Creating a Universal Newborn Support System (UNSS) in Illinois:

An Assessment of Opportunity Based on Wisdom and Experience from the Field

October 2021

Planning Committee: Allison Angeloni, Steans Family Foundation; Katie Kelly, J.B and M.K. Pritzker Family Foundation; Gina S. Lowell, MD, Rush University Medical Center; Bryce Marable, Ireta Gasner, Karen Berman, Nick Weschler, Start Early; Jennifer Vidis, Chicago Department of Public Health

Consultant Team: Margie Schaps, Health & Medicine Policy Research Group; Laura McAlpine, Mac Grambauer, McAlpine Consulting for Growth, LLC; Tiosha Bailey, T. Bailey Consulting Firm Inc.; Linda Diamond Shapiro, Conlon Public Strategies

Health & Medicine POLICY RESEARCH GROUP

mcAlpine consulting for growth

CONLON PUBLIC STRATEGIES

Table of Contents

Appendix

Creating a Universal Newborn Support System (UNSS) in Illinois: An Assessment of Opportunity Based on Wisdom and Experience from the Field

INTRODUCTION

The Universal Newborn Support System (UNSS) is a simple concept at first glance: provision of home visit by a nurse within a few weeks after birth.

In Illinois, a group of early childhood and maternal health advocates hopes to advance the implementation of a universal, voluntary UNSS initiative which will build a coordinated system of support for families with newborns and connect families to that system through a home visit by a nurse to all newborns at approximately three weeks of life, with follow-up as needed to engage families with ongoing services at a critical juncture in their lives.

The UNSS effort envisioned occupies a unique policy niche distinguished from home-based interventions by the intent to be offered *universally* to families of all newborns without regard to perceived risk factors or family economic status, and to include a process of community engagement that ensures families are connected to a system of support beyond the home visit.

An UNSS is a short-term, light-touch approach to help all parents of newborns feel equipped and confident by connecting them with advice, support, and an entry way to community services. The most promising of these programs offers every family who wants it either an in-person visit or virtual conversation with a nurse, community health worker, or other early childhood professional. Further, UNSS programs strengthen local systems of care, collecting and responding to information on local unmet need.

The offer of a visit by a nurse or other practitioner is a strategy to forge an early connection to ensure the well-being of every baby, new parent, and family by bridging the gap between a family's unique needs and wishes, and the resources and local systems of care in their community.

This report focuses on UNSS models based on a home visit offered *by a nurse*, while fully recognizing that UNSS models may be achieved using other practitioners and lay visitors. In this brief, the emphasis placed on a nurse-based intervention model reflects this as the prevailing approach within current Illinois UNSS programs. This approach easily flows from hospital to home as a first post-natal in the community intervention.

The time has never been better for exploration of the UNSS model which has considerable resonance with policy leaders across the state, many considering UNSS in the context of broader maternal and child health as well as early childhood care and education. The state legislature this year authorized Medicaid to cover home visiting by a range of professionals, from community health workers to nurses to doulas. Further, the Governor's office is undertaking a ground-breaking strategic initiative to bring together various state agencies concerned with maternal

and child health and child development—including investment in prenatal through age five services, and an exploration of regionalization of services across the state.

Given this momentum, a group of experts approached the Health and Medicine Policy Research Group, McAlpine Consulting for Growth and Conlon Public Strategies to capture and draw on local Illinois UNSS experience to date to inform policymakers and philanthropists interested in advancing UNSS statewide and explore the range of options to finance UNSS program expansion.

APPROACH

The key purpose of the study that follows is to develop insight as to how such a system might be shaped, administered, and funded as a universal statewide practice, learning from those closest to model programs already underway. As we spoke with Illinois leaders, we identified several UNSS experts in other states who have directly influenced the shape of Illinois programs and we reached out to them as well.

This brief is intended to provide foundational information and food for thought as advocates and analysts continue the important work of considering how an UNSS might be implemented to strengthen Illinois communities.

The effort to pursue our UNSS study that follows was animated by the Chicago Department of Public Health, Pritzker Family Foundation, Rush Hospital, Start Early, and Steans Family Foundation. Prior to launch of information gathering, research, and data analysis, these groups, along with our group of consultants, formed a Steering Committee that defined several premises for this study as follows.

UNSS Vision: Our point of departure is an understanding that a comprehensive perinatal support system is key to a successful start in life for newborns and their families. An element of this system, reflected on the strategic plans and policy agendas across Illinois, is expansion of voluntary universal newborn home visiting by a nurse to offer a comprehensive assessment of the health and risks and needs of the family and based on that assessment, to make a connection to a set of tailored services and supports.

The base of evidence for UNSS is growing, following on decades of study of families of newborns. For example, Family Connects International (a nationally recognized UNSS model described below) has found that 75 to 80 percent of parents participate in the program, and that participating families have more connections to community resources and high-quality childcare, have safer environments at home, need less emergency care for their babies, and report less anxiety in mothers. (See https://familyconnects.org/family-connects-model/evidence/.)

Mission and goals for this study:

- To identify stable resources that will permit the sustainability, expansion, and scalability of pilot UNSS efforts underway in Illinois

- To identify and understand resources needed to launch and sustain an UNSS across the entire state
- To formulate a set of recommendations for advancing an Illinois UNSS initiative

For our study, we sought to better understand the benefits or outcomes stakeholders representing various sectors might anticipate by implementing an Illinois UNSS initiative, and in turn, how each might envision financing such a system. We gathered information on pilot efforts in Illinois related to indicators of success as defined by the multiple service and advocacy sectors invested in healthy child development and family well-being.

While multiple UNSS models are in use across the country, our study places particular emphasis on Family Connects which is the UNSS model most visibly in wide-spread use in Illinois (see: https://familyconnectsil.org/). Family Connects is one of several national evidence-based systems with an infrastructure available to help communities replicate their models with fidelity. It is the model adopted by the Chicago Department of Public Health (CDPH) for communities in Chicago, and by the Home Visiting Task Force UNSS Subcommittee for additional UNSS pilot communities in Illinois. The Family Connects model is the only nurse-based UNSS approach that has been validated by a randomized controlled trial, pointing to long-term maternal and child health and child welfare benefits.

We conducted a literature review of UNSS and Family Connects programs to guide the development of semi-structured interview questions that we posed to interviewees. (The 35 experts interviewed are listed in Table 3 of the appendix.)

While nearly all of those interviewed were familiar with UNSS and with pilot efforts in Illinois, we opened each interview with a briefing to promote a common understanding on which to base our discussions with informants. This included the following basic information:

- *UNSS basic concept*: All newborns and their parents in Illinois would receive a home visit to provide them with information, supports, and resources to strengthen the capacity of parents to meet their children's needs. Guiding principles include reaching every baby born in Illinois and their families, providing at least one home visit, conducting basic health screens, and making community referrals to support services based on assessment findings.

- *Universality*: While Illinois currently offers multiple home visiting programs for at-risk families, there has also been increased awareness that birth is a critical moment, full of both possibility and challenge, for all families. The birth of a new child represents a window of opportunity to connect families to the community resources and knowledge they need to best support their children. A universal approach would go beyond current risk-based programs to introduce a public health and education infrastructure. This approach would assure an entry point to resources and services for all families caring for newborns.

- *Family connects/nurse-based models*: Various UNSS models are currently offered by a range of lay and professional visitors, including several that are evidence-based and nurse-based. The Family Connects model that is prominent in Illinois calls for a visit by a nurse with a structured protocol and includes a template for data collection as well as a structure for collaboration with a network of local community resources.

- *Resource network*: In addition to serving families, the Family Connects model focuses on building a strong collaborative relationship with hospitals, medical providers, local and state service providers, early care and education programs, and their county health departments. These relationships result in community linkages to a wide array of supports with varying levels of need, ranging from parks and libraries to shelters and food pantries, to medical providers and home visiting programs.

The Steering Committee for this study recommended an initial group of interviewees, and we supplemented this list as we learned about influencers who could offer critical input based on their UNSS design and implementation experience. With two exceptions, we reached all individuals identified to inform this study. With a primary focus on building a sustainable statewide effort based on an evidence-based design, we were unable to interview families for this study, but recognize that no Illinois program can be developed without family and user participation.

DELIVERABLE #1: INSIGHTS FROM VARIOUS SECTORS REGARDING ILLINOIS UNSS

We interviewed 15 experts—each informed and influenced by the various sectors they represent—to understand their range of perspectives on what UNSS currently means for Illinois communities and what it could mean for the state as a whole.

Intersectionality across sectors interested in UNSS

When interviewees were asked to self-identify the sector they represented, several mentioned that their work spanned across multiple sectors, pointing to the inherent intersectionality of their work across health, child welfare, public health, and early childhood care and education sectors.

> *"I oversee the WIC program, so that is public health. I would normally describe my sector as early childhood but can see how health overall works to describe my work too".*

Several noted that traditionally, these sectors have been segmented—reflective of various funding sources—and thus creating redundancies in operations, fractures in communication, disparate practices and limited opportunities for cross-collaboration needed to support large scale initiatives.

In discussing the potential for an UNSS initiative for Illinois, interviewees supported breaking down silos and building bridges across sectors using a systems level framework, with maternal and child health (MCH) and early childcare & education (EC) as central areas of focus. Experts noted the potential role that an UNSS initiative could play in meeting the needs of all children.

> "*These two camps [early childhood and child welfare] should work closer together. Family Connects could be a universal attempt to provide support to all kids."*

Interest across sectors in implementing an Illinois UNSS

Interviewees spoke with enthusiasm about the need for a coordinated, statewide universal home visiting model that could serve as a central portal of entry to services for newborns and their families. According to many, UNSS provides value by connecting with families with newborns and creating a web of support services, increasing utilization of critical services for those who need them.
Several experts expressed an interest in allowing local communities to select the specific UNSS model to be chosen for their region, given the uniqueness of needs in each community.

Balanced program focus on the newborn, mother, and family

Some interviewees noted the importance of using UNSS to attend to the newborn, mother, and family.

"Are communities implementing Family Connects, or any other UNSS model, prepared to ensure a balance of both mother and baby needs?"

Others noted that Family Connects appears to be focused largely on the newborn and family at large, and not specifically on the mother.

Two interviewees who know the Family Connects model well and one who is very familiar with home visiting models expressed the need to ensuring a proper focus on postpartum reproductive health and tracking follow-up for on-going comprehensive postpartum and reproductive health. One interviewee, while noting the need for Family Connects in general to ensure a balanced approach, noted that Family Connects Chicago "...is doing a great job with both moms and babies."

The reason for concern about a balanced emphasis on both infant and maternal health may, in fact, stem from the way home visiting program financing has been structured administratively in Illinois. Long-term evidence-based home visiting in Illinois have been financed and promoted as an early childhood intervention, and while those programs do attend to family need as well as child need, UNSS could be a stronger frame for integrating the perspective of multiple sectors.

"[There has been] struggle in Illinois historically between maternal and child health vs. early childhood. When MIECHV [federal funding for home visiting] came out, [there was] debate about where it should be housed administratively – in the Title V agency or early childhood development agency. MIECHV didn't go to Title V, so the emphasis was placed on early childhood. As a result, maternal and child support during pregnancy, post-partum period and first year did not become a focus at first."

A statewide UNSS could potentially play a role in integrating the perspectives of multiple sectors on the future well-being of the infant, mother, and family unit.

"UNSS can be the bridge in the maternal and child health and early childhood divided focus".

Alignment of UNSS utilization and outcome metrics with local sector needs

Current UNSS metrics—derived from the randomized controlled trial and replicated through the protocol administered by Family Connects International—are largely relevant and of interest to interview participants.

Of the 23 metrics defined through the trial, 15 were indicated by interview participants as either important to their efforts or currently measured as part of their programming.

Table 1 below provides a cross walk of UNSS outcomes with interviewee sector identification, reflecting the alignment between outcomes sought to benefit mothers, infants, and families with existing programming.

Specific metrics that were selected as relevant across all sectors focused primarily on the assessment of normal development for infants. Maternal physical and mental health were also important to multiple groups, including specific health issues and health promotion (including exclusive breastfeeding, decreased emergency room visits, post-partum depression screening, and completion of post-partum visit by 6 weeks). Additional metrics that were important to interviewees representing various sectors include safety and nurturance (including a home environment free of interpersonal violence, use of car seats, and promotion of learning).

Lastly, there was some discussion around the paring down of existing metrics to ensure greater focus and feasibility.

> *"All [metrics] look great; the list would need to be prioritized and more focused. We need to be more realistic—there are only one to three visits in our model. Bonding and prenatal outcomes may be outside of the scope of our intervention."*

> *"The birth outcomes metric is not typically measured in a post-partum program."*

Many noted that a shorter list might be more appropriately reflective of a home visiting model that consists of only one to three visits.

