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SCHOOL OF PUBLIC HEALTH AND TROPICAL MEDICINE

Department of Health Policy and Management

Family Connects New Orleans Evaluation Report #2

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Executive Summary

Background

Family Connects New Orleans (FCNO) is an initiative aimed at improving maternal and infant health. The program, a partnership between the city of New Orleans, Ochsner Baptist, and Touro Infirmary, offers families with newborns up to three free in-home nurse visits that include health screenings for both the mother and baby, as well as a family assessment to address social, environmental, and behavioral needs. This report presents the preliminary findings from an analysis of the program's impact on Medicaid spending, healthcare utilization, and maternal mental health outcomes, based on data available through September 2024.

Methods

The analysis focused on comparing Medicaid spending, emergency department visits, hospital stays, and diagnoses of postpartum depression, anxiety, and PTSD between mothers who participated in the FCNO program and those who did not. The evaluation utilized both unadjusted averages and regression-adjusted models to account for differences in participant characteristics and to assess associations between FCNO participation and outcomes.

Key Findings

- *Medicaid Spending:* FCNO participants had slightly higher Medicaid spending in the first postpartum month, with an average of $499.17, compared to $452.89 for non-participants. However, by 2 months post-delivery, non-participants incurred higher spending ($822.84) compared to participants ($689.26). This trend continued with non-participant spending averaging $1,882.54 and participant spending averaging $1,732.59 at 6 months post-delivery, though these differences were not statistically significant.
- *Utilization:* FCNO participants had higher emergency department (ED) visit rates than non-participants in the first six months postpartum. Specifically, 41.0% of participants visited the ED within six months compared to 36.9% of non-participants, though this difference was not statistically significant. In contrast, FCNO participants were less likely to experience inpatient hospital stays. At 2 months postpartum, participants were 3.6 percentage points less likely to have a hospital stay than non-participants, and by 6 months, the gap had widened to 4.6 percentage points, though these differences were also not statistically significant.
- *Maternal Mental Health:* Preliminary results indicate that FCNO participants had a lower rate of postpartum depression (PPD) diagnoses compared to non-participants. In the six months following delivery, 2.6% of participants received a PPD diagnosis, compared to 4.0% of non-participants, though this difference was not statistically significant. However, the program was associated with higher rates of anxiety and PTSD diagnoses. By six months postpartum, 20.5% of FCNO participants had received an anxiety or PTSD diagnosis, compared to 10.5% of non-participants. This finding suggests that the program may be associated with better

identification of mental health concerns among participants, possibly due to increased interaction with healthcare providers and enhanced surveillance.

Qualitative Insights

Participants overwhelmingly expressed positive feedback about their experience with the FCNO program. Many appreciated the convenience of home visits and the personalized care they received from the nurses. Participants reported feeling supported, reassured, and more confident in caring for their infants. The program's emphasis on maternal mental health and the resources provided for postpartum anxiety and depression were particularly valued.

Conclusion

The FCNO program has shown promising early results in terms of Medicaid spending and healthcare utilization. While there are no statistically significant differences in several key outcomes, the qualitative data suggest strong participant satisfaction and potential benefits, particularly regarding mental health support and outpatient care. However, due to sample size limitations and the preliminary nature of these results, further data collection and analysis are needed to more accurately assess the program's impact. Future reports will incorporate additional follow-up and data sources to provide a clearer picture of the long-term effects of FCNO participation on maternal health outcomes.

1. Introduction

Family Connects International was established in 2009 through a partnership between the Duke University Center for Child and Family Policy, the Center for Child and Family Health, and Durham County Health Department. The Family Connects program offers in-home visits from a registered nurse to those who have recently given birth with the aim of educating, assessing needs, and connecting new parents to community support services.[1] By 2022, the model was operating in 35 local agencies in 16 states and had provided nearly 19,000 home visits.[2]

In August 2023, the New Orleans Health Department partnered with Ochsner Health and Touro LCMC Health to launch a two-year Family Connects pilot program for people giving birth and living in Orleans Parish (FCNO). FCNO will offer up to 3 in-home visits beginning around the third week after delivery at no cost to participating families.[3] FCNO visits for those giving birth at Touro Infirmary began in October 2023, while visits for those giving birth at Ochsner Baptist hospital began in August 2024.

Prior studies have shown that participation in the Family Connects program was associated with fewer emergency department visits in the first year after birth[4,5], fewer instances of maternal anxiety and depression[6], and fewer instances of child abuse investigations.[6] However, all of these studies have been conducted using data from Family Connects participants in the original program site of Durham, North Carolina. In this report, we provide preliminary evidence of the impact of the FCNO program on health care utilization, spending, and health outcomes for parents and children in New Orleans.

Using Medicaid claims data, we examined healthcare utilization, spending, and mental health diagnoses up to 6 months postpartum among beneficiaries delivering at Ochsner Baptist hospital or Touro Infirmary. Preliminary analyses indicate that FCNO participants had lower non-pharmacy Medicaid spending, fewer hospitalizations, and reduced rates of postpartum depression diagnoses compared to non-participants. However, participants showed higher rates of anxiety and PTSD diagnoses, while ED utilization remained similar between the two groups. Due to limited statistical power from the current sample size, these differences did not reach statistical significance. As FCNO participation grows and additional data becomes available, future reports will likely provide more definitive findings. Future analyses will expand upon these preliminary findings, leveraging larger datasets and incorporating electronic health records to assess biometric outcomes and impacts on newborn health.

In addition to the quantitative analysis, we conducted a qualitative evaluation of the FCNO program to capture participants' experiences and perceptions, providing a more holistic understanding of the program's impact. The qualitative evaluation consisted of semi-structured interviews with 45 participants who received at least one home visit between January and September 2024. Participants were predominantly between the ages of 26 and 40, evenly split between Medicaid and private insurance coverage, and diverse in racial

and educational backgrounds. Thematic analysis revealed overwhelmingly positive perceptions of the program. Participants valued the convenience, emotional support, and practical assistance offered by their nurse, with many noting the reassurance they felt as new or single mothers. The home visits were described as more comprehensive and supportive than expected, addressing maternal and infant health, mental health, and postpartum needs. Nurses were praised for their empathy, expertise, and ability to normalize participants' experiences. Recommendations for program improvements were minimal but included adding a social worker, providing more mental health resources, and offering earlier outreach during pregnancy to set expectations. Nearly all participants would recommend the program, emphasizing its value for first-time and underserved mothers. We will continue to build upon this qualitative framework and results in future reports.

2. Quantitative Evaluation Strategy

2.1 Data and Sample

We will use two data sources to analyze the association between FCNO participation and outcomes for parents and children. Medicaid claims data will allow us to track utilization and spending for FCNO participants with Medicaid coverage, both before (for parents) and after (for parents and children) the delivery episode. We anticipate approximately two-thirds of births occurring at Ochsner Baptist and Touro Infirmary will be covered by Medicaid. Medicaid claims data for all beneficiaries in Louisiana are housed at the Tulane School of Public Health and Tropical Medicine in the Department of Health Policy and Management.

Because insurance claims data lack information on biometric measures of health such as A1C levels or blood pressure readings, we plan to supplement the claims data with electronic health record (EHR) data. We have partnered with the Louisiana Public Health Institute to purchase access to EHR data through the Louisiana Pregnancy Registry, which will allow us to track changes in biometric measures between program participants and non-participants. Another advantage of the EHR data is that it is not restricted to the Medicaid population, but will include data for all payor types. However, LCMC does not currently provide data to the Louisiana Pregnancy Registry, so analyses that use this data source will be limited to deliveries occurring at Ochsner Baptist hospital. While future iterations of this report will incorporate EHR data, the current report is based solely on Medicaid claims.

Table 1 includes our proposed study outcomes along with the preferred data source and measurement definition.

Table 1: Study Outcomes

Outcome	Data Source	Measurement
Emergency Department Use @ 3 months, 6 months, and 12 months	Medicaid claims	Revenue codes 450-459
Hospital stays @ 3 months, 6 months, and 12 months	Medicaid claims	Claim type code = 01
Non-Pharmacy Medicaid Spending @ 3 months, 6 months, and 12 months	Medicaid claims	Medicaid allowed amount for all non-pharmacy services
Adherence to ACOG Postpartum Care Guidelines	Medicaid claims	At least one physician visit within the first 3 weeks postpartum and a second visit no later than 12 weeks postpartum
Diagnosis for postpartum depression	Medicaid claims/EHR data	ICD-10 diagnosis code F53.0
Diagnosis for anxiety and PTSD	Medicaid claims/EHR data	ICD-10 diagnosis codes F41 and F43.1
HbA1c levels	EHR data	HbA1c levels below 7% at post-delivery follow-up
Blood pressure readings	EHR data	Blood pressure readings at post-delivery follow-up: 120/80 mmHg = normal 120-139/80-89 mmHg = prehypertension 140/90 mmHg = hypertension

2.2 Methodology

We have developed two separate methodological frameworks for identifying the association between FCNO participation and study outcomes. Ideally, we would follow the lead of prior Family Connects studies and randomize eligible families to program participation to ensure unbiased estimates of program treatment effects.[4-6] However, because NOHD made the FCNO program available to all who give birth and live in Orleans Parish, randomization was not feasible in this case. Instead, we used the following naïve approach to generate preliminary estimates. We plan to implement the quasi-experimental methodologies described below when additional data becomes available.

2.2.1 Naïve Approach

Our naïve approach simply compared those participating in the FCNO program (i.e., those with a recorded home visit) to non-participants. The non-participant sample was restricted to individuals who gave birth at Ochsner Baptist or Touro Infirmary during the same year-

month as participants. We calculated group-specific averages for each outcome at 1, 2, 3, and 6 months and assessed whether differences between participants and non-participants were statistically significant using t-tests.

The key drawback of this naïve approach is that it fails to account for systematic differences between participants and non-participants that are correlated with both participation and outcomes of interest. For example, suppose new parents who have less community and family support are more likely to accept an FCNO visit *and* are also more likely to rely on the emergency department as a usual source of care. In this case, FCNO participation will be positively associated with emergency department use, not because FCNO actually *causes* higher emergency department use, but simply because those with a higher proclivity to use the emergency department will select into FCNO participation.

In an attempt to minimize this form of selection bias, we supplemented the naïve approach with a regression framework that adjusted for characteristics of the participant and non-participant populations that could potentially confound estimates of program participation. Formally, the regression model took the following form:

$$(1)\ Y_{iht} = \beta_0 + \beta_1 FCNO_{ih} + \beta_2 X_i + \delta_h + \tau_t + \varepsilon_{iht}$$

where Y represents an outcome in Table 1 for individual i, giving birth in hospital h (Ochsner Baptist or Touro), in year-month t. We estimated separate versions of Equation (1) for each of the outcomes listed in Table 1. $FCNO$ is an indicator that equals 1 for those with at least one home visit through the FCNO program (i.e., program participants) and 0 for those with no home visit (i.e., non-participants). Estimates of the β_1 coefficient represent the association between FCNO participation and each of the Table 1 outcomes. The variable X_i represents observable characteristics of the sample population that may be correlated with both program participation and the outcomes of interest (i.e., regression controls). We included controls for mother's age, whether the baby was delivered via c-section, obstetric comorbidity score (OCS)[1], and source of insurance coverage in models that are not restricted to Medicaid beneficiaries. δ is an indicator for whether the birth occurred at Ochsner Baptist or Touro hospitals and τ represents the year and month of the birth. Finally, ε is an error term that captures unmodeled factors associated with regression outcomes.

