Early Care Best Practice Study Committee

Presentation By:
Local Community Empowerment Area
HOPES—Like Program

Partnerships 4 Families: Audubon, Carroll, Greene and Guthrie Counties
Cindy Duhrkopf, Coordinator
&
Cindy Kail, Public Health Director, Greene County Medical Center

Materials Provided:

Presentation outline
Ten Strategies for Increasing the Effectiveness of Using Home Visitation Programs for Parenting and Child Outcomes
Partnerships 4 Families HOPES Annual Report FY07
Partnerships 4 Families Home Visitation Assessment Tool

Why Partnerships 4 Families adopted a HOPES like model

- In 1980 and 1985 Greene County conducted a needs assessment that indicated a need for support to young parents.
- At the time, Cindy Kail, Greene County Public Health Director, was a member of the Home Care Iowa Board who held the state contract for administering the HOPES-HFA pilot project for home visitation in Iowa.
- Through her exposure to the development of the original HOPES project, as funding became available through DCAT and later Empowerment, we chose to align our home visitation very closely to the state funded HOPES and the Healthy Families America (HFA) guidelines.

Success and Challenges

- The success of the program has been choosing to align closely to the state HOPES and HFA, allowing our programs to utilize the HOPES software, trainings and guidance.
- Another success has been working as a four county project, learning from one another.
- An initial challenge was getting support from the other three counties on the importance of a home visitation project. Approximately two years ago we turned the corner and all four counties are making positive efforts toward quality programs.

HOPES like program

There is a broad definition in the state regarding HOPES-<u>like</u> home visitation programs. Our project has followed many of the HFA guidelines including the risk assessment, duration and timing of visits, family-driven goal setting, family support worker training and supervision, and caseload weights. Additionally, we have

incorporated most of the Iowa HOPES-HFA documentation forms, policies, and procedures.

There are two main areas of HOPES-HFA where we do not align:

- We accept enrollment prenatally through four years of age
  HFA model enrolls families prenatally up to 3 months of age
- We accept any family regardless of their risk level
  HFA model accepts only high risk families

Our program includes both prevention efforts, as well as treatment of dysfunctional families. We work closely with the Department of Human Services and the Family Court system in our treatment services. We find that in rural counties, the model of serving all families within a program allows for less stigmatization and greater acceptance by all families to engage in improving their parenting skills. Additionally, stronger families have the opportunity to mentor higher risk families in our group activities.

Our program could be described as highly aligned with the HFA model, blending in strong educational components of the Parents as Teachers (PAT) model and group socialization aspects of the Early Head Start model. We believe our blended model brings the strengths of all models together to provide excellent services.

However, we are cognizant that this blended approach is not research tested, and therefore, our outcomes may not align with the outcomes achieved by strict adherence to any single model. Recognition of this limitation has made us zealous in our pursuit of measuring our outcomes, as you will note in our annual report. Of particular interest, is our measurement of health, education, finance and social outcomes of the families enrolled in our project. Parents are actively engaged in setting, achieving, and evaluating progress towards goals on an ongoing basis. Project staff formally measure outcome achievement for each family every six months.

Continuous Performance Improvement

The project's budget and contracts are set up to provide incentives for meeting goals that are aligned with HFA and the American Academy of Pediatrics (AAP).

<u>Examples are</u>:

* Enrollment of a minimum of 10% of the 0-4 year old population in each county
* Proper number of visits for the level of service according to assessed need
* Immunizations, lead screening, physicals, and developmental screening according to the AAP frequency guidelines.

During FY07, we initiated a quality improvement incentive project. We wanted to improve our enrolled parents' abilities to provide educational opportunities to stimulate developmental skills in their children and improve school readiness. We used the Deming Model of continuous quality improvement (See P4F Home Visitation Assessment Tool) to assess, plan, implement action, check progress, and evaluate outcomes related to educational development/school readiness of the children. Retrospective record reviews were used as a measure of success to evaluate staff

documentation of efforts to work with parents and document outcomes of the children. Documentation of the process in family records has shown a dramatic improvement. We are continuing the project this year to further study the impact on child outcomes.

This fiscal year, we are initiating a quality improvement incentive project to incorporate the use of the Edinburgh Maternal Depression Screening tool. Agencies are in the process of receiving training to use the tool properly to assess maternal depression. We will implement the tool prior to the end of calendar year 2007.

A key to our project's ability to continually improve is the support that we receive by partnering with the state level HOPES team. For example, in FY06, we partnered with the Iowa Department of Public Health, State Empowerment staff, and state-funded HOPES-HFA projects to explore how to improve the State HOPES software program. We invested nearly $10,000 of our local Empowerment Area funds to improve the software capability to measure family outcomes. We carefully crafted changes in order to meet our specific needs for outcome measures, while not compromising data elements required for the HOPES-HFA sites. The software has improved capability and is more reliable as a result of our efforts.

We find that participation in statewide HOPES program manager meetings is beneficial to our continued project improvement. Our sub-contracts stipulate that our HOPES program coordinators participate in these meetings so that we can continue to be closely aligned with the state-funded HOPES-HFA program's operations and objectives.

