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Home visiting: A lifeline for families during the COVID-19 pandemic

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Background

In order to measure health in a population, one must take into consideration both the health of its inhabitants and how health is distributed. Many public health programs, including successful ones, fail at taking into consideration the context and vulnerabilities of the target population to whom they're aiming their interventions. One clear example is how vaccines for childhood diseases have been unable to reach vulnerable children due to structural and social factors (World Health Organization, 2011). These factors are known as social determinants of health. Social determinants of health can be defined as the physical and social environments, political and economic structures, and access to health care services. When social determinant of health factors are not addressed, those populations most disadvantaged are disproportionally affected by illness and ultimately poorer health outcomes as compared to the larger population (Palmer et al., 2019).

With the intention of reaching health equity, the World Health Organization (WHO) (2019) has issued recommendations to address social determinants of health and close the equity gap. These recommendations include addressing inequitable power distribution, resources and money, quantifying and understanding the problem, assessing the impact of the interventions implemented and improving daily conditions. From a social determinants of health approach, interventions need to target the root causes that block pathways to equitable health distribution and result in health inequities, perpetuating the equity gap.

As discussed in this paper, social determinants of health and Adverse Childhood Experiences (ACEs) play an important role in the health and wellbeing of individuals, families and communities. The WHO has dedicated taskforces to address social determinants of health globally (WHO, 2019). The United States also has over time accumulated a body of evidence on health inequities within its population.

Equity in care for women during pregnancy varies drastically across racial and socioeconomic status due to ongoing systemic racism and other social injustices that impact women. In the US, infant mortality disproportionately affects non-Hispanic Black populations who experience over twice the rate of non-Hispanic whites (11.4 versus 4.9 per 1000 live births) (Centers for Disease Control and Prevention, 2019). In addition, minority women as a whole experience unacceptably poor maternal health outcomes three to four times higher than White women, including disproportionately higher rates of death related to pregnancy or childbirth (National Partnership for Women and Families, 2018).

At a local level, sociodemographic characteristics including rates of poverty, lack of prenatal care, and smoking, affect maternal and birth outcomes and have been shown to be higher in certain wards within the District of Columbia (District of Columbia Department of Health, 2018). Additionally, women who live in poverty, are immigrants, live with extreme stress, experience conflict situations, and have low social supports are at a higher risk of experiencing perinatal depression (WHO, 2019).

In recent months, US news reports have chronicled facts which illustrate that minority populations and underserved communities are significantly impacted by the coronavirus, the lack of resources and economic hardships. The coronavirus pandemic has brought forth chronic systemic issues of racism that have plagued the US for generations, with an overrepresentation of COVID-19 related hospitalizations and deaths among Black populations and minorities nationally (Centers for Disease Control and Prevention, 2020; Garcia-Navarro, 2020). Infection statistics in the District of Columbia demonstrate stark differences in rates of COVID-19 infection and related deaths. Infection rates are heavily focused on communities with lower average income and higher rates of Black and Latinx populations and in parallel, death rates among Black individuals represent 75% (361 of 479 deaths) of the total deaths, while they constitute only 46% of the District population (District of Columbia, 2020; United States Census, 2020).

The economic downfall resulting from the pandemic and a never before seen demand to stay-at-home has unveiled higher rates of mental health concerns, life disruptions, as well as violence in the home. Not only putting lives at risk, these effects are also detrimentally affecting our society's capacity to serve as positive role models and to foster healthy environments in which to grow our children.

Research links the effects of social isolation and loneliness to poor mental and physical health. Parents, and especially low-income parents, are disproportionately worried about the infection, and disproportionately likely to feel "disrupted by the outbreak" (Hamel et al., 2020; Panchal et al., 2020).

