training and a shortage of resources for supporting families. Partnerships with evidence-based home visiting programs for very young children and their families can provide a resource that will help to reduce the impact of adverse early childhood experiences and facilitate health equity. Home visiting programs in the United States are typically voluntary and designed to be preventative in nature, although families are usually offered services based on significant risk criteria since the costs associated with universal approaches have been considered prohibitive. Programs may be funded within the health (physical orbehavioral/mental health), child welfare, early education, or early intervention systems or by private foundation dollars focused primarily on oneof the above systems (e.g., health), with a wide range of outcomes targeted by the programs and funders. Services may be primarily focused on the child, the parent, or parent-child interactions. Services include the development of targeted and individualized intervention strategies, better coaching of parents, and improved modeling of interactions that may assist struggling families. This paper provides a broad overview ofthe history of home visiting, theoretical bases of home visiting programs, key components of evidence-based models, outcomes typically targeted, research on effectiveness, cost information, challenges and benefits of home visiting, and funding/sustainability concerns. Significance for primary care clinicians isdescribed specifically and information relevant for clinicians is emphasized throughout the paper.

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Introduction

There has been a rapid expansion in programs delivering home visiting services in the United States following a large allocation of federal Affordable Care Act (ACA) dollars into the Maternal Infant and Early Childhood Home Visiting Program, operated under the joint partnership of the Health Resources and Services Administration (HRSA) and the Administration on Families (ACF). The interest in early prevention and intervention services focused on very young children and their families stems in great measure from a growing body of research that documents a strong association between early childhood adversity and negative health, behavioral and social outcomes across the lifespan.[1] This article provides a broad overview of the history of home visiting, theoretical bases of home visiting programs, key components of evidence-based models, outcomes typically targeted, efficacy research, cost information, challenges and benefits of home visiting, and funding/sustainability concerns. Significance for primary care is described specifically and information relevant to pediatric practice is woven throughout.

History of Home Visiting in the United States

In the United States, the origins of home visiting can be traced to several early movements in the 1800s, including the kindergarten movement, the public health nursing movement, and the settlement house movement.[2] Although there were some broad similarities between the three movements, each had a slightly different focus and relied upon different service providers. Original funding sources were primarily philanthropic, with government funding directed to programs later as the programs demonstrated efficacy

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and grew in size and scope. Because of the philanthropic sources of funding, a great deal of advocacy to improve the health, education, and environmental conditions of individuals within communities was initiated by the programs. Contemporary home visiting programs reflect the important influence and emphases of the pioneering work in the 1800s. The roots of advocacy and interagency collaboration can also be traced to these early programs.[2]

The early kindergarten movement in the United States, begun in Wisconsin in 1855, was modeled on the play-based early education programs originated by Friedrich Froebel in Germany in 1837.[3] In the United States, kindergarten programs were typically focused on non-English speaking, immigrant populations living in poverty in large cities. Kindergartens were not incorporated more widely into American society until the 1870s when Elizabeth Peabody and the National Education Association promoted adoption of kindergarten programs.[3] These kindergartens were originally funded by philanthropic groups. The teachers who taught young children in the morning performed home visits in the afternoon.[4] Home visiting was designed to focus on teaching families about mainstream child-rearing beliefs and how to use toys to stimulate learning in young children.[5] The visits were also intended to build community and family relationships. Teachers acted as family advocates with landlords, local stores, and the government. By the 1930s, demand increased for kindergartens and there was a shift to morning and afternoon kindergarten sessions and the elimination of the home visiting component.

Another early model of home visiting can be found in the origins of public health nursing in America.[6] Public health nursing was modeled after nurse home visiting programs in England; trained nurses provided health care and social support in specific geographic regions. In the United States, public health nursing began in the 1870s with a handful of nurses relying on funding from philanthropies. Lillian Wald is credited with establishing public health nursing in the United States with the establishment of the Henry Street Settlement in New York in the late 1800.[6,7] The approach included preventative care and family education until funding shifted from a philanthropic to government base. Once the funding shift occurred, the philosophical approach changed to that of a medical model focused on obstetrics, well-baby care, and health education. The focus remained on health care with little attention to the social support that was included in nurse home visiting programs in Europe.

In the early 1900, Visiting Nurse Associations, precursors to home health nursing, were created to provide health care in homes. The number of Public Health Nurses (PHNs) gradually grew between the 1870s and 1980 in the United States but declined more than 25% between 1980 and 2000, from 219 PHN's per 100,000 residents to 158 per 100,000 residents.[8] A serious shortage of nurses, particularly in public health has been predicted by 2020 by the Institute of Medicine.[9] This has significant implications for home visiting models that rely upon nurses to deliver services.

The Settlement House movement began in America in the 1880s.[10] Through this movement, upper class reformers worked to improve the living conditions of the immigrant poor through a broad reach across social and education programs. The reformers attempted to influence early education of young children, to provide support for families dealing with health and social crises, and to force improvements in environmental conditions such as housing, parks and playgrounds, and trash collection through both legislative advocacy and direct service.[5,10] Early Settlement House reformers in Chicago and New York lived and worked in the poverty communities to understand better the families being served and to model the behaviors and skills that they believed all individuals should possess. Wealthy women who were part of the Settlement House movement raised funds for day nurseries, advocated for the development of branch libraries, kindergartens, and night classes, taught homemaking and child care skills, provided homeless shelters, and taught English to new immigrants in urban communities.[2,5]

The Great Depression in the 1930s had a significant impact on philanthropic organizations, with more than one in three shutting down between 1929 and 1932.[11] The federal government initiated a variety of efforts aimed at assisting the millions of citizens who had lost their jobs and their homes.[12] The period of prosperity that followed World War II led to a decline in interest in funding social initiatives, but there was a resurgence in the 1960s with the federal "War on Poverty"[13] and initiatives such as Head Start[14] and Home Start.[15] Home visiting programs were funded with a focus on social issues such as teen parents and health issues such as increasing rates of very low birth weight babies due to technological advances in medicine. Home visiting programs in the 1960s and 1970s often utilized