Table 1: UNSS Metrics/Outcomes Crosswalk Table

	Sectors				
UNSS Outcomes	**Health**	**Public Health**	**Early Intervention**	**Early Childhood Education**	**Child Welfare**
Increase parents who:					
Are bonding with their infant and have positive interactions with their infant	X	X		X	
Are creating a safe and nurturing environment for their infant that is free of domestic violence	X	X	X	X	X
Are increasing their knowledge, skills, and insights into the parenting process	X				
Are experiencing pleasure in parenting	X	X		X	
Are screened for Post-Partum Depression and referred accordingly	X	X	X	X	X
Are continuing their education	X	X		X	
Space their births	X	X		X	
Know what formal and informal community resources are available and how to access those services	X	X	X	X	X
Are utilizing safe sleep practices	X	X		X	
Increase in number of infants who:					
Are born full-term and healthy	X	X	X	X	X
Do not experience Adverse Childhood Experiences (ACEs), including abuse and neglect	X	X		X	
Are exclusively breastfed for six months	X	X	X	X	X
Are immunized and receiving well baby checks with a medical provider	X	X	X	X	X
Ride in safe car seats	X	X	X	X	X
Live in a safe and nurturing environment that promotes school readiness and a lifelong joy of learning	X	X	X	X	X
Are achieving normal infant growth and development or are referred for assessment	X	X	X	X	X
Are bonded with and have positive relationships with their parents and caregivers	X	X		X	

	Sectors				
UNSS/Family Connects Durham Outcomes	**Health**	**Public Health**	**Early Intervention**	**Early Childhood Education**	**Child Welfare**
Parent-focused metrics:					
Mother reported positive parenting behaviors				X	
Connections to community services and resources	X	X	X	X	X
Use of quality out of home childcare					
Maternal report of anxiety and depression	X	X	X	X	X
Completion of maternal six-week postpartum health check	X	X	X	X	X
# of emergency visits for mother	X	X			
Infant-focused metrics:					
# of emergency visits for infants	X	X	X	X	X
Rates of CPS investigations for suspected abuse or neglect	X	X		X	
Quality and safety of home environments	X	X	X	X	X
Quality of childcare for those that chose out of home childcare				X	

Additional outcomes sought for an Illinois UNSS

In their responses, interviewees expressed the importance of capturing metrics that align largely with HEDIS (Healthcare Effectiveness Data and Information Set) measures as a step toward engaging managed care organizations in covering the cost of the UNSS visit.

> *Collection of HEDIS measures is important to the effort to move away from episodic fee-for-service health care delivery and toward a system focused on the provision of high-quality healthcare.*

Interview participants expressed an interest in better understanding the journey of families and how families have been successfully supported through the model.

> *UNSS metrics should capture how the program works to reach all families and how families are connected to resources for identified needs.*

In addition, the tracking of connections to identified community resources was a metric that was expressed by all represented sectors. Most stressed the importance of community resource use as a core tenant of the UNSS model, and would want a statewide program to track:

- types of services to which families are referred
- efforts relating to the coordination of community resources and respective challenges

- benefits associated with successful referrals

The purpose of tracking would be to lay the foundation for identifying best practices in building local community resource systems. A successful statewide initiative would ensure ongoing assessment of local capacity to provide follow-up services as well as capacity for responsiveness and growth at an adequate pace to meet demand.

Braiding and blending of program funds

Participants were asked to share their experiences with braiding and blending program funds as a way to support large scale initiatives (explored further in the next section). Their collective responses highlighted that braiding and blending funds is a current practice in many of their sectors. According to interviewees, effective use of these practices to support a statewide universal home visiting program would require a backbone organization that would oversee administration functions.

> *"[You] need an organization to be responsible for the multiple funding streams and for compliance. [There is a] need to ensure that funds are being distributed equitably…The work of coordination is critical…We would [need a] backbone organization with good transparency."*

Federal and state funding mechanisms currently support specific elements of UNSS programs such as referral coordination and screening services. Some coverage changes are yet to be fully defined; for example, Medicaid only recently approved coverage for home visiting programs in Illinois specific rules yet to be defined.

> *Two approaches to advocacy might be considered: either advocate for changes in existing funding sources so that they cover a nurse-based UNSS or, alternatively, advocate for changes in the Family Connects or other model to make the intervention more amenable to coverage.*

Creating a statewide universal home visiting program opens the door to revising existing federal and state funding streams that currently are not positioned to fully support this work.

> *For example, existing Family Case Management or Better Birth Outcomes (Illinois Department of Human Services intensive perinatal case management) programs might be transformed to contribute to UNSS statewide.*
>
> *Title V funding has been made available to a limited extent to provide program funding and may be a valuable resource for partial funding—such as for start-ups, or to support regional councils—if an Illinois UNSS becomes a statewide priority.*

Several foundations, including those responsible for this study, have been consistent thought leaders and architects of PN3 programming, with an intent to provide an infrastructure to

provide early childhood resources for parents and families. UNSS may indeed play an integral part within a larger PN3 picture. For example, UNSS is a potentially important component of the Community Parenting Saturation Project, a multi-year, multi-million-dollar effort with planning underway in Aurora, Rockford, and North Lawndale in Chicago. Anchored by philanthropy, led by Illinois Action for Children along with a board of advisors and administered by local lead agencies, this project aims to promote school readiness. Among the many initiatives supported by the project is a small-scale pilot, currently being planned, to initiate Family Connects in partnership with a health system.

Across our many conversations, experts expected that a combination of Medicaid, private insurance, and foundations are likely potential funding sources to support a statewide UNSS in the future.

DELIVERABLE #2: FINANCING AN UNSS SYSTEM

Over two decades ago, James Heckman's Nobel award shined a light on the economics of human development, establishing that investment in early childhood yields long range value. Among the many forms of programmatic investment in early childhood, programs that include home visits play a prominent role, long supported both by public programs and private philanthropy.

Home visiting programs, including universal early postpartum nurse home visits, are designed to achieve a range of outcomes, drawing on funding from a variety of public and private sources. Programs that serve infants, young children and families at home frequently rely on "blending and braiding" funds from multiple sources to maintain a predictable level of program sustainability and growth.

To facilitate discussion of how an UNSS might be implemented in Illinois, we have identified various avenues by which a universal nurse-based Illinois program might be financed.

Home visiting programs in Illinois

Currently, while a few Illinois communities offer an UNSS program, several offer voluntary home visiting for families at some level of perceived risk.

Most current Illinois home visiting programs, whether universal or risk-based, draw on some level of government funding. Most agencies draw on more than one government source, often supplemented by private funding.

About 300 home visiting programs serve Illinois families of infants and young children. The federal, state, municipal, private philanthropic and institutional funding sources that support each home visiting program generally specify goals for the home visit, as disparate as promoting health, preventing child maltreatment or adverse experiences, and preparing children for school success.

Universal newborn support programs in Illinois

Distinct from the many home visiting programs in Illinois, the model developed and evaluated by the Durham-based Family Connects International is the sole UNSS approach consisting of a visit by a nurse in the first month, offered for all births, that has been rigorously evaluated through multiple randomized controlled trials. This is the model considered in this review of financing for an UNSS program in Illinois.

The Family Connects model has been widely consulted by experts seeking to replicate program successes. Family Connects International, a program of Duke University and affiliated Center for Child and Family Health, provides technical assistance to governmental, health care and other non-profit entities to replicate this specific intervention with fidelity. The program offers "full

support for successful implementation, including building community alignment, training nurses, providing screening and assessment tools and a robust data system."[i]

With technical assistance from Durham experts, the Family Connects program has been successfully replicated in several states including in a handful of communities in Illinois, meeting specific replication criteria with fidelity:

- Visit by a nurse in the first month
- Community alignment
- Data collection

Our state's Family Connects programs operate in Chicago, Stephenson County, and Peoria, with a program in the early planning stages in Kane County, each embedded in their communities in distinct ways. Several other communities have assessed their readiness to implement a Family Connects program but lack the funding to launch the program.

An additional universal evidence-based nurse home visiting program, the Carle health system's Family Foundations (as part of their larger Healthy Beginnings program for families who deliver at Carle Foundation Hospital), offers a visit to families of newborns in the Champaign, Urbana, and Savoy areas. Family Foundations is based on the Family Connects model and is operated and funded by the Carle system; the UNSS component is a piece of a larger home visiting initiative.

Current financing of UNSS in Illinois

The Family Connects model programs operating and under development in Illinois all draw on multiple revenue sources that are customized by community, rather than being grounded in a core set of foundational funding streams that are consistent across communities. The lack of foundational funding available to all communities and over-reliance on local communities' abilities to navigate coordinating multiple funding streams present a barrier to further expansion. In fact, no single model of financing stands out as being readily replicable statewide.

A list of the multiple funding sources for nurse-led Illinois UNSS are detailed below. (Note: For a cost model for Family Connects, see HV Cost Model Narrative, Start Early, October 2019.)

Maternal, Infant, and Early Childhood Home Visiting (MIECHV) is a federal program that funds states to provide for home visiting, following one of several approved evidence-based models, to coordinate services and support infant health and development for families meeting risk criteria.

MIECHV is a program of the federal Maternal and Child Health Bureau (MCHB) of the Health Resources & Services Administration (HRSA). In Illinois, the MIECHV program is now housed within the Division of Family and Community Services of the Illinois Department of Human Services (IDHS) and currently provides partial funding support to the Family Connects programs in Peoria and Stephenson County.

As a recognized evidence-based home visiting model, MIECHV is a source of funding for some of the Family Connects programs in Illinois. While the MIECHV program design is intended to focus on families at risk, which is seemingly at odds with universal newborn support, the Family Connects program effectively accomplishes family engagement which is a covered MIECHV intervention.

The MIECHV program is intended to help states leverage their Title V Maternal and Child Health (MCH) Block Grant program funding to assure newborn access to health care, especially for low-income families. MIECHV supports Coordinated Intake programs which offer a connection to ongoing home visiting for low-income, high-risk families. The Family Connects programs refer families in need of follow-up home visiting to the MIECHV-funded Coordinated Intake programs in their communities.

Illinois State Board of Education (ISBE) supports various home visiting programs including Family Connects model programs in Illinois through its Prevention Initiative, funded primarily through state general revenue funds. IDHS is the lead agency for coordination and administration of ISBE programs.

Federal COVID-19 relief funds, passed through to the state, have helped this year to partially sustain regional councils for one Family Connects program. These councils, a critical component of the Family Connects model, help identify and maintain program linkages with local services to respond to issues identified during the nurse home visit.

Illinois Maternal Child Health Title V Block Grant, which is administered by the Illinois Department of Public Health, is the largest funder the Chicago Family Connects programs in Illinois. The funding supports all components of the program: nurse home visitors, community alignment boards, and data, as well as administrative leadership for the program. This funding could potentially be used to finance portions of a larger UNSS statewide initiative.

Illinois Department of Human Services is providing pilot funding to the Chicago Family Connects community through a mix of state general revenue and Title XX Social Service Block grant funds. Funding supports the home visiting component of the program.

Competitive grants may hold some promise for future funding. A HRSA planning grant[ii] was awarded to IDHS in July 2021 entitled, “Illinois Early Childhood Comprehensive System: Health Integration Prenatal-to-Three project (IL-ECCS).” The planning grant will be helpful to UNSS program expansion in Illinois as part of a broader effort to integrate state PN3 programs.

Municipal funding has also supported Family Connects programs in Illinois. In Stephenson County, for example, the County Board has provided direct grant support, which in turn, served to match funds from a private philanthropic grant source. While not considered a sustainable source of program funding, the County has played an important role in the braided and blended funding for their perinatal and early childhood service system. In Chicago, municipal funding is supporting the regional community alignment boards of the Family Connects program.

Hospital support, both in the form of direct funding and indirect support, has been essential to the launch and sustainability of the Illinois UNSS programs as well as to other home visiting programs across the state. In addition to the contribution of direct funding, the non-financial support of hospital leadership and the labor and delivery teams has been key to program success. Many birthing hospitals help facilitate the first point of engagement with families at the hospital, an effort that requires commitment of staff resources to facilitate collaboration with the UNSS programs.

The Family Connects program in Chicago—a collaboration between the Chicago Department of Health, four hospital systems and philanthropy—has demonstrated the economic value of hospital involvement to program success. For example, Rush University Medical Center allocated direct financial support to build infrastructure for their UNSS-related program operations, adding a care coordinator to help make a connection between prenatal care and an initial nurse visit. All four hospitals contribute personnel resources to help assure program success, ranging from labor and delivery staff time to the resources of individual leaders for participation in collaborative planning and administration.

Healthy Beginnings/Family Foundations in Champaign Urbana is an example of a universal nurse-based home visiting program directly supported by an affiliated birthing hospital. Operating in Champaign and surrounding communities, Carle supports its Healthy Beginnings program, funding all aspects of the program, either directly or through their health plan. Their own affiliated managed care system currently pays for visits for women and newborns covered by this plan, but the program is offered universally for to support all newborns born within the system. The future vision is to engage other insurers as well in covering visit costs.

Baby TALK in Decatur (developmentally oriented home visits by trained lay professionals) is a universally offered hospital-supported program but is distinct from other models studied in that it is not nurse-based. It is listed here as an example of an investment that a hospital is willing to make in a universal community-based perinatal system. In addition to funding for staff leadership, the two local hospitals in Decatur pay for Baby TALK supplies given to families including board books and child development tools. Representatives of both hospitals sit on the Baby TALK organization's non-profit board.

Public health departments also contribute personnel resources in kind to anchor UNSS planning as well as the coordination of follow-up services. For the current Family Connects programs, the local health departments receive data on program participation and resources requested by families, and in response, they work in partnership to fill identified resource gaps.

Health departments can serve as the local fiscal home for the UNSS intervention and related programming. For example, in Chicago and in Stephenson County, the health department is the locus for the administration of multiple PN3 resources, including Family Connects. This helps provide a larger programmatic and financial context for service delivery. Local health departments often also administer related federal Title V programs that may complement UNSS services, and these funds could potentially be leveraged to support UNSS services.

Medicaid and private insurance contribute indirectly to the UNSS model, given that initial family engagement during the labor and delivery hospital stay is a factor in programs success. Labor and delivery costs are typically paid by insurance for most families.

State Medicaid funds are matched by the federal Centers for Medicare and Medicaid Services (CMS) which administers the program. CMS is part of the federal Department of Health and Human Services (DHHS). Currently, none of the Family Connects programs in Illinois bill Medicaid for the nurse home visit. However, recently enacted legislation directs Medicaid to cover a post-natal visit and could be implemented to cover a visit as part of an UNSS. In April 2021, Illinois became the first state to receive a CMS waiver, valid for three years, to cover maternal and child health for up to one-year post-partum. This waiver may provide a window for coverage of the UNSS visit and program.