We have also seen the increase in domestic violence cases and considerable evidence points to the fact that domestic violence and child abuse often co-occur in nearly 30% of cases, experts believe the

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quarantine has high probability for increasing the rates of violence children are experiencing in the home (Bosman, 2020; Kamenetz, 2020; Institute of Medicine, 2011). Parenting is also impacted by social determinants of health. According to the most recent Public Dashboard published by Child Family Services Agency (CFSA) in the Washington DC, 36% of the number of children served by CFSA are between 0 and 5 years of age, and the two groups with the highest incident of reports are African American and Latinx families (Child Family Services Agency, 2020). The top family issues resulting in maltreatment reports for 0- to 5 year age group include substance abuse, inadequate resources/unstable living situation, domestic violence and abandonment (Child Family Services Agency, 2019).

The body of evidence is abundantly clear that social determinants of health and exposure to chronic stress have an impact on the body and overall health. However, risk is not destiny. Research also tells us that protective factors and resiliency within individuals, families and communities, prevent and ameliorate the effects of social determinants of health. They allow us to respond to adversity in an adaptive and functional way. Promoting protective factors and fostering resiliency is an effective strategy to address health disparities (Palmer et al., 2019). To this end, our federally qualified health care organization used this evidence base to develop and utilize the strategy of home visiting to foster resiliency among vulnerable individuals and families.

Our intervention

Home visiting is an essential preventative social service model that builds on the families' own strengths and supports them to navigate circumstances and stressors contributing to health inequities in underserved communities. Home visitors provide services that improve health care access and education to participants; they collaborate with families to assist in navigating health and social systems and give dedicated attention that may be more problematic to obtain in the traditional health system (Centers for Disease Control and Prevention, 2014). Nurses and clinically trained technicians are also direct-care providers in some home visiting models, including Nurse Family Partnership, supporting individuals with health education, counseling, and medical services outside of the clinic system.

While there is no nationally recognized definition for home visiting, the District of Columbia Home Visiting Council has developed a definition to better represent the services and position home visiting specific to the spectrum of social and health services in our geographic region. This definition will be published in their upcoming Annual Report with an excerpt below.

> Home visiting is a service delivery strategy that serves as a prevention and early intervention support for expecting parents and families of young children from before birth until entry into kindergarten. In these voluntary programs, trained home visitors and participant family members regularly meet in the home or another comfortable setting designated by the family.
>
> A key characteristic of these programs is that each implements a model for addressing specific maternal, family, and child outcomes through education, counseling, coaching, and other services. Home visitors also provide families with connections to community-based services and resources relevant to their goals.
>
> District of Columbia Home Visiting Council (2020a)

Moreover, home visiting programs are designed to support families who are overburdened. Individuals and families currently managing the health and social consequences of the COVID-19 pandemic are impacted greatly by the detriments of the health inequities that affect them. The specific tools, practices, and theories that guide home visiting programs are established to address extreme social challenges and therefore home visiting programs are well-positioned to support families in these extraordinarily difficult times. Today, home visitors are the lifelines to many families.

Evidence to support home visiting model

Home visiting program models vary based on factors such as target audience, outcomes measured, duration and frequency of home visits, and evidence available on the practice. Our organization, Mary's Center, currently offers four home visiting models supporting our organization's mission which is to embrace all communities and provide high-quality healthcare, education, and social services in order to build better futures. Mary's Center Home Visiting Department's mission is to engage families through different phases of perinatal and early childhood years, involving all members of the family through programming and resources.

Healthy Families America (HFA) and Parents as Teachers (PAT) are evidence-based national models (Home Visiting Evidence of Effectiveness, 2018, 2019). HFA provides intensive home visitation services to overburdened families at risk for child abuse and neglect and supports them to ultimately prevent abuse and neglect (Healthy Families America, 2015). PAT is based on a theory that influencing parenting knowledge, attitudes, behaviors and family well-being affects the child's developmental trajectory, with an intentional focus on school readiness (Parents As Teachers, 2017). The Father Child Attachment program is specifically designed to work with fathers in order to promote positive father involvement and work towards strengthening the father-child relationship. Lastly, Healthy Start is a national initiative designed to improve maternal and infant health outcomes and reduce racial and ethnic differences in adverse perinatal outcomes and infant deaths. While eligibility criteria differ between programs, all four serve to engage families who live throughout the metropolitan Washington DC area, including Prince George's County in lower Maryland.