Our project offers quarterly training opportunities for the professional development of our family support workers. Recent topics of education have included: maternal depression screening, developmental screening, adoption training, testifying in family court, dental health, and childhood nutrition.

In Conclusion:

We are proud of the success that our program has had with the children and families of Audubon, Carroll, Greene and Guthrie counties. Although we are not following one specific model of family visitation, we are providing appropriate and effective services to meet the health, social, financial, and educational needs of rural Iowa families with young children. Thank you for your support of our program!

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Ten Evidence-Based Practices for Home Visiting Programs

Susan Hegland & Kere Hughes
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Strategy	Recommendation	Research Support
1. Program Match	a) Match program goals to family needs and program resources.	Families with high levels of need make gains only with more intensive services from more highly trained professionals (Gomby, 2005).
2. Home Visitor Qualifications	a) Match qualifications of home visitor (e.g., paraprofessional, professional) to that demonstrated in model.	Paraprofessionals do best in programs with limited goals and a prescriptive curriculum; highly qualified home visitors needed for families with multiple, complex issues (Gomby, 2005).
3. Preservice & Inservice Training	a) Provide the same intensity (i.e., hours, group size) of pre-service training by qualified instructors as specified in the evidence-based model. b) Provide the same frequency and intensity of inservice training as specified in the model. c) Assess home visitors' understanding of adult learning styles as well as program goals and strategies through activities such as role plays and case studies.	Most effective training is spaced in time and includes on-site consultation and assessment of learning (Epstein, 1993). In less effective home visiting programs, staff receive less training—both pre-service and on-going; these changes have been linked to weaker outcomes (Gomby, 2005; Schorr, 1977; Yoshikawa, Rosman, & Hsueh, J., 2002).
4. Supervision	a) Ensure program fidelity by providing ongoing review of home visits by both supervisor and home visitor using written documentation, on-site observations, or videotapes.	Home visits tend to drift from a focus on parent-child interactions to pleasant, chatty, visits between host and guest (Peterson, 2002; Roggman, Boyce, Cook, & Jump, 2001).
5. Home Visitor Retention	a) Minimize turnover of home visitors through competitive salary and benefits packages.	High turnover, due to low wages for home visitors, is linked to negative program outcomes (Gomby, 2005).

Strategy	Recommendation	Research Support
6. Family Recruitment	a) Recruit families in need of services.	Up to 40% of families recruited fail to enroll (Gomby, 2005), limiting generalization of results.
7. Cultural Sensitivity	a) Ensure that home visitors use strategies and activities consistent with cultural values of family, not just parent, especially if the parent lives with an extended family.	Strategies and activities that are inconsistent with the cultural beliefs and values of the family are less likely to be implemented, and more likely to lead to drop outs (Cowan, Powell, & Cowan, 1998; National Research Council, 2000)
8. Family Engagement	a) Maintain family engagement during visits. b) Jointly plan for parent follow-up activities. c) Review parent follow-up at next meeting.	Less effective home visitors praise the parent, and demonstrate activities, rather than jointly planning, implementing, and reviewing activities (Hebbeler et al. 2002).
9. Parenting Focus	a) Address needs recognized bv the parent. b) Ensure that children in families with high needs participate in a high quality early care and education program.	Home visiting program are more successful at changing self-reported parenting attitudes, beliefs, and behaviors; child programs are more successful at changing child outcomes (Gomby, 2005; Love et al., 2002; Sweet & Appelbaum, 2004)
10. Program Intensity and Duration	a) Monitor frequency and duration of home visits. b) Minimize attrition by scheduling home visits at family's convenience. c) Monitor who is dropping out and why.	Families who stay with home visiting programs tend to be ones who least need the program, while highest need families drop out at rates above 50% (Gomby, Colross, Behrman, 1999; Innocenti, 2002; Wagner, Spiker, & Linn, 2002). High attrition limits generalization of results.

