Connecticut Office of Early Childhood

CONNECTICUT AMERICAN RECOVERY PLAN ACT:

INVESTING IN CONNECTICUT'S FUTURE THROUGH UNIVERSAL HOME VISITING

JULY 2021

HEALTHY BABIES: EQUITABLE HEALTH ACCESS FOR FAMILIES

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Connecticut plans to use American Rescue Plan State funds to expand family support through universal home visiting

- **COVID-19 has reinforced health disparities** that affect many Connecticut families, particularly in Black communities
- Health inequities are best addressed early in life: **home visiting pairs pregnant and new parents with registered nurses and community health workers to improve health outcomes and enhance social determinants of health**
- Universal home visiting reduces emergency medical care and child welfare engagement - **generating $3 in savings for every $1 spent in program costs**
- Having a baby is a big life change - every family can **benefit from early public health supports like home visiting regardless of income and risk profile**
- OEC would offer universal home visiting in communities **disproportionally impacted by COVID-19** and address health equity from the start
- **Prenatal engagement and 1-3 postpartum visits can have long-term impact**, promoting health for babies and connecting families to needed community services

WHY TAKE A UNIVERSAL HOME VISITING APPROACH?

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Population-level solutions

*As Connecticut recovers from COVID-19, it is important to **build population-level health impacts** and offer services to all families early in babies' lives. Broad, upstream interventions can prevent the health disparities that persist throughout life and were laid bare at a community-level by COVID-19.*

Reduced stigma for services

Universal home visiting reduces the stigma** associated with targeted eligibility requirements, which creates enrollment challenges for existing services statewide. This will help increase contact and create connections with **high-risk families to help them access higher intensity services.

Enhanced referral system

*Universal home visiting can **serve as an entry point** into Connecticut's existing service array **and connect high-risk families to needed resources** early in life.*

UNIVERSAL HOME VISITING RECOVERY PLAN PROPOSAL

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Who		▪ **Newborns** and their families within specific regions ▪ Offered **regardless of family income and risk profile**
What		▪ **Prenatal engagement and 1-3 postpartum visits** from a registered nurse and/or community health worker offered by hospitals and community-based organizations ▪ Home visits include **physical health assessments** and **connection to community resources**
Where		▪ **Start w/ towns in the Bridgeport region**, with plans for **expansion into other regions** in the state. This was cut in ARP negotiations. Plans were in place to expand into Waterbury, New London and New Haven Regions.
When		▪ **3 years** covered by State ARPA funds followed by **ongoing expansion in later years**
Why		▪ **Address health inequities and promote healthy starts** ▪ **Promote child development** ▪ **Connect families to community resources**
How		▪ **State American Rescue Plan Act funds in Years 1-3** ▪ **Potential for Medicaid, philanthropy, and additional state agency funding** to share costs in later years

OVERVIEW: IMPACT OF COMMUNITY HEALTH WORKERS PROGRAM

Integrating CHWs into a holistic care program can lead to a significant return on investment in the long run

- CHWs **can supplement universal home visiting programs** by creating a continuum of care for families starting before birth and helping individuals navigate health service options.
- **Community Health Workers support health care system navigation**, health education, health services access, social support, patient advocacy, health screenings.
- CHWs can **provide tailored care coordination services and are uniquely qualified** to work with vulnerable and high-risk populations.
- Many research studies have shown that CHWs **improve patient experience**, care coordination, and clinical outcomes, and **lead to lower inpatient and outpatient costs**
- A recently conducted study showed that the intervention of CHWs led to **both fewer and lower costs of admissions**, with a total inpatient cost of $2.3 million compared with $3.7 million in the control arm.
- The Individualized Management for Patient-Centered Targets (IMPaCT) model for CHWs was shown to have a **significant and sustained reduction in hospital-based care and decreased fragmentation around care**
- **Cut significantly in ARP Negotiations from $33M to $3M.**

Return of $2.47

When comparing program savings for every $1 invested

38% in reduced costs

with CHW intervention, saving $1.4 million in Medicaid costs over a year

2 months

the amount of time before seeing a reduction in hospitalizations after intervention