While each program is built and implemented differently, national research on home visiting strategies show that programs are instrumental in supporting families in their ability to process and navigate social and health challenges. US Health and Human Services departments have supported the Home Visiting Evidence of Effectiveness Programs (HomVEE) since 2009, a team conducting thorough and transparent reviews of home visiting research literature and outcomes. Positive health outcomes unveiled through HOMVEE and locally-hosted evaluations include the frequency of child visits for preventative care, improved school readiness, improved family economic self-sufficiency, and positive parental attitudes about their ability and competency as parents (DC Home Visiting Council, 2020a, 2020b; OPRE, 2019). Health and livelihood outcomes demonstrate that families who participate in home visiting programs are more likely to have healthy babies and healthy moms, confident parents with positive parenting practices and safe homes (Munns et al., 2016; National Home Visiting Resource Center, 2020).

In addition, cost savings from home visiting programs are manifested in lower rates of emergency room visits for children, reduced involvement in government systems such as Child Protective Services, as well as benefits to society encompassed in maternal and child health outcomes. Studies have found a return on investment of $1.80 to $5.70 for every dollar spent on home visiting (National Home Visiting Resource Center, 2020; The Pew Charitable Trusts, 2014; Nurse Family Partnership, 2017; Zaveri et al., 2014; Goodman et al., 2019).

Success within the parameters of home visiting has been quantified, revealing effectiveness on meeting health and social needs for families, women, and children. However, home visiting as a strategy looks differently for every family. To quantify what success looks like when each strategy is tailored to the needs of the family can miss the mark on how home visiting inevitably shows up and impacts a community as a whole. Home visiting's real success may be more difficult to measure in areas such as employment, or learning and practicing a different, less punitive strategy to parenting.

Home visiting practices to address health equities

Strategies applied in home visiting programs support participants and their families in developing tools and accessing resources to garner growth, confidence and self-sufficiency. Resources are not only those tangible and observable ones, such as a stress-management course for young parents or transportation to a health appointment, but also intangible, personal tools to support participants in becoming their best selves. Some of these practices and resources with impact on health equities are described below.

Standardized screenings are an integral part of home visiting that facilitate the early and regular identification of risk factors negatively affecting the health and livelihood of our participants. Screenings serve to monitor health and social risk factors for all participants, invite opportunities for discussion and allow for exploration of sensitive and difficult experiences, and identify risk situations warranting referral for further follow up. While screenings are often dictated by funders, those applied in Mary's Center programs include evidence-based tools to monitor depression and perinatal mood disorders, intimate partner violence, adverse childhood experiences, substance abuse, and child development milestones.

Family Goal Planning is a tool used to facilitate participant and home visitor working together to develop goals and break those goals into meaningful and manageable steps/objectives. When facing chronic social hardship, trauma, and challenge, it is difficult for one to think beyond survival, losing the ability to consider the future and possibly damaging one's feelings of self-worth and perceived or actual threats to family functioning. The process of breaking larger goals into small steps assists parents in developing problem-solving skills, increases the individual's sense of power over their situation, and supports adult brain development. The skills parents build in the process of outlining and achieving self-identified successes changes the way parents view the world, increases their self-efficacy, enhances internal motivation and builds protective factors.

A strength-based approach is another practice integrated into Mary's Center home visiting programs which draws attention to a participant's strengths and abilities rather than the problems, deficits, and pathologies they may be facing (Saleebey, 2006). In strength-based practice, the participant is supported to identify and build upon these positive traits and work towards positive change. With individuals who have been raised in communities of hardship and limited social and emotional support, this change in perspective and attention to personal strengths elicits a shift towards a more positive mind-set, optimism and confidence, ultimately contributing to healthier and more positive behaviors.

