sonoma county
DEPARTMENT OF HEALTH SERVICES

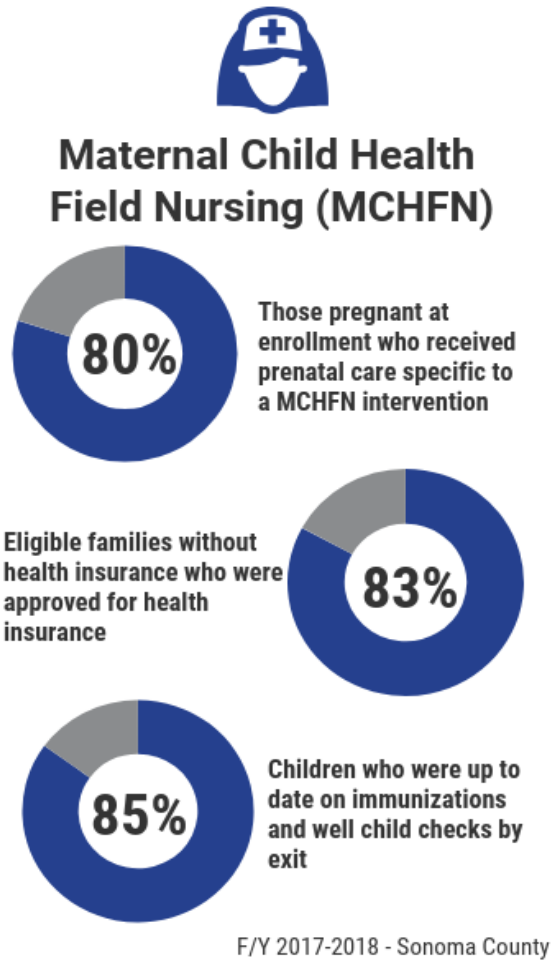
Home Visiting Programs

Field Nursing

The Field Nursing team uses a trauma-informed approach incorporating the research on Adverse Childhood Experiences (ACEs) to optimize health and well-being for high-risk pregnant women and families with children up to age 5. The team performs a comprehensive assessment with each family that includes depression screening for the mother and developmental screening for the child. Public Health Nurse (PHN) Case Managers provide health promotion information/education and linkages to needed resources based on individual service plans. Additionally, the team commits to having an ACEs conversation with each mother (and available partner if co-parenting) that includes information on brain development, an ACEs questionnaire, and a discussion on resilience building practices. The intent is to positively impact the health and well-being of the most at-risk families in our community.

Analysis of outcome data for this program indicates that that the ideal service dose and duration is 12 visits in 6 months. Approximately 350 referrals are received each year. To meet this demand would require a staff of 9.6 PHNs. Since 2016, the department has reduced the size of the Public Health Nurse team to 4. This has required staff to prioritize service to only the highest-risk families. Most families now served face multiple risk factors such as: substance use (42%), mental health concerns (48%), homelessness (36%), domestic violence (47%), and unstable medical conditions - resulting in extremely complex caseloads. With the reduced level of staffing, the program is only able to serve 42% of families referred. Referrals are received by a variety of community partners including community health centers (36%), hospitals (31%), child protective services (12%) and others (21 %).

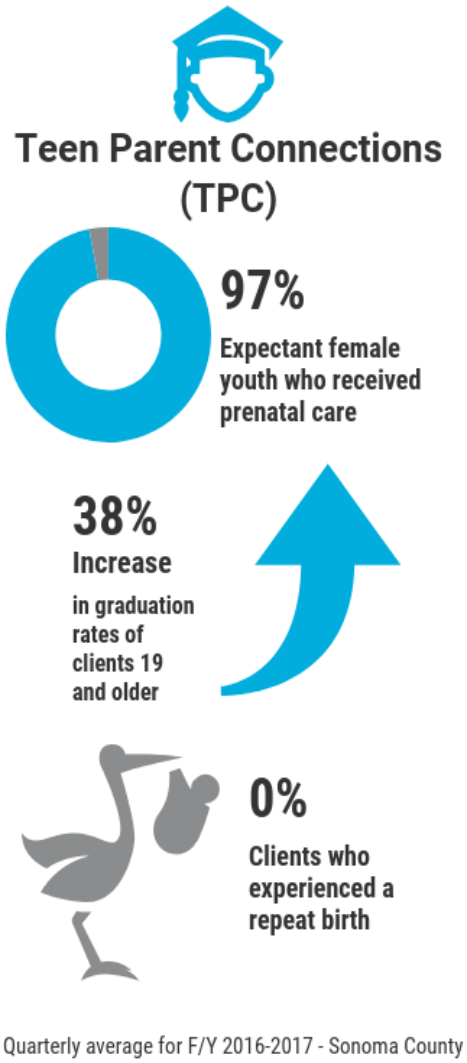
Desired outcomes include receiving prenatal care, post-partum follow-up, health insurance enrollment, linkage to medical homes, well child checks and current immunizations. Of all clients who participated in 2 or more visits at the time of exiting the program, half achieved 80-100% of potential outcomes, which is impressive given the significant challenges these families face. Eighty percent of clients achieved 50-100% of potential outcomes.