The nurse home visits provided by Carle health systems Healthy Beginnings/Family Foundations program are covered in part by the Health Alliance plan for covered participants. The system has reached out to other commercial insurers for coverage of the nurse home visit, with limited success. To cover the full cost of the program, Carle provides direct financial support.

Private philanthropy has been critical for seeding Family Connects programs start up (including recruitment, training, and the launching of operating, data collection and analysis systems) and to fund key elements such as "community alignment boards" that assure UNSS program integration with an available network of follow-up resources. Further, philanthropy has led the way to establish larger PN3 efforts, of which UNSS may be considered as a critical component. None of the Illinois programs depend solely on private philanthropy to sustain the actual nurse home visit. For Family Connects Chicago, private philanthropy is supporting the evaluation of the pilot.

Additional funding for complementary and related programs

The Family Connects programs in Illinois coordinate with a rich array of other complementary programs for which eligibility is selective rather than universal. Three federal programs of note coordinate with the Family Connects programs and the state's Family Case Management program to extend additional supports to families in need.

Early Head Start is a program of the federal DHHS, Administration for Children and Families, providing direct grants to eligible agencies that provide prenatal through age three services including home visiting. The intervention is evidence-based, offered by a credentialed visitor but is not a nurse-based program. IDHS is the administrative lead agency for coordination with the Illinois Head Start Association.

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides nutrition and health promotion for pregnant women and children through age five and collaborates with the state Family Case Management program which provides nurse-based home visiting. Administered by Illinois Department of Human Services through grantee agencies,

the WIC program is funded by the Food and Nutrition Service of the United States Department of Agriculture.

Adverse Pregnancy Outcomes Reporting Systems (APORS) is administered by the Illinois Department of Public Health to track adverse outcomes and offer a home visit by a public health nurse within two weeks of birth for infants meeting specific birth outcome criteria. Follow-up case management home visits can continue for up to two years. This program is funded by Illinois General Revenue Funds and Social Service Block Grant funds from the federal Administration on Children and Families.

These related resources may have potential for being woven into a future statewide system to meet comprehensive UNSS purposes.

Table 2A: Examples of Nurse-Based Home-Visiting Programs in Illinois That Are *Not Universal*

Program – model	Purpose	Funding	Organization
Nurse-Family Partnership (NFP)	Home visiting for at risk families by a nurse to promote health and development	Private funds; formerly funded by MIECHV	National program contracting locally with agencies that replicate the NFP model with fidelity
APORS	Public health nurse visit followed by case management following an adverse birth outcome	Illinois general revenue funds; Social Service Block Grant funded by the Administration on Children and Families	State contracts with public health departments and in turn with local organizations
Medicaid and commercial managed care plans	Nurse outreach, frequently by phone, to families of newborns with known risk	Managed care organizations	Medicaid and private health insurance plans contractual obligations or voluntary designs to improve health status

Table 2B: Examples of Universal Home-Visiting Programs in Illinois That Are *Not Nurse-Based*

Program - model	Purpose	Funding	Organization
Early Intervention	Evaluation offered universally without income criteria to assess for developmental delay	IDHS	Private agencies statewide contracting with the state
Baby TALK (Teaching Activities for Learning and Knowledge)iii	Home visiting birth to three initiated in the hospital to promote school readiness	ISBE, Early Head Start, hospitals, private funding	Baby TALK, Decatur

Non-financial resources

The start-up and sustainability of current Illinois UNSS programs depends on expert leadership, both from within the lead agency as well as from the surrounding eco-system interested in advancing newborn support.

Organizational infrastructure within the three lead agencies administering Family Connects programs in Illinois contribute to program success. Program executives who oversee multiple programs are able to exercise the advantages of scale that can contribute to program excellence and sustainability. For example, a large agency that administers an UNSS program may have resources for such important functions as nurse recruitment, data collection/analysis, external relations management, and grant-seeking to help support the UNSS program. Given equity issues across the state, some communities do not have existing infrastructure, which puts them at a disadvantage for program implementation.

> *"Having an infrastructure to address perinatal through early childhood programs is important. Because we have an existing service infrastructure, we were able to secure County funds to launch a pilot. This pilot was needed to secure the support of the birthing hospitals in our area."*

Technical support from staff experts in multiple agencies and organizations, including the Durham-based Family Connects International, Start Early, and the Governor's Office of Early Childhood Development, has been of value in promoting consistent program implementation, successful intervention, and potential for growth.

Regional councils (also known as "community advisory boards") represent an important component of the Family Connects model. By design, these councils, which meet at least quarterly, provide a resource for area planning based on data from the UNSS home visits. The community advisory boards, supported in part by UNSS program funds, play a role in differentiating and coordinating various newborn home visiting activity. Further, these community boards play a foundational role in building local community support and service systems to address unmet needs identified through UNSS visiting.

> *"UNSS only works to the extent there is a rich array of resources to in fact support families once their needs for support have been identified."*

> *"Case conferences at the regional council level have been useful in identifying barriers and gaps faced by families and for building a case for response."*

Momentum toward UNSS in Illinois

Resources to explore UNSS are currently in place to address the administrative and programmatic divide both within early childhood programs and also between early childhood and other community-based services primarily oriented toward health, education, and child

welfare for young children and their families. In July 2021, IDHS was competitively awarded Early Childhood Comprehensive System (ECCS) federal grant funding from the HRSA Maternal and Child Health Bureau to support service integration, planning, and expansion, and to further strengthen connections between health care and early childhood service providers through the adoption of a universal newborn support system. The Family Connects pilot communities are among the many agencies and initiatives that will be tapped for their insights as part of this planning effort.

As interest in creation of a statewide UNSS effort continues to unfold, the creation of a regional structure could be important to future UNSS planning. Among the many critical questions to address as UNSS systems are developed are: (1) how to integrate interests across sectors in maternal & child health, early childhood care & education, and child welfare, and (2) what local agency is best positioned by the fiscal and administrative leads for UNSS. These questions may be usefully addressed as PN3 planning proceeds, especially if UNSS is seen as a gateway into PN3 programming.

The recommendations of several recent task forces, with both public and private representation, signal an interest in expanding resources for voluntary home visiting for newborns. *Yet unresolved questions remain as to whether home visiting should be offered statewide, universally and with visiting by a nurse*. Considerable interest, however, continues in visits by professional or trained visitors other than nurses, with public funds allocated to support visiting for those most in need. As of this year, Medicaid coverage has been authorized for several professional and lay home visitors. Newly authorized Medicaid coverage for home visiting by doulas recognizes the importance of the post-partum home visit for maternal health.

Examples of recent Illinois task force recommendations aligned with UNSS include the following (further details are noted in the section *Mapping Perinatal Health Initiatives*):

"Ready Illinois: Simpler, Better, Fairer: Recommendations of the Illinois Commission on Early Childhood Education and Funding," Spring 2021.

- *Recommendation*: Leverage, centralize and integrate early childhood education and care programs, including newborn home visiting, consolidating funding streams to serve young children and families.
- *Commentary*: This will relieve administrative burden while strengthening service providers. Further, this will make access to services easier to navigate for families than the current "disjointed" and "bewildering" current array. A consistent, accountable funding system will make it possible to identify and address inequities and gaps in service.
- *Alignment with statewide UNSS*: This report recommends program consolidation and integration of funding to move toward sustainable financing; these recommendations prioritize service for low-income families and are silent on the Family Connects concept.

"2020 Report to the General Assembly: Illinois Task Force on Infant and Maternal Mortality Among African Americans," January 2021.

- *Recommendation:* Reimburse and offer greater access to a comprehensive array of maternal and child health services.
- *Commentary:* This task force advocates unbundling of the prenatal/delivery/postpartum visit in favor of a postpartum care bundle to be covered by Medicaid and other insurers, covering a range of professional, certified, and trained navigators.
- *Alignment with Statewide UNSS:* This report explicitly recommends increasing access and support for Family Connects as well as other perinatal support programs.

Illinois Maternal Health Strategic Plan, 2020 - 2024; Version 1 - February 2021 Working Draft, and *State MHI Strategic Planning Meeting Summary 3/29/2021; I Promote - IL (Innovations to Improve Maternal Outcomes in Illinois) and UI Health.*

- *Recommendation*: Increase funding for community-based perinatal support including home visitors; expand the number of communities that offer a system of universal supports across the continuum from early prenatal care through one year postpartum.
- *Commentary*: This report recommends advocacy to expand Medicaid funding for evidence-based home visiting and doula services.
- *Alignment with Statewide UNSS*: This report highlights that successful advocacy could help expand Family Connects to Medicaid beneficiaries; their recommendations also point to the value of increasing the number of communities with a universal system.

Illinois Prenatal to Three Policy Agenda, Raising Illinois, February 2020.

- *Recommendation*: Broad PN3 service expansion, anticipating increased services for 200,000 children and families by 2025.
- *Commentary:* This analysis views home visiting as one of six pillars of PN3 policy and recommends identification of sustainable sources of funding for UNSS expansion.
- *Alignment with Statewide UNSS:* This report projects that 30,000 new parents of newborns (20 percent of total) could be offered a nurse home visit through expansion of UNSS within 10 communities and four Chicago hospitals.

Legislation and other mechanisms for expanded funding

On April 12, 2021, Illinois received the first-in-the-nation CMS waiver for Medicaid coverage up to 1 year postpartum through 12/31/25.[iv] Recently enacted state legislation, The Illinois Health Care and Human Services Reform Act (Public Act 102-0004)[v], aims to eliminate inequities in the state's health care system based on race and other factors including low-incomes. Signed into law on April 27, 2021, it includes a key provision that will allow Medicaid reimbursement for approved home visiting: "…rate of [Medicaid] reimbursement for home visiting and perinatal doula services. (Article 175)" Improving Health Care for Pregnant and Postpartum Individual Act

(SB0967)[vi], sent to the Governor for signing on June 25, 2021, will allow nurse home visitation under Sec 5-5.24, which calls for universal postpartum visit within the first 3 weeks after childbirth and a comprehensive visit within 4 to 12 weeks postpartum for Medicaid eligible recipients. While this recent legislation opens the door to Medicaid funding for expansion of Family Connects programs in Illinois as well as other evidence-based home visiting programs, it does not specifically call for a universal system, and does not limit funding to nurse-based home visiting.

Enactment of the legislation, including rate-setting, is possible in 2021. While important for program expansion, Medicaid billing and coordination with Medicaid managed care organizations may represent a steep learning curve for some providers of newly covered services. A technical assistance effort for providers on Medicaid billing, such as that offered to health and human service providers by the Illinois Collaboration on Youth (ICOY), may be useful for promoting implementation.

States have a number of options for expanding Medicaid services for pregnant women and children. Among those most likely to be beneficial for Medicaid funding for a statewide UNSS program would be:

- Continuation of Administrative Case Management, giving the state some limited opportunity to draw federal matching funds for assisting with outreach and service coordination,
- An 1115 waiver to expand Medicaid eligibility, giving the state federal permission to cover nurse-based home visiting to an even broader population, and
- Targeted case management, giving the state an opportunity to finance an explicit evidence-based model of home visiting by a nurse; this would require a State Plan Amendment.

These mechanisms have all been used or contemplated for use in other states to extend Medicaid coverage for home visiting Including for their Family Connects programs.

Illinois stakeholder insights

Illinois health sector leaders, advocates, educators, and stakeholders interviewed between February and May 2021 identified multiple benefits and challenges associated with the concept of implementing a statewide UNSS system. The recommendations and insights dealt with the concept of universality, the selection of an UNSS model, the complexities inherent in program implementation, the limited availability of nurses in some parts of the state, the challenges of service coordination at the local level, the potential insufficiency of local follow-up services, and the potential opportunity for coverage by Medicaid and private insurance.

Three critical issues emerged related to program implementation:

Addressing racial, ethnic, and social inequities: Planners are cautioned to maintain a racial and social equity focus in the design of a future statewide UNSS program and to seek ways to address racial and ethnic health disparities through program financing and administration. Specifically, UNSS programs should not be built to simply sit on top of inequitable delivery systems in communities in which the service infrastructure is spare relative to the needs of underserved racial and ethnic populations. Rather, a statewide UNSS initiative should plan for ways to bring a fully resourced program to areas of specific need and affected by racial and ethnic disparities.

Integration of multiple professional disciplines and programs: Historically, Illinois agencies and professional experts responsible for maternal and child health and those concerned with child development and welfare have typically operated at various levels of isolation. Several experts noted that different professional disciplines maintain distinct approaches to issues associated with health, development, and well-being, in turn giving rise to prenatal and early childhood programs that operate with separate goals and interventions. For example, as they consider UNSS planning, some advocates may focus on maternal health and child health beginning in the perinatal period, while others may focus entirely on child development. Unless these professional issues are recognized and addressed by bringing multiple disciplines together, public and private sector leaders inadvertently risk replicating these divisions as they seek to build a statewide UNSS infrastructure.

Blending and braiding of funding: No Illinois UNSS program is funded by a single source, and all programs currently operate under some shadow of resource constraint, influenced by the way in which their funding is "blended and braided." UNSS program leaders face several program management issues in common as they finance an infrastructure to operate, sustain, and expand their programs: securing a point of engagement with families, assuring complete data collection, replicating the Family Connects model with fidelity, and establishing an infrastructure for long-term success.

Illinois reflections on opportunities and challenges

The intent of a statewide UNSS program is to assure access for *all* families of newborns. To achieve this, one avenue is for the visit to be covered by both Medicaid as well as commercial insurance, assuring a sustainable revenue source for service delivery for the majority of families accepting the offer of a visit.

Both commercial and Medicaid managed care plans in Illinois see the UNSS concept as aligned with their values and worth exploring. Most plans employ "community connections" teams that seek to reach out and offer assistance, often by phone, to provide referral information to families thought to be at risk. One Illinois plan's parent corporation supports Nurses for Newborns in another state, a home visiting program for families with identified risk factors (though not listed as a federally approved evidence-based model).

