



## YOUR FAMILY COUNTS

- ► 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

- 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)

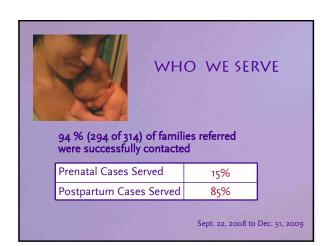


| Child Devel | opment <sup>-</sup> | Training | part 1 |
|-------------|---------------------|----------|--------|
|-------------|---------------------|----------|--------|



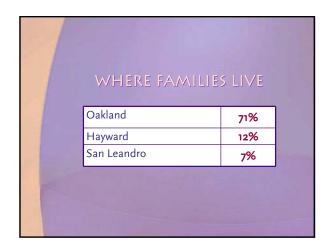
## YFC PROGRAM MODEL

- 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



## **FAMILIES ENROLLED** Hispanic 50% English 59% African Spanish 33% 25% American Asian Asian 9% 6% Languages Multi-Race 6% Other 3% White 5% Other 4% Sept. 22, 2008 to Dec. 31, 2009

| At the time of enrollment, families had or | пе  |
|--|-----|
| or more risk factors:                      |     |
| Problems breastfeeding                     | 82% |
| History of, or current depression          | 67% |
| Housing Unstable                           | 55% |
| History of, or current domestic violence   | 44% |







# 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 heath and wellness Reducing isolation Building community

## FIRST YEAR RESULTS

| # of face to face contacts per family     | Up to 50 |
|---|----------|
| % of cases where 2 or more staff involved | 84%      |
| % of cases held more than 3 months        | 50%      |

## 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

| Child has medical home            | 97% |
|-----------------------------------|-----|
| Child up to date on immunizations | 93% |
| Child has health insurance        | 99% |

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