Program Resources

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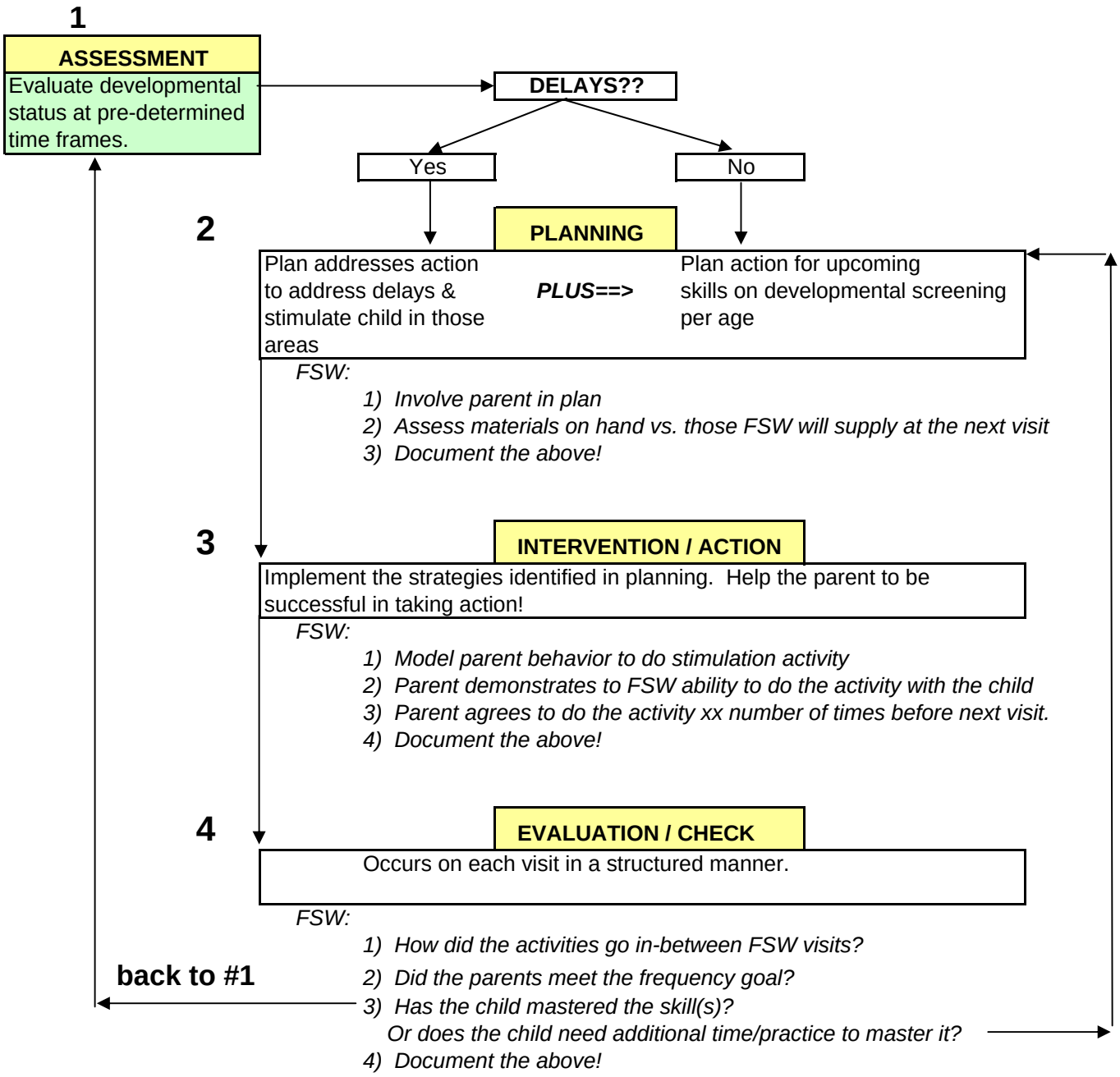
P4F HOPES
Quality Improvement Algorithm



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Partnerships 4 Families
Annual Report – FY 07

Program: HOPES **Contact: Cynthia Kail**

Part I – Local Indicator Information

Community Empowerment Area Local Indicator*	Baseline Data & Source	FY 06	FY 07	Goal (Projected Timeline)	Progress Update
Two-year-olds fully immunized according to the American Academy of Pediatrics guidelines. A. Healthy Children	FY 2001: 89% *Source: HOPES database*	59 of 60 or 98.3%	63 of 63 (100%) Exceeded Goal.	90% of children enrolled in HOPES will be fully immunized by age 2.	Tracking through HOPES software.
Parents are actively involved in their child's early childhood experience as evidenced by the percentage of visit appointments kept. D. Secure & Nurturing Families	Oct - Dec 2002 baseline = 99.9% *Source: HOPES database* Note: State funded HOPES were at 75.6% (FY02).	4126 of 4416 attempted visits were accomplished for 93.4%	4237 of 4523 (93.7%) Exceeded Goal.	HOPES families will keep 90% of planned parent visits/contacts.	Track not home/not found visits to calculate rate of visit engagement. Meeting baseline goal. Continue to monitor.
HOPES children remaining in their own homes (vs. out-of-home placement for foster care, etc.) D. Secure/Nurturing Families	FY02 = 98% *Source: HOPES database*	376 of 388 or 96.9%	382 of 397 (96.2%) Exceeded Goal.	95% of HOPES children remain in their own homes.	Tracking will occur through HOPES software.
4 year-olds enrolled in preschool. B. Children Ready to Succeed in School.	FY 02 = 65.2% *Source: HOPES database*	Measured 9/30/06: 20 of 23 or 90%	29 of 30 (96.7 %) Goal met.	90% of all 4 year-olds enrolled in HOPES will enroll in preschool.	Tracking will occur through HOPES software.

