

**Program: Safe Babies Safe Moms**

**Division: Community Health Intervention Prevention**

**Goal:** Provide case management to support mothers and their children in becoming more functional family units, financially independent, safe, healthy, and drug-free.

**PROCESS**→

← **OUTCOMES** →

Resources	Activities	Outputs	Outcomes(short, intermediate, long-term)	Measurement
Funding Staff Clients Providers Support Groups (AA & NA) Drug Court Chemical dependency residential treatment Denver II Kits Trainings Behavioral health specialist CPS CSO Data entry	<p><b><u>Client Services</u></b></p> <ol style="list-style-type: none"> <li>1. Initiate respond to and maintain contact until admitted into program</li> <li>2. Conduct intake interview</li> <li>3. Support mothers in setting goals and achieving them</li> <li>4. Act as an advocate for and help clients connect with community resources including scheduling appointments</li> <li>5. Provide support to clients through home visits, providing transportation, etc.</li> <li>6. Conduct exit interviews</li> </ol>	<p># of contacts</p> <p># on waiting list</p> <p># enrolled</p> <p># of intake interview forms</p> <p># of goal sheets</p> <p># of information releases signed</p> <p># of clients staffed</p> <p># of exit interview obtained, completion rate</p>	<p><b><u>Process Outcome</u></b></p> <ol style="list-style-type: none"> <li>1. Responded in a timely manner to incoming referrals</li> <li>1. Referral forms were completed</li> <li>2. Intake interview conducted according to protocol. All paperwork complete.</li> <li>3. Confidentiality was maintained. Staff were viewed as helpful and supportive and knowledgeable</li> <li>4 &amp; 5. Case management addressed client needs. Confidentiality was maintained. Forms were filled out correctly.</li> <li>6. Interviews were performed according to protocol within month of program completion. Timely and accurate information entry</li> </ol>	<ol style="list-style-type: none"> <li>1. Annually review % non-program-entering referrals and response time. Review referral retention rates. Evaluate communication w/referral sources.</li> <li>2. Monthly review data tracking forms (client summary) for completion</li> <li>3. Weekly review goal achievement, and life skills acquired. Every 4 months, update and evaluate goals sheet (client satisfaction survey)</li> <li>4. Quarterly chart reviews to assess service utilization. Annually review applicable client/case manager relationship</li> </ol>

			<p><b><u>Impact Outcome</u></b>          1. High-risk individuals were retained on waiting list.          1. Increase rate of pre-enrollment referral retention. Improved communication with referral sources           2. Able to determine services needed.           3. Goals are met during the course of the program.          3. Increased client's life skills and ability to cope with difficult situations           4 &amp; 5. Decreased barriers and increased access to services and treatment           4 &amp; 5. Increased client completion rate           4 &amp; 5. Decreased prenatal fetal alcohol and drug exposure and risk for associated birth defects</p> <p><b><u>Population Outcome</u></b>          Decreased incidence of associated birth defects and increased families that are self-sufficient</p>	<p>for confidentiality problems.          OMAHA (gain skills)           Biannual assessment of client progress, weekly time summary and supervisor time summary           Annually review exit interview forms for completion           OMAHA</p>
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