



## Ohio Family and Children First County FCFC H.B. 289 Planning Guidance

### **Purpose of the HB 289 Plan**

H.B. 289 was enacted August 17, 2006 to increase the accountability of the Ohio Family and Children First (OFCF) Cabinet Council and county Family and Children First Councils (FCFCs). It requires county FCFCs to identify local interagency efforts and establish a process to identify local priorities to increase child well-being. The local priorities must focus on one or more of the six Commitments to Child Well-Being.

The county FCFC must monitor progress toward meeting the local priorities through identified indicators associated with child well-being and provide an annual report to its board of county commissioners and the OFCF Cabinet Council. Statute enacted in 1993 mandates county FCFCs to develop and implement a process that annually evaluates and prioritizes services, fills service gaps where possible, and invents new approaches to achieve better results for families and children. H.B. 289 expands the existing statute by requiring the planning process to focus on increasing child well-being, culminating in a written plan.

This planning guidance is a tool to assist county FCFCs in the ongoing development of the HB 289 plan and is based on the Partnerships for Success (PFS) model. Extensive planning is needed to:

- effectively collect and analyze data;
- assess the county's needs and resources;
- conduct gap analysis;
- prioritize and select the indicator(s); and,
- implement strategies to impact the identified outcomes.

The comprehensive planning process rotates on a four year cycle to allow sufficient time to track movement of the intermediate and short-term indicators in and demonstrate change in the intended direction. Each county FCFC was required to submit its initial plan by July 2, 2007, as an attachment to the County FCFC SFY08 Operational Capacity Building Grant Application. H.B. 289 Summary and Plan Template is available in Appendix A. Appendix D provides a list of technical assistance resources to facilitate the implementation of HB 289 requirements.

During SFY 2007 - 2011, the county FCFC must monitor its original plan, annually report its progress toward achieving specified outcomes, and review and update the plan. HB 289 planning is a fluid process designed to provide flexibility in addressing multiple focus areas, drilling down further to increase specificity, and aligning initiatives. The county FCFC may revise its original plan to address new data and/or local priorities, but

will need to document the revisions annually utilizing the HB 289 Update & Report template. Each county FCFC must submit its first HB 289 Update and Report by July 1, 2008. The four year planning cycle will then culminate in the development of the next comprehensive HB 289 plan to be submitted in July 2011.

### **Ohio Family and Children First Statute**

Ohio Revised Code 121.37 provides the infrastructural and operational framework for the Ohio Family and Children First Cabinet Council and the county FCFC. The statute is available on the OFCF website, [www.ohiofcf.org](http://www.ohiofcf.org). The statutory language specifically addresses the requirement for the county FCFC to conduct planning and reporting as outlined in HB 289: *“A county council shall develop and implement the following:*

- *An interagency process to establish local indicators and monitor the county's progress toward increasing child well-being in the county;*
- *An interagency process to identify local priorities to increase child well-being. The local priorities shall focus on expectant parents and newborns thriving; infants and toddlers thriving; children being ready for school; children and youth succeeding in school; youth choosing healthy behaviors; and youth successfully transitioning into adulthood and take into account the indicators established by the cabinet council.*
- *An annual plan that identifies the county's interagency efforts to increase child well-being in the county.*

*On an annual basis, the county council shall submit a report on the status of efforts by the county to increase child well-being in the county to the county's board of county commissioners and the cabinet council. This report shall be made available to any other person on request.”*

### **HB 289 Planning Model**

The HB 289 planning model is based on the Partnerships for Success (PFS) planning model. The HB 289 Planning Guidance is built on a logic model that PFS has integrated into the planning model as a means to achieve effective planning and outcomes. The logic model provides a guide for the county FCFC in establishing local priorities and developing indicators to monitor progress towards achieving child well-being. Further, it establishes a link to bridge the PFS planning process and the HB 289 planning requirements. It serves as a common thread in tying together both common terminology and best practice (refer to page 12 and Appendix F for logic model examples). To be truly effective in carrying out the planning process, the following components are necessary:

- Needs Assessment
- Focus Area Identification
- Long-Term Commitment(s) to Child Well-Being Selection
- Intermediate Outcome(s) & Indicator(s) Selection
- Short-Term Outcome(s) & Indicator(s) Selection
- Resource Assessment
- Gaps Analysis
- Strategy Selection
- Completion of the Plan Summary and Template

### **Needs Assessment**

Each community has unique needs and councils will want to select a focus area, outcomes and indicators that are meaningful to the community. Completing a needs assessment is the first step in identifying key community issues that ultimately inform this selection process.

The general goal of needs assessment is to define targets for change in the community. Pertinent information gathered and compiled throughout this process will provide an accurate appraisal of the community situation and/or unique needs. The needs assessment process should utilize both quantitative data and public opinion to create a community profile that can be used for strategic planning. Careful consideration should be given to balancing community values with quantitative data. This will ensure that the selection of focus areas and outcomes are informed by data, but not necessarily driven by it. Together, this information will provide the community with the best opportunity to strategically and effectively serve Ohio's families.

Much of the information collected in the needs assessment process should be obtained through quantitative data from national, state and local sources. A helpful guide to national and state data sources of information compiled by the Partnerships for Success Academy can be found at: [www.pfsacademy.org/communitytoolbox/trainings/data/PfS%20Online%20Resources.pdf](http://www.pfsacademy.org/communitytoolbox/trainings/data/PfS%20Online%20Resources.pdf).

Communities can use existing data to compare their situation to other local, state or national trends or use it as baseline data. Below are some examples of existing data sources that have been utilized by counties:

- United Way Community Assessment and Report
- Evidence that identifies major priorities and RPA's for child/family serving systems
- Ohio Kids Count, Fatality Review Annual Report, PCSAO Fact Book
- Education Management Information System (EMIS)
- Maternal and Child Health Assessment data from the Ohio Dept. of Health
- Information and Referral data
- Any required agency specific needs assessments, strategic plans (example: MSPA)

Another important source of information collected in the needs assessment process is obtained through the assessment of public opinion, or "community values", as defined in the Partnerships for Success model. Obtaining information and feedback from a diverse group of community members will help to identify the issues that are viewed as critical and prevalent and therefore help to define community priorities and indicators. Below are some examples of methods to obtain community opinion or values:

- Focus groups
- Community and/or youth surveys

In both methods of data collection it is critical to engage key informants who are in a prime position to know what community needs exist and who may have first hand knowledge. Active involvement of a broad based group of child and family service systems, consumers, youth, etc. is needed in order to broaden and deepen the conversation about community needs.

Counties may find the need to balance quantitative data, or lack thereof, with community values. For example, data may not be available to show a prevalence of problem behaviors associated with mental illness. However, long waiting lists and citizen frustration with the lack of timely mental health services may prompt a county to prioritize this area even with the absence of quantitative prevalence data.

