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UNIVERSITY OF SAN DIEGO
Hahn School of Nursing and Health Science
DOCTOR OF PHILOSOPHY IN NURSING

PUBLIC HEALTH NURSE DECISIONS REGARDING AT-RISK POSTPARTUM
CASE CLOSURE

by

Denise K. Thompson

A dissertation presented to the
FACULTY OF THE HAHN SCHOOL OF NURSING AND HEALTH SCIENCE
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requirements for the degree
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Dissertation Committee

Lois C. Howland, DrPH, MSN, RN, Chairperson

Mary-Rose Mueller, PhD, RN

Mary Jo Clark, PhD, RN, PHN

Abstract

During the late 19th century, public health nursing emerged in the United States as an autonomous nursing specialty providing maternal-child health (MCH) home visitation services. Present day MCH public health nurses (PHNs), guided by their predecessors, focus on health promotion and disease prevention in at-risk maternal-child populations. Health policies, funding streams, and local public health nursing protocols are examples of extrinsic factors that may affect length of home visitation services for at-risk women and their children. The purpose of this study was to better understand the factors related to variations in PHN decisions to terminate home visitation services for at-risk postpartum clients.

The participants in this qualitative descriptive study were MCH PHNs working in a Southwestern United States public health nursing department. Snowball sampling was incorporated in order to reach a purposive sample saturation of 18 PHNs. The data consisted of verbatim transcripts of semi-structured, open-ended interviews with individual participants; field notes; and analytic memos. Data analysis was an ongoing process of conventional content analysis which included the incorporation of new data and researcher reflections. Consensual validation of the results was achieved through the participation of the research committee members' peer review of the analysis process and study results.

This work has resulted in three manuscripts. The first manuscript, "*The Patient Protection and Affordable Care Act of 2010(PL 111-148): An Analysis of Maternal-Child Health Home Visitation*", was published in the journal of Policy, Politics, and Nursing

Practice. The second and third manuscripts, “*At-Risk Postpartum Clients Receiving Public Health Nurse Home Visitation Services, Part I: Opening a Case; and Part II: Closing a Case*”, describe the study methodology and research findings. Study results indicated that PHN case closure decisions occur along a continuum of cognitive analysis and intuition. Services are rendered on a short-term or long-term basis and length of services are affected by PHN, workplace, and client factors.

The findings suggest the need to advance the research specific to PHN home visitation services for at-risk postpartum women and their children.

Dedication

“Service, in a way, is simply a means of expressing your being for that person – and often with the poorest people you cannot completely alleviate their problem. But by being with them, by being for them, whatever you can do for them makes a difference.”
Mother Teresa (Vardey, 1995).

This work is dedicated to public health nurses. May you never grow weary of serving the vulnerable members of our society.

I want to thank my 92 year old mother-in-law, Doris Thompson. Your unwavering faith in me kept me going on the most difficult of days. And this journey could not have been possible without the support of my husband, Dave. Whether he wanted to or not, he now knows about the work of public health nurse home visitation, about APA writing and journal publication, and more importantly that the power of love and prayer makes all the difference on a doctoral studies journey.

Acknowledgments

I would like to thank my dissertation chair, Dr. Lois Howland, who graciously agreed to walk alongside me on this journey. Her encouragement and many thoughtful and wonderful suggestions kept me moving forward. I also want to thank Dr. Mary-Rose Mueller for introducing me to the world of a qualitative researcher. I am grateful for her words of kindness and inspiration that were always sprinkled with excitement regarding the discoveries to be found in the stories of research participants. I have immense respect and gratitude for the help of Dr. Mary Jo Clark, the third member of my dissertation committee. My first attempt at journal submission would not have resulted in my first publication without her guidance and editorial support.

In conclusion, I would also like to express my appreciation to the public health administration and the public health nurse participants for their part in bringing this research to life. The work of public health nurses is often obscure, unfamiliar, and underappreciated by many. I hope that I have briefly directed a spotlight on the wonderful contributions that public health nurses bring to our neighborhoods and communities.

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Chapter 1

Introduction

During the late 19th century, public health nursing emerged as an autonomous nursing specialty providing maternal-child health (MCH) home visitation services (Frachel, 1988; Thompson, Kropenske, Heinicke, Gomby, & Halfon, 2001). Present day public health nurses (PHNs) continue to follow in the footsteps of their predecessors through the provision of home visitation services focusing on health promotion and disease prevention in at-risk maternal and child populations. Health policies, funding streams, and local public health nursing protocols are examples of extrinsic factors that may indirectly affect length of service and ultimate outcomes of home visitation services to at-risk populations (Advocates for Children and Youth, 2009; County of Mohave Arizona, 2007; County of San Diego, 2010b; Wasserman, 2006; Winning Beginning, 2011). Protocols guided by public health nursing standards provide structured or broad guidance regarding content, frequency, and duration of home visitation services. However, individual PHNs also have the opportunity to make independent decisions regarding termination of home visitation services to their clients. A decision to prematurely close a case to home visitation services has the potential to negatively affect achievement of optimal case outcomes.

Background

A public health perspective views MCH data as one indicator of the overall health of a country (MacDorman & Mathews, 2008; U.S. Department of Health and Human Services [USDHHS], n.d.). Home visitation is a global strategy used to promote health

and wellness in families (Wasik & Bryant, 2001). Industrialized European countries with a foundation of universal healthcare have a history of providing nurse home visitation services to MCH populations (Bingham, Strauss, & Coeytaux, 2011). Wasik and Bryant (2001) summarized the broad range of home visitation services provided to maternal-child populations in several European countries. The Netherlands was specifically noted for its quality postpartum care including home visits to new mothers and their infants. European countries, such as the United Kingdom, Switzerland, Belgium, and the Netherlands, share a fundamental belief that MCH home visitation services are an essential part of health services for all their citizens. The United States, on the other hand, continues to grapple with issues of universal access to healthcare (Reid, 2009). This, in turn, affects attitudes towards provision of and access to nurse home visitation services for MCH populations.

Infant mortality rates are an example of a marker of the health of a nation's maternal-child population. For more than three decades, the United States has reported a decline in its infant mortality ranking as compared to countries with universal access to healthcare (Bingham, et al., 2011). As of 2005, the United States ranked 29th among the developed nations of the world on this population health indicator (MacDorman & Mathews, 2008).

The USDHHS defines a maternal-child health population as inclusive of America's "...women, infants, children, adolescents, and their families..." (Maternal and Child Health Bureau, [MCHB], n.d.a, p.4). This population includes a subcategory of mothers and children considered to be an at-risk population group. Principles of applied epidemiology and public health surveillance measures are utilized in identifying these

individuals or groups of individuals considered to be “at-risk” (Centers for Disease Control and Prevention [CDC], n.d.). “High risk” and “vulnerable populations” are synonymous terms used interchangeably in the literature with the term at-risk (Stanhope & Lancaster, 2010). The CDC defined a high-risk population as “a group of persons whose risk for a particular disease, injury, or other health condition is greater than that of the rest of their community or population” (CDC, n.d. p.9).

This study focuses on services to at-risk postpartum women who are receiving PHN home visits as a result of identified increased risk for health and social morbidities. Research related to home visitation services initiated in the postpartum period is lacking for this population. Discovering factors that influence PHN decisions to terminate services to these women may help highlight areas amenable to future research in support of evidence-based practice. Home visitation services are one method used by PHNs to meet practice objectives aimed at “promoting and protecting the health of populations” (American Nurses Association, 2007, p.5). The provision of quality nursing services is critical to meeting this objective. In addition, national goals directed towards decreasing prenatal and postpartum at-risk outcomes, such as infant mortality rates and difficulty in accessing early prenatal care, are supported by federal dollars. The Title V Maternal and Child Health Block Grant Program is an example of designated federal funding for research and services, which includes home visitation services to postpartum women and their children (MCHB, n.d.b). Although the United States does not currently provide universal access to healthcare, the country as a whole does recognize at-risk women and their children as vulnerable populations in need of support services.

Identification of the Problem

The purpose of this research slowly evolved from conversations with PHNs. These PHNs were field nurses, supervisors, and managers of public health centers. No matter the role of the PHN, they all had a vested interest in delivering evidence-based, beneficial, and cost effective PHN home visitation services to the at-risk MCH population. The current United States economic recession, which began as far back as December 2008, has caused health professionals, government officials, and voters to question the cost-benefits of PHN home visiting services (Isidore, 2008; Wasserman, 2006). In the 2009 presidential budget proposal, newly-elected President Obama promised healthcare reform for the nation and included federal funding for evidence-based home visitation services to MCH clients (Child Welfare League of America, 2009; Office of Management and Budget, 2010). With promises of federal dollars supporting home visitation services, community organizations and health departments began to increase their scrutiny of these services. Local public health departments began to discuss strategies for providing the most cost-effective PHN home visitation services to at-risk MCH populations, including at-risk postpartum women. These strategies would also need to include ways to prove their cost-effectiveness to stakeholders.

One result of the search for cost-effective home visitation services has been countywide expansions of the Nurse Family Partnership (NFP) public health program. David Olds, founder of the NFP, has been reporting results of more than 30 years of research in the area of PHN home visitation services to low income, at-risk pregnant women. Although these services continue throughout the postpartum period, these home visitation services must be initiated early in the pregnancy. Olds and his colleagues have

been able to demonstrate beneficial program outcomes and fiscal accountability to government funders (Nurse Family Partnership [NFP], n.d., 2010). In 2010, based on the strong research results of the NFP, the county health department in which this study will take place converted a majority of their PHN generalist MCH positions to PHN NFP positions. However, an important question remained unanswered. If PHNs were to continue to provide in-home visitation services to at-risk women begun during the postpartum period, how long should these services be provided and when should the PHNs close these cases? Unfortunately, research in this area is limited. The time has come to find answers regarding PHN home visitation services begun in the postpartum period, following the research trail blazed by Dr. Olds and colleagues regarding services initiated in the early prenatal period.

As a former generalist MCH PHN and PHN supervisor, I saw firsthand and also heard anecdotal stories of lives that were changed as a result of PHN home visits to at-risk post-partum women and their children. PHNs incorporated guiding principles of public health nursing in their work of promoting healthy families and healthy communities. Results such as fully immunized children, mental health linkages for depressed mothers, breastfed babies, and finding safe shelter for domestic violence victims are just some of the outcomes resulting from PHN home visitation services initiated in the postpartum period. On the other hand, I also wondered at times, if my decisions to close cases to home visitation services were for the optimal benefit of the client or perhaps influenced by unnamed situational factors. As a PHN supervisor, I recalled conversations with PHNs regarding the influences of protocol, client, and PHN-work-environment-driven factors on decisions to terminate PHN home visitation services

to clients. General protocols allowed for some PHN autonomy in this decision-making process. However, broad protocols do not necessarily acknowledge the situational factors that may influence a PHN's final decision to terminate services to a client.

In reviewing the literature, I was disheartened to find that the research specific to PHN services to at-risk postpartum mothers is sparse. As government services continue to suffer the effects of budget cuts followed by more budget cuts, public health services to vulnerable populations are often the first to feel the repercussions from decreased funding (Krisberg, 2010; Schultz, 2009). Without rigorous research providing data to support the effectiveness of PHN services to at-risk postpartum women, funding may disappear. The at-risk women, however, will not disappear.

Time is of the essence. PHNs are unique providers of these public health home visitation services and thus should have a voice in the fate of these services. I plan to talk to the PHNs themselves, to better understand the decision-making process involved in terminating a case to home visitation services and to discover what factors are involved in the decision to terminate services to an at-risk postpartum woman. Perhaps factors will be discovered that are amenable to process improvement, whether on an individual client-centered or systems level.

Characteristics of the maternal-child at-risk population. What characteristics cause a postpartum woman to be considered at-risk? Poverty is one indicator of socioeconomic disparity affecting the health outcomes of individuals and populations beginning as early as birth (John D. and Katherine T. MacArthur Foundation, 2008; Lantz & Pritchard, 2010). Women and their children have an increased risk of living in poverty. Twenty-five percent of female, single, head-of-household families live in

poverty as compared to only 11.7% of single male head of household families (Administration on Children, Youth, and Families, 2010). Kramer, Seguin, Lydon, and Goulet (2000) investigated links between socioeconomic status and negative pregnancy outcomes. They concluded that poverty increases exposure to “stress and psychological reactions to stress...” (p. 197), which, subsequently increases the likelihood of negative outcomes such as preterm birth and intrauterine growth retardation (IUGR). Being born into poverty inherently predisposes a child to a life of poverty, thus perpetuating a cycle of negative health repercussions (Larson, 2007).

Pregnancy is considered by most people to be a positive experience in a woman’s life (Curtis, 2003; Office on Women’s Health, 2010). Unfortunately, this may not be true for at-risk mothers and their children. Aside from the increased risk of poverty, pregnant and postpartum women also have an increased risk of physical danger. Chang, Berg, Saltzman, and Herndon (2005) found homicide to be the “second leading cause of injury-related death among pregnant and postpartum women” (p. 472). As a result of infants’ dependence on postpartum mothers for care, they may also experience negative consequences from being born into an at-risk family. Stressors related to family violence, substance abuse, and lower income all contribute to reported cases of child abuse and neglect (Goldman, Salus, Wolcott & Kennedy, 2003).

Maternal postpartum depression is another condition currently receiving attention as a serious morbidity of the postpartum period, and poverty is associated with increased rates of postpartum depression (Brett & Williams, 2008; Wentzel-Rochester, 2010). In addition, infants dependent on depressed postpartum mothers are further subjected to the consequences of depression (Logsdon, Wisner, & Pinto-Foltz, 2006). Field (2010) found

that depressed mothers struggle to interact with their infant, parent their infant, and incorporate infant safety practices into their daily lives.

A caring and just society cannot ignore the vulnerability of postpartum women and their young children. Public health nurses must continue to support expansion of research regarding home visitation services to at-risk postpartum clients in efforts to advocate for a population that may not be able to advocate for themselves. (Quad Council of Public Health Nursing Organizations, 2004).

Gaps in the Literature

Literature targeting home visitation services to maternal-child health clients has continued to expand as funding sources increasingly call for evidence-based practice culminating in beneficial program outcomes. The majority of studies surrounding nurse home visitation services to women have targeted the prenatal period. Over the past 30 years, Olds and colleagues have done significant work in advancing research specific to public health nurse home visitation services to low-income, first time pregnant women (Goodman, 2006). Less attention has been devoted to the postnatal period except as related to child abuse prevention (Schaefer, 2010).

Home visitation research seeks to determine the effectiveness of home visitation programs; however, research focusing on the role of various factors affecting case closure and subsequent case outcomes has not been addressed. Furthermore, few studies are specific to PHNs, few have examined these factors from the viewpoint of the PHN, and few are considered to be empirically methodologically rigorous (Daro, McCurdy, & Nelson, 2005; Gomby, 2005; Stoltzfus & Lynch, 2009; Thompson et al., 2001).

A consensus is emerging that length of service affects case outcomes and premature termination of services to a client has significant ramifications for outcomes. PHN interventions directed toward achieving optimal outcomes can no longer occur once home visitation services are terminated. Anecdotal PHN and client viewpoints are prevalent, but these, along with author opinions, lack a foundation of rigorous methodological research regarding factors affecting PHN decisions to terminate home visitation services to at-risk postpartum women (Daro, McCurdy, & Nelson, 2005; Gomby, 2005; Paavilainen & Astedt-Kurki, 1997; Stoltzfus & Lynch, 2009; Thompson et al., 2001).

The social science disciplines have contributed substantially to advancing the understanding of human decision-making. The practice of nursing involves continuous implementation of decision-making courses of action. An understanding of the influence of situational factors on the decision-making process involved in PHN case management may provide insight into factors amenable to intervention. Application of decision-making theories will be commented on as dictated by the data during the analysis phase of the study.

Philosophical Underpinnings of a Qualitative Descriptive Study

Naturalistic inquiry, in contrast to empirical, randomized controlled trials, studies the world in an authentic, natural state (Schwandt, 2007). History speaks of the Milesians, pre-Socratic philosophers, who discarded mythological explanations of the nature of the world to report solely on observed interactions of the elements in the natural world (Trainer, 2011). A fundamental qualitative descriptive study, which reports the data in its natural state, is appropriate for this research. It is important for the research to

clearly document the reality of the factors affecting the practice of public health nursing in the provision of home visitation services to at-risk postpartum clients and their perceived influence on PHN decisions to terminate these services. Only then will PHN home visitation research be ready to proceed toward an ultimate goal of expanding the knowledge needed for best practice, evidence-based services for at-risk postpartum women.

Sandelowski's (2000, 2010) illuminating discourse on qualitative descriptive research supports this method of inquiry as one that is able to stand alone while undergirded by rigorous qualitative methods. A qualitative descriptive study of the factors affecting a PHN's decision to terminate home visitation services will give voice to the reality of the everyday work of individual PHNs. It may also uncover factors important to future research and evidence-based projects regarding PHN home visitation services. An accurate accounting of PHN participant's perceptions will be obtained through semi-structured open-ended individual PHN interviews. The data analysis will utilize principles of interpretive validity to guide the search for factor themes (Sandelowski, 2000). The researcher's role of gathering, interpreting and reporting the data is a critical component of qualitative descriptive work. Founded upon a naturalistic inquiry approach, the data will uncover factors affecting PHNs' real-life practice decisions to terminate home visitation services to at-risk postpartum women. This may ultimately dictate the future course of research and refinement of PHN home visitation services to this at-risk population. Further details regarding the methodology and analysis will be included in the methods section in Chapter Three.

Purpose of the Study

The purpose of this study is to identify factors related to the decision-making process of closing the cases of at-risk postpartum women to public health nurse home visitation services.

Specific Aims

The specific aims are:

1. To explore the decision-making process used by public health nurses in determining when to terminate home visitation services to at-risk postpartum women.
2. To describe factors related to closing cases of at-risk postpartum women to public health nurse home visitation services.

Research Questions

The research questions are:

1. What is the decision-making process that a PHN uses to determine when to close the cases of at-risk postpartum women to public health nurse home visitation services?
2. What are the factors that lead to a PHN decision to terminate home visitation services to at-risk postpartum women?

Summary

A better understanding of factors that influence the decision to terminate home visitation services to at-risk postpartum clients may contribute to improved PHN service delivery to at-risk mothers and to the ongoing development of evidence-based agency home visitation protocols regarding these services. Increased awareness of these factors

has the potential to support public health nursing agency mandates to optimize use of public dollars in the provision of PHN home visitation services to at-risk American families.

