CHILD MALTREATMENT PREVENTION: A PLANNING FRAMEWORK FOR ACTION

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It is our hope that this toolkit will provide other states and local communities specific assistance in:

- Formulating collaborative investment decisions across multiple options to promote child safety;
- Identifying a common set of benchmarks to guide all high priority interventions and policy changes; and
- Creating a set of implementation strategies to more effectively move ideas into practice.

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OVERVIEW

Since the passage of the Child Abuse Prevention and Treatment Act of 1972, articulating action plans to address child maltreatment has been a common activity among those seeking to build more effective response systems. In creating these plans, prevention strategists often emphasized a continuum of interventions each addressing some portion of maltreatment's many and complex causal factors. Following this logic, child maltreatment prevention plans generally recommended adding to the existing array of therapeutic and supportive services in ways that hopefully would better address the needs or challenges of vulnerable families. Each element of these service continuums were considered equally important to advancing the prevention cause regardless of its target population; its targeted outcomes; and, in some cases, evidence of its effects (Daro, 1988).

Today, the planning parameters governing child maltreatment prevention efforts have shifted in two important ways. First, improving the prevention response has moved from promoting an ever expanding plethora of prevention services to placing highest priority on starting early and linking interventions in a more intentional and effective manner, supporting families throughout a child's lifespan. Second, any intervention's long-term success is inherently dependent upon how context supports or contradicts its mission. As such, it has become increasingly important for state planning efforts to strike a balance between specifying the core elements of their prevention approach and providing local communities flexibility to craft a service response that builds upon each area's unique strengths and targets its unique challenges (Daro & Cohn-Donnelly, 2015).

These two principles – more efficient use of existing resources and the need to provide local stakeholders a common set of operational values and outcomes within which they can craft their unique response – have shaped the development of this framework. Specifically, this document is designed to help states and local communities clarify their priorities, identify key strengths and areas of opportunities, and expand on these opportunities to create a more focused and better integrated plan to prevent child maltreatment and to promote child well-being.

This effort was built on pilot work conducted by Chapin Hall at the University of Chicago in two states -- Colorado and South Carolina. In both states, a primary partner was the state lead agency (SLA) designated to administer the Federal Community-Based Child Abuse Prevention (CBCAP) Funds. Community-Based Child Abuse Prevention (CBCAP) programs were established by Title II of the Child Abuse Prevention and Treatment Act (CATPA) Amendments of 1996 and most recently reauthorized by the CAPTA Reauthorization Act of 2010 (P.L. 111-320). The purpose of the CBCAP program is to support community-based efforts to develop, operate, expand, enhance, and coordinate initiatives, programs,

and activities to prevent child abuse and neglect to better strengthen and support families to reduce the likelihood of child abuse and neglect. CBCAP programs further foster understanding, appreciation and knowledge of diverse populations in order to effectively prevent and treat child abuse and neglect.

In Colorado, the CBCAP SLA is part of the state government -- the State Office of Early Childhood. In South Carolina, the CBCAP SLA is a statewide non-profit organization -- Children's Trust of South Carolina. Although operating from different institutional platforms, both agencies play a lead role in defining and managing child maltreatment prevention programs throughout their state and have assumed leadership in formulating a comprehensive, collaborative plan to improve outcomes at the state and community level. The two states differ, however, in terms of their history with prior planning efforts, in the partners they have successfully engaged (a list of these partners is included in Attachment A) and in the policy, social and economic challenges they face. As outlined in Table 1, the two states represent different regions of the country, degrees of urbanization, demographic characteristics, and prevention priorities.