It will also be important to identify a person or group who will be responsible for data collection, organization and management. For example, data will need to be shared in a presentable format that facilitates discussion, comparisons, etc. Organizing data in a way that will ultimately support/defend the selected community priorities and indicators will also be critical.

Communities should anticipate allowing approximately 2 months time to complete the needs assessment process.

### **Focus Area**

Focus Area is defined as a categorical issue in the community of highest need or of the highest level of categorical concern to the community. Identification of a focus area enhances a FCFC's capacity to address competing areas of categorical concern through priority-setting and exploration of impact on child well-being. It also may connect multiple intermediate outcomes or long-term Commitments under a single focus area. Depending on the FCFC's capacity and the community's willingness, several focus areas may be selected or may be needed to allow county FCFCs to manage multiple issues identified during the needs assessment and/or current initiatives.

Begin by reviewing and discussing each key community issue focused on child well-being that surfaced during the needs assessment. Then start prioritizing the key issues. This can be done by consensus, voting, ranking or other methods deemed appropriate by the community. Consideration should be given to those issues that cross system lines, that is, issues that impact and can be impacted by various systems. The key issues selected will determine the community's focus area, such as Child Abuse and Neglect; Substance Abuse; Mental Health; Delinquency; Early Childhood; and Health Promotion.

To complete the plan template, FCFCs must clearly identify the Focus Area. The focus area should be seen as a simple category or issue title. In most cases, only one focus area will be identified per template. Examples of focus areas would include, Child Abuse and Neglect; Substance Abuse; Mental Health; Delinquency; Early Childhood; and Health Promotion. After the selection of the focus area, the long-term Commitment(s) to Child Well-Being and the intermediate outcomes will need to be identified.

### **Long-Term Commitments to Child Well-Being**

The six Commitments to Child Well-Being are considered broad, long-term outcomes. These outcomes may take years for any significant impact to occur. Short-term outcomes and intermediate outcomes must move in their desired directions to positively impact the movement of a long-term commitment. The six Commitments to Child Well-Being have been developed to reflect the elements of child well-being throughout the course of childhood, which are:

- Expectant Parents and Newborns Thrive (suggested target ages: 0-1)
- Infants and Toddlers Thrives (suggested target ages: 1-3)
- Children are Ready for School (suggested target ages: 4-5)
- Children and Youth Succeed in School (suggested target ages: 6-12)
- Children and Youth Engage in Healthy Behaviors (suggested target ages: 13-18)
- Youth Successfully Transition into Adulthood (suggested target ages: 18-24)

After a comprehensive needs assessment and identification of the focus area, one or more Commitment(s) to Child Well-Being needs to be selected for the plan template. Depending on the focus area, the capacity of the community, and the resources available, more than one long-term commitment may be selected to be impacted by multiple strategies, short-term and intermediate outcomes. For example, substance abuse may be the focus area with long-term commitments impacting expectant parents and newborns thriving as well as children and youth engaging in healthy behaviors. It is recommended for the county FCFC to reaffirm the selection of the focus area and Commitment(s) to Child Well-Being after the development of specific intermediate outcomes, short-term outcomes, and strategies as it is possible that additional commitments may need to be selected or reconsidered.

### **Intermediate Outcome**

Intermediate outcomes identify the condition to be changed in the community as it relates to the focus area (i.e., underage drinking) and the desired goal to be achieved (i.e., reduced youth alcohol use). Intermediate outcome selection is based on the quantitative data and/or community values information collected during the needs assessment.

Communities may choose one or more intermediate outcomes on which to concentrate efforts. However, a limited number is recommended to make the process more manageable and attainable. For example, a community might select substance abuse as the focus area for the community and reduce youth alcohol use as the intermediate outcome. Over time, selecting additional intermediate outcomes, either within the same focus area or within a different focus area will have more of a significant impact on a long-term commitment.

Only one Intermediate Outcome can be listed per plan template. This is to ensure the intermediate outcomes' indicators and short-term outcomes and indicators logically align with the defined intermediate outcome. If there is more than one intermediate outcome, the county FCFC will have to complete and submit additional templates.

Typically, one can expect to be able to measure intermediate outcomes 1-2 years after the strategy has started. Communities should be able to capture and measure the extent to which these outcomes are realized in subsequent years.

### **Intermediate Outcome Indicator**

Each intermediate outcome has an identified Indicator (i.e., number of alcohol related youth arrests) for which data is collected and then tracked on the report template. The data is utilized to monitor progress toward achieving the intermediate outcome (i.e., a decrease in the number of alcohol related youth arrests indicates progress in reducing youth alcohol use). FCFCs must select at least one indicator for an intermediate outcome.

Start listing the potential indicators (see Appendix B or develop local indicators) that closely relate to or directly impact the selected intermediate outcome(s). From that list, discuss and come to consensus on what indicators to monitor. Listed below are some key considerations to help guide community discussions:

- Indicators often reflect important community values – what is measured tends to be what is valued.
- Indicators should be appropriate and useful performance measurements.
- Indicator should be something on which the community feels it can make an impact.
- Indicators should measure as closely as possible the result it is intended to measure.
- Indicators should be clear on what is being measured and what kind of data will be collected.
- Indicators should be quantitative/measurable.
- Indicators should be practical in that data can be obtained in a timely way and at a reasonable cost. Consider data availability and data collection capacity issues.
- Indicators must be logically linked to the selected outcomes.

Communities may select single or multiple indicators to measure their outcomes. Instead of attempting to identify a perfect indicator, it is sometimes more feasible to identify a few decent correlated indicators. Examples of indicators include:

- % of youth who do not drink alcohol
- % of youth who have not ridden in a car with someone who has been drinking alcohol in the last 30 days.
- % of youth who have not drunk alcohol in the last 30 days.

Communities should anticipate allowing approximately 2 months time to complete the focus area, long-term commitment(s) to child well-being, intermediate outcomes, and indicator selection process.

### **Short-Term Outcome**

Short-Term Outcomes are factors that contribute to an intermediate outcome and are critically tied to the strategies selected. Short-term outcomes are often referred to as risk factors, protective factors, or assets (RPAs, see Appendix C). In most case to effectively impact an intermediate outcome, there will need to be more than one short-term outcome overtime.

The needs assessment process focuses on data and community valuing to determine a link between the intermediate outcome and the short-term outcome (i.e., research suggest that friends engaging in problem behavior is a major risk factor contributing to youth alcohol use; thus, friends do not engage in problem behavior can be selected as the short-term outcome).