Chapter 2

Review of the Literature

The practice of public health nursing has continued to evolve since its late 19th century inception (Frachel, 1988; Thompson et al., 2001). This specialized nursing practice has always stressed health promotion and disease prevention in at-risk populations, including a maternal-child health (MCH) focus. The content and frequency of public health nursing home visitation services is influenced by a myriad of factors, yet the individual public health nurse (PHN) retains some autonomy regarding the scope and duration of home visitation services to at-risk postpartum clients (Advocates for Children and Youth, 2009; County of San Diego, n.d.; Wasserman, 2006; Winning Beginning, 2011). This autonomy has the potential to influence home visitation case outcomes.

A better understanding of the factors affecting the decision to terminate PHN home visitation services to at-risk postpartum clients may contribute to overall knowledge aimed at process improvement of these services to at-risk postpartum women and their children. This chapter seeks to report these factors as found in the literature and identify the current gaps in knowledge with the goal of suggesting future research concerning PHN home visitation services to at-risk postpartum women.

This chapter begins with an overview of the population characteristics that support the need for home visitation services. A basic understanding of how the current PHN practice setting came to be places the work of home visitation in the community setting. The scope and potential consequences of neglecting health services to at-risk postpartum women and their children will also be covered. An appreciation of the risk

factors associated with this population supports the need for quality PHN home visitation services. At the heart of Chapter 2 is the review of the current state of research regarding factors associated with home visitation, and an attempt to uncover knowledge specific to termination of home visiting services. Finally, in light of the gaps in the literature, a rationale for the use of a qualitative research approach is discussed.

The Proposed Research Study

The proposed research study is an attempt to draw attention to the limited body of knowledge addressing current issues regarding termination of PHN home visitation services to at-risk postpartum clients. Journalist T. R. Reid believed the answers to the question, “Do people in your country have a right to health care?” (2009, p. 212) are crucial to the resolution of healthcare reform issues in America today. How does this apply to home visitation services to at-risk postpartum women? In reflecting on this question, decisions regarding funding allocations for health care services rest upon a fundamental moral question of who does and who does not qualify for healthcare services. A push for healthcare services supported by empirical evidence is a priority in today’s legislative actions affecting healthcare dollars. Vulnerable populations who often lack the skills or resources needed to provide this evidence are likely to suffer the consequences of limited spending on their behalf (Community Health Councils, n.d.). The findings of current empirical research related to PHN home visitation services initiated in the prenatal period are bolstering the inclusion of this population in today’s funding sources (NFP, 2011a, 2011c). However, the lack of research involving PHN home visitation services initiated in the postpartum period underscores the need to continue research in this area.

The study rests on the assumption that at-risk postpartum women are in need of PHN home visiting services. PHNs and stakeholders agree that resources should be designated for quality PHN services which result in beneficial MCH outcomes (Stoltzfus & Lynch, 2009). However, research specific to PHNs and at-risk postpartum women is limited. When is the optimal time to terminate home visitation services to an at-risk postpartum client? If a PHN prematurely ends these services, the quality of services and resulting outcomes may suffer. Therefore, this qualitative descriptive study seeks to explore the factors related to closing cases of at-risk postpartum women to PHN home visitation services. The results of the study will serve as a launching point for further research into this critical area of PHN service.

Background

This study addresses the population of at-risk postpartum women who are receiving PHN home visitation services based on recognition of their increased risk for health and social morbidities. The National Institutes of Health Prevention Research Coordination Committee is one example of support for research aimed at mitigating high risk behaviors and conditions and promoting health in identified populations (Office of Disease Prevention, n.d.). Federal funding for home visitation research and services to pregnant and postpartum women and their children has been included in the Title V Maternal and Child Health Block Grant Program (Boonstra, 2009; MCHB, n.d.b). These federal dollars are intended to support national goals related to decreasing adverse prenatal and postpartum outcomes (USDHHS, n.d., 2010). Examples of some of these adverse outcomes include high infant mortality rates, low infant and child immunization rates, and lack of access to care for pregnant women (MCHB, n.d.a). As mentioned,

prenatal home visitation programs have successfully begun to disseminate information demonstrating evidence-based outcomes, yet there is still a need for programs initiated in the postpartum period to do the same (NFP, n.d.).

Public health nursing. Historical accounts of nursing credit nurse leader Lillian Wald with establishing public health nursing (PHN) practice in the United States (Brody, 2011; Stanhope & Lancaster, 2010). In 1895, the practice of health promotion and disease prevention in local communities was formalized with Wald's founding of the first New York City Settlement House (Kalisch & Kalisch, 2004). A settlement house was specifically situated in the local community to provide nursing services in the homes. Wald was also an early promoter of social justice and health equity through her efforts to provide nursing services to anyone in need.

The early work of PHNs within the community, outside of a hospital setting, forged a foundation of autonomy still seen in the practice of public health nursing. Families living in the communities served by the settlement houses often could not afford to pay for medical services from a physician. PHNs independently provided nursing services to families unable to access physician care. Thus, these early PHNs were successful in establishing and running settlement houses with minimal physician involvement. Public health nursing continued to expand and evolve as a nursing specialty, and courses specific to the training of PHNs materialized around 1916. The first assimilation of public health nursing within a local health department did not take place until 1907, and inclusion of a specific focus targeting services to vulnerable maternal and child populations emerged in 1912 (Kalisch & Kalisch, 2004).

As public health nursing continued to be incorporated into state and local health departments, the decision to consolidate professional organization membership under the larger umbrella of the American Public Health Association (APHA) took place in 1923 (Stanhope & Lancaster, 2010). APHA continues to maintain its role as the national public health interdisciplinary professional organization. APHA's various public health disciplines collaborate in their mission of improving the health of the public and simultaneously striving for equitable social determinants of health (American Public Health Association, 2011).

Since consolidating with official health departments and APHA, public health nursing remains embedded in the larger discipline of public health. PHNs comprise the largest group of public health professionals. In 2000, nurses made up 10% of the public health workforce. (Gebbie, Merrill & Tilson, 2002). In 1997, the Quad Council of Public Health Nursing formally recognized eight guiding principles of public health nursing (American Nurses Association, 2007). Quality PHN home visitation services of today are built upon one of the eight principles which is the provision of services to all who may benefit, including at-risk postpartum women. PHNs practicing in the 21st century still share Wald's early public health vision of achieving health and wellness in vulnerable populations such as at-risk mothers and their children.

Public health nursing departments. Across the United States, public health nursing practice within official health departments encompasses different roles. Some of the typical areas in which a PHN may work are Maternal and Child Health, Family Planning, Tuberculosis Control, Communicable Diseases, Sexually Transmitted Infections, Immunizations, and Emergency Preparedness and Response (Clatsop County

Oregon, 2011; County of Los Angeles, 2010; County of Mohave Arizona, 2007; County of San Diego, n.d.; Louisiana Department of Health and Hospitals, 2011; Sacramento County, 2006; Tri-County Health Department, n.d.). Job descriptions for PHNs often include language specifically requiring qualifications to conduct PHN home visitation and case management of at-risk populations, and possession of MCH nursing skills (County of San Diego, 2010a).

Maternal-child health services are recognized as critical to a nation's potential for health and well-being (MCHB, 2008). The Nurse Family Partnership (NFP) is a public health MCH program that provides a specified number of PHN home visitation services to at-risk, low income, first-time-pregnant women. Expansion of the collaboration between this program and local health departments has resulted in a recent shift in the primary role of PHNs in many areas of the United States. The NFP program is currently operating in 32 states, and California alone has 13 county public health departments devoting many of their PHN staff to the NFP program (NFP, 2011b). The NFP has been successful in convincing stakeholders of the increased benefits of their PHN home visitation services with data produced from 30 years of longitudinal research, which included randomized controlled trials (NFP, 2011c). Six specific NFP program outcomes, the first of which is improved prenatal health, have been reported in the literature (NFP, 2011c). Unfortunately, it is too late for postpartum women to meet prenatal program outcomes and they are not eligible to participate in the NFP program unless they began services early in their pregnancy.

In view of the recent expansion of this program in health departments, the job description and duties of many PHNs have evolved from general MCH nursing care into

one with specific requirements mandated by the NFP program (NFP, 2009). For now, the health department [of this research setting] has continued to dedicate some of their remaining PHN staff positions to include home visits to at-risk postpartum women. The benefits of these services have recently been called into question due to the lack of research evidence specific to PHN services initiated in the postpartum period. It is not possible at this time to accurately determine the cost-benefits of PHN home visitation services to at-risk postpartum women or to accurately determine the optimal length of services due to this gap in the research. There is no doubt that establishing home visitation services early in the pregnancy allows for time to form a strong PHN-client relationship. On the other hand, there is also no doubt that until all *U. S. Healthy People 2020* MCH objectives are reached, the United States will continue to have a vulnerable population of at-risk postpartum women and their children not eligible for the NFP program and in need of PHN services. In 2007, 7.1% of all births in the United States were to women receiving late or no prenatal care; these women would not qualify for NFP services and would likely benefit from PHN home visitation services initiated in the postpartum period (Annie E. Casey Foundation, 2011, Martin et al., 2009).

Scope and Consequences of the Problem

In 2008, females comprised 50.7% of the total 304 million persons living in the United States and 40.1% of these females were between the ages of 15 and 44 – the basic childbearing years. Adult female-headed households with children represented 12% of the population in 2008 (MCHB, 2010a, 2010b). Many of these households have little or no health coverage (Maloney & Schumer, 2009). Neglecting PHN services to at-risk postpartum women may result in dire societal consequences.

Poverty. Forty million Americans are living in poverty, with 13% of all U. S. women falling into this group. Women who actually give birth have lower incomes than their non-childbearing counterparts (Braveman et al., 2010). Women and their children also have an increased risk of living in poverty. Twenty-five percent of female, single, head of household families live in poverty compared to only 11.7% of single, male-headed families (MCHB, 2010c). The childbearing years heighten the poverty gap between men and women (Cawthorne, 2008).

Sanders, Lim, & Sohn (2008) proposed that being poor poses a significant risk for population health and mortality. A high prevalence of lower socioeconomic status in childbearing women has been linked to difficult life situations, including poor health (Braveman et al., 2010). This further compounds the potential for negative pregnancy outcomes as represented by increased maternal and infant morbidity and mortality rates (Bingham et al., 2011).

Although the United States has long been considered a highly economically developed nation, the infant mortality rate is holding steady at 6.14 deaths per 1,000 live births. This situates the U.S. well below 42 other countries that have lower infant mortality rates ranging from 1.78 to 5.89 deaths per 1,000 live births (World by Map, 2010). Poverty is intertwined with other socioeconomic and biological factors and contributes to poor pregnancy outcomes, the worst of which is infant mortality (Nagahawatte & Goldenberg, 2008; Sims, Sims, & Bruce, 2007). Larson (2007) further suggested that being born into poverty inherently predisposes a child to a life of poverty, thus perpetuating a cycle of negative health repercussions.

Socioeconomic status is considered to have lifelong health implications that begin as early as birth (John D. and Katherine T. MacArthur Foundation, n.d., Kramer et al., 2000). Cohen, Janicki-Deverts, Chen, and Matthews (2010) created a conceptual model describing the pathway linking a child's early socioeconomic status to poor adult physical health outcomes. A child's adult health can be influenced simply by living in a "risky" (p.43) family. Families considered "risky" exhibit higher than average conflict, negligence in caring for their children, and ineffective parenting skills. These same families often live in high-risk communities plagued by violence, crime, and substandard schools (Cohen et al., 2010). The combination of these factors not only has repercussions for future adult health, but also affects the long-range economic self-sufficiency of lower socioeconomic families. Thus, a generational cycle of poverty and poor health is perpetuated (Smith & Smith, 2010).

Homicide. Studies specific to violence against women and children in the postpartum period are few. However, women who are abused during pregnancy are also likely to experience violence in the postpartum period (Martin, Mackie, Kupper, Buescher, & Moracco, 2001). In 2009, 23% of all homicide victims were female, and women of childbearing age accounted for over 50% of these fatalities (Criminal Justice Information Services Division, 2010). A study by Laughon, Steeves, Parker, Knopp, and Sawin (2008) reported long term traumatic effects in children whose mothers were killed by their fathers. This highlights the consequences of violence for children and their mothers. PHNs have an important role in assessing the risk of intimate partner violence as a routine part of home visitation services.

Postpartum depression. The uniqueness of postpartum depression to women increases a woman's risk for poorer mental health in comparison to men. Infants are also subjected to the consequences of maternal postpartum depression due to poor maternal-infant attachment (Fitelson, Kim, Baker, & Leight, 2011; Logsdon et al., 2006). These infants "can have serious biological, psychological, behavioral, and social consequences..." resulting from their dependence on depressed mothers (National Research Council and Institute of Medicine of the National Academies, 2009; p. 16).

It is reported that as many as 15% of childbearing women in the United States may experience postpartum depression (Brett & Williams, 2008; Fitelson et al., 2011). The link between mothers and young children is clearly articulated by Logsdon, Wisner, and Pinto-Foltz's (2006) concern that "the maternal role is vitally important to ensure the infant's safety, survival, and well-being..." (p. 653). A recent review of research on the effects of postpartum depression highlighted depressed mothers' early struggles with effective parenting, interactions with their infants, and infant safety practices (Field, 2010). Future child behavior and cognition are negatively influenced by the long term consequences of maternal depression (Kersten-Alvarez, Hosman, Riksen-Walraven, vanDoesum, & Hoefnagels, 2010; Murray et al., 2010).

Poverty is associated with increased rates of postpartum depression (Wentzel-Rochester, 2010). A recent study targeting low-income urban black women found an overwhelming 56% of the participants reported symptoms of postpartum depression (Chaudron et al., 2010). Women living in poverty and suffering from postpartum depression may seriously undermine the health and well-being of their infants (Fitelson et al., 2011; Wisner, Chambers, & Sit, 2006). These infants are less often breastfed than

their non-exposed counterparts, resulting in negative repercussions for achieving the U. S. *Healthy People 2020* breastfeeding indicators (Fitelson et al., 2011; McLearn, Minkovitz, Strobino, Marks, & Hou, 2006; USDHHS, 2010; Vericker, Macomber, & Golden, 2010). It has also been suggested that depressed mothers are less prone to engage in activities that stimulate their infants' growth and development, although this continues to be an area needing further research. Another serious concern is the increased chance that an infant of a depressed and poor mother will be exposed to domestic violence and substance abuse (Vericker et al., 2010).

Child abuse. In 2009, the United States reported a national child abuse rate of 9.3 per 1000 children –approximately 700,000 victimized children. Infants less than one year of age made up the highest percentage of these victims, at a rate of 20.6 per 1,000 children. Of the 1,676 child abuse and neglect fatalities reported in 2009, 46 % were children under the age of one year (Administration on Children, Youth, and Families, 2010; Criminal Justice Information Service Division, 2010). Also disturbing is the fact that parents were the cause of 75% of child fatalities, and mothers alone were responsible for 27 % of these fatalities (Administration on Children, Youth, and Families, 2010). A 1999 study involving mothers experiencing postpartum depression found that 41% of the mothers contemplated harming their infants was supported by the more recent work of Fairbrother & Woody (2008) (Jennings, Ross, Popper, & Elmore, 1999). Infants beginning life with an at-risk postpartum mother are in jeopardy of myriad life problems, including the possibility of death. Providing PHN home visitation services to these at-risk postpartum mothers has the potential to decrease abuse risk in these homes.

Nurse Home Visitation Research

The sobering risk factors inherent in the at-risk postpartum population compels PHNs to safeguard these home visitation services. However, judicious use of resources calls for quality services. Simply providing services is not enough. PHN home visitation services founded upon quality nursing research will include answers to the question regarding a PHN's decision to terminate home visiting services and the factors that influence this decision.

Literature targeting home visitation services to maternal-child health clients has continued to expand as funding sources increasingly call for evidence-based practice culminating in beneficial program outcomes. However, the majority of studies specific to nurse home visitation services to women have targeted the prenatal period. Olds and colleagues have been at the forefront of this research (Goodman, 2006). Unfortunately, less attention has been devoted to the postnatal period, except with respect to child abuse prevention (Schaefer, 2010). Furthermore, women who forego prenatal care often have associated substance abuse and other socioeconomic issues. A lack of prenatal care and entry into the healthcare system during the postpartum period automatically excludes these women from receiving prenatal home visitation services; thereby increasing the number of at-risk postpartum women in need of services (Friedman, Heneghan, & Rosenthal, 2009).

Home visitation research seeks to determine the effectiveness of home visitation programs; however, research examining the factors that lead to case closure and subsequent case outcomes has not been addressed. Many factors contributing to the dynamics of PHN-client home visitation interactions have been suggested. Nevertheless,

interviews with PHN participants regarding their home visitation services to at-risk postpartum women is essentially non-existent and many of the prior tangential research studies are considered to be methodologically weak (Daro et al., 2005; Gomby, 2005; Stoltzfus & Lynch, 2009; Thompson et al., 2001).

Kersten-Alvarez et al.'s (2010) study which looked at the results of early non-PHN home visitation services to depressed mothers and their infants is one example of the difficulty in extrapolating research findings that are able to provide foundational knowledge for this proposed area of research. They concluded that non-PHN home visitation services may serve to mitigate some child behavioral problems common to five year olds living in families with multiple life stressors. The researchers acknowledged several study limitations, including insufficient power resulting from a small sample size and a problem with treatment and control group attrition differences. Although this study serves to augment the research supporting home visitation services to at-risk postpartum mothers, it also serves to highlight the lack of research specific to PHN home visitors initiating services to at-risk families during the postpartum period. Ongoing efforts focusing research on the effects of PHN home visitation services to at-risk postpartum women and their children may have potential to strengthen and increase validation of these services (Dennis, 2004).

International PHN home visitation research. In the late 1990s Paavilainen and Astedt-Kurki (1997) obtained data from public health nurses in attempts to discover factors associated with the collaborative work of nurses and their clients. Incorporating a phenomenological methodology, a theme of “friendly and confidential” (p. 140) client-nurse relationships was uncovered. The majority of all home visitation research,

regardless of the strength of the study, emphasizes the importance of *trust* between a client and home visitor, and this is substantiated in the friendly and confidential relationship theme (Gomby, 2005; Thompson et al., 2001). Without PHN-client trust, home visiting services will likely end prematurely. Although, providing a foundation upon which further research can build, Paavilainen and Astedt-Kurki's work (1997) had several limitations. These included dated data, and failure to identify the specific target of PHN services. Perhaps the most significant issue regarding generalizability of the findings to the United States relates to the fact that the research was conducted in Finland. This is a country in polar opposition to the United States in their provision of universal healthcare and, specifically, services to postpartum mothers (Jarvelin, 2002).

