Ohio Children's Trust Fund

Central Ohio Regional Prevention Council

# SFY 17-18 CENTRAL OHIO REGIONAL PREVENTION PLAN

## NOVEMBER 2016

*In 2016, the Ohio Children's Trust Fund's Central Ohio Regional Prevention Council first convened to begin coordinating child abuse/neglect prevention activities in a 13-county region of central Ohio. This report summarizes the needs of the region along with a plan for targeted strategies chosen by the council to prevent child abuse and neglect.*

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# Executive Summary

## Needs Identified and Target Population

The Ohio Children's Trust Fund (OCTF) Central Ohio Regional Prevention Council (CORPC) conducted a region-wide Needs Assessment from July to September of 2016. As a result of the study of available data as well as county focus groups, it was determined that the growing substance-abuse epidemic was contributing greatly to an increase in reports of child abuse and neglect (CAN) without a proportional increase in CAN prevention programming to address this issue. Based on this information, the CORPC has chosen **pregnant substance-abusing mothers** and **families at risk of substance abuse** as target populations for the Central Ohio Regional prevention efforts.

## Strategies

All proposed strategies will be expected to **reduce the number of new reports of CAN to child protective services in which parental or caregiver substance use is a current concern**. As a result of the proposed strategies, **relationships will be strengthened** between child welfare agencies (CWA) and those addressing mental health, substance abuse, poverty, and other social services. Parents participating in CORPC-funded programs will be expected to **gain measurable knowledge in parenting and child development topics** including behaviors that promote healthy child and family well-being, build protective factors and reduce risk factors in families, and emphasize the importance of children's social and emotional development. Due to improved knowledge, parents are expected to **engage in behavior changes** that result in increases in natural positive supports and behaviors designed to build protective factors.

### Strategy I

The CORPC will implement a **pilot program**, based in part on the Material Opiate Medical Supports (MOMS) project[1], open to pregnant, substance-abusing mothers. OCTF funding will be used to provide **care coordination and wrap-around services** in the context of a program which uses separate funding sources to provide medication assisted treatment (MAT) and behavioral counseling. Expected outcomes include an increase in safe environments for children and an improvement in protective factors for children. The program aims to have 75% of participants receiving recommended prenatal care and beginning substance abuse treatment, which should reduce growth in Neonatal Abstinence Syndrome (NAS). It is estimated that this program could reach approximately 146 mothers within the region.[2]

### Strategy II

CORPC will also fund evidence-based or promising CAN prevention programs for **parents (including expectant parents) at risk of substance abuse**. The council will choose specific programs based on evidence of effectiveness, components included, and current infrastructure to implement the program within the region. Any funded program must include a component **related to parental substance abuse** or be supplemented with such a component. Strategy II's parenting programs are expected to improve social and emotional development in children. This program has the potential to reach approximately 2,560 families within the region.[3]

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[1] See Appendix A

[2] Based on Vital Statistics, CDC-BRFSS, and SACWIS data as well as a literature review and estimated rates of recruitment.

[3] Based on calculations from previous OCTF funding and data from prevention programs.

## Criteria for Funded Programs

Providers will be chosen based on multiple criteria including: ability to cover **multiple counties including rural areas**, commitment to and previous experience with providing **trauma-informed care** with hard-to-reach populations, access to **multiple funding sources** that can be braided with OCTF funds, demonstration of current and previous **community involvement**, commitment and ability to conduct a **gap analysis** of the service area, plans to ensure **parent involvement** in planning and implementing programs, and plans to conduct **outreach activities** to reach target populations in the area.

## Outreach Strategies and Plans for Parent Leadership

GRC will **coordinate a centralized effort** to reach the target populations by producing printed material, billboard and electronic advertisements, radio outreach, social network support, and web support to address the needs of both Strategy I and Strategy II in all CORPC counties. In addition, RFPs for both strategies will contain both **Outreach and Parental Involvement components** that are required to be completed by all vendors providing services through CORPC contracts.

## Evaluation Plans

The evaluation plan for Strategy I will examine outcome data collected through the Protective Factors Survey as well as case notes and other resources. The pilot will be evaluated by studying its success in **strengthening parenting knowledge, improving protective factors for children, increasing safe environments for children**, as well as other measures detailed in the Evaluation Design section.

For Strategy II, GRC will work with each provider to develop evaluation plans that will **describe essential characteristics of the program**, including the number of families who receive awareness information, the number of families served, and the number of families completing the program at different levels of program fidelity, as well as characteristics of the target population.

If possible, both strategies will be evaluated based on an examination of new CPS cases from the State Automated Child Welfare Information System (SACWIS) to determine the strategies' effectiveness in **reducing the number of families for whom reports of child abuse/neglect are filed during the 12-month pilot period.**

## Budget

The CORPC is requesting **$1.5 million** to implement the Central Ohio Regional Prevention Plan. The total cost of strategy I is estimated to be $550,000. Strategy II is budgeted for $900,000. There will be $50,000 set aside for the Regional Prevention Outreach Plan. This request is based, in part, on the proportion of the state's children living in the central Ohio region along with the projection of growth in the child population. Central Ohio currently houses **19.9%** of the state's children. Within the next 5 years, this population is **projected to grow by 3.9%**, while **the remainder of the state's child population will decrease by 1.8%**.

The budget request is also based on the tremendous potential value of the prevention plan. The epidemic of substance abuse is a problem statewide, and agencies have struggled with how to prevent substance abusing families from entering the child welfare system. This cohesive plan serves high risk (Strategy I) and selected (Strategy II) target populations, and the results of the pilot program will be **immediately relevant to prevention efforts statewide**.

# Description of Needs Identified for the Region

## Process for Identifying Unmet Needs

In June 2016, the CORPC convened to begin coordinating child abuse/neglect prevention activities in a 13-county region of central Ohio, including Crawford, Delaware, Fairfield, Fayette, Franklin, Knox, Licking, Madison, Marion, Morrow, Pickaway, Richland and Union counties. CORPC's first major activity was to conduct a needs assessment of the central Ohio region to understand the scope of child abuse/neglect, identify key risk and protective factors, summarize existing prevention resources, and present recommendations for developing a five-year prevention plan.

The needs assessment used a variety of methods, including:

- **Secondary analysis of data** from multiple sources, including the US Census Bureau, Ohio Children's Trust Fund, Ohio Department of Health, Ohio Department of Job and Family Services, Ohio Family Violence Prevention Project, Ohio Department of Education, Ohio Department of Development and the US Health Resources and Services Administration. The needs assessment provided figures for each county and for the 13-county region as a whole.
- An **online survey** of local agency professionals provided information on 43 home visiting programs, 29 parent education programs and 25 other efforts related to primary prevention of child abuse/neglect. Of the 138 people contacted, 97 (70%) completed the survey.
- **Focus groups** with stakeholders in 12 of the region's 13 counties as well as key informant interviews with individual stakeholders in the 13th county. Transcriptions from each focus group were analyzed to identify common themes across the counties.

