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Family Connects:

Supporting Birthing People and Newborns In Chicago

September 19th, 2023

Today's topics:

- Why Family Connects for Chicago?
- Family Connects Model
- Community Alignment Board (CAB)
- Frequently Asked Questions (FAQs)

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Overarching Vision: Healthy Chicago 2025

VISION: *A city where all people and all communities have power, are free from oppression and are strengthened by equitable access to resources, environments and opportunities that promote optimal health and well-being*

Specifically: Improve systems of care for populations most affected by inequities

- Further health and vibrancy of neighborhoods
- Strengthen community capacity and youth leadership
- Transform policies and processes to foster antiracist, multicultural systems

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Social Determinants of Health

Social Determinants of Health (SDoH) are conditions that have a major impact on pregnant people and family's health, wellbeing and quality of life.

Some examples include:

- Safe Housing during and after pregnancy
- Transportation to/from post-partum appointments
- Access to Food
- Job & Education Opportunities
- Income to support families (especially during the post-partum time)

What role does public health play in equity?

With an *equity* lens:

- Focus on prevention and social determinants of health
- Convene cross-sector stakeholders
- Coordinate initiatives and systems to improve health
- Create and champion policy
- Evidence-based solutions
- Data to assess and monitor population health and community needs and assets

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Why? Seeking Solutions for a Fragmented System

- Systems not coordinated; creating duplication and families slipping through cracks
- Many services not evidence-based
- Services focus on families pre-determined to be at-risk
- Families face barriers to enrolling in the best services for them

Source: Public Health Institute of Metro Chicago 2017 City of Chicago Home Visiting Landscape Analysis, as revised by CDPH to include high risk programming.

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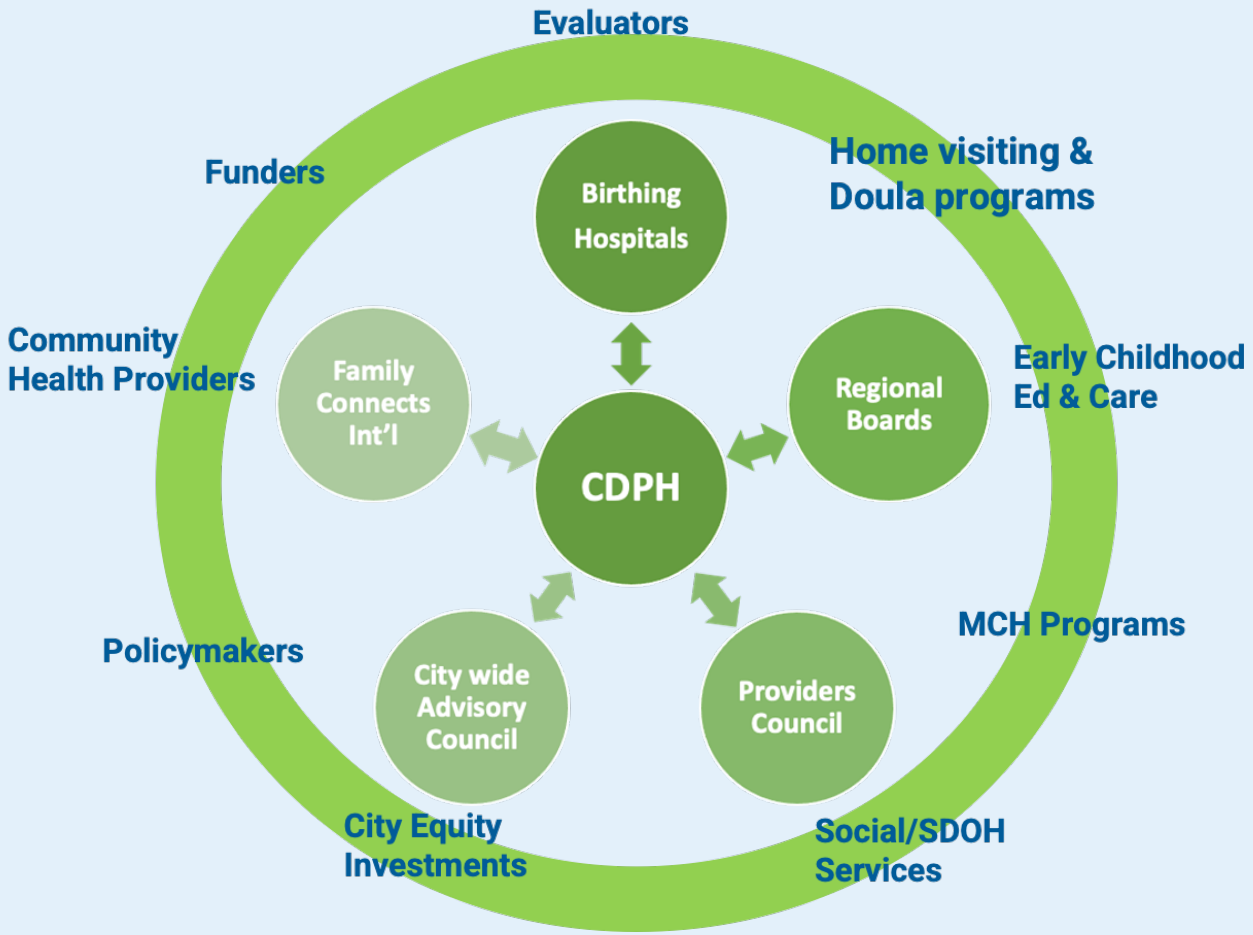
Introduction and Overview of the Model In Chicago

