

Maternal, Infant and Early Childhood Home Visiting: Lessons Learned from Health Innovations and Partnerships

This brief was prepared by the Maternal Infant and Early Childhood Home Visiting (MIECHV) Program and was last updated on December 1, 2022.

The Illinois Maternal, Infant and Early Childhood Home Visiting program (MIECHV) program is implemented by the Bureau of Home Visiting within the Illinois Department of Human Services Division of Early Childhood (IDHS-DEC).

Reflecting the key maternal and infant health priorities of the federal MIECHV program, strengthening connections between health and home visiting has been at the center of a number of Illinois home visiting innovations and partnerships. The brief below outlines several such initiatives led or supported by Illinois MIECHV and is intended as a resource to strengthen partnerships between home visiting and health systems.



Contents

| | |
|---------------------------------------------------------|---|
| Universal Newborn Support Systems | 2 |
| Family Connects Illinois..... | 2 |
| Family Connects Chicago | 3 |
| Summarizing lessons learned..... | 4 |
| Targeted screening and referral systems | 4 |
| Adverse Childhood Experiences..... | 4 |
| ConnecTeen | 5 |
| Summarizing lessons learned..... | 5 |
| Partnerships with managed care organizations | 6 |
| Summarizing lessons learned..... | 6 |
| Outreach to healthcare professional associations | 6 |
| Summarizing lessons learned..... | 7 |
| Additional Maternal and Child Health Partnerships | 7 |
| Title V partnerships | 7 |
| Substance Use Screening and Referrals..... | 9 |

Universal Newborn Support Systems

Universal newborn support systems (UNSS) represent an approach for screening all families welcoming a new baby to provide individualized referrals to a network of resources and supportive services based on a family's unique strengths, desires, and needs. Distinct from intensive, long-term evidence-based home visiting services, UNSS are short-term and time-limited interventions, offered universally to all families welcoming a new baby. UNSS approaches recognize that every family can benefit from additional support at the birth of a child. By offering services to all families within a community, UNSS can help to reduce stigma that may be associated with targeted programs based on certain family eligibility characteristics.

UNSS approaches may vary depending on local contexts and the model of choice, but broadly, these interventions consist of a nurse home visitor, community health worker, or other trained professional meeting with a new family (the birthing parent, other caregivers, and the newborn) to check-in on health and overall well-being in the immediate postpartum period. Referrals may be made to a range of community supports based on a family's needs and desires, including to home visiting services, mental health or health services, resources to support family economic well-being, childcare supports, and other community services across a variety of domains.

Since FFY17, the Illinois MIECHV program has made significant progress in implementing and supporting UNSS models as a mechanism for centralized intake to home visiting and other support services through partnerships with birthing hospitals. The expansion of universal newborn support services has been a longtime priority of the Home Visiting Task Force (HVTF) of the Illinois Early Learning Council, and the successful launch of these approaches has started to change the Illinois prenatal-to-three landscape. In addition, the expansion of UNSS services is one of the strategies at other early learning and maternal and child health tables, including the state's Raising Illinois action plan (previously known as the PN3 Coalition), and Illinois' HRSA-funded State Maternal Health Innovation Grant—I-PROMOTE (discussed in greater detail below). Finally, under IDHS' leadership, in 2021 Illinois was awarded a five-year planning grant under the Early Childhood Comprehensive Systems (ECCS) program, which will include developing a comprehensive prenatal-to-three continuum of services, inclusive of a plan to scale universal newborn screening throughout the state and linking this system to prenatal services. As described below, these UNSS approaches are mutually beneficial to partnering hospitals, local home visiting programs, and ultimately, families and children.

