Help Me Grow
Pierce County

Expanding Support for Families with Newborns in Pierce County

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Finding a sustainable path to supporting all families with newborns

In 2017, Pierce County had a child welfare crisis. That year, the county experienced the highest number of children entering foster care in Washington State with 1,009 children removed from the home. About 50 percent of those children were under age five, and 14% were removed in the first month of life. The statistics were shocking to community leaders who recognized that a child's brain develops fastest during the first five years of life, building the foundation for future learning, behavior, and health.

In response, community partners came together to brainstorm solutions. They agreed to work together to build a comprehensive system that connects families with young children to resources, using the nationally recognized model called Help Me Grow (HMG). The goal was to offer support before a crisis, rather than after. Today, parents, caregivers, early learning, health, and other service providers can call, text, or e-mail HMG and connect to caring people who are highly trained in child development. The resource navigators listen to families' needs, and link them to the most appropriate services.

Connecting with families during pregnancy, and at the time of birth, is a priority of HMG. To do so, Pierce County is piloting the Family Connects model, which offers families of newborns a nurse visit after they leave the hospital. Together, HMG and Family Connects provide a universal approach to offer supports to all children from pregnancy to age five. By keeping track of all available community resources, HMG and Family Connects enables families to choose the supports and resources that fit their needs and preferences.

Family Connects is currently funded as a small pilot in Pierce County through a state budget proviso. Expanding the program beyond a pilot, or into other areas of Washington State, will require sustainable financing. In December of 2019, Help Me Grow Pierce County contracted with the Public Leadership Group to research financing options to expand Family Connects in Pierce County, beyond the pilot stage. The intended scope of this report is the Pierce County pilot, however our hope is that the learnings and best practices discovered can be relevant to other communities interested in implementing Family Connects, and to state agency partners as they consider newborn nurse visits as a prevention strategy.

The earliest months of life are foundational for a child's development, and the pregnancy and postpartum periods are challenging for every family regardless of their circumstances. Pierce County is striving to be a community where every family feels supported, and parents know they are not alone.

Executive Summary

This report provides data and information about the financing options to expand universally offered nurse visits with newborns through the Family Connects program in Pierce County. Information in this report was gathered through research, key informant interviews with community-based providers, home visiting experts, staff at the Department of Children Youth and Families, the Washington State Health Care Authority, Family Connects International, and First 5 FUNdamentals in Pierce County.

Key Findings

The Washington Apple Health (Medicaid) First Steps Maternity Support Services (MSS) program offers support to pregnant and postpartum clients. This voluntary program is currently underutilized in Pierce County, with just half of eligible clients receiving MSS.

All components of the family visit of the Family Connects model are allowable and billable under the current MSS program. Family Connects can therefore be thought of as an evidence-based model of services that could be delivered within the MSS program during the postpartum period.

The estimated cost for implementing the Family Connects model is around $900 per family, based on community economic conditions. This price includes all time for the nurse visit, follow-up connections to resources, data gathering and reporting, and other activities to ensure model fidelity.

Potential changes to the MSS program that could support the successful implementation of Family Connects include:

- ✓ Ensuring units of services are available to all clients in the post-pregnancy period.
- ✓ Increasing the allowable units that can be billed by providers.
- ✓ Increasing the rate for each unit.
- ✓ Allowing for telephone visits to be billed as a separate unit of service.
- ✓ Changing the limitation that no more than six units can be billed per day by an MSS provider.

Private health insurance plans, including plans through the Public Employee Benefits Board and the School Employee Benefits Board offer maternity services and are required to cover and pay for medically necessary postpartum care ordered by the attending provider, such as the OBGYN or midwife, in consultation with the mother.