What role does CDPH play?



How the Model Works

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Model basics

Visit offered/scheduled prior to discharge at birthing hospitals

Visit scheduled ideally at 3 weeks postpartum up to 12 weeks postpartum, but may engage later if special needs are present

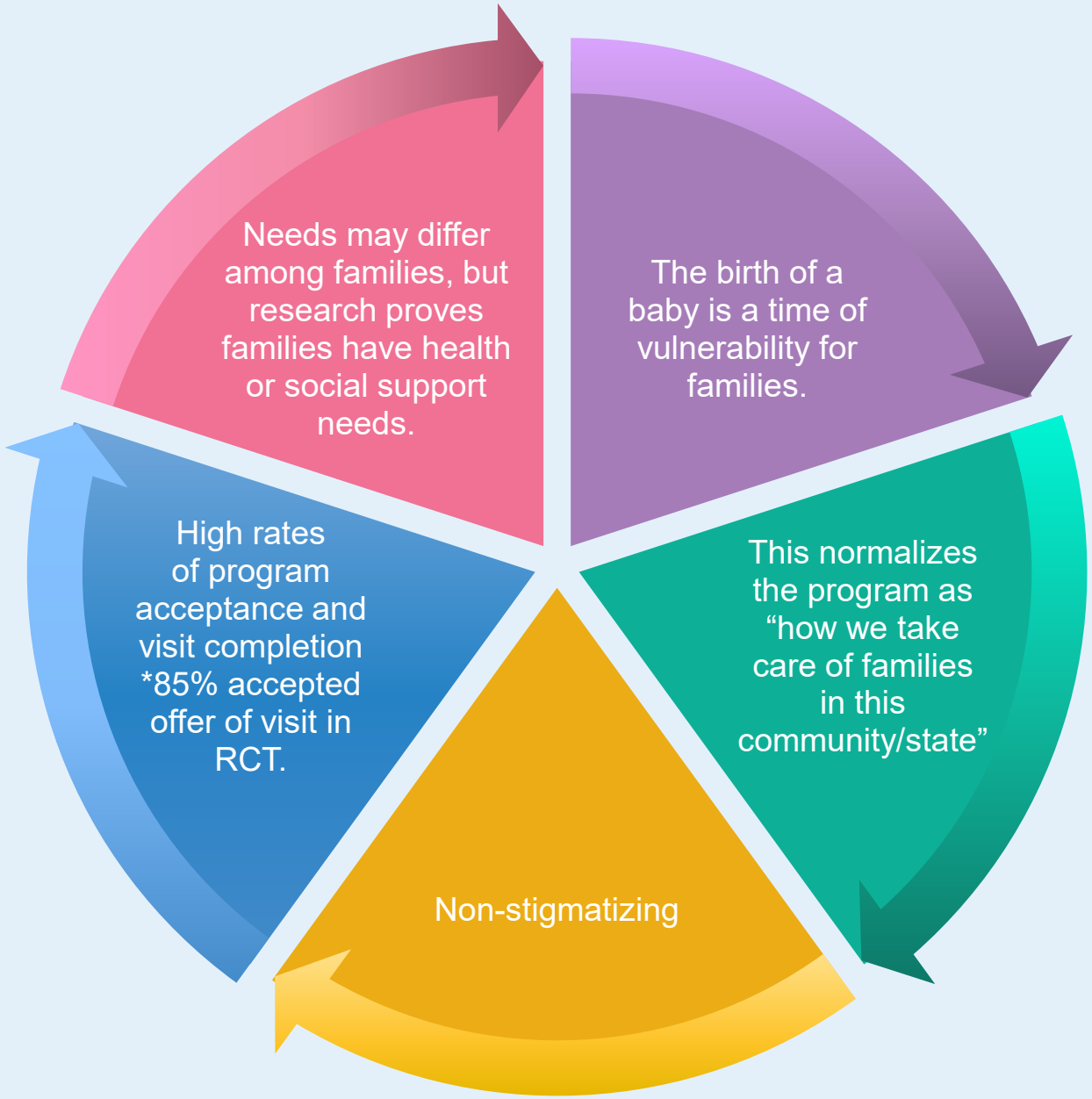
Available to all families with newborns residing within a defined service area, which could be a region, county, city or birthing hospital

