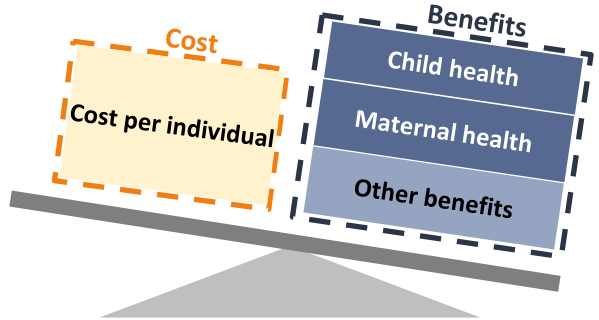
UHV / CHW Program Talking Points

September 2021

An Overview of Home Visiting

Home visiting provides families with critical supports at a low cost to states



What is home visiting?

OEC currently manages $19M in long-term home visiting programs

Home visiting provides pregnant mothers and families with children ages 0-6 the skills and connections to community resources to best raise happy and healthy children.

Goals include:

- Improving healthy births
- Promoting child development and preschool readiness
- Reducing child maltreatment, abuse, and neglect

A typical home visit could include:

- Prenatal health check-ups
- Breastfeeding support
- Screening the child for developmental delays
- Screening the mother for postpartum depression
- Connecting parents to benefits, employment, and/or childcare

Bottom line: Every parent could use a support system; prevention services set children up for life.

What are key outcomes?

Value Drivers	Key Outcomes
Child health	▪ **Low birth weight:** Reducing # of babies born under 2,500 g ▪ **Preterm birth:** Reducing # of babies born earlier than 37 weeks
Maternal health	▪ **Healthy birth spacing:** Reducing subsequent births within 2 years postpartum ▪ **Maternal depression:** Reducing # of mothers screening positive for depression ▪ **Maternal smoking:** Reducing # of mothers smoking prenatally ▪ **Maternal substance use:** Reducing # of mothers indicating substance use (especially prenatally)
Other benefits	▪ **Child maltreatment:** Reducing # of child injury and/or child maltreatment ▪ **Intimate partner violence referral:** Reducing # at risk of intimate partner violence for caregivers ▪ **Positive parenting practices:** Increasing # of caregivers demonstrating safe sleep practices for children ▪ **Employment/education:** Increasing # of caregivers referred to employment or educational opportunities

Potential model: Family Connects – Universal Home Visiting & Evidence

Family Connects, an illustrative example of a universal home visiting model, reduces health costs and improves health outcomes

Could pair Family Connects with other universal programs in the short-term

Overview

- Family Connects is a broadly implemented universal home visiting model that serves all families regardless of income or socioeconomic status.
- **Family Connects pairs registered nurses with new mothers and their newborn babies several weeks after birth with 1-3 postpartum visits.**
- Nurses check the baby's weight and mom's health, screen for postpartum depression, provide education on feeding and safe sleep practices, and connect families with other services such as childcare or employment.

Typical funding sources are MIECHV, Medicaid, Title V, PDG, philanthropy, and state and local dollars

Family Connects, or a similar model, could add to the Office of Early Childhood's existing home visiting network. OEC funds several home visiting models with evidence compiled by the Administration for Children & Families across the following outcome domains:[1]

Child development	**Child health**	**Family economic self-sufficiency**	**Linkages and referrals**
Maternal health	**Positive parenting practices**	**Reductions in child maltreatment**	**Reductions in family violence**

Snapshot of the Evidence

$3.17 in savings
for every $1 in program costs
spent by Family Connects[2]

50% reduction
*in **emergency medical care** use before child turns one year of age[3]*

28% reduction
*in mothers reporting **clinical anxiety**[4]*

44% reduction
*in rate of **child protective services investigations for maltreatment**[5]*

13% increase
*in **community connections**[6]*

Sources: [1] Home Visiting Evidence of Effectiveness (Administration for Children and Families). [2] Goodman et al. (2019). [3] Dodge et al. (2013). [4] Dodge et al. (2014). [5] Dodge et al. (2019). [6] Family Connects International.