The short-term outcome(s) should be clearly identified and logically aligned with the defined intermediate outcome for the given template. There can be more than one Short-Term Outcome per plan template, but only one short-term outcome per Short-Term Outcomes and Strategies page to assure alignment between the short-term outcome, its indicator(s), and proposed strategies. There are duplicate pages available in the template for multiple short-term outcomes.

### **Short-Term Outcome Indicator**

Each short-term outcome must have an identified Indicator for which data is collected and then tracked to monitor progress on the report template (i.e., a decrease in the number of youth who report having friends who use alcohol is an indication that the short-term outcome, friends do not engage in problem behavior, is being achieved.). This criterion for success will define the desired level of change to let communities know when benchmarks or goals are achieved (i.e., the baseline is 74% report having friends who do not use alcohol, and the criterion of success is 80% report having friends who do not use alcohol). Please note, counties should not allow the process to get bogged down by selecting criterion at this stage of planning, as the criterion may change based on strategies selected.

### **Outcomes and Indicators versus Outputs**

It is important to recognize the difference between a short-term outcome, short-term indicator, and an output. A *short-term outcome* is a statement of desired change in the status of a specific community issue. A *short-term indicator* measures change in behavior or achievement of the target population, reflecting the amount of movement toward the desired outcome. Typically, one can expect to see the impact of a strategy on the short-term indicator measurement/data within 12 months after the strategy is implemented. A *short-term output* tracks the number or attendance records of people served, or the number or frequency of units of service/information provided, etc., but this data does not measure change in behavior or achievement in the direction of the desired short-term outcome. Outputs do provide information about the dose of service being provided, which is useful in the development of service provision planning. Outputs do not indicate whether the service was effective or not.

Communities should anticipate allowing approximately 1 month to complete the development of short-term outcomes-and short-term indicators.

### **Resource Assessment**

The purpose of resource assessment is to create a profile of current programs, services and activities in the community that specifically address the changes desired to achieve the selected intermediate and short-term outcomes. A targeted, but thorough resource assessment will ultimately inform program/service gap identification.

A profile or inventory of current resources relevant to the selected intermediate and short term outcomes needs to be created. It is important to include both formal and informal supports and services. It is more manageable to only identify resources that may be impacting the selected intermediate and short-term outcomes.

As in the needs assessment process, it will be important to identify a person or group who will be responsible for data collection, organization and management. For example, resources will need to be shared in a presentable format that facilitates discussion, comparisons, etc. You may wish to organize resources by designating the:

- i. Intermediate and/or short-term outcomes impacted
- ii. Continuum of care (prevention, early intervention, treatment);
- iii. Target populations served (geography, ages, sex, etc); and,
- iv. Evidence of effectiveness (evidence based, promising practice, innovative).

Communities should anticipate spending two months time on resource assessment.

### **Gap Analysis**

Gap analysis is accomplished by reviewing and comparing data collected from both the needs and resource assessments. It is the process of identifying where discrepancies exist that will ultimately assist in the selection of strategies. For example, identifying any gaps that exist in the continuum of care and/or target populations will show where efforts to increase child well-being need to be targeted. The gaps analysis may also identify any systems issues that need to be addressed. To ensure the greatest impact and the most comprehensive strategy selection, a community should prioritize the gaps to address, where to avoid service duplication, and where collaboration needs to be built among service providers.

Communities should anticipate spending 1 month on gap analysis.

### **Selecting Strategies**

Once outcomes and indicators have been selected and a thorough resource assessment and gaps analysis is conducted, the FCFC must then determine the most appropriate strategy(s). A strategy is any action that will address the defined short-term outcomes and ultimately, the intermediate outcome (i.e., research suggests peer mentoring is effective in influencing youth not to choose friends who engage in problem behavior, use of alcohol). The strategies should be clearly identified on the plan template and logically align with the short-term outcomes and indicators and the intermediate outcome and indicators.

Strategies need to be considered based on several factors - Strategy Description, Type of Strategy, Feasibility of Strategy, and Phase of Strategy:

#### **Strategy Description**

Strategies selected may serve different purposes to impact the short-term outcome(s).

#### **Infrastructure Building Strategy:**

Some strategies may focus on infrastructure building. There may be cases where effective services cannot be delivered because of inadequate infrastructure. For example, coordinating the services to be delivered to high risk children may be considered essential to

addressing a particular outcome. This would be justified by research indicating that targeting multiple domains of development in a coordinated intervention approach is a best practice. A community may decide that building the capacity to deliver coordinated services is the strategy they want to implement and may want to engage and educate key providers in the process of local coordination of services. Infrastructure enhancements are necessary and changes may be constant, but the reason for infrastructure changes is to support programs that produce positive outcomes for kids. Examples of infrastructure building strategies are: systems of care; training; needs assessment; policy development; and coordination.

**Population-Based Strategy:**

Strategies may focus on a particular population-based service, such as screening and assessments; immunization; nutrition; Wellness; outreach/public education. These specific strategies or services are for a particular population that will produce positive outcomes for children and families and are most often prevention focused.

**Enabling Service Strategy:**

Enabling Service strategies focus on services that assist or enable children and families to meet their needs, such as transportation; translation; respite; WIC; family support services; case management; and outreach.

**Direct Service Strategy:**

Direct Service strategies are strategies that are filling a particular service gap in the community and provide a direct service to an individual, such as general health services; drug treatment services; Multi-Systemic Therapy; Functional Family Therapy; Life Skills Training; counseling; and anger replacement therapy.

**Type of Strategy**

Once the strategy description has been identified, the type or level of the strategy needs to be identified. The type of strategy describes how proven the strategy is in effectively achieving the desired outcomes. The three types of strategies are:

**Evidence-Based:**

An evidence-based approach has compelling evidence of effectiveness. Program designers can attribute participant success to the program itself, and have evidence that the approach will work for others in different environments. A study of the research that has been done on the selected practices or programs should tell whether a practice or program has been elevated to a standard of evidence based. There are clear standards of evidence that can and should be used to judge whether or not an approach “works”. Evidence should support the effectiveness of the strategy selected. The evidence should indicate there is a link between the strategy and the desired change in the risk factor, protective factor or number of assets and in the indicators selected. In order for strategies to be considered evidence-based they must be implemented with fidelity to the model. In other words, implementation or practice of the model must adhere to its design. The following website may be helpful in locating evidence-based programming: [www.alted-mh.org/ebpd/](http://www.alted-mh.org/ebpd/).

**Promising Practice:**

A promising approach has been implemented and significant impact evaluations have been conducted. While the data supporting the program is promising there may be contradictory evidence regarding its effectiveness or its scientific rigor is insufficient to suggest causality. Multiple, undefined factors may be contributing to the success of participants.

**Innovative Practice:**

Innovative Practices have little or no evidence supporting the effectiveness of such strategies. FCFCs should use caution when selecting such strategies as it may be more difficult to impact the selected short-term and intermediate outcomes when using innovative practices. These strategies may need to be monitored more closely to ensure movement in the intended direction.