Family Connects Illinois

In 2012, the Home Visiting Task Force began exploring the possibility of a universal newborn supports project to outreach to and screen all families with a new baby and provide connections to vital community resources. The HVTF conducted an extensive exploration of existing UNSS approaches and arrived at the Family Connects model as a suitable model for an initial pilot. Initially developed by Duke University, the Family Connects model starts with an offer to families, shortly after birth, of a follow-up nurse home visit 1-3 weeks postpartum. The Family Connects model, now led by [Family Connects International](#), leverages services delivered by nurse home visitor who provides an in-home screening including a physical assessment of the newborn and birthing parent and complete an evidence-based assessment of the entire family's psychosocial needs to understand a new family's level of support and provide educational materials, and referrals to services.

In 2017, the [Family Connects Illinois \(FC IL\) program](#) was launched in Peoria and Stephenson Counties as Illinois' first state-funded foray into UNSS. In both communities, Family Connects is implemented by the MIECHV Local Implementing Agency (LIA). These agencies bring a robust history of delivering home visiting services, strong connections to the local birthing hospitals, and extensive relationships with

other local community-based services. Public funding for Family Connects Illinois comes from the MIECHV program and the Illinois State Board of Education (ISBE). Notably, these funding streams support Family Connects as a coordinated intake (CI) and referral strategy to support connections to intensive home visiting services, as the universal approach has increased the ability of local agencies to identify and serve the highest priority populations and increase the referrals to and uptake of more intensive home visiting services among eligible families.

Family Connects Illinois Implementation Highlights

- Among families that are assessed by a Family Connects nurse home visitor, 100% receive at least one referral for services identified through the assessment
- Between July 1, 2019 and April 30, 2021, Stephenson had 585 births, 517 families that agreed to services, and 386 families that completed services by receiving the assessment. For the 386 families served, 982 referrals were provided.
- Between July 1, 2019 and April 30, 2021, Peoria had 1,529 births, 888 families that agreed to services, and 614 families that completed services by receiving the assessment. For the 614 Peoria families served, 1,314 referrals were provided. All eligible families were referred to HV programs.
- FC IL is the biggest referral source for home visiting services in Peoria and one of the biggest sources in Stephenson.

In these counties, families with newborns born in partner hospitals (two in Stephenson and one in Peoria) receive 1-3 in-home screening visits from a nurse, to determine the family's level of support and provide physical assessments, educational materials, and referrals to services. Services can range from lower-intensity services such as lactation consultation up to high-intensity services such as a home visiting services program. The birthing parent also completes screens for postpartum depression, substance use, and family violence. During the visits, nurses provide education and support for priority topics, and they provide over-the-phone guidance prior to and after the initial visit. All families receive a follow-up contact 30 days after completing services to assess satisfaction and connection to home visiting and other services. Continued effort is provided to assist with referrals that have not been successfully completed. When a referral to home visiting is indicated, the FC IL nurse contacts the Coordinated Intake worker to carry out the referral.

Access to birthing hospitals was restricted in response to COVID-19, forcing FC IL sites to adapt service delivery from the original approach of connecting with families face-to-face prior to discharge from the hospital. During the pandemic, both FC IL programs worked with participating hospitals, as well as local systems of support, to address systems challenges and to plan for building back the infrastructure for collaboration. Programs FC IL sites have noted an increased need for referrals to community resources for health, safety, food, and material needs since the beginning of the pandemic. Programs are now conducting in-person visits.

Family Connects Chicago

In 2018, the Illinois Department of Public Health (IDPH) released their first [Maternal Morbidity and Mortality Report](#), which called for the expansion of universal home visiting for postpartum mothers within three weeks of giving birth. In 2019, [Family Connects Chicago](#) was launched as a public-private partnership between the Illinois Department of Public Health's Maternal and Child Health Services Title V Block Grant program (Title V), the City of Chicago, Rush University Medical Center, IDHS, and private philanthropy. The program is administered and overseen by the Chicago Department of Public Health

(CDPH). CDPH convenes a Citywide Advisory Council and Community Alignment Boards at each Family Connects site, composed of cross-sector leaders working to ensure increased and strengthened partnerships among existing service providers and identify gaps in services. The Bureau Chief of the IDHS Bureau of Home Visiting serves on the Citywide Advisory Council for Family Connects Chicago.