For more complete information, please refer to the report: *Child Abuse and Neglect in Central Ohio: An Assessment of Needs and Resources*.

## Unmet Needs by Region and County

As a result of the needs assessment, CORPC identified the following needs in the central Ohio region. Given the limited time and resources and the anticipated regionalized approached, findings focused on regional, rather than county-specific, unmet needs. Please refer to the needs assessment report for additional details.

*The heroin/opioid epidemic poses new challenges to prevention*. The ongoing epidemic of heroin and opioids has devastated thousands of families across central Ohio. In particular, substance abuse during pregnancy has been a major source of reports to child protective services. Although county-level data on substance abuse during pregnancy are currently unavailable, it is possible to provide a rough estimate of the number of cases. Nationwide, 10% of women use alcohol or other drugs during pregnancy (see Table 1, column (b)).[4] The prevalence of substance abuse, however, varies from community to community. Using county-level data on fatal

[4] Centers for Disease Control and Prevention. *Behavioral Risk Factor Surveillance System, United States 2011-2013.*

drug overdoses[5] enables us to adjust our estimates of the number of births in each county that are to mothers who abuse substances during pregnancy.

**TABLE 1**. ESTIMATED ANNUAL NUMBER OF BIRTHS TO MOTHERS WHO ABUSE SUBSTANCES IN CENTRAL OHIO

| | Number of births (2014) | Unadjusted estimate of births to mothers who abused substances during pregnancy | Annual rate of overdose deaths per 100,000 | Percentage of annual rate of overdose deaths relative to the regional average | Adjusted annual estimate of births to mothers abusing substances during pregnancy |
|---|---|---|---|---|---|
| | *(a)* | *(b)* | *(c)* | *(d)* | *(b) x (d)* |
| Crawford | 473 | 47 | 16.7 | 88.8% | 42 |
| Delaware | 2,166 | 217 | 7.3 | 38.8% | 84 |
| Fairfield | 1,633 | 163 | 11.1 | 59.0% | 96 |
| Fayette | 341 | 34 | 28.1 | 149.5% | 51 |
| Franklin | 18,742 | 1,874 | 17 | 90.4% | 1,695 |
| Knox | 716 | 72 | 15.1 | 80.3% | 58 |
| Licking | 1,951 | 195 | 13.5 | 71.8% | 140 |
| Madison | 432 | 43 | 15 | 79.8% | 34 |
| Marion | 730 | 73 | 27.3 | 145.2% | 106 |
| Morrow | 367 | 37 | 16.6 | 88.3% | 32 |
| Pickaway | 600 | 60 | 19.4 | 103.2% | 62 |
| Richland | 1,379 | 138 | 18.4 | 97.9% | 135 |
| Union | 601 | 60 | 8.8 | 46.8% | 28 |
| REGION | 30,131 | 3,013 | 18.8 | 100.% | 2,564 |

Based on these figures, we estimate that about 2,560 babies are born in each year in central Ohio to a mother who abused substances during pregnancy. Not only are such children at high risk of child abuse/neglect, but the epidemic also complicates primary prevention efforts. Opiate-addicted parents, for example, may be less able to participate in, or benefit from, parenting classes, home visiting programs, and other prevention efforts.

*Given available resources, no single plan can address every factor that influences child abuse/neglect*. There are so many different influences on child abuse/neglect that a comprehensive plan is impractical given anticipated budget resources. The needs assessment enabled CORPC to focus on risk and protective factors that have three characteristics: (1) are grounded in the research literature and focus group findings; (2) can be reliably measured; and (3) are likely to change as a result of planned activities and programs. The needs assessment refers to these

[5] Ohio Department of Health. 2015 Ohio Drug Overdose Data: General Findings. Columbus, OH: Ohio Department of Health; 2016.

as **"priority outcomes."** CORPC also identified **"contextual factors"** that may confound efforts, yet are likely beyond the ability of CORPC programs to change. It would be too ambitious to try and change every known risk and protective factor, so Strategies I and II from will focus on a limited number that best meet these criteria, while monitoring the contextual factors that might also influence these outcomes (Figure 1).

**Figure 1. Recommended priority outcomes to change and contextual factors to monitor**

| Priority outcomes<br>*(CORPC programs may change in order to reduce child abuse/neglect)* | Contextual factors<br>*(CORPC programs probably will not change, but may still influence child abuse/neglect)* |
|---|---|
| <u>Parents</u><br>• Substance abuse by parents<br>• Nurturing parenting skills<br>• Household rules and child monitoring<br>• Parents' knowledge of children's needs and child development<br>• Parents' thoughts or emotions that justify abusive or neglectful behavior<br>• Parental stress<br>• Percent of mothers not receiving prenatal care in the first trimester<br>• Percent of mothers smoking during pregnancy<br><br><u>Child</u><br>• Percent of births that are low birth weight<br>• Rate of Neonatal Abstinence Syndrome<br><br><u>Family</u><br>• Access to health and social services<br><br><u>Community</u><br>• Public support for child abuse/neglect prevention<br>• Policy-makers support for child abuse/neglect prevention | <u>Parents</u><br>• Rate of Medicaid hospitalizations for alcohol and substance use disorders<br>• Rate of births to teen mothers<br><br><u>Family</u><br>• Percent of children living in households with Supplemental Security Income (SSI), cash public assistance income or SNAP benefits<br>• Percent of households with presence of unmarried partner of householder<br><br><u>Community</u><br>• Percent of households in poverty<br>• Percent of adults who are unemployed<br>• Percent of households that are vacant |

*Contextual factors can be monitored*. It is relatively easy to monitor risk factors like the percent of children living in poverty or adults who are unemployed that can influence child abuse/neglect above and beyond planned prevention efforts. Doing so will enable CORPC to provide a more accurate and useful evaluation of the five-year plan that accounts for the confounding influence of contextual factors.

*Counties vary in their prevention needs*. Across a wide range of indicators (e.g., % of families in poverty; % unemployment; rate of births to teen moms), Crawford, Fayette, Marion and Richland counties report higher than average levels of risk compared to other counties in the region.

*County population size matters*. A county like Delaware may have a low poverty rate, yet its large population may mean that it has more children living in poverty compared to a higher risk (yet smaller) county like Crawford. Also, more than half of the region's children live in Franklin County.

*Central Ohio's population is growing*. Over the next five years, the child population of central Ohio is projected to increase by 3.9%, with the greatest proportional growth in Fairfield, Franklin, Morrow and Pickaway counties. Even if prevention efforts are successful and child abuse/neglect becomes less common, a growing population can result in an increased caseload for child welfare professionals.