Local Indicator*	Baseline Data	FY 06	FY 07	Goal (Projected Timeline)	
Development of school ready skills and appropriate child development. B. Children Ready to Succeed in School.	FY 02 = 93.8% *Source: HOPES database*	17 of 17 or 100%	11 of 11 (100%) Exceeded Goal.	90% will either show school readiness or show developmental progress (if developmental disabilities present.	Denver screening will occur routinely during service and at kindergarten and will be tracked using HOPES software. **Measured fall quarter only.**
Lead screening. A. Healthy Children D. Secure/Nurturing Families	Baseline measurement will occur in FY04. *Source: HOPES database*	190 of 211 (90%) screened.	241 of 281 (85.8%) Goal Not Met in Audubon (77%) & Guthrie (56%) Counties.	90% of children aged 15 to 60 months will have lead screening.	Lead screening will occur annually during service and will be tracked using tracking tool.
Families meet their individual family service plan goals for health, social, finances, and education. A. Healthy Children B. Children Ready to Succeed in School C. Safe & Supportive Communities D. Secure/Nurturing Families	Baseline 6/30/05: 84.9% of Health Goals met 80.3% of Social Goals met 83.3% of Financial Goals met 96.4% of Education Goals met *Source: HOPES database*	 84.6% of Health Goals met 80.4% of Social Goals met 77.9% of Financial Goals met 89.7% of Education Goals met	Measured 6/30/06: 211 of 236 (89.4%) of Health Goals met 181 of 220 (82.3%) of Social Goals met 102 of 122 (83.6%) of Financial Goals met 261 of 279 (93.5%) of Education Goals met Exceeded Goal (for all measures)	Continue to meet minimum of 75%. *Note: State funded HOPES projects were at 68.6% on this indicator in FY06.*	Track goal attainment via tracking tool to determine current rate. **Measured every 6 months.**

*To which of the following State Results does the local indicator link (check all that apply).

A. Healthy Children (Birth to 5)
B. Children Ready to Succeed in School
C. Safe and Supportive Communities
D. Secure and Nurturing Families
E. Secure and Nurturing Child Care Environments

Part II - Early Childhood and School Ready – Progress Using Common Language Framework

Reporting Period	How Much Did We Put In? How Much Did Others Put In? (Input)	How Much Did We Do? How Much Did Others Do? (Output)	How Well Did We Do It? (Quality/ Efficiency)	What Difference Did It Make? (Outcome)
FY 07	**$ 302,812 Imp. Area Funds** **$ 5,000 Quality Imp. Funds** **Other Support**: **Medicaid, private insurance, or MCH/state grant** to cover early postpartum or infant visits for medical diagnoses: A – $ 356.00 C – $ 23,669.54 Gr – $ 25,123.50 Gu – $ 600.00 **Total – $ 49,749.04** **Donations:** Carroll Co. **$600** Greene Co **$275** **In-Kind Funding/Support: $ 87,066** A – $ 9,892 C – $ 7,873 Gr – $ 50,543 Gu – $ 18,758 **Total Funds (including in-kind):** **$ 445,502** **Marketing Efforts**: **46** Sites where brochures were placed or replenished **17** Newspaper articles **5** Presentation - Community Group **5** Community Events **1** Radio Spot **1** Health Fairs **1** Parade Entry Ongoing contacts with OB departments, social workers at hospitals, physicians, Stork's Nest, etc.	**117 families were screened for HOPES participation** **397 children were served** Audubon - 48 Carroll - 150 Greene - 128 Guthrie - 71 **283 families served** A – 32 C – 105 Gr – 84 Gu – 62 **Highest level families attained as of FY end:** Prenatal – 6 Level 1 – 36 Level 2 – 62 Level 3 – 51 Level 4 – 10 **5 Families were in creative outreach** (to encourage program enrollment) as of 6/30/07. **Another 9 families were ready to be enrolled.** **4217 Total Visits:** FAW – **523** Support Workers – **3694** **(87.6%)** Additionally, RN staff provided **595 postpartum home visits** right after discharge from OB.	**78 of 117 (66.7%) of the families screened were determined to be at *high risk.*** **77 of 78 (98.7%) of the families determined to be *high risk* on screening enrolled in HOPES.** **24 families at *low risk* opted to enroll & participate in HOPES.** **199 of 292 (68.2%) of the families served were below 185% of the Federal Poverty Income level.** **17 Children were referred to Early Access**. This represents 4.2% of the children served. **Attrition - 122 families discontinued services.** **Reasons:** **50** Exited, Goals met **35** Exited, Goals partially met **15** Exited, Goals not met **22** Moved/Unable to locate **Formal Customer Satisfaction:** *Is measured the last quarter of the grant year annually. See attachment.*	**Please refer to outcomes reported on the first 3 pages of this report.** **Additionally:** **Medical Home:** **396 of 397 or 99.7%** of children served had a medical home. **Lead Screening:** **%** of 15-60 month old children served were lead screened A = **77%** C = **98%** Gr = **90%** Gu= **56%**