**Feasibility of Strategies**

A community workgroup should gather information about strategies, practices, or programs that could potentially impact the selected outcomes. After collecting this information, the workgroup should consider existing and possible new strategies. Though it is not a requirement, councils are strongly urged to consider practices that are *feasible* to implement. Feasible practices are those that fit within the implementation capacity of a particular community. Collect as much information as possible on the implementation demands of the program being considered. Look at implementation requirements provided by the developers of the program. Look at implementation demands summarized by others in program reviews. If possible, talk to others who have implemented the program for additional insight. Study your community's capacity to implement the program based on the information collected. Consider available local resources that could support the program or strategy. Consider the values of your community in implementing a new program. Is the new program promoting activities that are consistent with community values? Is training required to implement program? If so, is the training available? Is the total cost of the program affordable? Is the training needed to implement affordable? Is the time commitment of new or existing personnel affordable?

**Ranking Proposed Strategies**

Next, each proposed strategy should be ranked based on:

1. The likelihood of impacting the selected outcomes
2. Its status as Evidence Based practice, as Promising Practice or as being Innovative with no evidence of effectiveness
3. High, medium or low feasibility to implement.

A chart to assist you in ranking the evidence and feasibility can be found at:

<http://altdmh.osu.edu/documents/evidence&feadibility/programselection.pdf>

The strategies most likely to achieve positive outcomes will be those that are known to be evidence based, best or promising practices; high or at least medium feasibility; and those that logically have a strong likelihood of impacting selected outcomes. If a strategy is selected for

which there is no evidence of effectiveness, the council will need to carefully design an evaluation process to determine whether the desired outcomes are being achieved.

### **Phase of Strategy**

The final step in strategy selection and identification is to identify the phase of the particular strategy. Some strategies selected may already be in place and be quite effective in meeting the desired outcomes. Others may be in the planning phase and will need much work to become operationalized. By tracking the phase of the strategies in the annual HB 289 report, the county FCFCs can monitor its progress with moving strategies in the intended direction of the defined outcomes. Each strategy selected will need to have the phase of the strategy identified. The phases include:

#### **Exploring:**

The HB 289 Core Team and/or FCFC is considering a possible strategy, research is being collected on its effectiveness and determining the feasibility of implementing such a strategy.

#### **Planning:**

The HB 289 Core Team and/or FCFC has selected a strategy and is currently planning or identifying the action steps needed to effectively implement the strategy.

#### **Implementing:**

The HB 289 Core Team and/or FCFC has selected a strategy; determined its feasibility; defined the action steps needed; and is now implementing the strategy through the defined action steps.

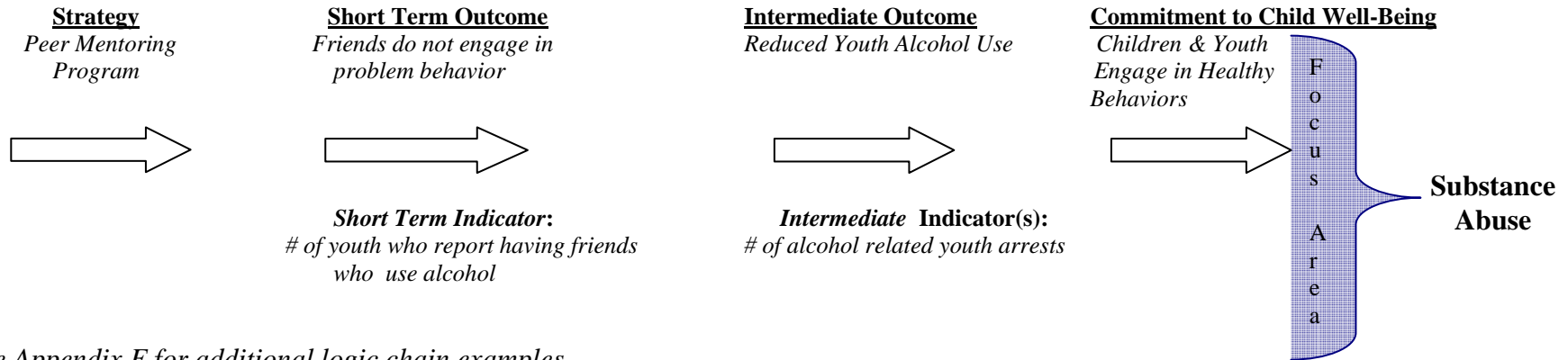
#### **Sustaining / Enhancing:**

The strategy selected has been implemented and has shown to have a positive impact on the selected outcomes. The HB 289 Core Team and/or FCFC may decide to sustain the strategy at the level it is currently being implemented or may decide to expand the services to reach a wider target population and increase the impact of the strategy.

Communities should anticipate spending 1 month on strategy selection.

**Logic Model**

The logic chain below offers visual representation of the connections of the required components:



See Appendix F for additional logic chain examples.

**Completion of the H.B. 289 Plan Summary and Template**

The components to be included in the written plan can be found in Appendix A, FCFC HB 289 Summary & Plan Template. Communities should anticipate spending 1 month writing the plan. The plan should include action steps that are needed to implement the strategy chosen or make the recommendations operational. The action steps should identify who is responsible for each step and should contain measurable activities to be achieved in a specified period of time. The action steps specify the resources needed for implementation and serve as a guide throughout the implementation process. Action steps serves as a helpful tool for local internal management purposes and therefore, are not required in the HB 289 Summary or Plan Template.

**H.B. 289 Core Team**

FCFCs are expected to create and maintain an organizational structure or infrastructure to support H.B. 289 planning. This organizational structure (referred to on the Plan Template as the H.B. 289 Core Team) should establish a consistent method of monitoring the HB 289 planning and reporting progress. The core team can consist of key leaders from the full membership of the FCFC and community at large to accomplish the planning and reporting work. Committee membership should include key informants and also tap into the expertise of FCFC members. Subcommittees can be in charge of each major planning phase: needs, resource and gap assessments, plan writing, data monitoring, reporting, etc. The FCFC Coordinator or if available, a planning coordinator, should be readily available to assist the county FCFC in accomplishing the planning tasks and timelines, and provide facilitation to the H.B. 289 Core Team. Although the core team takes on the primary monitoring responsibilities, the full FCFC should receive regular updates and have involvement in key decision making for H.B. 289.