Healthy Babies: Equitable Health Access for Connecticut Families

Investing in children and families right from the start helps all families and addresses health inequities

The American Rescue Plan Act of 2021 could fund universal home visiting with $12.5M in State ARPA funds for Years 1-3 with $9.8M in annual costs for the state

COVID-19 has reinforced **health disparities** that affect many Connecticut **families and communities** - a disproportionate share of COVID-19 related deaths were in the Black community.[1]

Home visiting, where nurses and community health workers offer home visits to pregnant and new parents, **improves health outcomes and prevents child maltreatment**

Having a baby is a big life change—every family can **benefit from home visiting** regardless of income or socioeconomic status

Even 1-3 postpartum visits can have long-term impact by **promoting health for babies and mothers** and connecting families to needed services

Who

- **13,700+ newborns** and their families in Connecticut
- Available regardless of parents' income or socioeconomic status

What

In addition to any other home visiting models that families are referred to through the universal home visits or other sources

- **1-3 postpartum visits** from a registered nurse, health worker
- Estimated cost of model at **$1,000/family**
- Services include **physical health assessment** (e.g., height, weight) and **connection to community resources** (e.g., housing, employment)

Why

- **Encourage health access** and prevent child maltreatment
- **Reduce stigma** associated with home visiting
- **Address health inequities** from day one

How

- **State ARPA funds in Years 1-3** with potential for OEC, DCF, DPH, DSS, Medicaid, & private insurance/philanthropy in Year 4 and onwards
- **Partner with hospitals and community-based organizations** to implement in regions covering five councils of governments (COGs) serving the state: South Central, Naugatuck Valley, Metropolitan, Capitol, and Southeastern

Source: [1] KFF (2019). COVID-19 Deaths by Race/Ethnicity.

Universal Home Visiting and Community Health Worker Programs

ARPA funding for these programs can create a robust continuum of care for children and families

- COVID-19 has reinforced health disparities that affect many Connecticut families and communities - a disproportionate share of COVID-19 related deaths were in the Black community
- **Home visiting**, where nurses and community health workers offer home visits to pregnant and new parents, **improves health outcomes and prevents child maltreatment**
- **Home visiting provides** pregnant mothers and families with children ages 0-6 the **skills and connections to community resources to best raise happy and healthy children**
- **1-3 postpartum visits** from a registered nurse or health worker **can have long-term impact by promoting health for babies and mothers** and connecting families to needed services
- Community Health Workers (CHWs) can supplement universal home visiting programs by **creating a continuum of care for families starting before birth** and helping individuals navigate the health service options available to them
- The **role of CHWs includes health care system navigation**, health education, health services access, social support, patient advocacy, health screenings, and capacity building
- CHWs can **provide tailored care coordination services and improve patient experience**, care coordination, and clinical outcomes, and **lead to lower inpatient and outpatient costs**

Universal Home Visiting and Community Health Worker Programs

ARPA funding for these programs can create a robust continuum of care for children and families

	Community Health Worker / Navigator Program	Universal Home Visiting for CT's Families	Supplement Home Visiting Programs for At-Risk Families
ARPA Funding Goal	*Build resilience for the next generation by providing 100 trusted community health workers for 2,500 highest risk families and children/year*	*More broadly introduce universal home visiting in certain areas of the state that suffered disproportionate impact, stress and child trauma during the pandemic*	*Provide additional funding to the state's home visiting program in regions disproportionately impacted by COVID-19, providing key services to at-risk families and building on the capacity currently afforded by existing home visiting programs*

Role of Community Health Workers (CHW)

Community health workers can engage perinatally to ensure equitable access throughout an individual's life

The American Rescue Plan Act of 2021 could fund a community health worker program with $33M in State ARPA funds for Years 1-3 with approximately $11M in annual costs for the state

10+

Number of services a CHW can provide to women, children, and families

0 – 5 years of age

During these years of life, CHWs can engage with children to foster healthy brain development

1 – 3 visits

Number of perinatal visits that can have a long-term impact by promoting health for babies and mothers

- CHWs **can supplement universal home visiting programs** by creating a continuum of care for families starting before birth and helping individuals navigate the health service options available to them
- The **role of Community Health Workers includes health care system navigation**, health education, health services access, social support, patient advocacy, health screenings, and capacity building
- CHWs can **provide tailored care coordination services and are uniquely qualified** to work with vulnerable and high-risk populations

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

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

Return of $2.47 for every $1 invested

when comparing program savings to overall program expenses

38% reduction in 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

- 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**

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