All components of the family visit of the Family Connects model can be implemented by private health insurance carriers. Like the MSS benefit alignment, Family Connects **can** be considered an evidence-based model of follow-up maternity services that provides essential health benefits to delivering parents and newborns. To implement the Family Connects model with fidelity, the private health insurance carriers and health care providers in Pierce County would need to ensure:

- ✓ Clients engage with their attending provider about needed follow-up services after the birth of their baby
- ✓ Attending providers order follow-up care that includes an in-person or telehealth visit as allowed by RCW 48.43.115
- ✓ Health insurance plans in Pierce County provide clarity on how providers can order, provide, and bill for these services
- ✓ Registered nurses conduct the ordered follow-up care at home or via telehealth within the first few weeks of the newborn's life
- ✓ Nurses engaging with the family are trained in and use the Family Connects protocols

To be successful, community leaders will need to engage families and local partners to design and implement the model leveraging local health and human services providers, and maximizing allowable Medicaid and private health insurance benefits and financing.

Since the delivery of the Family Connects program could happen through different implementing agencies and leveraging different funding sources within a service area, it will be critical to have a local "backbone" organization to lead and organize the efforts, ensure model fidelity and alignment with community needs, and serve as a platform for solving challenges as they arise.

The Family Connects Model

Family Connects is an evidence-based family engagement and support model. In the original model of the program, registered nurses visit the homes of families with newborn babies, working with the families to assess their strengths, risks and needs, offer supportive guidance, and connect families to community resources. In response to the COVID-19 public health pandemic, Family Connects has advised programs to conduct all visits with families through telehealth and telephone visits. The Family Connects program operates through three pillars: family visits, community alignment, and data and monitoring.[1]

Family Visits

Family Connects is universally offered to all birthing parents with newborns. Participation in Family Connects is voluntary. Family Connects services are offered to families shortly after the birth of the baby, during their hospital stay for the birth. Registered nurses have an initial visit with the families about three weeks after the birth. During this visit, 12 factors of maternal and child health and well-being are assessed:

Support for Health Care
- Factor 1-Maternal Health
- Factor 2-Infant Health
- Factor 3-Health Care Plans

Support for Caring for the Infant
- Factor 4-Child Care Plans
- Factor 5-Parent and Child Relationship
- Factor 6-Management of Infant Crying

Support for a Safe Home
- Factor 7-Household Safety/Material Supports
- Factor 8-Family and Community Safety
- Factor 9-History with Parenting Difficulties

Support for Parents
- Factor 10-Maternal Wellbeing
- Factor 11-Substance Abuse
- Factor 12-Maternal Emotional Support

During the assessment process, the nurse engages with the family to understand their needs, offer guidance, and plan for individualized connections to community resources and services. As needed, the nurse will follow-up by phone after the initial visit to support the linkage to community resources. The program does not provide comprehensive case management support for families.

Community Alignment
Community alignment is the process of working with local agencies, systems, and individuals to ensure that families have access to the right services and resources at the right time in the right amount. It is critical to the success of a Family Connects site to understand the needs of families and the capacity of service providers to meet those needs. This process begins months before the first home visit occurs by reviewing available information, engaging in discussions with parents and providers, and developing communication pathways and key partnerships.

This work requires an understanding of community needs and context. In Pierce County, Help Me Grow Pierce County can provide the infrastructure to complete the community alignment process for Family Connects.

Data and Monitoring
As an evidence-based model, Family Connects collects data on the engagement with families and connections to community resources. During the home visit, birthing parents and babies are assessed using the twelve factors of the Family Support Matrix. These assessments, including three validated screeners, help identify strengths and risk factors.

The information is utilized to create individualized referrals aligned with a family's unique needs, as well as provide aggregate data which allows the local team and the Family Connects International technical assistance team to monitor fidelity to the model, the strength of the implementation efforts, and review community-level demographic and risk profiles. Family Connects sites receive regular coaching to support adherence to fidelity and promote continuous quality improvement.