Illinois plans have also been involved in newborn home visiting pilots. For example, one plan supported a demonstration in southern Illinois in which home visitors rounded with the staffs of a small group of Federally Qualified Health Centers (FQHCs) to help identify and connect with high-risk pregnant women. (The nurse home visit can be billed for mothers and babies covered by Medicaid at the FQHC's enhanced rate only if the visit is made by an advanced practice nurse, physician assistant or physician.)

Several Illinois health sector leaders, advocates and PN3 stakeholders interviewed between February and May 2021 identified multiple benefits and challenges associated with the concept of implementing a statewide UNSS system.

Regarding universality…

On the concept of a universal system, one plan executive noted, "Those of us who are parents know that we can all use it. All parents of newborns could benefit from at least an initial visit."

In contrast, one stakeholder commented that in a state as financially constrained as ours, our limited resources should be allocated based on need. A program that is "nice to have" may not be a sufficiently high priority to implement universally.

Regarding program implementation…

Recruitment of nurses for home visiting may be challenging in times of nursing shortages, especially in less populous parts of the state. To address potential nursing resource gaps, stakeholders recommended (1) the use of telehealth to provide the UNSS visit, as has been demonstrated during the past year due to the pandemic; (2) reaching out to the network of parish nurses and nurses connected with rural faith-based organizations; and (3) involving Rural Health Centers in the program.

One strategist pointed out that "program integration is really hard." We run the risk of succeeding in implementing nurse home visiting while falling short in connecting families to an integrated network of services. "An UNSS program will only be effective only to the extent that needed services are indeed available and accessible."

Starting with a limited program or a pilot was important for the launch of some of the Illinois programs with a home visit by a nurse. Pilot data and experience was useful in securing both hospital and local government support for longer term investment in the program.

Regarding the UNSS model…

According to a plan executive, the model selected should also be aligned with HEDIS measures and attend to social determinants of health such as nutrition and food security.

Another leader suggested, "to succeed as a universal program, a statewide UNSS program should fit with priorities set by the Illinois Health and Family Services (HFS) for Medicaid program investment."

The UNSS home visit could become a strategy for addressing maternal morbidity and mortality which is a current priority of health and business sector advocates and elected leaders. According to several observers, the UNSS visit should focus on the health of both the mother and the child and be used to help encourage the mother's post-partum visit.

Regarding program administration to address service coordination…

Noting the potential for duplication of resources, one stakeholder suggested that "home visitors might be tripping each other at front door of these families. Implementing a statewide UNSS program will require the state to rationalize our many systems of home visiting."

Integration of multiple programs can challenge UNSS programs locally given the array of risk-based programs operational across the state:

- In some areas, multiple home visiting programs fall under the jurisdiction of one organization, such as the health department, which can help mitigate duplication of services.
- By design, Family Connects programs in Illinois are intended to avoid duplicative visits by other nurse home visiting program such as Nurse Family Partnership. For example, if another nurse-based relationship has been initiated, the Family Connects program would not proceed with a visit.
- On occasion home visits by two cooperating entities are made in tandem, for example a Family Connects nurse might join with a WIC nurse for an initial visit.
- The home visiting programs may work sequentially. For example, Family Connects nurses are a significant referral source to MIECHV-supported Coordinated Intake for follow-up home visiting services.
- Active Coordinated Intake and Family Connect community alignment boards both serve to mitigate the risk of unnecessary duplication.

Given that home visiting programs must be coordinated locally, UNSS lead agencies should have the capacity to navigate among the various programs locally available. Active Coordinated Intake and Family Connects regional councils both serve to mitigate the risk of unnecessary duplication.

Regarding insurance payment…

Use of an evidence based UNSS intervention is attractive to medical insurance plans, particularly as their brands are associated with preventive and wellness-oriented services.

One advocate suggested that a statewide UNSS program could gain momentum if offered by payers to providers through a capitated risk-sharing arrangement. "While you might get push

back against mandating plans to reimburse the UNSS visit, paying for better outcomes might be attractive."

Several advocates view insurance reimbursement as an eventual possibility for the UNSS visit. Already, insurers have invested in post-partum follow-up calls to patients and some even reimburse hospitals to make these calls, typically focused on the follow-up appointment. The UNSS visit would accomplish this, but with a nurse and an evidence-based approach.

Finally, one plan executive commented, "There is always a path. This is the time to be creative as we are reinvesting in communities."

Illinois UNSS implementation experience

No UNSS program is funded by a single source, and all programs currently operate under some shadow of resource constraint, influenced by the way in which their funding is "blended and braided." The way in which various programs have resolved inherent tensions around resource allocation is important for understanding how a future program may be designed and financed.

Data collection for replication with fidelity

The Family Connects programs in Illinois as well as those around the country are invested in replicating the model with fidelity to achieve the proven outcomes of the program, both clinical and financial.

The program requires collection of specific data in a Salesforce database linked to Family Connects International. While data collection and analysis are important components of UNSS initiatives, questions remain as how data would be managed within a future statewide system.

- Like many states, Illinois lacks a consistent maternal and child health system data infrastructure. The Family Connects database would add to the many operational data collection systems currently in use to portray health status.
- A few market-dominant electronic health record systems have taken hold in Illinois, and with them, a few systems have focused on integration of information regarding medical, behavioral, and social determinants of health status. As these systems emerge, their linkage to the Salesforce or other UNSS database would be an asset to the UNSS system.
- Medicaid managed care entities could have an interest in collecting UNSS visit data, and perhaps could build out their systems for UNSS data sharing using administrative funds paid to them by the state.

Focusing on the mother as well as the child

The Family Connects model has been noted by some experts as one that skews toward emphasis on the infant, and in response, leading advocates suggest that an UNSS system needs to ensure a balanced scope. "The home visit should be seen as part of the reproductive and perinatal

continuum of care, centering on the mother's needs as well as on the newborn and family." This could be potentially accomplished by focusing on service components and standards, such as attendance at the post-partum visit, without sacrificing fidelity to required elements of Family Connects model. Family Connect Chicago was noted by one interviewee as successfully balancing the focus on the mother and the infant.

Local decision regarding the model

If UNSS becomes a statewide system, the question emerges as to what visitation model might be chosen. With planned regionalization of services by the Early Childhood Transformation Team, the infrastructure may be emerging for local decision-making regarding the UNSS model that each jurisdiction would choose to implement. This decision may be restricted to models that are evidence-based, with the visit conducted by a nurse.

Some program leaders would like to see a universal system that allows for an initial visit by a professional other than a nurse as a substitute for an early postpartum nurse home visit. This may be due in part to respondents' familiarity with home visiting models, leading to some confusion about the value of the nurse UNSS visit as a model that is entirely distinct from home visiting.

The choice of home visiting intervention may be guided in part by federal standards for understanding the effectiveness of evidence based early childhood home visiting programs. The Home Visiting Evidence of Effectiveness (HomVEE) review, provided by DHHS, has identified 19 home visiting models that are eligible for MIECHV funding based on their effectiveness. Several of these HomVEE authorized programs are operational in Illinois, and a handful specify that the visit must be made by a nurse:

- Family Connects, which is offered universally
- Nurse Family Partnership, which serves families at risk

The local decision regarding the home visiting model has been guided to date through the involvement of local leaders and advocates in partnership with birthing hospitals, family service organizations, public health departments and early childhood agencies. The lead agency for UNSS administration has included a variety of entities, including the health department, hospital, and multi-service private agency.

Point of engagement

While seemingly a small part of the total UNSS program, engaging the family to offer the UNSS program can in fact represent a program implementation challenge. While engagement should reasonably be attempted in the hospital, not all hospitals will be ready to offer consistent collaboration, and not all UNSS programs will have sufficient nurse staffing to reach all new mothers prior to discharge. Engagement of the wider health care provider community – pediatricians, OB/GYNs, and family medicine providers – is key to reaching families and

improving uptake of the service. These are among the many considerations that communities will face as they organize locally to implement an UNSS program.

Infrastructure for success

Several Illinois UNSS programs are embedded in larger systems— for example, a hospital system or network of hospitals, or a local health department. This provides multiple advantages for UNSS program operations. Large systems can afford to attract and retain seasoned administrators who know how to secure and integrate multiple funding sources to sustain their programs. In large systems, staff teams draw on internal networks of professional colleagues, potentially helping with retention and sharing of expertise. When one agency administers multiple programs which include a home visit—such as both Family Connects and WIC home visiting—the visits can be coordinated to best benefit the family.

The synergies within these systems can be considered as having some financial value, for example, contributing infrastructure and professional leadership that may not be directly covered by the grants and contracts that support the UNSS program. For this reason, several Illinois leaders pointed to having sufficient program scale as a success factor in maintaining financial stability—either within the UNSS program itself or within the systems in which they are embedded.

Implementation insights from other states

The American Rescue Plan calls for specific investments in PN3. Family Connects programs will be among the organizations eligible to apply for the up to $150 million potentially allocated for home visiting programs.

For more than a decade, several states have pursued UNSS and are working on a gradual progression to offer this service without financial barriers to all families. In all cases, program architects seek a combination of public and private dollars to sustain and expand their programs. Reports one administrator, our current financial goal is to “secure sustainable funding from at least one medical payer, at least one public funding source, and ongoing philanthropic dollars.” Experiences in pursuing UNSS in Oregon, California and Texas have been instructive for Illinois leaders with regard to potential UNSS financing in our state.

Legislation

The state of Oregon is the nation’s leader in passing legislation to require coverage for an UNSS visit based on the Family Connects model, achieved under the legislative leadership of a physician champion in the state senate. The legislation achieved bi-partisan support from progressive and moderate leaders. The initiative hinged on clarification that the program would be voluntary for families.

The UNSS concept gained support through the efforts of working groups with broad representation including physicians and payers, drawing on momentum from years of innovative health promotion and expansion efforts that have succeeded in the Oregon legislature.

The Texas legislature is currently taking on the issue of scaling UNSS across the state, following from the efforts a diverse coalition, led in part by a child protection policy and advocacy non-profit. Momentum to expand UNSS, either legislatively or through voluntary efforts, sits within a broader PN3 agenda framed by coalition partners to reach 300,000 children. Their advocacy effort has extended to local businesses through chambers of commerce.

Insurance financing

The Oregon UNSS legislation specifies that Medicaid managed care and commercial payers must cover the cost of the service (though self-insured plans are not required to participate). Plans will pay health departments for the service. This includes a small fee to cover management of the program database and local advisory boards to help identify and respond to gaps in service. Rate-setting is underway for the visit plus administrative costs, as is the development of a process for defining Family Connects as a preventive service in order to secure the participation of high-deductible health plans with approval from the IRS.

In Tarrant County, Texas, the North Texas Family Connects program – My Health My Resources (MHMR) - operates within the second largest community center in Texas with more than 50 locations. MHMR covers the cost of the Family Connects visit for its own employees through its own self-insured plan. By starting with their own plan, they will be able to model the benefits and outcomes for their employees and for their plan that they are able to achieve by covering the service.

The Texas business communities will continue to be important constituents as advocates continue to seek coverage for UNSS. Notes one Texas advocate, “We are thinking that we may have more success reaching out to businesses rather than MCOs to cover the program. Businesses may like the concept for their employees.”

To address the cost of implementing a statewide UNSS program, Texas Health and Human Services may apply to CMS for a State Plan Amendment to modify their Child Health Insurance Program (CHIP) program to secure an allocation of up to $35 million to help match the cost of their UNSS expansion.

Other revenue sources

As in Illinois, several programs across the country started with seed funding for a pilot, either from private philanthropy, a hospital foundation or local government source.

In California, First 5 LA, an independent public agency, has supported an UNSS model, Welcome Baby, for over a decade, initially starting with a pilot effort that drew on an investment of tobacco settlement funds. First 5 LA continues to fund UNSS across LA County, remaining

agnostic regarding the intervention model. (Welcome Baby, the first model implemented, is not a MIECHV supported home-visiting model.) Program revenues are currently supplemented by Medicaid administrative funds to support the outreach component.

MIECHV and private philanthropy have been primary funding sources for UNSS in Texas in addition to Medicaid MCO and other insurance contracting. As in Illinois, Title V funds in Texas do not offer a sustainable financing source for home visiting. However, the Texas Title V program provides seed funding for program start up.

Texas intends to apply for federal competitive grants to help cover the cost of expansion and continued operations. In Austin, partial program support may come through a federally funded research collaboration with University of Texas. To support a program model well-aligned with Substance Abuse and Mental Health Services Administration (SAMHSA) direct funding priorities, a Texas Family Connects program will seek federal grant support to collaborate with an FQHC which is also a substance use treatment provider to help with program adherence.

While private philanthropy provides critical support for UNSS programs across the country, not all private foundations prioritize funding for the UNSS model. “Foundations struggle with funding universal home visiting, especially because the program serves all families including those with private health insurance.”

State infrastructure and regional administration

In Oregon, regional community leads, ultimately responsible for certifying program fidelity to the Family Connects model, will administer the program through service providers. The community leads will receive a small allocation of the UNSS fee paid by insurers. Private foundations will likely provide some additional support for these systems, given stretched capacities of the local health departments.

The goal of the Oregon program is for each regional hub to operate a program that is self-sustaining at the local level through “all payer” contributions and that sits within the local system of care. (Of note, the map defining these regions is not fully aligned with the map designating Coordinated Care Organizations—which bring providers together to deliver community-based care to promote population health.)

In Texas, the Department of Family and Protective Services, Prevention and Early Intervention Division will serve as the administrative home for blending and braiding UNSS funding. The agency would integrate new funding to assure program continuity, including Medicaid administrative funds that have been untapped, with the goals to “build, sustain and scale” the program statewide.

In Texas, the UNSS program is currently operated by local agencies. To our knowledge, Family Connects is the only universal evidence-based model being implemented.

