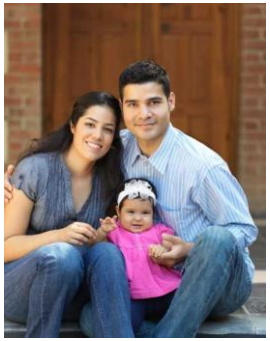


HEALTHY CHICAGO
CHICAGO DEPARTMENT OF PUBLIC HEALTH

CHICAGO DEPARTMENT OF PUBLIC HEALTH

FAMILY CONNECTS

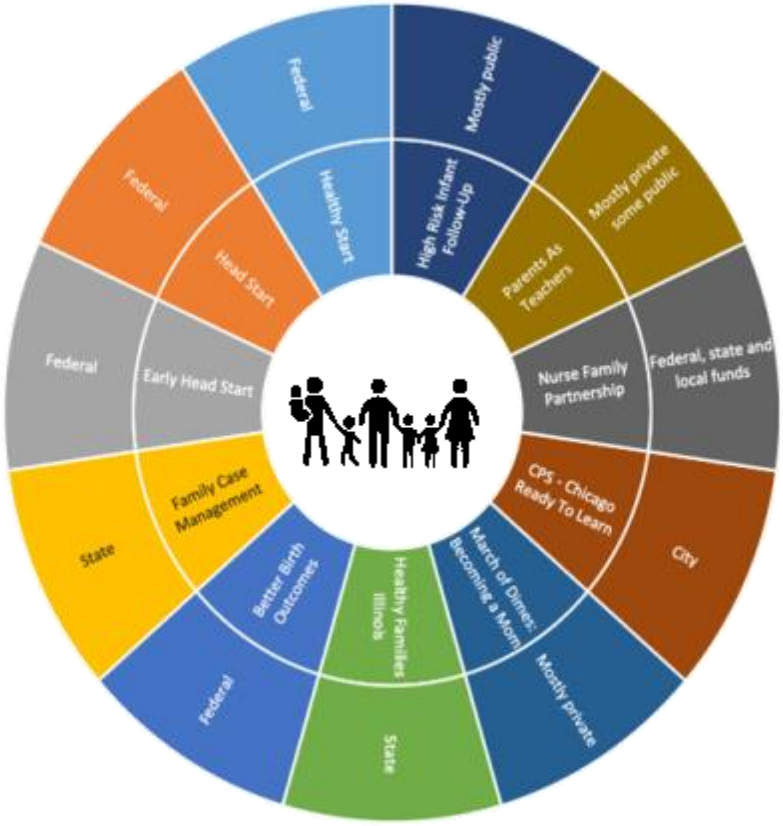
August 21, 2019

The Problem

- Black moms 6x more likely to die than white moms
- Black infants 3x more likely to die than white infants
- 22% of women feel down, depressed, or helpless after birth
- 94% of U.S. families need at least one education or community resource within 5 weeks of birth