Why Family Connects?
Pierce County is interested in piloting the Family Connects model because of the alignment of its outcomes with community goals. Extensive research conducted through randomized control trials in Durham County, North Carolina, where the program was first implemented, found that by the time a baby was 6 months old, families participating had the following outcomes as compared to a control group:

- **Greater community connections**
- **Better utilization of higher quality child care**
- **Higher-quality parenting behaviors**
- **Improved maternal mental health:** mothers were 28% less likely to report possible clinical anxiety.
- **Reduced emergency medical care for infants:** mothers reported 34% less total infant emergency medical care. Research shows that decrease is sustained through age 2.

Financing Options for the Family Connects Program in Pierce County

Given the interest of Pierce County to implement the Family Connects program, this report outlines the health financing options for the program.

Apple Health (Medicaid)

The first set of financing questions and options relate how Family Connects might be paid for through Apple Health (Medicaid), specifically the First Steps Maternity Support Services (MSS) program.

The MSS program is voluntary and available to eligible pregnant and parenting clients up to 60 days postpartum who are enrolled in Apple Health.[2] The purpose of the MSS program is to:

- Improve and promote healthy birth outcomes. Services are delivered by MSS interdisciplinary teams to eligible pregnant and post-pregnant clients and their infants.
- Help clients to access
    - Prenatal care as early in pregnancy as possible
    - Health care for eligible infants[3]

Maternity Support Services (MSS) Utilization

In 2018, 39,695 individuals statewide who were enrolled in Washington Apple Health (Medicaid) gave birth. Less than half of the clients who gave birth, 43.2 percent, received MSS. The average number of visits for these 17,154 clients was 6.1 visits.[4]

That same year in Pierce County, 5,298 of the 11,462 total births were covered by Apple Health (Medicaid). Of these, 2,626, or 49.6 percent, received MSS. Among clients who received MSS:

- 52.2 percent had services in the prenatal and postpartum periods,
- 20.5 percent of clients only received services in the prenatal period and
- 27.3 percent of clients only received services in the postpartum period.[5]

The average number of MSS visits per birthing parent was 5.7 visits.[6]

Maternity Support Services (MSS) Program

The Maternity Support Services and Infant Case Management Billing Guide[7] published on January 1, 2020 outlines the program components for MSS including screening, assessments, case conferences, care plans, case management, care coordination, and group services.

Screening

Screening is required for each client who chooses to participate in the program. The screening process is a method for systematically identifying and documenting risk factors and client need.

During the prenatal period of MSS, clients must be screened using the agency's *MSS Prenatal Screening Tool* (HCA 13-874). During the postpartum period of MSS, clients must be screened using the agency's *MSS Postpartum Screening Tool* (HCA 13-873). During the postpartum period of MSS, the infant and client must also be screened using the agency's *Infant Case Management (ICM) Screening Tool* (HCA 13-658). If the client is unable to be seen during the postpartum period, the provider must document in the discharge summary why the postpartum and ICM screenings were not completed. Agency approval is required for a provider to use an alternate screening tool.[8]

Assessment

An assessment or evaluation beyond screening may be necessary. An assessment should expand beyond screening in the content area being evaluated. All types of assessments must be documented in the client's chart and include the date the assessment took place.

Case Conference

Case conferences are a formal or informal consultation used by the members of the MSS interdisciplinary team to communicate and consult with each other and other health care providers, social services providers, and the client. A case conference is required for all high-risk clients receiving the maximum level of services during pregnancy.

Care Plan

A care plan is a written statement developed for a person that continues throughout the eligibility period and outlines any medical, social, environmental, or other interventions to achieve an improved quality of life, including health and social outcomes.

The community health nurse, behavioral health specialist, or certified dietitian must be involved in developing the care plan for clients eligible for expanded and maximum service levels. A list of the team members involved in developing the care plan must be kept in the client's file.

Case Management

Case management is a collaborative process of assessment, care planning, facilitation, care coordination, evaluation, and advocacy for options and services that meet the health and social service needs of infants and pregnant clients.