In the Dallas Fort Worth area, for example, the administering agency is a large multi-service non-profit with a strong Early Childhood Intervention (ECI) program administering Family Connects along with other programs to support families of young children. While not a MIECHV-funded provider, their ECI programs draw on general revenue funds and a significant number of other revenue streams.

In Austin, Family Connects Texas is a program of the United Way of Austin in partnership with the health department. The United Way offers substantial community alignment capacity to Family Connects, with deep relationships both with the business community and the network of faith-based and other private social services.

Indirect support for infrastructure

As in Illinois, size and scale confer some benefits to the administration of UNSS. For example, in Texas, "the Early Childhood Intervention program model, of which Family Connects is a part, operates with a 'systems framework' and a logic model that calls for family engagement, community and faith-based relationships, and a provider community supportive of evidence-based practice." This systems framework allows the parent program to place navigators within hospitals to engage families. The organization provides additional in-kind services to support the Family Connects program such as administrative data-entry support, and maintenance of relationships with the Governor's office and Family Connects International.

Hospitals in several states contribute critical infrastructure—a form of indirect support—through their participation in UNSS programs. As one administrator describes, "hospital participation is dependent on leadership. Hospital champions are important." In California, 14 hospitals offer UNSS programs, of which half are run by the hospitals.

Managed care organizations

In Oregon, Texas and California managed care organizations are supportive of the UNSS concept. (A willingness to consider a path to statewide UNSS was also reflected in conversations with Illinois MCO leaders.)

- California MCOs are looking to UNSS to show results, particularly in HEDIS measures such as screening for maternal depression.
- Texas MCOs consider UNSS programs to be a value-added service with potential to attract members.
- Further, the Family Connects Texas program compares favorably with the nurse newborn support already offered by both commercial and Medicaid MCOs because of the Family Connects program's strong relationships with hospital labor and delivery teams and community partners.

Health plans in Oregon analyzed potential returns on investment to their plans based on the Family Connects randomized clinical trial data, and found the savings related to medical care of

the child to be insignificant. However, the financial returns related to maternal post-partum care could yield cost savings, for example, due to depression screening.

In Texas, MCO representatives have met with UNSS advocates to explore their participation in coverage for UNSS. Three MCOs have expressed interest in providing coverage, and one currently contracts for UNSS services. In particular, the Texas UNSS program data show a "ramping up" of maternal postpartum visit numbers, helping them drive closer to the standard of two follow-up visits.

The Texas Nurse-Family Partnership, an evidence-based home visiting program targeting at risk families with a broader, non-universal intervention than the Family Connects model, contracts for its services with an area Medicaid MCO. This success of this contractual relationship may provide momentum for additional contracting between UNSS providers and Medicaid MCOs.

Not all leaders in other states are optimistic about Medicaid as a funding resource for UNSS. One policy leader commented, securing Medicaid payment for the UNSS visit may not be worth pursuing. "It could potentially cost more than the actual payment to bill Medicaid."

Self-insured plans are a possible source for insurance coverage for UNSS, but potentially harder to engage than Medicaid or commercial plans as has been the case in Oregon. In Austin, where the Family Connects program is jointly administered by United Way and the health department, the UNSS program has been able to draw on the United Way agency's connections with business to reach out and approach their self-insured plans regarding coverage.

Rate-setting

One of the most difficult negotiations faced by programs has been rate-setting. Some observers note that managed care entities may tend to view the UNSS service as a relatively small cost within the larger bundle of perinatal payments; nonetheless, rate-setting in partnership with MCOs has represented a significant negotiation as program implementation has proceeded in Texas and Oregon.

The widely quoted rate originating from the Family Connects Durham model is $650 per visit; observers quote rates ranging as low as $600 and as high as more than double that amount. In two randomized controlled trials of the Family Connects model in Durham, program implementation costs were estimated between $500 and $700 per community birth. Costs will vary according to local community context. In Oregon, the UNSS legislation requires commercial plans and Medicaid to reimburse providers at cost, at a rate yet to be defined. In Texas, per visit all in costs are estimated to approach $1,000 while medical payers are gravitating toward offering a rate of $650; one plan already contracts for the service at the $650 rate.

While professional costs for the visit vary from region to region and state to state, the largest driver of expense may be related to the cost of program launch and administration. As programs achieve scale, the per-visit cost attributable to administration should potentially decrease.

Replication with fidelity and driving toward standard outcomes

The Family Connects randomized controlled trial does not track all metrics that are of most interest to MCOs, creating some potential alignment issues between the Family Connects model and the goals of insurers interested in paying for the service. In Texas, for example, the MCOs want to see a better than average follow-up rate for families experiencing the nurse home visit in return for their investment. Texas MCOS use the following metrics of interest:

- Increase in percentage of women attending postpartum visits 7 to 84 days after delivery
- Reduction in emergency room visits in the first year of life
- Increase in percentage of women who score >10 on Edinburgh Postnatal Depression Scale (EPDS) being connected to referral source for follow-up
- Increase in percentage of children attending two well-child visits within the first eight weeks of life
- Reduction in hospital re-admissions

As one administrator noted, "There is some pressure to achieve the same metrics as those evaluated in the Family Connects randomized controlled trial—this is required for Family Connects certification. However, some additional metrics may be more important to pursue."

Family Connects International has expressed interest in partnering with Texas leaders to identify a group of metrics that will work well for the state while at the same time representing an acceptable level of alignment with core Family Connects program elements. Local Family Connects programs have found that program adaptation, particularly changes in the model that appeal to insurers, are of interest to Family Connects. According to one administrator, "Family Connects International is willing to take some risks with our programs, to look at a wider range of success outcomes."

In California, early program pilots have explored whether paying for outcomes would sustain the program, initially finding that they were tracking too many domains to make an effective analysis of program impact.

Data analysis has been important within other states for program advocacy and for demonstrating equity across geographies, races and ethnicities, and medical payer classes.

- Seasoned programs point to broad participation across participants of varying incomes, with nearly all visits resulting in identification of some level of need.
- One observer notes, "To increase support for UNSS we need to show how important the universal approach is to participants. We need to identify a unifying measure that will appeal to the business community" to help generate support for universal implementation.

Providers

UNSS programs tend to enjoy support by medical providers—in particular, for visiting by a nurse. In addition:

- Medical providers tend to appreciate home visiting that is evidence-based, professionally driven, and oriented toward outcomes, and they are willing to partner with these programs.
- Some providers have expressed interest in a broader intervention than offered by Family Connects, pointing, for example, to ZERO TO THREE's "Healthy Steps," which has been demonstrated to improve vaccine and screening rates for children.
- As one professional described, "the program makes hospital labor and delivery nurses happy and not worried about baby going home." And further, "Family Connects helps providers feel they are not the only person looking at the family. There is a comfort in knowing that someone is going into the home."

DELIVERABLE #3: ENGAGEMENT OF COMMUNITY-LEVEL EXPERIENCE AND EXPERTISE

In support of identifying new ways to approach funding sources that have not proven successful to date, but where new approaches might be successful, four interviews were conducted with Illinois communities that have been engaging in a readiness process to implement an UNSS initiative. Our intent was to learn more about their local funding landscapes and their preferences for a state infrastructure for funding UNSS.

Current MCH perinatal health initiatives

Interviewees identified several perinatal and maternal and child health initiatives in which their agencies are currently involved, including WIC, Family Case Management (FCM), Better Birth Outcomes (an intensive home visiting program), and the Nurse Family Partnership (an intensive nurse home visiting program that is not universal).

Some of the interviewed communities spoke of their emerging relationship to Family Connects and nurse home visiting as part of larger system perinatal efforts.

- As already noted, Family Connects implementation planning has started in one county through the Community Parenting Saturation Grant, which is allowing them to build a partnership with the hospital system on a small scale, as part of a larger multi-region initiative.
- Another interviewee talked about the initiative their agency started when they couldn't implement Family Connects. This program integrates housing, mobile market, mobile clinic, and international research all integrated, and using a model based on Family Connects.

Value of bringing UNSS to communities

Having nurses to assess universally the needs of all mothers and babies, and offer holistic support to families, was acknowledged by all interviewees as valuable.

- The inherent value in bringing UNSS to communities, is that, as one interviewee said, *"regardless of income, we all could use some support."*
- Another expounded on this idea, describing the value as "*being able to observe families in their own environment and build awareness around services that they would not otherwise know about. Also, taking a universal approach can work to normalize the utilization of preventive services because everyone is doing it—helps to take away the stigma of 'getting help' that some families struggle with. All parents need some support."*
- One interviewee pointed out that there are families who have higher incomes but may need support just as much need as some low-income families, and failing to connect with them is a current, disappointing gap.

Challenges to financing the model

Regarding UNSS financing, one interviewee said they envisioned *"having federal or state funding to support this model in the future,"* but there was no common vision among the four interviewees for funding a statewide UNSS initiative. Rather, they concentrated their comments on funding challenges. Common examples included:

- Despite high proportions of patients covered by Medicaid, Medicaid does not currently reimburse for UNSS services,
- The state funding sources are not reliable for program sustainability, and
- Grant funding is often limited in scope, with a focus on only reaching high need families and thus leaving out a large number of families.

Securing reliable funding to cover costs is a challenge. A corresponding challenge is not having sufficient infrastructure to reach out to local philanthropists and hospitals with the hope that they can become future funders and partners.

Housing the UNSS model

Hospitals and local health departments were the entities identified as the best places to house the Family Connects UNSS model. Hospital benefits include hospital staff having access to families right after birth, having the ability to look at their staffing models to see how existing nurses can support the Family Connects program, the possibility of using the birth certificate process to trigger entry into the program, and capturing large percentages of families with babies.

There are, however, some caveats to housing within hospitals:

- The UNSS programs would need a designated person at each of the hospitals that could work together despite competition. Perhaps an external organization could administer the program across multiple hospitals.
- There is concern that hospitals already have multiple patient care obligations that fully occupy their staffs.
- A hospital collaboration plan for data tracking would be needed.
- Hospital-based programs would need to develop significant partnership with community providers, a role that might be less familiar to their staffs.

Interviewees also pointed out that in capturing non-hospital births, partnerships with non-traditional birthing providers (birthing centers, doulas, and midwives) and pediatricians would be needed.

One person commented that if the program were to be housed within local health departments, the effort would have to be in partnership with hospitals. Local health departments, interviewees recognized, already have success in providing support to many people, and if

programs were housed at hospitals, health departments could continue to offer this support once families go home.

Vision for the administration of a statewide program

Three of the four interviewees talked about their vision for the administration of a statewide program, and while one person highlighted DHS having done a good job in creating community programs, all three identified local health departments as logical administrators, noting a history of and success with this type of work. Interviewees also pointed out that local health departments are familiar with the local service providers. They are able to get people connected and prenatal supports in place.

> *"Our health department is uniquely positioned to administer the program. They already have established relationships with us and all local hospitals. They already bring key stakeholders together and provide a constant shared check in and culture of learning. They help with bringing us together to support learning, sharing challenges and supporting implementation. As a result, there's scaling of shared practices."*

Ensuring universal access to all families with newborns

Broadly, partnerships and relationship-building were key themes when interviewees were asked about how universal access for all families and newborns could be ensured. Building connections to local hospitals, specifically, was identified by most interviewees as important. One interviewee said that they knew their current initiative was connecting to the vast majority of newborns and families, as the program is embedded in the local hospital, which sees 80 to 85 percent of area births. Another, similarly, commented that the program they were starting up would include a partnership with a local hospital and monthly tracking of births at that facility, as well as thinking through data sharing agreements with the hospital and evaluating the hospital's willingness to enter the data into the system. One person also said that they would be talking with the birth registrar to develop a relationship to track the number of births in the prior month and compare with how many assessments their agency completed. They pointed out that a challenge would be accurately accounting for high-risk babies born in Chicago but that live outside the city, and that they would need to learn from other programs already doing this work.

Data collection platforms and evaluation

These community interviewees identified several data collection systems (Chart 3 below), with two noting that while they use Cornerstone, they are either in the process of replacing it with another system or likely to do so in the near future. One interviewee said that they only use Excel for tracking case management, but that they would be working with Family Connects International to figure out their data system plans. Another interviewee stressed that their agency has been data-oriented, collecting robust data, using a research team and biostatistician, and looking at over 250 metrics. (Current Family Connects programs use a Salesforce system supported by Family Connects International.)

Table 3: Data Collection Platforms Used by Community Entities

Data Collection Platform	Notes	Evaluation	Billing	Referral Processing
Cornerstone	Used by FCM and Genetics Programs	X	X	X
iWIC	New System	Not specified	Not specified	Not specified
Sackwith	Used by Healthworks Program	Not specified	Not specified	Not specified
Visit Tracker	Doesn't talk to other systems	Not specified	Not specified	X
CareLogic		Not specified	Not specified	Not specified
IRIS	Pilot phase Can talk to other systems	Not specified	Not specified	X

Most interviewees were not far enough along in their processes to be able to talk in detail about evaluation. Only one interviewee identified concrete plans for formal evaluation, noting that Family Connects International would be providing the evaluation framework and providing evaluation support.

DELIVERABLE #4: SCAN AND MAP OF EXISTING PERINATAL HEALTH INITIATIVES

The project sought to map existing perinatal health initiatives, identifying funding levels, target populations, required outcomes and how children and families are identified and referred to programs.

The goal for the mapping exercise is to:

- Identify potential duplicative efforts for potential streamlining or simplifying of systems,
- Provide information about unique characteristics of programs to facilitate greater role clarity in the field and better refer families to the right service
- Identify existing programs who map in a way that align with UNSS and may benefit from flexible use at the local level

Perinatal Health Initiatives

Eight home visiting programs, 5 perinatal programs, and 6 coordination initiatives were examined. Information gathered from all interviewees was also useful in the mapping. In addition, key reports and web-based information identified by interviewees is also noted. In the course of our information gathering, we interviewed a number of key stakeholders who referenced various attempts to map the existing perinatal health initiatives in the state, which have been reported as incomplete. While this report does not provide a definitive map of all existing perinatal health initiatives, our conversations with key informants indicate that this documentation successfully builds on previous efforts and is anticipated to aid future mapping planned by state agency leaders.