Teen Parent Connections

Teen Parent Connections (TPC) has been serving pregnant and/or parenting teens in Sonoma County since 1987. The program utilizes a whole person approach that effectively addresses the complex health risks for adolescents and their children. The program focuses on four key objectives: access to health care, delay of second pregnancies, academic completion, and development of healthy relationships, including positive parenting. These have been shown to be key factors in the health and welfare of the parent/teens, but more significantly, in the health and development of their children, especially within the critical first years of life.

In Sonoma County pregnant and parenting teens comprise a highly vulnerable group. A snapshot of the referrals for fiscal year 2018-2019 shows the following: over 50% of referred teens lack parental support due to a variety of factors, such as childhood neglect and abandonment, parental deportation and incarceration, parental drug abuse and mental health conditions, and a history of child abuse; 33% are struggling with mental health conditions of their own; more than 25% have a history of truancy; and approximately 20% percent of referred teens have verified sexual abuse[1]; and 19% have had involvement with Child Protective Services. Twenty-three percent are at high risk of homelessness or are homeless. The main source of referrals for pregnant and parenting teens in our county are community health centers (40%), self-referrals (22%); schools (10%), and hospitals (9%).



To effectively address the complex issues these youth face – known as ACEs (adverse childhood experiences) - and optimize health outcomes for both generations of youth, the team utilizes leading edge, trauma-informed interventions. These interventions include connecting to and teaching the navigation of health, human and academic resources. It includes personal and parenting health education, teaching self-regulation and effective goal setting. Teen Parent Connections has a solid and well-documented history of making a significant contribution to reducing health disparities in this community. Participation has resulted in: 94% of teens are receiving primary preventive care; 93% are up to date with their immunizations; and 87% are enrolled in school or have earned their high school diploma or GED at 6 months in the program.

[1] This number is generally under-reported at intake and tends to increase during the teen's participation in the program as rapport with their case manager increases.

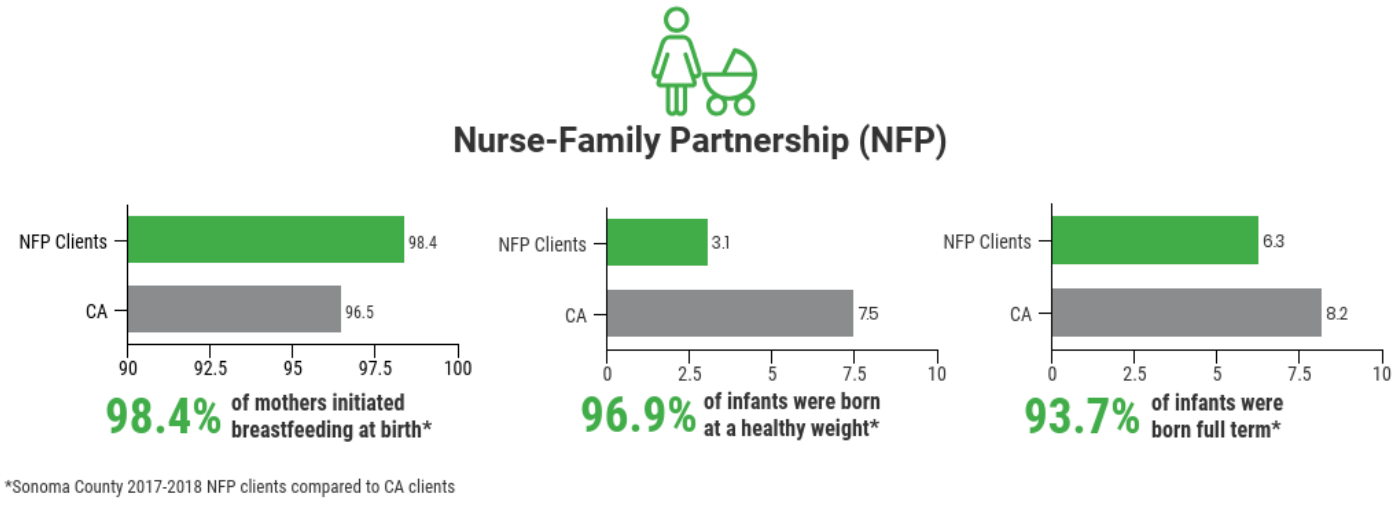
Nurse-Family Partnership® (NFP)

Established in Sonoma County in 2010, Nurse-Family Partnership is an evidence-based home visiting program with nearly 40 years of research demonstrating significant improvements in the health and lives of first-time moms and their children living in poverty. Each mother served by NFP is partnered with a registered nurse early in her pregnancy and receives ongoing nurse home visits that continue through her child's second birthday. Independent research proves that communities benefit from this relationship — every dollar invested in Nurse-Family Partnership can yield more than five dollars in return.

NFP works to improve pregnancy outcomes by helping women engage in good preventive health practices including:

- Thorough prenatal care from their healthcare providers, improving their diets, and reducing their use of cigarettes, alcohol and illegal substances;
- Helping parents provide responsible and competent care to improve child health and development;
- Improving the economic self-sufficiency of the family by helping parents develop a vision for their own future, plan future pregnancies, continue their education and find employment.

The program is currently funded through a combination of sources including: a local First 5 grant; Federal Maternal, Infant & Early Childhood Home Visiting (MIECHV) funds the CDPH California Home Visiting Program (CHVP); and County and federal share for Medi-Cal Targeted Case Management. The program can serve up to 150 families at any given time. Current funding levels limit annual enrollment of new moms to less than 20% of the county's eligible population.



*Sonoma County 2017-2018 NFP clients compared to CA clients