A more current study by Drennan and Joseph (2005) was specific to PHN home visitation services and looked primarily at the postpartum period. A public health nurse's ability to incorporate Maslow's hierarchy of needs in prioritizing case management needs and skill in communicating concern for the well-being of the child were factors influencing home visitation services discovered in this exploratory work. However, PHNs with inner city refugee mothers in their caseload were the targeted sample, and again more importantly, the research occurred in the United Kingdom, another country noted for its system of national healthcare, which includes universal postpartum home visitation services (Thompson et al., 2001).

Representing another country with a universal health care perspective, Canadian researchers Jack, DiCenso, and Lohfeld (2005) proposed a theory involving factors affecting the relationship of high-risk mothers and PHNs. Using a grounded theory approach, individual PHN "... characteristics, values, experiences, and actions..."

(p.185) were found to have an influence on the progression toward a trusting relationship. Study participants however, were questioned regarding services received from both PHNs and non-nurse home visitors. This makes it difficult to isolate factors associated with these different roles. Also problematic for this study is the lack of clarification regarding receipt of prenatal, postpartum or early childhood services. These issues in tandem with the study's international setting limit its overall applicability to PHN practice in the United States.

A randomized, controlled study specific to nurses and home visitation services for at-risk postpartum families took place in Australia (Armstrong, Fraser, Dadds, & Morris, 1999). Although the data is dated, it is one of the few reports of a randomized controlled study targeting the postpartum period. The intervention group received scheduled nurse home visits. Nurse factors such as communication, interpersonal approach, and availability were indirectly measured with a patient satisfaction questionnaire at six weeks postpartum. Other instruments, such as a parental self-report questionnaire, Edinburgh Postnatal Depression Scale, and Home Observation for Measurement of the Environment, were used to measure specific family, home, and child outcomes. Satisfied mothers were more likely to complete the full program of services. Mothers in the intervention group were more satisfied than mothers in the control group. The control group received the community standard of care which provided only one postpartum home visit. At-risk families were receptive to the home visitation services when these services were presented as supportive versus surveillance. Multi-disciplinary case conferencing served to augment nurse services. As previously noted, there are limitations in using data from a country providing national healthcare, the nurse visitors were not

specifically noted to be PHNs, and 37% of the participants did not return completed questionnaires (Australian Government, 2005). Since data for this study were collected at six weeks postpartum, there was no reference to closure of the cases. There were, however, recommendations to follow this cohort of mothers. Future use of patient satisfaction surveys and outcome measures with these mothers may serve to provide additional quantitative information to the current knowledge of nurse factors affecting case closure.

U.S. PHN home visitation research. PHN home visitation services in the United States do not provide universal coverage to the MCH population at large. This contributes to the difficulty in identifying literature specific to PHNs and more specifically to services rendered to postpartum women. The work of Olds and colleagues is well known for their research focus on PHN home visitation services, originating from three pivotal studies (NFP, 2011a). However, due to NFP's fundamental belief that successful outcomes are achieved when home visitation services are initiated early in pregnancy, this research is limited in its application to services initiated in the postpartum period (Goodman, 2006). In 2008, an estimated 180,000 women in the United States received late or no prenatal care, and the data indicate the possibility of greater numbers than are currently reported (Annie E. Casey Foundation, 2011). The infants of these mothers are five times more likely to die at birth and three times more likely to be considered low birth-weight than the infants of mothers receiving timely prenatal care (USDHHS, 2006). Unfortunately, this at-risk population of women and children is prohibited from participation in programs which solely target prenatal clients.

Expounding on their 1988 work with prenatal, low-income, first-time-pregnant, African American women, Kitzman, Cole, Yoos, & Olds (1997) looked at the challenges PHNs encountered in providing home visitation services. A logical assumption would be that nursing skills are of paramount importance to the success of PHN home visitation services. However, a preponderance of publications suggests that trust is the key to efficacious PHN engagement with a client and subsequently prevents premature case closure (Gomby, 2005; National Collaborating Centre for Determinants of Health, 2008; Thompson et al., 2001). Consequently, interpersonal factors combined with nursing competency, emerge as primary influencing factors in a home visit encounter. In Kitzman et al. (1997), interpersonal skills of caring, sensitivity to the context of the client's life, and engagement cues during each home visit were reported. It is unknown how applicable the results of this study are to services initiated in the postpartum period as the building of trust occurs over time, and postpartum women would miss out on the extra six or more prenatal months of involvement with a PHN.

Knowledge Gaps

In reviewing the literature it is apparent there is a lack of substantial information supporting identification of factors that may influence a PHN's decision to close a postpartum case to home visitation services. Stajduhar et al. (2010) found this same problem in their literature review of home visitation services provided to end-of-life clients. Although their study was specific to home care nurses and end-of-life clients, they also saw the gap in the knowledge concerning factors affecting decisions to terminate home visitation services to end-of-life clients.

Three major concerns emerge from the home visitation literature on nurse factors. The first involves international research from countries with a universal healthcare perspective. PHN and client world views from these countries are not amenable to direct application to distinct, targeted U.S. populations. Targeting clients for services versus providing universal services has the potential to stigmatize the targeted population, and these clients may be inclined to concur with or even initiate premature closure of cases to home visitation services (Thompson et al., 2001). Also, educational background and maternal-child health experience of PHNs may vary in scope from country to country (National Council of State Boards of Nursing, n.d.).

The second concern involves research that includes paraprofessional home visitors. This is problematic in its application to PHNs, as factors relating to nursing knowledge and process are not acknowledged. Finally, according to Olds (Goodman, 2006), research regarding home visitation services to pregnant women has greater potential for significant outcomes. It is believed that work initiated in early pregnancy has greater potential for notable case outcomes due to the early interventions. It has also been suggested that research with postpartum clients may not yield impressive outcomes in comparison to research and services targeting the prenatal period. The prevailing lack of long range research focusing on PHNs and at-risk postpartum clients invites policy makers and program funding sources to overlook this area of need (Goodman). Minimal research should not imply that studies involving home visitation services to postpartum women are meaningless. Refraining from premature termination of services to at-risk postpartum women may also indirectly impact the health and well-being of vulnerable infants. Recognizing the influence of budget constraints on public health nursing services

should be an exhortation to foster innovative and salient research supporting the work of PHNs with at-risk postpartum women.

Proposed Solution and Nursing Implications

Although some factors related to home visitors have been reported it is emphasized again that few studies are specific to PHNs and few have examined these factors from the viewpoint of the PHN. Additionally, research regarding the influence of other situational factors has been neglected. Without a PHN-centered focus, progress towards incorporating evidence-based practices into PHN home visiting services is difficult to support. A qualitative descriptive study identifying factors involved in the decision-making process related to terminating at-risk postpartum cases to PHN home visitation services may help identify factors that can be modified by PHNs and their employers to improve these services. Early training of PHNs in their respective schools of nursing may also benefit from a better foundational understanding of the process of PHN home visiting services. This study will also provide nurse researchers with a starting point upon which to expand knowledge in this area of PHN practice. Postpartum women and their children are worthy of exemplary PHN services. One of the eight public health nursing principles is an exhortation to "...reach out to all who might benefit from a ... service." (American Nurses Association, 2007, p. 8). The at-risk postpartum population is assuredly a group that would benefit from evidence-based PHN services.

Conclusion

When should at-risk postpartum PHN cases be closed? How does a PHN decide? A better understanding of influencing factors will help to answer these and other related questions. The goal of supporting improvement of the decision-making process of PHNs in the provision of home visitation services is an important link in caring for the health of America's at-risk families.

Chapter 3

Methods

Given the gaps in the knowledge identified in the review of literature, a qualitative descriptive study using semi-structured, open-ended interviews with public health nurses (PHNs) is proposed. As noted in Chapter 1, a qualitative descriptive study design is appropriate for this research based on a research goal of exploring PHNs' perceptions of factors influencing their decision to terminate services to at-risk postpartum clients. The researcher's use of reflexivity and reiteration through the process of data analysis will contribute to discovery of present day, real life themes regarding factors influencing decisions to terminate services as described by PHNs.

Research Design

A qualitative descriptive research design is capable of standing alone as a research method (Sandelowski, 2000, 2010). As introduced in chapter 1, Sandelowski (2000, 2010) emphasizes that rigorous research methods are fundamental to the integrity of a qualitative descriptive study. Hsieh and Shannon (2005) describe three approaches to the initial coding that occurs during the data analysis phase of the study. The first approach known as conventional content analysis is a traditional approach in which coding categories are directly gleaned from the data. The second approach, also called a directed approach, is directed or guided by theory. Summative content analysis is the third approach, and is one which begins with numeric quantifying of words identified from the data in order to make comparisons that may ultimately enrich the final analysis of the data.

Interviews with PHNs will provide the data essential to the interpretation process using conventional content analysis while being open to the use of summative content analysis (Hsieh & Shannon, 2005). A direct approach to content analysis is not useful for this study as themes that emerge from the data may or may not follow a preconceived model or theory. The chosen method of a qualitative descriptive design will provide a vehicle allowing the researcher to become immersed in the data in order to discover the truths and meanings derived from interviews with PHNs. Care must be taken to transcribe and accurately report the words of the PHNs and not construe meaning to their words based solely on the researcher's past home visitation experiences. However, as a fellow PHN, the researcher also shares a greater understanding and awareness of the experienced reality and context of the practice of a MCH PHN. This commonality cannot be isolated and removed from the analysis and interpretation process.

Setting

This study is in a public health nursing department of a large southwestern United States county. Public health nursing services are provided to more than 2.5 million residents living in urban, suburban, and rural geographic areas.

Sample

Utilizing the maximum variation sampling method, a purposeful, minimum initial sample of six to eight PHNs will be recruited from the available population of PHNs working within the county's public health nursing department. By selecting only PHN home visitors working within a specific health department, homogeneity of the sample is bolstered, which supports an initial small sample size (Holloway & Wheeler, 2002;

Sandelowski, 1995). Limiting a sample size may foster the gathering of comprehensive, quality data (Holloway & Wheeler).

On the other hand, incorporating maximum variation allows for heterogeneity of the data, which contributes unique details of each individual participant's experiences. Recruitment of PHNs with varied years of work experience, employed in different public health centers, and who visit clients in different cultural and geographic regions of the specified county will maximize the diversity of the participants and contribute to the heterogeneity of the sample (Robert Wood Johnson Foundation, 2008). Encouraging diversity in the sample reveals not only participant specific data, but also allows for identifying and exploring mutually shared themes (Hoepfl, 1997). Recruitment of participants will, however need to remain flexible; and snowball sampling may be incorporated, if necessary to obtain complete saturation of the data.

Data analysis and data collection must be conducted simultaneously in order to be aware of the point of data saturation (Robert Wood Johnson Foundation, 2008). By strictly adhering to this concurrent process, the researcher will reach an awareness that no new information or themes are emerging from the data. At this point, it will be determined that data saturation has been reached and recruitment will cease.

Inclusion criteria will include nurses with six months or more of MCH PHN home visitation experience. Newly hired PHNs on probation will not be included in the sample. PHNs not currently working as an MCH PHN are eligible as long as they are presently working for the county's public health nursing department and have worked as an MCH PHN conducting field home visits within the past 36 months. PHNs not meeting the inclusion criteria will be excluded from participation in the study. Eligibility will be

verified through the PHN's verbal confirmation of meeting eligibility criteria and possession of a current county employee ID badge.

Solicitations for participation in the study will take place by a mass email distribution of study recruitment flyers (Appendix A) to PHNs employed by the public health nursing department. A copy of the flyer will be sent via email to the chief of PHN for initial assistance in disseminating the flyer via email distribution. An explanation of the study, including the method of data collection, nature of the interview questions, informed consent, and confidentiality of the data will be noted on the flyer. Recruitment flyers will also be posted in a central PHN work area at each of the six regional public health centers. Interested PHNs will contact the researcher individually for further details, and to arrange a mutually agreed upon interview date and location. Snowball sampling may be incorporated, as needed; in order to recruit sufficient participants needed to add to the depth, richness, and saturation of the data. This method of sampling will also provide back-up recruitment for attrition resulting from one or more of the participants' early withdrawal from the study.

Ethical Issues

Approval to conduct the study has been obtained from the University of San Diego Institutional Review Board (IRB). The county agency's research department requires agency approval once IRB approval has been granted. An initial letter of support has been obtained from public health nursing administration (Appendix B). Written informed consent (Appendix C) for voluntary participation will be obtained from the participants prior to data collection, with sufficient time allotted to address participant questions and concerns related to participation. Signed informed consent forms will be

stored in a locked cabinet in the researcher's home office. In accordance with participating agency guidelines restricting PHN acceptance of outside gifts, no incentives will be offered.

Potential risks to participants of the study are concerned with protecting the privacy of the data along with personal and professional confidentiality. Another possible risk may be the disclosure of personal and professionally sensitive information. According to IRB guidelines, full declaration of potential risks will be given to participants, and they may exit the study at any time. Participants will also be assured that non-participation in the study will not have any effect on employment status. The identity of the participants will be strictly safeguarded, which may include conducting interviews in locations separate from the PHN's workplace. All published information will have aliases for names and places that might lead to disclosure of the identity of the participants. As will be elaborated on in the data analysis section, measures will be taken to manage the integrity and confidentiality of the data.

Definition of Terms

There are two terms relevant to this study, which require clarification. The first is the definition of a public health nurse essential to the participant inclusion criteria. The second describes the period considered to be postpartum for purposes of this study.

A public health nurse (PHN) is a baccalaureate prepared registered nurse "... who has received a certificate from the BRN. He or she is an integral part of the public health community and provides direct patient care as well as services related to maintaining public health." (California Board of Registered Nursing, 2011, [website definition]). For purposes of this study, the PHN must be a current employee of the specified county

health department, and have conducted MCH home visits to at-risk postpartum women within the past 36 months.

A generally agreed upon medical definition of the term postpartum is the “period from delivery of the placenta until return of the reproductive organs to their normal non-pregnant morphologic state. In humans, the puerperium generally last for six to eight weeks.” (Medical Conditions Dictionary, 2010-2011, [website definition]). For purposes of this study, the interest is in home visitation services that were initiated in this six to eight week period. These services may or may not have been terminated at eight weeks post-delivery, as individual PHNs have some autonomy in their decisions to terminate services to at-risk postpartum women. This study seeks to discover the factors that influence these final decisions.

Data Collection

The researcher will conduct semi-structured, open-ended interviews with each individual participant. An interview guide consisting of open-ended questions accompanied by follow-up probe questions will be used (Appendix D). A semi-structured interview is appropriate for data collection in order to probe for factors that may influence PHN decisions to terminate postpartum home visiting services. Richards and Morse (2007) supported this interview method if the researcher has background knowledge of the lines of inquiry. However, care must be taken not to assume the participant will respond a certain way as this will impair the integrity of the data. Open-ended prompt questions are suitable in qualitative research as consistent use across all interviews will serve to strengthen the reliability of the participants’ responses (Kvale & Brinkmann, 2009).

Initial data collection will begin in the summer of 2011, following University IRB and county agency approval. This will consist of one, one- to two-hour, digital audio recorded, face-to-face interview per participant. Holloway and Wheeler (2002) noted that interviews longer than three hours may be counterproductive due to participant and researcher fatigue.

The interviews will be scheduled at a date, time, and location mutually agreed upon by the participant and the researcher. Written permission to conduct interviews at the PHNs' worksites has been obtained; however, for purposes of confidentiality, participants may choose to be interviewed at a non-work location. Researcher field notes will include a description of the interview site. The researcher will honor and accommodate the requests of participants desiring to keep their participation in the study confidential from their co-workers and professional colleagues within the county agency.

A field log will be utilized to keep records of details regarding the data collection procedures and to ensure rigor via an audit trail (Holloway & Wheeler, 2002). This log will also include personal field notes recounting the ongoing thoughts, feelings, and perceptions of the researcher. This data will be continually reviewed throughout the research process to strengthen the validity of the data analysis.

Data Management and Analysis

All identifying data will be stored on a personal computer memory device and placed in a locked cabinet in the researcher's home office, separate from the data when not in use. Participants' personal data will be coded so that only the researcher has access to these identifiers.

Interview audio files will be transcribed verbatim by the researcher and cleansed of personal identifiers as soon as possible after the interview. A paid transcriber will be used to transcribe the data. Data entry by the researcher into a Word document computer program will be ongoing and completed after each interview. Analysis of the data will also be ongoing with frequent review of the data for coding and categorization purposes.

Cresswell (2009) recommended further strategies for validating findings. In accordance with these suggestions, participants may request access to their verbatim transcriptions and pertinent written interpretations. Follow-up interviews with participants will also increase the strength of the data and allow opportunity for member checking. Peer review will be incorporated throughout the research process with the assistance of the researcher's dissertation committee members.

Data analysis will take place in accordance with the research aims of the study. The first aim is to explore the decision-making process used by public health nurses in determining when to terminate home visitation services to at-risk postpartum women. The second aim is to describe situational factors related to closing cases of at-risk postpartum women to PHN home visitation services. Following the guidelines of conventional content analysis, the data will be coded and topically grouped to form early descriptive themes (Hsieh & Shannon, 2005). The continuous incorporation of new data, reflection, and field notes will allow the researcher to remain open to the discovery of new and emerging themes outside of the preconceived thoughts of the researcher.

Strengths and Limitations of the Method

Present day discourse promotes the value of randomized, controlled trials as the optimal method of producing evidence-based knowledge in support of public health nurse

home visitation practice (H.R. 3590, 2010, p. 220; NFP, 2010). However, in light of the limited research devoted to the work of PHNs with at-risk postpartum clients, a qualitative study uncovering PHNs' thoughts and perceptions of factors that influence their decision to close these cases to home visiting services is needed. A methodically rigorous qualitative descriptive study may identify new ways to assist and improve PHN decision-making regarding terminating cases to these at-risk mothers.