Since 2019 Family Connects Chicago has been available to families giving birth at Rush University Medical Center, Humboldt Park Health, and Mount Sinai Hospital. The recent addition of UChicago Medicine will make the service available to an estimated 5,500 families over the next year. Funded in part by a \$25 million increase in funding allocated to Family Connects Chicago in the 2022 City of Chicago budget, this expansion aims to scale the service to all 15 Chicago birthing hospitals by late summer 2023, eventually reaching the families of approximately 38,000 babies born in Chicago each year. While MIECHV does not fund Family Connects Chicago, the expansion of UNSS services in Chicago will result in increased referrals to home visiting services within the City, likely including MIECHV-funded home visiting programs.

Summarizing lessons learned

As Illinois is poised to expand UNSS through various federal, state, and local initiatives, the statewide home visiting system and MIECHV program is well positioned to draw on the experiences of the Family Connects Illinois, and Family Connects Chicago to inform connections between UNSS and intensive, long-term home visiting services. Given the overlap in populations served, it is important to distinguish between the aim and benefits of UNSS in contrast to home visiting to ensure an understanding of how the two initiatives complement each other, to avoid duplication and reduce potential concerns about competition between programs. As public awareness and support for UNSS grows, the experiences of Illinois MIECHV in connecting with these universal programs will be essential to informing the design, implementation, and reception of UNSS by families, providers, policymakers and the broader public.

Targeted screening and referral systems

Adverse Childhood Experiences

In close partnership with the Illinois MIECHV Program, Rush University Medical Center (“Rush”) launched its Adverse Childhood Experiences – Home Visiting Initiative (the “ACE-HV Initiative”) in June 2017. Rush is located on the West side of Chicago and serves communities with some of the highest rates of child poverty, infant mortality, and child abuse and neglect due to systemic barriers. Rush is universally screening pregnant and postpartum people for Adverse Childhood Experience (ACEs) across six clinical outpatient sites, including obstetrics, pediatrics, adolescent, and school-based health clinics. Women with high ACE scores are linked to existing community based HV programs through a CI model housed in Rush. While the Rush ACE-HV Initiative is not funded by MIECHV, Rush’s care coordinator is included in the MIECHV CI learning community and other professional development opportunities.

Despite the challenges of the pandemic, between March 2020 and March 2021, Rush referred 344 families to CI; 124 (36%) of these families were referred to home visiting. This initiative is a clear demonstration of how HV and the health care system can work collaboratively and have the potential to impact broader public health outcomes at the community level. The Illinois MIECHV team continues to work with Rush, as lessons learned are used to inform other health care opportunities and partnerships across the state.

ConnecTeen

Lurie Children's Hospital manages the ConnecTeen program to support pregnant people and families with young children in Chicago, including pregnant and parenting youth (PPY) who attend Chicago Public Schools (CPS) or live in the City of Chicago by connecting them with a network of home visiting providers in their community. Lurie Children's serves as the centralized intake point for this project. The referral pathway for ConnecTeen is as follows:

1. Pregnant person or family contacts or is referred to ConnecTeen
2. ConnecTeen Staff and the referred individual speak to discuss needs
3. ConnecTeen Staff identifies the best home visiting program for the referred individual and makes a referral
4. The referred individual is contacted by the home visiting program for intake and enrollment to start services
5. ConnecTeen staff host biweekly parent support groups and regularly assess the needs of referred individuals during the enrollment period
6. ConnecTeen staff maintain contact with the referred individual and the home visiting program to ensure successful linkages

ConnecTeen Implementation Highlights as of November, 2022

- Among ConnecTeen Referrals:
 - 22% of ConnecTeen referrals indicated unstable housing
 - 84% live in Chicago
 - 24% have DCFS involvement
 - 78% are first-time parents
 - 101 are CPS students
 - The average age of PPY is 21.2 years old
- 451 total referrals have been made to ConnecTeen
 - 48.2% of referrals successfully enrolled in home visiting
 - 33% of referrals to ConnecTeen were made prenatally
- PPY outcomes among enrolled parents show strong gains in caregiver and child health
 - 96% received a postpartum visit
 - 95.8% were practicing safe sleep (baby on back to sleep)
 - 93.7% of children received their well child visit
 - Referrals from ConnecTeen to other supports included connections to Early Intervention, Nutrition supports, Child Care, Health Insurance, and Therapy
 - Car seats, diapers, and housing/rental assistance were among other common referrals per parent needs