FY 06	**FTEs of Staff**: **0.10 FTE Overall HOPES Project Coordinator** – *Cindy Kail* **2.14 FTE Family Assessment Worker/local program coordinator** *Becky Thompson, RN (Audubon)* *Heather Beymer (Audubon)* *Laura Ludwig, MS Ed (Carroll)* *Cindy Wise, BSW (Greene)* *Sandy Eivins, RN (Guthrie)* **5.27 FTE Family Support Workers** *Provided by 9 different staff members* **0. FTE Clerical/Admin** **Topics of Staff In-service:** *CPR, Safety, Infection Control, Documentation, Early Access & AEA services, testifying in juvenile court, and motivational interviewing, attachment & bonding, couple/marital relationships, client rights & responsibilities, tobacco prevention, DHS referral system, Ready to Learn, cultural diversity, maternal depression, domestic violence, family planning, service excellence, stress management, nutrition, client rights, tobacco prevention, money management, HOPES software, Adoption, dental program, ethics, drug-affected children, early brain research, disaster mental health services, life progression tool, and Child Abuse conference.* **FAWs attended:** ***State HOPES Coordinator meetings***	**Multidisciplinary family resource coordination meetings were held monthly in Greene County.** **Parent Support Group Activities:** Mother's support group Mother's Day Out Whole Family Events **Parent Support Group Meetings or Parenting classes were held.** **Events: / Adult Attendance:** A – 14 / 194 C – 13 / 179 Gr – 10 / 175 Gu – 9 / 230 **Total 46 / 778** **Topics/Parent Education offered at meetings:** *Blank Children's Hospital, Employment Experience, That Loving Feeling Marriage Seminar on Communication, First Aid, Dads Make a Difference, Exercise & Fitness RSV awareness, Arts/Crafts, Mentoring, Community Partnerships to Protect Children, Healthy Economical Meals, Fetal Alcohol Syndrome, Birth Control/Family Planning, Stages Labor & Delivery, Holiday Safety, Motherhood in Africa, homemade greeting cards, pizza party, picnic, summer stress.*	**322 children aged prenatal up to the 4th birthday were served.** This represents **11.1%** of the 2911total population of children in this age cohort, meeting the 10% service goal.	

FY 07 Budget Information

Program Name: **HOPES (Healthy Opportunity for Parents to Experience Success)**
Person Completing Financial Report: **Cynthia Kail**

Expense Category	Expense Description	TOTAL Empowerment Area Dollar Allocation	7/1/06 to 12/31/06	1/1/07 to 3/31/07	4/1/07 to 6/30/07
Contracted Costs	FAW Visits	**$ 48,875**	**$ 22,270.00**	**$ 12,665.00**	**$ 9,520.00**
	FSW Visits	**$ 216,437**	**$ 112,377.50**	**$ 53,585.00**	**$ 51,185.00**
	Base Funds	**$ 8,000**	**$ 8,000.00**	**$ 0.00**	**$ 0.00**
	Curriculum	**$ 2,000**	**$ 2,000.00**	**$ 0.00**	**$ 0.00**
	Performance Measures	**$ 20,000**	**$ 9,625.00**	**$ 5,500.00**	**$ 4,875.00**
Project Admin	Project Coordination	**$ 7,500**	**$ 3746.49**	**$ 1,487.95**	**$ 4,975.00**
	Total	**$ 302,812**	**$ 156,118.99**	**$ 73,237.95**	**$ 71,555.06**
			(51.6%)	(24.1%)	(23.6%)

Percentage of Funds Expended by June 30 = <u>100%</u>

Note: Agencies were also paid a total of $5,000 for a Quality Improvement Plan project related to improved documentation of efforts to engage parents in activities to stimulate child development.
(Breakdown by county: A = $966, C = $1462, GR = $1462, and GU = $1110)

<u>Cost of HOPES services:</u>

Total Funds (including in-kind) $445,502
divided by 4812 visits = $ 92.58 per visit
divided by 397 children = $1122.17 per child
divided by 283 families = $1574. 21 per family

FY 2007 HOPES Program Narrative

Successes:

1) A quality improvement project has been underway this year to improve in documentation. First the agency staff assesses the developmental status of the child and plans activities with the parents to stimulate development either in areas of delay or upcoming skills. Staff ascertains if the parent has suitable materials and/or toys for the skill development activities, model how to stimulate the child to do the activity, and engage the parent in a return demonstration and commitment to try the activity between visits. At the next visit, the worker is assessing if the parent followed through and if the child is developing the skill, before planning the next intervention. All steps of the process are to be documented in the record. An algorithm was developed to assist the staff to learn the process. Charts were audited 3 times during the year by Cindy Kail and Cindy Duhrkopf, with follow-up education and encouragement at the regional in-services. By the end of the year, there was a marked improvement in the documentation present in the charts. The quality incentive funds ($5000) were used by the agencies to purchase supplies and toys to use for these activities.
2) Local indicators are being met, as noted above.
3) FY07 marked the first year of measuring state indicators. Participation in HOPES:
    a) Increased the parent's confidence at parenting – 55.8% strongly agreed, 41.6% agreed, and 2.7% disagreed
    b) Improved parenting abilities – 53.1% strongly agreed, 44.2% agreed, and 2.7% disagreed
    c) Increased the number of contacts/support persons – 42.1% strongly agreed, 45.8 agreed, 10.3% disagreed, and 1.9% strongly disagreed
4) All agencies continue to make the appropriate number of visits per the level system.
5) Quarterly staff in-services continue to be valuable.
6) All agencies are using the state-wide HOPES database.
7) A parents' room was completed in Greene County with a Community Foundation grant. This space is a comfortable setting for children to play, while parents meet with staff. The room also houses the Stork's Nest.