**APPENDIX A**

**FCFC HB 289 PLAN SUMMARY & TEMPLATE**



## FCFC H.B. 289 Plan Summary

**County:** \_\_\_\_\_

### Executive / Planning Summary

**Provide a summary of the HB 289 Planning Process:**

- Identify the major findings and recommendations of the county Family and Children First Council by completing the *HB 289 Plan Template (Attachment A)*. If data reviewed or community valuing process does not support the recommendations, please explain the rationale for your county's recommendations in this section.
- Attach a diagram of the *Table of Organization (Attachment B)* showing the relationship between the FCFC, core planning/workgroups, providers, and/or other community initiatives involved in planning/implementation/service provision. Identify workgroups and membership (*except core planning team members listed on Attachment A, HB 289 Plan Template*) here:
- Provide an overview of the planning process, including identification of leadership and/or facilitator of the process, number of meetings held, how work was shared among workgroup members, how data and other information was analyzed by the workgroup, and how decisions were made.

### Needs Assessment

**Data Collection:**

*Please include the following:*

- Provide an overview of the data collected and reviewed to inform HB 289 planning.

**Focus Area:**

*Please include the following:*

- Provide the rationale for the selection of the focus area:
- Explain how there is clear linkage between the focus area and the long-term commitment(s) to child well-being and the intermediate outcome(s) selected:

**Long-Term Commitment(s) to Child Well-Being:**

*Please include the following:*

- Provide the rationale for the selection of the long-term commitment(s) to child well-being:
  
- Explain how there is clear linkage between the commitment(s) to child well-being selected and the outcome(s) the community intends to achieve:

**Intermediate Outcome(s) and Indicator(s):**

*Please include the following:*

- Provide the rationale for the selection of the intermediate outcome(s) and intermediate indicator(s). Attach *supporting documentation (Attachment C)*, such as data graphs and charts, used in selecting these intermediate outcome(s) and indicator(s); or clearly describe the data that influenced the selection of these outcomes and indicators:
  
- Explain how there is clear linkage between the indicator(s) selected and the outcome(s) the community intends to achieve:

**Short-Term Outcome(s) and Short-Term Indicator(s):**

*Please include the following:*

- Provide the rationale for the selection of the short-term outcome(s) and the short-term indicator(s). Attach *supporting documentation (Attachment D)*, such as data graphs and charts, used in selecting these outcomes and indicators; or clearly describe the data that influenced the selection of these outcomes and indicators:
  
- Explain how there is clear linkage between the indicator(s) selected and the outcome(s) the community intends to achieve:

**Resource Assessment/Gap Analysis**

*Please provide the following:*

- Provide an overview of the resource assessment process, including how resources were determined and what criteria were used to determine gaps:
  
- List and describe the resources that currently exist in the community related to the Focus Area, the Commitment(s) to Child Well-Being, and outcomes to be achieved. Consider organizing the data based on the continuum of care (prevention, early intervention, treatment); the target populations (geographic, ages, etc.); and the evidence of effectiveness (evidence based, promising practice, innovative practice):
  
- Provide data/rationale that supports the selection of the gaps that have emerged:

## **Strategy Selection**

*Please include the following:*

- Describe the strategies (programs, infrastructural changes) the county will implement in order to move the selected indicators in the intended direction:
- Describe any program level data collection or evaluation that will be implemented to determine effectiveness of the strategy:
- Describe the action steps to be taken to implement the strategy, including a timeline for implementation:



## FCFC H.B. 289 PLAN

**County:** \_\_\_\_\_

<b>Focus Area:</b> (list one focus area per template)	
<b>Long-Term Child Well-Being Commitment(s) :</b>	
<b>Intermediate Outcome #_____:</b> (list one intermediate outcome per plan template. For additional intermediate outcomes, copy template.)	
<b>Indicator(s):</b>	<b>Baseline Data</b>
	Data: Year of Data:
	Data: Year of Data:
	Data: Year of Data:

**H.B. 289 Plan**  
***Short-Term Outcomes & Strategies for defined Intermediate Outcome***

**Short-Term Outcome #1:** (list one short-term outcome per template page, for additional short-term outcomes use page3 & 4)

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Indicator(s):	Baseline Data
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█	Data: Year of Data:
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█	Data: Year of Data:
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█	Date: Year of Date:
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Strategy(ies):	Strategy Description	Type of Strategy	Phase of Strategy
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	Select one:	Select one:	Select one:
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	Select one:	Select one:	Select one:
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**H.B. 289 Plan**  
**Short-Term Outcomes & Strategies for defined Intermediate Outcome**  
**Duplicate Page (copy as needed)**

<b>Short-Term Outcome #2:</b> (list one short-term outcome per template page)			
█			
<b>Indicator(s):</b>			<b>Baseline Data</b>
█			Data: Year of Data:
█			Date: Year of Date:
█			Date: Year of Date:
<b>Strategy(ies):</b>	<b>Strategy Description</b>	<b>Type of Strategy</b>	<b>Phase of Strategy</b>
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█	Select one:	Select one:	Select one:
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**H.B. 289 Plan**  
**Short-Term Outcomes & Strategies for defined Intermediate Outcome**  
**Duplicate Page (copy as needed)**

<b>Short-Term Outcome #3:</b> (list one short-term outcome per template page)			
[Redacted]			
<b>Indicator(s):</b>			<b>Baseline Data</b>
[Redacted]			Data: Year of Data:
[Redacted]			Date: Year of Date:
[Redacted]			Date: Year of Date:
<b>Strategy(ies):</b>	<b>Strategy Description</b>	<b>Type of Strategy</b>	<b>Phase of Strategy</b>
[Redacted]	Select one:	Select one:	Select one:
[Redacted]	Select one:	Select one:	Select one:
[Redacted]	Select one:	Select one:	Select one:

**H.B. 289 Core Team:**

List the key members of the county H.B. 289 Core Team responsible for ongoing planning, implementation, and reporting:

<b>NAME</b>	<b>ORGANIZATION</b>	<b>TITLE</b>	<b>ROLE</b>

# Appendix B

## Ohio Family and Children First

### Commitments with Indicators to Child Well-Being

#### **Commitment One: Expectants Parents and Newborns Thrive**

- Percent of expectant mothers who receive adequate prenatal care.
- Rate of tobacco use while pregnant.
- Rate of alcohol use while pregnant.
- Rate of substance use while pregnant.
- Rate of infants born under 37 weeks gestational age.
- Percent of newborns born healthy.
- Percent of children who live past their first birthday.
- Percent of newborns with health insurance.
- Percent of first time parents demonstrating basic knowledge of infant care.
- Percent of children born into poverty.
- Percent of mothers experiencing maternal depression.
- Percent of parents/caregivers with mental health diagnosis and/or receiving mental health treatment.