A System in Need

- 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

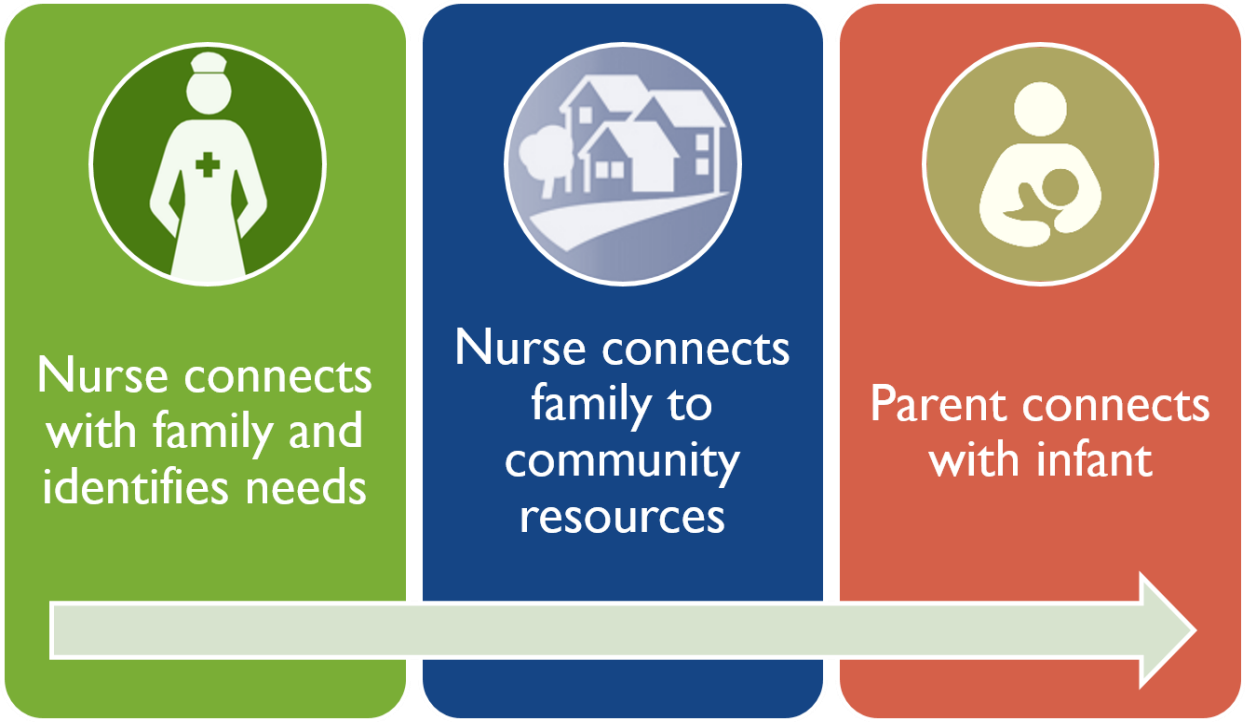


Source: Public Health Institute of Metro Chicago 2017 City of Chicago Home Visiting Landscape Analysis, as revised by CDPH to include high risk programming.

HEALTHY CHICAGO
CHICAGO DEPARTMENT OF PUBLIC HEALTH

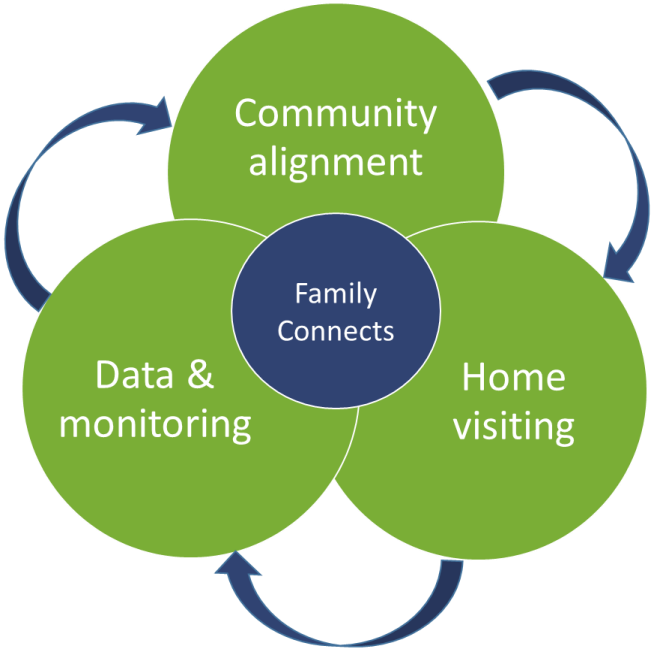
Solution: Family Connects

A model for universal, coordinated home visiting:



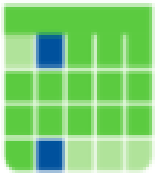
HEALTHY CHICAGO
CHICAGO DEPARTMENT OF PUBLIC HEALTH

Goals of Family Connects



- Screen all mothers and newborns to identify needs
- Respond to immediate needs through brief interventions, education and support
- Respond to longer term needs via referrals with warm hand off
- Improve agency coordination to ensure seamless experience for families, with follow-up services
- Identify service deliver gaps to improve resource allocation and inform policy

How It Works



THREE WEEKS
Visits are scheduled around 3 weeks after your baby's birth

A REFERRAL SYSTEM
Offered universally to help families access targeted interventions

