

THEORY OF CHANGE - FDM/PATHWAY PROJECT -

| <i>Model Component</i> | <i>Case Management</i> | <i>Family Activities</i> | <i>Pathway Interventions</i> | <i>Pathway Goals</i> | <i>FDM Outcomes</i> | <i>Long - Term Outcomes</i> |
|---|--|---|---|---|---------------------------------------|--|
| Building Relationships | Contact family within ** days of referral | Be on time and present at all visit | *Confirm safety of child *Work in partnership with Child Welfare *Support family to advocate for child in school | Children and Youth are Nurtured, Safe and Engaged | Child Safety | INCREASED CHILD, FAMILY AND COMMUNITY WELL-BEING |
| | Explain program | Share family story with the worker | *Connect to child care opportunities *Identify developmental concerns | | Children's Physical and Mental Health | |
| | Provide Informed Consent | | *Support children's social and emotional competence | | | |
| Intake | Obtain Confidentiality Agreement | Participate in the Family Development Matrix Assessment | *Positive parenting education | Families are Strong and Connected | Parent/Child Relationships | |
| | Explain Family Advocate Role | | *Effectively involve fathers and other relatives in parenting | | Family Communication | |
| | Ask about Family History | | *Connect to parent support groups and education | | | |
| Confirm safety of child | | | | | | |
| Family Assessment | Review Family Concerns | Review Visit Summary; agree on strengths and concerns | *Connect to financial supports for self-sufficiency *Provide health information *Provide transportation to access medical, counseling appointments as needed *Participate in multi-disciplinary teams to coordinate services | Identified Families Access Services and Supports | Basic Needs | |
| | Conduct FDM baseline assessment | State goal(s) and develop a family empowerment plan | | | Shelter | |
| | Enter data into Matrix Creator | Agree on steps needed to reach goal | | | Access to Services | |
| Establish family driven goals based on assessment and family interest | Follow up on referrals or participate in classes | | Families are Free from Substance Abuse and Mental Illness | Substance Abuse | | |
| Link family to community service provider | | Share with worker opportunities/barriers to meeting goals | | | Social Emotional Health | |
| Assign family homework | Meet regularly with family worker to review progress | | Communities are Caring and Responsive | Community Engagement | | |
| Set next meeting | | Establish family/ community supports | | | | |
| Record family and worker activity | Ensure goal achievement | | | | | |
| Follow up regarding effectiveness of referrals and adjust as needed | | Celebrate success | | | | |
| Review progress towards goals | Ensure community connections | | | | | |
| Conduct subsequent FDM assessments per protocols | | | | | | |
| Closure | | | | | | |
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