Illinois MCH and EC Strategic Plans, Reports, Legislation and Policy

In addition to perinatal health programs and initiatives, we also studied statewide MCH and EC strategic plans and key reports in Illinois to gather information for future efforts to align across the MCH and EC systems. These included the Illinois Maternal Health Strategic Plan (2020-2024)[vii], the IDPH Title V Action Plan 2021-2025[viii], the 2020 Report to the General Assembly: Illinois Task Force on Infant and Maternal Mortality Among African Americans, January 2021[ix], and the Illinois Prenatal to Three Policy Agenda[x].

We also reviewed the approved planning grant application proposal submitted on March 15, 2021 by the Illinois Department of Human Services to the U.S. Department of Health & Human Services for the Health Resources and Services Administration (HRSA) Early Childhood Comprehensive Systems (ECCS): Health Integration Prenatal-to-Three program. This 5-year award will support ECCS planning in Illinois. Critical to this award is the opportunity to address a key factor in the disparate nature of perinatal health programs in Illinois – connecting all state agencies currently providing MCH and/or EC programs – as well as promoting flexibility in funding and aligning data & data collection methods. Key state agencies noted for participation include many that we interviewed for this research: Illinois Department of Public Health (IDPH –

administers IL Title V program); Illinois Department of Health Care and Family Services (IHFS – Medicaid and CHIP agency); Illinois Department of Human Services (IDHS – applicant agency and Child Care Assistance; IL Head Start; Part C Early Intervention; Home Visiting (including MIECHV); Family Case Management; WIC); Illinois Governor's Office of Early Childhood Development (GOECD – coordinating and oversight of state early childhood advisory council); Illinois State Board of Education (ISBE – home visiting (0-3) and state preschool programs (ages 3-5), Part B early childhood special education); and the Illinois Department of Children and Family Services (DCFS – child welfare).

Lastly, we also reviewed recent key legislation and administrative policy with direct alignment with implementation of UNSS in Illinois, noted earlier in this report. Documentation of perinatal health initiatives and systems level approaches can be found in the appendix: Table A1: Perinatal Health Programs Engagement Time Period and Table A2: Perinatal Health Initiatives & Systems Approaches Mapping.

Findings

Period of engagement

In order to tease out how maternal & child health initiatives and early childhood care & education initiatives intersect with women, babies, and their families in the timeframe of "perinatal" and "newborn", we reviewed key definitions from the health and provider community for the establishment of practice standards. Noting the intersection by time period also allows an understanding of potential duplication or gaps in services. Sorting out the key recommendations for attention given to women and newborns during the perinatal period will also provide insights for how best to create a universal newborn support system that addresses key needs of both the mother and the baby.

The World Health Organization (WHO) defines the perinatal period as "commences at 22 completed weeks (154 days) of gestation and ends seven completed days after birth."[xi] WHO also defines the postpartum period as 6 weeks after birth. The American College of Obstetrics/Gynecology (ACOG) recommends women receiving prenatal care as early as possible in pregnancy, and that postpartum care is provided with an ongoing process, rather than a single encounter, receiving contact with their OB/GYN provider within the first three weeks postpartum, and a comprehensive postpartum visit no later than 12 weeks after birth.[xii] This ongoing process should be "individualized and woman centered….[and] include a full assessment of physical, social, and psychological well-being," as well as establish the handoff to an on-going primary care provider.

The American Academy of Pediatrics (AAP) also provides comprehensive health guidelines for well-child visits in the first week (3 to 5 days old), then by 1, 2, 4, 6, 9, and 12 months of age.[xiii] This "periodicity schedule"[xiv] includes screening by the pediatrician, not only for the baby, but also for maternal depression starting by the 1-month visit, continuing through 6 months.

The perinatal health programs and initiatives mapped for this report fall on the timeline continuum in the pregnancy, birth, and postpartum period as noted below in Table A1: Perinatal Health Programs Engagement Time Period. In addition, we have also noted for the sample home visiting programs those which have a nurse visit and/or are universal. Any aspect of universality is also noted where relevant.

Using these various guidelines, it becomes clear that effective transitions of care from three sets of clinical providers during the newborn and early postpartum period – which can be difficult to coordinate (two different providers from birth to 12 weeks (OB/GYN & pediatrician), and a third provider (primary care) coming into the picture 12 weeks after birth for the mother) - require warm handoffs and intentional care coordination. Disparate electronic health record technology is a significant barrier to care coordination between and among these providers and places the burden on the mother and her family to keep track of assessments and referrals. Many of the perinatal health programs may not be linked to the electronic heath records (EHRs) of the medical providers nor other perinatal programs, leaving open the distinct possibility of duplication of care, particularly for MCH and EC initiatives that are reaching at-risk families.

Variety of perinatal health initiatives

Illinois perinatal health initiatives to support women and families during pregnancy, labor, and the postpartum period have been substantial, yet run out of variety of public agencies, using a complicated set of federal, state, and local dollars to achieve identified outcomes. The outcomes themselves vary, based on target audience, geographic location, and volume of identified need. Very few are universal, with the vast majority focused on low-income women and families, as well as women and families who fall into a variety of “at-risk” categories.

Need for warm hand-offs

Our investigation into the mapping task also highlights another key finding of our research, that Illinois has consistently funded perinatal health initiatives along two distinct tracks - 1) maternal and child health, and 2) early childhood care and education – which start their work with families at different points in time in the perinatal period. The warm handoff between initiatives that focus on pregnancy, birth, and the early post-partum period (typically the purview of MCH) - to programs that support families with young children (typically the audience of EC) does not seem to exist in a coordinated way except for specific home visiting programs working with targeted at-risk women. Home visiting programs that use perinatal home visitors who start during pregnancy, participate in the birth, and visit within the first two weeks postpartum at home are more likely to have specific designed transitions of the woman and the baby to early childhood home visitors.

For large numbers of families, once the mother has left the hospital with the baby, these families do not surface again until seeking support, either while searching for childcare or for well-baby checkups with pediatricians. According to stakeholders, women may skip attending to their post-partum needs via follow-up medical appointments for themselves, particularly in low-income

families, due to prioritizing limited family resources to support the baby's needs. The April 2021 change of Medicaid eligibility up to one-year postpartum may support increased access for mothers to engage in postpartum care visits.

For this reason and other reasons, it is particularly important to connect with women in the birthing hospital for a coordinated transition of care in the first week or two after birth to outpatient providers and community support. AAP recommends a well-child visit 3 to 5 days after birth and ACOG recommends a postpartum visit with provider within 3 weeks. Women also experience significant hormonal changes in the first week, including lactation, and the baby tends to become much more active within a few days post-delivery, so newly postpartum women need key support between day 4 and day 7. The Doula home visiting program, which includes the home visitor attending the birth, is specifically designed for a home visit (or at least a phone call) in the first week postpartum, with a 2nd week home visit at the latest. A few of the other home visiting programs also note within 2 weeks. The Family Connects program specifically sets their 2-hr comprehensive assessment nurse home visit during the three to five-week period to align with the Edinburgh Postnatal Depression Scale, in order to identify postpartum depression versus baby blues. Family Connects will also provide a targeted nurse check-in sooner than three weeks if indicated by the needs of the mother/ birthing parent or the family. It is not entirely clear exactly when all the existing MCH and EC programs that are available in the postpartum period have significant interaction with mothers and babies. As part of future mapping, it will be important to specify when in the postpartum period significant engagement begins.

State-level recommendations

The four state-level reports that include strategic plans and recommendations, along with the IDHS award from HRSA for implementation of an Early Childhood Comprehensive System (ECCS), all call for universal newborn support services, with two plans noting specifically Family Connects. They also share key goals and objectives, including:

- Building a continuum of care from pregnancy, birth, postpartum, and early childhood, with identified initiatives for mothers, babies, and families
- Connecting across the variety of state agencies, provider systems, community-based agencies, funding streams, and disparate target audiences of the initiatives
- Removing barriers related to data sharing, financing, and effective collaboration
- Addressing inequity and disparities to promote the ability to reach full potential

The IDHS ECCS proposal, noting IDHS as the backbone organization, summarizes the Illinois context as follows:

"Contributing to the issues are uneven rates of access to EC, health, and MCH services for families with children. For example, both the PDG Birth-to-Five Needs Assessment and the Title V Maternal Child Health Needs Assessment note that service delivery systems need to be linked, coordinated, and integrated, yet barriers related to data sharing, financing, and effective

collaboration persist. Additionally, within the context of the Illinois EC and MCH systems, integrating health is challenging due to lack of communication pathways among health providers and EC and MCH programs, limited knowledge among cross-sector partners of services available, and lack of public awareness about P-3 services. Similarly, both assessments highlight social and systemic issues at the root of health inequity that alter the ability of families and communities to establish a foundation for children's health and wellbeing prenatally and in early life. Ultimately, long-term financing strategies are central to Illinois plan for a comprehensive P-3 system and the IL-ECCS project will propel what we currently have toward a more equitable cross-systems, innovative and sustainable strategy."

These plans, in addition to the recent legislation and policy changes, bring Illinois to the strongest position in many years to advance the vision and mission of the Universal Newborn Support Systems Expansion and Sustainability Project.

DISCUSSION AND RECOMMENDATIONS

Given the considerable momentum around investment in early childhood health, development and well-being arising associated with the HRSA Early Childhood Comprehensive System (ECCS) planning grant and other state-level initiatives, the state has an immediate opportunity to move ahead on consideration of a statewide UNSS.

The way in which various UNSS programs—both in Illinois and in other states—have resolved inherent tensions around program administration and resource allocation may be helpful to stakeholders as they anticipate how a future statewide program may be designed and financed in Illinois. The discussion and recommendations that follow are intended to help promote current statewide efforts to advance an UNSS in this context.

Financing discussion

No UNSS program has succeeded without integrating multiple funding streams. To finance UNSS implementation, whether by requiring coverage by insurers as in Oregon or by blending funds in a voluntary system, all programs have drawn on both public and private sources of funding. The recommendations that follow assume that UNSS expansion in Illinois will continue to depend on a rich mix of funding sources.

Several UNSS financing strategies that work in other states may have value for Illinois. The current Illinois UNSS programs have demonstrated remarkable capacity for sustainability, with the majority of program revenues supplied by Title V, IDHS, MIECHV and ISBE grants, hospital funding and private philanthropy. While these sources have been used to varying degrees in other states, several states have pursued additional approaches worth considering that have been only minimally explored in Illinois: securing insurance coverage, engaging self-insured programs, involving insurers and business in shaping UNSS, and localizing regional program operations within larger entities with durable administrative capacity.

Considerations for Illinois based on these approaches are as follows.

(1) Mandate or seek insurance coverage for the UNSS visit.

- Assure that the nurse home visiting intervention responds to the interests of insurers, such as completion of a depression screen and facilitation of follow-up care for the newborn and the mother,
- Consider entering into value-based contracts with MCOs to achieve performance metrics through the UNSS of interest to insurers and providers,
- Involve the business community in making the case for covering the UNSS program, particularly within self-insured plans.

(2) Promote UNSS through coalitions that involve insurers, business, hospitals, and providers in program architecture, in addition to researchers, policymakers and philanthropy, aligning interests that include renewed attention to public health in addressing recovery from the COVID-19 pandemic, as well as addressing racial and economic equity.

(3) Involve hospitals in identifying how to incentivize their participation in UNSS programming.

(4) Seek program leadership by a diversity of large, financially stable entities that have a known track record and sufficient infrastructure for success—for example, hospitals, health departments, social service agencies and United Way.

Recommendations regarding statewide implementation and sustainability

UNSS advocates continue to raise important questions of how a statewide program should be shaped, staffed, administered, and evaluated. Perhaps even more fundamental is the overarching question of how a statewide program could be funded. The experts consulted this year have embraced complexity, pursued innovation, and pushed forward to identify the best ways to braid and blend funds that can make UNSS possible for every newborn and family.

The recommendations that follow assume that UNSS expansion in Illinois will continue to depend on a rich mix of current and new funding sources. However, in order to be implemented as an adequately funded, sustainable, equitable system, some core sources of support (such as Medicaid, MIECHV or state program funding) should ideally be identified that will allow communities the foundational opportunity to cover the majority of operating expenses.

The following recommendations regarding funding for UNSS have emerged from conversations with experts and advocates in Illinois, Oregon, Texas, and California, supplemented by a review of scholarly articles and task force recommendations.

Integrate program administration and financing:

- Integrate funding streams for UNSS at the state level; build on the integration of programs already underway by the Early Childhood Transformation Team to consolidate administration of MIECHV and ISBE, DHS and IDPH funding available for UNSS.

- Seek rational ways to prioritize and integrate UNSS funding within the larger set of MCH and EC programs supported by state grants including family case management.

- Set pricing based on both the visit as well as the administrative costs. Additional costs that should be built into the price include those associated with data collection and with staffing regional councils to maintain an array of responsive community-based follow-up resources.

Leverage federal funding sources:

- Streamline and systematize the financing distinction between UNSS and related federally supported programs including APORS, WIC, MIECHV and Early Head Start funds; explore possible ways in which a connection among funding for these programs can provide leverage for sustainable funding.

- Allocate Title V funds to support new UNSS program start up, scaling and long-term operations.

- Continue to leverage Medicaid administrative matching payments applicable to UNSS services, including outreach and engagement, and ensure that billing codes related to UNSS are implemented.

- Continue to seek competitively awarded grant support to build on the restructuring already underway by the Early Childhood Transformation Team and IDHS with its recent HRSA award, and to support the development of a regional system for UNSS administration.

