

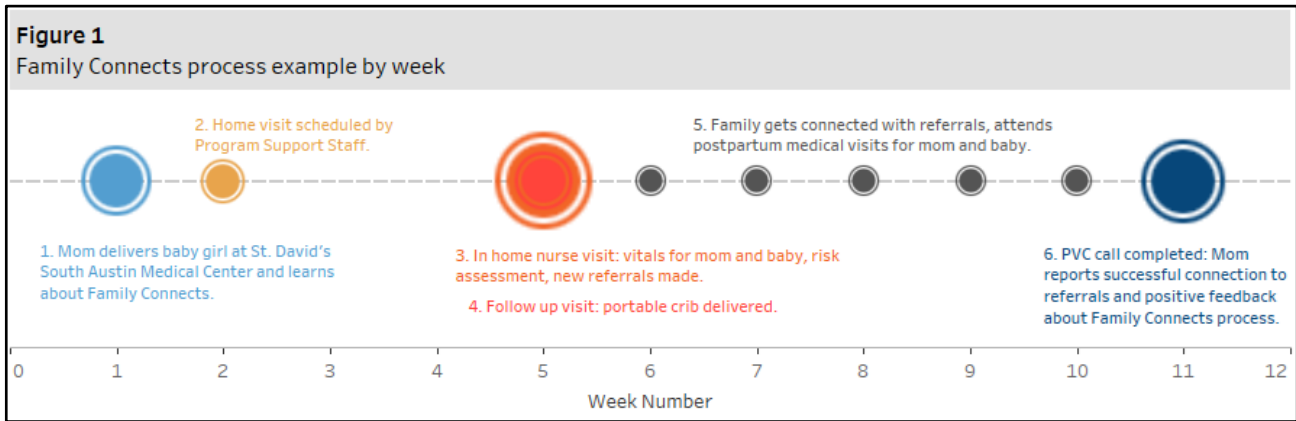
# FAMILY CONNECTS TEXAS OF AUSTIN/TRAVIS COUNTY 2024 ANNUAL REPORT



Family Connects of Austin/Travis County is a partnership of United Way for Greater Austin and Austin Public Health to support families with newborns through postpartum nurse visits, education, and referrals to resources. Austin Public Health provides program support staff, nursing staff, and clinical expertise. United Way for Greater Austin facilitates connections to community resources through ongoing strategic work, such as convening of community coalitions like Success By 6.

### Family Connects History and Program Overview

Family Connects follows an evidence-based approach created by Family Connects International (FCI) at Duke University in 2008. The process is designed to support the universal program's vision of equitable outcomes for every newborn. Steps include scheduling and managing postpartum nurse home visits for families with newborns, completing visits with follow-up as needed, providing education and material resources, and connecting families with community programs through referrals. Staff make Post Visit Connection (PVC) calls to follow up with caregivers on referral outcomes and document feedback about their experience with Family Connects. A realistic example of this process for a family is shown in Figure 1. Currently, the Family Connects model is active in 20 states across the country with 62 operating sites.



During visits, nurses assess these twelve areas of potential risk to caregivers, infants, and families:

- Management of Infant Crying
- Postpartum Health
- Infant Health
- Household Safety & Basic Needs
- Caregiver Mental Health
- Health Care Plans
- Child Care Plans
- Caregiver Emotional Support
- Caregiver-Child Relationship
- Family & Community Safety
- History of Parenting Difficulties
- Substance Use

Based on the risks identified in each of the twelve areas, families may receive resources during the visit such as diapers or breast pumps. Families are educated during visits on topics including infant safe sleep practices, infant feeding, and lactation. Nurses also facilitate caregiver connection with additional community resources by placing referrals. Nurses conduct follow-up visits as needed to deliver supplies or provide additional support on things like postpartum or infant health concerns.