Six to eight new cases per nurse per work week (~44 work weeks per year – 264-352 new cases per nurse per year)

Follow-up contact with families four weeks post visit to confirm families' successful linkages with community resources

Nurse is an RN but is not required to be a BSN

Why offer the intervention to all?



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Why a nurse?

1. Timing
2. Knowledge
3. Trust

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The model in practice

- Recruitment and visit scheduling typically done within three weeks of birth
- Comprehensive in-home visit (~2 hours)
- Referrals to matched community agencies for the identified family needs
- Second or third visits made as needed
- Follow-up phone call

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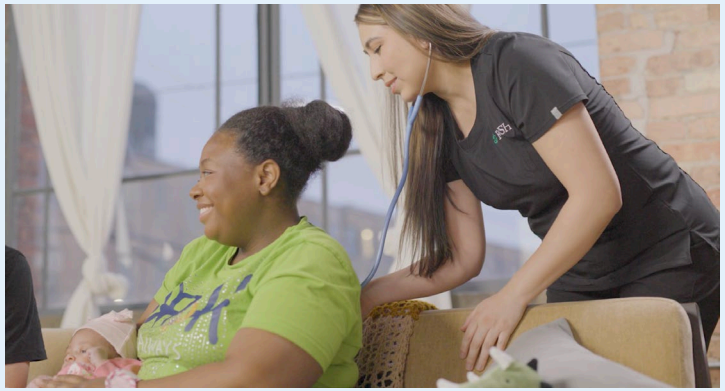
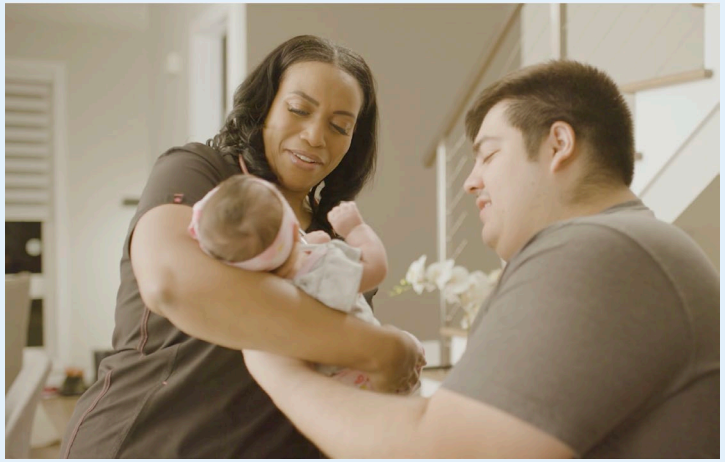
What happens during the Home Visit?

- Newborn health assessment
- Postpartum assessment for the mother
- Supportive guidance about normal newborn and maternal health needs
- Specific education in response to mothers' questions and concerns or those that arise from observation during the visit





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Family Connects Support Matrix Domains

Support for Health Care

- Maternal health
- Infant health
- Health care plans

Support for a Safe Home

- Household safety/material
- Family and community safety
- History with parenting

Support for infant care

- Child care plans
- Parent-child relationship
- Management of infant crying

Support for parents

- Parent well-being
- Substance abuse in household
- Parent emotional support

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Examples of Common Community Referrals

Support for Health Care

- OB/ Primary Care Provider
- Pediatrician/ Family Practice
- Case Management
- Shelter
- Lactation Support

