Holistic Family Services

FY 2017 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.

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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 2017 Community Impact Report* offers highlights of community conditions 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 conditions information and then provides performance highlights about the programs within that issue area. Each program is classified into the issue area most closely aligned to its goals and objectives.

Although this report highlights community conditions 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 community conditions.

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 conditions discussed in this report reflect 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, 2016 through September 30, 2017) 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

Our Investment

The FY 2017 investment in Holistic Family Services represents the second 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

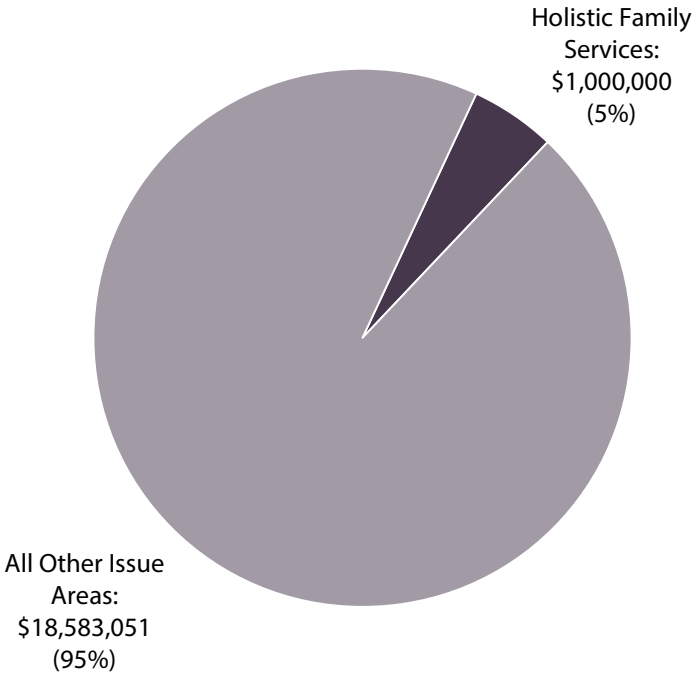
Identified program outcomes for each of the five targeted social service issue areas include:

- 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 2017



Funding Summary

The FY 2017 Funding Amount reflects 12–month funding (October 1, 2016 through September 30, 2017).

Agency Name	Program Name	FY 2017 Funding Amount
Integral Care	Families With Voices/Familias Con Voces Collaborative	$1,000,000

Holistic Family Services 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	93	61%
Male	60	39%
Total	*153*	*100%*

Ethnicity		
Hispanic or Latino	68	44%
Not Hispanic or Latino	79	52%
Unknown	6	4%
Total	*153*	*100%*

Race		
Black or African American	68	44%
White	57	37%
Some other race	12	8%
Two or more races	16	10%
Total	*153*	*100%*

Income	Num.	Pct.
<50% of FPIG	8	25%
50% to 100%	12	38%
101% to 150%	8	25%
151% to 200%	4	13%
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, Family Wraparound Team Care Coordinator, 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. Food Services staff meet with the FWT on an as-needed basis.
- 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 Planning (PCCP) process. 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 and Food Services: Foundation for the Homeless staff 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. The Food Services Specialist conducts food needs assessments with the family, attends Family Team meetings, transports fresh food to the family as needed, provides food vouchers to the family as needed, and through effective outreach efforts, assists in developing and maintaining community gardens in 78653 service area.
- 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, medication management, physical therapy, occupational therapy, and speech language therapy.
- Behavioral Health Services: The Behavioral Health Specialist meets and addresses all of the behavioral health service needs of the family, including children and adults. Services 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, the In-Home Counseling Program for youth on juvenile probation, and Integrated Primary Care and Behavioral Health School-Based Clinic Services. 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.

Funding

The total HHS investment in the Families With Voices/Familias Con Voces Collaborative from October 1, 2016 through September 30, 2017 was $1,000,000. This investment comprised 100% of the 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.

Integral Care

Families With Voices/Familias Con Voces Collaborative

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 guidelines: 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

This fiscal year was the first full year of service delivery for Families With Voices. The Collaborative served 32 families in FY 2017 (see the first output). Staff noted that they served fewer than expected existing families but had more new families referred to the program (see the second and third outputs). The size of these families was larger than estimated, resulting in more clients being served (see the fourth output).

Self Sufficiency Matrix assessments were conducted at intake and at 90–day follow up (see the fifth output). For families to go through coordinated assessment for a VI–SPADT, they must meet literally homeless criteria; however, staff reported that they have not encountered many families that are literally homeless at referral or who become literally homeless during their participation (see the sixth output). Initially, Housing Stability Assessments were being conducted monthly. The frequency was adjusted in the third quarter so that assessments were only conducted at intake, after 180 days, and at exit (see the seventh output). Food and nutrition assessments were done periodically for some families (see the ninth output). CANS assessments were completed for children at intake, every 90 days, and at exit, while ANSAs were conducted for adults at intake, 180 days, and at exit. Ongoing participation from children and adults resulted in a greater than expected number of assessments conducted (see the tenth and eleventh outputs).

Staff reported that there were twelve exits from the program, seven of whom were closed due to loss of contact with staff. Limited follow-up data was available as a result. Three families disengaged shortly after receiving their final rental assistance from the program, so staff were unable to obtain exit data.