#### **Commitment Two: Infants and Toddlers Thrive**

- Percent of children receiving complete immunization series before turning three.
- Percent of infants and toddlers living in families with the occurrence of reported abuse or neglect.
- Percent of infants and toddlers screened and identified with developmental delays.
- Percent of infants and toddlers being cared for out of their home who are in high quality settings.
- Percent of infants and toddlers living in stimulating cognitive environments.
- Percent of infants and toddlers demonstrating secure attachments with parents/caregivers.
- Percent of infants and toddlers with primary caregivers with a high school degree or GED.
- Toddler mortality rates.
- Percent of infants and toddlers with health insurance.
- Percent of children living in poverty.

#### **Commitment Three: Children are Ready for School**

- Percent of 3 and 4 year olds enrolled in preschool.
- Percent of 4 year-olds age eligible for fall kindergarten cognitively and socially/emotionally prepared to attend kindergarten.
- Percent of preschoolers living in families with the occurrence of reported abuse or neglect.
- Percent of preschool children who have been screened for vision, lead, hearing, and oral health.
- Percent of children living in communities with high rates of high school completion.
- Percent of parents/family members who understand Ohio's academic content standards.
- Percent of children exposed to crime or violence.
- Rate of child visits for injuries requiring hospitalization (or emergency room treatments).
- Preschool child mortality rate.

- Percent of preschoolers being cared for out of their home who are in high quality settings.
- Percent of preschool children with health insurance.
- Percent of preschool children living in poverty.

#### **Commitment Four: Children and Youth Succeed in School**

- Percent of students who report parental involvement with their education.
- Percent of students passing achievement tests.
- Percent of students who have a 95% attendance rate or better.
- Percent of students entering 9<sup>th</sup> grade who graduate from high school.
- Percent of third graders with obvious dental needs.
- Percent of students annually who are not suspended (in or out) or expelled from school.
- Percent of children in communities with sufficient access to high quality after-school programming.
- Participation and passage rates for students with disabilities on Ohio's achievement tests.
- Percent of children with substantial functional limitations. Percent of children exhibiting age-appropriate social emotional behaviors.
- Percent of core academic courses taught by fully-certified teachers.
- Annual elementary school age child mortality rates.
- Percent of students living in neighborhoods with a high rate of high school completion.
- Percent of school aged children with health insurance.
- Percent of school age children living in poverty.

#### **Commitment Five: Children and Youth Engage Healthy Behaviors**

- Percent of children and youth reporting healthy nutritional choices.
- Percent of youth who do not use tobacco.
- Percent youth who do not drink alcohol.
- Percent of youth who do not use drugs or other illegal substances.
- Annual birth rate to teenagers.
- Percent of youth who have had suicide ideation.
- Percent of parents who demonstrate effective monitoring skills.
- Number of community assets available in support of positive youth development.
- Percent of adolescents who identify meaningful non-familial adult involvement in their lives.
- Percent of children and youth involved in extracurricular school activities.
- Percent of children and youth involved in community activities.
- Percent of court involved children and youth.

#### **Commitment Six: Youth Successfully Transition into Adulthood**

- Percent of high school graduates who continue their education.
- Percent of employed young adults.
- Percent of youth who did not graduate from high school who earned a GED (through age 20).
- Percent of youth prepared to enter a career.
- Percent of homeless and runaway youth.
- Percent of youth committing felony offenses.

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County FCFC H.B. 289 Plan Guidance

Revised, 12/07

- Percent of youth committing misdemeanor offenses.
- Percent of youth successfully making system to system (youth to adult) transitions.
- Percent of youth successfully transitioning in and out-of-home (county, state) placements.
- Young adult suicide rate.
- Percent of youth who report involvement in community activities.

## Appendix C

### Examples of Intermediate Outcomes with RPAs

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Identification of **Intermediate Outcomes** is a critically important step for a community because it becomes the priority that propels planning in the county. Below is a list of examples of intermediate outcomes. *This list is not intended to be all inclusive.*

- Reduced delinquency
- Increased school success
- Reduced teen pregnancy
- Reduced substance abuse
- Reduced violence and neglect
- Reduced behaviors associated with mental illness

#### **Risk Factors**

Increase levels of negative **behaviors/outcomes** and decrease levels of positive **behaviors/outcomes**.

#### **Protective Factors**

Decrease levels of negative **behaviors/outcomes** and increase levels of positive **behaviors/outcomes**. Protective Factors are thought to be independently related to specific **outcomes**.

#### **Assets**

Similar to protective factors in that they decrease levels of negative **outcomes and increase levels of positive outcomes**, but are thought to work together in an additive fashion. That is, the different assets listed on the matrix below complement each other and increase each other's effects on **outcomes**. Thus, the more assets a community pursues the better the outcomes.

The following four pages provide a detailed listing of RPAs and how they align with examples of Intermediate Outcomes.

## Risk Factors with Examples of Intermediate Outcomes

<b>RISK FACTORS</b>	<b>INTERMEDIATE OUTCOMES</b>					
	Reduce Delinquent Behavior	Increase School Success	Reduce Teen Pregnancy	Reduce Substance Abuse	Reduce Violence	Reduce Behaviors Associated with Mental Illness
<b>NEIGHBORHOOD RISK FACTORS (9)</b>						
1. Availability of Drugs	✓			✓		
2. Availability of Firearms	✓				✓	
3. Community Norms Tolerant of Violence	✓				✓	
4. Community Norms Tolerant of Crime	✓				✓	
5. Community Norms Tolerant of Substance Abuse	✓			✓		
6. Low Neighborhood Attachment	✓	✓				
7. Community Disorganization	✓	✓	✓		✓	
8. Transitions and Mobility	✓	✓	✓	✓		✓
9. Poverty	✓	✓	✓	✓	✓	✓
<b>FAMILY RISK FACTORS (5)</b>						
10. Family History of Problem	✓	✓	✓	✓	✓	✓
11. Inconsistent and/or Inappropriate Discipline	✓	✓	✓	✓	✓	✓
12. Lack of Adult Monitoring and/or Supervision	✓	✓	✓	✓	✓	✓
13. Family Violence		✓			✓	✓
14. Favorable Family Attitudes toward Problem	✓	✓	✓	✓	✓	
<b>SCHOOL RISK FACTORS (3)</b>						
15. Antisocial Behavior	✓	✓				
16. Academic Failure	✓	✓	✓	✓		
17. Lack of Commitment to School	✓	✓	✓	✓		
<b>PEER/INDIVIDUAL RISK FACTORS (4)</b>						
18. Alienation from Mainstream	✓	✓	✓	✓	✓	
19. Favorable Attitudes Toward Problem Behavior	✓	✓	✓	✓	✓	✓
20. Friends Engage in Problem Behavior	✓	✓	✓	✓	✓	✓
21. Early Initiation in Problem Behavior	✓	✓		✓	✓	✓

\*Borgenschneider, 1996; Catalano, Hawkins, Berglund, Pollard & Arthur, 2002; Elliott, Wilson, Huizinga, Sampson et al, 1996; Jessor, Turbin & Costa, 1998; Lerner & Castellino, 2002; Sampson, Morenoff & Earls, 1999.