Support for Health Care

- DSS Social Worker
- Local Housing Authority
- Domestic Violence

Support for Caring for Infant

- Child care services
- Healthy Families
- Early Head Start
- Case Management

Support for Health Care

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

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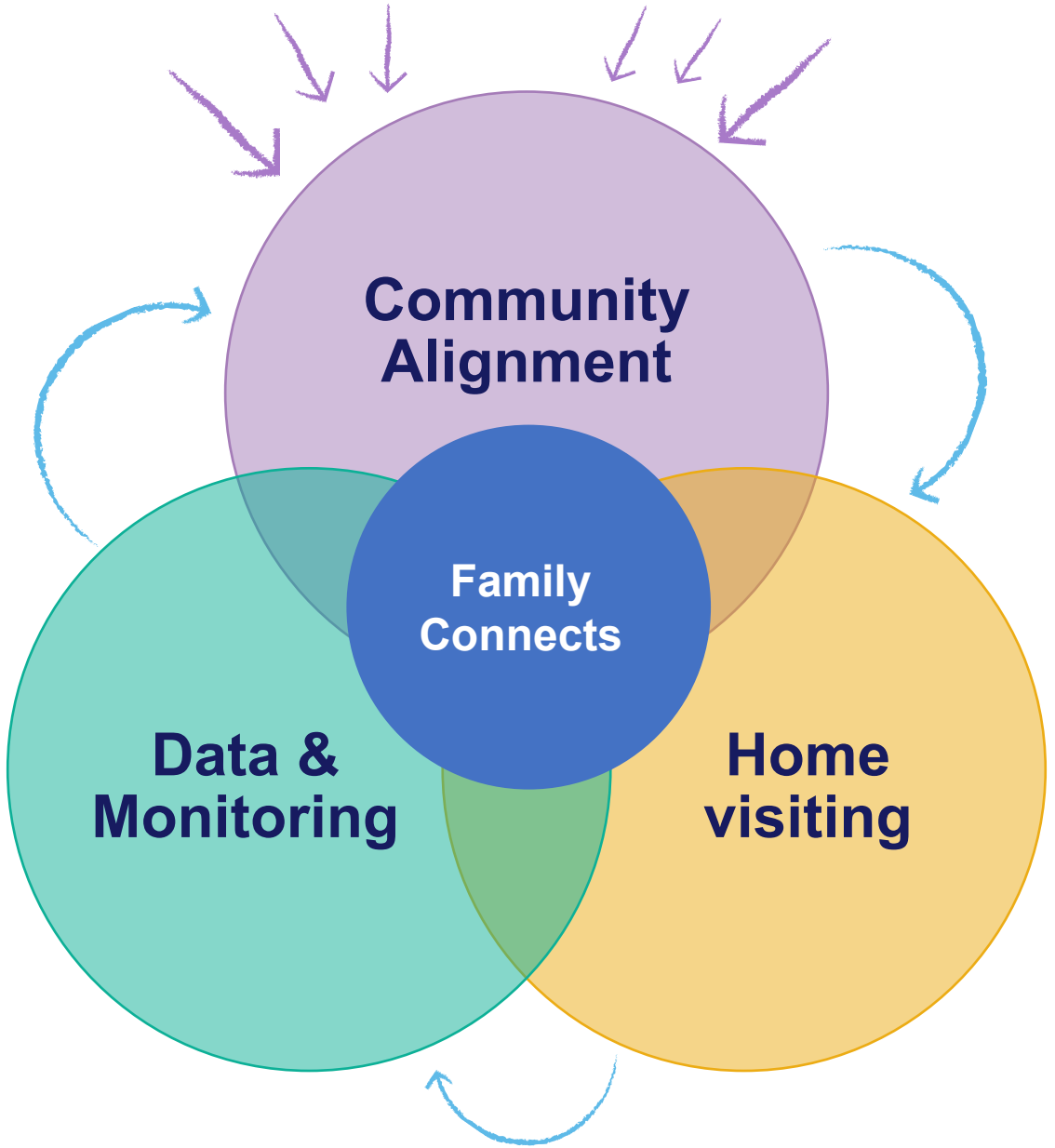
Community Alignment



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Introduction to FCC Regions

Region A Hospitals:

- Humboldt Park Health
- St. Mary
- Rush
- Stroger
- Mt. Sinai
- UI Health
- St. Anthony

Region C Hospital:

- Roseland

Region D Hospitals:

- UChicago
- Trinity

Region E Hospitals:

- IL Masonic
- St. Joseph
- Swedish
- Northwestern

Region F Hospital:

