



Implementation of the Family Connects Model & CHIP Alignment

Community Health Improvement Plan Priorities



| Priority Area | Goal Area | Objective | Strategy |
|---|--|---|--|
| Increase Economic Security and Mobility | 5. Improve Access to Affordable Physical and Behavioral Care | By December 30, 2026, offer at least one home visit from a nurse and connection to community resources to families with a new baby through the Family Connects Model. | Increase realized access to community-based programs and services. |



Connecting every family to a healthy future



3 Weeks In

Expect a visit around 3 weeks after birth



For All

Helping every family with a newborn



Registered Nurses

All nurses are highly skilled professionals

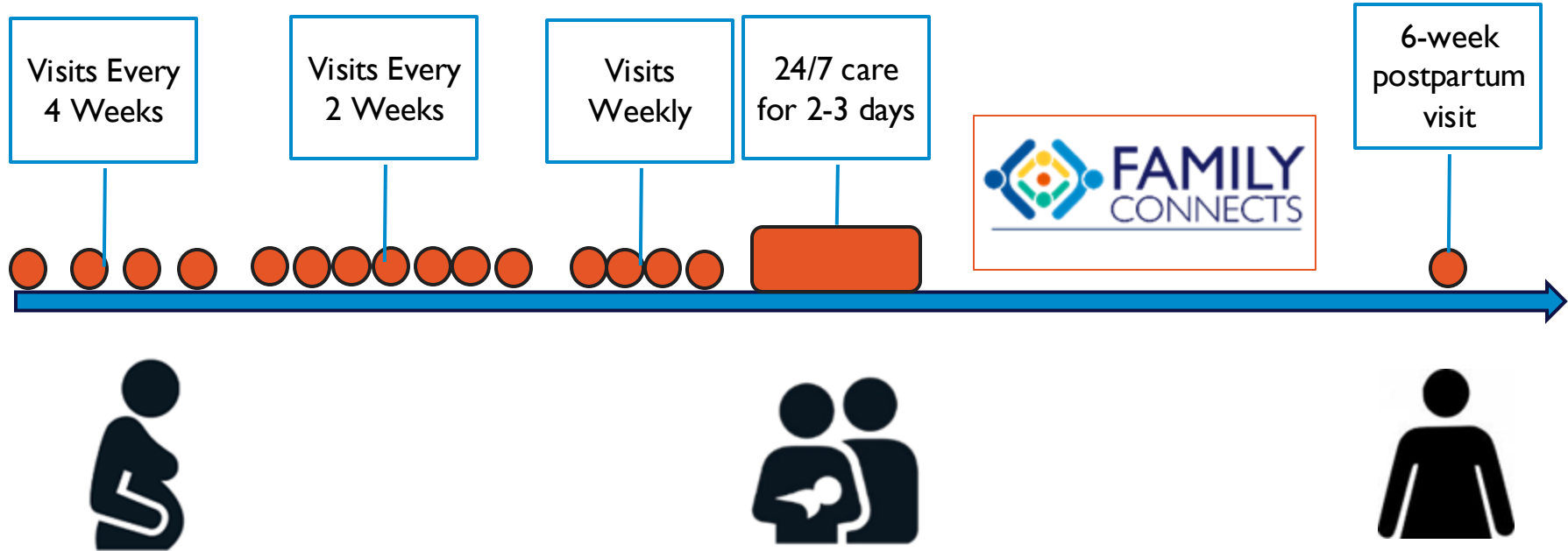


No Cost

As a parent, there is no additional cost to you



Family Connects Intervention



Why It Matters

Connection from the Start

All newborns deserve a warm and secure connection to family and community from the start. Too often, however, medical providers and community agencies aren't well aligned, creating gaps and possibly leading to poor health outcomes.

A Critical Period

No family should navigate this period of tremendous change alone. We connect newborn families to home-visiting nurses and community resources for critical postpartum support.

In Relationship

FC sites build relationships with local community agencies and providers to meet the needs of families with newborns.



REQUIRED ROLES



**Program
Admin**

**Michele
Ebendick**



**Community
Alignment
Specialist**

**Mikayla
Branz**



**Nurse
Supervisor**

**Rebecca
Rapport**



**Nurse
Home
Visitor**

**Kena
Pina**



**Medical
Director**

**FCI
Colorado**



**Program
Support
Specialist**

**TBD,
Funding
needed**



Home Visit Components

| Support for Healthcare | Support for Caring for Infant | Support for a Safe Home | Support for Parent |
|---|-------------------------------|--|---|
| Maternal Health (Physical assessment) | Childcare Plans | Household Safety and Material Supports | Parent Well-being (Assessment of support networks) |
| Infant Health (Physical assessment, feeding assessment, and lactation support) | Parent-Child Relationships | Family and Community Safety | Substance Use |
| Healthcare Plans | Management of Infant Crying | History with Parent Difficulties | Parent Emotional Support (Postpartum depression screening) |



Community Alignment Domains



MODEL FIDELITY

Family Connects has **three primary Key Performance Indicators** that are used to demonstrate model fidelity.



Population Reach: ≥60% of the eligible population must complete an Integrated Home Visit (IHV) or Virtual Visit (Modified Integrated Home Visit)



Average Age of Infant at IHV: ≥70% of infants are 14-34 days old at the time of the integrated home visit.