Care Coordination

Care coordination is professional collaboration and communication between the client's MSS provider and medical or health and social services providers to address the individual client's needs as identified in the care plan. Care coordination must be documented in the client's file and may include any of the following:

- Face-to-face meetings

- Phone calls
- Secure emails

Maternity Support Services (MSS) Levels of Service

The MSS program defines three levels of service: Basic, Expanded, and Maximum. The following table outlines the service level, unit limit, and required services.

Level of service and allowable units during the entire maternity cycle		**Required Services**
Client enrolled in MSS during prenatal period	Basic = 7 units	Screening, Care Coordination, Case Management, and Basic Health Messages
	Expanded = 14 units	Screening, Care Coordination, Case Management, Basic Health Messages, and Interventions
	Maximum = 30 units	Screening, Care Coordination, Case Management, Basic Health Messages, Interventions and Case Conferences
Level of service and allowable units during the post-pregnancy eligibility period		**Required Services**
Client enrolled in MSS post-pregnancy period only (client did not receive MSS during the prenatal period)	Basic = 4 units	Screening, Care Coordination, Case Management, and Basic Health Messages
	Expanded = 6 units	Screening, Care Coordination, Case Management, Basic Health Messages, and Interventions
	Maximum = 9 units	Screening, Care Coordination, Case Management, Basic Health Messages, and Interventions

If the client's needs change during pregnancy or in the post-pregnancy period, more units can be accessed. A unit of service is a 15-minute block of time. Clients enrolled in MSS in the prenatal period are required to be screened during post-pregnancy to assess whether an increase in level of service is needed due to new risk factors. If all available units are used during the prenatal period, the provider must document why all units were used and what actions were taken to connect the client to other services to meet their post-pregnancy needs. An MSS provider can submit a limitation extension request to exceed the number of allowable units for a client, if needed. The provider must submit the request to the Health Care Authority and include justification and chart notes. Determinations are made on a case-by-case basis.

Family Connects Model Fidelity – Apple Health (Medicaid)

All components of the family visit in the Family Connects model are allowable and billable under the current MSS program, up to 60 days postpartum. Family Connects can therefore be thought of as an evidence-based model of services that could be delivered within the MSS benefit of Apple Health. However, additional services must be proved to maintain compliance with the provision of MSS as currently structured within Apple Health.

To implement the Family Connects model with fidelity, the MSS providers in Pierce County would need to ensure

- ✓ clients enrolled in MSS receive post-pregnancy services
- ✓ clients are visited at home or via telehealth in the first weeks after birth by a registered nurse
- ✓ providers use the Family Connects assessment and screening tools that have been approved by the Health Care Authority

MSS providers in Pierce County would need to complete the appropriate documentation for both the MSS and Family Connects program. This approach ensures that clients enrolled in the MSS and Infant Case Management (ICM) program have access to the variety of services and providers that are part of the standard benefits.

The following sections describe the alignment of the MSS and Family Connects programs.

Eligibility

First Steps MSS is available to all clients within a maternity cycle (pregnancy through 60 days postpartum) and who are covered by Washington Apple Health (Medicaid) under the alternative benefit plan, categorically needy, medically needy, or state-funded medical program.[9]

Family Connects is a universally offered home visiting program available to all new parents in a community, typically provided from 2 to 12 weeks. In order to bill for the Family Connects protocol under MSS, services would need to conclude by 60 days postpartum.

Program Design and Benefits

Clients may receive services through MSS after they give birth up to 60 days postpartum. Clients who received services during the prenatal period must be screened during post-pregnancy to assess whether an increase in the level of service is needed due to new risk factors. Clients may also enroll in MSS during the post-pregnancy period.

The MSS program includes screening, assessment, case conferences, care plan development, case management and care coordination. These services can be provided through a

multidisciplinary team including registered dietitians, behavioral health specialists, and community health workers, in addition to community health nurses. Services may be provided in the following settings: the provider's office or clinic, the client's residence for individual services, or an alternative site other than the client's home, as supported by documentation.