- Resurrection

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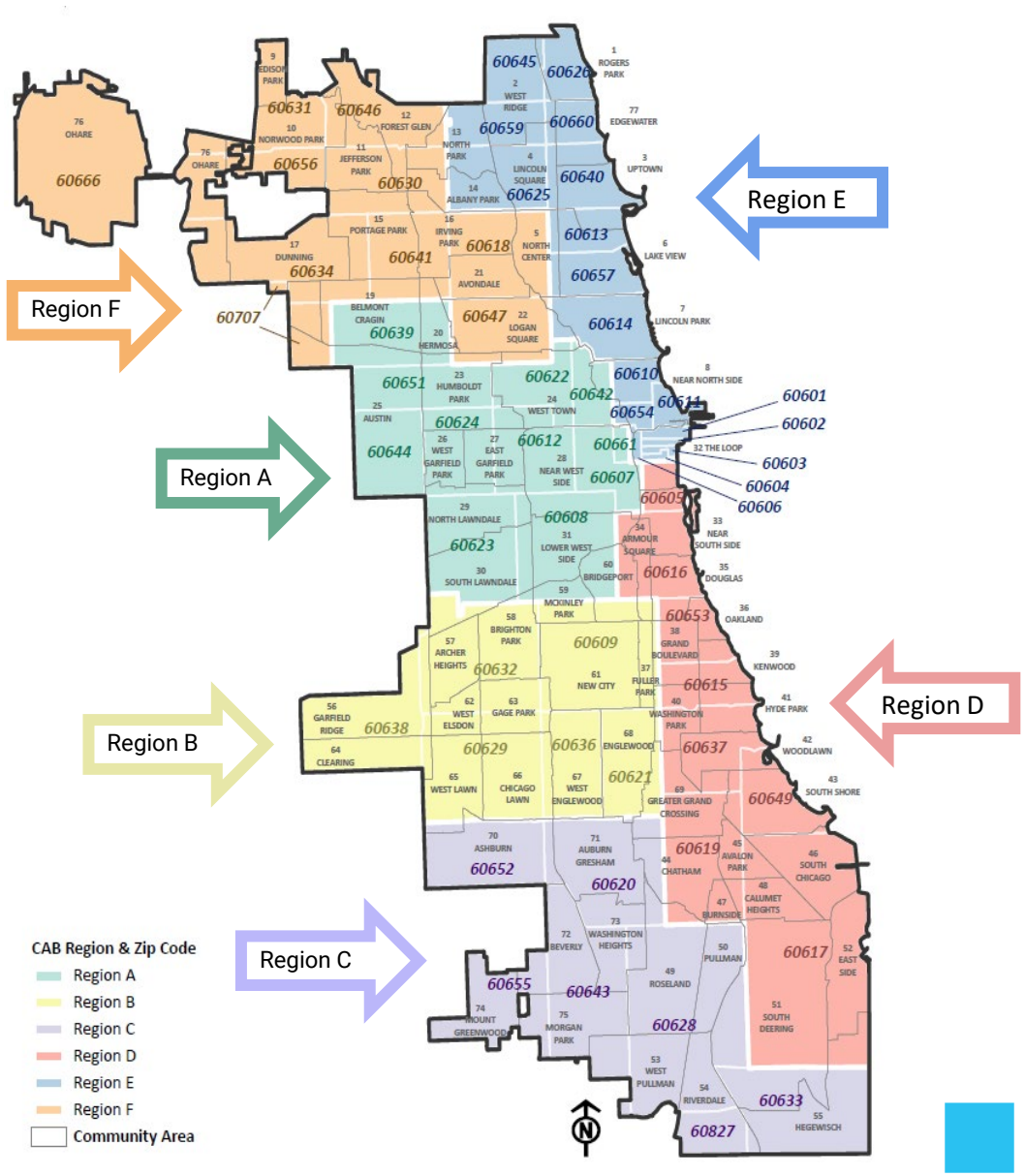

Community Alignment Board (CAB) Purpose

1. **Align resources** relevant to families
2. **Find solutions** to address community needs
3. **Listen to feedback** and updates from community stakeholders
4. **Disseminate information** from Family Connects to community stakeholders

