Babies First! and CaCoon

Manual 2024- Chapter 3

PUBLIC HEALTH DIVISION
Maternal and Child Health

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Evidence-Based and Evidence-Informed Practices

Evidence-based practice (EBP) incorporates the latest scientific research into clinical practice, while honoring clinical experience and client preference (see John's Hopkins Center for Nursing Inquiry).

Evidence-based practice is a structured approach that follows a series of steps to implement a practice shown to be effective. Evidence-informed practice (EIP) integrates multiple approaches to apply evidence to practice and relies on practitioners to apply evidence-based steps while considering client circumstances (16).

Both EIP and EBP use the approach of implementing research and evidence into practice. Examples of this are using validated and evidence-based tools like:

- The Patient's Health Questionnaire – 9 (PHQ9)
- Ages and Stages Questionnaire (ASQ)
- Social Determinants of Health (SDOH)

However, there are significant differences between the clinical approach of EIP and EBP. While evidence-informed practice still relies on the use of the best available research, it typically includes a wider scope than evidence-based practice, such as incorporating multiple types of research (e.g., qualitative), practitioner knowledge and expertise and client preference. In addition, evidence-informed practice can provide more flexibility by encompassing information besides clinical studies, like clinical best practice guidelines, more quickly than evidence-based practice.

Figure 2. Oregon Nurse Home Visiting Programs include EBP and EIP

Healthy Outcomes from Positive Experiences

Healthy Outcomes from Positive Experiences (HOPE) is a model of assessing, interacting and being with families that supports the growing body of research that shows positive experience in childhood have long lasting positive effects on health, even in the face of adverse childhood experiences. The HOPE model delineates four building blocks upon which “hopeful moments" are built: Relationships with adult and other children; safe, stable, and equitable Environments; social and civic Engagement; and social and Emotional Growth. The HOPE framework can be used in multiple aspects of home visiting, from policy development, to referrals, to screenings and assessments. For example, the HOPE framework details three stages of conducting a screening:

- Preparing (explanations and consent)
- Conducting the screener (brain science, safe space, screener)
- After the screener (positive experiences and HOPEful messaging)

Please see this one-pager and visit the HOPE website for more details related to this concept. Throughout the manual, HOPE ideas will be detailed in block quotes. Please reach out to your state nurse consultant for more information and available training in this foundational concept.

Family-Led and Family-Centered

Family-led and family-centered care form the bedrock of home visiting. Its core tenets revolve around forming a true partnership between the families and the home visitors, one that celebrates family strengths while acknowledging the unique challenges each family faces.

Family-centered care assures the health and well-being of children and their families through a respectful family-professional partnership. It honors the strengths, cultures, traditions, and expertise that everyone brings to this relationship. Family-centered care is the standard of practice and marks a significant shift from conventional healthcare dynamics. It means placing the family at the center of all decisions related to care and treatment plans. In family-led care, families take an active role in identifying their needs, stating their preferences, and contributing to the strategies that impact their lives. This means they are not just recipients of care but active participants in the care process, often providing valuable insights and making decisions that healthcare professionals support and facilitate. Family-led care dovetails seamlessly with family-centered care by deepening the partnership between families and healthcare professionals. If family-centered care lays the groundwork for collaboration, family-led care takes it a step further by handing over the steering wheel, metaphorically, to families.

The foundation of family-centered care is the partnership between families and professionals. Based on the work done by the Maternal and Child Health Bureau, Division of Services for Children

with Special Health Needs, the key to this partnership are the following principles (https://familyvoices.org/familycenteredcare/):

Families and professionals work together in the best interest of the child and the family. As the child grows, they assume a partnership role.

- Everyone respects the skills and expertise brought to the relationship.
- Trust is acknowledged as fundamental.
- Communication and information sharing are open and objective.
- Participants make decisions together.
- There is a willingness to negotiate.

Based on this partnership, family-centered care:

- Acknowledges the family as the constant in a child's life.
- Builds on family strengths.
- Supports the child in learning about and participating in their care and decision making.
- Honors cultural diversity and family traditions.
- Recognizes the importance of community-based services.
- Promotes an individual and developmental approach.
- Encourages family-to-family and peer support.
- Supports youth as they transition to adulthood.
- Develops policies, practices and systems that are family-friendly and family-centered in all settings.
- Celebrates successes.

To this end, Babies First! and CaCoon clients shall receive upon enrollment a Client Bill of Rights as shown in Appendix F.