## Ability of Current Programs and Activities to Meet Needs

The needs assessment also yielded the following conclusions about available resources related to primary prevention of child abuse/neglect. Please refer to the needs assessment report for additional details.

*Counties have used OCTF funds in very different ways.* Some counties have supported home visiting and/or parent education and/or training of agency professionals.

*OCTF-funded programs have varied widely in their cost per participant*. Expensive programs may be more effective, but not always.

*Each county has a distinct array of programs*. Respondents from 97 programs reported basing their efforts on 36 different "evidence-based" models.

*Nearly every county used one of four evidence-based models*. A range of agencies in 12 counties based their programs on models of *Active Parenting, Healthy Families America, Parents as Teachers* or *Triple P.*

*Programs have a mixed record of engaging special populations*. Agencies have done a good job reaching lower income families, but have had less success with young or first-time parents. Such a focus may help align CORPC's plan with OCTF's emphasis on primary prevention. **Very few efforts, however, have specifically focused on prevention among pregnant, substance-abusing mothers or families at heightened risk of substance abuse.**

*It is impractical to reliably measure each program participation and funding*. Available data on program participation and prevention funding are difficult to summarize and compare across counties, given differences in how programs define "participant" and report their budgets.

# Plan for Prevention Strategies

The CORPC needs assessment found that **stakeholders overwhelmingly cite drug abuse**, especially opiate and opioid addiction, as the primary risk factor for child abuse/neglect. In some central Ohio counties, **up to 85%** of CPS cases are related to substance abuse.[6] In addition to substance abuse, participants also identified mental health issues, poverty, intergenerational parenting issues (e.g., cycle of abuse or neglect), and a lack of knowledge relative to parenting as main causes of child abuse/neglect.

The growing epidemic of heroin and opioids has devastated thousands of families across central Ohio. And abuse of other substances (e.g., marijuana, methamphetamines) during pregnancy can be even more common. Not only does such substance abuse **increase the likelihood of child abuse/neglect**, but the epidemic also complicates primary prevention efforts. Opiate-addicted parents, for example, may be less likely to participate in, or benefit from parenting classes, home visiting programs and other prevention efforts.

The epidemic of parental substance abuse also exacts a tremendous economic toll. A 2013 study[7] found that the average hospital stay for an Ohio newborn with Neonatal Abstinence Syndrome (NAS) can approach $60,000. Ohio has already spent well over $70 million on NAS, with Medicaid being the primary payer source for 85% of NAS discharges.[4] With over 400 cases of NAS in central Ohio each year,[8] averting just 30 such cases would equal $1.5 million in medical cost savings alone. Moreover, **virtually all NAS cases are automatically screened-in to CPS.**[9]

## Developing a plan

CORPC recognizes that, without very significant resources, no plan can address every factor that influences child abuse/neglect. Given this, several recommendations were made in the needs assessment to serve as a foundation for the prevention plan. Some of those key **recommendations** are:

- **Reduce the number of reports of child abuse/neglect per year**. This should focus on the number of new reports –those involving families who had not previously entered the child welfare system.
- **Consider targeted prevention approaches for families with a drug-addicted parent**. CORPC should consider prevention efforts that work with families struggling with addiction before maltreatment occurs. One approach may involve support to pregnant women struggling with addiction or with parents at heightened risk of substance abuse.

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[6] Based on internal county case data reviews.
[7] Massatti R, Falb M, Yors A, Potts L, Beeghly C, Starr S. Neonatal abstinence syndrome and drug use among pregnant women in Ohio: 2004-2011. Columbus, OH: Ohio Department of Mental Health and Addiction Services; 2013.
[8] Figure based on 30,131 births in central Ohio and an annual incidence of 13.4 per 10,000 births. See: Ohio Department of Health. *Neonatal Abstinence Syndrome (NAS) in Ohio: 2004-2014 Report*. Columbus, OH: Ohio Department of Health; 2016.
[9] Ohio's Child Protective Services Worker Manual and CAPMIS Field Guides: Ohio Department of Job and Family Services Office for Children and Families. Available at: http://jfskb.com/sacwis/attachments/article/508/CPS%20Manual%20and%20CAPMIS%20Field%20Guides%2010-2-14.pdf.

- **Focus on a limited number of programs and activities**. These should align with priority outcomes, and should have a successful track record of implementation in central Ohio. Nonetheless, CORPC should also consider novel, promising approaches that may fit the Central Ohio Region.

Given the findings and recommendations highlighted above, CORPC is proposing to focus on a **limited number of programs and activities** organized around **two complementary, innovative strategies** to reach families struggling with, and at heightened risk for, substance abuse. Funding for planning and implementation of the both strategies is included in the initial 18-month CORPC funding request. Both strategies meet the OCTF mission "to prevent child abuse and neglect through investing in strong communities, healthy families and safe children."

## Strategy I

To reach pregnant women struggling with substance abuse, CORPC proposes **supplemental care coordination to boost parental substance abuse services in the region**. The CORPC will pilot a team-based healthcare delivery model (hereafter referred to as "the pilot") based in part on the MOMS program[10], which includes clinical components such as medication assisted treatment (MAT) and behavioral health care with an emphasis on care coordination and wrap-around services; specifically, the engagement of expecting mothers in a combination of counseling and case management. The model will include non-clinical services such as housing, transportation, early childhood education services, peer supports, recovery coaches, parenting coaches, and other identified support services. **OCTF funding would not be used for clinical treatment services, but rather for the care coordination, non-clinical, and wraparound services so critically important to success.**

The pilot is expected to improve the lives of children in multiple ways, including lowered likelihood of experiencing CAN, improved family lives due to the elimination of parental drug use, a higher likelihood of kinship care due to pre-planning with Child Protective Services (CPS), as well as faster reunification rates in the event of CPS involvement. It is estimated that this program has the potential to reach **approximately 146 mothers** within the region.

Identifying and recruiting these women will require close collaboration with health care providers and CPS. Doctors routinely contact CPS during a mother's pregnancy when they have a suspicion that there is substance abuse or when the expecting mother screens positive for substances. However, representatives from CORPC report that CPS typically only handles such information as documentation in the SACWIS system and does not even make the unborn child a "child subject" in the report. In many of these instances, the medical professional does not even let the expecting mother know they have contacted CPS. In order to provide more comprehensive wraparound services, the Central Ohio region would include **evidence-based or promising parenting modules** to increase knowledge of child development, positive parenting practice, and positive social supports for mothers, making sure programs cover parental substance abuse prevention. This may involve programming that is currently in place in the counties which contains a parental substance abuse prevention component, or it may be another evidence-based program supplemented with a substance abuse component. Unlike previous efforts to

[10] See appendix

serve this population, a key measure of success will be to **prevent these families from entering the child welfare system**.

