Holistic Family Services

FY 2018 Community Impact Report

Travis County Health and Human Services

Research & Planning Division

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TRAVIS COUNTY
HEALTH and HUMAN SERVICES

PURPOSE

Who we are:

A Department of Travis County that serves the community under the guidance of the Commissioner's Court

What we do:

Address community needs through internal and external investments and services

What we strive to accomplish:

Maximize quality of life for all people in Travis County

- Protect vulnerable populations
- Invest in social and economic well-being
- Promote healthy living: physical, behavioral, and environmental
- Build a shared understanding of our community

VALUES

We value helping people.

- We provide accessible, person-centered services with respect and care.
- We work to empower people through our service to them, always honoring the strengths and differences of the individuals and families of Travis County.

We value the accountability and integrity of our staff.

- We value the diversity of our staff and the experience each of us brings to HHS.
- We honor our collective service to the public, including the careful stewardship of public funds.
- We value the quality services we provide to the community in a spirit of shared responsibility.

We value cooperation and collaboration in the community at large and within HHS.

- We are interdependent and connected.
- We treat one another with respect and value effective communication and teamwork.
- We honor our partners in the community and engage with them to more efficiently and effectively serve our clients.

Table of Contents

Introduction 5

Investment Overview 7

Integral Care: Families With Voices/Familias Con Voces Collaborative 10

Appendix 16

Introduction

The Travis County Commissioners Court, through the Travis County Health and Human Services Department (HHS), annually invests over $19.5 million in community-based social service programs. These Department investments align with and supplement our direct services to meet the needs of local residents. Community-based organizations are frequently geographically and culturally embedded in the communities they serve and are often best positioned to provide needed services.

Purpose of Report

The annual Community Impact Report provides an overview of HHS investments in health and human services. The *FY 2018 Community Impact Report* offers community context most pertinent to the services purchased, and details investment, programmatic, and performance information on the Department's social service contracts. This information allows policy makers, program managers, and others to better understand these investments, recognize accomplishments, identify areas for improvement, disseminate lessons learned, and highlight areas warranting further research.

Organization of Report

This report addresses nine issue areas—Access to Basic Supports, Behavioral Health, Child and Youth Development, Housing Continuum, Planning and Evaluation, Public Health, Safety Intervention Services, Supportive Services for Community Living, and Workforce Development—as well as a pilot project under Holistic Family Services. The Investment Overview summarizes information from all nine issue areas and the pilot project. Each issue area section begins with community context and then provides performance highlights. Each program is classified into the issue area most closely aligned to its goals and objectives.

Although this report provides community context for individual issue areas separately, each issue area must be considered in a broader context. Community conditions related to a single issue area may have similar or related root causes and broad-level consequences. Current economic conditions also have a global impact on the community.

This report provides detailed information about each program covered by an issue area, including an overview of program goals, services provided, eligibility criteria, and funding. Also captured are each program's performance results, compared to its contractual performance goals, and explanations of notable variance (+/- 10%) between the performance results and goals.

Notes on Methodology

Community context discussed in this report reflects the most recent information available at the time of writing. The majority of the social service contracts included in the report followed a fiscal year calendar (October 1, 2017 through September 30, 2018) unless otherwise noted. Program and performance highlights are drawn from contracts and reports provided by contracted service providers. Estimates from the American Community Survey have been tested at a 90% confidence level for reliability. In some cases, all noted, estimates were unreliable due to small sample sizes.

Considerations When Reading This Report

Performance results provide only a starting point for understanding the impact of these programs. These summary statistics are not necessarily an indication of the programs' overall performance, but rather a snapshot of their performance over a one-year period. Within these reports, service providers offer explanations for variance in performance, which provides context and meaning to summary results.

Performance results do not reflect programs' full value to and impact on the community. Therefore, it is important to keep the following considerations in mind when reviewing program performance.

Readers should use caution when comparing output and outcome results across programs, as participant characteristics can significantly influence a given program's performance goals and results. For example, performance results may be lower for programs with clients who face considerable challenges (e.g., serious mental illness or addiction issues) and have little social support.

Factors beyond the program's control may also impact the program's performance. For example, the relative scarcity or abundance of jobs in the local economy will impact client employment rates for a workforce development program, regardless of the quality of training and support provided. Without controlling for these factors, the true impact or efficacy of the program on outcomes cannot be discerned.

Readers should also use caution when examining outcome results for programs with less than 30 clients, in which the outcome of just a few clients can greatly affect the program's total outcome result. In these instances, examining percentages may be less helpful than examining raw numbers.