Barriers:

1) Agencies without dedicated HOPES staff will continue to struggle with competing demands on staff time that makes it difficult for them to meet goals and objectives as timely as might otherwise happen. Staffing alternatives have been explored.
2) The children on the program at year-end were measured for lead screening (as reported above). The percentage of children lead screened fluctuates as families leave the program and are replaced with new families on the caseload. It should be noted that lead screening is an ongoing priority and that all agencies hit 90% of the children lead screened within the past 6 months. We will continue this measure as a program priority in FY08.
3) Several staff positions have turned over in Audubon, Carroll, and Greene Counties. These events make it difficult to maintain all the appropriate number of visits while interviewing and orienting new staff. Replacement staff has worked out well, however.
4) Audubon & Guthrie Co. have renewed a focus on billing Medicaid, private insurance, and state PH grant funds for eligible pre & postnatal visits, since this was brought to their attention at a P4F Board meeting. Cindy Kail provided billing codes to the agencies to assist them.
5) Space constraints have affected the agencies. Audubon County recently acquired more space in the Courthouse. Carroll County is evaluating space needs and potential solutions.
6) Prenatal enrollment continues to be more difficult in Audubon and Guthrie Counties. Two important sources of prenatal referrals are physicians and hospitals, and neither county has those services within the county. Contacts with sources where women seek care are continuing.
7) Agencies worked to maintain the percentage of serving the 0-4 aged population in their county. There were no incentive funds available this year (as in FY06) so agencies had to fund outreach and marketing out of their regular budgets. Only Carroll and Greene Counties met the

goal of serving a minimum of 10% of the 0-4 aged population cohort. Audubon Co. decreased 1.3%, Carroll Co. increased 1%, and Guthrie Co. increased from 0.3%.

County	0-4 Population in 2000	Goal for Number of Children to be served in FY 07	Total Number of Children Served During FY 06	Total Number of Children Served During FY 07	% of goal reached	Number of 0-4 Children served (includes prenatal)	% 0-4 population served
Audubon	396	50	42	48	96%	36	9.1%
Carroll	1287	150	138	152	101%	138	10.6%
Greene	602	maintain	138	128	N/A	94	15.6%
Guthrie	626	75	70	71	95%	56	8.9%

Two (2) FAMILY SUCCESS STORIES: AUDUBON COUNTY

Family A	Family B
Goals: Complete Cosmetology Program at EQ School of Hair Design in Des Moines. Complete "Partners for a Healthy Baby" Curriculum. Find reliable daycare for son while attending classes. Keep son up-to-date on immunizations.	**Goals:** Married couple with two children wants to purchase own home. Keep children up to date with immunizations and well-baby checks. Explore options for college and decide whether to attend or not. Attend HOPES/Stork's Nest Socializations to maintain current support systems and build new ones.
Interventions by HOPES Staff: Encourage client to continue classes even when the going gets tough. Remind her of the benefits of completing the classes. Provide her with daycare provider numbers. Schedule HVs around her classes and be flexible. Provide information about immunizations and provide reminders of when due. Provide binder for her to keep all curriculum together in.	**Interventions by HOPES Staff:** Let client know of available housing availabilities. Provide realtor information. Consider HUD and Region 12 assistance. Network with others about possible leads. Review immunization schedule often and provide reminders. Gather college and career information. Discuss changes in lifestyle that would occur if client would attend school, etc., including pros, cons. Keep client aware of socialization and programming dates. Encourage her and husband to attend and meet new friends. Introduce her and husband to new people
Outcomes: Finished her schooling and graduated from EQ College of Hair Design. Passed her State Boards and is a licensed cosmetologist. Continues to raise her son with the assistance of the baby's father and her family.	**Outcomes:** Couple did obtain financing and purchased a two story home, which they are very proud of and happy to be in! Mom decided to complete CNA training for now and will maybe revisit the idea of college later. She has completed her certification and is working as a CNA now and enjoys this very much. This couple does attend socializations and programs and mixes very well with other parents. They meet people easily and seem to enjoy the programs.

Two (2) FAMILY SUCCESS STORIES: CARROLL COUNTY

Family A	Family B
Goals: 1. Carry baby to full term and deliver a healthy baby	**Goals:** 1. Take steps to engage in healthy behaviors during pregnancy