NO COST TO RECIPIENTS
As an eligible recipient, you will not be charged

REGISTERED NURSE
All visits are made by highly-trained nurses

HEALTHY CHICAGO
CHICAGO DEPARTMENT OF PUBLIC HEALTH

An Evidence-Based Intervention

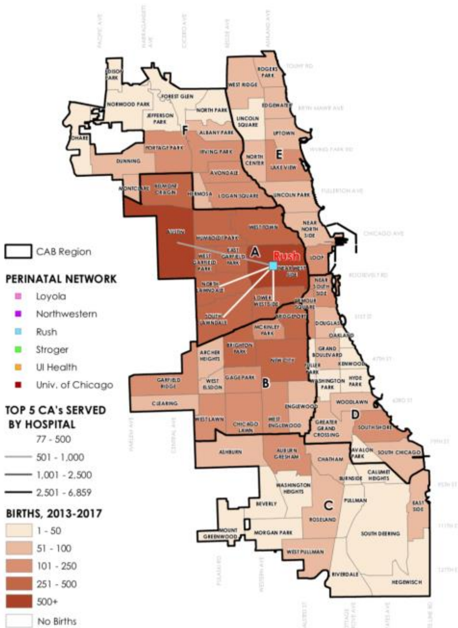
Documented results include:

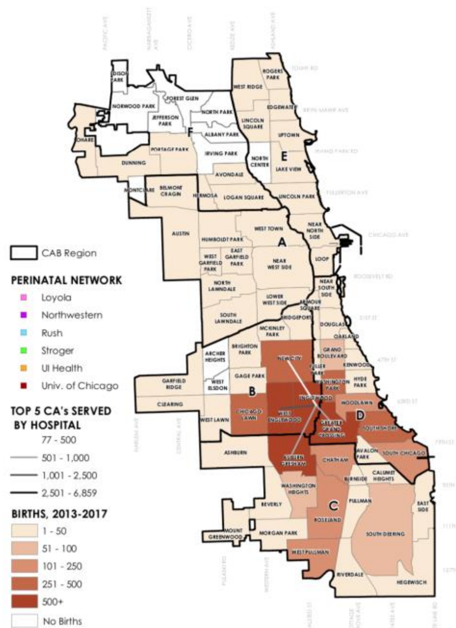
- Increased parenting skills
- Increased connections to resources
- Safer homes
- 28% reduction in maternal reports of clinical anxiety
- 50% less infant emergency medical care at 12 months, 37% at 24 months
- 39% reduction in Child Protective Services investigations through 60 months

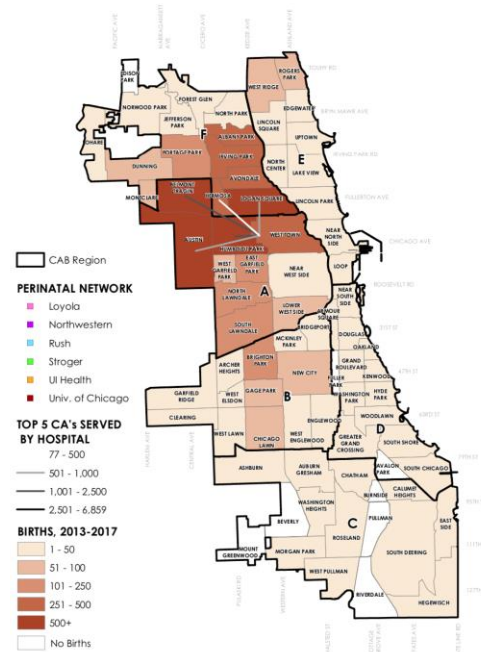
CDPH Pilot

- Fall 2019: Pilot begins with three hospitals
- Program will be offered at scale through 18 birthing hospitals to 37,000 families a year
- Follows stakeholder engagement process and assembling task force to guide program

Where Do Infants & Families Live?



