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Health and Government Operations Committee

Subcommittees
Health Occupations and Long Term Care
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HB334 Universal Newborn Nurse Home Visiting Services - Program Establishment and Insurance Coverage

- **What the Bill Does**
  - HB334 will reduce maternal health disparities, improve maternal and infant health outcomes, and reduce health care costs by supporting dedicated, sustainable funding for all Maryland families with newborns at no cost regardless of income or insurance status so that they may have access to the evidence-based Family Connects model which was developed by Duke University in Durham, NC.
- **How the Bill Works**
  - HB334 requires the Maryland Department of Health to create a plan to set up universally-offered home visits for families with newborns in local communities – following the requirements of an evidence-based model. At the moment, the only evidence-based model that meets the requirements of the bill is Family Connects.
  - The Department of Health will be tasked with developing a plan for families with Medicaid to access the service, including a reimbursement rate to local community organizations that will be offering the visit.
  - The Maryland Insurance Administration will require insurance reimbursement without copays or deductibles for all state-regulated health plans and set the reimbursement rate for the full operational and clinical cost of the case to the local community organizations (like hospitals, health departments, or local nonprofits) that will be offering the visits.
  - An annual report on the status of the will be provided to Senate Finance.
- **Why the Bill in Maryland**
  - The first few weeks after delivery are critical for both moms and babies.
  - 80% of maternal deaths are preventable.
  - 24% of pregnancy-related maternal deaths in Maryland occur within 42 days of birth.
  - Non-Hispanic Black women die from pregnancy-related causes at 2.6x non-Hispanic White women.
  - 10% of women miss their 6-week check-up

Commented [GU1]: 80% of maternal deaths are preventable.

- 94% of families with newborns have at least one identified risk
- Family Connects complements the existing systems of care and home visiting
  - Maryland's current approach is focused on risk assessments done prenatally and before hospital discharge, but new risks can emerge after hospital discharge.
  - Current home visiting models have very narrow eligibility which can miss families that need support.
- Right from birth positive parent newborn interactions are critical for building strong brain architecture, therefore undiagnosed and untreated maternal depression can leave a lasting impact on children's development.

- **Other States**
  - Oregon, Ohio, New Jersey are leading the way on improving maternal and newborn health outcomes by implementing the Family Connects model statewide.
    - Ohio and New Jersey are implementing with general funds.
    - Oregon is creatively financing through commercial insurance mandate, drawing down federal funds through Medicaid, and state funds for infrastructure for a phased-in roll out.
  - New Mexico is in the planning stage.
- **Overview of the Model**
  - The Family Connects model offers health and wellness checks for all birth parents and newborns in a community at home with a well-trained registered nurse at no charge to families.
  - Families schedule the visit before they leave the hospital because of staff co-located in the hospital.
  - Visits are made about three weeks after the baby's arrival.
  - Families are connected to services to meet the needs that are identified by the nurse during the visit.
  - The universal approach – unique among home visiting models -- reduces stigma and increases participation.
  - The nurse uses a conversational approach to conduct a comprehensive assessment across four domains of family wellbeing
    - health care
      - maternal health
      - infant health
      - health care plans, including primary care provider, insurance changes
      - this could also include connecting other family members with resources to meet their health care needs
    - infant care
      - child care plans
      - parent-child relationship

        - management of infant crying
    - a safe home
        - material and household supports
            - do they have what they need for food, diapers, formula
        - family and community safety
        - any history with parenting difficulties
    - Parents
        - parent wellbeing
        - substance use disorders
        - parent emotional support
- Risks are rated on a scale of 1-4 with the most urgent or emergent needs rated as 3s and 4s. 3s or 4s require a referral. 4s require the nurse to help the family get connected to help right away.
- All visits include
        - Screenings for postpartum depression and anxiety and intimate partner violence
        - Blood Pressure Check
        - Incision or Wound check
        - Newborn weight and temp check / Full Assessment
- The 90-minute visit allows time for the nurse to listen and answer questions
- Re-education on post-birth warning signs
- Coaching on self-advocacy
- Care coordination = visit notes sent to health care providers like pediatricians and obstetricians to close the loop and have continuity of care
- Warm connection to local and virtual support groups and resources
- Families may request and receive up to three more visits at home targeted for a specific need like blood pressure check, infant weight check, lactation support -- during the 12 weeks (about 3 months) after delivery.
- Families with newborns have unique service needs so another important component of the model is community alignment:
    - Identification and regular updating of local resources that meet the unique needs of families with newborns
    - Regular meetings of a community advisory board including local maternal child health service providers and advocates
    - Sharing of performance data and service gaps with the community advisory board to identify new resources or better align existing resources to reduce service gaps

- **Why Universal?**
    - Offering a visit to all families with newborns reduces stigma created by risk-based models. People don't feel as if they are being singled out or targeted.
    - Normalizes the service as a part of the perinatal experience

- Increases participation for population health impact
- Virtually all families with newborns have needs
- Identifies needs in families that traditional risk-based assessments can miss
- Maternal health disparities for African American families cross education, insurance, and income levels, which is one of the reasons by a universal approach is successful. It offers every family an opportunity to identify needs and concerns regardless of what a standard risk assessment might reveal.
- Needs arise after hospital discharge, some incredibly important to address.