Trauma-informed care is applied in home visiting to support participants in understanding the effects of trauma on their minds and bodies, as well as identify triggers, physical manifestations of stress, and methods of self-regulation and self-care. Utilizing a trauma-informed lens in home visiting allows for the creation of a safer and more trusting environment where participants can explore emotions and past experiences without judgement or expectations. Home visitors form connections, support participants in recognizing and naming emotions, help people improve their self-agency, and create consistent and clear boundaries (Gates, 2020). Application of this approach with adults has been shown to help them to build positive attachments with children, create a safe environment and nurture relationships with their children (Cairone et al., 2017).

An essential part of home visiting is flexibility. Prior to the pandemic, staff would hold visits where families were physically located; whether it be in the home or a doctors' office waiting room. Using the Facilitating Attuned Interactions Approach, this presence is not only felt physically but also expressed emotionally (Erikson Institute, 2018). Home visitors tailor their support according to the needs of the participants and are consistently present adjusting to what may be most beneficial at the time. For example, a parent may be seeking a listening ear to express frustration with accessing health services, while a moment later, he/she may be seeking assistance in planning for her child's upcoming medical appointment. The tools and models outlined contribute to the development of trusting relationships while positively contributing to participants' sense of self and confidence. All the while, these approaches model practices that parents themselves can put in place with their children and contribute to more positive productive parent-child relationships.

Adaptations made to home visiting in pandemic

Home visiting programs have had to quickly adapt their interventions and models under the new remote environment in response to COVID-19. The most significant adaptation has been to transition the services in the home to tele-home visiting, in which all services were provided remotely via tele- conferencing. National models such as Parents As Teachers, Nurse Family Partnership (NFP) and Healthy Families America provided guidelines and adaptations in response to COVID-19 to continue to support local programs (National Alliance of Home Visiting Models, 2020).

As an agency, Mary's Center quickly developed guidelines and protocols in response to the pandemic following the guidelines provided by the Centers for Disease Control (CDC), home visiting national models, and allied professionals such as medicine and behavioral health who had research to support this service modality (Hutkins Seda, 2020). For example, in a systemic review of tele-behavioral health services using Cognitive Behavioral Therapy (CBT), it was found that tele-behavioral health services are equal to in-person therapy and may have more long-term impact beyond the end of treatment (Dettore et al., 2015; Vogel et al., 2012). In addition, Mary's Center has provided telemedicine and tele-behavioral health services for several years showing success since our use of tele-health in 2017. A Managed Care Organization partner, AmeriHealth, has publicly commented that Mary's Center's telemedicine has been "extremely beneficial" with performance outweighing other similar providers, and exceeding national quality assurance benchmarks for medical services such as diabetes care (Evans & Koppelman, 2018). It is with these successes that many protocols were easily adapted to home visiting programming.

When visits became virtual, HFA released prompts to support home visitors with achieving the HFA Best Practice Standards to "assess, address, and promote positive parent-child interaction, attachment, and bonding and the development of nurturing parent-child relationships" (Healthy Families America, 2018). These new guidelines allow for home visitors to either use observations through video visits, or open-ended questions to elicit parents description of their interaction with their children on phone calls (Healthy Families America, 2020). Similarly, to adjust to tele-home visits, Parents as Teachers introduced "Verbal Videos," a technique that guides parents to narrate telephone visits, which allows parents to observe their children's cues while stimulating language development. With the parent-child interaction observations or narrations, home visitors continue to follow programmatic guidelines as part of in-person visits, and address specific strengths while introducing relevant curriculum to address parents' concerns.