Results of the study may not be representative of other public health nursing departments across the United States. The geographic locale and culture of the study setting may influence PHN practice. Also, in light of the current economic recession influencing shifts in public health nursing away from service to individuals to a strictly population focus, study findings may no longer apply to selected public health nursing departments across the country (Carlisle, 2008; County of Los Angeles, 2010; Gebbie & Hwang, 2000).

There are also known limitations to an interview method of data collection. Participants may vary in their verbal communication skills and unforeseen problems related to the interview setting may also affect the interview process (Holloway & Wheeler, 2002; Kvale & Brinkmann, 2009). On the other hand, the uniqueness of each individual participant's contribution to the data serves not only to enrich the data but also to open the gateway to new insights and knowledge (Holloway & Wheeler, 2002).

Reporting Findings

Final results of the study will be presented in a publishable journal article format. It is anticipated that the PHNs will provide valuable insight into the factors that affect their decisions to terminate home visiting services to at-risk postpartum clients. It is

hoped that public health nursing service agencies will use the study results to gain insight into the process of providing PHN home visiting services to at-risk postpartum clients. A better understanding of these factors and the process that PHNs use in determining case closure will help inform further research. New knowledge built upon the foundation of the results of this study will contribute to an ongoing long range goal of providing high quality PHN home visiting services, including accountability to public stakeholders who fund these services.

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Chapter 4

Manuscripts

The Patient Protection and Affordable Care Act of 2010 (PL 111-148): An
Analysis of Maternal-Child Health Home Visitation

Denise K. Thompson, MSN, RN, PHN, CPNP

Mary Jo Clark, PhD, RN, PHN

Lois C. Howland, DrPH, APRN

Mary-Rose Mueller, PhD, RN

University of San Diego

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Abstract

On March 23, 2010 President Obama signed the Patient Protection and Affordable Care Act (H.R. 3590, 2009-2010), setting in motion a historic and, for many, a long-awaited radical change to the current American healthcare system.

Section 2951 of the PPACA addresses provision and funding of maternal, infant and early childhood home visiting programs (Child Welfare League of America [CWLA], 2010b). The purpose of this paper is to acquaint the reader with the legislative odyssey of home visitation services to at-risk prenatal and postpartum women and children as delineated in the PPACA and to discuss the nursing practice and research implications of this landmark legislation.

Few question the need for more rigorous methodology in all phases of home visitation research. Public health nursing may provide the comprehensive approach to evaluating effective home visitation programs.

Key words: Patient Protection and Affordable Care Act (PPACA); Maternal-Child Health; At-risk prenatal women; At-risk postpartum women; Home visitation; Public health nursing

The Patient Protection and Affordable Care Act of 2010 (PL 111-148): An Analysis of
Maternal-Child Health Home Visitation

On March 23, 2010 President Obama fulfilled his campaign promise to institute healthcare reform for the American people. His endorsement of the Patient Protection and Affordable Care Act (PPACA, H.R. 3590, PL 111-148) of 2010 set in motion a historic and, for many, a long-awaited radical change to the current American healthcare system. Congressional Democrats and Republicans still continue to vehemently extol or berate the action. The primary goal of the PPACA is to decrease the number of uninsured Americans by providing accessible, affordable and comprehensive health coverage (CWLA, 2010a). This healthcare reform addresses six focus areas: (a) individual mandate, (b) expansion of public programs, (c) health benefit exchanges, (d) changes to private insurance, (e) employer requirements, and (f) coverage and cost estimates (Kaiser Family Foundation, 2010). Ensclosed within the pages of the PPACA is Section 2951. This section addresses provision and funding of maternal, infant and early childhood home visiting programs (CWLA, 2010b). The purpose of this paper is to acquaint the reader with the legislative odyssey of maternal child home visitation services as delineated in the PPACA of 2010 and to discuss the nursing practice and research implications of this landmark legislation.

Introduction

Population focused health is the mainstay of public health nursing practice (American Nurses Association [ANA], 2007). Populations considered “at-risk” are the primary recipients of home visitation services in the United States. Home visitation is a service directed to specific populations as one solution to reducing at-risk factors in a

targeted group. Funding and provision of home visitation services is a concern for government, community agencies, nursing, and at-risk recipients of services.

The Problem

There is a general consensus that at-risk families engender multiple costs for society (Children's Bureau, 2008; Pew Center on the States, 2011). An array of publications describes home visiting interventions that target various at-risk populations for health, social and economic reasons (Centers for Disease Control and Prevention [CDC], 2003; Duggan et al., 2000; Olds, Henderson, Tatelbaum, & Chamberlin, 1986; Stoltzfus & Lynch, 2009; Vasquez & Pitts, 2006). The Minnesota Department of Health (2003) described "at-risk" populations as persons who share similar characteristics that may have a detrimental effect on their health. The terms "high risk" or "vulnerable" populations are frequently used synonymously with health and socially defined "at-risk" populations. Stanhope and Lancaster (2010) included individuals or groups of individuals who are at a heightened risk of experiencing poor health outcomes in their definition. Home visitation services to these high risk families have the potential to modify risk factors and decrease the consequential societal burden (Karoely, Kilburn & Cannon, 2005).

Home visitation work in this country focuses primarily on the public health perspective of preventive services for a maternal child health (MCH) population, with a special emphasis on those at risk for adverse health and social consequences (Pew Center on the States, 2011; Thompson, Kropenske, Heinicke, Gomby & Halfon, 2001). In comparison to the United States, European countries with a national healthcare infrastructure do not generally target only the at-risk MCH populations for home visit

services. Based on a core philosophy that healthy mothers and children are indicators of a healthy society, they instead choose to provide universal nurse home visitation services for their MCH population (Kamerman & Kahn, 1993).

Over the past 30 years, Olds and colleagues have contributed to the body of home visitation research with extensive studies on a model of nurse home visitation services for a specifically identified at-risk population of low income, first time, early trimester pregnant women, the Nurse Family Partnership (NFP) program (NFP, 2010e). Although the work of Olds and colleagues dominates the home visitation literature, current home visitation services in the United States also target other subsets of the at-risk MCH population (Stoltzfus & Lynch, 2009). In a 2009 Congressional Research Service (CRS) Report on MCH home visitation, Stoltzfus and Lynch reviewed six national home visiting models and found that each one focused on different health and social needs of at-risk prenatal, postpartum, and early childhood populations.

Current statistics reporting problems associated with at-risk women and children are sobering. In 2009, the U.S. population consisted of 155 million women and girls, and 61.6 million of them were between the ages of 15 and 44, considered to be the childbearing years (Chandra, Martinez, Mosher, Abma, & Jones, 2005; Maternal and Child Health Bureau [MCHB], 2009b; U.S. Census Bureau, 2011). Of these women, 58.4% gave birth to a cumulative average of 2.3 children (Chandra et al., 2005). Lower socioeconomic status increases health and social risk factors in women and children (Kalil & Ryan, 2010). In 2009, 11% of the families in the United States were living in poverty, and 29.9% of single female-headed households were considered poor (National Poverty Center, 2009). Almost one fourth of the total U.S. household population consists

of children, and of these, 21% were living in poverty in 2009 (Child Trends DataBank, 2010; Feeding America, 2010).

Another factor contributing to risk is the 15.5% of children exposed to domestic violence in the home (Family Violence Prevention Fund, 2010). Partner violence is now recognized as a risk factor for pregnant and postpartum women. Chang, Berg, Saltzman, and Herndon (2005) reported that homicide has increasingly become the most frequent cause of death in pregnant and postpartum women. Mandating child abuse reporting for children exposed to domestic violence situations is a recent policy attempt at mitigating this health and social risk factor in the MCH population (Children's Bureau, 2009). Still other disturbing facts include a Child Protective Services (CPS) 2006 report indicating that there were 905,000 victims of child maltreatment, and 19% of the fatal episodes of maltreatment occurred in children less than 12 months of age (Division of Violence Prevention, 2008).

Statistics highlighting at-risk factors in childbearing women inevitably become intertwined with young children. Maternal depression, especially in the postpartum period, is increasingly recognized as placing women and their children at risk for health and social problems (Cheng, Fowles, & Walker, 2006). Civic and Holt (2000) found a significant association between maternal depression and behavioral issues in their children. The literature concerning MCH issues supports the U.S. national MCH goals and objectives of Healthy People 2020, directed towards improving the health of women and children (U.S. Department of Health and Human Services [USDHHS], 2009). Home visitation is one interventional strategy designed to decrease risk factors in women and children, thus improving their health and well being, which ultimately benefits all of

society. However, there is limited information comparing long-term health, social, and economic impacts of various home visitation programs. More importantly, access to these programs is limited with numerous at-risk mothers and children receiving few, if any, services.

The Solution

Home visiting in the United States has embraced many different models, theoretical frameworks, and target populations, which influence the design and implementation of specific programs. The Pew Center on the States (2011) defined a program of home visitation as a voluntary service delivered in a family's home for the purpose of providing health and social information and support to childbearing women and their young children. In a recent survey, the Pew Center on the States reported 117 home visitation programs scattered throughout the nation, except in Alaska, Idaho, Mississippi, and Nebraska.

Prior to the passage of the PPACA, home visitation programs operated on fragmented funding, primarily dictated by annual state and local budgets (Pew Center on the States, 2011; Stoltzfus & Lynch, 2009). A limited amount of supplemental funding from federal government programs, such as Temporary Aid for Needy Families (TANF), the MCH Block Grant, and Medicaid, also supported various programs. The passage of the PPACA brought assurance of secure, mandated federal funding, providing much needed stability and allowing long-range planning for home visitation programs.

These earmarked federal dollars came with certain provisos. Prior to the passage of the PPACA, NFP was situated as one of several home visitation congressional lobbying partners. NFP policy staff worked to promote the NFP model and was

successful in convincing Congress that funds for home visitation programs should only be granted to programs using evidence-based home visitation models (NFP, 2010f). Five nationally recognized home visitation program models were introduced during the 2009 Congressional hearings (Hearing on Proposals, 2009). All of these national models were identified as having national level program oversight, specific program curricula and protocols, and above all, accountability for outcome evaluation (Pew Center on the States, 2010).

In the 2009 CRS report for Congress, six home visitation models were examined: (a) Healthy Families America (HFA), (b) Home Instruction for Parents of Preschool Youngsters (HIPPI), (c) NFP, (d) Parent-Child Home Program (PCHP), (e) Parents as Teachers (PAT), and (f) the SafeCare Model (SCM) (Stoltzfus & Lynch, 2009). Each model targets different subsets of the MCH population, and each has different outcome objectives and home visitor qualifications. Specifically or indirectly, they all aim to achieve one or more Healthy People 2020 leading indicator outcomes related to decreasing premature births, low birth weight (LBW) infants, infant mortality, child maltreatment, poverty, crime, substance abuse, unemployment, and school drop outs or improving school readiness in children (Stoltzfus & Lynch, 2009; USDHHS, 2009). These programs collaborated in efforts to urge Congress to support home visitation services to at-risk families. In light of recent promises of financial backing from the federal government, these same organizations are now eagerly moving forward in the quest to provide effective, evidence-based home visitation services.

Who qualifies as a home visitor is broadly defined. NFP is the only program that exclusively uses baccalaureate educated nurses, with a preference for experienced public

health nurses (NFP, 2010b). Each of the other six national programs permits the hiring of diverse college educated workers, such as nurses, social workers, or teachers; however, they might also utilize lower-cost high school educated community workers who may be former clients of the program (Stoltzfus & Lynch, 2009).

Because of the variances in the target populations and educational levels of the home visitor, program approaches are varied. NFP exclusively targets low-income, first time mothers early in their pregnancy. Intensive, regulated home visiting services are administered through the child's second birthday. The PAT program also includes pregnant women, although not exclusive to early trimester first-time mothers. The four other national models, HFA, HIPPI, SCM, and PHCP, direct their program efforts toward the well-being of young children and their families. The women in these programs do not have to be pregnant to receive home visitation services. The longest period of time that families receive services is through a child's fifth year of life or upon kindergarten entry (Stoltzfus & Lynch, 2009; Wasserman, 2006). See Table A1 for a comparison of the features of various programs.

The Stakeholders

The six national home visitation programs were obvious stakeholders in the passage of the PPACA. With promises of secure funding, which included 25% of the 1.5 billion dollar, five-year budget allotted for funding of potential new effective models, home visitation organizations collaborated in the political lobbying process (CWLA, 2010b; Pew Center on the States, 2010; Redhead & Williams, 2010). In December, 2008, just one month into President Obama's term of service, the National Home Visiting Coalition, comprising over 700 local and national home visitation agencies, sent an action

letter to the White House requesting support of early childhood home visiting services (Home Visiting Coalition, 2008).

President Obama is a strong supporter of MCH home visitation programs. While serving as U.S. Senator from Illinois, he gave a speech at Hampton University in which he clearly proclaimed a political platform in support of parents and their young children. He firmly believed that money spent on home visitation interventions to low-income families is cost-effective and ultimately decreases government spending on health and social programs (Stone & Page, 2009). Preserving and expanding MCH home visitation was a core essential of Obama's campaign promises to address the needs of at-risk parents and children.

Elected members of the 111th Congress were the final decision makers in the move to include home visitation in healthcare reform, but as different versions of the healthcare reform bill were lobbied back and forth between the House and Senate, it became obvious that a bipartisan line was drawn. Republicans called for less government involvement and less spending, while Democrats supported President Obama's healthcare reform agenda that included much needed health and social programs. Re-election concerns undergirded Congressional debates and votes for or against healthcare reform bills. The ultimate inclusion of home visitation in the PPACA was a testament to the democratic majority in both the House and Senate (Capitol Net, 2009).

Political involvement of nurses. Nurses are inextricably intertwined with healthcare reform, and public health nursing lies at the heart of nurse home visitation to pregnant and parenting mothers and their children. Two months prior to the passage of the PPACA, Congress began receiving letters supporting healthcare reform specifically

referencing nurse home visitation services (Home Visiting Coalition, 2009; Home Visiting Coalition and National Organizations, 2009). Nursing Community, a collaboration of 55 nursing organizations, including public health nursing and other professional nursing organizations, pointed out that nurse home visitation services are crucial to the care of at-risk families (Nursing Community, 2010a, 2010b; American Association of Nurse Executives [AONE], 2010). Lois Capps (R-CA) is a former school nurse and one of only three nurse members of Congress. As founder and member of the Congressional Nursing Caucus and vice-chair of the House subcommittee on health, she was instrumental in including nursing's voice in the discourse surrounding home visitation as presented in the PPACA (Capps, n.d.). In May of 2009, the Congressional Nursing Caucus joined the American Nurses Association (ANA) in a Capitol Hill briefing regarding nursing's involvement with the proposed healthcare reform act (ANA, 2009a).

The individual recipients of home visitation services and individual taxpayers are the ultimate stakeholders. At the June 2009 hearing before the House Ways and Means Subcommittee on Income Security and Family Support, Cheryl D'Aprix, a taxpayer and recipient of home visitation services, testified to the benefits her family received from HFA home visitation services (Hearing on Proposals, 2009). Today's diverse technological and written media channels continue to provide an avenue for the ongoing dissemination of praise and protests regarding government support of home visitation services to at-risk families.

The Political Process

A look at events prior to the passage of the PPACA offers a deeper understanding of the current implications of the bill. The 2009 hearing before the House Ways and Means Subcommittee provides a glimpse of key stakeholder views regarding the issue of home visitation. Finally, an overview of the final events leading up to March 23, 2010, completes the background story of the PPACA.

Antecedent Events

The final version of MCH home visitation in the PPACA evolved from prior unsuccessful legislative attempts to secure federal funding for home visitation services. While serving their senate terms in the 110th Congress, President Obama (D-IL) and Vice-President Biden (D-DE) joined other like-minded senators to co-sponsor the Education Begins at Home Act (S. 667), a bill dedicated to funding home visitation programs and research (Civic Impulse, 2010; National Human Services Assembly, 2007). During that same Congress, Danny Davis (D-IL), a fellow Democrat from President Obama's home state of Illinois, introduced a partner home visitation bill H.R. 2343 in the House (Civic Impulse, 2010). Unfortunately, with the closing of the 110th Congress, both bills died in their respective houses.

Stakeholder groups continued to follow the legislative journey of home visitation. Even before President-elect Obama's January 2009 inauguration, action and support letters from across the country poured into Washington (NFP, 2009). Collaboration among the National Home Visiting Coalition, NFP, nursing, and other social organizations resulted in political action letters requesting support for evidence-based home visitation programs and research in the 2010 federal budget (Home Visiting

Coalition, 2008; NFP, 2009). Senators Menendez (D-NJ) and Casey Jr. (D-PA), composed a Senate sign-on letter thanking President Obama for referencing the NFP in the FY2010 budget (Menendez et al., 2009). Senate Representative Bennett (D-CO) from the home state of the NFP may have been instrumental in the choice of NFP as the home visitation exemplar, as described in the letter. This letter was copied to House committee leaders considered essential to the inclusion of home visitation in the PPACA.

During the last week of February 2009, President Obama released his first presidential budget proposal (Briceland-Betts, Sciamanna, Weidner, & Varner, 2009; CWLA, 2009b; Office of Management and Budget [OMB], 2010). True to his commitment to early childhood well-being, the proposal included a mandated 8.5 billion federal dollars over 10 years to fund evidence-based home visitation services for low-income families (CWLA, 2009b; OMB, 2010). The budget called for health and social outcomes yielding benefits in the areas of "...child health and development, readiness for school, and parenting abilities to support children's optimal cognitive, language, social-emotional, and physical development and reductions in child abuse and neglect" (OMB, 2010). This presidential budget proposal became the precursor to the Congressional debate surrounding home visitation as included in the 2010 PPACA.

As budget reconciliation took place in the House and Senate (H.Con.Res. 85 & S. Con. Res. 13), House representatives who championed home visitation sent letters of support to the Chairman and ranking members of the House Committee on Budget. Diana DeGette (R-CO), an advocate from NFP's home state, together with Lois Capps (R-CA), made reference to the NFP model in their action letter (DeGette & Capps, 2009).