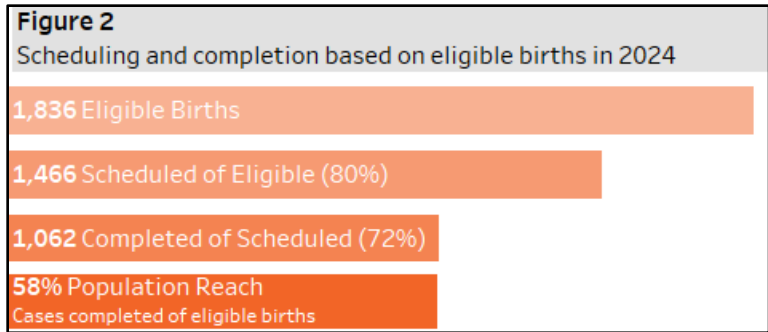
Family Connects Texas of Austin/Travis County launched in late 2018. The success of the Family Connects model hinges on the strength of programmatic partnerships, which currently include key hospital systems in Travis County (St. David's South Austin Medical Center and Ascension Seton Medical Center Main) and Women, Infants, & Children (WIC). After their own teams explain the purpose of Family Connects and gain consent from each family, partner hospitals allow program staff to conduct outreach in the Labor & Delivery and postpartum departments to recruit and schedule participants. WIC participants are referred directly to program staff through the FindHelp referral platform. All residents of Austin/Travis County who deliver newborns at participating St. David's or Seton hospitals or who are referred by WIC are eligible for a postpartum Family Connects nurse visit. The program has served a total of 5,573 families through the end of 2024.

### Data Presented in this Annual Report

This report aims to summarize program performance and data collected during visits in 2024. Family Connects staff enter data into the FCI Health Cloud Salesforce database to track interactions with caregivers, visits, assessments, and follow-ups. This is the source for all data presented including visit completion, demographics, risks identified, and referrals placed for caregivers. This report will also summarize data collected from caregivers during PVC calls like program satisfaction. It will conclude with a recap of key 2024 events along with strategic initiatives anticipated for 2025.

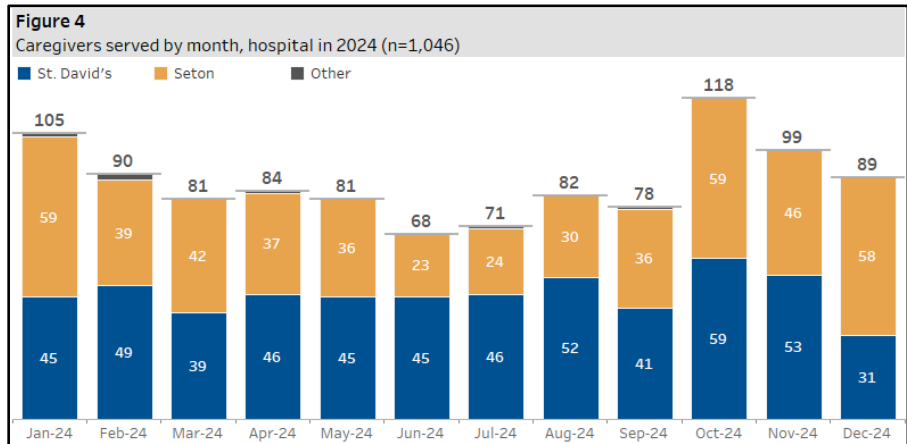
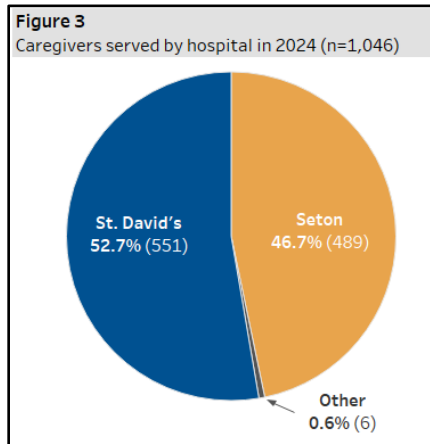
### Cases Scheduled and Completed Based on Births in 2024 (Figure 2)

Eligible births include babies delivered at partner hospitals for Austin/Travis County residents where families have consented to learn about Family Connects along with those referred by WIC. Out of 1,836 eligible births in 2024, 80% were scheduled for a Family Connects visit which exceeds the FCI goal of a 75% scheduling rate. Out of the 1,466 cases scheduled for a visit, 1,062 completed visits for a 72% completion rate. Population reach represents cases completed of eligible births and came to 58% in 2024, compared to 55% in 2023. Note that these measures are based on babies delivered in 2024; subsequent data in this report focuses on caregivers with completed visits in 2024, regardless of delivery date.