To implement a project as innovative and targeted as the pilot in the region, CORPC recommends a significant **planning time of six months to a year**. Key service providers and program partners within the region such as psychiatrists, neonatologists, addiction and recovery support, social service agencies, child welfare departments, public assistance, hospital administration, local health departments and others would need to be engaged and educated.

Strategy I will focus on the following **OCTF Strategic Planning goals and strategies**:

**Goal 1**: Educate and empower communities (**Strong Communities**)

1. Increase capacity within communities to support the needs of children and families by implementing effective early childhood development and family strengthening strategies.
    - *Parent education*
    - *Care coordination and wrap-around services*
2. Increase the awareness, understanding and promotion of protective factors while reducing risk factors that contribute to child maltreatment.
    - *Parent education*
4. Increase availability of cost effective, evidence based and/or evidence informed programs and practices statewide.
    - *Introduces a new CAN prevention option for families affected by substance abuse*

**Goal 2**: Strengthen Families (**Healthy Families and Safe Children**)

1. Promote the healthy growth and development of children.
    - *Parent education*
    - *Care coordination and wrap-around services (e.g., housing)*
2. Increase awareness, understanding and promotion of protective factors to reduce the risk factors that contribute to child maltreatment.
    - *Parent education*
3. Ensure families and children are linked with concrete solutions to temporary challenges.
    - *Care coordination and wrap-around services (e.g., housing)*

**Goal 4**: Create and maintain a strong OCTF infrastructure (**money, people, processes and outcomes**)

1. Invest in qualitative and quantitative research to promote evidence informed practice.
    - *Evaluation will be conducted on pilot to determine effectiveness*
2. Invest in Continuous Quality Improvement.
    - *Changes will be made to the program as data become available*

## Strategy II

In order to engage a broader range of families during the pilot program period, CORPC will implement evidence-based or promising CAN prevention programs for parents (including expectant parents) **at risk of substance abuse**. This represents a departure from previous efforts, few if any of which specifically targeted parents at heightened risk substance abuse. The RFP process will ask applicants to specify exactly how they will identify and recruit this population.

The council will choose specific programs based on evidence of effectiveness, components included, and current infrastructure to implement the program within the region. Widely used models that are currently being employed within the region will be considered; however, the Council will also consider newer, innovative approaches that also meet the funding criteria. Regardless, any funded program must include a component **related to parental substance abuse** or be supplemented with such a component.

Based on counties previous experiences OCTF-funded parent education programs, this program has the potential to reach approximately 2,560 families in all 13 counties.

Strategy II will focus on the following **OCTF Strategic Planning goals and strategies**:

**Goal 1**: Educate and empower communities (**Strong Communities**)

1. Increase capacity within communities to support the needs of children and families by implementing effective early childhood development and family strengthening strategies.
    - *Parent education*
    - *Outreach*
2. Increase the awareness, understanding and promotion of protective factors while reducing risk factors that contribute to child maltreatment.
    - *Parent education*
    - *Outreach*
3. Increase awareness of the negative impact child maltreatment has on a community and state as a whole.
    - *Outreach*
4. Increase availability of cost effective, evidence based and/or evidence informed programs and practices statewide.
    - *Fund evidence based and promising programs that reach across county lines to improve efficiency*

**Goal 2**: Strengthen Families (**Healthy Families and Safe Children**)

1. Promote the healthy growth and development of children.
    - *Parent education*
    - *Outreach*

2. Increase awareness, understanding and promotion of protective factors to reduce the risk factors that contribute to child maltreatment.
    - *Parent education*
    - *Outreach*
3. Ensure families and children are linked with concrete solutions to temporary challenges.
    - *Parent education*
    - *Outreach*

# Criteria for Funded Programs and Target Populations

## Criteria for Developing, Selecting, and Funding Evidence-Informed or Evidence-Based Programs and Activities

The specific programs and activities for Strategies I and II will be determined through an RFP process. CORPC will choose which programs are eligible for areas of the region based on the target populations served and components included. Any funded program **must include a component related to parental substance abuse** with the expectation that fewer families will enter the child welfare system as a result of substance abuse.

Given the correlation between past traumatic experiences and mental illness/substance use[11], each RFP will require the use of **trauma-informed care**. This will help ensure the best outcomes for women and the families of women who have been negatively impacted by past traumas. In particular, applicants will need to demonstrate that their programming:

- Provides for the holistic needs of participants,
- Takes into account the views and preferences of the program participant, and
- Trains all staff interacting with participants on the signs, symptoms, and results of trauma and how best to help someone who has a history of trauma.

Given the switch from county to regional planning, applicants for Strategy II should have the ability and willingness to **serve multiple counties including rural counties**.[12] Those who can demonstrate past multi-county project successes and experience will be given preference. Minimizing the number of grantees presents the possibility of benefiting from economies of scale.

The success of the program depends on continued participation and service provision for the participants. Preference will be given to those providers that can **identify and access non-OCTF funding that can be braided with OCTF funds**, if needed, to provide seamless coverage for participants such as those women who have been a part of a pilot program, but become ineligible for OCTF funding. Providers with the ability to blend funding will also have to show how duplication of coverage will be prevented.

Each applicant must include a **gap analysis** as part of their proposal. As part of this requirement, the applicant will need to show that they have a staff member who thoroughly understands the safety net systems in the counties they propose to serve and how these systems fit together. Current or previous successful relationships with local agencies and providers will be considered in scoring.

Responses must outline how providers will **involve parents** in the planning and implementation of programs. This requirement may be satisfied by including parents as part of focus groups, implementing a parent council, or creating an implementation team with parent representatives.

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[11] Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults Felitti, Vincent J et al. American Journal of Preventive Medicine , Volume 14 , Issue 4 , 245 - 258

[12] Counties participating in Strategy I will be selected based on their interest and readiness to implement the program.

In order to determine how easily an applicant can move into a community and successfully start a program, the RFP will request information on whether the applicant is **currently involved in the community** and how this is a benefit for the program. In particular, providers must demonstrate their capacity to provide the community with information related to the program resources as listed in the RFP. Relationships with schools, churches, law enforcement, child services, Family and Children First Councils, housing organizations, OB/GYNs, and Managed Care Plans will be considered beneficial. Demonstrating effective relationships with local mental and behavioral health organizations (e.g., ADAMH Boards) will be particularly important.

Providers will be required to outline and implement **outreach activities** for their programs, based on consistent outreach components listed in the RFP. This includes leveraging existing community organizations and relationships to disseminate resources to and educate pregnant and parenting mothers who are abusing substances.

## Target Population and Projected Numbers

### Strategy I

Strategy I will focus on counties in the Central Ohio region that have about 4,000 total births during the nine months when participants will be recruited. As shown in Table 2 below, it is estimated that, of all births in these pilot counties, approximately 10% (400) will have abused substances during pregnancy, of whom 327 will not have had prior involvement with the child welfare system. CORPC anticipates being able to identify and recruit half of these women, and retain 89% in the program until birth, resulting in a final cohort of (327*.50*.89=) **146 mother/child dyads**.