In June of 2009, the Early Support for Families Act (H.R. 2667) was introduced in the House and was scheduled to be heard before the House Ways and Means subcommittee on Income Security and Family Support (Hearing for Proposals, 2009). Title IV of the amended 1935 Social Security Act was originally created to provide for the financial needs of dependent children, and H.R. 2667 intended to amend Title IV with a provision of federal dollars for statewide expansion of early childhood home visitation programs (CWLA, 2009a; Participatory Politics Foundation, 2010; Ridenour, n.d.; Social Security Administration [SSA], 2010a). A companion stand alone bill, the Evidenced-Based Home Visiting Act of 2009 (S. 1267) was introduced in the Senate by Menendez (D-NJ). S. 1267 also proposed an amendment to the Social Security Act; however, this amendment was to Title V, of the 1981 Maternal and Child Health Services Block Grant (MCHB, 2009a; SSA, 2010b). Both bills were eventually absorbed into the final two healthcare reform acts of 2010, the PPACA and the Affordable Health Care for America Act (AHCAA).

The 2009 Hearing

Following the introduction of H.R. 2667, a hearing was scheduled for June 9, 2009 before the 111st Congress House Ways and Means Subcommittee on Income Security and Family Support (Hearings on Proposals, 2009). The proposal of billions of federal dollars directed towards home visitation services elicited intense deliberation among subcommittee members. The hearing included the testimony of public witnesses and written submissions, both pleading for members of Congress to pass H.R. 2667 (Hearing on Proposals, 2009). With the exception of submissions entered by the NFP, most of the statements were presented by non-medical, non-nursing individuals and

organizations. Chairman McDermott (D-WA) introduced the purpose of the hearing, which was to discuss home visitation work aimed at decreasing child abuse and improving children's health and school readiness. The hearing concluded that evidence-based home visitation is an important public service, that nurses are the preferred home visitors, and that there is still a need to consider new innovative evidence-based programs.

Final Legislative Actions

Two events with the potential to affect the ultimate passage of the PPACA occurred in the late summer of 2009. One was the annual legislative summer recess, which gave congressional representatives and stakeholders time to strengthen their claims for or against home visitation. The other, more somber event was the death of Senator Edward Kennedy (D-MA), a well known champion of healthcare reform. His death came as a great loss to all in favor of healthcare reform, and was consequently a concern for the future of home visitation. Paul Kirk Jr. was temporarily appointed to fill the vacant Massachusetts Senate seat, with the understanding that he would uphold the healthcare reform goals of Senator Kennedy, thus temporarily blocking a Senate filibuster on healthcare reform bills during the 111th Congress (Associated Press, 2010).

At the conclusion of the legislative summer recess, the Senate Finance Committee released America's Healthy Future Act of 2009 (S. 1796) for Senate discussion and vote. This bill would ultimately merge with the Affordable Health Choices Act (S. 1679) released in mid-July from the Senate Health, Education, Labor and Pensions Committee (HELP). The consolidated bill would continue to travel the legislative pathway and, together with the original House home visitation bill, H.R. 2667, its amended version

would be assimilated into America's Affordable Health Choices Act of 2009 (H.R. 3200). By mid-summer of 2009, the amended healthcare reform bill, H.R. 3200, was introduced in the House. The Ways and Means Committee reviewed this bill and, by October, reached consensus on recommending passage of an amended version of H.R. 3200 (House Committee on Ways and Means, 2010). Section 1904 of the bill called for a state grant program for maternal, infant, and early childhood home visiting programs and would ultimately be incorporated into Section 511 of the Social Security Act (SSA, 2010a). By the end of November, H.R. 3200's marked version, the AHCAA (H.R. 3962) passed in the House and Senate assisted by the process of budget reconciliation (Committee on Energy and Commerce, 2010). This version would include the amendment left out of the PPACA, an amendment to section 1905 of the Social Security Act allowing for Medicaid reimbursement of nurse home visits (Pew Center on the States, 2010). With President Obama's signature, H.R. 3962 became Public Law 111-192, three months after the historic passage of the PPACA (H.R. 3590, 2009-2010).

Concurrently, the House was busy working on healthcare reform. House chairman Rangel (D-NY) sponsored H.R. 3590 (H.R. 3590, 2009-2010). His bill, initially called the Service Members Home Ownership Tax Act of 2009, would subsequently be rewritten to include the final House healthcare reform bill, the PPACA. This bill, which did not include Medicaid reimbursement for nurse home visitation services, was thought to be a relatively conservative form of healthcare reform, and thus had a high probability of successful passage through the Senate with minimal roadblocks. House and Senate Democrats planned to use budget reconciliation as a means to include the agenda reform items left out of the PPACA. With a favorable Democratic majority in the House and

Senate, the PPACA final congressional passage occurred on December 24, 2009 and became Public Law 111-148 on March 23, 2010.

Analysis

Further examination of the political backdrop surrounding home visitation services takes into account purported benefits along with legislative compromises. Specific areas in which concessions were made included the role of research in home visitation, the designated target population, and home visitor qualifications.

Benefits

The discussion of who benefits and who does not from a mandated federal provision for home visitation looms over every debate on the topic. Some would argue that the PPACA is more needless government involvement in the lives of its citizens, while strong advocates of the bill claim that all of society benefits (Beck, 2009; Burke, 2009; Cawthorne & Arons, 2010; Estrada, 2010; Norris, 2009; Sprinkle, 2009b; Sullivan, 2009). For example, a 1998 and subsequent 2005 RAND study looking at the cost-benefits of the NFP program reported that the government could expect a return of \$5.70 for every dollar infused into the NFP home visiting program (Karoly, Kilburn, & Cannon, 2005). Projected savings include decreased use of government aid programs for the poor, savings in health and education dollars, and safer communities through decreased involvement in the criminal justice system.

Legislative Compromises

As is to be expected, the concluding version of the PPACA incorporated numerous compromises. Much of the debate centered on the issue of home visitation models that had research-based outcomes supported by randomized controlled trials. The

strength of the NFP lies in its program model based on 30 years of randomized controlled studies, which over time has grown to include supportive longitudinal data. Unlike many smaller programs, which may not have had the funding to support a government liaison department, NFP's Federal Policy and Government Affairs Department assured a voice in Washington and probably had a strong influence on the final bill (NFP, 2010c, 2010f). A concession was made to include programs documenting rigorous quasi-experimental research-based outcomes and to permit states to use 25 percent of federal dollars in support of research for "promising" new programs (H.R. 3590, 2010). Regrettably, there was no mention of qualitative research, which was a lost opportunity to incorporate participants' voices and home visitation experiences in the final bill.

Another concession in the PPACA was the generalization of the target population. If the bill had supported only programs with a strong history of gold standard nurse involved quantitative research such as the NFP, many MCH populations would have been excluded. The NFP only enrolls low-income, first time mothers, early in pregnancy. With average caseloads of 25 families per nurse, this translates to an annual average of 21,500 out of a potential 650,000 families receiving nurse home visitation services (NFP, 2010d; Sprinkle, 2009a). This is just a fraction of the 4.3 million infants born each year; even more disheartening would be the 154,508 women in 2007 (7.1% of births) who received late or no prenatal care, who would have been unable to benefit from these services and were probably most in need of them (Annie E. Casey Foundation, n.d., Martin et al., 2009, p. 4). Fortunately, the final bill was broad enough to include other dimensions of MCH services related to child health and development such as child abuse, domestic violence, and school readiness.

A third accommodation in the bill addressed the qualifications of the home visitors. Again, using the NFP model as the gold standard would require the strict use of baccalaureate prepared registered nurses. Nurses are long considered trusted home visitors with invaluable health education (ANA, 2009b). There was considerable discussion regarding not only the cost of hiring additional home visitation nurses, but also how the current reported nursing shortage would affect hiring new staff to expand home visitation programs. The final wording encompasses, “well-trained and competent staff” (H.R. 3590, 2010), which leaves open the option for hiring paraprofessionals if the home visiting model can prove beneficial participant outcomes in designated benchmark areas.

Public health nurses (PHNs) have long been considered strong advocates for prevention and health promotion services to at-risk populations. Considering their background in public health melded with nursing and the social sciences, the NFP would agree that PHNs are the ideal home visitor candidates. Utilizing Clark’s Population Health Nursing Model, the legislated home visitation outcomes arise from six determinants of health; the “biological, psychological, environmental, sociocultural, behavioral, and health systems” (Clark, 2010). Taking this foundational knowledge into account, public health nurses assess and provide nursing interventions to MCH clients during a home visit. The ultimate goal for these families is improved health and well-being; for the PHN, it is improved population health; and for government, it is a decreased use of resources by at-risk populations.

By and large, the compromises achieved strengthen, rather than detract from, the effectiveness of the bill. For example, expansion of the types of fundable programs increases the potential for multiple positive effects of home visitation services and also

increases the potential numbers of clients served. Similarly, expansion of the target population beyond first-trimester first-time pregnant women permits more of the at-risk population to benefit from services. Expansion of the definition of preferred service providers beyond baccalaureate-prepared public health nurses could have both positive and negative repercussions. Use of PHNs to oversee and coordinate care by other levels and types of providers might be more cost-effective than use of PHNs alone. In the total absence of PHN involvement, however, clients would be left to receive services from providers who do not have knowledge of the full scope of health issues, concerns, and strategies for their resolution.

Research and Policy Implications

The PPACA contains 21 pages delineating the implementation of home visitation services. All states requesting grant money must immediately conduct an assessment for the purpose of identifying at-risk communities. Strings are attached to the federal dollars, and the home visitation programs must meet quantifiable benchmark goals of: “(i) improved maternal and newborn health; (ii) prevention of child injuries, child abuse, neglect or maltreatment, and reduction of emergency department visits; (iii) improvement in school readiness and achievement; (iv) reduction in crime or domestic violence; (v) improvements in family economic self-sufficiency; and (vi) improvements in the coordination and referrals for other community resources and supports” (H.R. 3590, 2010). Various agencies under the jurisdiction of the U.S. Department of Health and Human Services will be responsible for implementation and oversight of the law and are in the process of disseminating instructional information to interested parties.

Dr. Olds, founder of the NFP, has blazed a trail for outcomes-based nurse home visitation research, but rigorous studies that extend beyond the scope of NFP's targeted early prenatal clients still need to be done. Numerous literature reviews agree that a considerable number of home visitation research studies have methodological and reporting limitations which can affect implementation of evidence-based programs (David & Lucile Packard Foundation, 1999; National Human Services Assembly, 2007; Thompson et al., 2001). Until the *Healthy People 2020* MCH goals are achieved, a percentage of childbearing women will still receive late or no prenatal care. Although legislated home visitation services often target families' social needs such as school readiness and economic self-sufficiency, these needs cannot be achieved without good health. Public health nurses are in a pivotal position to participate in the advancement of research that will guide current and future disbursement of federal dollars for home visiting programs. Children cannot be ready for school if they are not healthy; child abuse cannot be prevented if parents' physical and emotional health is not supported; vulnerable women cannot escape the welfare rolls if they are not physically and emotionally healthy. Public health nursing research may provide the comprehensive approach to evaluating effective home visitation programs.

The general policy implications of the bill lie in three basic areas: the need for continued funding that supports both program services and related research, exploration of the effectiveness of different providers in achieving optimal program outcomes, and defined mechanisms by which policy makers can remain apprised of the related evidence base. Continued funding will be required, not only to support home visitation services, but also to develop the evidence-base required to effectively support policy formulation

in this area. Although current policy supports several types of programs, more research is needed to identify the most effective approaches to achieve expected outcomes. This research needs to extend to an examination of the relative effectiveness of different levels and types of providers in achieving those outcomes. Finally, there is a need for a defined approach by which policy makers can be apprised of the results of research and incorporate it into evidence-based policy. Such an approach might include something akin to the work of the U.S. Preventive Services Task Force in developing guidelines for preventive services that are used to formulate policy on covered services.

It is possible that with successful home visitation service outcomes, providers and consumers of the healthcare system would benefit. Healthy pregnant women would have healthier newborns and shorter hospital stays. A decrease in child abuse would lead to a decreased use of emergency medical and social services. Overall good health achieved through health promotion measures has long been believed to have a positive effect on child development and school achievement (Eide, Showalter & Goldhaber, 2010). Finally, improved family economic self-sufficiency leads to higher socioeconomic status which is associated with better health status (Adler, 2010).

Nursing Implications

Once again, legislation has been formulated that so desperately needs the input of nurses (Gaffney, 2011). Public health nursing's holistic view of caring for women and young children in the social context of their families and communities is critical to the success of home visitation programs. Public health nurses often are privileged to know the intimate details of the lives of at-risk women and children which place them in a unique position to advocate for the most effective home visitation approach.

Over 100 years ago, Lillian Wald distinguished public health nursing as a nursing specialty focused on bringing nursing into the homes and communities of at-risk populations (Jewish Women's Archive [JWA], 2010). Wald tirelessly advocated on behalf of vulnerable populations in the political and healthcare arenas. In order for home visitation funding to pass through Congress, it became clear that there was a need to blend health and social services into one bill. "Social workers, educators, child development specialists, or other well-trained and competent staff..." (H.R. 3590, 2010), although capable of providing admirable services, cannot singlehandedly address the complex health needs of at-risk families. Nor can PHNs achieve intended home visitation outcomes independently. They must be willing and able to work in concert with other professional and non-professional staff to achieve program outcomes.

Implications of the PPACA for the nursing profession lie in three areas: workforce preparation, promotion of evidence-based practice, and education for leadership. If PHNs are to provide services or oversee home visitation services provided by others, there will be a need for far more nurses prepared in this specialty area. This will entail support for educational funding and programs to prepare nurses with the required public health background and skills. In addition, there is a need for PHNs to have a stronger grounding in the use of evidence-based practice and in the research skills needed to create that evidence base. Finally, PHNs will need additional preparation for leadership and coordination of the efforts of health visitation teams.

Salmon (2009) expressed praise for the recent involvement of today's PHNs in the political process of healthcare reform; at the same time, she exhorted PHNs to

continue to push forward in an effort to familiarize our legislators with *avant garde* PHN services provided to the most defenseless members of our society.

Conclusion

As American healthcare reform continues its journey, investigative journalist, T. R. Reid, exhorted Americans to take a step back and address the fundamental ethical question, “Do we believe everyone has a right to basic health care?” (Reid, 2009). If we believe this, are home visitation services to MCH families worthy of being included in the definition of basic health care? Many European countries believe that nursing services to MCH families are essential to the vital health of the country (Kamerman & Kahn, 1993). With the passage of PPACA, America has concurred, at least for now.

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Appendix

Table 1

Characteristic Features of Six National Home Visitation Programs

Program	Target population	Program mission	Home visitor qualifications	Maximum length of service
Healthy Families America (HFA) ^a	At- risk pregnant or immediate postpartum families	Prevention of child abuse and neglect	Paraprofessionals (optional bachelor's degree)	Birth through enrollment in preschool or kindergarten
Home Instruction for Parents of Preschool Youngsters (HIPPY) ^b	Families of preschoolers living in at-risk neighborhoods	Promote school success	Paraprofessionals who are current or former clients	Through child's enrollment in kindergarten
Nurse Family Partnership (NFP) ^c	Low-income, first-time pregnant (<28 weeks) women	Improve pregnancy outcomes, child health and development, and economic family self-sufficiency	Registered Nurse (Prefer public health nurses)	Through child's 2 nd birthday
Parent-Child Home Program (PCHP) ^d	Families of educationally at-risk preschoolers	Promote school readiness and early literacy	Paraprofessionals from the service community	Through preschool entry or when child turns 5.
Parents as Teachers (PAT) ^e	Prenatal and families with children not yet enrolled in kindergarten	Promote school readiness and optimal child development	Paraprofessionals (optional bachelor's degree)	Through child's enrollment in preschool or kindergarten
SafeCare (SCM) ^f	Families with preschoolers at-risk for child abuse and neglect	Prevention of child abuse and neglect	Paraprofessionals (optional bachelor's degree)	Maximum 20 weeks of services; Eligible through child's 5 th birthday

^a Healthy Families America (2011).^b Home Instruction for Parents of Preschool Youngsters (2011); Klein, Weiss & Gomby (2006).

^c Nurse Family Partnership (2010a).

^d Parent-Child Home Program (2011).

^e Parents as Teachers (2010, 2011).

^f National SafeCare Training and Research Center (2010); Washington WorkFirst (2007).

At-Risk Postpartum Clients Receiving Public Health Nurse Home Visitation Services,

Part 1: Opening a Case

Denise K. Thompson, MSN, RN, PHN

Lois C. Howland, DrPH, MSN, RN

Mary Jo Clark, PhD, RN, PHN

Mary-Rose Mueller, PhD, RN

Abstract

During the late 19th century, public health nursing emerged in the United States as an autonomous nursing specialty providing maternal-child health home visitation services. Present day public health nurses (PHNs) primarily focus on health promotion and disease prevention for at-risk maternal and child populations. Health policies, funding streams, and local public health nursing protocols are examples of extrinsic factors that may affect length of service and ultimate outcomes of home visitation services to at-risk populations. However, individual PHNs also make independent decisions regarding termination of services. An understanding of the process of opening a case will provide the needed context for this qualitative study's two major queries, namely:

1. What factors lead to a PHN's decisions to terminate home visitation services to at-risk postpartum women?
2. What is the decision-making process used to determine when to close a case?

Eighteen public health nurses participated in semi-structured, open-ended interviews. Research committee members participated in the data analysis process. Part 1 provides the background context for the study results to be reported in Part 2, Closing a Case.

Keywords: *maternal-child health, public health nursing practice, qualitative descriptive, vulnerable populations*

During the late 19th century, public health nursing emerged in the United States as an autonomous nursing specialty providing maternal-child health (MCH) home visitation services (Thompson, Kropenske, Heinicke, Gomby, & Halfon, 2001). Present day public health nurses (PHNs) continue to follow in the footsteps of their predecessors through home visitation services with a focus on health promotion and disease prevention for at-risk maternal and child populations. Health policies, funding streams, and local public health nursing protocols are examples of extrinsic factors that may affect length of service and ultimate outcomes of home visitation services to at-risk populations (Advocates for Children and Youth, 2009; County of Los Angeles, 2007; Wasserman, 2006). Protocols guided by public health nursing standards provide broad guidance regarding content, frequency, and duration of home visitation services. However, individual PHNs also make independent decisions regarding termination of services. A decision to prematurely close a case to home visitation services has the potential to negatively affect case outcomes. An understanding of the process of opening a case to service will provide a background context for a study exploring factors influencing PHN decisions to terminate home visitation services to at-risk postpartum mothers.