Best Practice:

- Bill of rights shall be translated into client's primary language.
- Bill of rights shall be read to client if they cannot read.
- Bill of rights may be printed, texted, or emailed, based on client's preference.

Family Engagement

Goal setting: Readiness to Change

A key tenant of family-centered care is supporting the client to accomplish their goals. This is often thought of as “behavior change"; however, a more strength-based approach is to focus on the client as the agent of their own behavior change, rather than the home visitor intervening to create behavior change in the client “for their own good."

Motivational Interviewing is a method for facilitating and engaging intrinsic motivation within the client to change behavior. MI has been described as goal-oriented, client-centered technique for eliciting behavior change by helping clients to explore and resolve ambivalence. It can also be used to assess a client's readiness to change. MI is considered an evidence-based approach; but it is important to note the technique is based in western psychology. Cultural adaptation of MI is under investigation and has been limited in scope (2). However, even within the limited western-based research, evidence is emerging that cultural adaptations in MI should be considered (e.g., appropriate greetings, congruence of language, use of humor, use of storytelling, more open therapeutic use of self) (3). The Babies First! and CaCoon programs will be exploring these concepts more in the future.

Care Coordination

The Maternal and Child Health Bureau defines care coordination as “the effective and efficient organization and utilization of resources to access the necessary comprehensive services for children with special health care needs and their families (Omnibus Reconciliation Act, 1989).

Care coordination involves arranging and integrating the delivery of health and related services across providers and service systems over time. Care coordination is a proactive process that “evaluates the delivery of comprehensive health care to the child and support services to the family in conjunction with the family and community providers." It is directed toward the family unit and includes assessment, individualized service planning, implementation, monitoring, and evaluation of the domains of health, environment, financial, psycho-social-cultural and community resources (1).

Care coordination is an essential component of service delivery for children and youth with special health needs and their families. Children with chronic illness or disability often have complex medical, education, social and/or vocational needs that require a wide range of services. The number of providers and agencies involved in their care can be overwhelming for families. In addition, not all services are available locally, so families often travel some distance for specialty and tertiary care. Fragmentation, duplication of services, gaps in communication or service, and failure to actively involve the family in the overall plan for care become barriers to effective ongoing care for children. In home visiting, the ultimate goal is for families to learn to navigate systems of care independently of the home visitor: the home visitor meets families where they are at while scaffolding skills needed at discharge.

Relationship-Based Care and Infant Mental Health

Relationship-based care is an important paradigm in providing Home Visiting to families. It's predicated on Attachment Theory, the Parallel Process (pg. 50), Infant Mental Health and Early Relational Health concepts. Research clearly shows that children grow and thrive in the context of close and dependable relationships that provide love and nurturance, security, responsive interaction, and encouragement for exploration.

The Infant Mental Health (IMH) paradigm is a core tenet of home visiting services. It uses the parallel process and is relationship-based, culturally responsive and trauma informed. IMH focuses on the infant's experience, and “always keeps the baby in mind." Infant mental health endorsement is encouraged, but not required. See the Oregon Infant Mental Health Association to learn more or contact your state nurse consultant.

Nurses and CHWs in home visiting programs work on early relationships in the context of the greater environmental and cultural context. We assess and intervene in social, emotional, mental and physical domains to help improve the lives of children and families. We institute key relational health activities with clients to improve the health of our families. These include education, case management, and behavior change, all of which require a strong relationship between provider and client. There are many opportunities for professional development in this area: contact your state nurse consultant for more information.

Trauma-Informed

Trauma-informed care (TIC) shifts the paradigm from focusing on illustrating what's wrong with an individual to what has happened in an individual's life. Using this approach can improve engagement and health outcomes.

Trauma-informed care seeks to:

- Realize the widespread impact of trauma and understand paths for recovery.
- Recognize the signs and symptoms of trauma in patients, families, and staff.
- Integrate knowledge about trauma into policies, procedures, and practices.
- Actively avoid re-traumatization.

(Adapted from the Substance Abuse and Mental Health Services Administration's Trauma-Informed Approach.)

The core principles of trauma-informed approach are:

- Safety
- Trustworthiness
- Transparency
- Peer Support
- Collaboration
- Empowerment
- Humility/ Responsiveness

See TIC for more information.