2. Learn the signs of problems during pregnancy and when to call a doctor. 3. Learn about the different options for pain control during childbirth; what to expect if a C-Section becomes necessary 4. Obtain information on basic infant care and what you need for babies; how to handle stresses of taking care of a baby 24/7. 5. To have a successful breastfeeding experience. 6. Spend time with friends/family after baby is born for support & get out of the house	2. To maintain a positive support system 3. Interact with each child individually a few minutes per day 4. Take steps to decide if I want to parent my unborn child 5. Take steps to minimize depression 6. Check into Head Start for oldest child
Interventions by HOPES Staff: **1**. Partner's for a Healthy Baby prenatal curriculum and "Baby Basics" every 2 weeks. 2. Prenatal information on "How Your Baby Grows", Signs of Preterm Labor, Eating for Two, information on when to call your doctor, and healthy choices during pregnancy. 3. "The Miracle of Birth" video for information on different choices of pain control during labor and the video "Labor Of Love – Childbirth". Transportation and a health issue prevented family from attending the class at the hospital. This video explained why sometimes it is necessary for unplanned C-sections to occur and helps families become familiar with what happens if C-Section becomes necessary. 4. Offered information on stress management through the PHB Curriculum and other information available from the office. 5. Breastfeeding education and support - Breastfeeding Your Baby, What's Best for Baby, PHB your Baby Birth – & info on collecting/storing breast milk & nipple care. 6. Encouraged mom to attend the breastfeeding support group and to seek out a neighbor or family person to spend time with.	**Interventions by HOPES Staff:** 1. Prenatal curriculum (Partner's for a Healthy Baby and Baby Basics) and provided information about nutrition during pregnancy 2. Encouraged client to maintain her support and to ask for help when she needs it. Encouraged socializations. 3. Discussed/demonstrated structured play; the benefits, and activities client could do with each of her children. Offered puzzles, nesting cups, games and books. 4. Provided information in on Catholic Charities and Bethany Services (who specialize in adoptions). Encouraged her to make her own choice and not let friends influence her decision. 5. Administered Edinburgh Postnatal Depression Scale (EPDS) tool and will continue to administer monthly. Encouraged her to go to Doctor/psychiatrist often in order to monitor medication and let them know how she is feeling. Talked about signs of post partum depression. 6. With mother's permission, FSW gave a referral to Head Start. Talked about how Head Start would be an excellent option for preschool.
Outcomes: 1. Healthy baby was born at 41 weeks by C-Section. 2. Mom had some issues with false labor, fluid retention, and back aches. Mom used information given to her on these conditions for relief and peace of mind. 3. Mother and father both watched the Miracle of Birth and the Labor Of Love childbirth videos. As a result, the decision was made to have an epidural for pain control during labor, and the mother learned the reasons why a C-Section sometimes necessary. 4. Parents prepared to care for baby. Mother concentrates on deep breathing techniques shown in the curriculum, gets plenty of rest, and is getting help from the father of the baby. 5. Breastfeeding is going very well. Baby gained a little over 1 lb in 2 weeks. Bonding and attachment are good. 6. Mom and baby spend time with her sister and young niece several times a week to get out of the house and for support. Mom also goes to the breastfeeding support group at the hospital every week.	Outcomes: 1. Mother quit drinking during her pregnancy, went to Doctor for depression, kept all prenatal visits, and gained appropriate weight. She delivered healthy baby. 2. Mother continues to have her parent's support with transportation and finances as needed. She has also developed a friendship, & is re-visiting the goal of getting driver's license. Friend is helping her to practice driving. Attended one HOPES/Stork's Nest socialization. 3. Mother implemented structured play with praise each child. Children are listening better and not fighting with other. Mother has purchased games, puzzles, and books for home that she is using for play. She has organized toys and activities so that she and the children can easily access them. 4. Although client did not pursue counseling from agencies, client about parenting and about adoption. Talked about pros and cons of either choice. 5. Mother tested borderline depression. She was treated with anti-depressants by her physician, with increased medication after delivery. Mother states she is feeling good, and she is more relaxed with the children. She is attending more actively to children and is taking better care of home. She is providing toys for them and giving them more 1:1 attention. Her home is much less cluttered. 6. Child has been accepted into Head Start.

Two (2) FAMILY SUCCESS STORIES: GREENE COUNTY

Family A	Family B
Goals: 1. Take necessary steps to winterize home	**Goals:** 1. Will continue to build good credit to purchase a home.