"Alone we can do so little; together we can do so much"
- Helen Keller

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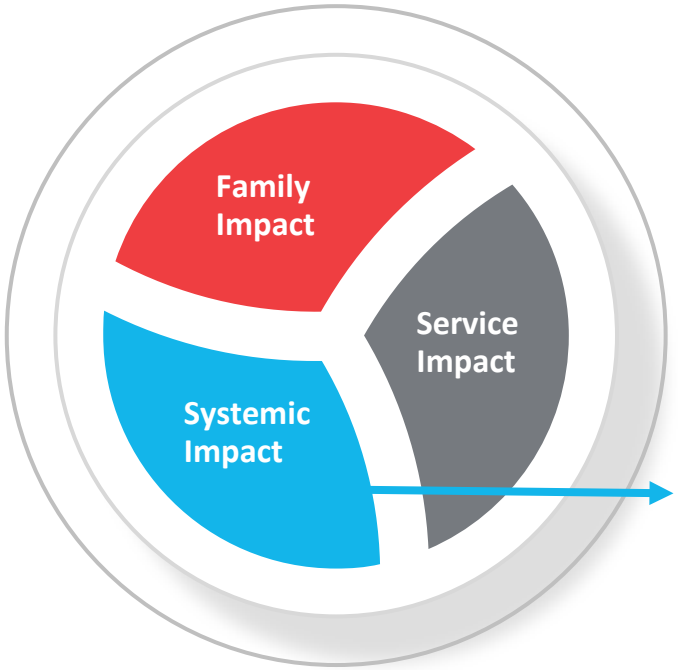
Identifying priorities through our structures



Today's work is to leverage insights gathered throughout the FCC structure towards a set of priorities to guide the future

Agenda Setting: based on data, experience, and collaborative solutioning - what priorities might result in the most change for families?

Citywide Board, Provider's Council: patterns and trends in support services across regions or citywide

Regional Boards: common gaps across neighborhoods/ communities

Case conferences: gaps in support for individual families

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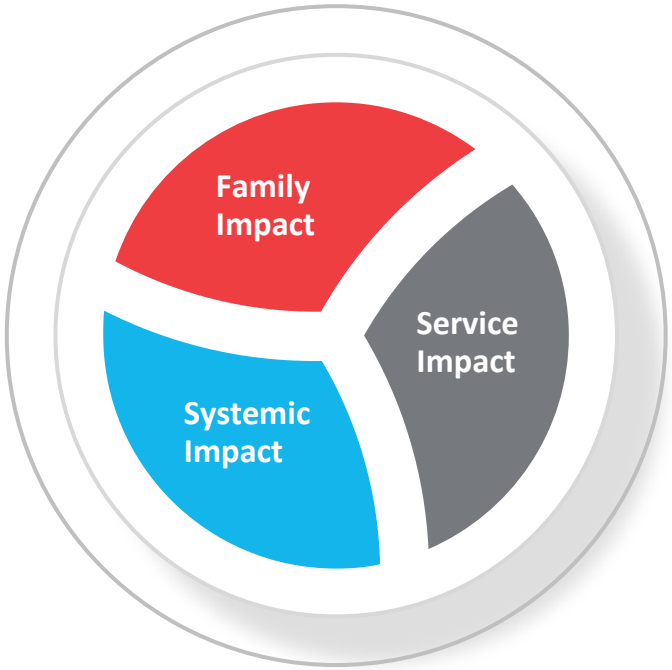
Case Example: Diaper Equity



Diaper Equity efforts within Family Connects Chicago demonstrate how our 'triple purpose' can leverage clinical and community alignment assets to create change for families, the supports they access, and at the policy level for systemic change.

1

Case conferences identify pressing diaper-related needs across multiple families supported by nurses

2

Delegates develop regional plans to address diaper needs among families living in their geography

3

Based on Regional Board feedback and data in NOWPOW, CDPH finds that diaper referrals far outpace every other referral type

4

In reviewing data, Citywide board members meet to ID pathways to meeting diaper needs across regions. A study involving a monthly stipend for 100 families is created and launched winter 2023. Simultaneously, a policy agenda for diaper equity work is developed in order to create sustainable change for families citywide.

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Data and Progress Monitoring