## Protective Factors with Examples of Intermediate Outcomes

<b>PROTECTIVE FACTORS</b>	<b>INTERMEDIATE OUTCOMES</b>					
	Reduce Delinquent Behavior	Increase School Success	Reduce Teen Pregnancy	Reduce Substance Abuse	Reduce Violence	Reduce Behaviors Associated w/ Mental Illness
<b>NEIGHBORHOOD PROTECTIVE FACTORS (9)</b>						
1. Access to Quality Prenatal Health Care						
2. Access to Quality Pediatric/Adolescent Health Care						
3. Access to Quality Mental Health Care		✓	✓		✓	✓
4. Community Norms Against Violence					✓	
5. Community Norms Against Crime	✓					
6. Community Norms Against Substance Abuse	✓			✓		
7. Neighborhood Attachment & Organization	✓	✓			✓	
8. Residential Stability		✓				✓
9. Increase in Jobs with a Family Wage	✓	✓	✓	✓	✓	
<b>FAMILY PROTECTIVE FACTORS (6)</b>						
10. Consistent, Age-Appropriate Discipline	✓	✓	✓	✓	✓	✓
11. Adult Monitoring and/or Supervision	✓	✓	✓	✓	✓	✓
12. Family Problem-Solving Ability		✓		✓	✓	✓
13. Family Members can Communicate Supportively	✓	✓		✓	✓	✓
14. Significant Attachment to Pro-Social Adult	✓	✓	✓	✓	✓	✓
15. Family Members Value Education		✓	✓			
<b>SCHOOL PROTECTIVE FACTORS (3)</b>						
16. Parent-Teacher Cooperation		✓	✓			
17. Specialized Instruction for At-Risk Students		✓	✓			
18. School-to-Work Transition Programs		✓				
<b>PEER/INDIVIDUAL PROTECTIVE FACTORS (4)</b>						
19. Committed to some form of Pro-Social Ideology	✓	✓				
20. Pro-Social Attitudes	✓	✓				
21. Friends DO NOT Engage in Problem Behavior	✓	✓	✓	✓	✓	
22. Friends Disapprove of Problem Behavior	✓	✓	✓	✓	✓	

\*Borgensneider, 1996; Catalano, Hawkins, Berglund, Pollard & Arthur, 2002; Elliott, Wilson, Huizinga, Sampson et al, 1996; Jessor, Turbin & Costa, 1998; Lerner & Castellino, 2002; Sampson, Morenoff & Earls, 1999.

## The Search Institute 40 Developmental Assets

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Through extensive research, Search Institute has identified the following 40 building blocks of healthy development that help young people grow up healthy, caring, and responsible. The asset definitions shown in this chart are based on research on adolescents (6th to 12th grades).

### *EXTERNAL ASSETS*

#### **Support**

- Family support: Family life provides high levels of love and support.
- Positive family communication: Young person and her or his parent(s) communicate positively, and young person is willing to seek advice and counsel from parent(s).
- Other adult relationships: Young person receives support from three or more non-parent adults.
- Caring neighborhood: Young person experiences caring neighbors.
- Caring school climate: School provides a caring, encouraging environment.
- Parent involvement in schooling: Parent(s) are actively involved in helping young person succeed in school.

#### **Empowerment**

- Community values youth: Young person perceives that adults in the community value youth.
- Youth as resources: Young people are given useful roles in the community.
- Service to others: Young person serves in the community one hour or more per week.
- Safety: Young person feels safe at home, at school, and in the neighborhood.

#### **Boundaries and Expectations**

- Family boundaries: Family has clear rules and consequences, and monitors the young person's whereabouts.
- School boundaries: School provides clear rules and consequences.
- Neighborhood boundaries: Neighbors take responsibility for monitoring young people's behavior.
- Adult role models: Parent(s) and other adults model positive, responsible behavior.
- Positive peer influence: Young person's best friends model responsible behavior.
- High expectations: Both parent(s) and teachers encourage the young person to do well.

#### **Constructive Use of Time**

- Creative activities: Young person spends three or more hours per week in lessons or practice in music, theater, or other arts.
- Youth programs: Young person spends three or more hours per week in sports, clubs, or organizations at school and/or in community organizations.
- Religious community: Young person spends one hour or more per week in activities in a religious institution.
- Time at home: Young person is out with friends "with nothing special to do" two or fewer nights per week.

## ***INTERNAL ASSETS***

### **Commitment to Learning**

- Achievement motivation: Young person is motivated to do well in school.
- School engagement: Young person is actively engaged in learning.
- Homework: Young person reports doing at least one hour of homework every school day.
- Bonding to school: Young person cares about her or his school.
- Reading for pleasure: Young person reads for pleasure three or more hours per week.

### **Positive Values**

- Caring: Young person places high value on helping other people.
- Equality and social justice: Young person places high value on promoting equality and reducing hunger and poverty.
- Integrity: Young person acts on convictions and stands up for her or his beliefs.
- Honesty: Young person "tells the truth even when it is not easy."
- Responsibility: Young person accepts and takes personal responsibility.
- Restraint: Young person believes it is important not to be sexually active or to use alcohol or other drugs.

### **Social Competencies**

- Planning and decision making: Young person knows how to plan ahead and make choices.
- Interpersonal competence: Young person has empathy, sensitivity, and friendship skills.
- Cultural competence: Young person has knowledge of and comfort with people of different cultural/racial/ethnic backgrounds.
- Resistance skills: Young person can resist negative peer pressure and dangerous situations.
- Peaceful conflict resolution: Young person seeks to resolve conflict nonviolently.

### **Positive Identity**

- Personal power: Young person feels he or she has control over "things that happen to me."
- Self-esteem: Young person reports having a high self-esteem.
- Sense of purpose: Young person reports that "my life has a purpose."
- Positive view of personal future: Young person is optimistic about her or his personal future.

This list is an educational tool. It is not intended to be nor is it appropriate as a scientific measure of the developmental assets of individuals.

The following information has been adapted from the Search Institute website at [www.searchinstitute.com](http://www.searchinstitute.com).  
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# Appendix D

## Available Technical Assistance

### **Ohio Family and Children First**

OFCF Regional Coordinators are available to offer ongoing local and regional technical assistance on OFCF HB 289 Planning Guidance and overall HB 289 requirements, as well as provide recommendations and linkages to additional technical assistance resources. Please contact your OFCF Regional Coordinator for assistance.

