**MODEL COMPONENTS**

- Asthma Case Management (Pediatric Asthma Project)
- Prenatal Case Management
- Dental Varnish and Oral Health Education (Begin With A Child)
- Case Management for NICU babies and Medically Fragile children
- Assessments
- Nutrition and Exercise Education

**ACTIVITIES**

- **HEALTH CARE COORDINATION & SUPERVISION**
  - Monthly Home Visits with a RN
  - Medical Records request, review, and tracking
  - In-home comprehensive assessments
  - Parent/Caregiver health education
  - Monitoring of child and prenatal health status, immunizations, well child visits, specialist services and treatment plans
  - Chronic disease management
  - Dental varnish application/Oral health education
  - Collaboration with provider network for coordination of health care services
  - Transportation to prenatal and health care appointments

- **FAMILY STRENGTHENING SERVICES**
  - Monthly Home Visits with a Family Case Manager
  - In-Home comprehensive assessments
  - Development of parenting capacity
  - Monitoring of progress toward age-appropriate developmental milestones
  - Child and family literacy building
  - Home and child safety
  - Group Meetings
  - Bilingual Support for Spanish-speaking families
  - Promotion of life skills development to increase family self-sufficiency
  - Transportation to WIC, developmental appointments and social service agencies

- **School Readiness**
  - Monthly Home Visits using Kindergarten Readiness curriculum
  - Referrals to Pre-K
  - Referrals/Linkages to after school homework/tutoring programs
  - Support for navigation of Kindergarten registration process
  - Link with Early Intervention

- **MENTAL HEALTH SERVICES**
  - Behavioral health risk screening with all parents
  - Outpatient Counseling for adults and children
  - Mental health consultation provided by Licensed Mental Health Professional (LMHP)
  - Referrals to other needed mental health services
  - Screening for depression, substance use and intimate partner violence
  - In-home consultation with LMHP about mental health issues and concerns
  - Outpatient counseling for adults
  - Play therapy for children and parental support
  - Assessment and Individualized treatment planning in collaboration with client/caregiver
  - Transportation to counseling
  - Child care provided during counseling sessions as available
  - Coordination of care with other systems with client/caregiver consent (medical providers, school system, etc.)
  - Referrals to additional mental health services as needed for all family members (psychiatry, substance use treatment, crisis services, etc.)

**SHORT TERM OUTCOMES**

- 95% of CHIP children will have a medical home.
- 60% of CHIP children will have a dental home.
- 50% of all CHIP children who use the emergency room will show a reduction in ER visits at annual recertification.
- 65% of CHIP enrolled infants will have had 6 well child (EPSDT) visits within the first 15 months of life.
- 45% CHIP children ages 3, 4.5 or 6 years old will have had at least one comprehensive well-care visit (EPSDT) per year.
- 64% of CHIP children 2 years of age will have had 4 dTap, 3 Pev, 1 MCV, 1 V2V, 1 PCV, 1 HEP A, 2 RV, 2 PLL 24 months.
- 66% of CHIP children will be screened for at least one chronic condition prior to their second birthday.
- 60% of CHIP ages 5 7 during the measurement year will have had at least one dental exam with a dental practitioner in the measurement year.
- 5% of CHIP children are asthma case managed and 5% are respiratory monitored.
- 5% of CHIP children have an asthma action plan.
- 86.4% of Medicaid CHIP deliveries of live births during measurement year had a prenatal care visit in the first trimester.
- 64% of CHIP deliveries had a postpartum visit on or between 21 and 56 days after delivery.
- % of women, regardless of age, who gave birth during a 12-month period were seen at least once for prenatal care and entered a behavioral health screening risk assessment that included the following screenings at the first prenatal visit: depression screening, alcohol use screening, tobacco use screening, drug use screening (illicit and prescription, over the counter), and intimate partner violence screening.
- 50% of CHIP enrolled postpartum moms breastfed their babies for the first 2 months.
- SCHIP clients utilized transportation services for health care coordination.

**LONG TERM OUTCOMES**

- Improved health literacy
- Optimal health and nutritional status
- Early detection and treatment of developmental delays
- Reduced infant and child mortality
- Improved quality of life
- Disease management
- Cost savings for health care systems

**VISION**

Every child will have equal access to health care and enter school ready to learn.

**TARGET POPULATION**

Low-income pregnant women and children from birth to 1st grade residing in the Southwest Virginia cities of Roanoke and Salem and counties of Botetourt, Craig and Roanoke. “Low-income” is defined as having a gross annual income at or below 185% of the Federal Poverty Level (FPL) at enrollment and at or below 200% of the FPL at annual recertification.

**MISSION**

Child Health Investment Partnership (CHIP) changes the lives of underserved children and their families through access to comprehensive healthcare services and community resources.

**CORE VALUES**

We believe that interventions have the greatest impact when:
- Provided through an interdisciplinary approach, in partnership with parents, in the home setting;
- Initiated early in life (prenatal through 1st grade);
- Offered with dignity and respect in regard to cultures, beliefs and parenting styles;
- Provided using evidence-based practices and established and emerging research.

**REV. 8/22/17**

**Child Health Investment Partnership of Roanoke Valley**

**LOGIC MODEL**

- Improved family self-sufficiency
- Improved quality of life
- School success as measured by passing SOL scores
- Increase in on-time High School graduation rate
- More participatory citizens
- Cost savings for school systems
- Reduced public expenditures
- School success as measured by passing SOL scores
- Increase in on-time High School graduation rate
- Cost savings for school systems
- Early detection and treatment of social-emotional disturbance
- Improved quality of life
- Improved child functioning
- Reduced in problem behaviors
- Positive parent-child interactions
- Optimal household functioning
- Improved parenting capacity
- Management of mental health illnesses
- Reduced child abuse and neglect
- Reduced foster care placements
- School success