

FY11 United Way Mid Year Report

Program: Home Visiting Collaborative

Agency: Children, Youth and Family Services, The Arc, Jefferson Area CHIP

Date: February 2, 2011

1. For the current funding period, please highlight your program's goals, activities and results, noting any changes to your original plan/proposal. Include any relevant budget and/or financial information. Limit your response to no more than one page.

There have been no changes in our program goals or activities. Funding has remained stable for each program.

Outcomes reported reflect families that were closed. Many of the families were closed because they could not be located. The data from these families lowers our overall percentages in meeting outcomes.

The Home Visiting Collaborative works with families with young children to promote family health and to increase access to appropriate services in the community. We also work with pregnant women to ensure optimal prenatal care and to prepare families for caring for their child. Families receive a home visit by a Family Support Worker, a nurse or a developmental specialist, or all three as needed. Visits are scheduled around the needs of the family and/or by program standards. While some families receive monthly visits, other families are seen 1-2 times per week.

Family visits focus on assessing family needs and building on family strengths. Education is the key to most services provided. The home visitors with CHIP and Healthy Families have been trained in Parents as Teachers curriculum, a nationally known program that works with families in the home to promote positive parent child relationships and to encourage the parents' interaction with their child. We work with parents on parenting issues; including literacy, discipline, growth and development, attachment and bonding, and the importance of play in a child's life. We assist families in identifying and addressing issues such as housing, jobs, health care and education. We work with parents to identify and appropriately use services in the community that will improve their lives and the lives of their children. We work to give families the knowledge, self esteem and confidence to be the best parent they can be. Visiting in the home gives us first hand knowledge of how many families live, and allows them, in the safety and comfort of their own home, to express concerns and fears they have as individuals and as parents. Every parent wants to be successful but may not have the financial and emotional support, or the knowledge of what it takes to raise a healthy child. The Home Visiting Collaborative offer families the education and support to improve their ability to raise a healthy child. Collaborating with other agencies in the community increases the awareness of the needs of families served by the HVC.

Please share a success story from your program. We are especially interested in stories that show a long-term impact on a person and families that show collaborations or referrals to other agencies.

Scott is a 2 ½ year old boy who receives services from both the Infant Development Project and Jefferson Area CHIP. An older sibling was referred to IDP many years ago due to concerns about his development. At the time there were not many opportunities or activities in the home to encourage learning and development.

When she was pregnant with Scott, his mother had many difficulties. She was extremely depressed and Scott's father was not supportive of the pregnancy. Scott's mother suffered nausea and vomiting throughout her pregnancies. During this pregnancy she was hospitalized on several occasions for both mental health and physical reasons. She was referred to Jefferson Area CHIP for prenatal services and support.

After Scott was born his mother's health and the family dynamics improved. When he was close to a year developmental screenings done by IDP and CHIP began to show that he was not developing on target. The family was reluctant at first to have him evaluated further. Two of his older siblings had also been behind in communication skills prior to elementary school, but were now developmentally on target. With support by both agencies and his pediatrician, mom eventually agreed to a referral to Infant Toddler Connection for further evaluation. He was found eligible for speech and receives speech therapy in his home.

As Scott grew older he began to show delays in other areas as well as some atypical behaviors. When he turned two years he was referred to the local school system but the family decided not to pursue having him evaluated for school services at that time. Several months later it was recommended that he have his sensory differences assessed. An occupational therapist observed his skills and recommended some activities to the family. They were not interested in having him receive occupational therapy on a regular basis.

When Scott approached 2 ½, he was again referred to the public schools because he would soon be ineligible for therapy services through the Infant Toddler Connection. His mother was again reluctant to pursue school services but finally, with encouragement from IDP and CHIP, agree to begin the evaluation process. In addition, with the assistance of IDP and CHIP, she had him evaluated at Kluge. Although she was disappointed when he was diagnosed with autism she is moving forward with the eligibility process for the school system.

IDP and CHIP have worked collaboratively to make sure the family was able to get to the various meetings and appointments. They made sure the family had their questions answered and that their goals for Scott were kept in mind. They also provided support and listened to family concerns about sending Scott to school. With the support of these agencies the family is moving toward obtaining the early intervention services which will be best for Scott.