Finally, this report captures a selection of performance measures, which may not reflect the program's full impact on participants and their families, peers, and neighborhood. Performance measures may not all be equal in importance or value to the community.

Investment Overview

Goals and Services

The FY 2018 investment in Holistic Family Services represents the third year of implementation. This pilot program uses a Wraparound Family Intervention approach to address multiple complex needs of whole families, in an effort to create lasting, positive change for children in these families. Services focus on families with children in the outlying areas of Travis County, and more specifically, impacted block groups in areas of very low or low opportunity outside of the City of Austin. Services currently target families residing in the 78653 ZIP code. The program service design includes:

- Home-centered services to families with children, which begin with family assessment and reduce the need for multiple providers to do the same assessment work with family members
- Centralized coordination of services to perform assessment, develop a service plan, coordinate and monitor services across multiple service providers and areas of intervention, and demonstrate results of services provided
- Family-driven service planning for all household members that includes the family in discussions to determine the best intervention for the family
- Culturally and linguistically appropriate service delivery system
- Access to a network of services that can address each of the five targeted social service issue areas: housing, workforce development and/or adult education, child and youth development, behavioral health, and food and transportation (access to basic supports)
- Periodic assessment during the service delivery period to measure progress and/or need for additional services
- Step down planning and community integration
- Evaluation of status at exit and at 6 and 12 months following family exit from the program

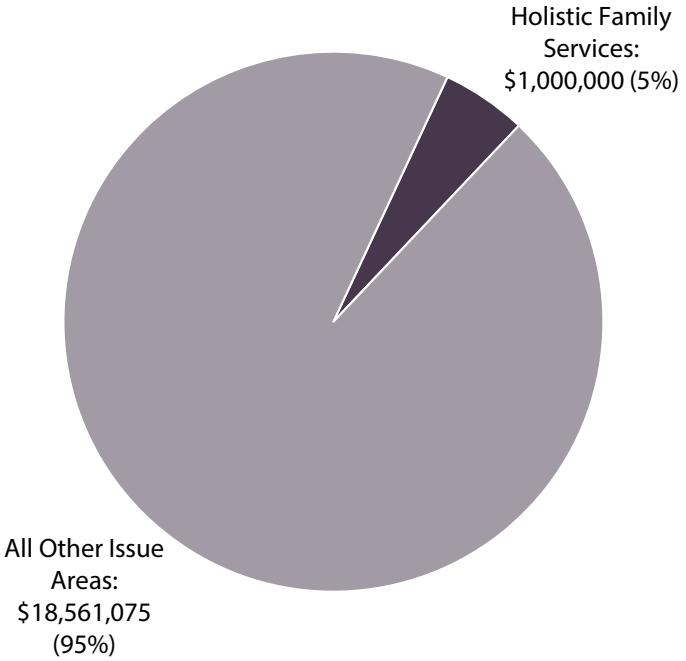
Identified program outcomes for each of the five targeted social service issue areas include:

- Housing
  - Stable housing while in the program (stay in current housing or move to an improved housing situation)
  - Sustained stable family housing conditions
- Workforce Development and/or Adult Education
  - Enter or advance in the workforce by gaining employment or having an increase in earnings
  - Increase earned income to support greater stability (increased family financial resources earned)
  - Retain employment

  - Earn recognized credentials, academic (diploma, GED, degree) or vocational (employer recognized certification)

- Child and Youth Development
  - On target or improved developmental functioning
  - School ready and/or improved school functioning
  - Social and emotional functioning
  - Avoid or resolve Child Protective Services and/or juvenile justice involvement
- Behavioral Health
  - Receive services based on assessed needs
  - Establish a service home for ongoing behavioral health needs
  - Decrease in crisis situations and hospitalizations
  - Self or family report of improved functioning and management of diagnosis
- Access to Basic Supports
  - Regular access to fresh and healthy food
  - Reasonable plan for transportation to work and/or education activities during service and at exit

Investment in Holistic Family Services and Other Issue Areas, FY 2018



Funding Summary

The FY 2018 Funding Amount reflects 12–month funding (October 1, 2017 through September 30, 2018).

Agency Name	Program Name	FY 2018 Funding Amount
Integral Care	Families With Voices/Familias Con Voces Collaborative	$1,000,000

Client Demographics

The table below summarizes the demographics for clients served in the Families With Voices/Familias Con Voces Collaborative. Individual demographics are reported for gender, ethnicity, and race, while income status reflects families. Due to HIPAA privacy concerns, and specifically, the risk of re-identification, age information has been removed from this report.