Promote effective implementation:

- Approach UNSS implementation with a clearly articulated goal of serving both the mother/ birth parent and the baby as identified patients. Although medical insurers in another state have identified the infant as the covered and enrolled Family Connects patient, the full value of UNSS initiatives is achieved by promoting the health and well-being of the infant, mother/ birth parent, and family.

- Seek clarity as to how UNSS fits within the larger PN3 framework of advancing medical, developmental, child welfare and educational readiness goals. This clarity should lay the groundwork for blending and braiding funding for UNSS matched to goals derived from both medical and developmental perspectives.

- As mechanisms for administration and financing of a statewide system are addressed, maintain a focus on addressing racial and ethnic disparities and social inequities to prevent the development of a system that ignores, replicates, or even exacerbates these disparities and inequities.

- Consider limiting the statewide UNSS to one or possibly two evidence-based nurse home visiting models approved by HomVEE. This will help streamline the costs of program replication, administration, and data collection.

- Implement data-collection and analysis using a single system. If possible, promote interoperability with other state maternal and child health data bases and with hospital

and health system electronic health records. Finally, consider interoperability with record systems tracking social determinants of health.

- Consider launching new programs only within entities that have a track record and sufficient infrastructure to facilitate program start up, growth and expansion.

- Support UNSS entities to recruit nurses, leveraging telehealth as needed, and engaging networks of parish nurses, rural health centers, and schools of nursing.

- Provide technical assistance for providers on Medicaid billing, such as that offered to health and human service providers by the Illinois Collaboration on Youth (ICOY).

Engage MCOs and insurers:

- Involve MCOs in making the case for insurance coverage for statewide UNSS and in decision-making regarding implementation on such issues as: allowable intervention models, metrics to be pursued and rate-setting parameters.

- Reach out to MCOs to pilot value-based contracts with UNSS providers.

- Collaborate with insurers along with program experts to develop the cost-basis for the visit and program administration.

- Assess the potential value of including UNSS in the postpartum bundle of services, to capture the importance of fostering maternal health during the visit.

Reach out to business:

- Urge business leaders to consider covering UNSS in their self-insured plans.

- Support providers to collaborate with self-insured businesses to pilot UNSS for their employees.

- Seek established avenues for engaging business leaders, for example through United Way or local Chambers of Commerce.

Promote UNSS pilots and demonstrations:

- Demonstrate how outcomes of interest to MCOs and business can be achieved through UNSS.

- Implement UNSS pilots that can generate preliminary findings, providing a foundation for comprehensive research projects of national significance.

- Pilot collaborations with diverse community providers and entities to reach special or underserved populations.

- Develop standards for replication of evidence-based models with fidelity that may permit adaptations. (If Family Connects is chosen as the statewide UNSS model, collaborate with Family Connects International to select adaptations aligned with other national efforts.)

Appeal to philanthropy and other grant sources to support UNSS:

- Establish linkages between regional programs and philanthropic funders.

- Continue to seek philanthropic and competitive grant funds to supplement program infrastructure and operations, conduct pilots, pursue expansion, build programs to scale, stimulate program collaboration and innovation, assure effective data analysis and use of data for evaluation, and test adaptations to the evidence-based program.

- Involve foundations associated with hospitals, insurers, organized medicine, and other health sector entities.

- Pursue competitive research grants to create the evidence basis for UNSS adaptations.

Advocate in Illinois and nationally for UNSS:

- Urge medical and health sector associations to make explicit reference to UNSS in their policy positions; encourage provider entities to participate in supporting pilot programs.

- As public health entities seek COVID-response and other funding to rebuild their infrastructure, include requests for resources for UNSS implementation or participation.

- Consider advocacy to establish a Medicaid home visiting cost-based encounter rate for a nurse UNSS system, following the well-established precedent for FQHCs and emerging efforts for Certified Community Behavioral Health Clinics (CCBHCs).

- Consider advocacy to provide cost-based reimbursement for FQHCs to provide an UNSS visit by a nurse for Medicaid newborns.

APPENDIX

Table A1: Perinatal Health Programs Engagement Time Period

Programs with Home Visits					
	Pregnancy	Birth	Postpartum 1st home visit	Nurse Visit? Y/N	Universal? Y/N
Better Birth Outcomes	X	X	X *(within 6 weeks (clinic F&F applies))*[xv]	N	N
Doula Home Visiting	X (by 3rd trimester)	X	X *(in 1st week (phone applies) thru 2-3 mos)*[xvi]	N	N
Early Head Start – Home Visiting	X	X	X *(within 2 weeks)*[xvii]	N	N
Healthy Families IL	X	X	X *(within 3 mos; weekly)*[xviii, xix]	N	N
Parents as Teachers	X	X	X *(within 2 weeks)*[xx]	N	N *(2 criteria in IL; universal in other states)*[xxi]
Nurse Family Partnership	X *(necessary engagement prior to 29 weeks)*[xxii]	X	X *(within 2 weeks)*[xxiii]	Y	N
Family Connects			X *(around 3-5 weeks)*[xxiv]	Y	Y
High Risk Infant Follow-up			X *(within 14 days hospital discharge thru 2 yrs)*[xxv]	Y	N (*APORS is a universal screen, which triggers this program*)

Other Perinatal Programs					
	Pregnancy	Birth	Postpartum 1st home visit	Nurse Visit? Y/N	Universal? Y/N
Healthy Start	X	X	X *(up to 18 mos)*[xxvi]		
Healthy Choices/ Healthy Futures (web-based linkage only)xxvii	X	X	X		
WIC (Women, Infants, & Children	X	X	X (*0 to 6 mos (not breastfeeding) or 12 mos (breastfeeding) thru 5th year*		
Perinatal Depression Treatment Program (all screened for depression by OB & HV providers PP)	X	X	X		
Early Childhood Prevention Initiative	X	X	X *(0-3)*		

Coordination Initiatives					
	Pregnancy	Birth	Postpartum 1st home visit	Nurse Visit? Y/N	Universal? Y/N
Family Case Management (Medicaid)	X	X	X *(thru 12 mos)*		
ConnecTeens (to HV)	X	X	X		
Coordinated Intake (to HV)		X	X		
Regional Perinatal Care System	X	X	X *(thru transfer to appropriate care)*		
APORS (Adverse Pregnancy Outcomes Reporting System) (for DD)		X	X *(based on criteria, nurse home visit within 14 days hospital discharge thru 2 years)*		
Illinois Interagency Council on Early Intervention (for DD) (all screened for development by Peds & HV providers PP) Local Interagency Councils		X	X *(0-5 yrs)*		

Table A2: Perinatal Health Initiatives & Systems Approaches Mapping

Key Evidence-Based Home Visiting Programs				
	Better Birth Outcomes[1]	**Doula Home Visiting**[2]	**Early Head Start Home Visiting**[3]	**HV/**[4] • **Healthy Families Illinois** • **Parents as Teachers** • **Nurse Family Partnership**
Funding	IDHS *(IL General Revenue Fund; Federal Social Services Block Grant*)	MIECHV (*US DHHS (ACF/HRSA))* ISBE IDHS	US DHHS (ACF/HRSA)	MIECHV (*US DHHS (ACF/HRSA))* ISBE IDHS (*(IL General Revenue Fund)*
Communities	Targeted Illinois counties through WIC; areas with higher Medicaid birth outcome costs & premature infants.	Statewide 17 (Start Early) + 7 (City of Chicago) programs integrated into long-term home visiting.	Statewide	Statewide
Target Population	High-risk pregnant women to prevent poor birth outcomes.	"At risk" teens and other parents. Must meet Early Head Start income eligibility guidelines.	Low-income families. Families with special needs.	"At risk" families. NFP = 1st time moms.
Services & how mothers/birth parents, children, families referred	Prenatal education, intensive case management, support, and perinatal medical care coordination. At least one home visit per trimester.	Prenatal (any age, and any stage of pregnancy) up to 2 months postpartum and continued services in home visiting. * Start Early doulas transition to other home visitors after baby is born. Approx. 10% doula only.	Requires prenatal and birth-to-3 home and center-based services. *(Not all EHS programs require enrolling pregnant women; grant dependent.)*	Comprehensive and intensive home visiting; all models begin prenatally. HFI and NFP require prenatal engagement. Continue up to 2-5 years of age depending on model.

[1] Lead staff: Grace Hou
[2] Lead Staff/Start Early: Mark Valentine; Matt Sulzen; Michele Jackson
[3] Lead Staff: Unknown.
[4] Lead Staff: Grace Hou; Charles Dooley; Lesley Schwartz; Mark Valentine; Matt Sulzen; Michele Esquivel; Penny Smith; Cindy Bardeleben; Julianna Sellett

UNSS Programs			
	UNSS/Family Connects Illinois[5]	UNSS/Family Connects Chicago[6]	UNSS/Family Foundations[7]
Funding	MIECHV (*US DHHS (ACF/HRSA)*) ISBE	Chicago Department of Public Health	Carle Foundation Hospital System financing.
Communities	Stephenson County Peoria County	South and West sides Chicago: Mt Sinai Humboldt Park Health University of Chicago Rush	Champaign, IL
Target Population	100% of all county births in Stephenson Co. 100% of all Peoria County births at OSF/Peoria.	100% of all births at participating hospitals.	100% of all births at Carle Foundation Hospital.
Services & how mothers/birth parents, children, families referred	Approx. 5 weeks: family find, education, support, resource, and referral. Community Networking for R and R alignment through Community Alignment Boards and AOKs, etc.	Approx. 5 weeks: family find, education, support resource and referral. Community Networking for R and R alignment through Community Alignment Boards Community: Sinai Health System (Region A) Sinai Community Institute (Region B) Ever Thrive Illinois (Region D)	Enroll in hospital with the birth. Assess mom & baby at home, up to 3 visits. Connectivity to housing, food initiatives, healthcare via shared medical records for strong continuum of care. If they need long-term HV, make referrals at that point to other HV services in the community.

[5] Lead Staff**:** Nick Wechsler, Start Early (SE)
[6] Lead Staff: Jen Vidis/CDPH, Dr. Gina Lowell, Rush
7 Lead Staff: Julianna Sellett/Carle Foundation Hospital, https://carle.org/services/family-foundations

Other Perinatal Programs					
	Healthy Start	Healthy Choices/Healthy Futures Toolkit[8]	WIC (Women, Infants, and Children)[9]	Perinatal Depression Treatment Program[10]	Early Childhood Prevention Initiative[11]
Funding	U.S. DHHS MCHB	Funded in part by Title V Block grant.	IDHS *(USDA)*	IDHS *(Federal funding)*	ISBE *(USDE):* Early Childhood Block Grant; IL General Revenue Fund.
Communities	Chicago; southern Illinois	Illinois, and Chicago	Illinois	Chicago (*Statewide consultation)*	Illinois
Target Population	Target communities with infant mortality rates that are at least one and a half times the U.S. national average. Improve birth outcomes, reduce infant mortality, maternal mortality and improve the health & wellness of families, mind, body, and spirit.	Website/toolkit designed to help families and social service providers access reliable, evidence-based tools and resources to support women during the reproductive years.	Pregnancy through child's 5th year; families with low to medium income.	Women referred during pregnancy and postpartum.	Birth to Three
Services & how mothers/birth parents, children, families referred	Connect mothers to health care services beginning in pregnancy, ensure they attend until their child is two years old. Collaborate with high-risk obstetric providers. Screenings, lactation support, counseling, and referrals including substance use disorders, behavioral health concerns, domestic violence, and homelessness.	List of services and programs offered in Illinois to support the health of people during the perinatal period.	Food including breast feeding materials and nutrition education.	Perinatal depression screening, assessments, treatment, psychotherapy & psychiatric care, follow-up. Referred by FCM and HFI Programs and the Perinatal Depression Hotline by therapists, psychologists, and case managers.	Child development and family support services for expectant parents and families with children from birth to age 3 to help them build a strong foundation for learning and to prepare children for later school success. Can include home visits.

[8] Lead staff: EverThrive, IDPH, HFS.
[9] Lead staff: Grace Hou/IDHS
[10] https://www.dhs.state.il.us/page.aspx?item=30524
[11] Lead staff: Carisa Hurley, Director/ISBE

Coordination Initiatives						
	Family Case Management (Via Medicaid)[12]	**ConnecTeen** (To HV)[13]	**Coordinated Intake** (To HV)[14]	**Regional Perinatal Care System**[15]	**APORS (Adverse Pregnancy Outcomes reporting System)** (For DD)[16]	**Illinois Interagency Council on Early Intervention** (For DD)[17]
Funding	IDHS: IL General Revenue Fund; Federal Social Services Block Grant.	Lurie Children's Hospital	MIECHV (*US DHHS ACF/HRSA)*	IDPH ** Noted in the MCH strategic plan*	IDPH *(U.S. DHHS ACF)*	IDHS
Communities	Throughout Illinois	City of Chicago	Locations statewide	Statewide, with 10 regions, each with an administrative perinatal center that supervises all obstetric hospitals in the region.	Throughout Illinois through county health departments; licensed hospitals provide birth data.	Throughout Illinois via Regional Local Interagency Councils
Target Population	Pregnant women with children under the age of one who are on Medicaid or are part of a low-income family. High risk infant follow-up.	Pregnant & parenting youth who attend Chicago Public Schools or live in the City of Chicago.	Priority populations and at-risk families.	Prenatal and birth, for women and infants at high risk (maternal morbidity or mortality; low birth weight).	All children born with birth defects/high-risk conditions.	Children birth to three with developmental disabilities and delays.
Services & how mothers/birth parents, children, families referred	Service coordination to improve health, social, education and developmental needs of women and infants.	Resource and referral primarily to Chicago home visiting programs.	Resource and referral primarily to statewide home visiting programs beginning at birth.	APCs monitor the care and transport of mothers and infants to facilities within their region for appropriate level of care.	Comprehensive assessment, referral, education by nurse home visit 14 days post discharge, up to 2 years.	Early Intervention system providers; one or more EI services in their home or community.