### Caregivers Served in 2024

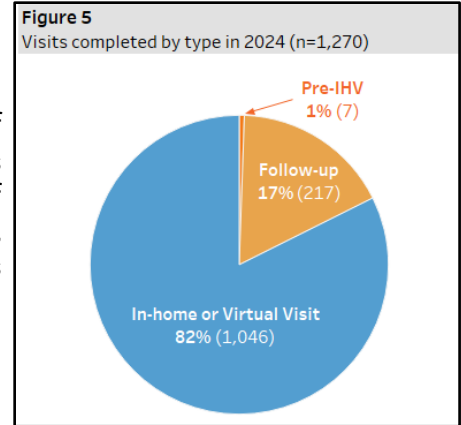
A total of 1,046 caregivers completed an in-home or virtual visit in 2024. Just over half of caregivers (52.7%) were served through St. David's hospital system and 46.7% were served through Seton hospitals (Figure 3). Only six caregivers delivered in other hospitals and were eligible because they were referred from WIC. The number of families served ranged from 68 to 118 per month and averaged 87 per month (Figure 4).



Families are encouraged to schedule in-home visits whenever possible. Virtual visits are offered to families as an alternative for a variety of reasons (e.g., caregiver availability, inclement weather). Visits include the same level of service, except hands-on assessment of mother and infant vitals and in-person lactation support is excluded from virtual visits. Most of the families served in 2024 received in-home visits (87%) and the remaining 13% received virtual visits.

**Visits and Follow-Up Visits Completed in 2024 (Figure 5)**

In 2024, nurses completed 1,270 visits, including 1,046 standard visits and 217 follow-up visits. About 21% of caregivers received a follow-up visit. Follow-ups are done in person (e.g., delivery of supplies to the home) or by phone (e.g., activation of a basic needs gift card). Primary reasons for follow-up visits include delivery of supplies, additional information on referrals, or follow-up on infant, postpartum, or mental health. In addition, a handful of Pre-IHV visits were completed which are occasionally used to gather information and address needs before a standard visit.

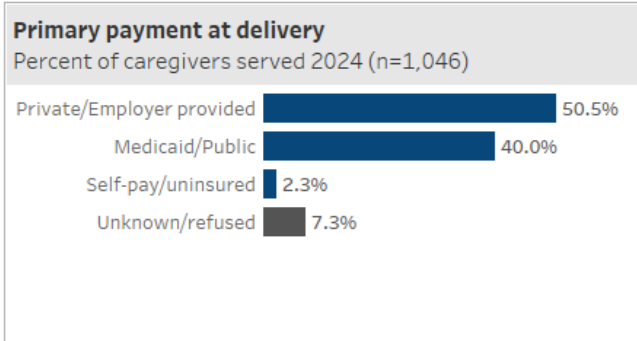
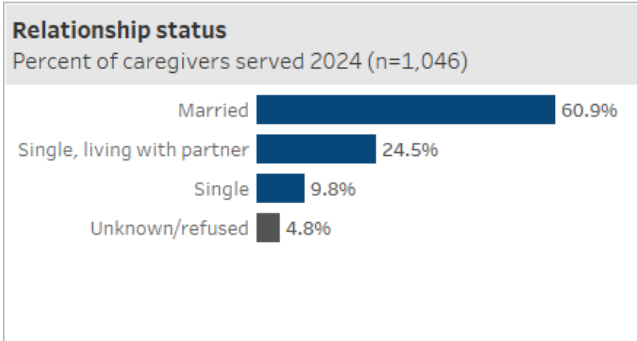
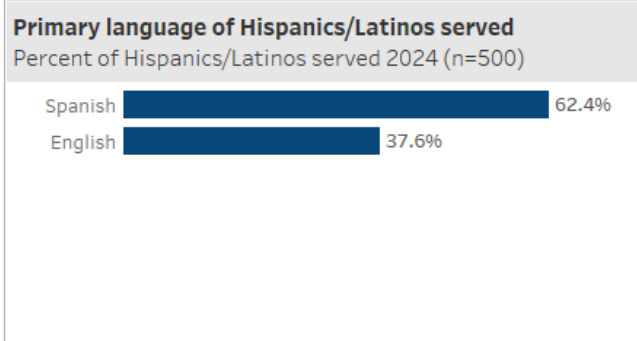
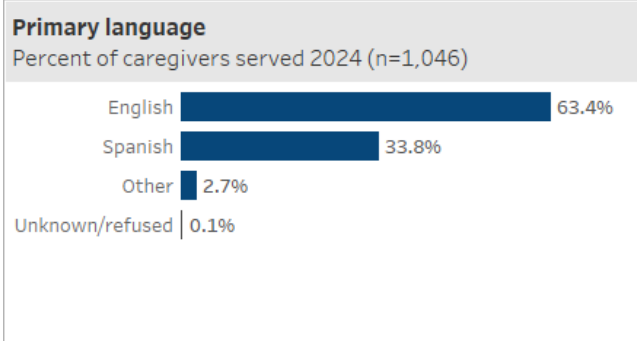
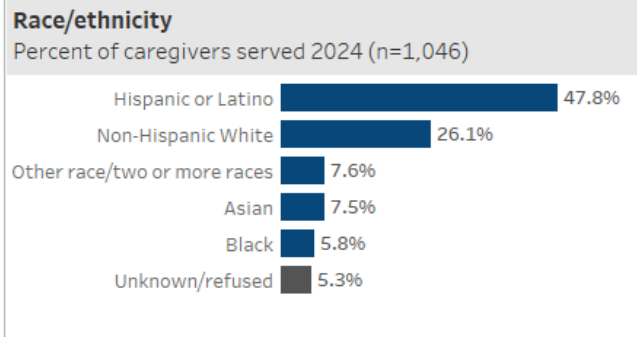
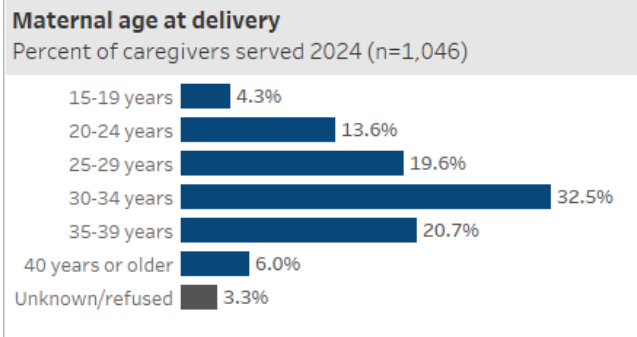