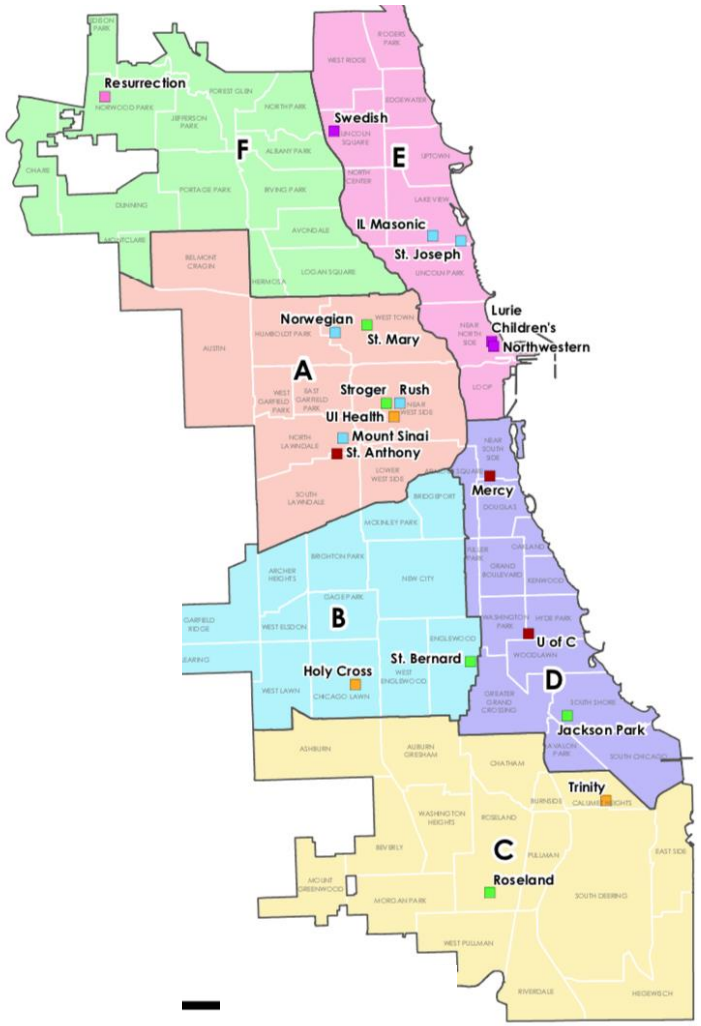




Almost 2,600 infants and their families will be reached through the first three pilot hospitals, concentrated on the west and south sides

HEALTHY CHICAGO
CHICAGO DEPARTMENT OF PUBLIC HEALTH

Community Engagement As Cornerstone



6 regional "Community Alignment" bodies will form to:

- Provide transparency and accountability
- Improve family connections with health care and hospital providers
- Provide community-led expertise
- Activate resources to fill needs across a range of human services

HEALTHY CHICAGO
CHICAGO DEPARTMENT OF PUBLIC HEALTH

Pilot Goals

Primary sites are hospitals

Organize referrals around hospitals, where 98% of births take place

Diversity to maximize learning

Select mix of hospitals to reach many populations, provide range of infrastructure and capacity, and offer lessons for scaling

Leverage existing resources

Establish CDPH as execution lead, using existing nurses, with potential for additional staffing through hospitals

Establish a proof point

Reach enough families (est. 3,000-4,000) to ensure a large sample size that can make the case for going to scale

HEALTHY CHICAGO
CHICAGO DEPARTMENT OF PUBLIC HEALTH

Public Health & Hospital Partnership

Staffed by the Chicago Department of Public Health

Staffing Varies by Hospital

HEALTHY CHICAGO
CHICAGO DEPARTMENT OF PUBLIC HEALTH

Criteria for Selecting Pilot Sites

1. **Disparities:** Serve populations with higher risk for infant mortality, low birthweight, and/or maternal mortality or morbidity

2. **Diversity:** Serve populations representative of Chicago as a whole on income, race, language, neighborhood, family type, etc.

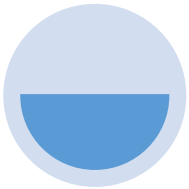
3. **Buy-in:** Ensure management of anchor hospital is enthusiastic about executing, shows competence engaging with broad network of social services, and recognizes positive outcomes for the hospital through participation

4. **Organizing structures:** Ensure potential to collaborate on an ongoing basis on community alignment to form the basis for ongoing community alignment

5. **Service capacity:** Ensure existing infrastructure is sufficient to enable effective referrals

HEALTHY CHICAGO
CHICAGO DEPARTMENT OF PUBLIC HEALTH

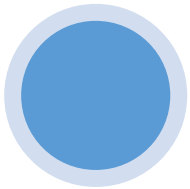
Evaluation for Family Connects



Implementation Evaluation

First 1.5 Years:

Identify how to adapt the model to a large urban landscape; establish realistic plans for future scale; lay the foundation for impact evaluation



Impact Evaluation

First 2.5 Years:

Show how program is impacting maternal and child well-being, early learning, service delivery, and service costs across diverse settings and populations

HEALTHY CHICAGO
CHICAGO DEPARTMENT OF PUBLIC HEALTH