Augmenting the naïve approach with the regression framework described in Equation (1) should help to mitigate selection bias from observable confounders, however there are still likely to be unobserved correlates of program participation and outcomes that will lead to selection bias. To further address this issue, we propose an alternative

[1] The obstetric comorbidity score (OCS) is a scoring system designed to identify predictors of severe maternal morbidity.[7,8] The score ranges from 0 to 100 with higher scores indicating a greater likelihood of severe maternal morbidity. See Appendix Table 1 for a list of comorbidities included in the index and their corresponding ICD10 codes.

methodology that uses a quasi-experimental research approach designed to approximate randomized treatment assignment even when such randomization is infeasible. The quasi-experimental approach will be employed once additional data become available.

2.2.2 Quasi-Experimental Approach

Our quasi-experimental approach exploits the fact that those giving birth at Ochsner Baptist or Touro hospitals who do not live in Orleans Parish are not eligible for home visits under the FCNO program. Conceptually, these people constitute our "control" group as their exposure to the intervention is not determined by selection into the FCNO program, but rather by their parish of residence. On the other hand, the "treatment" group in this scenario are those giving birth at Ochsner Baptist or Touro Infirmary who live in Orleans Parish and thus are eligible for the FCNO program. We will use this treatment/control designation to estimate a regression model similar to Equation 1:

$$(2)\ Y_{iht} = \beta_0 + \beta_1 Eligible_{ih} + \beta_2 X_i + \delta_h + \tau_t + \varepsilon_{iht}$$

The variable $Eligible$ in Equation (2) is an indicator that equals 1 if person i lives in Orleans Parish (and thus eligible to participate in the FCNO program) and is equal to 0 otherwise. All other variables in Equation (2) are as defined previously.

Since it's unlikely that people would choose their parish of residence based on the availability of the FCNO program, Equation (2) should help to mitigate the selection bias inherent in the naïve approach. However, the model in Equation (2) is designed to provide an estimate of the effect of program *eligibility* and not program *participation* on Table 1 outcomes. This type of estimate is known as an "intent-to-treat" (ITT) effect. If FCNO participation rates are high, then the effects of eligibility and participation will be similar. But if participation rates are low, the effects of eligibility and participation could be quite different, and the ITT estimate will be largely uninformative.

To address this issue, we plan to use an instrumental variables (IV) procedure to return an unbiased estimate of the effect of FCNO participation on outcomes of interest. The IV design is a two-stage procedure where, in the first stage, we estimate the effect of eligibility on participation and, in the second stage, we estimate the effect of (predicted) participation on outcomes. Formally, the two stages of the IV model are as follows:

$$(3)\ FCNO_{ih} = \pi_0 + \pi_1 Eligible_{ih} + \pi_2 X_i + \delta_h + \tau_t + \varepsilon_{iht}$$

where all variables in Equation (3) are as defined previously such that Equation (3) predicts the likelihood of FCNO participation for an individual who is eligible due to the fact that they reside in Orleans Parish. The value in Equation (3) is that *predicted* FCNO participation depends only on eligibility (parish of residence) and not on factors that could confound estimates of participation leading to selection bias. Once we obtain predicted

FCNO participation from Equation (3), we will use it as a regressor in a modified version of Equation (1):

$$(4)\ Y_{iht} = \alpha_0 + \alpha_1 F\widehat{CNO}_{ih} + \alpha_2 X_i + \delta_h + \tau_t + \varepsilon_{iht}$$

Note that Equation (4) is identical to Equation (1) with the exception that the key independent variable in Equation (4) is *predicted* FCNO participation as opposed to *actual* FCNO participation in Equation (1). As long as eligibility (i.e., parish of residence) is uncorrelated with other determinants of Table 1 outcomes, conditional on the model covariates, then estimates from Equation (4) will be free from selection bias. To rephrase, *actual* participation is likely to depend on various unobserved factors that we cannot include as controls in Equation (1). If these factors are also correlated with Table 1 outcomes, then treatment effect estimates will be biased. *Predicted* participation does not depend on these unobserved factors – only on parish of residence. Therefore, treatment effect estimates that use *predicted* participation should be free from bias.

3. Qualitative Evaluation Strategy

The qualitative evaluation of the Family Connects program used a semi-structured interview guide with participants who consented to an interview (see Appendix B for the full survey instrument). The Tulane evaluation team consisted of one research faculty member and three research assistants to assist with interviews and coding. The Tulane evaluation team received contact information for the 134 participants who agreed to be interviewed and received at least one visit with Family Connects between January 10, 2024 and September 6, 2024. Interviews were conducted between June and October 2024. The Tulane evaluation team attempted to text and/or call each of these 134 participants, and ultimately 45 were interviewed.

Once the data collection was complete, the research team employed a thematic analysis approach to understand the data. The transcripts were transcribed, reviewed by two of the interviewers, and then each reviewer independently created a code book. The code books were reviewed, refined, reapplied to select transcripts, and then finalized into a single codebook. The final codebook included themes based on the codes. Three researchers then coded the transcripts. The results of the analyses are reported in Section 5 below.

4. Quantitative Results

Due to the delayed rollout of the FCNO program and the lengthy claims adjudication process[2], our quantitative results at this point remain preliminary and focus on a limited set of outcomes. For the purposes of this report, we are only including results for people

[2] It can take several months for a Medicaid claim to be adjudicated once the claim has been received by Louisiana Medicaid. Because claims are often denied and/or adjusted during the adjudication process, it is important to include only final adjudicated claims in the quantitative analyses.

giving birth through September 2024.[3] Consequently, most FCNO participants in the dataset gave birth at Touro Infirmary, while Ochsner Baptist births are only reflected in analyses covering the first month postpartum. It is important to note that not all Medicaid claims through September 2024 may have been adjudicated at the time this report was created, meaning the values presented below are subject to change in future versions.

Additionally, this report focuses on the naïve evaluation strategy described earlier. Quasi-experimental analyses require additional data that are not yet available. Future reports will incorporate results from the Pregnancy Registry EHR data and Medicaid claims.

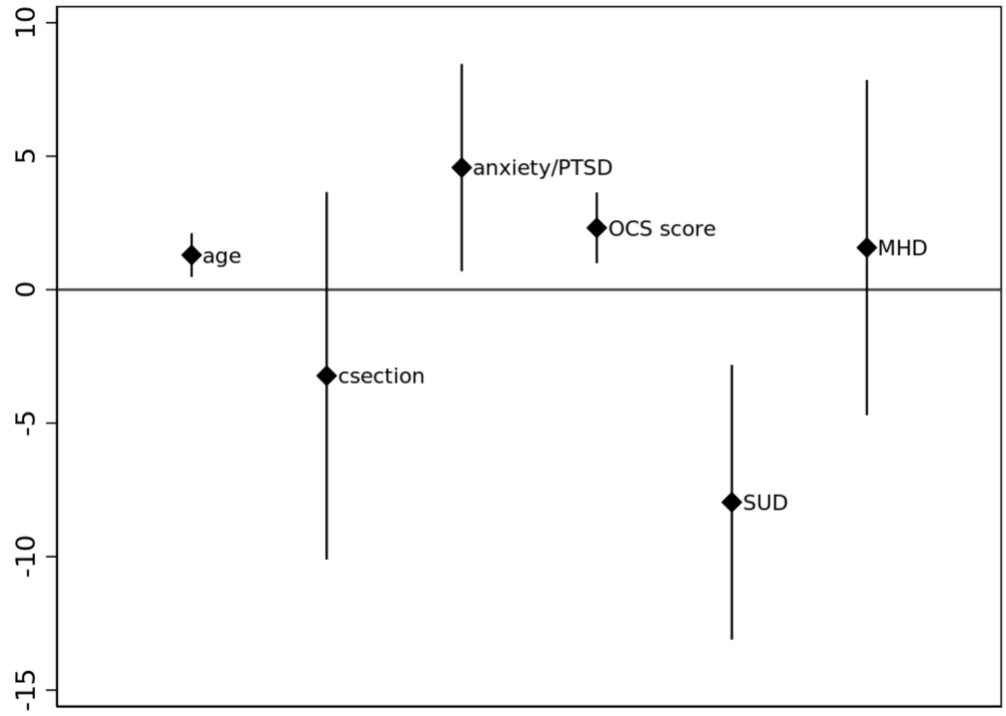
Participant Characteristics

We began by assessing differences in characteristics between Medicaid members who participated in the FCNO program and those who were eligible for participation based on their parish of residence and delivery hospital, but chose not to receive a home visit. Figure 1 plots coefficients from a simple regression of FCNO participation on participant characteristics that included mother's age in years, whether the delivery occurred via c-section, whether the mother had a prenatal diagnosis of anxiety or post-traumatic stress disorder (PTSD), obstetric comorbidity score (OCS), whether the mother had a prenatal substance use disorder diagnosis (SUD), and whether the mother had a prenatal major mental health diagnosis[4] (MHD).

[3] We did not include outcome measures for the newborns in this report, but plan to do so in future reports when more data is available.

[4] See Appendix Table 1 for ICD10 codes corresponding to conditions included in the definition of a major mental health disorder.

Figure 1: Characteristics Associated with FCNO Participation



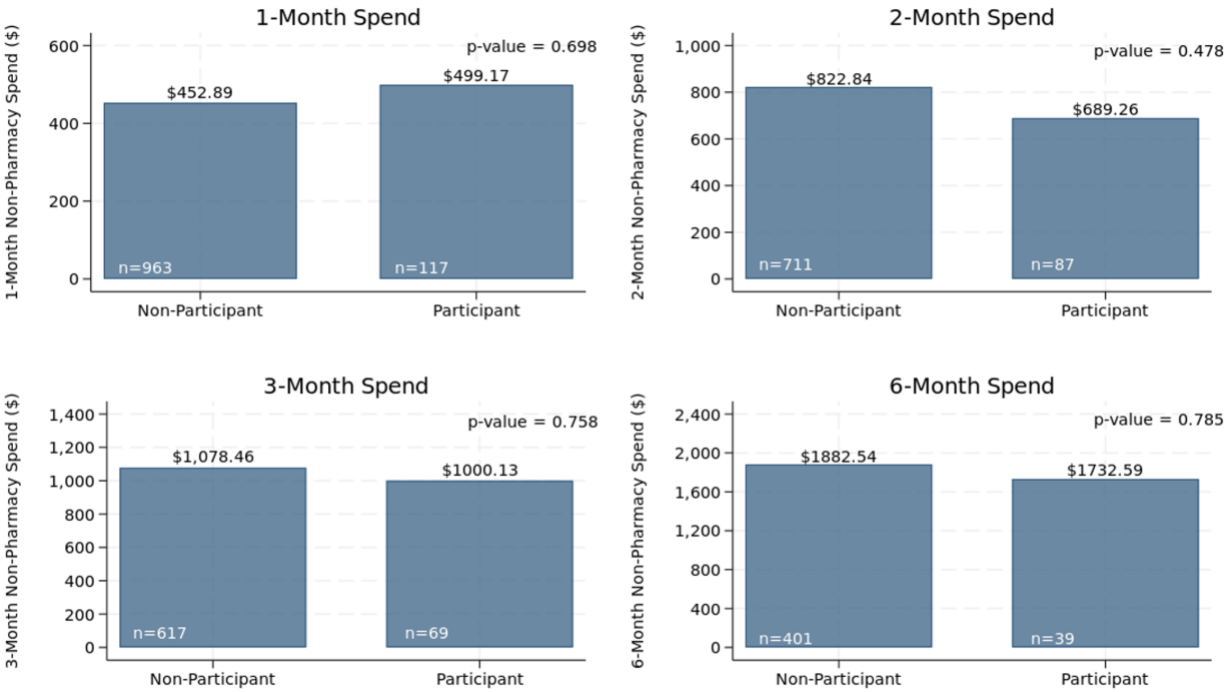
Notes: Each marker represents the percentage point difference between FCNO participants and non-participants. Lines represent 95% confidence intervals. Anxiety/PTSD was measured as a diagnosis for anxiety or PTSD in the prenatal period. PTSD=post-traumatic stress disorder. OCS=obstetric comorbidity scoring system. SUD=substance use disorder. MHD=major mental health disorder.

