Neighborhood nurses

The US spends a higher percentage of GDP on healthcare than any other OECD country, yet its citizens experience the worst health outcomes.

One solution to this mismatch of expense with poor outcomes is to link every resident with a nurse/community health worker team. They would go door to door, available by text or app, and stationed at schools, libraries, and senior centers. Calling it the Neighborhood Nursing model, we propose that from birth to death, from prevention to palliative care, in any mental state, all people should have someone who comes to their home ready to listen to what matters to them. They will have multiple strategies, abilities, and skills to support residents’ self-efficacy, connect them with other services, and provide care on the spot.

This model has the potential to improve many crucial health indicators, through improving what matters to people. We hypothesize this model will decrease infant mortality, decrease premature death rate, increase vaccination rates, decrease depression and anxiety among other important indicators of health and well-being. It will improve health equity.

Not only would this be a groundbreaking model with potential to change the nation’s health outcomes; it could help solve the nursing shortage over time. If the nation had such a preventive model, then the current state of 1 nurse for every 80 residents could be robust.

In a city like Baltimore that has 94% insured yet such startling health disparities, the neighborhood nursing model will reduce structural barriers by meeting people where they are, both geographically and metaphorically. All residents would receive an in-person home visit once a year (if desired) and be digitally connected with their health care teams for telehealth visits and additional in-person visits as needed based on their individual health care needs. Residents with multiple chronic conditions, young children, or others at higher risk would receive more frequent visits.

Many successful international models exist and can be adapted, including Costa Rica’s community-oriented primary health care model – ([or EBAIS](https://www.commonwealthfund.org/publications/case-study/2021/mar/community-oriented-primary-care-lessons-costa-rica)), that brings multidisciplinary team-based primary care directly to people’s homes and the [UK’s district nursing approach](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213363/vision-district-nursing-04012013.pdf), which delivers nursing-led team-based care. Our model will not substitute for traditional primary care, the way it does in Costa Rica, but be coordinated electronically.

Johns Hopkins in the early design phases, in partnership with University of Maryland, Morgan State, Coppin State, and several community organizations such as Sisters Together and Reaching. In these early phases we are determining together how many residents per RN/CHW team, which will determine how many will be needed total and the cost of the program. We are also determining whether to initially offer in a rural area as well as Baltimore and which rural area (likely Western Maryland or on the Eastern Shore).

Why start in Maryland? Maryland is a perfect test bed because of existing all-payor model for hospitalization that will address primary care financing in its next stage. These reforms have focused on what hospitals do. Hospitals are the right focus for acute issues but not for preventive health. Federal government regulators and Maryland leadership are examining soon how all insurers can band together to fund better community care. Standing up this model now can show the next phase of health care financing what can happen next.

The likely benefits:

* Decreased hospital admissions
* Decreased hospital length of stay
* Improved mental health through cognitive behavioral therapy
* Improved vaccination rates through increased access and increased trust in health care
* Decreased maternal morbidity and mortality, and better infant outcomes