Identification of the Problem

A research study began to emerge from conversations with PHNs, including field nurses, supervisors, and managers of public health centers as well as a federal push to fund evidence-based home visitation services to MCH clients (Child Welfare League of America, 2009). One result of a quest for cost-effective home visitation services is the expansion of the Nurse Family Partnership (NFP) public health program (Nurse Family Partnership [NFP], 2010a). David Olds, founder of the NFP, has shared impressive

results obtained from over 30 years of research in the area of PHN home visitation services to low income, at-risk pregnant women. Although these services continue throughout the postpartum period, these home visitation services must be initiated early in the pregnancy (NFP, 2010b). In 2010, based on the strong MCH home visitation research results of the NFP, the local county health department converted a number of their PHN generalist MCH positions to PHN designated NFP positions.

These changes did not encompass answers to an important practice concern. If generalist MCH PHNs were to continue to provide home visitation services initiated in the postpartum period, how long should these services be provided and when should the PHNs close these cases? Unfortunately, research in this area is limited which subsequently limits the evidence upon which to base PHN home visiting practices. A qualitative descriptive study may uncover PHN home visiting practices that are amenable to evidence-based modifications.

Gaps in the Literature

Literature targeting home visitation services to maternal-child health clients has expanded as funding sources increasingly call for evidence-based practice culminating in beneficial program outcomes. Studies, such as the work of David Olds, have tended to focus on nurse home visitation services to low-income, first time pregnant women initiated in the prenatal period (Olds et al., 2002). Less attention has been devoted to services initiated in the postnatal period except as related to child abuse prevention (Schaefer, 2010).

A consensus is emerging that length of service affects case outcomes, and premature termination of services to a client has significant ramifications for outcomes.

PHN interventions directed toward achieving optimal outcomes cease to occur once home visitation services are terminated. Anecdotal PHN and client viewpoints are prevalent, but these, along with author opinions, lack a foundation of rigorous methodological research regarding factors affecting PHN decisions to terminate home visitation services to at-risk postpartum women (Daro, McCurdy, & Nelson, 2005; Gomby, 2005).

The practice of nursing involves continuous implementation of decision-making courses of action. An understanding of the influence of as yet unnamed factors on the decision-making in PHN decisions to initiate or terminate home visitation services may provide insight into factors amenable to intervention. Part II of this series of articles, Closing a Case, will highlight the salient results of the study and address factors that influence PHN decisions to close cases.

Purpose of the Study

The purpose of the study was to identify factors influencing the decision-making process of closing the cases of at-risk postpartum women to public health nurse home visitation services. Opening a Case, Part 1, will set the stage for Part 2, Closing a Case, and will include discussion of the background setting of the study as informed by the following two research questions.

1. What are the factors that lead to a PHN decision to terminate home visitation services to at-risk postpartum women?
2. What is the decision-making process that a PHN uses to determine when to close the case of an at-risk postpartum woman to public health nurse home visitation services?

In answering these questions, data were obtained to explore the process of opening a case for PHN home visitation services, and that is the focus of this article. Information on case closure decisions is addressed in Part 2 of this series.

Methods

The study employed a qualitative descriptive research design that permitted rich description of how the context of the everyday work of PHNs influences their decisions to close cases of at-risk postpartum clients. Data were gathered by means of individual interviews with PHNs experienced in home visitation to mothers and children.

Setting

The study took place in a public health nursing department in the southwestern United States, serving well over one million residents. The PHNs of this county provide home visitation services to eligible clients living in urban, suburban, and rural geographic areas.

Two events influenced the participant interviews during the course of the study. One was the expansion of the NFP program, which converted a number of the previously identified MCH PHN positions to NFP positions. As PHN home visitation services to low-income, first-time, pregnant women increased there was a simultaneous decrease in the number of postpartum women eligible for PHN services and PHNs to provide these services. Of note, in 2007, 7.1% of all births in the United States were to women receiving late or no prenatal care; these women would not qualify for NFP services and would likely benefit from PHN home visitation services initiated in the postpartum period (Annie E. Casey Foundation, 2011, Martin et al., 2009).

The NFP program consists of detailed, specific protocols. Clients are expected to engage in PHN home visits until their child reaches the age of two years. NFP PHNs also receive specialized training to optimize the consistency of PHN services. Study participants agreed that provision of non-NFP home visitation services to postpartum clients allowed for more PHN autonomy and variability in the length of services and final case closure decisions.

The second event that occurred during the course of this study was a very recent introduction of a new department-initiated MCH protocol guiding the provision of home visitation services to at-risk postpartum clients. Although not every PHN in the study had thorough knowledge of this protocol, most of the PHNs stated that this protocol began one to two months prior to the study interviews. The new protocol was intended to strengthen the consistency of home visitation services by (a) increasing the standardization of the content and frequency of visits, (b) limiting caseloads at 35 to 45 cases, and (c) keeping cases open for 18 months. One PHN indicated that the decision to close cases at 18 months was based on the premise that referrals for indicators of autism would have occurred by this time. As the researcher became aware of the influence of these two events, it became evident that the interview questions needed to reflect these changes and their influence on PHN practice.

Sample

Inclusion criteria included PHNs with six months or more of MCH PHN home visitation experience. Newly hired PHNs were not included in the sample. PHNs not currently providing services to postpartum clients were eligible if they were still working

for the public health nursing department and had conducted home visits to postpartum clients within the past 36 months.

Incorporating maximum variation in tandem with homogeneity led to a purposeful sample of 18 PHNs, representing just under one-third of the total number of PHNs who provide maternal-child home visitation services in the county. The selection of PHNs from a specific health department, bolstered the homogeneity of the sample (Holloway & Wheeler, 2002; Sandelowski, 1995). Maximum variability of the individual PHNs (e.g., length of employment as PHNs) enhanced heterogeneity of the data and contributed specific details unique to each participant's experiences. The limited sample size also enhanced the gathering of comprehensive, quality data (Holloway & Wheeler, 2002).

Initial solicitation of participants involved email distribution of flyers; however it became necessary to engage in snowball sampling to reach data saturation. Interested PHNs contacted the researcher individually to arrange for a mutually agreed upon interview date and location.

The PHNs ranged in age from 27 to 61 years, with an average age of 44 years. Of the 18 PHNs, two were educated beyond the BSN degree. The sample also included two males and two PHNs currently working in an administrative capacity. Years of PHN experience ranged from six months to 20 years, which provided variation in experience to the sample. For some of the PHNs, this was their first nursing employment with a maternal-child population following nursing school; for others this was the only nursing specialty they had ever worked in. Some of the PHNs were adult immigrants to the United States and English was their second language. The uniqueness of each individual PHN's work in the various geographically located health centers throughout the county

maximized the diversity of the participants along with the cultural and geographic diversity of their clients. Encouraging diversity in the sample revealed not only participant-specific data but also allowed for identification and exploration of mutually shared themes (Jansen, 2010).

Participants had worked as MCH PHNs at various public health centers located throughout the county. Caseload sizes varied, from as low as 27 to as high as 70 cases per nurse. PHNs with less experience generally carried smaller caseloads, while the higher caseloads were often associated with periods of short staffing or due to individual nurse preference for a larger than average caseload. At-risk postpartum cases comprised at least 50% of a typical PHNs caseload while four of the PHNs had caseloads reflecting 80% postpartum clients. One PHN noticed that a dramatic increase in the percentage of postpartum clients coincided with the expansion of the Nurse Family Partnership (NFP) program at her health center.

PHN Interviews

The researcher, an experienced PHN, conducted semi-structured, open-ended interviews with each of the PHNs. Each PHN answered the same open-ended questions regarding his or her experience with home visitation services to at-risk postpartum clients. Consistent use of interview questions strengthened the reliability of participant responses (Kvale & Brinkmann, 2009).

Ethical issues

Approval to conduct the study was obtained from the Institutional Review Board (IRB) of the participating university. Approval was subsequently granted by the county agency's research department. Participants were assured that participation in the study

would not have any effect on employment status. No incentives were offered in accordance with the participating agency guidelines restricting PHN acceptance of outside gifts.

Data Analysis

Interviews with PHNs provided the data to address the research questions. All interviews were audio-recorded and transcribed. Data collection and data analysis were conducted simultaneously to the point of data saturation. By interview #16, it was suspected that data saturation was approaching and the final interview was conducted to confirm the absence of new emerging codes. The interview transcripts resulted in 419 pages of verbatim conversations with participants. Mid-way through data collection, research committee members reviewed randomly chosen transcripts and field notes and contributed analytical feedback to the research process. This process was repeated at the conclusion of data collection.

Hsieh and Shannon (2005) described approaches to the initial coding used in data analysis. Coding began with conventional content analysis, in which coding categories were gleaned directly from the data. Summative content analysis involved numeric quantification of words identified to make comparisons that ultimately enriched the final data analysis. Three to four cycles of coding resulted in clarification of categories emerging from the data, and analytic memos were kept in tandem with this process.

Results: Opening a Case

Results of data analysis were rich with qualitative descriptions of the work of PHNs conducting home visitation services to at-risk postpartum women. The remaining discussion will focus on the background context for opening a case to services. The

section will begin with an understanding of the origin of referrals and the process whereby referrals reach the hands of the PHN.

Referrals. PHN home visitation services were triggered by a referral process. Knowledge of this process provides an understanding of the context of PHN service delivery. Local hospitals' neonatal intensive care units (NICU) were reported as the number one source of postpartum referrals. NICU mothers were described as anxious mothers in need of increased support in dealing with the birth of a premature or medically fragile infant. These infants were often in need of long-term medical and growth and developmental follow-up services.

The second most common source of referrals was Child Welfare Services (CWS). Whiting, Scammell, and Bifulco (2008) stressed the importance of a strong alliance between CWS workers and healthcare providers in achieving mutual child welfare goals. CWS referred mothers for myriad reasons, ranging from giving birth to a infant exposed in-utero to drugs or alcohol, to living in a home at risk for domestic violence, to suffering from various mental health problems. Other typical sources of referrals were pediatrician and OB-GYN offices, Women, Infants, and Children (WIC) supplemental nutrition offices, area HeadStart programs, public school programs for pregnant and parenting teens, and local county programs such as the Medi-Cal office. There was even an occasional self-referral from individuals in the community.

The PHNs described other reasons for postpartum referrals which included low functioning, mentally disabled mothers; income, cultural and language barriers to obtaining appropriate postpartum care; multiple births due to both natural and in-vitro phenomenon; military mothers with minimal social support; teenage mothers; mothers

with a history of multiple high-risk pregnancies; mothers who did not receive prenatal care; mothers who did not qualify for NFP services; and mothers who displayed signs and symptoms of depression during their hospital stay.

The referral agencies had access to a public health nurse referral website. The majority of referrals were initiated via this method, with a few entering the system through telephone calls and faxes. PHNs felt it was important for the researcher to know that referrals frequently did not provide sufficient background information and that clients were often not informed, or did not remember being told, that they would be contacted by a PHN. One PHN described the difficulty in connecting with an uninformed new client this way: “If they [*were*] not prepared, they [*got*] spooked...Who are you? And how do you know about me?”

Role of the supervisor. PHNs supervisors played a significant role in assigning new referrals to PHNs. The web referral system automatically assigned referrals to one of the six designated public health centers by matching the client’s residence census tract to the health center catchment area. Health center clerical staff entered the electronic referrals into the PH nursing computer system. The referral was then forwarded to the PHN supervisor. New referrals were generally assigned to PHNs according to designated census tracts; however, accommodations to assignments could be made if a particular PHN already had a large caseload or had limited experience with difficult cases.

Some supervisors also considered PHN expertise in the assigning of referrals, as one PHN stated: “...I guess she [*the supervisor*] feels that person is the best suited for that kind of referral.” The PHNs eventually received their new referrals in the computer system, usually accompanied by a paper copy that was either handed to them by the

supervisor or placed in some type of referral inbox. PHNs did a daily check for new referrals.

Pre-visit activities. Once the PHN received a referral there was some variation in the process of connecting with the client. The timeframe to initiate contact with a client ranged from the day the referral was received to as long as two weeks. The process of finding a client followed a consistent pattern of an attempted initial telephone call, followed by a drop-in home visit, and one final effort to reach the client through the mail. There was no mention of the use of newer technology such as email or texting. Drop-in home visits were generally made within two weeks of the initial telephone attempt. PHNs agreed that they were more successful at engaging clients in an initial home visit, after failed telephone calls, if they were fortunate in establishing an initial face-to-face contact. This was congruent with the findings of a study by Selby-Harrington et al. (1995), who found that participants who received a face-to-face home visit from a nurse more readily agreed to the services provided by the study.

Initial visit. PHNs agreed that a case officially opens to PHN services with the first home visit and concurred that these home visitation services were essentially voluntary. Most felt that the client retained all of the decision-making power to accept or refuse services. “You can’t force them...” was a common theme that resonated among the PHNs.

Referrals from Child Welfare Services (CWS) reflected less client autonomy in accepting or rejecting PHN services. Clients involved with CWS had the added pressure to cooperate with this government agency, and PHN home visits were one of several strategies used by CWS social workers to provide child-protective services. First-time

mothers, teenaged mothers, and NICU mothers were considered the most receptive to PHN services. One PHN summarized her efforts to open a case to services as: “We saw them whenever we could find them.”

As previously noted, initial face-to-face encounters were more likely to result in a referral being opened to service. PHNs thought NICU clients tended to be the easiest clients with whom to arrange initial home visits. These mothers were described as more anxious and receptive to PHN services than other postpartum clients, perhaps due to their infants’ vulnerability. Clients referred for mental health disorders, such as depression, often needed that face-to-face, physical presence of the PHN knocking at their door along with verbal convincing to consent to PHN home visits.

PHNs talked about strategies they used to obtain agreement to an initial home visit. By far, the most common strategy was the drop-in, unannounced, home visit. Promoting PHN home visits as a “free service” was frequently used to entice clients to try out the services, as was offering to measure and weigh the baby and conduct developmental screenings. Another approach was to suggest the client agree to just one home visit in the hope that they would see the benefit of PHN services and change their mind regarding participation in long-term services.

Kaser, Bugle, and Jackson (2009) looked at patient preferences for nurse attire and exhorted nurses to consider the impact that clothes have on the nurse-patient relationship. Wearing scrub uniforms instead of street clothes was not a common practice among the PHNs; however, one PHN believed this facilitated entry into the home by implicitly promoting the trusted role of the nurse.

People see me in the scrubs, they see [that] I'm a nurse. It's safer. When they see me in the regular...office clothes, [and] this badge [ID badge], I look like a social worker and it will close doors...because I'm a nurse. I'm not a social worker. And they [the clients] trust me.

One of the more experienced PHNs emphasized the need to gently yet persuasively convince a client that she absolutely needed and would benefit from PHN services. "So that's what I mean by getting in the door, making our services necessary, even though they are voluntary." Another PHN with several years experience employed a positive approach: "And I try to make it sound like fun, like – Congratulations! You've got a new little baby! I'd love to come see it. I just love seeing new little babies!"

Once in the home, PHNs attempted to make the first visit as informal as possible to promote a trusting client-PHN bond. The majority of home visitation research, regardless of the focus of the study, emphasizes the importance of *trust* between a client and home visitor (Gomby, 2005). Without PHN-client trust, home visiting services will probably end prematurely, as indicated by one PHN:

[It's] very important if I managed to build trust between, and [a] relationship, between me and [the] client – [then] all [of] our visits [are] really productive and helpful... If [there is] no trust, it's 50% productive... And it's most likely [that] those kind of cases wouldn't last long – because my client would have a lot of excuses...would have another priority except me...

The PHNs would begin a visit by informing the client of the reason they were referred for services. Several PHNs mentioned that it was important to focus initially on the mother and get to know her as a person, instead of following the natural inclination to

make the baby the center of attention. One PHN made it a point not to emphasize health education on the first visit; instead she focused on building a bond of trust with the client by highlighting and praising the client and her baby. Another PHN described the give and take involved in opening a home visit in this way:

So it became a dance where you listen to the client's verbal and visual cues that she's presenting – and that would give you an indication of where you can go, and where you shouldn't go yet. But sooner or later if the client remained receptive, you would be able to touch on everything that was on your checklist of things to do with that client... And many times the questions or concerns she [*the client*] had were things that were on my checklist.

During the first visit, some of the PHNs felt that it was best not to mention how long the services would continue. If the PHN felt strongly that services are client-directed, he or she was less inclined to talk about length of services as it might give the client the idea that they could stop prematurely or they might refuse services because long range planning seemed too overwhelming. Other PHNs were forthcoming and, on average, would suggest six to eight months of services for mothers with healthy infants and 12 months if they had a medically fragile baby. Length of home visitation services will be elaborated on in Part II: Closing a Case.

PHN challenges. Although all clients served were considered at-risk postpartum clients, PHNs viewed some clients as more “difficult” than others. Medically fragile babies and mothers requiring more PHN time were one group of difficult clients. Another group was substance abusing mothers who gave birth to drug- or alcohol-exposed infants, frequently with CWS involvement. Some PHNs also considered undocumented

immigrant clients as difficult to serve due to limited access to resources. There was however, a consensus that “hard to engage or nonresponsive” clients were always difficult to open to services and difficult to prevent early closure as suggested by one PHN:

Those [difficult] are the clients that need us the most and usually those are the clients that we tend to give up on quicker. I think it’s natural to want to help the person that wants to help themselves. I think that’s where the attention ends up going.

The home visit would usually conclude in one of three ways. The PHN might schedule an appointment for a subsequent home visit, the timing of the next home visit might be left open-ended dependent upon a follow-up phone call, or the client might decline further home visitation services.

Conclusion

Over 100 years later the practice of public health nursing in the United States has evolved from its New York City origins. Early PHNs practiced autonomously from community settlement houses supported by limited government funding supplemented by wealthy donors. PHNs of today seek to stretch limited government dollars by demonstrating evidence-based practices. The NFP is expanding home visitation services because they have been successful in promoting more optimal maternal and child health outcomes. Incorporating additional valid and reliable tools into practice protocols, along with standardization of the referral process and home visiting practices are other important exemplars of change. This qualitative study is another step towards substantiating evidence-based practices.

The client-PHN dance begins when a home visitation case is opened. The dance ends when the case is closed. What major factors affect the closing of a case? Do cases close when they should close? Or do unexpected dynamics play a part? This discussion will be the focus of Part 2.