**Demographics of Caregivers Served (Figure 6)**

Nurses gather demographic information from caregivers during visits, with a goal to keep unknown under 5%. Data and completeness are monitored monthly. Missing data rates have increased in some categories, primarily due to Health Cloud no longer requiring certain demographic fields. Most caregivers reported maternal age, race/ethnicity, language, relationship status, and primary payment at delivery. Demographics of caregivers served were comparable to 2023 except where noted. A map of caregivers served by home zip code is also included (Figure 7).

**Figure 6**

Caregiver demographics



## Demographics of Caregivers Served (continued)

### Maternal Age

Most caregivers were in the 30-34 years age group at delivery (32.5%). Age groups 35-39 (20.7%) and 25-29 years (19.6%) followed. An additional 13.6% were 20-24 years old at delivery and few were 40 years or older (6.0%) or 15-19 years (4.3%).

### Race/Ethnicity

In 2024, the most common racial/ethnic background was Hispanic or Latino, represented by 47.8% of caregivers served, up from 39.7% in 2023. An additional 26.1% of caregivers were non-Hispanic White, down from 31.8% in 2023. Another 7.5% of caregivers were Asian and 5.8% were Black. Caregivers of some other race or ethnicity, including individuals who identified as multiethnic/multiracial, represented 7.6% of the population served.