On average, FCNO participants were slightly older than non-participants (27.6 years vs. 26.3 years), had higher rates of prenatal anxiety and PTSD diagnoses (12.4% vs. 7.9%), were at higher risk of sever maternal morbidity as measured by the OCS score (16.3 vs. 14.0), and had lower rates of prenatal SUD (7.0% vs. 15.0%). While c-section deliveries were less common among participants (31.9% vs. 35.1%), the difference was not statistically significant. Rates of prenatal MHD were similar between FCNO participants and non-participants (27.0% vs. 25.5%). Taken together, the estimates in Figure 1 indicate that participants and non-participants differed on several characteristics that are likely to be associated with the outcomes we study in this report. As a result, naïve estimates of program effects should be interpreted with caution.

Spending

Figure 2 compares non-pharmacy Medicaid spending at 1, 2, 3, and 6 months postpartum among those with at least one FCNO visit ("participants") versus those without a visit ("non-participants").

Figure 2: Association between FCNO Participation and Medicaid Spending

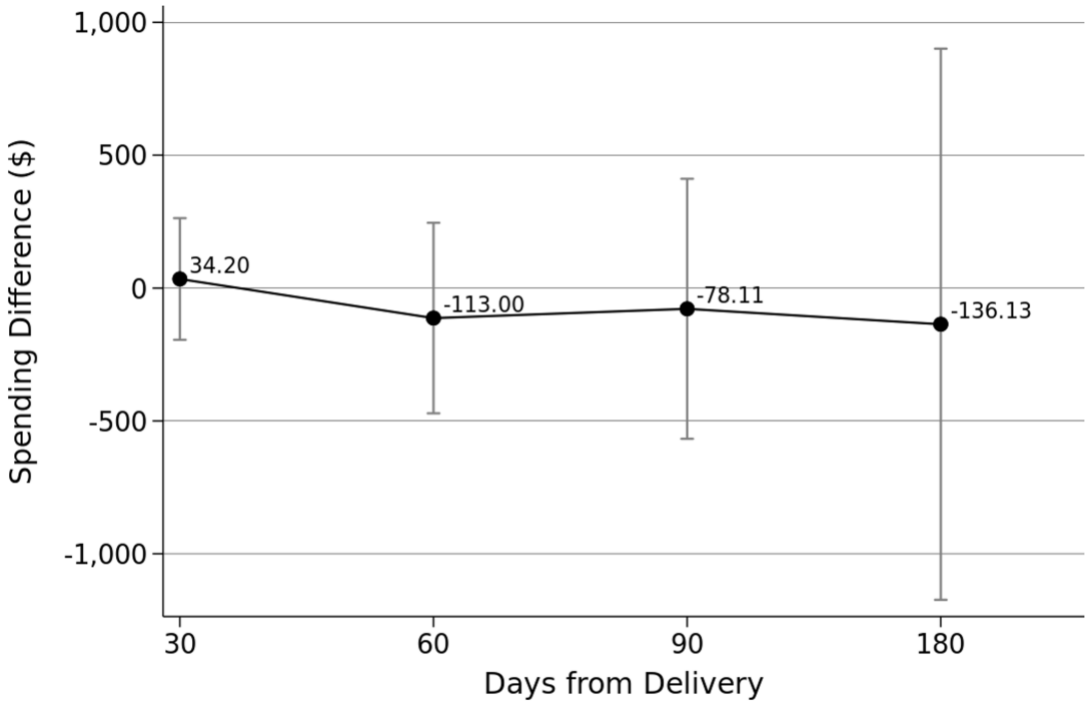


Notes: Sample includes Medicaid beneficiaries who gave birth at Ochsner Baptist since July 2024 or Touro Infirmary since September 2023.

Medicaid spent an average of $499.17 per FCNO participant in the 30 days following delivery compared to an average of $452.89 for non-participants. While FCNO participant spending was higher within the first 30 days of delivery, non-participant spending had surpassed participant spending at two months post-delivery ($822.84 vs. $689.26, p=0.478) and remained higher through six months ($1,882.54 vs. $1,732.59, p=0.785). Due to small sample sizes (e.g., 401 non-participants and 39 participants at six months), differences in spending between the groups were not statistically significant. We expect the precision of these estimates to improve as the sample size grows.

Spending estimates in Figure 2 are "unadjusted" in the sense that they represent simple averages for FCNO program participants and non-participants. Following the approach described in Section 2.2.1, we estimated separate regression models with Medicaid spending at various intervals as the dependent variable and included delivery hospital, delivery year, delivery month, mother's age, obstetric comorbidity score, and whether the baby was delivered via c-section as covariates. Figure 3 plots the coefficients on FCNO participation from these regression models and, similar to the unadjusted estimates in Figure 2, indicates that Medicaid spending is lower, on average, for program participants at 2 months, 3 months, and 6 months post-delivery. Again, it is important to note that these differences are not statistically significant.

Figure 3: Regression-adjusted Association between FCNO Participation and Medicaid Spending

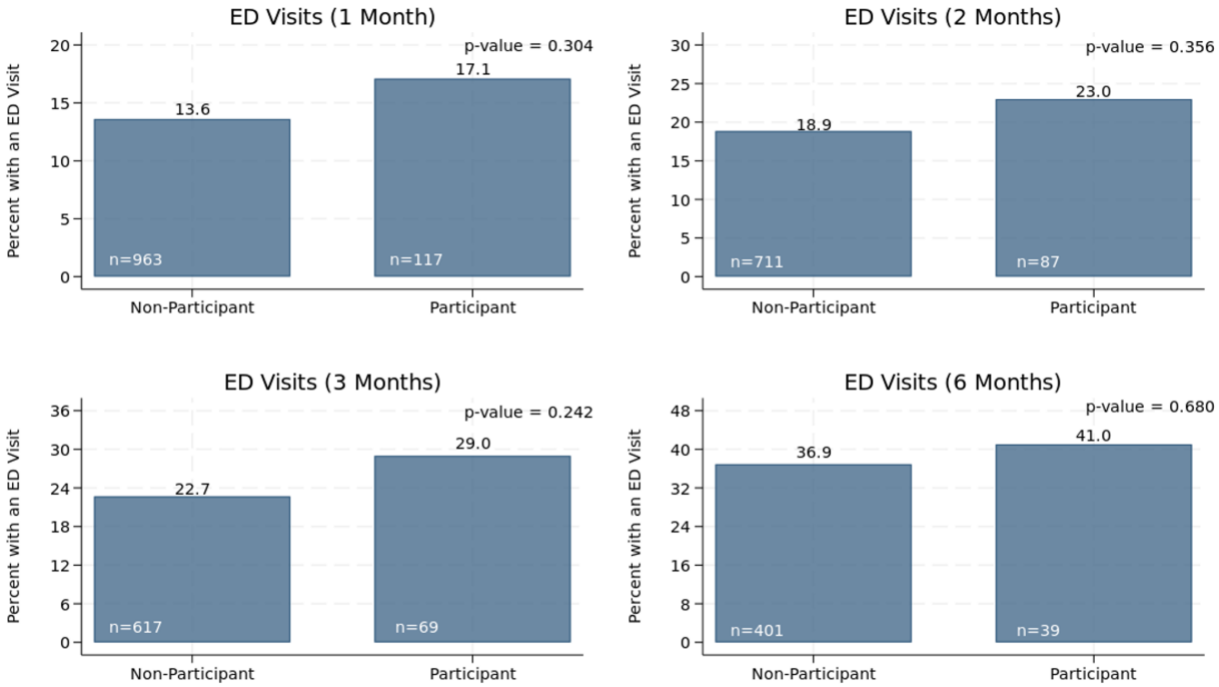


Notes: Estimates are from separate regressions of FCNO participation on outcomes at 30-, 60-, 90-, and 120-days. Regression models include controls for delivery hospital, delivery year, delivery month, mother's age, obstetric comorbidity score, and whether the baby was delivered via c-section.

Emergency Department Visits

We next examined the percentage of participants and non-participants with an emergency department (ED) visit within 1, 2, 3, and 6 months post-delivery, with unadjusted results presented in Figure 4.

Figure 4: Association between FCNO Participation and Emergency Department Visits

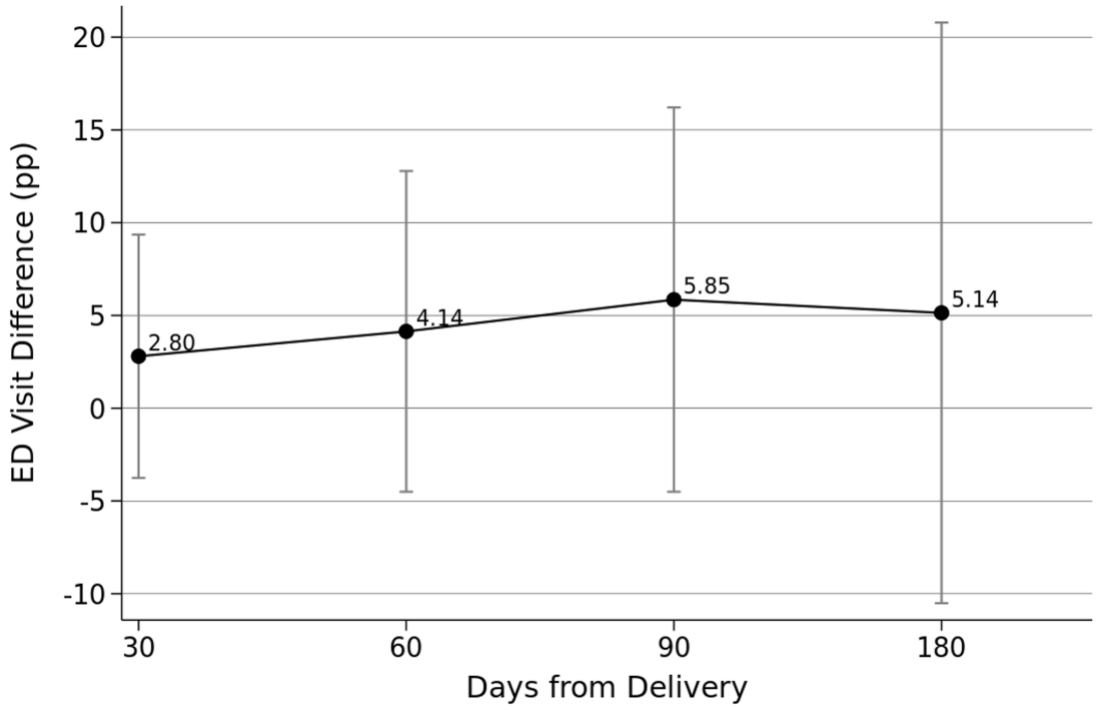


Notes: Sample includes Medicaid beneficiaries who gave birth at Ochsner Baptist since July 2024 or Touro Infirmary since September 2023.