Gender	Num.	Pct.
Female	77	57%
Male	57	43%
Total	*134*	*100%*

Ethnicity		
Hispanic or Latino	40	30%
Not Hispanic or Latino	91	68%
Unknown	3	2%
Total	*134*	*100%*

Race		
Black or African American	91	68%
White	21	16%
Some other race	12	9%
Two or more races	10	7%
Total	*134*	*100%*

Income	Num.	Pct.
<50% of FPIG	15	47%
50% to 100%	12	38%
101% to 150%	4	13%
151% to 200%	1	3%
Total	*32*	*100%*

Note: Percentages may not total to 100% due to rounding.

See Appendix for specific income guideline levels.

Integral Care

Families With Voices/Familias Con Voces Collaborative

Program Description

The goals of the Families With Voices/Familias Con Voces Collaborative include:

- Using the Self-Sufficiency Matrix, assess each eligible family and family member in the following key service need areas (outcome scales) to determine level of need, self-sufficiency, stability, and functioning. These areas are: behavioral health, child and youth development, food and transportation, housing continuum, and workforce development;
- Using a Wraparound Holistic Family Team approach, address each outcome scale with the family and family members and assist them in achieving progress in identified benchmarks as they move through the continuum on the Self-Sufficiency Matrix; and
- Through the collection and management of data, demonstrate improvements and progress, creating lasting and positive change for children in these families.

Services provided include:

- Care Coordination and Case Management: A Family Wraparound Team (FWT) is developed around every family served. The FWT consists of the following team members: the family, formal and informal supports identified by the family, Family Wraparound Team Care Coordinator (FWTCC), a housing specialist, a behavioral health specialist, a workforce development specialist, and any external providers who provide non-traditional services such as mentoring, respite care, and recreational therapy. The FWTCC also serves as the transportation specialist and facilitates access to food assistance needs if identified.
- Coordinated Assessment: The Fenn-Jorstad Self-Sufficiency Matrix is used as a guide for the coordinated assessment tool developed by Integral Care. Families are screened for eligibility and assessed across all five required issue areas at program entry (housing continuum, workforce development, child and youth development, behavioral health, and food and transportation). The assessment is administered every ninety days with each family receiving services and is used to facilitate and guide the Person Centered Care Plan (PCCP). The PCCP allows individuals receiving services to have a strong voice in the development of their care plan and in the guidance of the plan moving toward successful individual and family outcomes.
- Career Case Management Assessment: The Goodwill Career Case Manager completes a career case management assessment and an initial Individual Career Plan with the client, reviews program forms and documentation, and initiates services with the client.
- Workforce Development Services: The Goodwill Career Case Manager works closely with clients to achieve their vocational goals. Services include job readiness training, job development/placement, job retention support, and occupational skills training leading to an industry-recognized credential. Vocational outcomes for participants of occupational training programs include placement, earnings increase, credential attainment, and six- and twelve-month job retention.

Integral Care

Families With Voices/Familias Con Voces Collaborative

- Housing Continuum: Integral Care's Adult Behavioral Health (ABH) Supportive Housing service has two dedicated housing specialists for this program's families. The housing specialist develops a housing service plan and works directly with families to rapidly find suitable housing (if the family is homeless) or assist the family in maintaining stable housing. Financial assistance is available, covering expenses such as rent, utilities, mortgage, rent/utilities debt, minor home repair, and basic furnishings. Housing services include an assessment of housing needs, landlord outreach, provision of emergency housing supports, and homelessness prevention and rapid re-housing. All families receiving housing continuum services receive ongoing case management.
- Food Services: The FWTCC assesses food security and nutritional needs for families at intake and at 90–day intervals. The FWTCC provides resources to families about available food pantries, coordinates access to SNAP benefits, and provides gift cards for food assistance to supplement the family's food budget. Families also receive basic information on nutrition at intake and receive referrals to community resources on nutrition classes when needed.
- Child and Youth Development Services: Children ages 0-3 are screened using the Ages and Stages Questionnaire (ASQ) or ASQ-SE as appropriate. All children age four or over who are identified as having behavioral health issues by the parent are screened using the Child and Adolescent Needs and Strengths (CANS) assessment. The program provides evidence-based care for children with emotional and cognitive diagnoses and works with their families to provide guidance and understanding. Services include, but are not limited to: psychiatric evaluations, individual therapy, individual/group counseling, cognitive-behavioral therapy, family therapy, parenting sessions, and medication management. The FWTCC facilitates linkages to social and emotional learning opportunities by exploring children's extracurricular interests.
- Behavioral Health Services: The Behavioral Health Specialist meets and addresses all of the behavioral health service needs of the family, including children and adults. Service options available to children and families include, but are not limited to: intensive outpatient services (including individual and family counseling/therapy), psychiatric evaluations and medication management, skills training, case management, care coordination using the System of Care Wraparound practice model, the Youth Empowerment Program for children with a serious emotional disturbance, and Integrated Primary Care and Behavioral Health School-Based Clinic Services located in Manor ISD. Services are provided by licensed counselors and/or qualified mental health practitioners. All service options can be and are provided in the home, community, school, or clinic.