3. Complete the following Outcome Measurement update (based on your application for funding) for the fiscal year.

**Projected Number of Intended
FY10 Primary Beneficiaries:**

**Actual Number of
Primary Beneficiaries: 675**

Projected FY11 Outcomes	FY11 Indicators Tracked	FY11 Outcome Results (provide specific numbers and percentages)
Families will use their medical homes as recommended	<p>95% and 700 children will have UTD immunizations</p> <p>90% and 670 children enrolled more than 6 months will have up-to-date well child care.</p>	<p>622 (93% of 675) of enrolled children were up-to-date on immunizations.</p> <p>457 (94% of 490) of children enrolled more than 6 months had up-to-date well child care.</p>
Families will relate to their children in a more positive, nurturing manner.	<p>95% and 717 children will not have a CPS report made by program staff.</p> <p>(75% of 350) enrolled at least one year will show appropriate parent/child relationship as measured by two subscales on the HOME Scale.</p>	<p>669 (99% of 675) of children did not have a CPS report made by program staff.</p> <p>Not measured until June</p>
Children's' healthy growth and physical, learning, and emotional development will be enhanced	<p>(75% of 450) children will be developing on the Ages and Stages Questionnaire.</p>	<p>411(84% of 490) demonstrated typical development on the ASQ Numbers include only those enrolled long enough to completed an ASQ.</p>

4. Impact Report. We are looking for issues and statistics specific to our local area; you are also welcome to include some general issues that set the framework for the local statistics. Under the Actual Results heading, we are looking for impact, especially long-term results, not just numbers served. For the Financial Impact section, have each example highlight a different thing (in other words, don't just multiply the first answer three more times).

Community Needs or Issues Your Program Addresses -- please include at least 3 local issues/statistics and cite your source

1. The Charlottesville/Albemarle area continues to experience an increase in the

number of Latino families as well as refugee families. Their limited ability to communicate in English makes it difficult to access resources and to provide their children with needed services.

2. Data from Growth and Development assessments indicates that 1% of children living in poverty are delayed at birth. By school age 25% of children living in poverty are delayed. By high school 40% are delayed. (From Ounce of Prevention Fund) 80% of developmental delays are not determined through a well child visit and 70% of mental health issues are not determined through regular well child visits. (First Sign.org) While it is difficult to obtain local stats, we do know that many children locally are entering school with developmental delays not detected before entering. Data from Smart Beginnings indicate that only 60% of disadvantaged children met benchmarks in language and literacy.
3. Research from Zero to Three and from the Smart Beginnings illustrates the difficulties parents in poverty have in understanding and meeting their children's needs. The financial and emotional stress as well lack of education (CHIP shows the average grade completed is the 10th with only 33% having a high school or GED) creates barriers for successful parenting.

Your Program's Solutions that United Way Community Impact Funds Support

1. **Latino Population and Refugee population:** Smart Beginnings funding has allowed IDP to focus on parent-infant education to Latino families. CYFS and CHIP are providing group activities to Latino families using the Parents as Teachers curriculum. CHIP has phone interpreter services that allow us to communicate with anyone in any language. There are 6 staff persons in the collaborative that are bilingual. These services increase the opportunities Spanish speaking families as well as refugee families to have the help so their children will be healthy and to enter school ready to learn.
2. **Developmental Screenings:** Children served through the Home Visiting collaborative receive developmental screenings using the Ages and Stages Questionnaire. Children who fall below a standard goal are referred to follow-up. Staff work with parents to provide education around normal growth and development and provide activities for parents' involvement with their child that promotes growth in all areas. Through the PAT training we are able to provide growth and development screenings beginning at birth. Screenings also look at learning environments and styles and connect families to intervention, prevention, and community resources. This year the HVC is also offering approximately 150 developmental screenings to children not case managed through their programs.
3. **Parenting and Poverty:** While both IDP and Healthy Families do not have income as a requirement for services both recognize the challenges of working with families in poverty. Training for all three agencies recognizes the different and difficult issues

that families who experience poverty face. The curriculum used is particularly focused on families who need extra help. We have diversity within our staff and we

meet families where they are the most comfortable – in their homes. We recognize that change occurs slowly and that building the relationship is crucial to success.

Actual Results - *based on your stated outcomes; please use percentages and numbers served to help show outcomes*

Mid Year outcomes:

1. 622 children (93%) enrolled were up-to-date on immunizations.
2. 457 children (94%) enrolled more than 6 months had up-to-date well baby care.
3. 669 children (99%) did not have a CPS referral made by the program person
4. 411 children (84%) were typically developing on A&S

Financial Impact of Donations:

A \$5 donation will buy a book for a child

A \$10 donation will provide light refreshments for one group activity.

A \$20 donation will purchase 40 bus tickets for a needy family.

A \$15 donation will provide one hour of parent education to a family

A. \$25 – 30 donation will provide a home visit by a registered nurse

A \$60 donation will purchase a DVD player to provide education in a family's home

A \$100 donation will provide 200 miles of travel to an at risk child or family.