On average, FCNO participants had higher ED use rates after giving birth than non-FCNO participants. While differences were not statistically significant at any post-delivery time interval, 41.0% of FCNO participants experienced an ED visit in the 6 months after giving birth compared to 36.9% of non-participants (p=0.680).

Figure 5 plots regression-adjusted estimates of the association between FCNO program participation and ED rates at each of the follow-up intervals.

Figure 5: Regression-adjusted Association between FCNO Participation and Emergency Department Visits



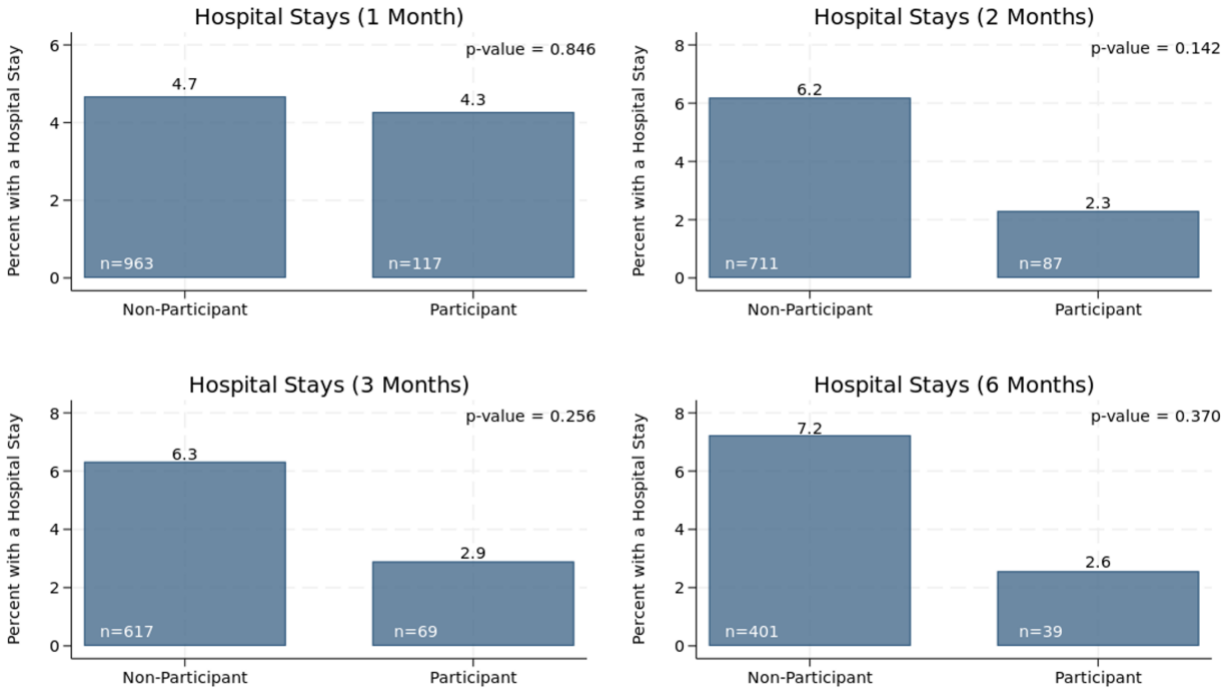
Notes: Estimates are from separate regressions of FCNO participation on outcomes at 30-, 60-, 90-, and 120-days. Regression models include controls for delivery hospital, delivery year, delivery month, mother's age, obstetric comorbidity score, and whether the baby was delivered via c-section.

The regression-adjusted estimates in Figure 5 reveal that the difference in ED visit rates between FCNO participants and non-participants increased from 30- to 60-days and from 60- to 90-days, before falling from 90- to 180-days. FCNO participants were 5.1 percentage points more likely to have an ED visit within the first 180 days postpartum (p = 0.519), although the difference was not statistically significant.

Hospital Stays

We compared the proportion of FCNO participants and non-participants with a hospital stay within 1, 2, 3, and 6 months post-delivery. Unadjusted results are presented in Figure 6.

Figure 6: Association between FCNO Participation and Hospital Stays

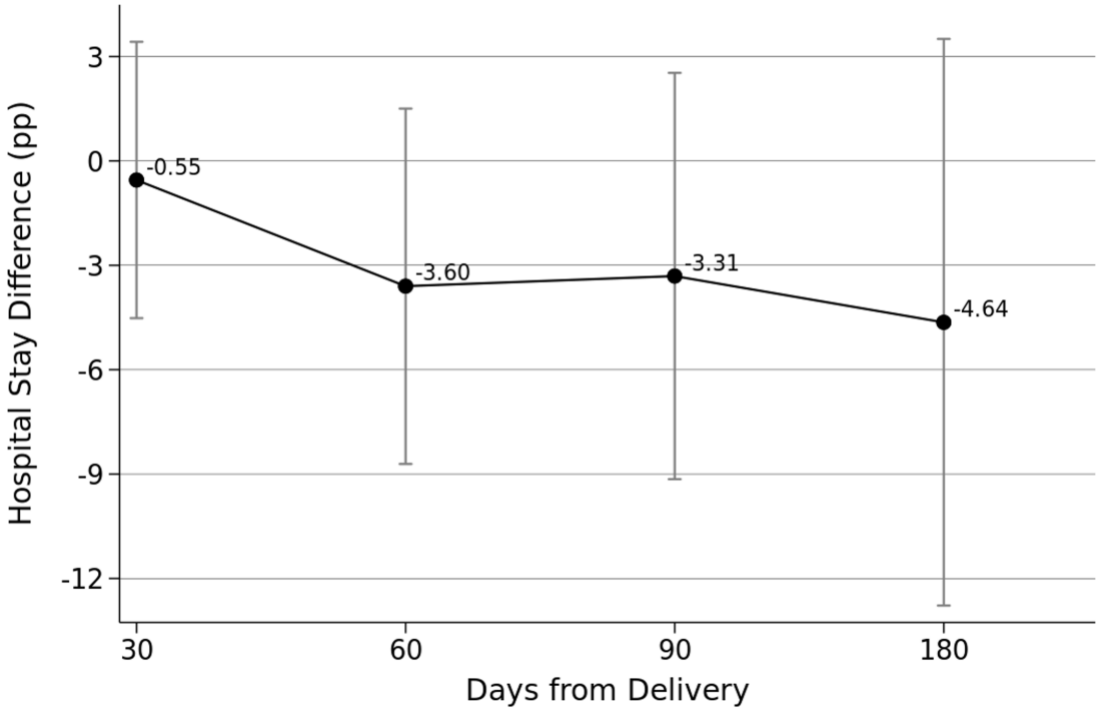


Notes: Sample includes Medicaid beneficiaries who gave birth at Ochsner Baptist since July 2024 or Touro Infirmary since September 2023.

On average, FCNO participants were less likely to experience an inpatient hospital stay compared to non-participants, though differences were not statistically significant. Despite this lack of statistical significance, trends in ED visits and hospital stays between participants and non-participants are suggestive of a pattern where FCNO visits may lead to greater utilization of outpatient services that obviate the need for inpatient care. Were this to be the case, this may explain why overall spending tends to be lower among FCNO participants than among non-participants (see Figures 2 and 3).

Figure 7 plots regression-adjusted estimates of differences in the association between FCNO participation and the share of Medicaid beneficiaries with hospital stays over each of the follow-up time periods for FCNO participants compared to non-participants.

Figure 7: Regression-adjusted Association between FCNO Participation and Hospital Stays



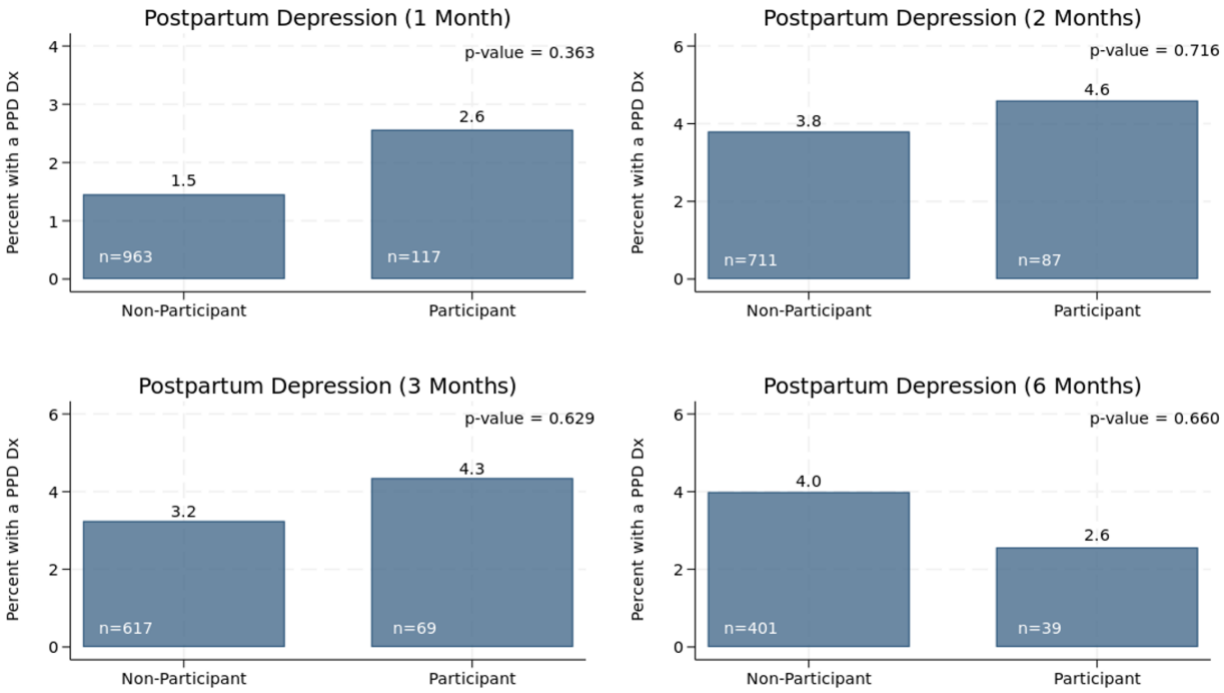
Notes: Estimates are from separate regressions of FCNO participation on outcomes at 30-, 60-, 90-, and 120-days. Regression models include controls for delivery hospital, delivery year, delivery month, mother's age, obstetric comorbidity score, and whether the baby was delivered via c-section.

Inpatient stay rates were similar for participants and non-participants at 1 month post-delivery. At 2 and 3 months from delivery, participants were 3.6 and 3.3 percentage points less likely to experience a hospital stay, though the differences were not statistically significant. The gap between participants and non-participants had grown to 4.6 percentage points by 6 months from delivery, but remained statistically insignificant.

Postpartum Depression

Figure 8 presents the unadjusted rates of postpartum depression (PPD) diagnoses among FCNO participants and non-participants. In the six months following delivery, 2.6% of participants received a postpartum depression diagnosis, compared to 4.0% of non-participants. Although this suggests a lower rate of PPD among those receiving home visits, the difference was not statistically significant ($p = 0.660$).