The Family Connects program includes a single integrated home or telehealth visit within weeks of the birth of a baby. The visit is conducted by a registered nurse. The visit is designed to make a connection with the family, assess health and psychosocial wellbeing, engage the family about postpartum and newborn care, and plan for connections to community supports. One or two follow-up home visits or telephone calls are included in the program, as needed.

Screening and Assessments

The screening guide provided by the Health Care Authority covers several areas related to the physical and mental health and well-being of the new birthing parents and infants. It also includes questions about substance use, social support, safety, and social risks such as food insecurity.

The Family Connects Family Support Matrix includes questions in four domains: Support for Health Care, Support for Caring for the Infant, Support for a Safe Home, and Support for Parents. The Family Connects program currently uses the following screeners as part of their protocol: CAGE-AID (substance use screening), Conflict Tactics Scale (Intimate Partner Violence screening), and the Edinburgh Postnatal Depression Scale.

The MSS program rules allow for tools such as the Family Support Matrix Assessment to be used in addition to the approved MSS program tools.

Referral and Case Management

Referral to community-based services is a component of both MSS and Family Connects. Clients can receive case management services as part of MSS. The Family Connects protocol explicitly states that case management is not part of the protocol. Implementation sites must create an agency finder within the Family Connects database to provide information and referrals, or utilize an existing community information and referral system with approval. The Help Me Grow Pierce County resource directory is integrated within United Way's 2-1-1. As part of the community alignment process, stakeholders could work to align infrastructure between the Help Me Grow and Family Connects models, and seek approval to use this existing referral system to fulfill Family Connects' agency finder requirements.

The Family Connects protocol includes a Post-Visit Connection telephone call one month after the nurse closes the case. A staff member discusses the original Integrated Home Visit, and evaluates the success of referrals to community services as well as consumer satisfaction.

Providers

MSS providers can be community clinics, federally qualified health centers (FQHCs), local health departments, hospitals, nonprofit organizations, and private clinics. Community Health Nurses that provide services through MSS must be currently licensed as registered nurses in the State of Washington by the Department of Health under Chapter 246-840 WAC.

The Family Connects protocol requires that Registered Nurses conduct the home or telehealth visit. To bill as an MSS provider, the nurse and/or the MSS provider organization would have to be an enrolled provider with Apple Health.

Cost of Maternity Support Services (MSS) and Family Connects

The current fee schedule for MSS is:

Procedure Code	Short Description	Comments	Max Allowable
T1002	RN Services, up to 15 minutes	1 unit = 15 minutes during an MSS community health nursing visit	$35.00 home setting $25.00 office setting
S9470	Nutritional Counseling, dietitian visit	1 unit = 15 minutes during an MSS dietitian visit	$35.00 home setting $25.00 office setting
S9482	Behavioral Health Specialist	1 unit = 15 minutes during an MSS behavioral health visit	$35.00 home setting $25.00 office setting
T1027	Family Training or Counseling for child development, community health representative/worker	1 unit = 15 minutes during an MSS community health representative/worker visit	$18.00 home setting $14.00 office setting

MSS providers must bill for services delivered fee for service in 15-minute increments for individual services. Providers may not bill for more than six units per client for date of service. Travel expenses, documentation time, phone calls, and mileage are built into the reimbursement rate for MSS and cannot be billed separately.

If a client only receives care through the MSS program in the post-pregnancy period, the benefit limits and maximum allowable billing for Family Connects services are:

- 4 units for the basic level of services, 4 units x $35 = 1 hour of services and $140
- 6 units for the expanded level of services, 6 units x $35 = 1.5 hours of services and $210
- 9 units for the maximum level of services, 9 units x$ 35 = 2.25 hours of services and $315

Family Connects estimates total implementation to be about $900 per family, based on local economic factors. This price includes all time for the nurse visit, follow-up connections to resources, data gathering and reporting, and other activities to ensure model fidelity.

