TexProtects
Champions for Safe Children

Family Connects Model Overview

DALLAS COUNTY HOPES ADVISORY COUNCIL

MAY 9, 2018

Family Connects

- Nurse home visiting model (NFP also uses nurses)
- Universal model that serves all eligible families in a community (all families eligible after birth)
- Provides 1-3 home visits; First visit 1.5 – 2 hours at about week 3 post discharge
- Launched in 2008 as Durham Connects funded by the Duke Endowment for 10 years specifically to reduce community levels of child maltreatment
- Currently being funded by Texas PEI in four counties – Travis & Bastrop (UWGA), Bexar and Victoria

Family Connects Evidence

- 18-month RCT between 2009 – 2010 in Durham County
- Every resident in Durham was assigned to the control or intervention (n=4,777)
- Random, representative subsample participated in blinded impact evaluation interviews beginning at infant age 6 months (n=549)

Outcomes

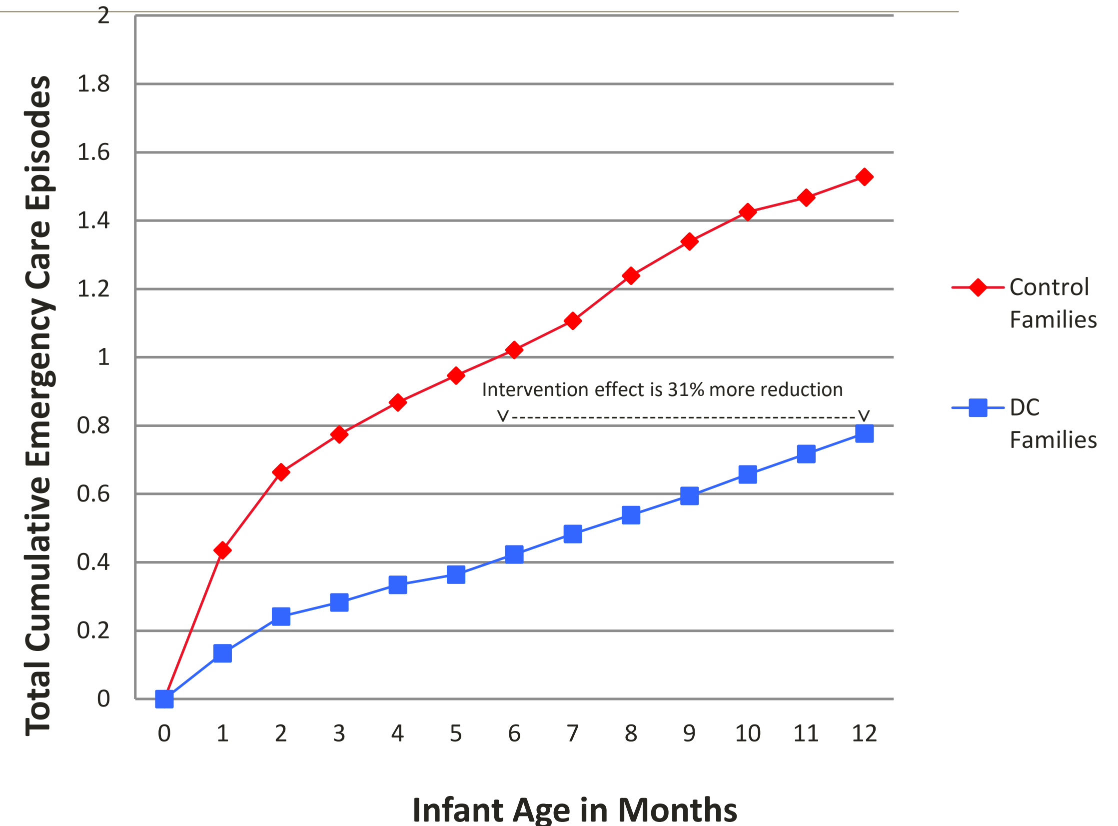
Compared to control families, Durham Connects-eligible families had:

- More connections to community services / resources
- More mother-reported positive parenting behaviors
- Higher quality (blinded observer-rated) mother parenting behavior
- Higher quality and safer (blinded observer-rated) home environments
- Higher quality child care for those that chose out of home care
- Less maternal reported anxiety

Outcomes Continued

Impact Using Hospital Admission and CPS records:

- at infant age 12 months – **50% less** total infant ER visits and overnights
- at infant age 24 months **– 37% less** total infant ER visits and overnights
- **39% Reduction** in CPS Investigations per child through age 60 months for intervention group



Program Components

Program

- Recruitment & Visit Scheduling Done in Hospital
  - Typically within 24 hrs. of birth
- Comprehensive In-Home Visit (~2 hours)
  - Newborn & mother health assessments
  - Education about newborn care (e.g., breastfeeding)
  - Assessment of family strengths & needs (Risk Assessment)
    - **12 factors empirically-linked to child maltreatment risk**
  - Referrals to matched community agencies for identified risk
- 2nd or 3rd visits made as needed to conduct additional assessment and assure community connections
- Follow-up phone call 4 weeks after case closure to ensure connections are made

Home Visits

Scheduling Visit	Integrated Home Visit (IHV)	Follow Up	Post-Visit Call (PVC)
• Ideally face-to-face • By nurse or program support workers	• 2 hours long • 3 weeks post hospital discharge	• In home or via phone as needed • 0-2 total	• 1 month after case closure • Confirmation of connections to resources • Customer satisfaction and program feedback

12 Factors Measured in Assessment

Support for Health Care

1. Maternal Health
2. Infant Health
3. Health Care Plans

Support for a Safe Home

7. Household Safety/Material Supports
8. Family and Community Safety
9. History with Parenting Difficulties

Support for Infant Care

4. Child Care Plans
5. Parent-Child Relationship
6. Management of Infant Crying

Support for Parent(s)

10. Parent Well Being
11. Substance Abuse in Household
12. Parent Emotional Support

Each factor is rated as:

1 = No family needs
2 = Needs addressed during visit
3 = Community resources needed
4 = Emergency intervention needed

Common Referrals

Support for Health Care

- OB / Primary Care Provider
- Pediatrician / Family Practice
- Care Coordination for Children (Case Management)
- Lactation Support

Support for a Safe Home

- DSS Social Worker
- Local Housing Authority
- Domestic Violence Shelter

Support for Caring for Infant

- CCSA (Child Care Services)
- Healthy Families
- Early Head Start
- Care Coordination for Children
- (Case Management)

Support for Parent(s)

- Mental Health Service
- Substance Abuse Treatment
- Mother Support Groups

Implementation

- Utilize a Community Alignment Approach – also have a Community Advisory Council as part of the model;
  - Travis County, for example, is using the Family Support Network Workgroup of the School Readiness Action Plan to serve as the Advisory Council for Travis County.
- Travis County project – anticipated launch September 2018 – about 12 -18 month scale up needed. United Way of Greater Austin is managing the $250k initial contract from PEI.
- St. David's South Austin Medical Center will be implementing hospitals utilizing nurses hired through the county health department
  - Approximately 2,000 births/year
  - Second site will be Seton Northwest Hospital in 12-18 months following implementation at St. David's
- Target saturation of 60-70% of all births receive first visit/dose; 35% receive second visit and smaller percentage receive third
- Linking community resources and referrals to their Agency Finder
- Anticipated cost to serve 17,000 in Travis County = $8 – 10 million ($470-$488 / birth)

Discussion/ Integration into Dallas HOPES model