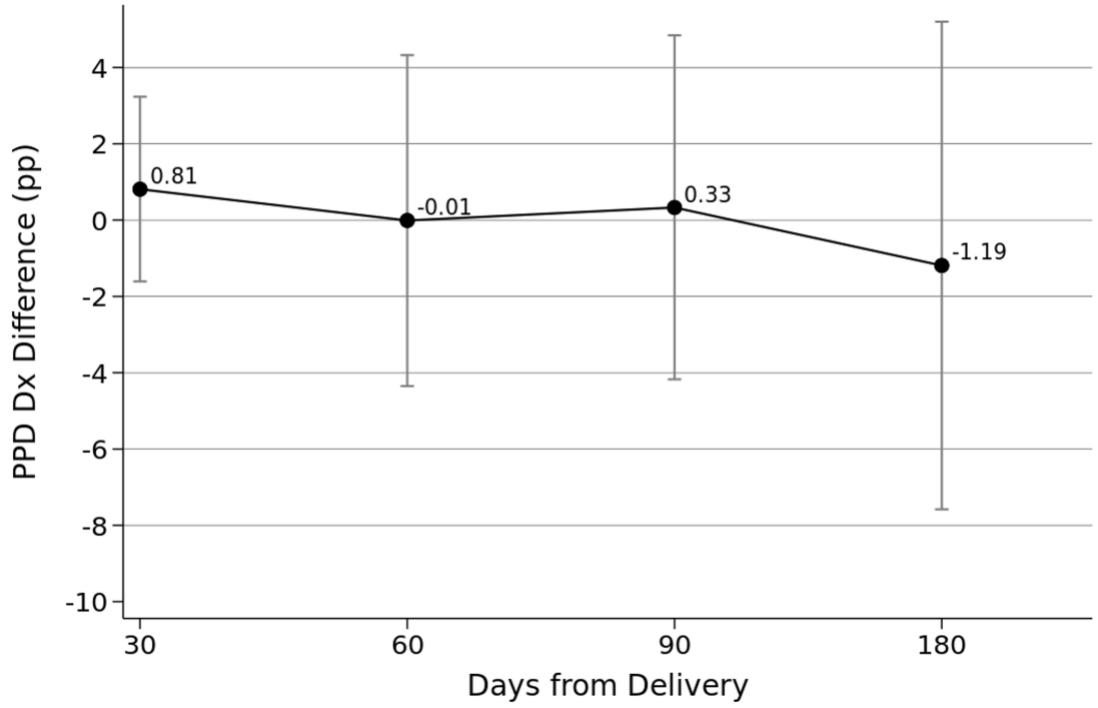
Figure 8: Association between FCNO Participation and Postpartum Depression Diagnosis



Notes: Sample includes Medicaid beneficiaries who gave birth at Ochsner Baptist since July 2024 or Touro Infirmary since September 2023.

Regression-adjusted estimates, controlling for maternal age, delivery hospital, obstetric comorbidity score (OCS), and mode of delivery, are shown in Figure 9. After adjustment, FCNO participants were 1.2 percentage points less likely to receive a PPD diagnosis at 6 months after delivery, though the difference remained statistically insignificant.

Figure 9: Regression-adjusted Association between FCNO Participation and Postpartum Depression Diagnosis



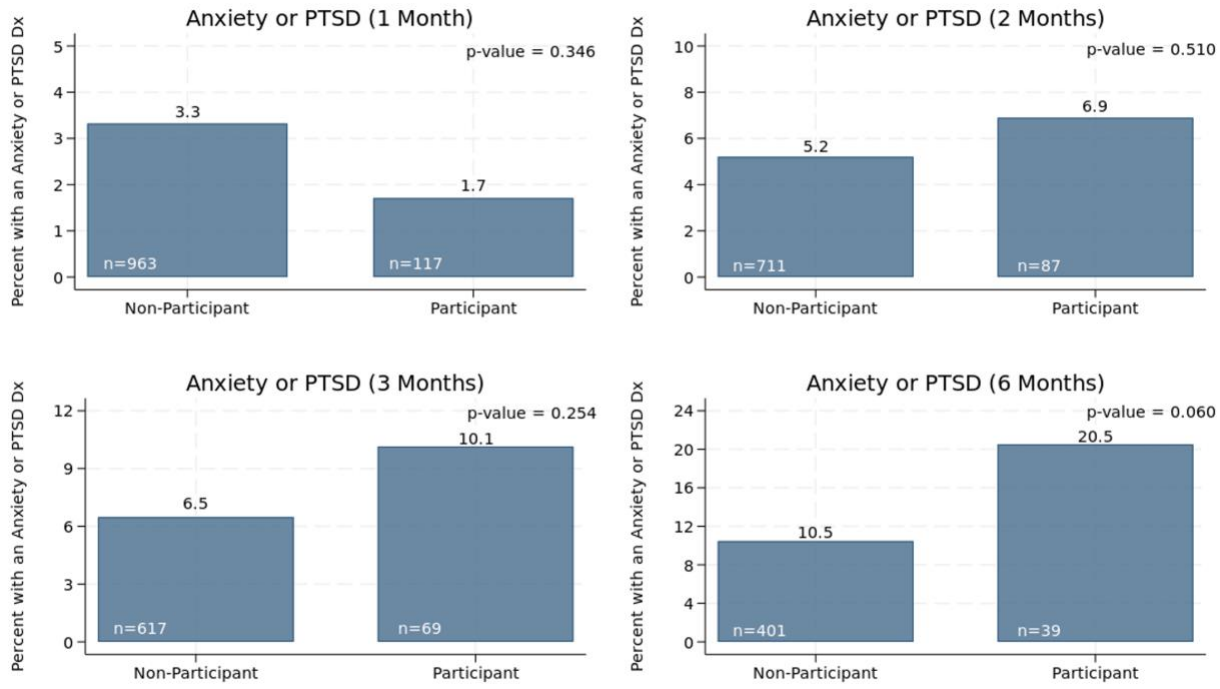
Notes: Estimates are from separate regressions of FCNO participation on outcomes at 30-, 60-, 90-, and 120-days. Regression models include controls for delivery hospital, delivery year, delivery month, mother's age, obstetric comorbidity score, and whether the baby was delivered via c-section.

While preliminary results indicate a potential association between FCNO participation and reduced postpartum depression risk, the lack of statistical significance highlights the need for larger sample sizes and additional follow-up periods.

Postpartum Anxiety and PTSD

To assess the association between FCNO participation and postpartum anxiety or PTSD, we examined diagnosis rates within the first six months following delivery. Figure 10 presents unadjusted rates of anxiety and PTSD diagnoses among FCNO participants and non-participants.

Figure 10: Association between FCNO Participation and Anxiety or Posttraumatic Stress Disorder Diagnosis



Notes: Sample includes Medicaid beneficiaries who gave birth at Ochsner Baptist since July 2024 or Touro Infirmary since September 2023.

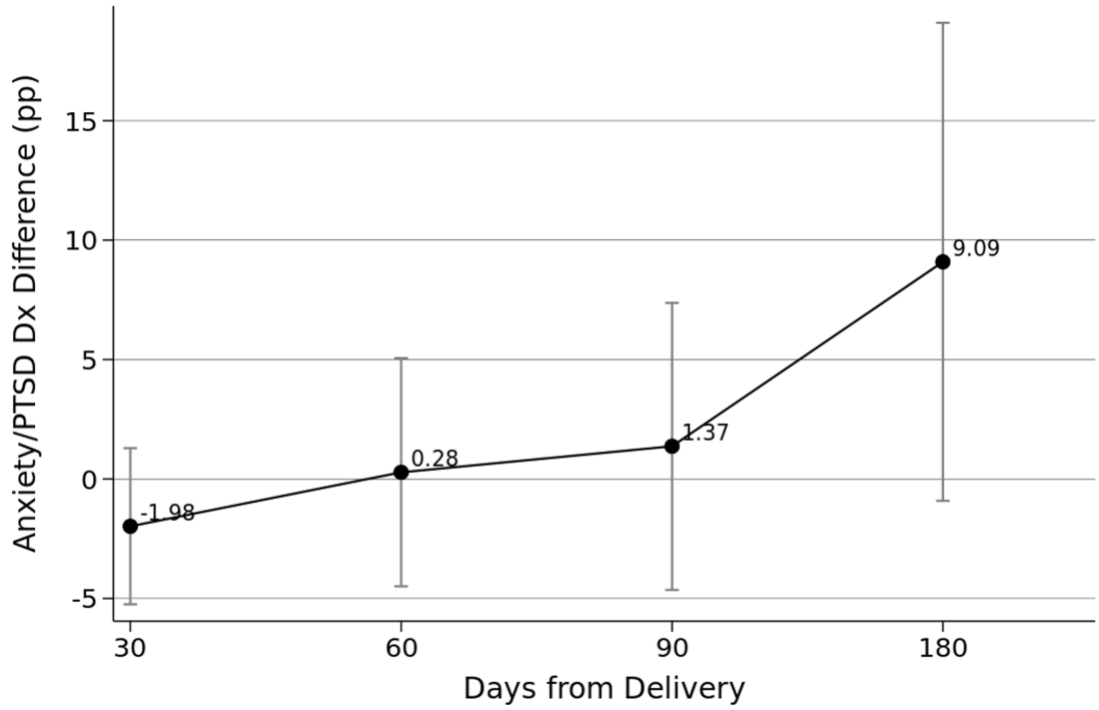
Across the 2-, 3-, and 6-month intervals, FCNO participants consistently exhibited higher rates of postpartum anxiety or PTSD. By the six-month mark, 20.5% of program participants had received a diagnosis of anxiety or PTSD, compared to 10.5% of non-participants. This difference highlights a notable increase in anxiety and PTSD diagnoses among those who engaged with the FCNO program.

Interestingly, this pattern diverges from the findings on postpartum depression (PPD) shown in Figures 8 and 9, where FCNO participants experienced lower rates of PPD relative to non-participants. The contrasting trends suggest that while the program may be associated with lower rates of PPD, it could also coincide with a heightened likelihood of identifying and diagnosing anxiety or PTSD in the postpartum period. This could reflect greater surveillance, increased interaction with healthcare providers, or a differential impact of FCNO participation on various dimensions of maternal mental health.

Regression adjustment can help to account for these potential differences in health care engagement, demographic characteristics, and other underlying factors that could influence diagnosis rates. After adjusting for observable covariates, the difference in anxiety and PTSD diagnoses at six months postpartum narrowed to 9.1 percentage points, though the gap between participants and non-participants remained substantial. This adjusted estimate reinforces the association between FCNO participation and higher

postpartum anxiety or PTSD diagnoses, while highlighting the importance of accounting for confounding factors in understanding the program's impact.

Figure 11: Regression-adjusted Association between FCNO Participation and Anxiety or Posttraumatic Stress Disorder Diagnosis



Notes: Estimates are from separate regressions of FCNO participation on outcomes at 30-, 60-, 90-, and 120-days. Regression models include controls for delivery hospital, delivery year, delivery month, mother's age, obstetric comorbidity score, and whether the baby was delivered via c-section.