Potential changes to the MSS program that could support the successful implementation of Family Connects include:

- ✓ Ensuring units of services are available to all clients in the post-pregnancy period.
- ✓ Increasing the allowable units that can be billed by providers.
- ✓ Increasing the rate for each unit.
- ✓ Allowing for telephone visits to be billed as a separate unit of service.
- ✓ Changing the limitation that no more than six units can be billed per day by an MSS provider.

Private and Employer Sponsored Health Insurance

The second set of financing questions and options relate how Family Connects might be paid for by private health insurance plans.

The United States Census Bureau estimates approximately 905,000 individuals lived in Pierce County in 2019, and that 93.2 percent of residents have health insurance.[10]

Public Employee Benefits Enrollment

In April 2020, 37,538 members were covered by the Public Employee Benefits Board through 13 different health plans in Pierce County.[11] The following table provides a summary of the top five health plans for public employees.

Uniform Medical Plan Classic	20,948
Kaiser WA Classic	3,163
Uniform Medical Plan – UW Accountable Care Network	2,667
Kaiser WA Value	2,312
Uniform Medical Plan Plus – Puget Sound High Value Network	2,208

School Employee Benefits Enrollment

In April 2020, 32,114 members were covered by the School Employee Benefits Board Program through 15 different health plans in Pierce County.[12] The following table provides a summary of the top five health plans in the County for school employees.

Premera High PPO	5,000
Kaiser Permanente Washington Sound Choice	4,771
Kaiser Permanente Washington WA Opt 3	4,307
Premera Standard PPO	4,146
Kaiser Permanente Washington WA Opt 2	2,802

Washington Health Benefit Exchange – Washington Healthplan Finder Enrollment

The Health Coverage Enrollment Report from the Washington Healthplan Finder, published in Spring 2019, indicates that 16,803 residents are covered by health insurance purchased through the exchange. Of these, 64%, or 10,790, received a subsidy for their coverage, and 36%, or 6,013 individuals, did not receive any financial assistance to purchase their coverage.[13]

Private Health Insurance Benefits

Pregnancy, Maternity, and Newborn Services

National and state regulations require most private health insurance plans to cover a standard set of essential health benefits including pregnancy, maternity, and newborn services. Some individual health plans, those purchased by individuals and families, may not offer coverage for pregnancy and maternity care.

In Washington, all individual health benefit plans, other than catastrophic health plans, must cover maternity services including diagnosis of pregnancy, prenatal care, delivery, care for complications of pregnancy, physician services, hospital services, operating or other special procedure rooms, radiology and laboratory services, appropriate medications, and anesthesia services.[14]

In 2018, the American College of Obstetricians and Gynecologists (ACOG) issued a committee opinion on optimizing postpartum care. In the opinion, the College asserts:

"*The weeks following birth are a critical period for a woman and her infant, setting the stage for long-term health and well-being…Optimal postpartum care provides an opportunity to promote the overall health and well-being of women, and evidence suggests that current care falls short of that goal…Changes in the scope of postpartum care should be facilitated by reimbursement policies that support postpartum care as an ongoing process, rather than an isolated visit."*[15]

Specifically, ACOG recommends a visit for follow-up care at three weeks postpartum, rather than the routinely offered visit at six weeks postpartum. Washington state law already explicitly recognizes the role of health care providers and patients in determining the care needed for women and newborns including decisions about length of stay after delivery and the type and location of medically necessary follow-up care. [16] Specifically, RCW 48.43.115 states:

"Covered eligible services may not be denied for follow-up care, including in-person care, as ordered by the attending provider in consultation with the mother. Coverage for providers of follow-up services must include, but need not be limited to, attending providers as defined in this section, home health agencies licensed under chapter 70.127 RCW, and registered nurses licensed under chapter 18.79 RCW."

This coverage requirement applies to health carriers, health maintenance organizations, plans operating under the Health Care Authority, the state health insurance pool, and other insuring entities.