TABLE 1: CHARACTERISTICS OF COLORADO AND SOUTH CAROLINA

Variables	Colorado	South Carolina
Population	5.4 million	4.9 million
Total Population Under 18	1,257,065 (23%)	1,091,588 (22%)
Urban/rural/suburban	86% of the population lives in an urban county and 14% of the population lives in a rural county	66% of the population lives in an urban county and 34% of the population lives in a rural county
Race/Ethnicity	Majority of the population is white (83%) followed by Hispanic/Latino (17%) and African American (4%)	Majority of the population is white (65%) followed by African American (28%) and Hispanic/Latino (6%)
Median Household Income	$60,000	$45,000
Percent of Children Living in Poverty	190,045 (15%)	260,646 (24.4%)
Education	38% of residents have a college degree or higher	25% of residents have a college degree or higher
General Trends	Population is growing (9% increase from 2010), housing prices are up, new industries, 12% of the population is living in poverty	Growing population (6% increase from 2010), 17% of the population is living in poverty

CBCAP State Lead Agency	Colorado Office of Early Childhood	Children's Trust of South Carolina
History of Planning	Significant planning by multiple agencies and disciplines focusing on early child development, improved preventive health care, violence prevention and economic self-sufficiency	Minimal interagency planning with virtually no attention to prevention.
Current Prevention Environment	New state leadership, increased interest in the problem	Increased interest in the problem, particularly focused on expanding ACE training and recognition of the impact early adversity has on later adult development.

While no two states can capture all of the challenges facing state planning teams, Colorado and South Carolina offered us the opportunity to test out different approaches and deepened our understanding of how best to introduce complex concepts, generate a shared agenda and disseminate the plan throughout the state.

Our framework is divided into two sections. The first section, Crafting a Statewide Plan, focuses on the steps Community-Based Child Abuse Prevention (CBCAP) Grantees or lead state agencies focused on child maltreatment prevention can follow in developing a prevention plan. Specifically, the toolkit guides state leadership in:

- Clarifying key operational values or "best standards" that define an effective prevention response;
- Identifying specific programmatic and system objectives (and related population-level outcome areas) which the plan is designed to alter; and
- Identifying an implementation plan for advancing those interventions or policy changes that offer the strongest probability for achieving the plan's outcomes.

With these three core elements defining the plan, CBCAP SLAs can work with their stakeholders at the state level to identify potential new investment opportunities or, in some cases, realign existing resources to foster meaningful state level collaborations, more efficient implementation strategies and operational success. In certain instances, robust community planning efforts may precede clarity at the state level. However, these local activities are not a substitute for state level discussion of these critical core components. State leaders can draw on existing community innovations in developing the state framework, creating a platform in which such local activities are represented.