### Primary Language

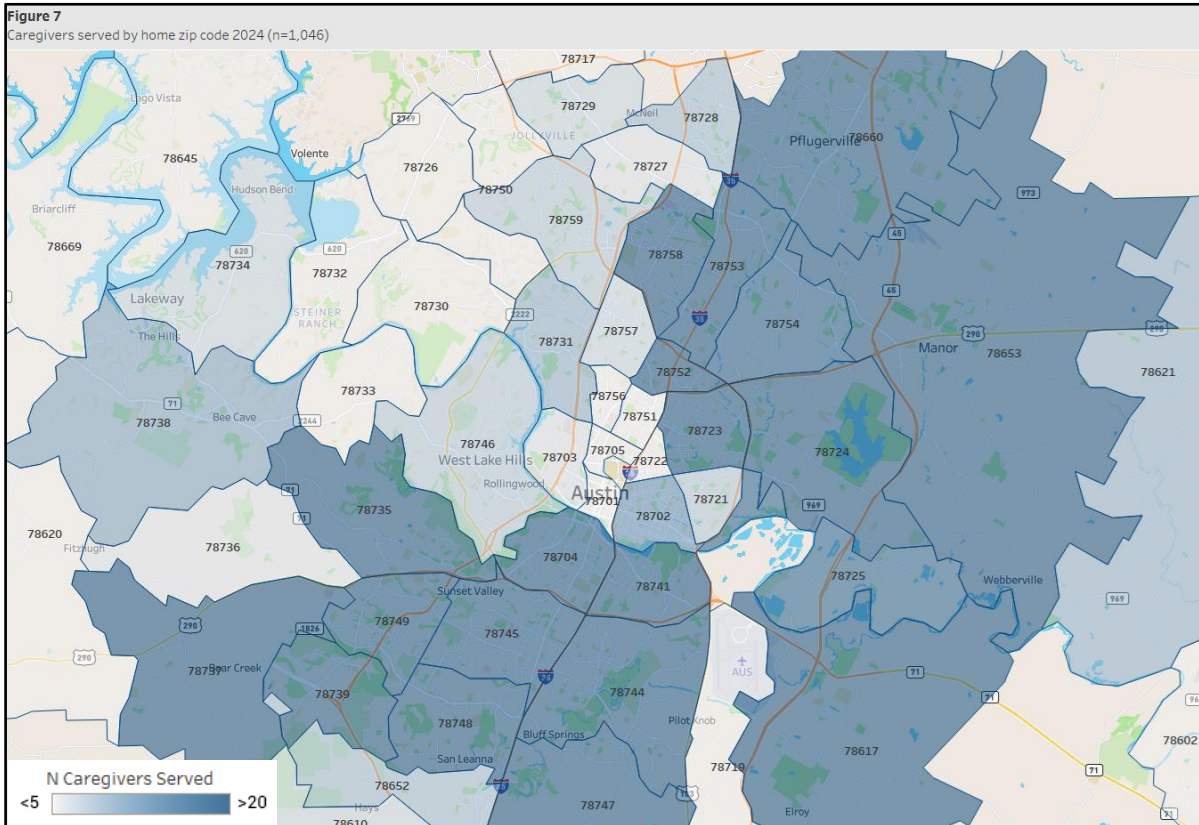
Most caregivers reported English as their primary language spoken at home (63.4%). Spanish speakers followed at 33.8%. A small group of caretakers reported another primary language (2.7%) which included 18 other languages. The most spoken languages in this category were Pashto (0.4%) and Arabic (0.3%). More than half of Hispanic/Latino caregivers spoke Spanish as their primary language (62.4%). This subset has gradually increased over time, highlighting efforts to reach a historically underserved population and a change in caregiver demographics as the program expands.

### Relationship Status

Most caregivers reported being married (60.9%), down from 68.7% in 2023. Some reported they were single/living with a partner (24.5%), up from 18.9% in 2023. Others reported being single (9.8%).

### Primary Payment for Delivery

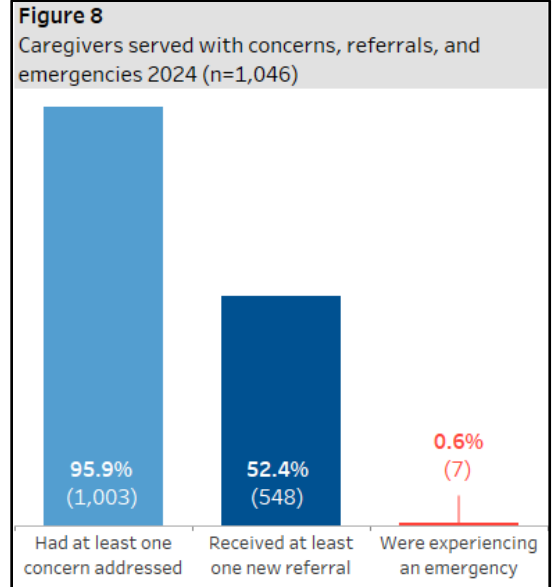
Most caregivers served had private/employer provided insurance (50.5%), and 2.3% were uninsured/self-pay at the time of delivery. The program has continued to focus on caregivers with Medicaid to ensure equitable population reach. The share of caregivers with Medicaid in 2024 was 40.0%, continuing a trend upward since 2020.



### Concerns and Needs for Caregivers

During visits, nurses assess twelve categories of potential risk (refer to page 1 and Figure 9). Nurses rate each area using a matrix scale from 1: no concerns to 4: an emergency requiring immediate assistance. Almost all caregivers (95.9%) had concerns addressed with a matrix rating of 2, 3, or 4 in at least one category (Figure 8).

Just over half of families (52.4%) were identified as having at least one risk that required a new referral to community resources. Seven caregivers (0.6%) were experiencing an emergency during their visit. Examples of emergencies include postpartum health concerns such as elevated blood pressure or infant health concerns such as feeding and weight gain issues. In all emergencies, nurses immediately intervened by directing caregivers to emergency services or by securing immediate appointments.