**TABLE 2:** PARAMETERS FOR ESTIMATING PROJECTED NUMBERS FOR STRATEGY 1

| Parameter | Count | Percent | Source(s) |
|---|---|---|---|
| (a) Number of births in a six-month period | 4,000 | 100% | Ohio Vital Statistics |
| (b) Births to mothers who abused substances during pregnancy | 400 | 10% | CDC – BRFSS |
| (c) Women in (b) with no prior CWS involvement | 327 | 82% | SACWIS, ODH, Census |
| (d) Women in (c) that program can identify and recruit | 163 | 50% | CORPC estimate |
| (e) Women in (d) that complete program | 146 | 89% | Wilder et al., 2015[13] |

With a budget of $550,000 this would represent **a cost of $3,767 per dyad**. In comparison, in the absence of Strategy 1 (along with non-OCTF-funded clinical services) it is likely that many of these 146 mother-child dyads would be entering the child welfare system. Many of the newborns, for example, would test positive for

[13] Wilder C, Lewis D, Winhusen T. Medication assisted treatment discontinuation in pregnant and postpartum women with opioid use disorder. *Drug Alcohol Depend*. 2015 Apr 1;149:225-31.

substances at birth, resulting in an automatic screen-in. Others may be identified in reports from day care providers, physicians, neighbors and others in the months following birth.

The figures in table 2 represent the best available current data. Nonetheless, CORPC plans to refine them in the coming weeks as more data become available. Sensitivity analysis (i.e., comparing "best case" and "worst case" scenarios) will help in optimizing the program's feasibility and potential cost effectiveness.

## Strategy II

In addition to the pilot program, CORPC will develop a competitive RFP process to solicit approaches for reaching families at risk of substance use and child abuse/neglect who have not yet been in the child welfare system through additional evidence-based **parenting classes containing a parental substance abuse component.** Based on calculations from previous OCTF funding and data from prevention programs, the CORPC Prevention Plan has the potential to serve as many as 2,560 families in a 12 month period through multiple programs serving multiple counties in the region.

# Outreach Activities for Special Populations and Region

The goal of the CORPC outreach is to **educate pregnant and parenting mothers who are abusing substances as well as their families and their community support networks** about child abuse and neglect prevention services available in the region. The outreach plan will utilize community-based partners to develop a coordinated **word-of-mouth approach** to connect the targeted population with resources that are imperative to achieving healthy and positive parenting.

By empowering existing community organizations and family supports, the outreach effort will provide a sense of ownership of the prevention project, and motivate them to encourage friends, family, and colleagues to spread the word among their networks. The goal is to i**ncrease awareness and provide support** from all parts of the community for pregnant and parenting mothers who are abusing substances.

Through a competitive RFP process, providers will be required to outline a comprehensive outreach plan that **supports and enhances existing outreach** for their evidence-based parenting modules. Components of an outreach plan should include traditional messaging and referral strategies that are already occurring in the evidence-based parenting module, such as child development, positive parenting practice, and positive social supports for mothers. Additional components of the outreach plan must now include connecting the targeted population with substance abuse treatment resources.

Providers must list a plan to **coordinate message dissemination** to the community-based partners who are integral to reaching the targeted population. Partners include, but are not limited to, child welfare organizations, faith based communities, social workers, obstetricians, local health departments, law enforcement, libraries, and schools. These community-based partners must receive consistent messaging and outreach materials in order to build trust and provide and support child abuse and neglect prevention services to the target population.

Providers must **monitor and report the number of people who receive awareness information** at coordinated events, trainings, or after contact with a resource provider. Additionally, CORPC members will track the number of participants at local April Awareness Month events. Finally, GRC will track the coordinated print and electronic media campaign. Social media metrics will gauge interest and measure interactions.

Existing evidence for using community outreach to reach families affected by substance abuse shows that successful campaigns start using word-of-mouth marketing, ensuring that the targeted population is first approached by people they know and trust. Thus, providers must demonstrate how their outreach will ensure the building of **trusting, non-judgmental relationships** that encourage the targeted population to get treatment and stay in treatment. Applicants must provide evidence about how the power of community-based message coordination and a word-of-mouth resource-sharing campaign will prevent child abuse and neglect within the targeted population.

Outcomes of the outreach activities will be measured on the increased awareness of the role of substance abuse in child abuse and neglect. Specifically, CORPC will measure the number of local news stories focusing on the issue in the Central Ohio news broadcast, print, and electronic media outlets. Increased awareness of child abuse

and neglect prevention strategies will also be measured by the number of individuals attending outreach events and receiving prevention information.

# Plan for Parent Leadership and Involvement

Parent leadership and involvement will be crucial to CORPC's prevention efforts. Their insight and first-hand experiences will **ensure the efficacy and effectiveness** of the proposed plan. Applicants should utilize this insight and experience by involving parents who have successfully completed substance abuse treatment and have maintained a substance abuse free lifestyle for at least six months. Applicants can recruit these parents through the substance abuse treatment centers found in their local community. Applicants should involve these parents in the planning process, as their feedback can help guide recruitment strategies for the pilot and ensure the project stays focused on successful elements of their own substance abuse treatment plans. Further, they will offer important insight into areas that were lacking during their own substance abuse treatment experience to improve the current pilot. Community trust is an effective means of recruiting difficult to reach or stigmatized populations such as substance abusing pregnant women and mothers. Involving former substance abusing parents in the recruitment process can help with participant buy-in.

Applicants will ensure parent participation in existing, non-pilot site parenting programs by engaging them during the **coordinated outreach campaign**. This includes the **surveying of mothers** for feedback related to their prenatal and postnatal experience with community supports and brand recognition.

CORPC will also request that providers make **peer-to-peer support**, specifically involving former substance abusing women who successfully completed treatment during pregnancy, available to participants of the OCTF funded programs in order to increase the likelihood of success in preventing or treating substance abuse and addiction.

# Evaluation Plans

GRC will work with each selected provider to develop realistic evaluation plans that will describe essential characteristics of the program, including the number of families reached and served, the number of families completing the program at different levels of program fidelity, as well as characteristics of the target population. If possible, GRC will also assess the number of families for whom reports of child abuse/neglect are filed during the 12-month pilot period.

Evaluation of the pilot program will include both process and outcome measures. Evaluation plans for both Strategy I and Strategy II will be organized around the same process questions.

## Process

CORPC's efforts to assess how well the program is implemented will be organized around four questions.