Summary

In summary, preliminary findings indicate that FCNO participation is associated with modest differences in Medicaid spending and health care utilization in the postpartum period, although these differences were not statistically significant. FCNO participants tended to incur lower Medicaid costs in the months following delivery. While the program was linked to higher emergency department visit rates in the initial months postpartum, participants were less likely to experience hospital stays. FCNO participation was associated with a lower rate of postpartum depression (PPD) diagnoses, but a higher rate of anxiety and PTSD diagnoses, although neither difference reached statistical significance. These contrasting trends suggest that while FCNO participation may be linked to reduced risk of PPD, it could also coincide with increased identification of anxiety or PTSD, warranting further investigation. Future iterations of this report will explore these findings in greater detail, particularly to understand the potential reasons behind the divergent impacts on maternal mental health. Overall, while these results offer valuable insights, additional data and follow-up are necessary to fully assess the long-term effects of FCNO participation on postpartum health outcomes.

5. Qualitative Results

Sociodemographics

The sociodemographic characteristics of the participants are presented in Table 2. The majority (82%) of participants delivered at Touro (Ochsner Baptist began home visits in August 2024). Most participants had one home visit (80%) and were between the ages of 26 and 40 (80%). Participant insurance type was nearly evenly split between those with Medicaid (51%) and those with private insurance (49%). Most participants were Black (47%) or White (38%) and were employed (73%). More than half of the participants had either a bachelor's degree (27%) or an advanced degree (29%). For nearly half (47%) of the participants, their most recent birth was their first child, whereas about one-quarter had 2 children in total (24%) or had 3 or more (26%) children in total.

Table 2. Sociodemographic Characteristics of Participants in the Qualitative Evaluation, 2024

	%	n
Total (N)		45
Number of home visits		
1	80	36
2	7	3
3+	7	3
Unknown	7	3
Delivery hospital		
Touro	82	37
Ochsner Baptist	18	8
Age range		
<15	0	0
15-20	2	1
21-25	11	5
26-30	22	10
31-35	36	16
36-40	22	10
41-45	2	1
>45	0	0
Unknown	4	2
Insurance type		
Medicaid	51	23
Private	49	22
Race/ethnicity		
Black	47	21
White	38	17
Hispanic	0	0

Asian	2	1
Other	11	5
Prefer not to say	2	1
Education		
<High school	7	3
High school diploma	24	11
Some college	13	6
Bachelor's degree	27	12
Advanced degree*	29	13
Employed		
Yes	73	33
No	18	8
Student	4	2
Unknown	4	2
# of children		
1	47	21
2	24	11
3	13	6
4+	13	6
Unknown	2	1

Notes: Due to rounding, category percentages may not equal 100.
*Advanced degrees include Master's, Doctorate, and JD

Thematic analysis

Themes identified and exemplary quotes are presented in Appendix Table 2. Each quote within a theme is from a different participant. The quotes shown in the table either represent a frequent response (bolded), show a nuanced view of that response, or were unique and potentially of interest to the Family Connects program.

The themes largely corresponded to the interview guide questions, but there were recurring topics that were frequently brought up unprompted by the participants. For example, most participants had very positive things to say about their nurse although we rarely specifically asked about the nurse herself.

Program introduction themes focused on how the participant first learned about Family Connects and why they decided to participate. Nearly all participants heard about Family Connects in the hospital after they delivered their baby. Primary reasons to participate included the convenience of the nurse home visit, the free cost to participate, and the desire to have any extra help with their newborn, especially for first-time and single mothers. Others were more interested in the health check-up given their health status during pregnancy or during previous postpartum periods.

“It sounded like a really good program. Sometimes you have like so many questions, and then you forget what to ask when you're in a doctor's office and you feel rushed and everything. She came to me, so I didn't have to like, you know, pack up the baby and go anywhere.”

Program experience themes include the participant’s overall experience, their satisfaction with the structure of the program (e.g., number of visits), their description of their nurse, and how the nurse interacted with their families during the home visit. Several participants described their experience with Family Connects as a supportive program that demonstrated someone cared about them and their newborn. Others said their home visit normalized their postpartum experiences, and others appreciated the extra medical attention they received between regularly scheduled postpartum and pediatric appointments. Most participants were satisfied with the number of home visits they received. Without any prompt, most participants described how much they enjoyed and appreciated the nurse herself. Several women described how their interactions with the nurse felt familial and left them feeling supported, reassured, educated, and more confident after their visit. A few participants appreciated how the nurse interacted with and included their families in the home visit.

“It's just the support system like that they feel someone's there to help, or you know you can have someone there to come check up on you from time to time. Just to have somebody there to so show that they actually care after you leave the hospital.”

“She's like, I'm here for you. You don't need to offer me anything, like, just leave it, and it's like she's so amazing, because it's so tough right now.”

“She helped me understand the basic needs, the basic needs of myself for my baby. She understand me. She helped me like, yeah, helped me be a better mother.”

Postpartum support was a theme with many subthemes: nutritional support, infant health, maternal mental and physical health, and resources. Several participants described how their nurse improved their experiences with breastfeeding, via tips to make it easier, supporting their decisions to continue or discontinue, or assuring them their baby’s intake was sufficient given the baby’s appropriate weight gain. The nurse helped several participants with specific infant health issues. Several participants brought up their mental health (commonly referred to as “postpartum”). They described their home visit as alleviating anxieties and helping with resources for depression. Several participants described the relief they felt when the nurse encouraged them to take some time for themselves. A few participants were having blood pressures issues that the nurse discovered and then provided timely recommendations for treatment. Many women discussed their appreciation for all of the resources the nurse gave them.

“I would say my postpartum experience probably would have been a little worse if I didn't do that, because I was really really going through it. I was having breakdowns after

breakdowns, and I even told the nurse about you know what I was dealing with. That's why she suggested the me having a me time, or just just taking some time for myself."

Program expectations themes centered around how the home visit was more than what the participant anticipated. Participants commonly described their visits as being longer (which was welcomed), more comfortable, and more holistic than they were expecting the visit to be. A few participants were at first apprehensive about the idea of the home visit, but they become more comfortable as the visit(s) progressed.

"I was expecting it to be just a nurse to come and check my baby and check her weight and etc., and they checked me. She's talking with me about everything and about more topics than I expected."

Barriers themes were not common, but the ones that were focused on difficulties following-up with recommended resources or transportation issues.

"I reached out to more than one [mental health provider on the list] and left some messages, but none of those people ever got back to me."

Program Improvement themes have a high number of codes, but most participants did not recommend any improvements. Of those who had recommendations for improvement, some would have preferred more information about what to expect during their home visit. A few participants suggested the timing of the home visit could have been earlier. Some participants would have liked a lactation specialist or a social worker to help them follow-up on recommendations.

"Honestly, there's nothing I would change."

"I guess I would provide like more mental health people available like through the program."

Recommend the program themes focused on if the participant would recommend Family Connects to others. Everyone said they would recommend it, and several people have already done so. Many participants think this program is needed by everyone, especially those who do not have a sufficient support system, are single mothers, and/or are first-time mothers.

"I think every woman needs this to be honest. Every family, woman, child deserve this type of service. We need services, especially in New Orleans."

"I will recommend it to a friend. Most of my friends are like me, for as being a single parent, and don't have transportation. So I will refer it because it'll be convenient for another mom like me."

"Absolutely for the help, and also just like having someone that can normalize your feelings as a first time parent."

Qualitative Results Discussion

Overall and overwhelmingly, participants had positive experiences with Family Connects. It was perceived as an added layer of support at a critical time when extra support is needed. Participants felt supported across a range of topics, including physical health and mental health. Participants like all of the resources they received. Many participants, particularly those who are first-time and/or single mothers, described how the reassurance that they and their baby were ok was immensely helpful. Although we did not explicitly start asking about the participants' mental health until late September, several patients discussed it, either in terms of the nurse helping with mental issues they were having or in terms of how the nurse simply made them feel better by asking how they were and assuring them that things were indeed normal. The nurses were highly regarded for their knowledge, empathy, and genuineness.

There were not many recommendations for program improvements, but a few participants would have added more to the program (e.g., a social worker to the team) rather than changing something about the current program. There were a few participants who would have liked to have better understood what to expect from the program before the home visit. Outreach during the prenatal period may be beneficial for recruitment and setting expectations. Although most participants felt their number of home visits was sufficient, there was some confusion about eligibility for additional visits.

6. Conclusion

The preliminary findings from the Family Connects New Orleans (FCNO) program suggest several important insights regarding Medicaid spending, health care utilization, and maternal mental health in the postpartum period. Although the data is still in the early stages, the results indicate a modest association between FCNO participation and lower Medicaid spending in the postpartum period. While this difference was not statistically significant, it provides a promising indication that home visit programs may help reduce healthcare costs by encouraging outpatient care and reducing hospital stays. Additionally, the analysis of emergency department visits and hospital stays suggests that FCNO participation may be linked to increased utilization of outpatient services, which could reduce the need for inpatient care. However, the results regarding emergency department visits were mixed, with no significant differences between participants and non-participants.

FCNO participants showed a slightly lower rate of postpartum depression diagnoses compared to non-participants. However, participants exhibited a higher rate of postpartum anxiety and PTSD diagnoses, possibly reflecting more proactive healthcare engagement or more thorough identification of mental health issues. These contrasting trends underscore

the complex nature of postpartum care and suggest that further investigation is needed to better understand the program's impact on maternal mental health.

Despite these preliminary results, several factors must be considered when interpreting these findings, including sample size limitations and the unadjusted nature of some estimates. As additional data and follow-up become available, future reports will be able to provide a more comprehensive analysis of the program's effects on maternal health outcomes.

In conclusion, while the initial findings offer valuable insights, the need for larger sample sizes, longer follow-up periods, and additional data sources will be essential for a deeper understanding of the long-term effects of the FCNO program. These results highlight the potential value of home visiting programs for maternal health, but further research is required to fully assess their efficacy.

The remaining evaluation deliverables will be provided based on the schedule in Table 3.

Table 3: Evaluation Deliverables

Deliverable	**Date**
Evaluation Report #1 (preliminary report)	June 2024
Evaluation Report #2 (first year report)	December 2024
Evaluation Report #3 (year 2 mid-term report)	June 2025
Evaluation Report #4 (final report)	December 2025

7. References

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7. Leonard SA, Kennedy CJ, Carmichael SL, Lyell DJ, Main EK. An expanded obstetric comorbidity scoring system for predicting severe maternal morbidity. *Obstetrics & Gynecology*. 2020;136(3):440-449.
8. Leonard SA, Main EK, Lyell DJ, et al. Obstetric comorbidity scores and disparities in severe maternal morbidity across marginalized groups. *American journal of obstetrics & gynecology MFM*. 2022;4(2):100530.