2. Take necessary steps to build a stable financial base. 3. Secure a reliable vehicle. 4. Take necessary steps to organize living environment. 5. Will address need to take time for nurturing self. 6. Will increase awareness of child's development through curriculum and by by tracking progress. 7. Will promote school readiness by implementing developmental activities. 8. Will receive services from health care providers as needed.	2. Will make constructive decisions concerning relationship with children's father. 3. Will increase awareness of child's development through curriculum and by tracking progress. 4. Will promote school readiness by implementing developmental activities. 5. Will receive services from health care providers as needed.
Interventions by HOPES Staff: 1. Work to analyze current condition & identify resources for making needed changes. 2. Identifying monthly living expenses and provide feedback on developing a monthly budget. Discuss options of employment with mother and encourage action steps. 3. Discuss involvement in Promise Jobs and development of her Family Investment Agreement and provide feedback regarding desired progress. Encourage mother in organizing the means to purchasing a vehicle. 4. Assist to develop an organizational plan for her household. Provide informational resources to empower mother's ability to plan. Provide alternative organizational methods as needed. 5. Encourage mother to be aware of her emotional need to find rest. Provide getaway time in the parents' room where mother could converse while baby played in an atmosphere away from home providing mental stimulation and refreshment. 6. Provide curriculum and other information to help mother track child's develop-mental progress and identify skill areas for activity work. 7. Model child interaction using developmentally specific activities & assist in developing and implementing her own teaching methods 8. Assist in tracking appropriate health screenings. Encourage healthy living habits in the home.	**Interventions by HOPES Staff:** 1. Provide mother with feedback in her search for an appropriate residence to purchase. Discuss with mother her financial ability to cover a monthly house payment and corresponding utilities. Provide mother with any needed linkage to local and government resources for purchasing a home. 2. Discuss with mother the importance of healthy relationship decisions. Provide mother with informational resources for help in identifying her behavioral tendencies in relationships. 3. Provide curriculum and other information for tracking child's develop- mental progress and identifying which areas need special attention. 4. Model appropriate interaction with child by using activities that specifically address child's developmental needs and help mother to develop her own ability to interact with her child in a way that enhances his ability to grow and learn. Use activity algorithm in this process. 5. Assist mother in tracking appropriate health screenings and encourage healthy living habits.
Outcomes: 1. Established definite plans for future winterizing of her home and identified needed resources to complete the plan. 2. Established paternity of child with plans to secure appropriate child support. Working with her Promise Jobs advisor to secure personal employment as needed. 3. Working with Promise Jobs towards the purchase of a vehicle. 4. Completely organized downstairs in order to provide a pleasant & useful environment for her child to eat, sleep, grow, and play. 5. Aware of taking advantage of her child's sleep time for her own nap time and is developing this helpful habit. Mother has made periodic visits to the parents room in order to be emotionally replenished. 6. Keeps regularly scheduled home visits and is tracking child's developmental progress. Mother identifies areas of development to address specific needs. 7. Observes worker's interaction with child & incorporates this in developing creative ways to enhance her child's progress through regular and frequent activity times. 8. Keeping well-child checkups, immunizations, and Denver screenings up to date. Aware of upcoming lead screenings.	**Outcomes:** 1. In the process of buying a home that is comfortably sized and within her ability to meet monthly financial obligations. 2. Making sound decisions concerning the way she communicates with children's father about summer visitation. Executing self control and discretion in her necessary dealings with extended family. 3. Keeps regularly scheduled visits and is cooperating with worker to identify child's developmental needs. 4. Observing worker's way of interacting with her child and using her observation to develop enhanced time with her child through planned activities. 5. Keeping well-child checkups, immunizations, lead screenings, & Denver screens.

Two (2) FAMILY SUCCESS STORIES: GUTHRIE COUNTY

Family A	Family B
Goals: 1. Mother will attend drug rehab meetings on Monday and Wednesday evening for the next 6 months. 2. Mother will try to purchase a car in the next 6 months. 3. Mother will keep her new job for the next 6 months. 4. Mother wants her children to keep on target for age appropriate development for the next 6 months. 5. Mother is trying very hard to make the above goals, so she will get approval from DHS to have full custody of her children again. Children currently are in the home of another relative.	**Goals:** 1. Increase parent's awareness of infant's development from Handouts and tracking. 2. Mother to attend marketing seminars to further herself on her current job. 3. Parent to start a saving fund now toward infant's future. 4. Mother would like to lose 10# of baby weight in her 6 month goal. 5. Parents would like to have a "date night" 1 x month.
Interventions by HOPES Staff: 1. Mother has to make arrangement ahead of time for transportation to get to the rehab meetings. 2. FSW helped create with the MOB a budget plan by providing a monthly budget calendar. 3. FSW encouraged MOB to have a daily routine and keep a weekly calendar for her work schedule. 4. FSW gave MOB information on age appropriate activities. FSW explained and demonstrated, as well as gave the Denver skills test. 5. MOB was always in the relative's home to meet with the HOPES FSW for all appointments for HOPES meetings.	**Interventions by HOPES Staff:** 1. FSW gave HOPE handouts monthly along with nutrition information and support to continue breastfeeding. 2. Worked on finding out the dates and places of seminars, guiding MOB on which seminars would help her most and registering to attend. 3. Parents decided to put $50.00 a month into infant's saving account. Discussed ways to achieve this goal. 4. FSW gave MOB nutrition information and discussed ways MOB could achieve this goal that was comfortable for her. 5. FSW shared with family fun and inexpensive ways to spend an evening alone. Discussed the importance of nurturing parent's relationship after the birth of their child.
Outcomes: 1. MOB has stayed drug free for 6 months and still goes to the rehab meetings twice a week. 2. MOB has purchased a used car, makes monthly payments. 3. MOB is working 32-40 hours per week and has kept the same job for 6 months. 4. Children have passed Denver Pre-Screen Test. 9 month old daughter was 5 weeks premature, is now on target for age appropriate activity. 5. DHS has given MOB the approval to find a home to live in and have custody of the children. She will still have supervision; under DHS services; but will be able to care for her children on her own. FSW has provided information for HUD.	**Outcomes:** 1. All immunization and well baby check ups are up to date. Parent's informed about lead poisoning and infant CPR. Parents worked with infant each month on "plan" of development and they achieved each month's goal. MOB continues to breastfeed, also pumping and freezing milk for bottles at daycare. 2. MOB attended several marketing seminars for work. 3. Parents decreased their spending by 10% and stopped buying items in bulk. Parents were able to put $50.00 each month into infant's saving. 4. MOB walked 30 minutes 3 times a week. She also ate 3 vegetables and 2 fruits each day cutting back on sugar foods. 5. Parents planned evenings out and enjoyed time together as a couple.