1. **How many eligible participants is the program able to identify?** Other data (see Target Population and Projected Numbers) may provide a rough estimate of the total number of individuals potentially eligible for each program. However, given the challenges of reaching these populations, it is unrealistic that CORPC will be able to identify all eligible individuals. Understanding this figure can help in assessing the success of outreach efforts.
   Measure: Staff record basic information, including name, address, race, age, number of children, marital status, any substance(s) used, Medicaid status for every woman directly contacted by the program. In addition, staff will record how the participants learned about the program.

2. **How many eligible individuals agree to participate?** Of the eligible individuals identified, the percent who agree to participate will be determined. Understanding this figure can help in assessing the extent to which the programs are engaging the target populations. If, for instance, many identified individuals decline to participate, characteristics of the program or criteria for participation may need to be revised.
   Measure: Signing a consent form to participate in the program (and for IRB purposes) will represent a person's willingness to participate.

3. **How many participating women complete the program?** Especially when working with a high-risk population, it is critical to document how many participants drop out of the program. For Strategy I, program completion will be defined differently for each participant depending on the range of services she needs, seeks and accesses. Understanding this figure can help in assessing whether the program has unrealistic expectations of, or imposes excessive burdens on participants. Moreover, such information will help determine those needs each program is best positioned to address.
   Measure: A robust electronic record on each participant will document contact with the range of service providers. Detailed data-sharing agreements with participating service providers (with the consent of the participant) will enable the care coordinator to record the date and type of each

participant's every contact with each service provider. This will also include missed appointments and significant milestones (e.g., initiating MAT, completing a parenting education module).

4. **Do OCTF-funded services integrate well with other (non-OCTF-funded) services used by participants?** Given the acute needs of participants, it is important that OCTF-funded efforts not interfere with other services already being offered. For Strategy I, it will be particularly important to consider how care coordination and parent education efforts align with mothers' treatment for addiction.
   Measures: Semi-structured key informant interviews will be conducted with care coordinators and different types of service providers from multiple sites to identify both challenges and successes in this area. In addition (and if possible), a focus group of participants will be conducted to understand their experiences and react to the challenges and successes identified in the key informant interviews.

## Outcomes

For both strategies, the central outcome is the reduction in the number of new (i.e., a family that has not previously been in the child welfare system) **reports of child abuse/neglect to child protective services in which parental or caregiver substance use is a current concern**. In October 2016, SACWIS recently added this as a mandatory field, so six months of data collection during the project planning period (January -June 2017) and another 3 months during the beginning of the implementation phase before any births occur (July-September 2017) will enable CORPC to establish a baseline trend and benchmark rate of reports.

Based on anecdotal reports from CORPC members, it is likely that the rate of these reports will be increasing throughout the benchmark period as the opiate/opioid epidemic continues to grow. For this reason, CORPC will assess changes in the growth (i.e., slope) of relevant reports across the benchmark period and observation periods. Because of the steep incline of cases related to substance abuse, a successful program may not necessarily reduce the number of reports, but may only slow the rate of increase in these reports.

Ideally, CORPC will be able to follow individual program participants and identify whether they are involved in a new report of child abuse/neglect. This will require a careful data-sharing agreement with Ohio Department of Job and Family Services (ODJFS) and the SACWIS system. CORPC looks forward to working with OCTF to try and make this happen. If it is not possible, CORPC will assess success by changes in the growth of the rate of all new reports in each county.

As a result of the proposed strategies, **relationships will be strengthened** between child welfare agencies (CWA) and those addressing mental health, substance abuse, poverty, and other social services. Agencies will be educated and engaged on the CORPC prevention programs. This will create opportunities to prevent automatic screen-ins of mothers currently in treatment and allow for relationship building between the consumers and providers of services.

Three quarters of parents participating in CORPC-funded programs will be expected to **gain measurable knowledge in parenting and child development topics** including behaviors that promote healthy child and

family well-being, build protective factors and reduce risk factors in families, and emphasize the importance of children's social and emotional development. As a product of improved knowledge, parents are expected to **engage in behavior changes** that result in increases in natural positive supports, behaviors designed to build protective factors.

For Strategy I, additional expected outcomes include an increase in safe environments for children and an improvement in protective factors for children. Due to the unique nature of the pilot, the program will aim to have 75% of the participants receiving recommended prenatal care and beginning substance abuse treatment, which is expected to reduce the growth in Neonatal Abstinence Syndrome (NAS).

Strategy II's parenting programs are also expected to improve social and emotional development in children.

**See Table 3 below for detail on outcomes, the strategies that aim to change them, as well as how the evaluation plan will measure them.**

**TABLE 3:** PILOT PROGRAM OUTCOMES

| Strategy | | Outcome | How measured | Observation period |
|---|---|---|---|---|
| I | II | Parental knowledge of behaviors that promote healthy child and family well-being | Protective Factors Survey | June 2017 – June 2018 (varies by program) |
| I | II | Parental knowledge of building protective factors and reducing risk factors in families | Protective Factors Survey | June 2017 – June 2018 (varies by program) |
| I | II | Parental knowledge of the importance of children's social & emotional development | Protective Factors Survey | June 2017 – June 2018 (varies by program) |
| I | | 75% of pregnant women entering the program, will receive recommended pre-natal care | Case note review | July 2017 – June 2018 |
| I | | 75% of recruited participants begin substance abuse treatment | Case note review | July 2017 – March 2018 |
| I | II | Increase in natural positive supports | Case note review; Protective Factors Survey | July 2017 – June 2018 |
| I | II | Increase in behaviors designed to build protective factors | Case note review; Protective Factors Survey | July 2017 – June 2018 |
| I | | Increase in safe environments for children. | Case note review; Protective Factors Survey | July 2017 – June 2018 |
| | II | social and emotional development in children. | Protective Factors Survey | July 2017 – June 2018 |
| I | | Improve protective factors for children | Case note review; | July 2017 – June 2018 |
| I | II | Decrease first-time reports to child protective services for which parental or caregiver substance was noted as a reason for referral | SACWIS | October 2017 – March 2018 (compared to benchmark period of January – June 2017) |
| I | | Reducing the growth in Neonatal Abstinence Syndrome | screening results from selected sentinel hospital | October 2017 – June 2018 (compared to benchmark period of January – June 2017) |
| I | II | Among participants, decrease substance abuse by xx% percent | Case note review; toxicology screening at birth | October 2017 – June 2018 (compared to benchmark period of January – June 2017) |

# Evaluation Design

## Strategy I

Strategy I will employ a complex evaluation design, as women will be recruited at different points during their pregnancy and, depending on when they give birth, will be followed for different periods after they give birth. When recruitment begins in July 2017, for example, some mothers will be expected to give birth as early as October 2017 or as late as March 2018 (the project only recruits women during their first or second trimester). Figure 2 illustrates how the observation periods for different outcomes will vary for each mother, depending on when she is recruited and when she gives birth. Cohort *z*, for example, includes women recruited in December 2017 and giving birth in April 2018. Figure 2 shows that those women will be observed for roughly 4 months of prenatal outcomes during their prenatal period and two months of postnatal outcomes after they give birth.