Appendix Table 1: Obstetric Comorbidity Scoring System and ICD10 Codes

Comorbidity	Score	ICD10 Codes
Placenta accreta spectrum	27	O43.213, O43.223, O43.233
Pulmonary hypertension	20	I27.0, I27.2
Chronic renal disease	17	O10.2, O10.3, O26.83, I12, I13, N03-N05, N07, N08, N11.1, N11.8, N11.9, N18, N25.0, N25.1, N25.81, N25.89, N25.9, N26.9
Cardiac disease, preexisting	14	I05-I09, I11-I13, I20, I25, I27.8, I31, I32, I34-I39, I44, I45, I47-I49, I50.22, I50.32, I50.33, I50.42, I50.43, I50.812, I50.813, O10.1, O10.3, O99.41, O99.42, Q20-Q24
HIV/AIDS	13	O98.7, B20
Preeclampsia with severe features	12	O14.1, O14.2, O11
Placental abruption	9	O45
Bleeding disorder, preexisting	9	D66, D67, D68.0-D68.6, D69
Anemia, preexisting	9	O99.01, O99.02, D50-53, D55, D56, D58, D59, D57.1, D57.20, D57.3, D57.40, D57.80, D64.9
Twin/multiple pregnancy	9	O30, O31, O-63.2, Z37.2-Z37.7
Preterm birth (< 37 weeks)	8	Z3A.20-Z3A.36
Placenta previa, complete or partial	8	O44.03, O44.13, O44.23, O44.33
Neuromuscular disease	6	G40, G70
Asthma, acute or moderate/severe	5	O99.5, J45.21, J45.22, J45.31, J45.32, J45.4, J45.5, J45.901, J45.902
Preeclampsia without severe features or gestational hypertension	5	O13, O14.0, O14.9
Connective tissue or autoimmune disease	4	M30-M36
Uterine fibroids	4	D25, O34.1
Substance use disorder	4	F10-F19, F-55, O99.31, O99.32

Gastrointestinal disease	3	K50-K52, K70-K77, K80-K83, K85-K87, K94, K95, O26.6
Chronic hypertension	3	O10.0, O11, I10
Major mental health disorder	3	F06, F20-F25, F28-F34, F39, F40.0, F41, F43, F53, F60
Thyrotoxicosis	3	E05
Preexisting diabetes mellitus	2	E08-E13, O24.0, O24.1, O24.3, O24.8, O24.9, Z79.4
Previous cesarean birth	2	O34.21, O66.41
Gestational diabetes mellitus	1	O24.4
Delivery BMI $\geq$ 40	1	Z68.4, E66.01, E66.2

Sources: Leonard SA, Kennedy CJ, Carmichael SL, Lyell DJ, Main EK. An Expanded Obstetric Comorbidity Scoring System for Predicting Severe Maternal Morbidity. *Obstet Gynecol*. 2020 Sep;136(3):440-449. Leonard SA, Main EK, Lyell DJ, Carmichael SL, Kennedy CJ, Johnson C, Mujahid MS. Obstetric Comorbidity Scores and Disparities in Severe Maternal Morbidity Across Marginalized Groups. *Am J Obstet Gynecol MFM*. 2022 Mar;4(2):100530.

Appendix Table 2: Family Connects Codes for the Thematic Analysis, 2024

Name	Description	# of transcripts	# of codes
Program Introduction	How the participant first learned about the program.	42	67
	*"**When I was in the hospital**. I received some information about it through a nurse or an employee who visited my postpartum room gave me some information and asked if I would be interested in participating."*		
	"Right after I deliver, a representative team in in mentioned the program to me, and because I have severe hypertension, they suggested that it would be a good thing to follow up with once I was discharged from the hospital."		
	"Through my insurance [Amerihealth]"		
Reasons to Participate	Reasons to participate and motivations for joining the program	43	86
	*"Being a **free** program was definitely like the main factor. And having someone come in and be like, alright what issues are you experiencing or what is going on."*		
	"Might as well take advantage of the resource that's there."		
	*"It was **convenient**, and I felt comfortable because I **didn't have to leave my house**."*		
	"It sounded like a really good program. Sometimes you have like so many questions, and then you forget what to ask when you're in a doctor's office and you feel rushed and everything. She came to me, so I didn't have to like, you know, pack up the baby and go anywhere."		
	"For one because of transportation, and I just knew that me leaving from out the hospital, I hemorrhaged so I wasn't trying to do too much going around. So I said, it's best to stay in the house. Let them come here."		
	"I liked that it was before my six week postpartum visit so that I could like see a medical professional before going in to see my OB…this just made it much easier having like a newborn at home and having someone just come to the house."		
	*"Because my husband and I do not have family close by, and we also don't have a lot of friends that are parents…so we **needed all the help we could get**, couldn't pass it up."*		
	*"I'm a **first-time mom and single mom**. And so I needed all the help I can get."*		
	*"Knowing that I was gonna need the **extra help**, because this is my 4th kid."*		
	"Because in the past, with my last 2 deliveries, after that, I		

Name	Description	# of transcripts	# of codes
	have had like blood pressure issues. And I didn't have anyone to kinda check it or anything like that, nobody to kinda see what was going on and ***make sure that everything was okay****."*		
Program Experience	The participant's overall experience with the program	40	140
	"I actually really love the program. I thought ***it was great****."*		
	*"****It made me feel like somebody cared.****"*		
	"It's just the support system like that they feel someone's there to help, or you know you can have someone there to come check up on you from time to time. Just to have somebody there to so show that they actually care after you leave the hospital."		
	"The people that I dealt with [at Family Connects] were just so, you know so good, just so like open and caring, not judgmental at all, giving good information, like factual information, without being overbearing, which is such a hard thing to master. The people I worked with were just like so incredibly fabulous."		
	"She talked to us for about two hours…We got to ask a bunch of questions [that] we didn't even know that we needed to ask when we were at the hospital. So it was so nice for like a few weeks later we had all these questions built up and we could just like ask somebody and not feel bad about it or you know stupid or anything."		
	"It's been helpful…just checking in on me to see how me and the baby was doing and stuff like that, because a lot some people don't have that."		
	*"It helps to…****give some sort of normalcy to this phase of life*** *and just overall support and, you know, it's hard and it's OK…and there are a lot of people around that can help and if they can't help, they can help you find resources to get you help. I think they did a good job."*		
	"I also like the fact that they're checking in on you a couple weeks after you had the baby and we, at the time, like didn't know what to really expect."		
	"I felt like it was a positive impact overall to my postpartum experience. I think ***it sort of added like one more visit in that 1st month****. That was a chance to ask questions and make sure that everything that was going on was sort of normal. This funny thing with babies is when you're like, is this normal? It's like, well, a lot of things are normal unless it's not so having the chance to actually like talk to*		

Name	Description	# of transcripts	# of codes
	someone who seemed very like confident and knowledgeable, and had been doing this work for a long time was really helpful."		
	"It's always nice to have an outside input that is professional nature because you end up with kind of a space in between doctor's visits…so it's nice to kind of have someone in that in between time when a lot of stuff can be going on, some that you might think is just normal and it really isn't or just even to [tell you] that you're doing a good job and that you're on the right direction. I think is important."		
	"She said, we can also just come to NICU with the baby, and we could just sit on the sofa and talk to them while you ease your nerves of being close to your child…So it actually did help me. It was a really good conversation. I actually forgot that she was a staff member, and it was more like an actual mom coming to me and talking to me."		
	"You can tell that she went over my chart to kind of familiarize herself with me as well. So she made me feel really comfortable. It was really helpful, and ***I really wish they would have had that [Family Connects] when I had my other one.****"*		
	"I love the experience. I'm glad that I had the experience. None of my other friends have had anything like that and when I talk to them about it they all kind of like man, I wish I had that when I had my baby."		
Program Satisfaction	Describes participants' satisfaction with the number of visits they received, convenience of home visits	31	74
	"I didn't know if they did, any more than just the one, so I wasn't planning on it. And I ***don't necessarily need another one****."*		
	"It feels like a big deal to like, leave the house and get the baby altogether, and it was just ***very convenient*** *that the nurse came right to our house."*		
	"I wanted to get another [visit], but I haven't heard from them in a while."		
Nurse	Ways that participant described their nurse	37	114
	"Your nurse was just ***so fabulous****, and she was like, I will spend as long as you need like. No rush at all type of thing"*		
	"I like the nurse. She was pretty fun and funny, pretty sweet, very knowledgeable. Had a lot of information and tips to advise. I like that. She ***made me feel like she was***		

Name	Description	# of transcripts	# of codes
	part of, you know, part of my family, or a friend *that came to visit and help. very, very, very nice, very sweet. My kids loved her. She made my kids feel comfortable around her."*		
	"It didn't even feel like a visit from a nurse. It felt like a visit from a friend…I think it helped me to just see things from a different perspective, and hearing from another woman."		
	"So it was two women. They came. We talked, laughed. They was real helpful with the baby during the time they were there. They were real hands on with her, which was helpful. It was real nice it was…We all were talking the whole time. I've really enjoyed it."		
	"She's like, I'm here for you. You don't need to offer me anything, like, just leave it, and it's like she's so amazing, because it's so tough right now."		
	"She actually was personable…relating and giving me advice and things that I can do for myself that I really took to heart, because nobody was really telling me that. And she just made it feel like it was okay for me to just be and not have to be superwoman all the time. So it I ***definitely appreciated her*** *as it lifted my spirits. And I was just like, Thank you."*		
	"She helped me understand the basic needs, the basic needs of myself for my baby. She understand me. She helped me like, yeah, helped me be a better mother."		
Family description	Information related to the participant's family, such as the number of children and marital status and who was present during the home visit	29	53
	"To me this program, or at least our visit, what was really nice about it wasn't just about him. It wasn't just about my experience as a mom at that moment. ***Our nurse talked to us, to all of us and included us as a family****. So it was really nice to have someone kind of see us as not just individuals but a family."*		
	"She [nurse] talked to my mother-in-law. They was talking more about old ways that they used to soothe the baby and stuff like that, and then we start talking about how she's sleeping. Just better ways to help her when she's little fussy."		
	"I don't have any help like no mom, no dad. The father is in another state like, I don't have any help."		
	"My husband was able to be [at the home visit]."		

Name	Description	# of transcripts	# of codes
Postpartum Support			
Nutrition/breast-feeding	Advice and tips received about feeding the baby and breastfeeding	14	22
	"I do remember my biggest problem was with breastfeeding… so she helped me kind of like reposition…I think it mostly had to do with like finding a more relaxed seating arrangement and that that really helped, too."		
	"I was about give up the breastfeeding, but I was like, no, let me stick to it, she said on demand. Let's stick to it, and here I am still breastfeeding her."		
	"I was having a difficult time with breastfeeding in the middle of the night, but when the nurse came she just reassured me that if I didn't want to breastfeed no more, it's okay to stop breastfeeding. And it's okay to breastfeed and formula feed, which I didn't know. I can do that, and she showed me how I can monitor it, measure the bottles and stuff."		
Infant health	Ways in which the nurse supported and addressed infant health issues	21	37
	"I had no clue what to do…he hadn't had a bowel movement in a while, and he had a bad umbilical hernia that I was concerned about…asking [the nurse] to come the second time to look at his umbilical hernia. And he ended up actually having to have surgery. and so having her there, looking at it between [doctor visits] was very helpful."		
	"It was like kind of a fragile period of time where we had actually had to bring our baby to the hospital for just for jaundice, and we wanted to make sure that he was gaining weight. So it definitely just helped reassure us. Having somebody check him out and weigh him at home, and all of that."		
	"[The nurse] telling us about like tummy time and things like that that we weren't necessarily thinking about right away. That was helpful for us."		
	"We discussed certain risk factors for sudden infant death syndrome, because we have family members who are occasional smokers. So dealing with how to have the baby safely be around them and interacting with them when we were concerned about that exposure. In addition, family members who weren't interested in getting like the Tdap vaccine. How would we best		