Equity and Inclusion

Local programs must ensure they maintain an equity and inclusion commitment. Health equity is achieved when everyone can access affordable, culturally safe care to attain their full potential for health and well-being. The Babies First! and CaCoon program joint values are stated in Chapter 1.

OCCYSHN and OHA Maternal and Child Health Section have equity statements that must also be fulfilled by home visiting programs.

OCCYSHN operates on the principle that all children and youth with special health care needs (CYSHCN) deserve equitable access to quality health care. Because racism and other forms of discrimination affect the health and health care of Oregon CYSHCN and their families, OCCYSHN will:

- Challenge ourselves to identify and address our own practices that reinforce bias.
- Educate ourselves and our partners about the needs of diverse families we serve, and the health disparities they face.
- Seek guidance from diverse families and partners and welcome their feedback.
- Be accountable to communities of color and other underserved populations.
- Prioritize health equity, diversity and inclusion in our programs, policies, and practices.
- Address systemic barriers to equitable health care in Oregon.

OCCYSHN depends on input from and collaboration with families, youth, and professional partners as we pursue health equity for all Oregon CYSHCN.

Likewise, the Maternal and Child Health Section commits to working against racism by stating:

- We acknowledge that communities of color and tribal and indigenous communities in Oregon experience inequities and disparities in health due to racism, oppression and historical trauma.
- We envision an Oregon where racial inequities and disparities are eliminated and communities of color experience lifelong health and wellbeing.
- We will create policies, programs and procedures to address structural and institutional racism, and hold ourselves accountable to them.

Racial and ethnic diversity of the target population in a county's home visiting program should be established based on populations in the county and should be addressed through targeted outreach, appropriate policies, staff training and support to assure equal access, equitable services, and non-discriminatory practices.

Cultural Responsiveness and Creating Cultural Safety

The First Nation's Health Authority defines cultural responsiveness as a practice that,

“enables individuals and organizations to respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientations, and other diversity factors in a manner that recognizes, affirms, and values their worth." (4)

And Cultural Safety as,

“an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care." (4)

Thus, we embrace cultural responsiveness to provide cultural safety. We move beyond “cultural competence" to challenge the cultural systems that hold power so that all our clients feel safe and respected and have equitable access to, and utilization of, home visiting services.

Disability Etiquette

As our society continues to grow toward including persons with differences into the mainstream of community life, it is important that we adopt communication styles and behaviors that will be respectful of others regardless of their abilities. The attitudes and behaviors of nurses and other health care providers toward an infant born with, or a child diagnosed with, a disability can influence parental reaction. How parents react to their child has the greatest impact on their child's growth and development. We need to recognize and be supportive of the potential that exists for each child and each family, even though it will be different than they anticipated (Wong, 2004). This resource from the United Spinal Association provides a helpful guide on interacting with people with disabilities.

Reflective Practice

Reflective Practice is “regularly 'stepping back' to consider the meaning of what has transpired in relationships, and to examine one's professional and personal responses to these interactions for the purpose of determining further action." (7) Reflective Supervision (RS) is the process through which we carry out reflective practice. RS is a requirement in many home visiting programs precisely because reflective practice is shown to have multiple positive effects on client-provider relationships, enhancing effectiveness while reducing staff burnout and turnover. Reflective practice is an expectation for Babies First! and CaCoon staff and is fulfilled by using the practice methods of Facilitating Attuned Interactions (FAN) and Reflective Supervision (see below).

FAN

Facilitating Attuned Interactions (FAN) is a methodology (or tool, or framework) by which we implement reflective practice and relationship-based care. It's a language and a communication style, which enhances the relationship between client and home visitor, with the goal (remember the parallel process!) of enhancing attunement between parent and child. The Oregon Maternal and Child Health program is committed to supporting the use of FAN in home visiting through on-going trainings. Please reach out to your State Nurse Consultant for more details.

Reflective Supervision

Reflective supervision promotes and supports the development of reflective practice and a relationship-based program.

The approach expands on the idea that supervision is a context for learning and professional development. The key principles of reflective supervision are:

- Supervisors need and deserve training and support
- Reflection is a lifelong developmental process
- Reflective Supervision occurs within a relationship created over time
- Reflection requires slow and intentional stepping back
- Feelings matter
- Parallel process is explored: the child is always held in mind

See the Three Building Blocks of Reflective Supervision from Zero to Three and the Oregon Infant Mental Health Reflective Supervision Toolkit (particularly pages 1-18) for more information. See Appendix E for supporting material for reflective supervision sessions.