Such information will be critical for employing the appropriate statistical models and for estimating how the available observation periods affect the probability of detecting whether the program is truly improving outcomes. If, for example, it is determined that 6 months is the minimum period of time for following mother/child dyads after birth to observe if they enter the child welfare, then Figure 2 indicates that only 6 cohorts (*a,b,c,d,e* and *f*) will provide sufficient data for that particular outcome.

## Strategy II

For Strategy II, the pre/posttest design is more straightforward. It is anticipated that providers will implement programs from June 2017 to May 2018. Within each funded program, providers will be required to use the Protective Factors Survey to collect pretest and posttest data on the relevant outcomes listed in the logic model. In order to promote comparability across different programs, a common, standard period between pre and posttest results (e.g., 6 months) will be determined. Analyses will consider how dropping out of the program may bias differences between pre and posttests.

If possible, GRC staff will also seek to work with SACWIS data to tally the number of participating families who end up entering the child welfare system, especially for those for whom substance abuse is a reason for referral.

**Figure 2. Strategy I pilot observation periods for different types of outcomes, July 2017 – June 2018**

| | 2017 | | | | | | 2018 | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | J | A | S | O | N | D | J | F | M | A | M | J | *Cohort* | *Key* |
| For births October 2017 | p | p | p | B | x | x | x | x | x | x | x | x | *a.* | p = *prenatal* |
| For births November 2017 | p | p | p | p | B | x | x | x | x | x | x | x | *b.* | *outcomes* |
| | | p | p | p | B | x | x | x | x | x | x | x | *c.* | *measured* |
| For births December 2017 | p | p | p | p | p | B | x | x | x | x | x | x | *d.* | *(e.g., utilization of* |
| | | p | p | p | p | B | x | x | x | x | x | x | *e.* | *recommended* |
| | | | p | p | p | B | x | x | x | x | x | x | *f.* | *prenatal care)* |
| For births January 2018 | p | p | p | p | p | p | B | x | x | x | x | x | *g.* | |
| | | p | p | p | p | p | B | x | x | x | x | x | *h.* | |
| | | | p | p | p | p | B | x | x | x | x | x | *i.* | B = *birth outcomes* |
| | | | | p | p | p | B | x | x | x | x | x | *j.* | *measured* |
| For births February 2018 | p | p | p | p | p | p | p | B | x | x | x | x | *k.* | *(e.g., NAS)* |
| | | p | p | p | p | p | p | B | x | x | x | x | *l.* | |
| | | | p | p | p | p | p | B | x | x | x | x | *m.* | |
| | | | | p | p | p | p | B | x | x | x | x | *n.* | x = *postnatal* |
| | | | | | p | p | p | B | x | x | x | x | *o.* | *outcomes* |
| For births March 2018 | p | p | p | p | p | p | p | p | B | x | x | x | *p.* | *measured* |
| | | p | p | p | p | p | p | p | B | x | x | x | *q.* | *(e.g., [lack of]* |
| | | | p | p | p | p | p | p | B | x | x | x | *r.* | *involvement with* |
| | | | | p | p | p | p | p | B | x | x | x | *s.* | *child welfare* |
| | | | | | p | p | p | p | B | x | x | x | *t.* | *system)* |
| | | | | | | p | p | p | B | x | x | x | *u.* | |
| For births April 2018 | | p | p | p | p | p | p | p | p | B | x | x | *v.* | |
| | | | p | p | p | p | p | p | p | B | x | x | *w.* | |
| | | | | p | p | p | p | p | p | B | x | x | *x.* | |
| | | | | | p | p | p | p | p | B | x | x | *y.* | |
| | | | | | | p | p | p | p | B | x | x | *z.* | |
| | | | | | | | p | p | p | B | x | x | *aa.* | |
| For births May 2018 | | | p | p | p | p | p | p | p | p | B | x | *bb.* | |
| | | | | p | p | p | p | p | p | p | B | x | *cc.* | |
| | | | | | p | p | p | p | p | p | B | x | *dd.* | |
| | | | | | | p | p | p | p | p | B | x | *ee.* | |
| | | | | | | | p | p | p | p | B | x | *ff.* | |
| | | | | | | | | p | p | p | B | x | *gg.* | |
| For births June 2018 | | | | p | p | p | p | p | p | p | p | B | *hh.* | |
| | | | | | p | p | p | p | p | p | p | B | *ii.* | |
| | | | | | | p | p | p | p | p | p | B | *jj.* | |
| | | | | | | | p | p | p | p | p | B | *kk.* | |
| | | | | | | | | p | p | p | p | B | *ll.* | |
| | | | | | | | | | p | p | p | B | *mm.* | |