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At-Risk Postpartum Clients Receiving Public Health Nurse Home Visitation Services,

Part 2: Closing a Case

Denise K. Thompson, MSN, RN, PHN

Lois C. Howland, DrPH, MSN, RN

Mary-Rose Mueller, PhD, RN

Mary Jo Clark, PhD, RN, PHN

Abstract

This article continues the discussion of public health nurses' (PHNs) decisions regarding home visitation services. Part 1, Opening a Case, described the study methodology and the background context of opening home visitation services for at-risk postpartum women. Part 2 addresses two questions:

1. What factors lead to a PHN's decisions to terminate home visitation services to at-risk postpartum women?
2. What is the decision-making process used to determine when to close a case?

Study results brought to light an important distinction between crisis management and case management services. Crisis management services were of short duration, while case management services, on average, were longer. Factors influencing case closure decisions fell in one of three categories: PHN, workplace, and individual client factors. Client factors were implicit and explicit in nature. An understanding of these factors and their affects on closing cases may provide insight into factors amenable to intervention. Future research focusing on optimal length of PHN home visitation services to at-risk postpartum clients may serve to strengthen PHN case closure guidelines.

Keywords: *maternal-child health, postpartum, public health nursing practice, qualitative research, vulnerable population*

This article continues the discussion of public health nurses' (PHNs) decisions regarding home visiting services for at-risk postpartum women. Part 1 (Thompson, Howland, Clark, & Mueller, 2012, manuscript in progress) described the intricacies of opening a case to home visiting services. Part 2 describes the closing of cases addressing two questions: (a) what factors lead to a PHN's decisions to terminate home visitation services to at-risk postpartum women, and (b) what is the decision-making process used to determine when to close a case to service.

In interviews, PHNs distinguished between crisis management and case management services. We begin with a discussion of these two types of services, and then address factors affecting PHN closure decisions.

Case Management or Crisis Management

As described in Part 1 (Thompson et al., 2012, manuscript in progress), the 18 PHN participants came from diverse backgrounds, educational, and work experiences. Years of work experience as a PHN fell into three categories: PHNs with fewer than 5 years experience (n = 5), those with 5 to 10 years experience (n = 6), and those with 11 to 20 years as PHNs (n = 7). PHNs with more than 10 years of experience were unique in that they differentiated between case management and crisis management:

There are clients who want case management. There are clients who only want crisis management. Meaning they were receptive to services as long as they had an immediate need. Once that immediate need was met, then they were not available for any other services... The interesting thing about those clients [*crisis management clients*] is that sometimes they would call back later. Six, seven months, when another problem occurred. But by then you [*had*] closed the case.

One of the PHNs described the distinction this way: “When you’re doing crisis management you let a lot of minor things go. And when you’re doing good [*case management*] maintenance, you don’t let those little things go.”

Closure decisions varied depending on the distinction between crisis management and case management. Clients who were receptive to long-term case management services generally were kept open for at least a year. The crisis management clients typically received one or two home visits and were often lost to follow-up once the crisis had passed. A PHN described the challenges she encountered in providing case management services to an unreceptive client:

She was so difficult to get a hold of. She didn’t want me there. And that was the hard part, because she was trying to hide things. You know, her place was a disaster. It wasn’t safe for the children. There were things all over the place that they could fall over, hit their head on; there was food left out, just dirty crusty food within the kids’ reach. There were roaches, there was..., she tried to hide a lot. So I tried to see her frequently, but sometimes it could be like six to eight weeks before I could get her. You know, she was one you didn’t want to close...

PHNs tended to view themselves as case managers not crisis intervention providers. This view may have originated from their mandated participation in Targeted Case Management (TCM) which is a source of monetary revenue supporting PHN home visitation services. This was elaborated on by a PHN:

It’s case management, yes – because our policies...and protocols have always been to provide case management services. And even we ourselves are case managers...That stands for Targeted Case Management. And that’s a term that’s

used through Medi-Cal. And basically part of our funding can be through TCM funding.

This distinction between crisis management and case management is congruent with the work of the New York State Department of Health AIDS Institute's (2006) Case Management Standards Workgroup, which delineated two distinct types of services. Comprehensive case management consisted of intensive, frequent services offered over a long time. In contrast, supportive case management involved services to meet immediate client needs in hope of motivating them to later accept comprehensive case management services. Although New York State Department of Health services were not specific to MCH home visitation services, the strategy of not closing the doors on short term, crisis management clients bears consideration in formulating future PHN policies.

Factors Influencing Closure Decisions

The PHNs shared insights regarding factors influencing their decisions to close cases. Three types of factors emerged from the data: PHN, workplace, and individual client factors. These factors are depicted in Figure 1.

PHN-driven Factors

The concept of *doing well* arose from the data as a prominent PHN-driven factor influencing case closure. A PHN's assessment and determination that a mother and baby were doing well was critical to the decision to close a case. There was a standard repertoire of tools available for the PHNs to guide and support assessment and final closure decisions. One tool everyone mentioned was a "checklist" of items to cover on home visits. The checklists were mandated PHN chart forms which included separate forms for postpartum and infant visits.

The postpartum checklist included specific assessment and education points, such as (a) information about client health and medical care, (b) common postpartum discomforts and complications, (c) postpartum self-care, (d) postpartum psychosocial health (e.g., maternal-child bonding and risk for domestic violence), (e) family planning, (f) a section to record objective measurements such as blood pressures, and (g) a section for narrative charting beyond the checklist. The infant form was similarly formatted and included areas such as physical assessment, growth and development, nutrition, safety, and immunizations. Step-by-step instructions on how to document home visit activities on these forms were included in the PHN practice manual provided on employment.

One PHN described the influence of the checklists in this way:

I'm kind of like a global thinker. So I've kind of like enveloped the tools that I've been trained for...and just take them to each home visit...The flow sheets are pretty self explanatory. And those guide you on every visit. And the anticipatory guidance sheet...as well as the growth grid – and those kind of tools kind of guide you.

Checking off the topics on these forms indicated that appropriate care had been provided, minimally required PHN services had been offered, clients were doing well, and it was now time to consider terminating services.

Other measures used by PHNs were client involvement with community resources such as Women, Infants and Children Program (WIC), Social Security disability services, and local First Five programs. Keeping postpartum medical appointments and obtaining contraception were considered successful outcomes and indicators that a mother was doing well. Standardized growth and developmental measurements provided an objective

way to determine if the child was also doing well. The MCH protocol also included the use of several other assessment tools for parent-child interaction, health education, environmental assessment, depression, and family violence..

Previous research indicates that PHN assessment practices are guided by Maslow's hierarchy of needs (Drennan & Joseph, 2005). In this study, PHNs took into account Maslow's hierarchical factors like food, shelter, safety, health status, and so on in reaching decisions to close cases to home visiting services. Foundational basic needs were at the forefront of a PHN's assessment as mentioned by one PHN: "So she was getting food and money. And the child was well dressed and groomed." In contrast, mothers whose lives were approaching the top of the hierarchy of needs would have higher aspirations as suggested by another PHN:

You feel like you've influenced the direction that they're going, and that their life will be more successful. They might want to go back to school, they might want to get their degree...Those are the best. The other ones, at least you've given them what you can for where they are. And it's up to them to be motivated to find the next steps.

The mother's psychosocial status was another important measure assessed by PHNs. There were some variations in the descriptions of this status. Postpartum depression was evaluated by routine screening according to PHN practice guidelines. Some PHNs described other indicators and talked about mothers who were appropriately engaged in activities of daily living and caring for their families. A PHN mentioned that an action as simple as changing out of pajamas might illustrate that a client was psychosocially doing well.

But at least the last few times I saw her, she was dressing in regular clothes. Got out of the pajamas. She had combed her hair...And she was in there cooking lunch for the little boy. And the kids were happy.

Financial stability and education were also indicators of doing well, although there was a spectrum ranging from the ideal to the acceptable. Simply having someone in the household that was employed might be enough for one client, whereas a client accessing childcare and returning to work or school would indicate doing well in another case.

PHNs also felt that a client was doing well if the home was safe. Safety might encompass elimination of injury risks as well as freedom from abusive situations. Mothers who provided a home environment that had a low risk of injury to the child were considered to be doing well.

As time passed, a client who was doing well asked fewer questions of the PHN and appeared to be less anxious about the parent/caretaker role. Clients who were doing well kept most of their appointments with the PHN, medical providers, and other community agencies. They also followed through on PHN referrals to community agencies and may even have sought out resources on their own. One PHN recalled a conversation with a client. "Oh, did you call about that car seat? Should you really use it [*referring to car seat*]? Has it been recalled?" [*the client's response*] "Yeah, I called. Everything's good."

Some other indirect measures of doing well were clients who no longer needed prompting to know what to do for their children and those who could verbalize an understanding of normal growth and development. Doing well was also equated with

clients believing they no longer needed a PHN in their lives and feeling self-sufficient. One PHN described a feeling of pride in a client attaining self-sufficiency: “I feel really proud of them. It’s nice when they don’t need me anymore. It certainly can work me out of a job, but that’s good. I want them not to need me.” Although the PHNs used different terms to describe a client doing well, they emphasized clients’ newly acquired skills in dealing with whatever life brought their way. One PHN summarized it this way:

...squared away means you take care of what needs to be taken care of. You know, if you have a question about insurance – that you’ve called the [Medi-Cal] Access line and talked to them about Medi-Cal. You take your child to the doctor instead of waiting until midnight and taking your child to the ER. So you get things done that need to be done.

PHNs varied in their personal views on an optimal time to close a case but consistently mentioned that a child’s developmental milestones helped to guide closure decisions. Promoting a child’s optimal growth and development is a goal of most MCH home visitation programs (Gomby, 2005). A case might be closed after only one visit if the client was doing well and the child did not have any developmental delays. MCH protocols did not dictate a specific length of services, but instead allowed for use of clinical judgment and autonomy by the PHN.

Closing a case at three or four months of service reflected a PHN’s judgment that, along with a mother doing well, the child was developing normally. For some PHNs, waiting for six to nine months was preferable because the child should be starting to crawl and transitioning to solid foods. A child starting to walk and being fully established on solid foods made 12 months a better indicator for some PHNs. There was

disagreement as to whether cases should be kept open for as long as 18 months. Some PHNs felt that this was just too long to keep visiting the same client; for others this was optimal as it reassured them that the child had attained important developmental milestones. As expressed by one PHN, "...if they were almost walking and starting to verbalize, that was a good time to close them." In summary, although PHNs did not agree on length of services based on developmental milestones, they did agree that appropriate achievement of these milestones supported the conclusion that a child was doing well.

A few cases were described that were kept open far longer than the typical 3 to 12 months. Cases that were considered difficult might be kept open for as long as 2 to 3 years. Conversely, they might be closed after one or two visits due to minimal responsiveness on the part of the client. One PHN described a difficult case in this way: "When you say difficult, I think right away of the person that is not responsive. You go to the visit and they're not home." PHNs agreed that there were no set guidelines on when to close a difficult case, which is why responsive difficult cases tended to be the ones kept open longer. Engaged difficult clients frequently formed a strong attachment to the PHN and often requested to receive home visiting services longer than average. As reported by one PHN: "sometimes the moms would say, 'You know, I'm not quite ready to let you go yet.'"

Workplace-driven Factors

The workplace was also found to influence PHN decisions to close cases to home visitation services. Three prominent workplace factors were revealed in the interviews with the PHNs: other health center staff, workload, and the overshadowing expansion of the Nurse Family Partnership (NFP) program.

Health-Center staff. Two categories of health center staff influenced PHN case closure decisions – supervisors and peers. PHN supervisors were influential in PHNs' closure decisions. Using an analogy from the sports world, supervisors are like athletic coaches. They have the knowledge, expertise, and extensive training to coach PHNs in their work, ultimately affecting the quality of the nursing services to clients (Agency for Healthcare Research and Quality, 2012). Josten et al. (2002) concurred that PHN supervisors play a critical role in assisting PHNs to develop perspicacity in their client interactions.

PHNs in this study repeatedly commented on regular interactions with their supervisors. The extent of this interaction, however, tended to depend upon PHN experience and the particular supervisor. Inexperienced PHNs wanted regular consultations with their supervisors; these consultations included guidance on closure decisions. Consultation with supervisors tended to occur informally as part of the workday. Newer PHNs might have regularly scheduled case reviews with their supervisors, while more experienced PHNs met quarterly. The experienced PHNs tended to function autonomously in case closure decisions. However, supervisors provided final review of a case submitted for closure.

Relationships with peers also mattered. PHNs felt supported by their peers and believed they had sufficient opportunity in the workweek to consult with each other informally. When asked about formal case presentations, PHNs were not receptive to this idea because they felt a potential for case management decisions to come under increased scrutiny and judgment. Inexperienced PHNs were grateful for the support of veteran PHNs. Experienced PHNs, on the other hand, tended not to consult with their peers and

instead sought out their supervisors for case closure validation. They might also occasionally consult with a peer content expert. For example a peer educated as a nurse practitioner was seen as someone with advanced physical assessment skills. When the experienced PHNs did discuss cases with their peers, it was not to seek advice, but to validate and share common experiences.

Workload. As anticipated, PHN workload had a definite impact on case closure. A common belief was that closing cases would permit opening more new cases: “So you do have control in that way because the more people you close, the more people you’ll be able to open.”

In periods of high caseloads, PHNs compared needs of clients and would close those deemed “less needy”. “Then you’ve got a few people who [are] kind of just hanging out... they don’t need much. Maybe I’m going to close those and focus on the ones that really need my attention.” Another PHN felt strongly about the need to proactively close the less needy cases:

You need to be doing something with them. You need to be progressing toward goals. Or you need to close the case. Because there’s hundreds of people out there waiting to be seen that have huge needs... You’ve got to close cases so you don’t keep getting them and end up with 500 patients.

PHN supervisors were also influential in decisions to close cases during periods of short staffing, as mentioned by one PHN: “...we just didn’t have enough nurses, and we had so many more high-risk referrals coming in , that we were told to close [*by the supervisor*].” The influence of the workload and appropriate staffing cannot be understated (CNA Healthpro, 2009).

Nurse Family Partnership. As a result of increased funding for home visitation in the 2010 Patient Protection and Affordable Care Act (Thompson, Clark, Howland & Mueller, 2011) the Nurse Family Partnership's (NFP) sphere of influence has enlarged, indirectly affecting PHNs' view of home visitation practices. As described in Part 1, over the course of this study a number of maternal-child PHN positions were dedicated to the NFP program. PHNs in NFP positions only provide services to first-time prenatal clients who meet program eligibility requirements (NFP, 2011). PHN participants compared the very specific protocols of NFP home visiting services to the more autonomous MCH protocols. They believed that the special training the NFP PHNs received contributed to preventing premature closure of cases. NFP clients are told up front how long they will be kept open to services and how often they will be visited. NFP PHNs are obligated to keep the cases open even if a client was considered to be doing well. In contrast, non-NFP postpartum clients who were doing well were presumed ready to close. One PHN summarized it this way:

But there's a little bit more of an expectation with Nurse Family Partnership that the client really follows through and be part of the partnership with the nurse – meaning the frequent home visits. Whereas, with maternal-child health, it's almost like there's more freedom to decline further services.

Client-driven Factors

PHNs agreed that clients had the most control over the decision to close a case. The PHNs believed that final closure decisions were client-driven. "But it is up to you if you want to accept our visitation, or our services, or [not]. So it depends if the clients, [if]

they say okay.” Client-driven factors influencing closure were either implicit or explicit in nature.

Implicit factors. Interviews with the PHNs revealed factors that appeared to influence closure decisions. Data analysis revealed three main categories of implicit factors: (a) a client’s passive refusal behavior, (b) the client-PHN bond, and (c) postpartum depression.

Josten et al. (2002) studied reasons for client-driven termination of nurse home visitation services. The term *passive refusal*, defined as “not responding to visiting or unable to locate” (p. 4), is in contrast to actively refusing a home visit. Client *freedom of choice* went hand in hand with passive refusal. Actions of passive refusal were reflected in: (a) not answering or returning phone calls from PHNs, (b) not acknowledging PHN attempts to contact the client, (c) intentionally missing scheduled appointments, and (d) going so far as to hide from a PHN knocking on the door. A PHN described this type of scenario in this way: “...I feel like [*the*] client [*is*] faking, if [*the*] client [*is*] avoiding me...” PHNs would attempt to contact the client by mail, but usually ended up closing these cases and labeling them as *lost to follow up*.

I would close the case if I [*could not*] locate a client. If I [*made*] one appointment after another, and [*the*] client [*was*] just not home. [*There would be*] no reason for me to keep a case open – because I [*haven’t*] seen a client for three months. I can’t find her.

Kitzman et al. (1997) found that, for some clients, passive refusal did not mean permanent active refusal. Instead, they discovered that clients had individual reasons for temporarily distancing themselves from PHNs. Sometimes they just wanted a respite

from home visits, as suggested by one PHN: "...these people [the clients] are busy, whether they're busy with work, or they're busy watching Jerry Springer, they're busy in their mind..."

PHNs implemented strategies to prevent premature closure precipitated by a client's passive refusal behaviors. PHNs reminded clients that they were receiving free services and that the goal of these services was to support the client and her family. One PHN described how she would highlight weaknesses in a client's life in order to prevent premature closure:

Sometimes I would talk to them if they were ready to close and I didn't think that they had all their ducks in a row. Sometimes I'd sit and I'd talk to them, and say, "You know I'm concerned. And this is what I see... I'm seeing that you're saying that you're ready to go back to work, but then when I ask you who's going to take care of the baby, you don't have that set up yet...you say you're ready. I, I have trouble with that." So a lot of times I'd sit and we'd discuss it. [*Sometimes*] they'd choose any way to say, "Nope, we're done."

PHNs' descriptions of implicit factors were similar yet there was some variation in the interpretation of these factors such as the perception of a client passively refusing services. One of the more experienced PHNs viewed this simply as a client asking to have their case closed in the only way they knew. Less experienced PHNs had a more negative view and felt that clients were rejecting services that would be good for them.

As supported in the literature, PHNs believed the client-PHN bond implicitly affected decisions to close cases: "You know, it depends on the kind of relationship that you've built with that client..." This is congruent with the findings of Paavilainen and

Astedt-Kurki (1997) who found “friendly and confidential” client-nurse relationship to be essential to the collaborative work of PHNs and their clients. The majority of home visitation research, regardless of the strength of the study, emphasizes the importance of *trust* between client and visitor (Gomby, 2005; Thompson, Kropenske, Heinecke, Gomby, & Halfon, 2001). The PHNs in this study discussed the importance of this trusting relationship in preventing early case closure decisions. This was highlighted by one PHN’s comment:

Very important if I managed to build trust between – and a relationship – between myself and the client. Then all of our visits are really productive and helpful... Yes. If not, if there is no trust – it’s 50% productive... And it’s most likely those kind of cases wouldn’t last long – because my client would have a lot of excuses...