- **Overview of the Evidence / Savings**
  - The evidence for the model comes from the gold standard of research -- two random control trials -- conducted in Durham, NC, and a recent quasi-experimental design.
    - Reduced emergency room visits and hospital overnight stays for infants by 50% in the first year of life.
    - Lowered child protective services investigations for suspected child abuse or neglect through age 5 by 39%
    - Mothers were 28-30% less likely to report possible postpartum clinical anxiety.
    - Community connections increased by 13-15%.
    - Mothers were more likely to complete their 6-week postpartum health check.
    - **Reduced racial disparities** for maternal anxiety/depression child maltreatment investigations, and other impacts.
- **Return on Investment:**
  - The evidence for the model showed a return of $3.17 in reduced costs for infant emergency department visits and overnight stays for every $1 invested.

- **Additional Impacts**
  - Ability to reduce postpartum health care costs for birthing parents.
    - Preliminary review of all charges data in CRISP for Frederick County birthing parents who delivered at Frederick Health in 2023 showed a reduction of postpartum health care costs by patient and by visit.
  - Family Connects nurses actively seek families who are eligible for WIC support
    - Women who participate in WIC have less anemia, a lower risk of obesity at the onset of a subsequent pregnancy and fewer infant deaths
    - Children enrolled in WIC show significantly improved rates of childhood immunizations and of having a regular source of medical care

- Family Connects nurses provide breastfeeding education
  - CDC recommends breastfeeding through 6 months
  - Maternal health benefits include decreased risk of breast and ovarian cancer, type 2 diabetes and high blood pressure
  - Infant health benefits include decreased risk of asthma, type 1 diabetes, sudden infant death syndrome and obesity

- **Crosswalks with Maryland Health Goals**
  - The model aligns with several key Maryland Health Goals
    - State Integrated Health Improvement Strategy
      - Health Quality: reduce avoidable admissions and readmissions to the hospital
      - Maternal Health: reduce severe maternal morbidity rate
    - Maternal Mortality Review Team Recommendations, 2020
      - All postpartum individuals in Maryland should be offered a referral to a home visiting program or community health worker (embedded in the hospital or clinic setting) during their delivery hospitalization.
        - Family Connects is the only evidence-based universal home visiting model included in Home Visiting Evidence of Effectiveness (HOMVEE).
    - **Moore-Miller 2024 State Plan**
      - Improve eligibility and access to quality care, particularly focusing on ***maternal and infant health.*** . . .
        - Family Connects supports both birthing parent and newborn.

  - **2024 State Health Improvement Plan Priority 3: Women's Health**
    - **Goal 1:** Improve maternal health outcomes through improved maternal care before, during and after pregnancy
      - Family Connects fills a gap in maternal care between hospital discharge and the 6-week postpartum appointment.
  - MDMOMs
    - Improve monitoring of blood pressure for patients at risk or with severe hypertension in pregnancy or postpartum
      - Family Connects can offer patients an early visit to check on blood pressure and reinforce education on how to use the blood pressure cuff provided by the hospital.
      - Blood pressure is taken during the visit at 3-weeks.
    - Support warning signs education for bleeding, fever, pain, high blood pressure, and postpartum depression and anxiety.
      - Nurses provide re-education on post-birth warning signs.
      - The visit includes postpartum depression and anxiety screening.

- **Family Connects in Maryland – 3 sites**

- The Family Tree offers visits to City of Baltimore residents who deliver at Sinai Hospital.
- Child Resource Connect offers visits to Prince George's County residents who deliver at University of Maryland Capital Region Health
- Frederick Health Hospital offers visits to Frederick County families no matter where they deliver.

- **Reported Family Experiences in Maryland**
  - **98%** patient satisfaction
  - **100%** of families with risk identified received at least one referral. The top referrals were for health care, household safety and materials support, and mental health care.

Some comments from the patients included:

- *"I'm a nurse and I didn't realize my headaches were from postpartum preeclampsia – diagnosed after the nurse checked me."*
- *"My blood pressure was extremely high, and she helped me get care when I was reluctant."*
- *"I am not breastfeeding exclusively."*
- *"This visit was helpful because I was alone with no friends."*
- *"She gave me information I did not know, even after having multiple children."*
- *"The nurse helped me understand my baby blues and was supportive with breastfeeding."*
- *"I remembered her education on postpartum anxiety when my symptoms started. I reached out to get connected to support and got care right away."*

- Phase-In Approach
  - SB156/HB334 lays out the vision for a state-wide strategy to improve maternal newborn health
  - A large-scale system improvement like this takes time to develop and it's important to develop capacity as we adapt to existing local service delivery systems and to meet the workforce needs that will be necessary to provide and manage these services efficiently and effectively.
  - Significant start-up investments have already been made in these 3 sites and SB156/HB334 would create a path for additional public/private dollars to grow our system of care.
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  - We recommend a phase-in approach that creates the state infrastructure for a statewide implementation but that starts with the 3 current sites

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