It is in this same space where home visiting has adapted its strategy to provide the support matching participants' most immediate needs. Basic material needs including groceries, diapers and formula, safe transportation, and safe secure housing all came to the forefront as most sought-after resources during the initial months of the pandemic. Within this context, many resources and opportunities became available in the metro area, yet logistics were consistently changing, eligibility criteria was often restricted or varied, and communication about what was available was challenged by the stay-at-home order itself. While families are required to stay at home, the home visitor is a central resource providing access to important services relevant and appropriate for families. Home visitors also have already-established relationships with other community-based programs, consistently receiving up-to-date information and a direct contact to optimize family's time and chance of

success.

Beyond the creative contact methods and structural strategies of home visiting, home visitors recognized that simply living under COVID-19 is a new norm for participants. Mary's Center Home Visiting is aware that COVID-19 has magnified issues already present in the environment and our program makes space to intentionally incorporate self-care strategies for our participants, especially parents. An example of this is the Father-Child Attachment program that has opened forums for fathers to discuss masculinity and mental health amid the social upheaval of the pandemic and evolving awareness around police brutality. Home visitors and participants have co-created space that allows for the discussion of the emotional and mental toll these stressors present.

While the most notable consequences of the pandemic have been those hindering health and access to services, there are positive effects of the paradigm shift caused by the pandemic. Access to some health services available through a tele-format has increased during the past few months. At Mary's Center we have seen an increase in number of patients seeking mental health services offered virtually. Anecdotally, reasons for this increase may be attributed to participants having more time available to attend clinical appointments remotely while increased need for these services may also be a factor. In complement to individual therapy, group care is increasing across the country; Postpartum Support International reports the number of women participating in online support groups has increased 400% from February to April 2020 (Maternal Mental Health Leadership Alliance, 2020). This expansion is not exclusive to mental health services and the potential of tele-health services expanding access to other areas of care is changing entire landscapes of health systems. At Mary's Center, tele-health services are already an integral component of our service delivery strategy, and are growing in areas of medical, dentistry, behavioral health, social services, and home visiting, improving access for those who previously did not attend in-person appointments. National home visiting models have made these easy, establishing guidelines for tele-visits years ago, and now expanded support and investment for their implementation is warranted within this system as well as nationally (Healthy Families America, 2020; Nurse Family Partnership, 2020).

Conclusion

Families have been negatively impacted by the pandemic yet the effect is deeper among families who are suffering from social and health inequities. The pandemic has unveiled countless examples of the wide-ranging disparities - unemployment, food scarcities, anxieties, depression, loneliness and family stressors. As these social determinants and upstream aspects of well-being and health are supported with safety net services such as home visiting, these programs need to be financed, utilized and expanded now more than ever.

There is a call for investment in innovative home visiting models to address the new and developing needs of families in this time of crises. NFP is an evidence-based model where nurses deliver in-home clinical and social services directly to women and families during vulnerable periods of life such as pregnancy and postpartum. Programs where fathers and male partners are engaged limited even as the literature focuses attention to the role of the father in a child's development and the importance of the family unit. Mary's Center is at the forefront of moving these new models forward, through participation in local advocacy and leadership in home visiting coalitions. Increased investment and support for this work would extend the reach and the impact of home visiting services to those who most need it.

While existing evidence demonstrates positive outcomes, additional research on innovative home visiting models would support funding and expansion of such services. Research on the fidelity of programs to a national model is informative. Of even greater value would be further understanding of program outcomes in different contexts and amid new social and economic challenges. Particularly now, as models across the country are adjusting to virtual engagement, understanding of home visiting best-practices and effectiveness of this strategy is warranted.

Until larger systemic changes occur in social and economic policy to address racial and ethnic disparities, families will continue to experience hardships resulting from inequity in social determinants of health. Moreover, independent of the time it will take for that systemic change, all families experiencing vulnerable times during early childhood, pregnancy, and parenting can benefit from the availability of a home visitor to be that steady force when needed.

Funding information

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