Summarizing lessons learned

The successes of the ACE-HV Initiative and ConnecTeen program remain bright spots for Illinois home visiting. These targeted initiatives demonstrate the importance of well-designed referral pathways to connect families to home visiting services, particularly when families are facing multiple and complex challenges. Bringing these successful strategies to scale in other communities by documenting lessons learned and best practices could be a fruitful next step of benefit not only to Illinois MIECHV, but also to the broader statewide home visiting system as it works to improve access to home visiting services for priority populations.

Partnerships with managed care organizations

Several years ago, Illinois underwent a significant reform of its healthcare system, which included transitioning from a primarily fee-for-service Medicaid system to a managed care system. To impact the systems outcome on preterm birth, Illinois MIECHV has been working to strengthen connections with Medicaid Managed Care Organizations (MCOs) to build referral pathways for pregnant persons with risk factors. Illinois MIECHV has presented home visiting information to a statewide phone meeting of Medicaid MCOs; participated in a care coordination pilot with one MCO (Meridian); connected a second MCO (Aetna) to Coordinated Intake in Rockford; and connected a third MCO (Advocate Aurora Health) to Coordinated Intake in the Chicago Southside Cluster.

Through the Health Subcommittee of the Early Learning Council Integration and Alignment Committee, the Governor's Office of Early Childhood Development (GOECD) was connected to one of Illinois' Medicaid managed care organizations (Wellcare, formerly known as Meridian). GOECD met with Wellcare staff in 2019 to introduce MIECHV health benchmarks and discuss how home visitors and care coordinators could complement each other's roles. Wellcare identified two MIECHV communities of interest—DeKalb and East St. Louis. GOECD reached out to LIAs in both communities and confirmed that they were interested in exploring a partnership with Wellcare. By fall 2019, Wellcare had developed small community grants with both LIAs to establish data sharing and participation in monthly “huddles” to discuss progress and barriers experienced by specific families. Through these huddles, Wellcare was able to successfully fulfill infant care seat needs identified by the home visiting programs. Unfortunately, key staff turned over at Wellcare following a merger. As a result, the pilot data were not examined, and the pilot was not continued. The Early Learning Council has also been restructured, and the Health Subcommittee has been reconfigured as the Health and Home Visiting Committee, along with the former Home Visiting Task Force.

The MIECHV MCH Nurse Consultant contacted 4 Illinois MCO groups and requested training for MIECHV Home Visiting Supervisors and their staff. Two MCO representatives provided training on care coordination and other supportive services that they offer to enrolled members. MIECHV MCH Nurse Consultant gave presentations to the Perinatal Outreach Educators of Illinois and to groups of their regional staff working in hospitals throughout the state. In addition, on-site presentations on Home Visiting, eligibility for enrollment, and use of the iGrow website for initiating referrals were conducted in-person at 3 hospitals within Cook and Lake County, and a virtual training with staff in a Peoria hospital.

Summarizing lessons learned

Ultimately, while there was initial momentum and interest in building collaboration between home visiting and managed care organizations, Illinois MIECHV encountered challenges connecting with the right individuals within the MCOs who are best positioned and eager to refer families to home visiting services. Additionally, the complexity of the Illinois home visiting system, including the mix of models, various target populations and eligibility criteria, and braided funding make it difficult for healthcare providers and MCOs to navigate, particularly in areas without a mechanism for Coordinated Intake for home visiting.