Referral Connection Rate: ≥50% of all nurse referrals related to a support score of 3 or higher resulting in a successful connection

Program Evidence

- Families had 44% lower rates of Child Protective Services investigations for suspected child abuse or neglect through child age 2; 39% lower investigation rates through child age 5.
- Out of 630 home visits by Family Connects in Colorado nurses, 2 referrals were made to Child Protective Services (0.003%)
- Positive impact on access to community resources for families
 - At 6 months:
 - Decreases maternal anxiety disorder by 34% and closes race disparity gap by 89%
 - At 60 months:
 - Decreases emergency medical care by 33% and closes race disparity by 14%
 - Decreases child abuse investigations by 39% and closes race disparity by 28%
- In a replication randomized controlled trial, there were even better outcomes in decreasing child abuse investigations by 44% and a 57% reduction in race disparity.
- 95% of families indicate support needs following a hospital discharge.



Source: <https://familyconnects.org/wp-content/uploads/2023/01/v2-FCI-Model-Overview-of-Evidence-2021.pdf>

Family Connects Colorado Implementation Structure

National Model Purveyor



State Intermediary & Colorado Admin Home



Initial Implementation Sites

Eagle County
Public Health

Boulder County
Public Health
(Joint Site with
Broomfield HHS)

Jefferson County
Public Health

Public Health
Institute at
Denver Health

Expansion Sites

Mesa County
Public Health

Arapahoe County
Public Health

Weld County
Public Health
(Pending / TBD)

Great Expectations
- Garfield & Pitkin
(Structure TBD)

Adams County
Public Health
(Structure TBD)



Family Connects Colorado Participating Hospitals



Aspen Valley Hospital
Avista Hospital
Boulder Community Foothills Hospital
Denver Health Medical Center
Good Samaritan Medical Center
Longmont United Hospital
Longs Peak Hospital
Lutheran Medical Center
Vail Health
Valley View Hospital
Mesa County - TBD (1 or 2 hospitals)

ACPH Year I Catchment Area (Eligibility):

Arapahoe County residents who birth at Denver Health*
~850 births a year, ~510 home visits a year

*Current NFP clients are not eligible for FC

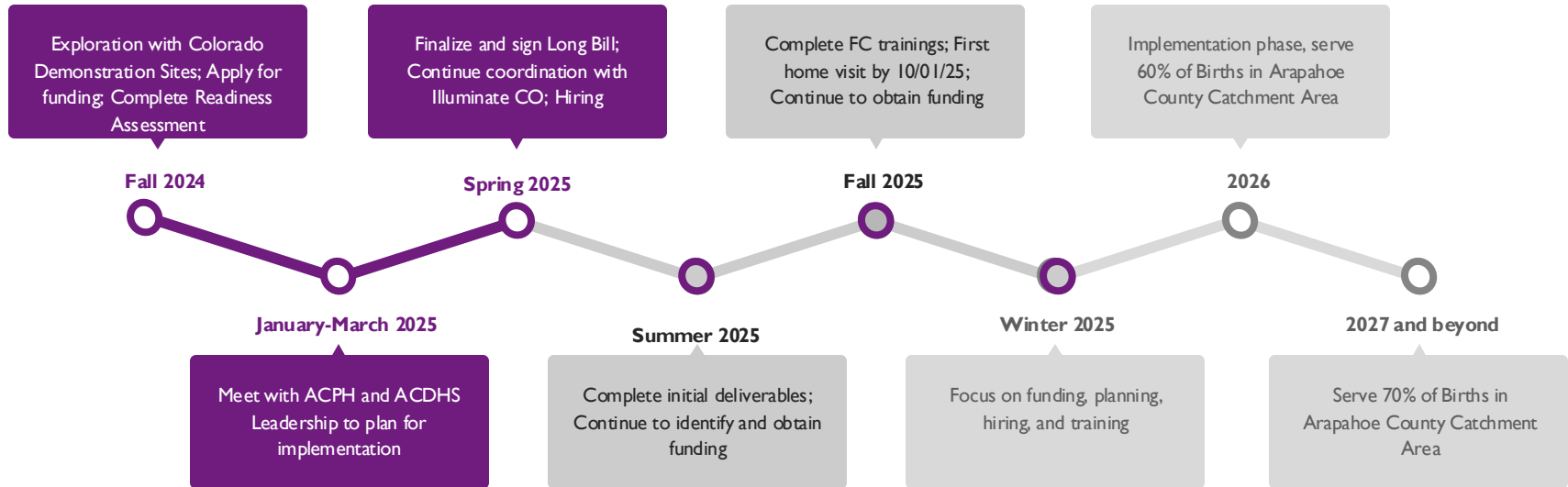


Funding Sources

- ACPH MCH Title V Block Grant
- Public Health Institute at Denver Health subcontract for CDEC R-06 funds
- Illuminate Colorado subcontract for Office of Minority Health funds
- Colorado Access Community Giving grant
- *In progress: Health First Colorado Medicaid Reimbursement*



Family Connects at ACPH Timeline



ACPH CHIP Alignment

- Screening, Resource & Referral
- Upstream changes to improve social and emotional wellbeing of families
- Increase awareness of tax credits
- Partner with Regional Accountable Entity
- Advocate for policy change to improve access to care
- Improve safety resources and partnerships
- Address food insecurity



BOH Call to Action

- Identify funding opportunities
- Support hospital connections, especially with OB/GYN
- Share training opportunities for nurse home visitors
- Identify organizations that support families for our Provider Directory

Thank you!