Integral Care

Families With Voices/Familias Con Voces Collaborative

Funding

The total HHS investment in the Families With Voices/Familias Con Voces Collaborative from October 1, 2017 through September 30, 2018 was $1,000,000. This investment comprised 100% of their total program budget. HHS funds additional programs and services at Integral Care, including the Main Mental Health Interlocal, Parenting In Recovery/Family Drug Treatment Court, Substance Abuse Managed Services Organization, and System of Care Managed Services Organization programs, which are described in the Behavioral Health issue area report, and the Community Advancement Network program, which is described in the Planning and Evaluation issue area report.

Eligibility Criteria

To be eligible for this program, families must:

- Have dependent children between the ages of 0-22;
- Reside in the 78653 ZIP code or be identified by the Manor Independent School District as homeless;
- Fall within the income level requirements: at or below 60% of Median Family Income (MFI) at intake (80% of families) or up to 80% of MFI at intake (20% of families); and
- Demonstrate need in one or more of the five core areas of housing continuum, workforce development, child and youth development, behavioral health, and access to basic supports (food and transportation).

These families show systemic struggles meeting the basic necessities of everyday life including nutritious food, housing, employment, clothing, transportation, healthcare, and psychological well-being, including optimal physical and mental health.

Integral Care: Families With Voices/Familias Con Voces Collaborative

The Families With Voices Collaborative met or exceeded most performance goals. Staff reported that the VI-SPADT assessment is done when a family meets the criteria for literal homelessness, and staff did not coordinate this assessment for any of the families that entered the program this year (see the sixth output). Most families complete this assessment before entering the program. Staff also noted that many children receiving therapy services completed these services this year, which led to a reduction in the number of children assessed with the CANS (see the tenth output). As families enter the program, the number of CANS assessments will increase as new children engage in therapy.

The goal for the number of Self-Sufficiency Matrix (SSM) assessments conducted did not account for 90–day follow-up SSM assessments, so the program exceeded expectations; this goal has been adjusted for FY 2019 (see the fifth output). The number of Housing Stability Assessments conducted was also higher than expected due to the transition of the program's housing services and the use of the SSM for assessing housing stability when the program did not have a housing specialist in place (see the seventh output). Currently the housing specialist completes an assessment when they make first contact with a family and updates this assessment every three months at minimum. The SSM was also used to assess nutrition and food needs (see the ninth output). Integral Care resumed this responsibility with the change in housing provider.

The program overestimated the number of families expected to graduate during the year. Several families experienced unexpected emergencies such as job loss or housing loss near their expected graduation date and were unable to exit as expected until the crisis was resolved. However, for the families that did exit, the program met goals for maintaining or obtaining both transportation and housing (see the first and sixth outcomes). Further, the program significantly overestimated how many people would score at risk for childcare at intake. This outcome was revised for FY 2019 to more accurately capture the need for childcare (see the second outcome).

Staff explained that attendance for children attending Manor ISD continues to be a challenge (see the third outcome). It is unclear what is impacting attendance rates. There is often a drop in attendance for children over 12 years of age and for young children in families with complex needs. Transportation also impacts attendance, and Manor ISD has experienced challenges setting up transportation for homeless families.

The program measures housing stability at every 180 days for participants. The majority of the families experienced safe housing when assessed (see the fifth outcome). Income assessments each 180 days also show that the majority of families are experiencing increases in income (see the seventh outcome).

Integral Care: Families With Voices/Familias Con Voces Collaborative

Please note that due to HIPAA privacy concerns, and specifically, the risk of re-identification, certain performance information has been removed from this report.