Outreach to healthcare professional associations

In 2020, MIECHV began to explore potential strategies to connect with health providers to increase awareness of home visiting and develop more robust bi-directional referral pathways. Specifically, MIECHV was seeking to connect with health professionals that interact with families and young children to:

- Increase awareness of the benefits of and availability home visiting among health professionals;
- Facilitate referrals to home visiting from health-focused providers; and
- Open a dialogue about ways to improve connections to healthcare, health promoting activities, and relevant public, maternal and child health messages.

Initial communication was sent to the healthcare professional associations and other coordinating entities for health providers (Illinois Academy of Family Physicians, Illinois Chapter of the American Academy of Pediatrics, Perinatal Outreach Educators of Illinois etc.) with follow-up discussions occurring in 2021 and 2022. Strategies explored included co-locating coordinated intake within health settings, or formalizing referral information and pathways to local home visiting programs.

Summarizing lessons learned

Key challenges to these types of partnerships were surfaced by health stakeholders, including that home visiting is not universally accessible across the state, even for families who would meet eligibility requirements. For providers to feel comfortable referring families to home visiting services, services would ideally be accessible regardless of where a family lives so that providers are not responsible for sorting through available programs/services, or potentially referring a family who then cannot be served due to eligibility constraints or the lack of available services. Additionally, MIECHV heard concerns that if home visiting or Coordinated Intake providers enter health provider waiting rooms to offer information and support referrals, providers would feel obligated to offer equal access to other community services which was deemed unsustainable. Finally, Illinois MIECHV heard concerns that pediatricians' offices are understaffed, with providers already burdened by the need to fit required screenings, health services, and other supports into short visits. Health stakeholders shared that it would be unfeasible to ask pediatricians to make referrals to home visiting without receiving reimbursement or other financial support for this additional activity.

Additional Maternal and Child Health Partnerships

Title V partnerships

The Illinois MIECHV partnerships with Title V programs include projects supporting breastfeeding and maternal health, respectively. In FFY19, 27% of Illinois MIECHV families were meeting the breastfeeding benchmark of children receiving breastmilk at 6 months of age for those whose mothers enrolled prenatally. A review of the data revealed racial inequities, with Black families less likely than white families to breastfeed at six months. To address this priority, Illinois MIECHV established a partnership with the state's CDC-funded Illinois State Physical Activity and Nutrition (I-SPAN) project. The Illinois Public Health Institute (IPHI) leads the I-SPAN initiative. An electronic survey was disseminated in 2020; over 500 Illinois home visitors responded (from MIECHV and non-MIECHV funded programs). The vast majority of respondents (89.3%) agreed that helping families achieve their breastfeeding goals is part of their role as home visitors, but 58.7% of respondents reported not having received training on breastfeeding in the last 3 years, with no statistically significant differences by race/ethnicity. The results

revealed a strong interest and need for additional trainings on breastfeeding. Black, Latinx, and White home visitors reported slightly different priorities in terms of the types of supports they preferred, but they all wanted more web-based training. Black home visitors ranked online training as most important, Latinx home visitors ranked incentives and supplies for families as most important, and White home visitors ranked online/print resources as most important.

In response, MIECHV now requires home visitors to complete on-demand web-based training from the Institute for the Advancement of Family Support Professionals, and through IPHI, a virtual training was offered in November 2022 to address practice-based topics for home visiting programs. IPHI is also hosting a learning collaborative for home visiting programs, “Delivering Chest/Breastfeeding Equity in Home Visiting.” Through this initiative, 16 home visiting staff members will become trained as Certified Lactation Counselors or Certified Lactation Specialists, and the programs will explore how to will make sustainable policy, process or procedural changes to support both breastfeeding and the newly trained staff person.

In addition, the public funders of HV issued a joint statement confirming that funds may be used for breastfeeding materials for families. Also, the MIECHV nurse consultant developed breastfeeding guidance for MIECHV programs, which has been promoted nationally in the e-newsletters of the National Association of County and City Health Officials and the United States Breastfeeding Committee.