### Caregiver Assessments by Category (Figure 9)

Out of all caregivers, 84.9% received education around infant crying and coping strategies with no referrals required. Almost 91% of families had a concern or risk addressed in the areas of postpartum health and/or infant health. These stem from nurse assessment of vital signs, nutrition and lactation, and other health concerns for mom or baby. Household safety and basic needs remained the top area requiring referral for the fifth consecutive year at 34.4% of caregivers. In many cases, these families were given material resources like diapers or basic needs gift cards during visits. Many caregivers received support or education for mental health concerns (39.5%), and 4.5% necessitated a referral. A quarter of caregivers received education or referrals related to Health Care Plans. Less common areas of concern or referral included Child Care Plans, Caregiver Emotional Support, Caregiver-Child Relationship, Family & Community Safety, History of Parenting Difficulties, and Substance Use.

| Sum: percent of caregivers | Matrix Category                   | Concern Addressed/Education Provided | Risk-related Referral Required | Emergency |
|----------------------------|-----------------------------------|--------------------------------------|--------------------------------|-----------|
| 84.9%                      | Management of Infant Crying       | 84.9% (888)                          |                                |           |
| 82.7%                      | Postpartum Health                 | 72.2% (755)                          | 10.1% (106)                    | 0.4% (4)  |
| 78.6%                      | Infant Health                     | 68.6% (718)                          | 9.8% (102)                     | 0.2% (2)  |
| 48.9%                      | Household Safety & Basic Needs    | 14.5% (152)                          | 34.4% (360)                    |           |
| 44.1%                      | Caregiver Mental Health           | 39.5% (413)                          | 4.5% (47)                      | 0.1% (1)  |
| 25.0%                      | Health Care Plans                 | 16.9% (177)                          | 8.1% (85)                      |           |
| 11.4%                      | Child Care Plans                  | 10.7% (112)                          | 0.7% (7)                       |           |
| 11.1%                      | Caregiver Emotional Support       | 8.4% (88)                            | 2.7% (28)                      |           |
| 6.0%                       | Caregiver-Child Relationship      | 5.4% (56)                            | 0.7% (7)                       |           |
| 4.8%                       | Family & Community Safety         | 4.1% (43)                            | 0.7% (7)                       |           |
| 2.8%                       | History of Parenting Difficulties | 2.5% (26)                            | 0.3% (3)                       |           |
| 1.8%                       | Substance Use                     | 1.7% (18)                            | 0.1% (1)                       |           |

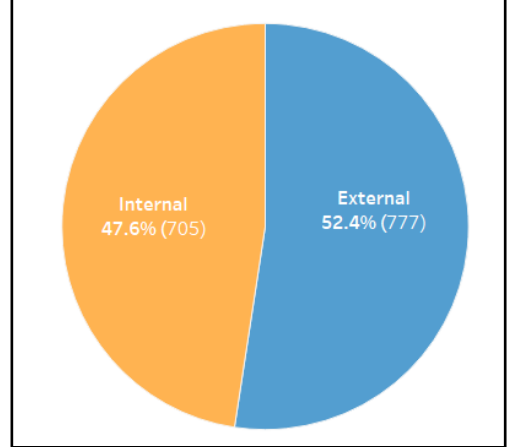
### Referrals to Community Resources

Nurses made a total of 1,567 referrals to connect families to services in 2024, which are categorized in several ways. New referrals are related to concerns that require establishing new connections between caregivers and resources, such as lactation support. Existing referrals can be resolved by an established connection, such as a current mental health provider. Referrals can also be risk-related (matrix rating of 3 or 4) or recommendation only (e.g., possible interest in arranging childcare for an older sibling).

When monitoring caregiver connection to services, focus centers on new referrals related to risk, which accounted for 95% (1,482) of all referrals. These referrals are significant because they intend to connect families with services they did not previously have in areas that were assessed as a risk. Just over half of new, risk-related referrals went to external agencies (52.4%) and the remaining 47.6% went to internal resources (Figure 10). Internal referrals are categorized as such because they are completed during or shortly after visits by distribution of resources including diapers, basic needs gift cards, breast pumps, portable cribs, and other health or household items (Figure 11).

