We believe that interventions have comprehensive healthcare services to low poverty level (FPL) at enrollment to health care and parenting styles; in regard to cultures, beliefs and practices and through initiated early in life (prenatal underserved children and their children or below 185% of the Federal annual recertification.

### 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.

### 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.

### Health Care Coordination & Supervision
- Asthma Case Management (Pediatric Asthma Project)
- Prenatal Case Management
- Dental Varnish and Oral Health Education (Begin With A Grin)
- Case Management for NICU babies and Medically Fragile children
- Assessments
- Nutrition and Exercise Education

### Activities
- 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 and case management
- Dental varnish application/oral health education
- Collaboration with provider network for coordination of health care services
- Transportation to prenatal and health care appointments

### 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
- Savings for health care systems

### 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.
- 66% of CHIP enrolled infants will have had 4 well child (EPSDT) visits within the first 15 months of life.
- 43% of 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 6 DTaP, 3 IPV, 1 MMR, 2 HepB, 2 VV, 2 MMR, 2 PCV. 1 HepA, 2 PCV.
- 66% of CHIP children will be screened for at least once prior to their second birthday.
- 60% of CHIP children ages 3-7 during the measurement year will have had at least one dental exam with a dental practitioner in the measurement year.
- % of CHIP children are asthma case managed and % are respiratory monitored
- % of CHIP children have an asthma action plan.
- % of CHIP children who use the emergency room will show a reduction in ER visits at annual recertification.
- % of CHIP children have at least one dental exam with a dental practitioner in the measurement year.
- % of CHIP children who use the emergency room will show a reduction in ER visits at annual recertification.
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