Sources: https://www.cthealth.org/wp-content/uploads/2017/04/CHW-Brief-April-2017.pdf; https://ldi.upenn.edu/healthpolicysense/community-health-worker-interventions-new-evidence-effectiveness-reducing

INTEGRATION OF UHV AND CHW INITIATIVES

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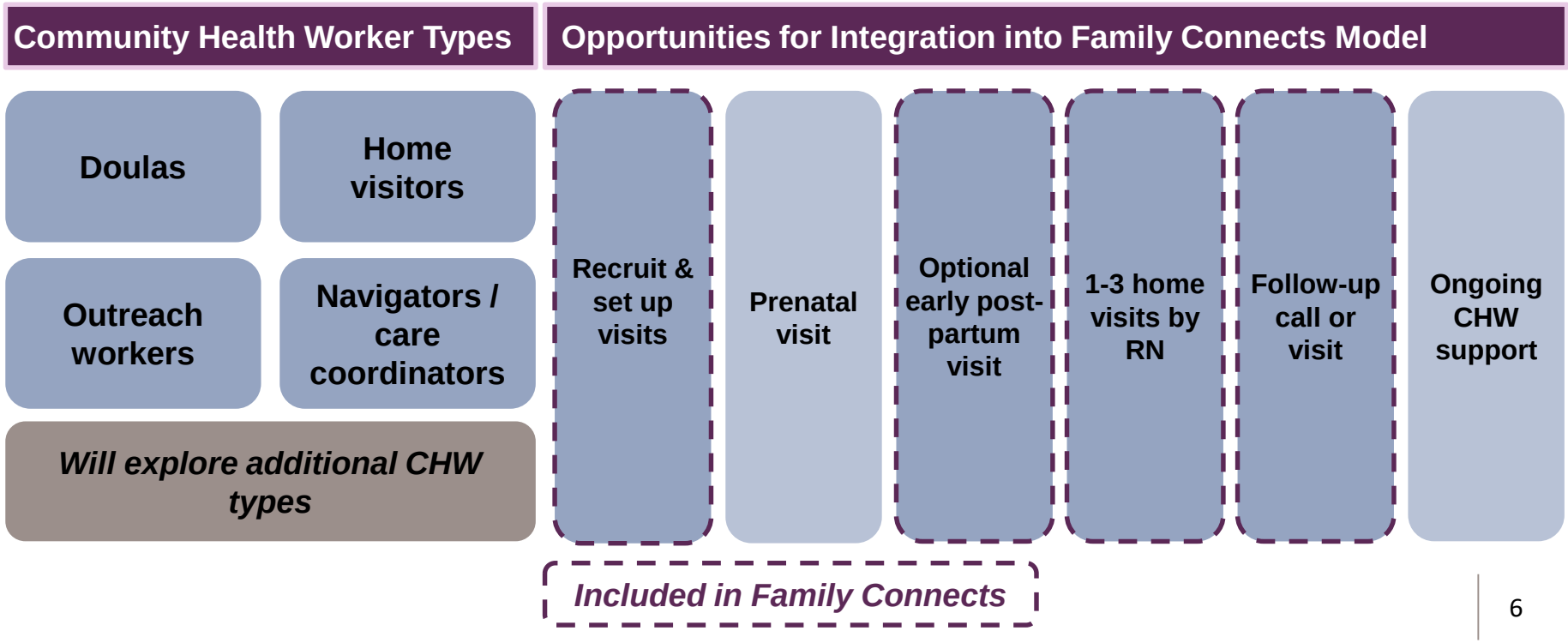
- **Universal home visiting (UHV) would be implemented through the Family Connects model**, which includes recruitment, 1-3 home visits conducted by registered nurses (RNs), and follow-up.
- **Community health workers (CHWs) could integrate and enhance** existing service delivery components, provide prenatal visits and an early postpartum visit, and/or provide continued support for families that could benefit from longer-term engagement.
- CHWs typically come from communities that they are serving; **integration is needed to maximize community take-up and best address health disparities that Connecticut faces.**