[12] Lead staff: Grace Hou
[13] Lead staff: Kaitlyn Kanweisher
[14] Lead staff: Lesley Schwartz, Michele Esquivel, Bryce Marable
[15] Lead staff: Kenya Mcrae, Title V Director, IDPH
[16] Lead staff: Dr. Ezike
[17] Lead staff: Local Interagency Councils

Strategic Plan & Systems Approaches				
	I Promote – Illinois[18] (Innovations to Improve Maternal Outcomes in Illinois)	**IDPH Title V Action Plan, 2021-2025**[19]	**January 2021 Report to IL General Assembly, IL Task Force on Infant and Maternal Mortality Among African Americans** (IMMT)[20]	**Prenatal to Three (PN3) Policy Agenda Feb 2020**[21]
Funding/Level	HRSA/MCHB 5-yr grant beginning Sept 2019, for the State Maternal Health Innovation Program.	IDPH Title V *(US DHHS HRSA/MCHB)*	Public Act 101-0028, creating the IL Task Force on Infant and Maternal Mortality among African Americans.	Multiple private foundations, including Irving Harris Foundation and Pritzker Children's Foundation.
Communities/ Target Population	Health equity for women, pregnant persons, and families in Illinois, across race, ethnicity, class, geography, immigration status, and ability, where all have what they need to be healthy and reach their full potential.	Well-being of all mothers, infants, and children, particularly children with special health care needs. Vision includes "future free of health disparities, where all Illinoisans have access to continuous high-quality health care."	African Americans in Illinois.	Illinois' youngest children and their families, especially those furthest from opportunity, in the prenatal to three years' time period.
Goals/Key Findings	Call to action to address the stark inequities in maternal, infant, and family health outcomes in Illinois.	Priority Areas cover Women's/Maternal Health; Perinatal/Infant Health; Child Health; Adolescent Health; Children with Special Healthcare Needs; Cross-Cutting/Life Course	Identify and to present key strategies to decrease infant and maternal mortality among African Americans in Illinois.	Improve access to high-quality services for 50,000 Illinois infants and toddlers in families earning under 200% FPL by 2023, and 100,000 Illinois infants and toddlers earning under 200 FPL by 2025.

[18] Lead staff: Kenya McRae, Title V Director IDPH; Arden Handler, UIC, Co-Principal Director I Promote-IL
[19] Kenya McRae, Title V Director, IDPH
[20] Lead staff: Phallisha Curtis, Division Chief, IDPH Office of the Women's Health and Family Service
[21] Lead staff: Governor's Office of Early Childhood Development/Jamilah Jordan; Start Early/Karen Berman, Carie Bires, Simone Santiago, Karen Yarbrough

	I Promote – Illinois[22] (Innovations to Improve Maternal Outcomes in Illinois)	IDPH Title V Action Plan, 2021-2025[23]	January 2021 Report to IL General Assembly, IL Task Force on Infant and Maternal Mortality Among African Americans (IMMT)[24]	Prenatal to Three (PN3) Policy Agenda Feb 2020[25]
UNSS specific objectives	*Strategic Priority Area #1: Care Coordination & Case Management* Objective: Expand coordination of services prior to, during, and after pregnancy. Strategy #1: Expand the number of communities who offer a system of universal supports across the continuum from early prenatal care to one year postpartum *(Year 1 Action Step, includes Family Connects).* Strategy #2: Increase funding for community-based perinatal support, home visitors, and doulas as well as perinatal health workers, educators (e.g., peer breastfeeding counselors), and advocates. *Strategic Priority Area #2: Public Education & Community Empowerment & Engagement* Strategy #1: Widely disseminate Healthy Choices, Healthy Futures toolkit *(Year 1 Action Step).* *Strategic Priority Area #3: Equal Access to High Quality Care* Strategy #1: Unbundle postpartum care from global obstetric billing, advocating for reimbursement for 2 preventative visits within 6 weeks PP.	Priority Area/Perinatal & Infant Health #3: Support healthy pregnancies to improve birth and infant outcomes. Strategy I: Support the Chicago Department of Public Health (CDPH) in implementation of Family Connects Chicago to ensure nurse home visits for all babies and parents immediately following birth and linkage to a network of community supports to assist with longer term, family identified needs.	Postpartum Medicaid Reimbursement: The state through HFS should reimagine the current framework of bundled Medicaid reimbursement for obstetric care by unbundling the postpartum visit from prenatal care and labor and delivery services. Specifically, the state should support the implementation of a universal early postpartum visit within the first three weeks and a comprehensive visit within 4-12 weeks postpartum. This will improve postpartum access to care and positively impact the incidence of maternal morbidity and mortality in the postpartum period.	*Healthy Parents & Babies* Perinatal Support: Prenatal, Intrapartum, and Postpartum Objective 1.1. Expand universal newborn nurse home visits for all newborns. Projected Impact: UNSS available in no less than 50% of all Illinois counties over a ten-year period. Tactic: Identify and advocate for additional funding streams to support expansion (year 1 and each year). *Home Visiting* Objective 5: Expand universal newborn supports (which may include Family Connects or BabyTALK newborn encounters) to offer every family a new birth to a comprehensive health screening and nurse home visit, and referrals to health services and local community resources, including home visiting, based on individual needs and family wishes.

[22] Lead staff: Kenya McRae, Title V Director IDPH; Arden Handler, UIC, Co-Principal Director I Promote-IL
[23] Kenya McRae, Title V Director, IDPH
[24] Lead staff: Phallisha Curtis, Division Chief, IDPH Office of the Women's Health and Family Service
[25] Lead staff: Governor's Office of Early Childhood Development/Jamilah Jordan; Start Early/Karen Berman, Carie Bires, Simone Santiago, Karen Yarbrough

Additional IL MCH systems level approaches

Statewide Perinatal Advisory Committee (PAC)
IL Perinatal Quality Collaborative (ILPQC)
Chicago Collaborative for Maternal Health
IDPH Maternal Mortality & Morbidity Report

Additional plans noted with shared priorities of the IL MCH SP:

Healthy Chicago 2025
State of Illinois Opioid Action Plan

Additional Systems Level Related Initiatives

Healthcare Transformation Collaboratives:[xxviii] IL Department of Healthcare and Family Services

Table A3: List of Interviewees

Interviewees	Sector Scan	Technical Funding Exam	Community Engagement	Community Engagement Only
Samantha Olds Frey, CEO, IAMHP	X			Jennifer Graham, Dir Good Beginnings, Children's Home Association of Illinois
Andrea McGlynn, Director of Clinical Services, CountyCare	X			Julia Marynus, Maternal and Child Nurse Specialist, Stephenson County Health Department
Lance Kovacs, Dir Health Policy & Jordan Powell, Sr VP Health Policy & Finance, Illinois Hospital Association	X	X		
Julianna Sellett, VP Community Health Initiatives, Carle Hospital	X		X	Cindy Bardeleben, Executive Director & Ellen Walsh, Director, Learning Institute, Baby TALK
Gina Lowell, MD, Assistant Dir Dept of Pediatrics, Rush Family Connects	X		X	Glynis Cailteux, Program Coordinator, Kankakee County Health Department
Stephanie Altman, Dir Healthcare Justice & Senior Dir Policy, Shriver Center on Poverty Law	X	X		Trish Rooney, VP Programs, Fox Valley United Way
Theresa Hawley, First Assistant Deputy Governor, Illinois Governor's Office	X			Lenny Rivota, Program Supervisor, DuPage County Health Department
Stephanie Bess, Interim Associate Dir, Illinois Department of Human Services	X			
Deborah Daro, Senior Research Fellow, Chapin Hall	X	X		
Lesley Schwartz, Bureau Chief of Early Childhood Development, Illinois Department of Human Services	X			
Kirbi Range, Maternal & Child Health Manager, EverThrive	X	X		
Arden Handler, Professor, Maternal and Child Health, UIC School of Public Health	X			
Cate Wilcox, Maternal and Child Health Section Manager, Oregon Health Authority	X	X	X	
Ann Courter, Principal, Courter Consulting		X		
Kim Friedman, Dir Policy & Engagement, Family Connects International		X		

Jane Longo, Deputy Director; Laura Phelan, Dir of Policy, Illinois Department of Healthcare and Family Services		X		
Mike Koetting, Consultant		X		
Harmony Harrington, VP Government, Communications and Community Relations, Blue Cross and Blue Shield of Illinois		X		
Jim Kiamos, CEO; Ann Cahill, VP Medical Management, Meridian Health		X		
Jess Trudeau, Dir Strategic Initiatives, Tex Protects		X	X	
Anna Potere, Sr Program Officer; Diana Careaga, Dir Family Supports Team First 5 LA		X		
Shalyn Bravens, Dir Family Connects and MIECHV; Becca Bice, Project Manager, FC; Hope Hunt, FC Nurse Supervisor, United Way Austin		X		

* Staff from the Chicago Department of Public Health and Start Early provided additional information.

Endnotes

[i] Duke Family Connects International. "What we do." Accessed at: https://familyconnects.org/what-we-do/ on May 16, 2021.
[ii] U.S. DHHS HRSA Early Childhood Comprehensive Systems (ECCS): Health Integration Prenatal-to-Three program.
[iii] The hospital engagement component of Baby TALK is offered universally within two hospitals, funded by ISBE and the hospitals; program funds are insufficient to offer ongoing Baby TALK service to all area families.
How Will the American Rescue Plan Strengthen the Prenatal-to-3 System of Care? Prenatal-to-3 Policy Impact Center, University of Texas at Austin LBJ School of Public Affairs, March 16, 2021. Accessed on June 1, 2021 at: https://pn3policy.org/brief-and-webinar-how-will-the-american-rescue-plan-strengthen-the-prenatal-to-3-system-of-care-a-summary-of-the-2021-acts-benefits-for-infants-and-toddlers/.
First 5 LA, Pathways to Progress: Indicators of Young Child Well-Being in Los Angeles County. Accessed on June 5, 2021 at: https://www.first5la.org/wp-content/uploads/2020/09/First-5-LA-2020-Indicators-Report.pdf
[iv] CMS waiver for Illinois Medicaid coverage up to 1 year postpartum through 12/31/25.
[v] Illinois Heath Care and Human Services Reform Act, April 2021.
[vi] Improving Health Care for Pregnant and Postpartum Individual Act (SB0967), sent to Governor June 2021.
[vii] Received from Arden Handler, University of Illinois School of Public Health, ver. Feb 2021.
[viii] Title V Block Grant Application FY2021, Illinois Maternal and Child Health Action Plan 2021-2025, web retrieval May 29, 2021
[ix] Ibid.
[x] PN3 Agenda, web retrieval May 29, 2021
[xi] WHO definition of perinatal period, web retrieval May 29, 2021
[xii] ACOG Optimizing Postpartum Care, May 2018
[xiii] AAP Well-Child Visits, web retrieval May 29, 2021.
[xiv] AAP Periodicity Schedule 2021, web retrieval May 29, 2021.
[xv] https://www.dhs.state.il.us/page.aspx?item=118939 7.2.21
[xvi] Nick Weschler, Start Early
[xvii] Early Head Start, 07.2.21
[xviii] Healthy Families Illinois,07.02.21
[xix] Received from Jen Vidis/CDPH: IL Program Inventory Quick Reference Guide, January 13, 2020.
[xx] Nick Weschler, Start Early.
[xxi] Ibid.
[xxii] Ibid.
[xxiii] Ibid.
[xxiv] CDPH Family Connects, 07.02.21
[xxv] Received from Jen Vidis/CDPH: IL Program Inventory Quick Reference Guide, January 13, 2020.
[xxvi] Healthy Start, Access Community Health Network 07.02.21
[xxvii] Healthy Choices/Healthy Futures website 07.02.21
[xxviii] HealthCare Transformation Collaboratives, HFS

Planning Committee

Allison Angeloni, Director of Policy, Steans Family Foundation
Katie Kelly, Director of Communications and Community Initiatives, J.B. and M.K. Pritzker Family Foundation
Gina S. Lowell, MD, Assistant Professor in Department of Pediatrics, Rush Medical College
Bryce Marable, Family Recruitment Specialist; Ireta Gasner, Vice President of Illinois Policy; Karen Berman, Director of Illinois Policy; Nick Wechsler, Director for Program Development, Start Early
Jennifer Vidis, Deputy Commissioner, Chicago Department of Public Health

Consultant Team

Margie Schaps, Executive Director, Health & Medicine Policy Research Group
Laura McAlpine, Principal; Mac Grambauer, Senior Consultant; McAlpine Consulting for Growth, LLC
Tiosha Bailey, Principal Consultant, T. Bailey Consulting Firm Inc.
Linda Diamond Shapiro, Senior Vice President, Conlon Public Strategies

Health & Medicine Policy Research Group

Health & Medicine is a Chicago based non-profit working to improve the health of all people in Illinois by promoting health equity. Founded in 1981 by Dr. Quentin Young, it was formed as an action-oriented policy center—nimble, independent, and focused on regional health issues.

Health & Medicine's mission is to promote social justice and challenge inequities in health and health care. It conducts research, educates, and collaborates with other groups to advocate policies and impact health systems to improve the health status of all people. Health & Medicine has successfully developed health policy recommendations and implementation strategies for different public and private entities, earning the trust of the legislature, advocates, the media, researchers, and policymakers at all levels of government in Illinois to become the region's "honest broker" on healthcare policy matters.

Learn more at hmprg.org

Citation: Shapiro LD, McAlpine L, Grambauer M, Bailey T, Schaps M: *Creating a Universal Newborn Support System (UNSS) in Illinois: Wisdom and Experience from the Field*. Chicago, Health & Medicine Policy Research Group, October 2021.

This report was completed through the generous support of the J.B. and M.K. Pritzker Family Foundation and the Steans Family Foundation.