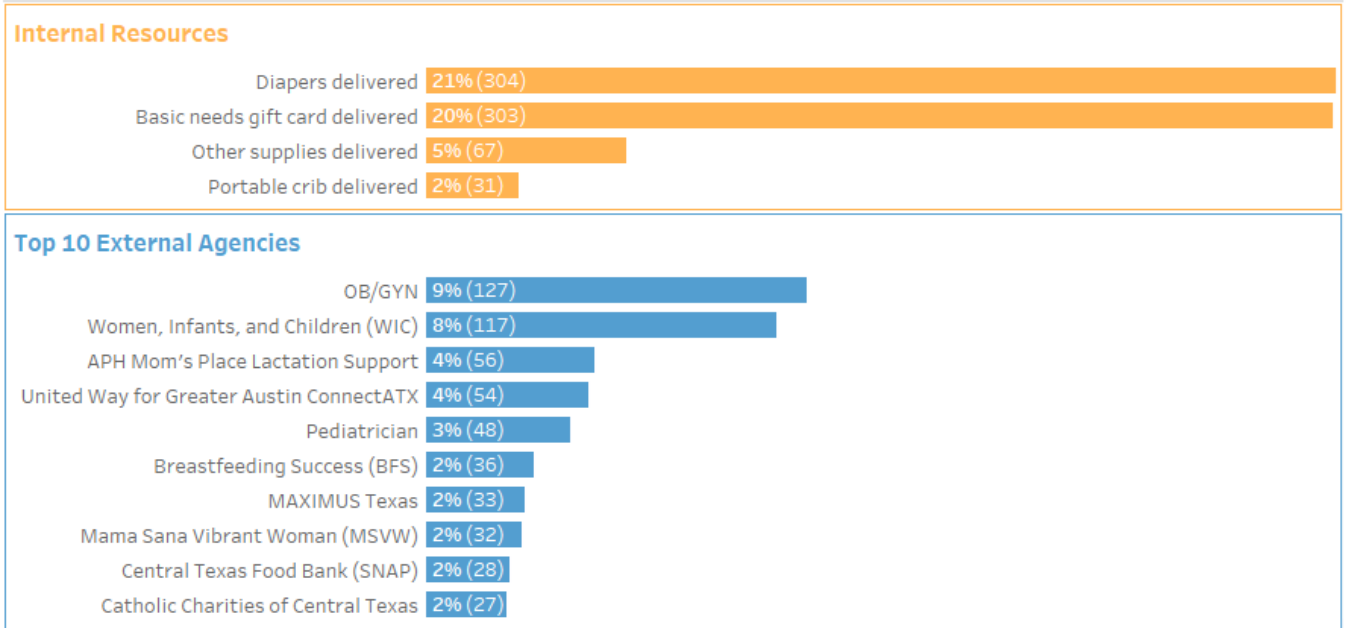
External referrals require follow-up by the referral agency and/or caregiver after the visit. Top new external referrals (Figure 11) were centered around medical and mental health care, supplemental nutrition, lactation support, parent emotional support, and basic needs support.

**Figure 10**  
Percent of new, risk-related referrals made for internal resources or external agencies 2024 (n=1,482)



**Figure 11**

Percent of new, risk-related referrals made for internal resources and top external agencies 2024 (n=1,482)

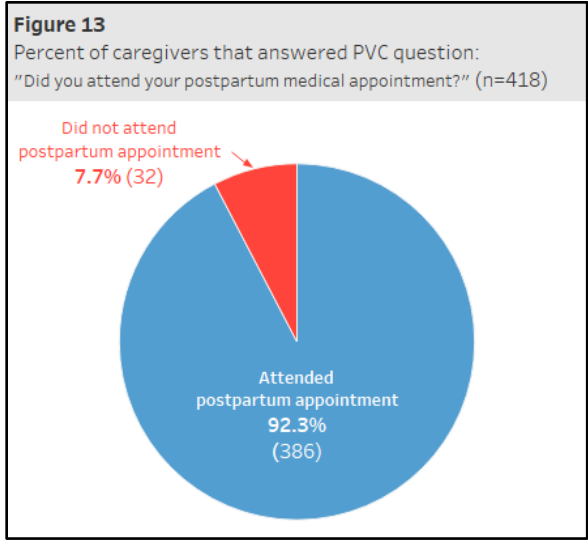
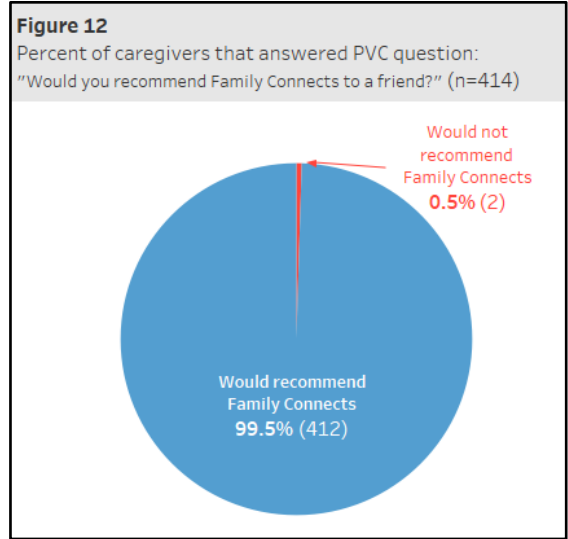


