NORTH CENTRAL REGION REFERRAL PATHWAY TOOL

In-Home Services for At-Risk Pregnant & Postpartum Women

User Guide:

Based on the client's traits determine which program is best first referral.

- ✓* = program's primary focus/specialty
- ✓ = program's focus areas
- ▭ = risk factors addressed
- ⊠ = programs accept only pregnancy referrals, but continue services through postpartum

See program description of Referral Pathway Tool (RPT) for targeted zip codes and additional information.

PREGNANT/POSTPARTUM WOMEN

Client's Traits		Black Infant Health (BIH)	First5 First Steps Home Visiting Program	Maternal-Child Health/ Public Health Nurse (MCH)	Nurse-Family Partnership/ Public Health Nurse (NFP)	Project Concern Int'l/ CA Border Healthy Start (PCI/CBHS)	Vista Hill Perinatal Case Mgmt. (PCM)	San Diego Adolescent Pregnancy and Parenting Program (SANDAPP)
Income	Any Income	✓					✓	✓
	200% Below Federal Poverty Level (FPL)		✓	✓	✓	✓		
Parent Age	Any Age	✓		✓	✓	✓	✓	
	23 and below		✓*					✓*
Location	County of San Diego	✓	✓	✓	✓		✓	✓
	Specific Zip Codes					✓*		
Race	Any Race		✓	✓	✓	✓	✓	✓
	U.S. Born African American	✓*						
Pregnancy	Any Pregnancy	✓	✓	✓		✓	✓	✓
	1st Pregnancy and less than 29 weeks				✓*			
Pregnancy Risks	Current/Recent Domestic Violence	▭	▭	▭	▭	▭	▭	▭
	No High School Diploma/GED	▭	▭	▭	▭	▭	▭	✓*
	Substance Abuse	▭	▭	▭	▭	▭	✓*	▭
	Medical/Mental Risk Factors, and/or Inadequate Access to Care	▭	▭	✓*	▭	✓*	▭	▭
Postpartum Risks	Bonding	▭	▭	✓*	⊠	⊠	▭	▭
	Current/Recent Domestic Violence	▭	▭	▭	⊠	⊠	▭	▭
	No High School Diploma/GED	▭	▭	▭	⊠	⊠	▭	✓*
	Substance Abuse	▭	▭	▭	⊠	⊠	✓*	▭
	Medical/Mental Health Risks, and/or Inadequate Access to Care	▭	▭	✓*	⊠	⊠	▭	▭

PROGRAM DESCRIPTION - NORTH CENTRAL REFERRAL PATHWAY TOOL - PREGNANT/POSTPARTUM WOMEN

Program Info	BIH	First 5 First Steps	Maternal-Child Health (PHN)	Nurse-Family Partnership (PHN)	PCI CBHS	Vista Hill (PCM)	SANDAPP
Program Focus/ Goal	Improve African American infant and maternal health and decrease health disparities.	Provide prevention and early intervention home visitation services, from pregnancy until child is 3 years of age.	Improve access to healthcare and other resources for at-risk pregnant and postpartum women and their children.	Improve pregnancy outcomes by assisting women to engage in preventive health practices; improve child health & development by helping parents provide responsible competent care; and improve economic self-sufficiency.	Reduce the number of infant deaths and low birth weight. Increase early prenatal care in the first trimester. Increase the number of women who complete screening for postpartum and domestic volence.	Case manage pregnant or parenting women with history of substance abuse or alcohol dependency.	Increase high school Graduation rate, enhance parenting skills; improve health outcomes. Case management and counseling services are provided to both pregnant/ expecting and parenting female and male youth
Eligibility Criteria	U.S. born African American women (18+ years) who are pregnant or postpartum with an infant under 4 months old	Pregnant parents and expectant parents up to 2 weeks postpartum that meet one or more of the following: -Teen -Low income (200%FPL) -Military (child is dependent of active, reserve, guard, or veteran) -Immigrant/Refugee (foreign-born parent)	Any pregnancies with current/recent domestic violence, history of prenatal loss or preterm births, no prenatal care after 1st trimester, high-risk pregnancy, postpartum families with current/recent DV, postpartum depression/bonding issues Low income ***For CWS Referral Only:*** *Children < 6 y with medical condition; first time entry into CWS and within 3 months of involvement; must be with parents with resource family*	First time mother Less than 29 weeks pregnant Low-income	Pregnant Low-income (200% FPL) High-risk Women who reside in in the following zip codes may be eligible: 91977, 91978, 92101,92102,92104, 92105,92113,92114,92115,92116,92139,91945, 91950,92019,92020, 92021	Substance or alcohol dependency issues withiin the last year. Pregnant or parenting Ages 12 and up, with children up to age 17.	Pregnant/expecting or parenting youth (male or female) 23 years old and younger
Program Capacity	170 Pregnant/ postpartum women and their infants throughout San Diego county	144 Families	100 Families	100 Families	150 Families	165 Families/year throughout San Diego County	800 Pregnant/parenting youth and their children countywide per year
Service Duration	Pregnancy, Postpartum until child is 18 months of age, depending on case need	Ongoing home visits until the child is 3 years old	Pregnancy, and 18 months of services to infant/child	Pregnant until child is 2 years old	Pregnant until child is 2 years old Services are primarily home-based	Case management services offered for 18 months	Day of intake until high school graduation. Longer term services may be available on a case-by-case basis
Method of Referral *Preferred Method*	Program Director Tel: 619-266-7466 Fax:619- 262-9188 www.cdph.ca.gov/programs/BIH	Supervisor Tel: 619-283-9624 x251 Fax referral and consent to: 619-961-1025 www.firststepssd.com	PHN Supervisor Tel: 858-573-7339 Fax: 858-573-7325 Web Referral: www.persimmony.com/referralsd www.sandiegocounty.gov/hhsa/programs/phs/phs_nursing/	PHN Supervisor Tel: 858-573-7339 Fax: 573-7325 Web Referral: www.persimmony.com/referralsd www.nursefamilypartership.org	Director of California Programs Tel: 619- 791-2610 x305 or Lead Patient Navigator Tel: 619-791-2610 x312 Fax: (619) 791-2600 www.pciglobal.org	Program Manager Tel: 619- 668-4265 Fax: 619- 668-4264 www.vistahill.org	Intake: Tel: 619-235-5000 Fax referral to: 619- 696-5127 www.sandi.net/sandapp