- SW – Joyce Calland, 937-484-1526, jcalland@postoffice.ag.ohio-state.edu
- NE – Janice Houchins, 330-263-3632, jhouchins@ag.osu.edu
- East - Cindy Lafollett, 740-732-2381, clafollett@postoffice.ag.ohio-state.edu
- NW - Teresa Reed McGlashan, 419-579-4397, trmcglash@postoffice.ag.ohio-state.edu
- South - Sherry Ward, 740-286-2177, sward@postoffice.ag.ohio-state.edu

### **Partnerships for Success Academy Staff**

The PfS Academy is available to provide training and technical assistance to counties on how to utilize specific PfS tools and procedures to implement the planning requirements of HB 289. Academy staff will be available to all counties in varying capacities:

**Currently funded PfS counties** (planning and implementation counties) will have continued access to PfS Academy staff that will provide coordination of TA needs relative to planning and reporting requirements of HB 289.

**Formerly funded PfS counties** (sustainability counties) will have continued access to PfS coaches. Counties that have already been assigned a PfS Academy Coach via the PfS Academy Support Agreement, please contact your assigned coach for assistance needs relative to HB 289 planning and reporting. If you previously declined support or did not submit a support agreement, but are interested in receiving HB 289 planning assistance from the PfS Academy, please call Melissa Ross at 614-292-0175 so that a coach can be assigned.

**Non-PfS counties** will be provided with training opportunities and technical assistance from the PfS Academy Staff at the state level, regionally, and as requested and feasible, one on one. Please inform your OFCF Regional Coordinator if such support and assistance from the PfS Academy is desired.

# Appendix E

## HB 289 Planning Timeline

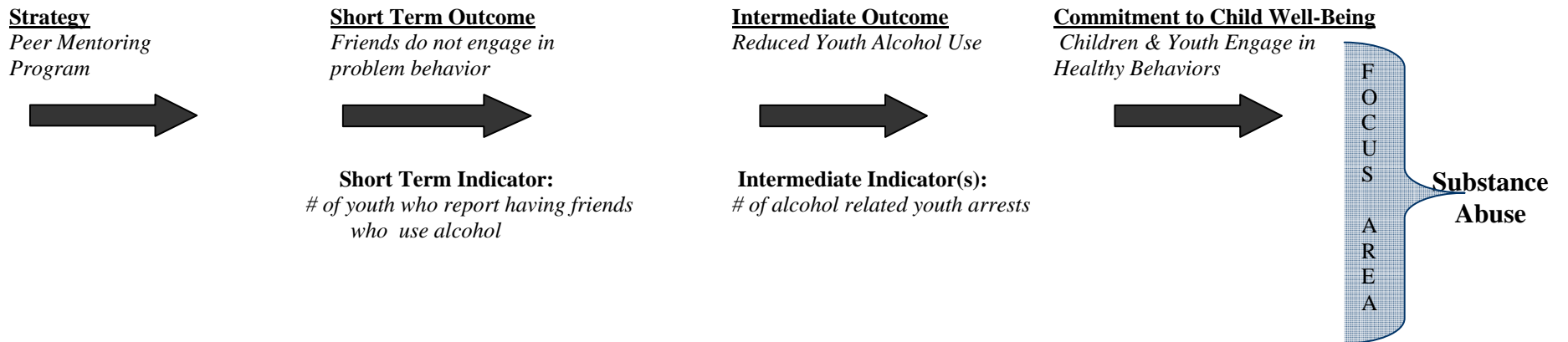
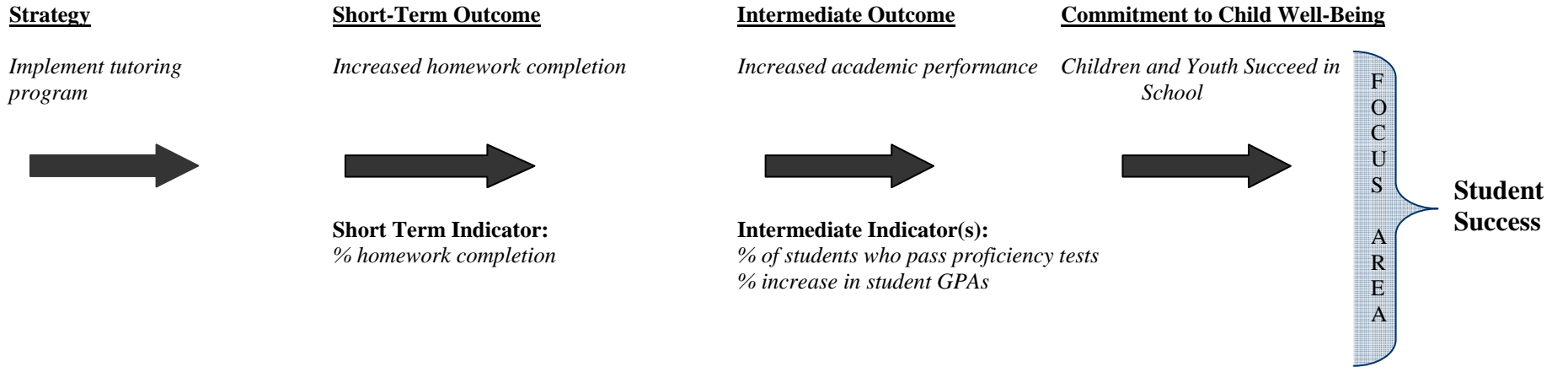
2 months	2 months	1 month	2 months	1 month	1 month	1 month
Data Collection	Focus Area; Commitment(s) Selection; Intermediate Outcome & Indicator Selection	Short-Term Outcome & Indicator Selection	Resource Assessment	Gap Analysis	Strategy Selection	Completion of HB 289 Plan Summary and Template



Needs Assessment

# Appendix F

## Logic Chain Examples



**Strategy**  
Implement  
Immunizations Outreach Program

**Short-Term Outcome**  
Increase access to quality  
health care

**Intermediate Outcome**  
Increased immunizations

**Commitments to Child Well-Being**  
Expectant Parents and Newborns  
Thrive; Infants and Toddlers Thrive



**Short Term Indicator:**  
# of parents who have a medical  
home

**Intermediate Indicator(s):**  
% of children receiving complete  
immunization series before the  
age of 3

F  
O  
C  
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A  
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E  
A

**Health  
Promotion**

**Strategy**  
Mentors assigned to  
at risk students with no post  
secondary education or  
training plan

**Short-Term Outcome**  
Increased encouragement for at-risk  
students to participate in post secondary  
education or training program

**Intermediate Outcome**  
Increased Post Secondary  
Education/Training Participation

**Commitment to Child Well-Being**  
Youth Successfully Transition into  
Adulthood



**Short Term Indicator:**  
% of high school seniors who  
plan to attend post secondary  
education or training program

**Intermediate Indicator(s):**  
% of Students who attend post secondary  
education/training after high school

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A  
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E  
A

**Economic  
Self-  
Sufficiency**