### Caregiver Feedback from Post Visit Connection Calls

About six weeks after the visit, staff members attempt to reach families for a Post Visit Connection (PVC) phone call to gather feedback about the visit, confirm postpartum visit attendance, and understand caregivers' referral experiences. In 2024, PVC completion dropped to 41% from 67% in 2023, due to Health Cloud process changes. To improve future feedback from PVCs, the team has requested database updates and has introduced new processes to increase PVC completion rates.

#### Program Satisfaction (Figure 12)

Of the caregivers who answered the PVC question, "Would you recommend Family Connects to a friend?" all but two (99.5%) reported that they would recommend Family Connects based on their experience with the program.

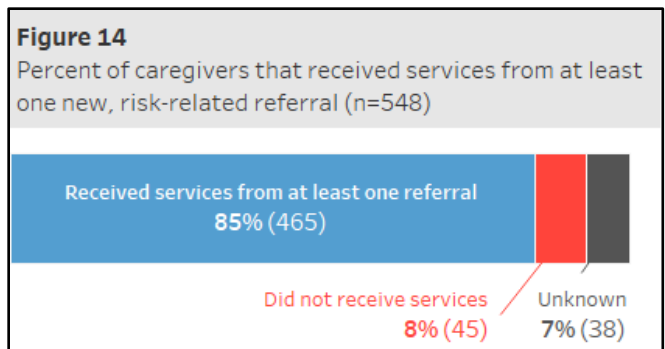


#### Postpartum Medical Visit Attendance (Figure 13)

During visits, nurses emphasize the importance of medical follow up appointments for mom and baby and help schedule appointments when needed. When asked about postpartum medical visits during the PVC, 92.3% answered that they had attended the visit.

#### Referral Connection (Figure 14)

For the group of 548 caregivers that received new, risk-related referrals in 2024, 85% received services from at least one referral. This data is determined by internal resources being delivered along with PVC referral feedback from caregivers.



### Highlights from 2024 and Looking Ahead to 2025

In February 2024, the Salesforce Sales Cloud database transitioned to Salesforce Health Cloud for all FCI partners, significantly affecting data collection and availability for this report. Since then, the team has worked diligently to develop new workflows, update processes, and build new dashboards for program monitoring and evaluation. Staff continue to collaborate with FCI to troubleshoot issues, request training, receive updated documentation, and call for enhancements to better capture program outcomes.

In April 2024, the program was awarded recertification from FCI. This certification is reviewed every three years and is contractually renewed based on the successful implementation of the Family Connects model and fidelity measures. This includes population reach, satisfaction rates, and caregiver risk assessment quality.

In May 2024, the Family Connects Physician Advisory Committee (PAC) convened under the leadership of Austin Public Health. Consisting of local physician leaders, the PAC meets regularly to review program data and operations. Members contribute to program growth by providing strategic insights, connecting staff with local leaders, fostering community interest and involvement, and encouraging their colleagues to inform families with newborns about the benefits of Family Connects.

Midway through 2024, program administrators began meeting regularly with Ascension Seton Medical Center leadership to improve hospital consent rates and increase Family Connects participation for those giving birth at Seton. Efforts focus on raising program awareness, improving the consent process, and potentially expanding access for program staff to educate families on the benefits of Family Connects home visits. These strategic initiatives will continue in 2025.

In late 2024, Family Connects partnered with CommUnityCare Health Centers to receive referrals for patients attending prenatal visits. Prenatal partnerships introduce caregivers to Family Connects before delivery, on the recommendation of their trusted prenatal care provider. Family Connects staff reach out to patients to provide program details and schedule home visits. This approach is expected to boost participation and lead to increased program engagement and completion rates. Expansion to People's Community Clinic and other sites is planned for 2025.

### More Information on Family Connects Texas of Austin/Travis County

Contact us to learn more about how supporters, agencies, and medical providers can collaborate with Family Connects of Austin/Travis County: [FamilyConnects@uwatx.org](mailto:FamilyConnects@uwatx.org).

# THANK YOU TO OUR PARTNERS!



**BUENA VISTA  
FOUNDATION**



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