Name	Description	# of transcripts	# of codes
	manage our baby's health and safety and the emotional side of that in explaining that to our family members."		
Mental Health	Emotional and mental health guidance provided, including around anxiety and medication use, normalizing experience, gave participant confidence	25	43
	"It really stood out to me that they asked me just blank statement like how are you doing, are you doing OK? And thankfully like this time around I'm totally fine, but if you would have asked me if my first kid, I would have probably burst out into tears. So I think it was great that you know they even had that easy question in there which is an important one that covers a lot of stuff and opens the doors for a lot of discussion and conversation"		
	"I was worried about my baby since we're having breastfeeding difficulty my baby gaining weight and I think her visit and like her weighing him and giving me breastfeeding tips really like ***relieved a lot of that anxiety*** *and then I don't think I had postpartum depression but yeah I had pretty bad anxiety about the breastfeeding."*		
	"I was always on medication for anxiety and so like I got to kind of talk to her about like continuing that kind of medication too without feeling bad about it …There's a lot of things that I was kind of feeling shame about that she was able to like help me like answer questions and give me resources and stuff like that."		
	"[It] ***really helped me*** *with like the issues I was personally experiencing with the* ***postpartum depression****."*		
	"I would say my postpartum experience probably would have been a little worse if I didn't do that, because ***I was really really going through it****. I was having breakdowns after breakdowns, and I even told the nurse about you know what I was dealing with. That's why she suggested the me having a me time, or just just taking some time for myself."*		
	*"****Encouraged me*** *to get out of the house, even if it was just to walk to the corner with the baby and back, and to* ***spend some time by myself****, cause I hadn't been doing it."*		
	"I didn't have any [mental health issues] except for just ***general stress,*** *which* ***she definitely helped with****. But she did talk about like what to do if I do start having issues. So I have like resources available, which was great."*		

Name	Description	# of transcripts	# of codes
	*"Yeah, she **gave me confidence**…I'll hear him cry and literally stop using the bathroom like she was like, it's okay, they're gonna cry. It's okay…If you gotta use the bathroom, or…You just want to eat, and they're just fussy. It's okay. So that gave me more confidence. And like, **Okay, I got this.***		
Physical health	Influence of the program on maternal postpartum physical health, medical support	24	34
	*"When the nurse came out, **she noticed that my blood pressure was elevating**…and I didn't have a visit with my actual doctor until like later that week. So it was kind of good because I was able to see someone sooner. Actually, I end up having to go to the emergency room because my pressure was elevating so high. I probably would have just stayed at home and got sicker and not even known I was suffering with like my pressure was rising."*		
	"We talked about slowing down, because lately I've been moving around like I didn't just have a baby which can also contribute to why my pressure has been high."		
	"She gave me a little insight on my pressure, so I didn't know like my pressure was that high. and that was one of the 1st red flags Cause I ended up going getting back re readmitted into the hospital like like 2 days later. And she told me the signs of what to look for like. Not only was my pressure high, I had bloating like fluid and stuff. I was swelling, and I had chest pains. She said, yeah, if it's like pains, it's hard to breathe. Go to the doctor, and that's exactly what happened."		
Resources	The range and quality of resources provided by the program, or what they wished to receive for post-birth challenges.	33	74
	*"[She] **gave us so many resources."***		
	"Just like the amount of resources that are available that I found out about was really amazing. You don't even know what's what to look for unless someone brings it up."		
	*"I had issues with my son with **breastfeeding** and stuff, and she gave me like information about different groups."*		
Program Expectations	The participant's expectations of the program, including comfort with the idea of nurse coming into home	41	73
	*"It was **lengthier and just more comfortable than I expected**."*		
	*"It's more...I was expecting it to be just a nurse to come and check my baby and check her weight and etc., **and they checked me**. She's **talking with me about everything** and about more topics*		

Name	Description	# of transcripts	# of codes
	than I expected."		
	"When it was described to me I kind of thought it was gonna be like a… home inspection. I kind of thought it would be a nurse or somebody coming with the nurse to be like, 'oh, don't use this kind of car seat, use this. Don't use this kind of crib, use this.' and not so much focused on the health of me and the baby. I mean, I thought that would be a component of it, too…but I thought it would be like more recommendations about what to do, which I'm actually glad that it wasn't. That's [not] what I wanted."		
	"At first I was a little skeptical, but then, when she finally came, it's just like, let all the release gone."		
	"[comfortable with a nurse home visit?] Not in the beginning, due to scams and people pretending to be people, so not at first. So the 1st two visits I received from her, I made sure my family was home, but after that, and when I realized it was quote unquote legit that was when I got comfortable.		
	"Actually, I met her at a center. I just didn't want anyone coming to my home, you know. I was freshly postpartum, and I just I just thought it was better for me to meet her somewhere instead of having someone come into my home."		
Barriers	Describes the participant's challenges when interacting with healthcare or social services, especially around follow-up	12	23
	*"You know, **transportation** is not always a must. The bus is not always viable, and everyone don't got time to be wasting money on gas."*		
	"I reached out to more than one [mental health provider on the list] and left some messages, but none of those people ever got back to me."		
Program Improvement	Recommendations or desired changes to the program.	41	74
	*"Honestly, there's **nothing I would change**."*		
	*"I think **everything was perfect**."*		
	"[Learn about the program prior] to being in the hospital [like in our prenatal] class."		
	*"Maybe had I known more [of **what to expect**]…I would have had her look at more of our setups and help us a little bit more with some of the sleep stuff…I would have taken more advantage had I fully understood more about the program."*		
	"There was the weirdness of the Ochsner scheduling where, like it showed up as an appointment at Ochsner's Baptist campus, and I was like, I can't bring this newborn		

Name	Description	# of transcripts	# of codes
	out back to the hospital…If there was any way to like change that location cause that was what was super confusing…I mean it was an amazing visit, but maybe some expectations around how long [the visit could be] because the visit was actually quite long. I remember she was there an hour or more."		
	"I wish they would have came out a little bit sooner but just cause like I was really postpartum that first month...but I still think that they came out within a reasonable amount of time."		
	"I guess I would provide like more mental health people available like through the program… if they had someone where they're like, oh, like, let me put you in touch with this person or this person will give you a call, and they might be able to help you through it."		
	"[Add a] case specialist or like a social worker…in case there's assistance needed for some individuals, bridge that gap… to say, 'Okay, well, we can fill out the paperwork right now'. To like directly connect them to those services, and not just giving in the information, but sitting down with people and helping them make sure they're registered, and have all the paperwork."		
	"[The nurse] wasn't exactly a lactation specialist, like that would have been nice to have that as well."		
	"It'd be easier to schedule…trying to get in contact with somebody to schedule. That was the hardest part, and I ended up having to go directly through the nurse to schedule."		
	*"**More visits** and just like maybe like a few hours available on the weekend."*		
Recommend the Program	Willingness to recommend the program to others and reasons for doing so.	41	52
	"I would **definitely recommend the program** to a friend. I think that the healthcare system doesn't have enough support for postpartum situations for females or even for like for babies."		
	"I absolutely would recommend it to friend, because…it's free…one on one individualized care and attention is just kind of a why not? … You just stay [home] and have someone come to you, and it's just **a wonderful resource**. I would absolutely tell friends or family members about it."		
	"I most definitely would. I think **every woman needs this to be honest**. Every family, woman, child deserve this type of service. We need services, especially in New Orleans."		

Name	Description	# of transcripts	# of codes
	"Yes…you never know if somebody have support…I have friends that don't have support. It's definitely needed because it can kind of create a safe space for someone."		
	"Yes, I have been already...you know some people be ready to fall apart [after having a baby] but like having somebody come out and talk to you and like help y'all with certain things, it helps eases you know."		
	"I will recommend it to a friend. **Most of my friends are like me, for as being a single parent, and don't have transportation**. So I will refer it because it'll be convenient for another mom like me."		
	"Absolutely for the help, and also just like **having someone that can normalize your feelings** as a first time parent."		
	"I did already because what I realized…a lot of people don't even know it exists."		
	"I mentioned it to a couple of friends. A couple of people's initial impulse was like, Oh, you've got people coming into your home. Is this like a gotcha CPS kind of a thing? And so there were some concerns about that that hadn't even occurred to me, I guess, but privilege so that was something that I was like, oh, yeah, I could see why some people would be really uncomfortable with that, but I mostly just found it useful."		

Notes: The number of transcripts column shows the number of transcripts that include that code. The number of codes shows the number of times the code was used in all of the transcripts. Bolded quotes were the most common for that code (i.e., sentiments frequently expressed by the participants), but I also included quotes that stood out for their message and consideration for the program managers.

Appendix B: Qualitative Survey Questionnaire

Today's Date:_____
Name/Participant ID #:_____

[Introduce self: name, graduate student at Tulane SPHTM working as a research assistance on this project]

[Explain that you are about to read them something that describe this research and want to make sure they understand it and agree to participate before we begin the interview:

> *You are being invited to participate in an evaluation about your experience with the New Orleans Family Connects Program. We will use this information to improve the program and procedures to better support postpartum mothers in New Orleans.*
>
> *This will be a brief interview, lasting no more than 30 minutes.*

At the end of this interview, you will receive a $50 Amazon gift card. It will be emailed to you within two weeks. We will collect your email address at the end of the interview.

Your participation is completely voluntary, and you have the right to withdraw your consent or discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled. You may ask to skip any question that you do not want to answer.

Your personal information will be kept confidential, and is only being collected so we can issue you a gift card. Your responses to this interview will not be attached to any personal information. Your privacy will be maintained in all data analyzed in this study. Your responses to this study will in no way impact future healthcare.

The interview will be recorded to ensure we correctly and accurately capture your responses.

Do you have any questions?

Do you consent to this study?

Obtain verbal consent (Yes/No)_____

[Begin recording]

Interviewer: **"This is [*interviewer's name*], conducting interview with [*participant ID #],* on [*today's date*] at [*start time*]. A reminder that your personal information and any information relevant to identifying you and quotes reported from this study will not be attributed to you. Your responses will be coded by an identifying number only, kept confidential, and analyzed in group form so that no personal information is revealed. Thank you for participating in this interview.**

First I have some basic questions about your background, and then I have some broad questions to guide our conversation about your experience with the New Orleans Family Connects (NOFC) program."

<u>Section A: Respondent Profile</u>

a. Age:
- [ ] Less than 20 years old
- [ ] 21-25
- [ ] 26-30
- [ ] 31- 35
- [ ] 36 or older

c. Insurance status:
- [ ] Private
- [ ] Medicaid
- [ ] Self-pay

[ ] Other

d. Race/ethnicity (check all that apply):
[ ] White
[ ] African American/Black
[ ] Hispanic/Latino(a)
[ ] Native American/Native Hawaiian
[ ] Asian American
[ ] Other (please specify):_____

e. Highest educational level completed:_____
f. Occupation:_____

g. How many children do you have:
[ ] 1
[ ] 2
[ ] 3 or more

g. How many visits with a NO Family Connects nurse did you receive:
[ ] 1
[ ] 2
[ ] 3 or more

Section B. General Questions

1. How did you first learn about the NOFC program?

2. Why did you decide to participate in the NOFC program?

3. Can you describe your experience with the NOFC program?
    a. PROBE: Was it what you expected? Why or why not?

4. In what ways, if any, do you think participating in the NOFC program influenced your pregnancy and postpartum experience?

5. If you were in charge of the NOFC program, what, if anything, would you change about the program?

6. Would you recommend this program to a friend? Why or why not?

7. Was there anything else you would like to add that we haven't discussed?

End of survey

Interviewer: *"Thank you for sharing your time. This is [interviewer's name], conducting interview with [participant ID___ #], on [today's date] at [end time].Thank you so much for your time. I'm going to turn off the recording now."*

[Turn off recording]

[Gift card procedure]
To receive your e-gift card, we need your email address. You will receive you e-card approximately within 10 business days .

Email address: _____

RE-SPELL EMAIL ADDRESS TO MAKE SURE IT IS CORRECT.