Preventive Care and Screenings
In addition to maternity services, health plans that provide essential health benefits are required to provide preventive health services to women[17] and children. These benefits include services such as breastfeeding support and counseling, domestic violence and interpersonal violence screening and counseling, tobacco use screening and intervention, and maternal depression screening.

Nurse Advice Lines
Many health insurance plans provide free nurse advice lines for members. Members are encouraged to call the nurse advice line on an as needed basis when they need care advice or guidance about when to seek additional medical attention.

Case Management Services
Some private health insurance plans provide case management services for members with complex health and social needs. For example, the Uniform Medical Plan Classic certificate of coverage outlines the care management services available to members through the Care Gap Closure Program. [18]

"Care Gap Closure Program encourages members to receive recommended preventive and chronic care services and screenings, also known as "gaps in care." These include screenings for cancer, diabetes, and more at no cost to you. This support includes helping members find a primary care provider, making appointments, ensuring members understand their benefits, and providing members ongoing support through case management as appropriate."

Family Connects Model Fidelity – Private Health Insurance Coverage

All components of the family visit of the Family Connects model can be implemented by private health insurance carriers. Like the MSS benefit alignment, Family Connects **can** be considered an evidence-based model of follow-up maternity services that provides essential health benefits to delivering parents and newborns.

To implement the Family Connects model with fidelity, the private health insurance carriers and health care providers in Pierce County would need to ensure:

- ✓ Clients engage with their attending provider about needed follow-up services after the birth of their baby
- ✓ Attending providers order follow-up care that includes an in-person or telehealth visit as allowed by RCW 48.43.115
- ✓ Health insurance plans in Pierce County provide clarity on how providers can order, provide, and bill for these services

- ✓ Registered nurses conduct the ordered follow-up care at home or via telehealth within the first few weeks of the newborn's life
- ✓ Nurses engaging with the family are trained in and use the Family Connects protocols

The following sections describe the alignment of private health insurance coverage benefits and the Family Connects program.

Eligibility
Follow-up maternity services can be made available to all women with private health insurance coverage. Family Connects is a universally offered home visiting program available to all new parents in a community.

Program Design and Benefits
Provisions within state and federal law ensure that most women with private health insurance, either individual plans or plans they access through their employer, have access to maternity care services, preventive care services, screenings and treatments, and follow-up care after birth.

The Family Connects program includes a single integrated home or telehealth visit within weeks of the birth of the baby. The visit is conducted by a registered nurse. The visit is designed to make a connection with the family, assess health and psychosocial wellbeing, engage the family about postpartum and newborn care, and plan for connections in the community to provide support for the family. One or two follow-up home visits or telephone calls are included in the program, as needed.

Providers
Many health plans and hospitals have nurses that staff nurse advice lines or conduct calls or visits with patients after a hospitalization. In addition, private pediatrician practices, community clinics, or federal qualified health centers have nurses on staff. Since registered nurses are specifically named in statute as a provider that can provide follow-up maternity care after the birth of a baby, nurses from some or all of these organizations could be trained in the Family Connects protocols to visit with families, make community connections, and record data.

The Family Connects protocol requires that Registered Nurses conduct the home or telehealth visit. To bill a private health insurance plan, the nurse and/or their employer would need to be an enrolled provider for that health plan.

Conclusion

All women need support during the postpartum period to recover from childbirth and optimize their own health and well-being, and the health and well-being of their infant. The Family Connects model can provide an evidence-based approach and process to creating this universally offered support to families, and connections to critical community resources. To be successful, community leaders will need to engage families and local partners to design and implement the model leveraging local health and human services providers and maximizing allowable Medicaid and private health insurance benefits and financing as described in this report. Since the delivery of the Family Connects program could happen through different implementing agencies and leveraging different funding sources within a service area, it will be critical to have a local "backbone" organization to lead and organize the efforts, ensure model fidelity and alignment with community needs, and serve as a platform for solving challenges as they arise.

End Notes

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