Staff reported that transportation has been a difficult issue to address, as clients experience a variety of barriers to transportation, many of which cannot be influenced (see the first outcome). Few clients identified childcare as a need at intake, and the need for childcare fluctuated throughout the families' time in the program. Staff noted that this outcome has not captured the need and impact on access to childcare as planned, but the measure has since been improved upon for FY 2018 and will hopefully capture this information more effectively (see the second outcome).

The program is considering programmatic changes to have a stronger impact on school attendance, and noted in the fourth quarter that they were seeing improved attendance rates at the beginning of the school year (see the third outcome). The program saw an increase in participation with Goodwill services in the fourth quarter of the year, which they largely attributed to the onboarding of the Goodwill Career Case Manager (see the fourth outcome).

Integral Care: Families With Voices/Familias Con Voces Collaborative

Staff reported that housing continues to present as a challenge. Most families have been able to get into safe housing but affordability continues to be an issue for families with challenges to sustained employment. The cost of housing has also proven to be a significant challenge given the wages that families are able to earn (see the fifth outcome). Finally, the loss of contact with families exiting the program negatively impacted the number of families able to report exiting into safe, permanent, and affordable housing (see the sixth outcome).

Staff provided additional comments regarding this program and its performance over the course of the year: One of the main advantages of the program is that families have access to numerous providers to help address various needs and advance their goals in housing, employment, mental health, and child development. While the program goes to great lengths to streamline processes to reduce redundancies, families still had to meet with the service providers regularly to take advantage of the services. For many families, attending appointments while trying to work and tend to their children's needs was very difficult. In October 2016, the program implemented a participation agreement that outlined more specifically the expectations of program participants, which includes attending appointments and maintaining communication with service providers. This process has improved engagement in services, as families fully understand the commitment required for obtaining full benefit from participating in the program.

A second issue that may have impacted engagement was that many changes happened slowly. Due to the pilot nature of the program, many of the challenges that families presented required a review and consideration to the program's processes and procedures by management. This process may have caused delays in addressing the families' needs. It is possible that families did not feel the immediate benefit of participating versus the time commitment that was required. Staff are working on being more aggressive in addressing housing barriers, engaging families with the service providers more quickly, and providing more immediate assistance with food and transportation to help keep families engaged.

Finally, there were many social determinants that have continuously proven to be a challenge. Single parent households, chronic medical conditions for parents and children, affordability of housing, limited permanent supportive housing resources, large debts, poor credit, and limited access to public transportation in the suburbs have presented barriers to long-term stability for many of these families.

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

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
Outputs			
Number of unduplicated families served	32	30	107%
Number of unduplicated existing families served	8	10	80%
Number of unduplicated new families served	24	20	120%
Number of unduplicated clients served	153	120	128%
Number of Self-Sufficiency Matrix assessments conducted	94	45	209%
Number of Family VI-SPADT assessments conducted	1	3	33%
Number of Housing Stability Assessments conducted	85	35	243%
Number of employment plans and employment plan updates developed	32	20	160%
Number of food and nutrition assessments completed	39	35	111%
Number of Child and Adolescent Needs and Strengths (CANS) assessments conducted	28	15	187%
Number of Adult Needs and Strengths Assessments (ANSAs) conducted	26	10	260%
Outcomes			
Percentage of families whom have obtained or maintained a "safe or self-sufficient" score on transportation at program exit	27% (3/11)	50% (6/12)	55%
Percentage of families reporting increased access to safe, reliable, sustainable childcare at program exit	50% (1/2)	33% (3/9)	150%
Percentage of children enrolled in MISD with an attendance rate of 93% or higher in the reporting quarter	52% (121/233)	60% (30/50)	87%
Percentage of Goodwill participants who accomplished at least one educational/vocational goal on their Goodwill Career and Education Plan at exit	64% (7/11)	67% (6/9)	95%
Percentage of families reassessed around the 180 day participation mark that report obtaining or sustaining safe, permanent, affordable housing	30% (7/23)	50% (6/12)	61%
Percentage of families who obtained or maintained safe, permanent, and affordable housing at program exit	33% (4/12)	67% (8/12)	50%

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 maintain or increase their income resources (earned and unearned income as well as debt reduction)	45% (14/31)	50% (6/12)	90%

Appendix

2017 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	$6,030	$12,060	$15,075	$18,090	$24,120
2 persons	$8,120	$16,240	$20,300	$24,360	$32,480
3 persons	$10,210	$20,420	$25,525	$30,630	$40,840
4 persons	$12,300	$24,600	$30,750	$36,900	$49,200
5 persons	$14,390	$28,780	$35,975	$43,170	$57,560
6 persons	$16,480	$32,960	$41,200	$49,440	$65,920
7 persons	$18,570	$37,140	$46,425	$55,710	$74,280
8 persons	$20,660	$41,320	$51,650	$61,980	$82,640
For families/households with more than 8 persons, add $4,180 for each additional person.					

Data source: "2017 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 26, 2017, https://aspe.hhs.gov/poverty-guidelines.

2017 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	$17,100	$28,500	$45,600
2 persons	$19,550	$32,600	$52,100
3 persons	$22,000	$36,650	$58,600
4 persons	$24,600	$40,700	$65,100
5 persons	$28,780	$44,000	$70,350
6 persons	$32,960	$47,250	$75,550
7 persons	$37,140	$50,500	$80,750
8 persons	$41,320	$53,750	$85,950

*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 2017 Income Limits Summary," U.S. Department of Housing and Urban Development, https://www.huduser.gov/portal/datasets/il/il2017/2017summary.odn.