Performance Measure	Total Program Performance Results	Total Program Performance Goals	Total Program Performance Goal Achieved
Outputs			
Number of unduplicated families served	32	30	107%
Number of unduplicated existing families served	10	10	100%
Number of unduplicated new families served	22	20	110%
Number of unduplicated clients served	134	120	112%
Number of Self-Sufficiency Matrix assessments conducted	72	45	160%
Number of VI-SPADT assessments for families completed	0	1	0%
Number of Housing Stability Assessments conducted	49	35	140%
Number of employment plans and employment plan updates developed	23	20	115%
Number of food and nutrition assessments completed	72	35	206%
Number of Child and Adolescent Needs and Strengths (CANS) assessments conducted	10	15	67%
Number of Adult Needs and Strengths Assessments (ANSAs) conducted	12	10	120%
Outcomes			
Percentage of families who have obtained or maintained a "safe or self-sufficient" score on transportation at program exit	50% (7/14)	50% (10/20)	100%
Percentage of families reporting increased access to safe, reliable, sustainable childcare at program exit	50% (2/4)	60% (9/15)	83%
Percentage of children enrolled in Manor ISD with an attendance rate of 93% or higher in the reporting quarter (duplicated count of children)	53% (79/149)	60% (30/50)	88%
Percentage of Goodwill participants who accomplished at least one educational/vocational goal on their Goodwill Career and Education Plan at exit	85% (11/13)	67% (6/9)	127%
Percentage of families reassessed around the 180 day participation mark that report obtaining or sustaining safe, permanent, affordable housing	63% (15/24)	50% (10/20)	125%

Integral Care: Families With Voices/Familias Con Voces Collaborative

Performance Goals and Results

Performance Measure	Total Program Performance Results	Total Program Performance Goals	Total Program Performance Goal Achieved
Percentage of families who obtained or maintained safe, permanent, and affordable housing at program exit	71% (10/14)	65% (13/20)	110%
Percentage of families who maintain or increase their income resources (earned and unearned income as well as debt reduction)	69% (18/26)	50% (10/20)	138%

Appendix

2018 Federal Poverty Income Guidelines

Most HHS contracts require programs to serve participants with household incomes at or below 200% of the Federal Poverty Income Guideline (FPIG) level. Some programs have chosen to follow a more stringent threshold. The following table presents the federal poverty thresholds by household size and income.

Household Size	Income Limits by Household Size				
	50%	100%	125%	150%	200%
1 person	$6,070	$12,140	$15,175	$18,210	$24,280
2 persons	$8,230	$16,460	$20,575	$24,690	$32,920
3 persons	$10,390	$20,780	$25,975	$31,170	$41,560
4 persons	$12,550	$25,100	$31,375	$37,650	$50,200
5 persons	$14,710	$29,420	$36,775	$44,130	$58,840
6 persons	$16,870	$33,740	$42,175	$50,610	$67,480
7 persons	$19,030	$38,060	$47,575	$57,090	$76,120
8 persons	$21,190	$42,380	$52,975	$63,570	$84,760
For families/households with more than 8 persons, add $4,320 for each additional person.					

Data source: "2018 Poverty Guidelines for the 48 Contiguous States and the District of Columbia," Office of The Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services, January 13, 2018, https://aspe.hhs.gov/poverty-guidelines.

2018 Austin Median Family Income Guidelines

Some programs may also use Austin MFI guidelines when measuring client incomes. The following table presents the median family income limits established by the U.S. Department of Housing and Urban Development (HUD) for the Austin-Round Rock, TX Metropolitan Statistical Area (MSA).

Household Size	Income Limits by Household Size		
	Extremely Low*	Very Low (50%)	Low (80%)
1 person	$18,100	$30,100	$48,200
2 persons	$20,650	$34,400	$55,050
3 persons	$23,250	$38,700	$61,950
4 persons	$25,800	$43,000	$68,800
5 persons	$29,420	$46,450	$74,350
6 persons	$33,740	$49,900	$79,850
7 persons	$38,060	$53,350	$85,350
8 persons	$42,380	$56,800	$90,850

*The FY 2014 Consolidated Appropriations Act changed the definition of extremely low-income to be the greater of 30/50^{ths} (60%) of the Section 8 very low-income limit or the poverty guideline as established by the Department of Health and Human Services, provided that this amount is not greater than the Section 8 50% very low-income limit.

Data source: "Austin-Round Rock, TX MSA FY 2018 Income Limits Summary," U.S. Department of Housing and Urban Development, https://www.huduser.gov/portal/datasets/il/il2018/2018summary.odn.