# Logic Model

| Inputs | Outputs | | Outcomes | | |
|---|---|---|---|---|---|
| | *Activities* | *Participation* | *Short* | *Medium* | *Long* |
| **Funding:**<br>• OCTF<br><br>**Staff:**<br>• Council members<br>• GRC Administrative Support<br><br>**State support:**<br>• 7 other regional prevention councils<br>• OCTF staff<br>• OCTF board<br><br>**Partners:**<br>• OB/GYN<br>• Child welfare<br>• Mental health<br>• Substance abuse (ADAMH)<br>• Public health<br>• Early education/schools<br>• Pediatricians/health care providers<br>• COHHIO (homeless coalition)<br>• Medicaid<br>• Law enforcement | Conduct a comprehensive needs assessment related to child maltreatment prevention.<br><br>Provide evidence-based and promising programs and strategies which prevent child abuse and neglect.<br><br>• Pilot program in 2 sites that provides case management, wraparound, and parenting services<br>• Other promising parenting programs in the rest of the region that contain a parent substance abuse component<br><br>Increase awareness of child maltreatment prevention and enhancing child wellbeing<br><br>Identify community partners for purposes of "warm hand offs" for pilot program for mothers who become ineligible for the program (e.g., child welfare involvement; absence of funding for MAT, counseling).<br><br>Evaluate and monitor funded programs and activities | OSU partners, with input from CORPC<br><br>Pregnant and parenting mothers who are abusing substances with no prior substantiated case of child maltreatment with child protective services.<br><br>Pregnant and parenting mothers who are abusing substances or have a partner who is abusing substances with no prior substantiated case of child maltreatment with child protective services.<br><br>Community leaders and any organization that serves pregnant and parenting mothers who are abusing substances<br><br>Pregnant and parenting mothers who are abusing substances, their families, and their support networks.<br><br>Local funded providers<br><br>OSU partners, with input from CORPC | **System Level**<br>Collaborate with child welfare agencies to inform them of the pilot program<br><br>Collaborate with mental health, substance abuse, poverty, and other social services agencies to inform them of the pilot program<br><br>**Community Level**<br>Increase awareness of the role of substance abuse in child abuse and neglect as measured by the number of local news stories focusing on the issue in the Central Ohio news broadcast, print, and electronic media outlets.<br><br>**Family/Child Level**<br>Based on pre/posttest measures, 75% of participants will gain additional parental knowledge of:<br>• behaviors that promote healthy child and family well-being;<br>• building protective factors and reducing risk factors in families;<br>• the importance of children's social & emotional development by 25% as indicated by Protective Factor Survey (PFS).<br><br>75% of pregnant women entering the program will receive recommended pre-natal care as indicated by case notes.<br><br>75% of participants become involved in substance abuse treatment as indicated by case notes. | **System Level**<br>Explore opportunities to prevent an automatic screen-in for mothers who are involved in the pilot.<br><br>Form collaborative partnerships with mental health, substance abuse, poverty, and other social services providers for wraparound services as indicated by minutes and sign in sheets at community partner meetings. 50% of partners with MOUs attending meetings.<br><br>**Community Level**<br>Increase community involvement in CAN and substance abuse prevention and treatment as measured by the number of outreach efforts targeting potential community referral sources- early childhood education/schools, family, friends, neighbors, churches, food pantries, etc.<br><br>**Family/Child Level**<br>In 75% of participants, behavior changes:<br>• Increase in natural positive supports.<br>• Increase in behaviors designed to build protective factors.<br>• Increase in safe environments for children.<br>• Improve social and emotional development in children.<br>• Improve protective factors for children as indicated by case notes. | **System Level**<br>Meaningful and effective relationship with local child welfare agencies indicated by regular contact regarding the pilot as measured by KI interviews with stakeholders<br><br>Meaningful and effective relationship with local child welfare agencies indicated by regular "warm hand offs" for families who become involved in child welfare, and regular contact regarding wraparound services.<br><br>**Community Level**<br>Decrease the rate of growth in number of first-time reports to child protective services for which parental or caregiver substance was noted as a reason for referral as indicated by SACWIS.<br><br>Reducing the growth in Neonatal Abstinence Syndrome as indicated by screening results from selected sentinel hospitals.<br><br>**Family/Child Level**<br>Among participants, decrease substance abuse by 75% percent as indicated by case notes. |

3/28/2017

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Ohio Children's Trust Fund
Central Ohio Regional
Prevention Council

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Kristen Rost
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Dear Ms. Rost:

Thank you for the opportunity to clarify several items within the Ohio Children's Trust Fund Central Ohio Regional Prevention Council's (CORPC) Prevention Plan.

We understand that additional clarity is needed related to Strategy 2 and its uniqueness compared to previous efforts. Strategy 2 is innovative in three respects:

(1) Strategy 2 focuses programming on families at higher risk for substance abuse. In the past, programs tended to serve lower risk families that were easier to reach, but were less likely to benefit from the program. Given the current opiate epidemic in the State of Ohio, this target population is a critical population for making meaningful change related to child maltreatment prevention.

(2) Strategy 2 emphasizes producing *measurable* changes that OCTF is likely to be able to detect. In previous years, each funded program often handled its own evaluation. As a result, small sample sizes and lack of adequate resources limited the ability to see change. The internal CORPC project team is building an evaluation plan that involves the use of the Protective Factors Survey in all projects to evaluate outcomes, compare results, and allow for improvement. CORPC will then have the ability to make informed decisions during the next program planning cycle and to improve the services provided to families and children in Central Ohio.

(3) Strategy 2 coordinates a limited number of prevention efforts across multiple counties. Unlike in previous years when each county pursued its own programming, CORPC will work with a limited number of vendors (perhaps 3-4) across all 13 counties in the region.

Doing so create will opportunities for economies of scale by sharing training and other resources as well as creating a community of learning across the counties.

Also, attached please find a revised budget per our discussion on March 21. The following items were addressed:

- **Strategy 1:**
  - Clarification and more detailed breakdown of the following:
    - Personnel, rates, and evaluation costs;
    - Travel costs and allowable rate;
    - Utilities and rent in the Other category.
- **Strategy 2:**
  - Clarification and more detailed breakdown of the following:
    - Personnel, rates, and evaluation costs;
    - Travel costs and allowable rate.
- **Outreach Plan:**
  - Clarification and more detailed breakdown of the following:
    - Radio expenses.
- **Overall:**
  - Clarification of parent participation funding requests.

Please don't hesitate to contact us with additional questions, concerns, or comments. Hilary Metelko Rosebrook, OCTF CORPC Project Manager, can be contacted at 614-688-9292 or Hilary.Rosebrook@osumc.edu.

Sincerely,

Heather Reed

**Heather Reed Robinson**
Healthcare Access Program Director
Government Resource Center

Attachments: March OCTF CORPC Prevention Plan Budget Revision VF.pdf

2/28/2017

Ohio Children's Trust Fund
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**Dear Ms. Rost:**

Thank you for the opportunity to clarify several items within the Ohio Children's Trust Fund Central Ohio Regional Prevention Council's (CORPC) Prevention Plan. Below please find additional information per your request:

- **Strategy 2**:
    - Funded programs must employ evidence-based, evidence-informed, or promising practices that address up to five key outcomes to be evaluated using the Protective Factors Survey:
        - *Required:*
            - Family Functioning/Resiliency: Having adaptive skills and strategies to persevere in times of crisis. Family's ability to openly share positive and negative experiences and mobilize to accept, solve, and manage problems.
            - Child Development/Knowledge of Parenting: Understanding and utilizing effective child management techniques and having age-appropriate expectations for children's abilities.
            - Concrete Support: Perceived access to tangible goods and services – especially substance abuse treatment – to help families cope with stress, particularly in times of crisis or intensified need.

        - *Optional:*
            - Social Emotional Support: Perceived informal support (from family, friends, and neighbors) that helps provide for emotional needs.
            - Nurturing and Attachment: The emotional tie along with a pattern of positive interaction between the parent and child that develops over time.
    - Applications that propose addressing additional outcomes will be viewed favorably, so long as the plan includes a realistic approach to attracting and retaining higher risk caregivers in the program.

- **Budgets**:
    - An updated budget is attached with revisions to include additional funding for a thorough evaluation of the programs in Strategies 1 and 2. Given the pilot status of these strategies, it is imperative that they be evaluated for effectiveness so timely changes to programming can be made, if necessary.

Please don't hesitate to contact us with additional questions, concerns, or comments. Hilary Metelko Rosebrook, OCTF CORPC Project Manager, can be contacted at 614-688-9292 or Hilary.Rosebrook@osumc.edu.

Sincerely,

Heather Reed

**Heather Reed Robinson**
Healthcare Access Program Director
Government Resource Center

Attachments: OCTF CORPC Prevention Plan Budget Revision 2 VF.pdf