YOUR FAMILY COUNTS
A MULTIDISCIPLINARY
HOME VISITING PROGRAM

Commission Meeting
March 25, 2010

Every Child Counts Family Support Services
Alameda County Public Health Department

FAMILY SUPPORT SERVICES

Balancing prevention and targeted services...
and direct services and systems change

YOUR FAMILY COUNTS:
AN HISTORICAL PERSPECTIVE

- 2001 Universal 1-3 Home Visits
- Development of the Specialty Provider Team
- Reconfiguration – Birth of YFC
WHO WE ARE

Alameda County PHD – Family Health Services
- 4 Public Health Nurses
- 4 Family Advocates

ECC Specialty Provider Team
- 1.5 Lactation Consultants
- 1 Child Development Specialist
- 2.5 Mental Health Specialists

YOUR FAMILY COUNTS

2 week intensive, multidisciplinary training

Started serving families September 22, 2008

Multidisciplinary meetings - 3 times/mo

On-going training
YFC PROGRAM MODEL

Target services to prenatal and postnatal high risk clients at:
- 2 birthing hospitals
- 2 high risk clinic

- Prenatal – Family Advocate and Mental Health
- Postpartum – Lactation Consultants, Public Health Nurses, Family Advocates, Mental Health, Child Development specialists

YFC PROGRAM MODEL

- Each family receives at least 3 visits
- Maximum length of care is 12 months

WHO WE SERVE

Prenatal/Postpartum Criteria
- Homeless
- Substance use
- Depression/mental illness
- Domestic Violence
- Developmental Delay
- Immigrant
- Grief or Fetal loss History
- CPS – current or history
- Lactation/Feeding issues
- NICU < 48 hours (unless Highland NICU)
Pregnant and postpartum women screened for maternal depression - Edinburgh
All families screened using the 4Ps Plus
Newborn Behavioral Observation Tool
All clients screened with ASQ twice before case closure at 6 months and at 12 months
Life Skills Progression

WHO WE SERVE

94% (294 of 314) of families referred were successfully contacted

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal Cases Served</td>
<td>15%</td>
</tr>
<tr>
<td>Postpartum Cases Served</td>
<td>85%</td>
</tr>
</tbody>
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Sept. 22, 2008 to Dec. 31, 2009

FAMILIES ENROLLED

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Hispanic</td>
<td>50%</td>
</tr>
<tr>
<td>African American</td>
<td>25%</td>
</tr>
<tr>
<td>Asian</td>
<td>9%</td>
</tr>
<tr>
<td>Multi-Race</td>
<td>6%</td>
</tr>
<tr>
<td>White</td>
<td>5%</td>
</tr>
<tr>
<td>Other</td>
<td>4%</td>
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<table>
<thead>
<tr>
<th>Language</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>English</td>
<td>59%</td>
</tr>
<tr>
<td>Spanish</td>
<td>33%</td>
</tr>
<tr>
<td>Asian Languages</td>
<td>6%</td>
</tr>
<tr>
<td>Other</td>
<td>3%</td>
</tr>
</tbody>
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Sept. 22, 2008 to Dec. 31, 2009
### WHO WE SERVE

At the time of enrollment, families had one or more risk factors:

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Problems breastfeeding</td>
<td>82%</td>
</tr>
<tr>
<td>History of, or current depression</td>
<td>67%</td>
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<tr>
<td>Housing Unstable</td>
<td>55%</td>
</tr>
<tr>
<td>History of, or current domestic violence</td>
<td>44%</td>
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Sept. 22, 2008 to Dec. 31, 2009

### WHERE FAMILIES LIVE

<table>
<thead>
<tr>
<th>Location</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Oakland</td>
<td>71%</td>
</tr>
<tr>
<td>Hayward</td>
<td>12%</td>
</tr>
<tr>
<td>San Leandro</td>
<td>7%</td>
</tr>
</tbody>
</table>

### WHAT WE DO
Build trust
- Determine “family’s needs”
- Identify the crisis supports
- Focus on family’s strengths
- Focus on the infant
- Support navigating systems
  - Medi-Cal
  - Other entitlement programs (WIC, CCS, Regional Center, etc.)
  - CPS

Parenting education and support
- Fostering relationships
- Focusing on Child/Family Development
- Assessing financial fitness
- Promoting health and wellness
- Reducing isolation
- Building community
FIRST YEAR RESULTS

<table>
<thead>
<tr>
<th># of face to face contacts per family</th>
<th>Up to 50</th>
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</thead>
<tbody>
<tr>
<td>% of cases where 2 or more staff involved</td>
<td>84%</td>
</tr>
<tr>
<td>% of cases held more than 3 months</td>
<td>50%</td>
</tr>
</tbody>
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Connecting to community services - Top Referrals:

- Health Insurance
- Food and basic needs
- Housing / Shelter
- Mental health support

Sept. 22, 2008 to Dec. 31, 2009

FIRST YEAR RESULTS

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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Child has medical home</td>
<td>97%</td>
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<tr>
<td>Child up to date on immunizations</td>
<td>93%</td>
</tr>
<tr>
<td>Child has health insurance</td>
<td>99%</td>
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Sept. 22, 2008 to Dec. 31, 2009
WHAT WE HAVE LEARNED

- Serving much higher risk than anticipated
- Multidisciplinary team works
- Low drop rate (6% compared to 22% for 1-3 program)
  - more than one person who can connect to family
  - more options for families
- Quality child care is key for many families
  - Offers respite
  - Gives child other ways of engaging with adults

WHAT WE HAVE LEARNED

- Identifying program sustainability options
- Need to identify "next step" for when case is closed
- Identifying community/neighborhood support programs
- Not enough community supports for fathers
Your Family Counts