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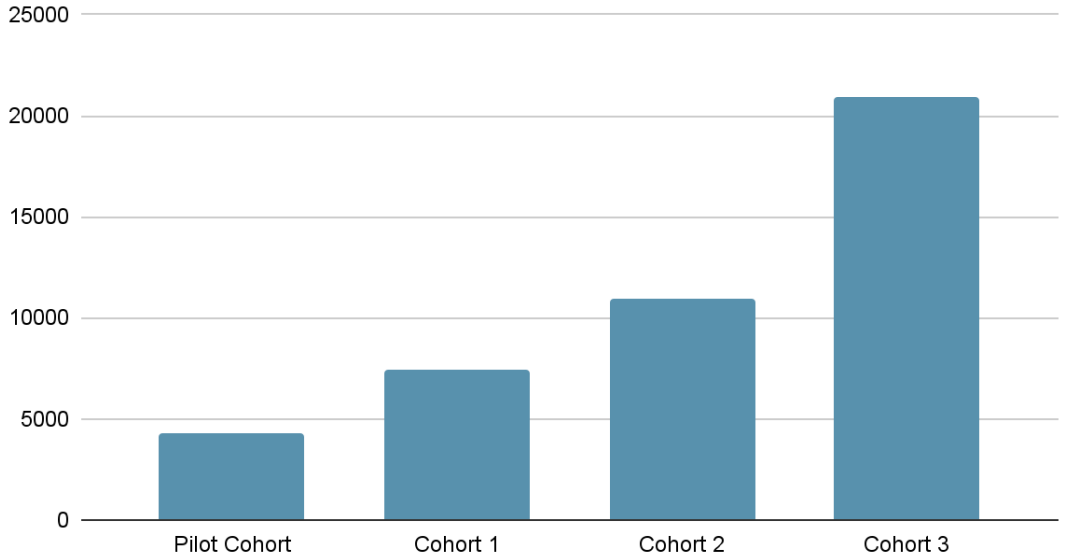
Path to universality

Projected progress towards universality / FCC implementation in all city birthing hospitals



Through 2023 and 2024, FCC will continue expanding in an effort to reach 28,000 families - representing all city births to city residents

Pilot cohort: 4 hospitals, already fully implementing
Cohort 1: 4 more hospitals, in early stage partnership formation
Cohort 2: 3 more hospitals, also in early stage planning
Cohort 3: 4 more hospitals, in initial exploration

Public awareness campaign

Hiring campaign

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Performance Metrics 2022

4,328 births

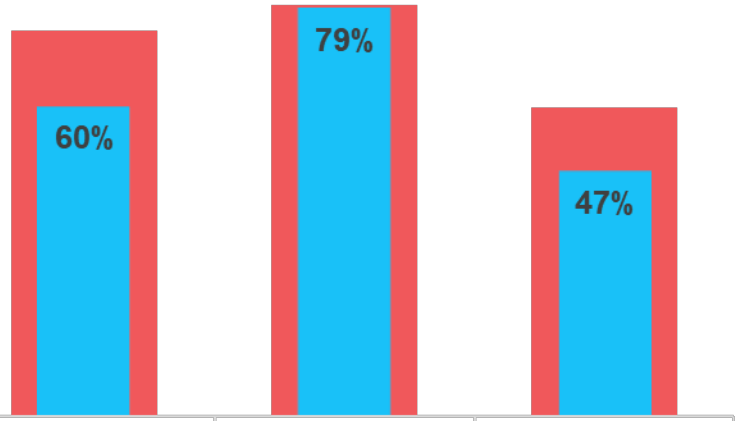
2,055 nurse visits

17,782 referrals

26% of referrals = connection
80% of these resulted in a service

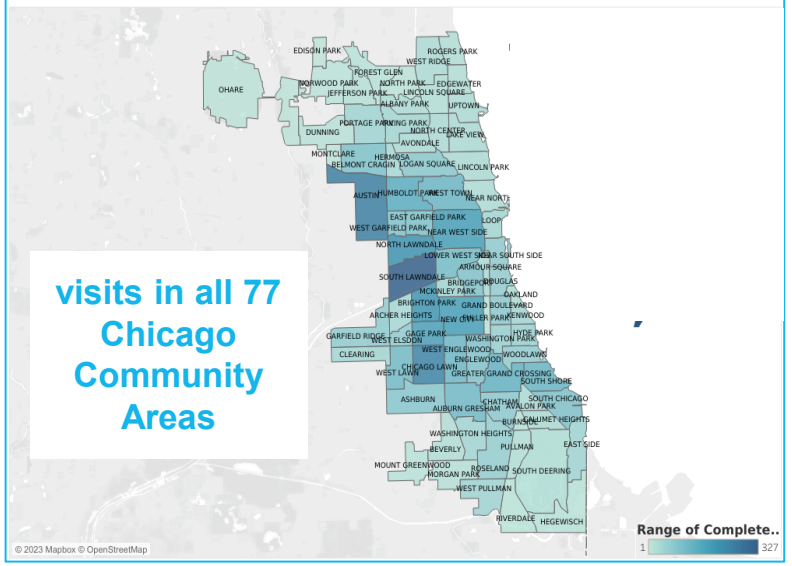
92% think FCC service is helpful

Of eligible Chicago births



	Acceptance Rate	Completion Rate	Reach
Goal	75%	80%	60%
2022	60%	79%	47%

Completed Family Connects Visits by Community Area



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Progress monitoring

Intensity

Of families receiving initial visits, **10%** required a follow-up visit or call related to elevated need or risk

Equity

Program reach has been more successful with **Latinx** and **Non-Latinx-Black** families than it has been for Non-Latinx-White, Asian, and Other populations.