Stronger bonds of trust between the PHN and client also facilitated clients opening up and sharing their lives, which in turn allowed the PHN to help in ways beyond the home visit protocols. As one PHN concluded: “You know, it depends on the kind of relationship that you’ve built with that client”, the quality of the client-PHN relationship influences the closing of a case.

Postpartum depression was another implicit factor affecting case closure. As many as 15% of childbearing women in the United States experience postpartum depression (Brett & Williams, 2008; Fitelson, Kim, Baker, & Leight, 2011). Infants of depressed and poor mothers also have an increased risk of exposure to inherent dangers associated with domestic violence and substance abuse in the home (Vericker,

Macomber, & Golden, 2010). Mothers in these situations were more likely to refuse ongoing home visitation services as explained by an insightful PHN:

If they're...depressed, it's really hard to get in. They're afraid. They're just afraid. They're afraid of you, they're afraid of the outside, they're afraid of removal, they're afraid of... if there's drugs, they're afraid of [the system] finding out, they're afraid of all kinds of things...And I find that the rate of refusal in that category is high. There's too many fears. They've been let down too many times by the system, or their background, their [personal] history or whatever, so they are, they're just not open to anybody knowing their business.

Josten et al. (2002) submitted that PHNs may benefit from advanced mental health training to better serve these clients and avoid prematurely closing their cases.

Explicit factors. PHNs agreed on two explicit client-driven factors influencing the decision to close a case. The first factor was a client moving to another geographic location not served by the PHN. As an aside, moving for clients suffering from domestic violence often meant moving into a local shelter. This was an explicit factor influencing case closure that bears a deeper look into the problem of PHN access to clients living in shelters.

The second factor identified by PHNs was a client's outright refusal to participate in home visitation services. On the surface, refusing services appears to be a simple act. "If someone refuses and says 100% I don't want it [home visitation services], there's nothing you can do." However, understanding the context of refusal sheds light on a client's active refusal. Clients, such as those referred from Child Welfare Services (CWS), may not have wanted PHN services in the first place. Other clients may have

attained a short term goal, such as enrolling in Medi-Cal health insurance, and no longer want visits. Still other clients had passed the immediate postpartum period and were returning to work or school, so home visits have become a burden. as indicated by one PHN:

...they're starting to – “Okay, I'll go back to school, or I'll get a job. Or something.” They sort of are in the parent role, it doesn't feel new anymore. And so, they actually start possibly getting bored, too - [*with*] being at home. But then they are actually ready to think of doing other things. “but I don't know if I can fit it in [home visit appointment].”

In addition, there are also clients who were simply bored with the home visitation activities. They saw no need for PHN services. One PHN described this scenario in this way:

Usually they're asking me, “Is this going to take very long?” Or they've got the glassy eyes... And once they start making up their mind [that the home visits are boring], it may be kind of hard to turn them around. Kind of like the horse headed for the barn.

Some PHNs were more creative in coming up with new educational topics that they felt would hold the client's interest. More experienced PHNs often contacted the original referral source for support in keeping the case open. This was especially true with clients referred from CWS for child safety issues. Decreasing the frequency of home visits was yet another commonly used technique that PHNs used to prevent closure. “You had the freedom to be like, ‘Okay, well maybe we can stay in contact just a little less frequently.’” PHNs overwhelmingly felt that they should always be able to *do more* to

stop a client from closing a case before the PHN felt they were ready. An awareness of a dichotomy of *doing more* by *doing less* frequent visits came to light as a result of the conversations with PHNs and warrants a closer look in light of research indicating frequent visits strengthen the client-PHN bond and promote longer length of services. (Bornstein, 2012)

Other clients believed they were indeed finished with home visitation services. The clients who only wanted short-term crisis-management services were finished once they met their short-term goals. These short-term clients also included experienced multiparous mothers with strong social and economic support. On the opposite end of the spectrum were clients who received long-term services. This afforded them the time to experience the process of personal growth and eventually believe that they were ready to be on their own. A PHN summed it up in this way, “Because usually by the time it came to close services, we’ve accomplished a lot. And more specifically, the mother and the child had accomplished a lot.”

Conclusion

An understanding of the factors affecting the decision-making process involved in closing cases to PHN home visitation services may provide insight into factors amenable to intervention. Muir (2004) suggested that insights into the decision-making process of nurses have the potential to improve patient care. Kenneth Hammond, well known for his groundbreaking decision-making work regarding Cognitive Continuum Theory (CCT), described human decision-making as a process that occurs along a continuum of cognitive analysis and human intuition (Fabbs Foundation, 2012). The PHN interview data from this study supports his premise. There is an ongoing *dance* influenced by

factors found in the workplace, associated with clients, and with the individual PHN. PHNs used both intuition and cognitive analysis to interpret these factors and make final closure decisions. The decision-making process described by the PHNs was largely an unconscious one that did not exhibit conscious reflection, as evidenced by this PHN's comment.

What this [*the interview*] has pointed out to me is what criteria would be good to know before they [*the client*] are closed. Is there something that you should look at? Are they really ready to close? What has been accomplished?... [*This*] is a good point. I'm so – can't see the forest through the trees because I'm so busy trying to get the job done.

Research seeks to determine the effectiveness of home visitation programs; however, research questioning the role individual factors play in affecting case closure and subsequent case outcomes has seldom been addressed. Many factors contributing to the dynamics of postpartum home visitation interactions have been suggested. However, few studies are specific to PHNs, few have examined these factors from the viewpoint of the PHN, and few are considered to be empirically methodologically rigorous (Daro, McCurdy & Nelson, 2005; Gomby, 2005; Stoltzfus & Lynch, 2009; Thompson et al., 2001).

Future research focusing on optimal length of PHN home visitation services to at-risk postpartum clients may serve to strengthen PHN case closure guidelines. Leeman and Sandelowski (2012) posited that qualitative inquiry provides *practice-based evidence* that has potential to bolster evidence-based home visitation practices. Increased awareness of the effect of factors that influence PHN decisions to terminate services has

the potential to support accountability of public dollars spent on PHN home visitation services to at-risk mothers and their children.

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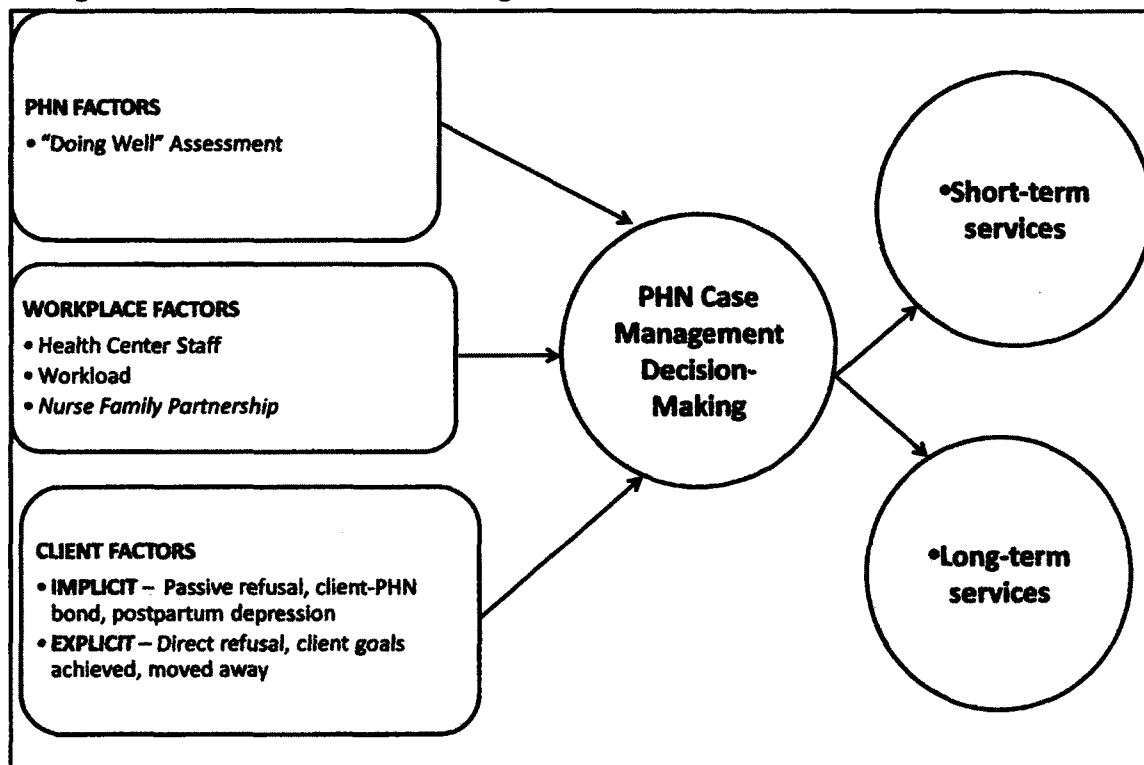
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Appendix

Figure 1

Model of Factors Influencing PHN Case Closure Decisions

Figure 1 Model of Factors influencing PHN Case Closure Decisions



Closing Statement

This study's findings suggest the need to continue efforts to discover and implement evidence-based data in support of public health nurse (PHN) home visitation services to at-risk postpartum women and their children. PHNs reported positive outcomes of home visitation services. Further research must concentrate on modifiable factors associated with closing cases.

There is urgency to this call for research as funding sources are currently diverting much of postpartum home visitation dollars towards prenatal home visitation services. Expanding the research in this area may serve to provide the evidence needed to convince policy makers of the value of PHN home visitation services for postpartum women. In 2007 the Schuyler Center for Analysis and Advocacy drafted a model of a universal system of services for New York families, among which included universal postpartum home visitation services; thus suggesting a need for postpartum home visitation services in this country. Perhaps U.S. policy makers should consider countries such as Great Britain which have routinely incorporated public health nurse postpartum home visitation into their maternal-child health care services (Cawthorns & Arons, 2010).

More qualitative descriptive data is needed. The following are suggested areas of research that have emerged from this study:

- A qualitative study using focus groups comprised of at-risk postpartum clients clarifying and describing their perceptions of implicit and explicit client factors which influence the termination of home visitation services.

- A qualitative study with both PHN and interpreter participants exploring the influence of interpreters on decision to end home visitation services.
- A retro-active PHN chart review examining differences associated with short (less than six months) and long term home visitation services.
- Tracking the epidemiology of problems associated with at-risk postpartum women, paying special attention to increases or decreases observed since the 2010 expansion of the Nurse Family Partnership program.
- A quantitative study comparing measurable outcomes of short (less than six months) and long term services. Clients would choose to receive either short or long term services and outcomes would be measured at baseline, at six months and at the time of long term closure for both groups.
- An evidence-based project investigating the efficacy of current PHN postpartum home visitation protocols which includes differentiating between short and long term services.

It is hoped that ongoing research in this area will support evidence-based PHN home visitation practices and ultimately vulnerable postpartum women and their children who are priceless members of our society.

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Appendix A
Recruitment Flyer

Participants are needed for a Research Study:

*Public Health Nurse Decision-Making and At-Risk Postpartum Case
Closure*

I am seeking public health nurses (PHNs) currently employed by the County of San Diego public health nursing department. You must have six months or more of Maternal-Child Health (MCH) PHN home visitation experience and have conducted field home visits to postpartum clients within the past 36 months. PHNs currently working outside of the generalist MCH services are eligible if they meet the eligibility requirements.

I am a Doctoral nursing student at the University of San Diego conducting a study of factors that affect PHN decisions to close at-risk postpartum cases to home visitation services. Participation involves one, face-to-face, audio-recorded, confidential interview. The interview will take 1 to 2 hours of your time. Please contact Denise Thompson at 619-244-5977 for more information or email denisethompson@sandiego.edu

8/9/11



Appendix B

County of San Diego

HEALTH AND HUMAN SERVICES AGENCY

PUBLIC HEALTH SERVICES

NICK MACCHIONE, FACHE
DIRECTORWILMA J. WOOTEN, M.D., M.P.H.
PUBLIC HEALTH OFFICER1700 PACIFIC HIGHWAY, SAN DIEGO, CALIFORNIA 92101-2417
(619) 531-5800 FAX (619) 515-6707

Community Epidemiology
Emergency & Disaster Medical Services
HIV, STD and Hepatitis
Immunization
Maternal, Child and Family Health Services
Public Health Laboratory
Prenatal, Border Health
TB Control & Refugee Health
Vital Records

April 25, 2011

Institutional Review Board
University of San Diego
5998 Alcalá Park
San Diego, CA 92110

RE: Support of research project

I have discussed the research project, "Public Health Nurse Factors Associated with Postpartum Home Visitation Case Closure" with Ms. Denise Thompson, R.N. I understand that Ms. Thompson is conducting this study as part of her doctoral dissertation in Nursing at the University of San Diego. I am looking forward to providing support as needed with her dissertation.

It is a pleasure to be of assistance in supporting this research project. Should you need additional information or have further questions, please do not hesitate to contact me at 619-515-4207 or linda.lake@sdcourty.ca.gov.

Sincerely,

Linda Lake, R.N., M.S.N., P.H.N.
Chief Public Health Nurse

Cc: Wilma J. Wooten, M.D., M.P.H., Public Health Officer, County of San Diego

Appendix C

**University of San Diego
Institutional Review Board**

Research Participant Consent Form

For the research study entitled:

Factors Associated with Public Health Nurse Home Visitation Case Closure

I. Purpose of the research study

Denise Thompson is a student in the Hahn School of Nursing and Health Science at the University of San Diego. You are invited to participate in a research study she is conducting. The purpose of this research study is to explore factors that affect final decisions by public health nurses to close postpartum cases to home visitation services.

II. What you will be asked to do

If you decide to be in this study, you will be asked to:

Participate in a private, semi-structured interview about your experience of being a public health nurse providing home visits to postpartum clients and what affects your decisions to terminate services to these clients. You will also be asked to provide basic demographic information.

You will be audiotaped during the interview.

Your participation in this study will take a total of 60 to 120 minutes.

III. Foreseeable risks or discomforts

Sometimes when people are asked to think about their feelings, they feel sad or anxious. If you would like to talk to someone about your feelings at any time, you can call toll-free, 24 hours a day:

San Diego Mental Health Hotline at 1-800-479-3339

IV. Benefits

While there may be no direct benefit to you from participating in this study, the indirect benefit of participating will be knowing that you helped researchers better understand the factors affecting public health nurses' decisions to close a postpartum case to home visitation services.

V. Confidentiality

Any information provided and/or identifying records will remain confidential and kept in a locked file and/or password-protected computer file in the researcher's office for a minimum of five years. All data collected from you will be coded with a number or pseudonym (fake name). Your real name will not be used. The results of this research project may be made public and information quoted in professional journals and meetings, but information from this study will only be reported as a group, and not individually.

VI. Compensation

You will receive no compensation for your participation in the study.

VII. Voluntary Nature of this Research

Participation in this study is entirely voluntary. You do not have to do this, and you can refuse to answer any question or quit at any time. Deciding not to participate or not answering any of the questions will have no effect on any benefits you are entitled to, like your health care, or your employment. You can withdraw from this study at any time without penalty.

VIII. Contact Information

If you have any questions about this research, you may contact either:

1) Denise Thompson

Email: denisethompson@sandiego.edu

Phone: 619-244-5977

2) Dr. Lois Howland

Email: lhowland@sandiego.edu

Phone: 619-260-7672

I have read and understand this form, and consent to the research it describes to me. I have received a copy of this consent form for my records.

Signature of Participant

Date

Name of Participant (**Printed**)

Signature of Investigator

Date

Appendix D

PHN Interview Guide

Consent Process

- a.) Researcher and participant introductions
- b.) The interview will take about 1-2 hours of your time.
- c.) Explain the purpose of interview: To talk about your experience of being a public health nurse providing home visits to at-risk postpartum clients and what affects your decisions to terminate services to these clients. I am interested in descriptions of your feelings, opinions, and experiences surrounding the process of closing post-partum cases to services.

All of the questions are specifically related to recent work as a maternal-child health generalist PHN providing home visitation service to postpartum clients.
- d.) I will ask you some preselected questions regarding your work as a PHN providing home visitation services to at-risk postpartum clients. You are free to answer in any way you choose.
- e.) There are no right or wrong answers

You are free to ask questions, to not answer questions, and to withdraw from the interview, at any time
- f.) **ASSURANCE OF CONFIDENTIALITY:** no personal identifiers, secure storage of data, confidentiality of interview responses
- g.) Request for verbal consent to be interviewed

Request for verbal consent for audio recording

Obtain participant signature on Consent Form

- h) Ask participant to complete the Participant Demographic Data Form

Participant Demographic Data Form

Please write-in your answers to the following questions:

1. What is your gender? Male_____

Female_____

2. What is your age? _____

3. What is your highest level of nursing education?

4. How many years/months have you worked as an RN?

5. How many years/months have you worked as a PHN?

6. How many years/months have you worked as a PHN providing home visitation services to postpartum clients?

Interview Questions

1. Tell me about your current PHN position
 - a. as a PHN maternal-child health generalist
 - b. workload and caseload
2. How do you come to provide home visitation services for postpartum mothers?
 - a. Researcher to probe the process
3. What does a routine postpartum case look like?
 - a. Describe an example of a routine case
 - b. What home visitation services do you provide?
 - c. How do you determine what the services should be?
4. Tell me about a difficult case.
 - a. What sets this case apart from other cases?
 - b. What services did you provide?
 - c. How did you determine what the services should be?
5. Please help me understand what happens when you close a postpartum case
 - a. Researcher to probe the process of the participant's thinking and decisions
 - b. Researcher to probe regarding participant receiving input from other sources such as other people, protocols, etc.
 - c. Please describe examples of what happens when you close a postpartum case
 - i. If applicable – elaborate on the routine and difficult case
6. Is there any aspect of providing home visitation services, including the opening and closing of cases that we haven't talked about? Please elaborate.

7. Conclusion: Is there anything else that you would like to share about your experience in making home visits to postpartum clients?

Thank you for your participation in the study.