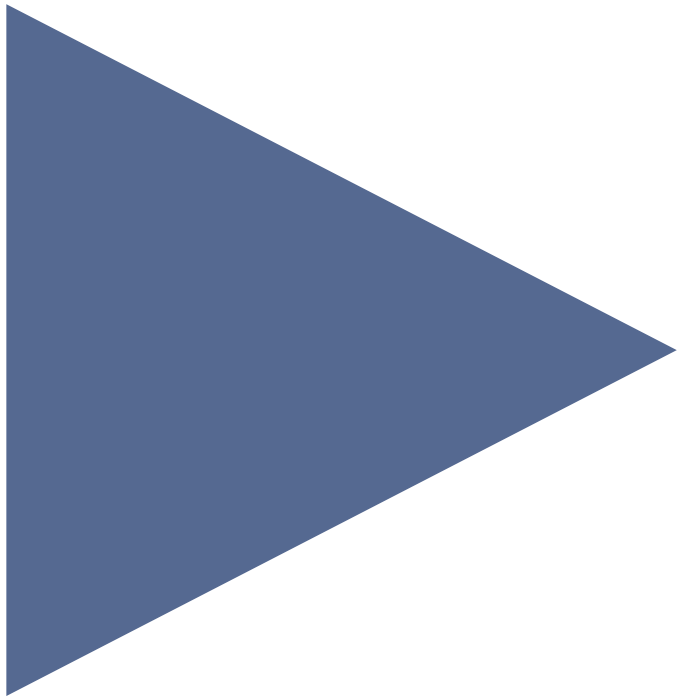
FAMILY CONNECTS IMPLEMENTATION PLANNING (2 OF 2)

Population health model includes nurse visits, community alignment, and integrated data

Nurse Activities	▪ **Nurses are RNs** but not necessarily BSNs ▪ **Nurse activities** may include physical examinations of the mother and baby, breastfeeding support, perinatal mood disorder screening and referral, postpartum care, safe sleep practices, intimate partner violence screening, substance use screening and referral, and connection to community resources[1]
Fidelity Standards	▪ **13 model elements** include establishing community advisory board, assessing family risk during the first visit, collaborating with social service organizations, and having quality assurance protocols[2] ▪ Quarterly dyadic home visits (nurse home visitor plus nurse supervisor) adheres to **63 fidelity items**[3]
Community & Data	▪ Family Connects International uses **a JAVA-4 database for monitoring implementation and evaluation**[3] ▪ **Community alignment consists** of an advisory board, community resource directory, links to DSS, data review, other systems & collaboratives, post visit calls, and weekly case conferences for the clinical team[3]

Sources: Family Connects conversations (May-June 2021).
1. Overview of the Family Connects Model (Family Connects International). 2. Implementing Family Connects, Home Visiting Evidence of Effectiveness, Administration for Children & Families. 3. Family Connects Program Overview.

APPENDIX



FAMILY CONNECTS IMPLEMENTATION PLANNING (1 OF 2)

Population health model includes nurse visits, community alignment, and integrated data

Population Coverage	▪ **Offered to all families** who are residents and deliver birth within a designated catchment area ▪ Requires coverage of **60-70% of families to be truly universal**[1]
Assessment of Risk	▪ A **registered nurse determines family "risk" using a Family Support Matrix across 12 factors:** 1) parent/maternal health, 2) infant health, 3) health care plans, 4) child care plans, 5) parent-child relationship, 6) management of infant's crying, 7) household safety and material supports, 8) family and community safety, 9) history with parenting, 10) parental well-being, 11) substance use, and 12) social and emotional support[2] ▪ **Each factor is rated** as follows: score of 1 (no family needs), score of 2 (needs addressed during visit), score of 3 (community resources needed), and score of 4 (emergency intervention needed)[2]
Visit Schedule	**Families receive 4-8 connections**, which include: ▪ **First connection in the hospital** within 24 hours of the birth ▪ **1-3 visits. First is an Integrated Home Visit**, starting at 3 weeks and generally before the baby is 12 weeks, followed by 0-2 visits depending on family needs ▪ **1-2 connections** with other service providers, depending on family need ▪ A **follow-up connection** via phone or home visit four weeks after the family engages ▪ Some programs offer an **optional pre-Integrated Home Visit** when the child is one week old.[1]

Sources: Family Connects conversations (May-June 2021).
1. Family Connects Program Overview. 2. Overview of the Family Connects Model (Family Connects International).