Connections to Health Care

Of families responding to follow-up calls at the 30-day mark…

- **92%** had attended well-baby appointments
- **88%** had attended postpartum maternal appointments

Referral Needs

44% of families needed referrals for community support…

- the highest referral percentages were for Non-Latinx-Black families (47%)
- Of almost 18K referrals, around a quarter were contacted by families
- Once a contact was made, **80%** of families received services
- Virtually all who received services reported satisfaction

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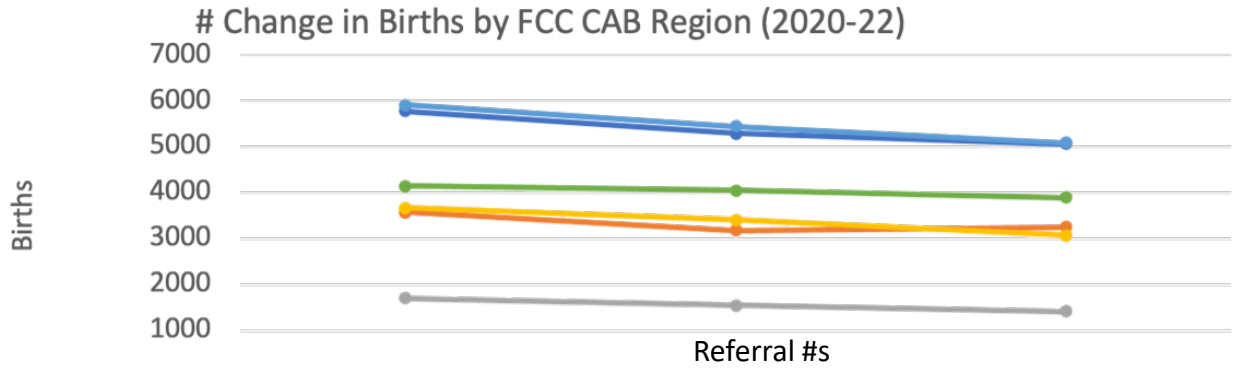
Learning Metrics

Declining Birth Rates

- Births to Chicago residents in Chicago hospitals decreased by 11% since FCC launch - from 24,757 in 2020 to 21,967 in 2022
- Births declined in every region, but by greater volume in A & E, and greater percent in C & D



Referral Types

- Highest 'need' referral areas included household safety/materials support, parent well-being, and childcare plans
- Top ten referral types are listed at right, with high concentration in diapers & WIC app assistance

Diapers	2187
WIC application assistance	1198
Child care	882
Parenting support program	749
Breastfeeding support	730
Income-based housing	636
Food pantry	598
Car seat safety checks	571
Early learning program	537
Utility payment assistance	526

Source: CY22 FCC Referrals from NOWPOW Database Searches on May 24, 2023 (CDPH only-does not include Rush)

Referral Success

- Referral connection rates are lower than average for childcare & support related to parent-child relationship, infant crying, & parent well-being

Even after connection to services, receipt of services* is less likely for safety, substance abuse, and parent emotional support

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Testimonials

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Impactful Home Visit Discovery: Nurse Stories

- "I had a home visit with a mom that seemed perfectly healthy. It was her second child, and after providing lactation help, I started our routine vital checks. Her blood pressure was dangerously high — a sign of pre-eclampsia, which can cause seizure, stroke and organ failure in women…After alerting her obstetrician, **the mother was hospitalized for three days to lower her blood pressure**."

- "Following an extremely traumatic domestic violence and sexual assault incident just 10 days before I saw her, I helped a mom of a newborn and five children. She had numerous financial worries as she waited for a spot in domestic violence program. She was on unpaid maternity leave, which disqualified her from receiving financial support …She had kids to prepare for returning to school and doctor appointments that included on-site parking fees, which add up. **I was able to connect her with a social worker, who provided free parking for her post-natal visits and found an organization that provides school supplies for children**… *followed up to confirm she got the help she needed when* **I connected her directly with mental health resources**…."

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A little extra care and attention can make a big difference

Whether you have questions about your baby's health, need help scheduling doctor's appointments, or just want someone to talk to, Family Connects is here for you.

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