Illinois MIECHV is also a partner in Illinois’ HRSA-funded State Maternal Health Innovation Grant—I-PROMOTE—which is led by the University of Illinois at Chicago (UIC). Illinois MIECHV staff participated in the project’s Maternal Health Task Force and contributed to the development of its strategic plan. I-PROMOTE includes a project to examine and expand maternal health training for home visitors. UIC conducted key informant interviews with selected MIECHV sites to understand home visitors’ past training on maternal health and to identify additional training needs. The interview findings showed that home visiting programs wanted more training specifically on maternal health warning signs and chronic conditions that affect maternal health. In response, UIC worked with Start Early’s Professional Learning Network (Illinois’ home visiting T&TA provider) to develop a training that will be piloted in November 2022.

In July 2019, the Illinois General Assembly passed Public Act 101-0028, creating the Illinois Task Force on Infant and Maternal Mortality Among African Americans. The Task Force (also known as IMMT) was charged with identifying strategies to decrease infant and maternal mortality among African Americans. The MIECHV MCH Nurse Consultant is an appointed member on the state legislated Task Force on Infant and Maternal Mortality Among African Americans (IMMT) and serves as a Co-Chair on the IMMT Systems Sub-committee. In 2020, the IMMT issued its first annual report, which included recommendations on provider education, use of telehealth to advance access to equitable care, increasing access to birthing centers to address maternity deserts in Black and African American communities, the unbundling of postpartum visit from prenatal care and labor and delivery services and the implementation of a universal early postpartum visit within the first three weeks and a comprehensive visit within 4-12 weeks postpartum, and the reimbursement of doula services for prenatal and postpartum care. The group is now working on recommendations regarding a system of care for infants born with high-risk conditions, and guidelines for post-partum care in the first 12 months post-delivery.

In addition to these ongoing partnership projects, MIECHV is exploring ways in which home visiting can partner with Illinois Title V projects involving Children/Youth with Special Health Care Needs (CYSHCN) and their regional system, pregnant and parenting families with substance use disorder (SUD), and

adolescent suicide prevention. Furthermore, Illinois MIECHV plans to review MCH benchmark data annually with Title V to jointly identify strategies for collaboration and improvement.

Substance Use Screening and Referrals

Through the needs assessment process, Illinois MIECHV developed a new partnership with the IDHS Division of Substance Use Prevention and Recovery (SUPR). MIECHV joined the Women's Committee of the state's Substance Use Disorder Advisory Council and presented data from Illinois home visiting programs using the 4P's Plus[©] screening tool, which indicated a trending rise in the use of marijuana and opiates by pregnant persons. The ensuing discussion identified the need to support warm referrals from home visiting programs to substance use treatment and recovery services.

In May 2018 the Centers for Medicare & Medicaid Services (CMS) approved Illinois' application for a Section 1115 Medicaid Demonstration Waiver focused on behavioral health, which included a pilot project to offer HV services to families of children born with withdrawal symptoms from opioid addiction. However, there were subsequent leadership changes in the state's Medicaid agency (HFS), combined with difficulties in identifying eligible families. As a result, the pilot did not go forward. Instead, Illinois MIECHV is working with the Department of Healthcare and Family Services (HFS) to explore broader mechanisms for Medicaid reimbursement of home visiting and doula services.

Illinois MIECHV continues to strengthen its partnership with the substance use disorder (SUD) system. MIECHV is a member of the Women's Committee of the Illinois SUD Advisory Council, which has prioritized messaging and public awareness of the SUD system to facilitate warm referrals from home visiting and other programs. In 2021, guidance on substance use screening and referrals was developed in partnership with SUPR and the Women's Committee and shared with IDHS and MIECHV programs. Illinois is developing a plan for increasing the capacity of MIECHV programs to support and refer families with SUD.

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under Grant Numbers X10MC32189 and X10MC33578 in the total award amounts of \$8,744,850 and \$8,345,310, respectively, for the Maternal, Infant and Early Childhood Home Visiting Program, and 0% financed with nongovernmental sources. This information, content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.