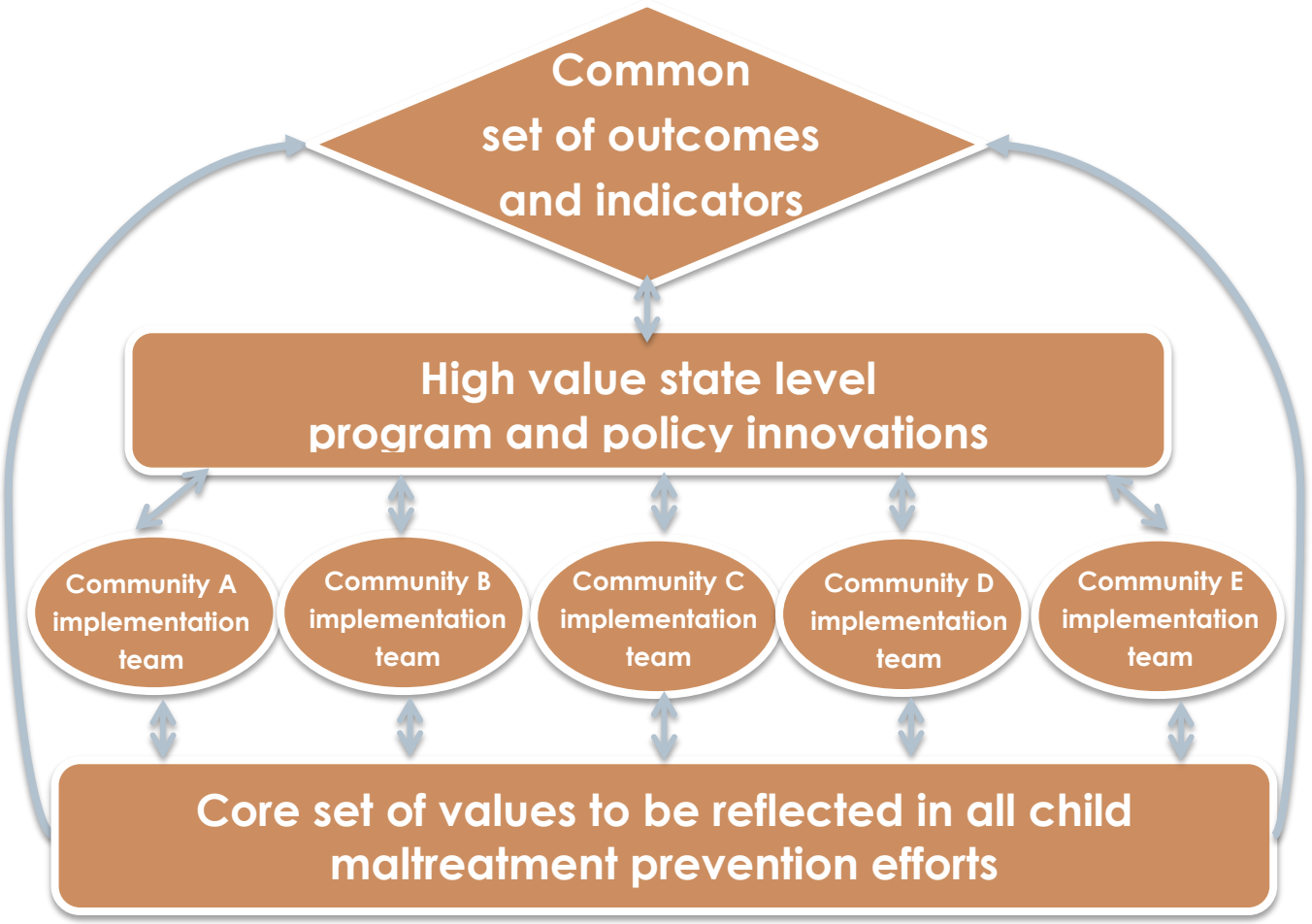
Once states have completed this broad conceptual framing of their child maltreatment prevention approach, the CBCAP SLA, if resources are available, can assist local communities in replicating the planning process, operating within the boundaries or framework established by the state. Specific activities at the local level can include:

- Creating within all or a selected number of communities clear action plans on how to draw on existing resources in identifying three to four target priority areas for change;
- Creating corresponding action plans for each priority area; and
- Designing monitoring systems to track the extent to which these changes are implemented and produce measurable progress on one or more of the state's population-level outcome areas.

This community planning process is outlined in Section II, Community Planning. As with the state section, the Community section outlines a set of specific planning and action steps local community planning teams can adopt within the broad framework articulated at the state level. Specific tasks include approaches communities can use in defining their key strengths and limitations; securing input from all key stakeholders including parents; identifying their highest priorities; and implementing and monitoring these priorities in light of the state's core outcomes. The figure below (Figure 1) depicts the overall framework and relationship between the two processes at the state and local levels.

The final section of the document includes specific tools and templates states and local communities can use to guide their discussions on such issues as core outcomes and related indicators, surveying the general parent population as well as "consumers" of family support services; addressing possible implementation challenges; and monitoring overall progress. The toolkit is designed as a "living document" and, as such, is not overly prescriptive. It is our hope that those using the document will share their experiences with other states or communities, building a more robust and generative understanding of how best to support families and nurture child well-being.

FIGURE 1: FRAMEWORK FOR THE PLANNING PROCESS



PLANNING AS A CHANGE AGENT

At its most basic level "planning" is about articulating a road map that has a clear destination, a pathway to reach the destination, mile markers to let you mark your progress along the path you have identified, and decision points where you can choose to continue down the path you are on or take an alternative route to your destination. According to Rittle and Webber (1974) planning is defined as a process of "putting frames around worries". Specifically, one of the primary tasks facing those developing an approach to improve a specific set of outcomes, is to define the scope of the problem and determine the extent to which thoughtful interventions and policy reforms can be expected to improve outcomes for those most affected. Blum (1974) has identified four ways to "estimate" the scope of the problem and determine the extent to which your plan can reduce the incidence or scope of the problem you are targeting. He suggests asking four sets of questions:

- **Reference point:** What is the current magnitude of the problem? What is the incidence rate and which populations are experiencing the greatest impact?
- **Advanced Reference Point:** In the absence of any explicit intervention to reduce the problem, what do you think the incidence will be in five years, ten years? How will the scope change – will the current populations at risk experience greater harm (depth)? Will the problem extend to new populations (breadth)?
- **"Wishful" Projection:** Where would you like the level to be? At what level would you consider tolerable for the populations at greater risk?
- **"Planning" Projection:** If your proposed interventions achieved maximum impact, where would things stand?

In applying this logic to our planning process, state leadership will want to create a crude estimate of the child maltreatment problem, drawing on official reports of child maltreatment as well as other indicators related to an elevated risk for maltreatment (such as poverty). They should then consider various economic, political and demographic trends which might be expected to increase this estimate, such as major economic development loss or expansion or an influx of new residents. State partners should identify those aspects of the problem most amenable to interventions and set realistic estimates for population-level change. States might set a numerical goal, such as a 10% reduction in confirmed cases of physical abuse or a 10% reduction in young children living in poverty as an indicator of a reduced risk of child neglect. The goal of this discussion is not to lower expectations or convey the message that some types of maltreatment are acceptable. Rather, the purpose is to explicitly link a potential reduction in the problem to specific activities states and communities can implement going forward. Regrettably, some children will fall victim to physical abuse, sexual abuse, neglect or emotional maltreatment because not all "rotten outcomes" for children are preventable. However, careful planning can make a significant difference in the frequency and severity of these actions.

Achieving this outcome requires a careful examination of the factors contributing to higher likelihood of maltreatment and taking early action to intervene in a consistent and high quality manner.

The wealth of knowledge we have gained in recent years about risk factors that lead to child maltreatment can help to enumerate the leverage points for prevention. Common factors associated with increased risk of child maltreatment often include (Child Welfare Information Gateway, 2016):

- Parent or caregiver factors (e.g. substance abuse or teen parenthood);
- Child factors (e.g. early developmental risk due to pre-term birth or complex medical needs);
- Family factors (e.g. family structure or intimate partner violence);
- Community and environmental factors (e.g. high-poverty neighborhoods, community norms, and media messages);
- Risk factors for recurrence of child maltreatment (e.g. families facing multiple stressors such as mental health and housing instability, limited access to appropriate services over the course of their child's development); and
- Co-occurring risk factors (e.g. simultaneous risk factors such as family functioning and community violence).

As outlined in Figure 2, each of these areas suggests opportunities for prevention. In examining these and related causal factors, state planning teams should consider (a) how prevalent these issues are within their overall service area; (b) the degree to which the public and policy makers view these issues as a "high priority" for expanded attention; (c) the opportunities that exist within the state to impact the scope or severity of these issues; and (d) the initial actions steps required to act on these opportunities. This type of discussion will help set realistic parameters around what the planning process might achieve over a 3 to 5 and 10-year period and identify priority outcome areas.

FIGURE 2: MOVING FROM CURRENT REALITY TO FUTURE STATE

Identify Planning Questions	List Priorities	Highlight Opportunities for Action

• Who else needs to be involved?
• What additional information is needed? What can we learn from other states?
• Are changes needed at the program level, policy level or both?
• What resources are necessary to move forward?
	• Consider magnitude of key indicators, for example rates of:
	  ○ Teen parenthood
	  ○ Substance abuse
	  ○ Intimate partner violence
	  ○ Housing instability
	  ○ Community violence
	• Rank and prioritize level of urgency and severity
	• Use this to guide action steps
		• What is currently happening to address these issues?
		• Who is involved in such activities?
		• Can more be done?
		• Should a different approach be adopted?
		• What needs to happen to move forward?

GUIDELINES FOR USING THIS FRAMEWORK

States come to the task of planning from many different perspectives. They will differ in the scope of the problem and will differ in their capacity to address it. They also will differ in attitudes toward local control and decision making. Some states will have the human and fiscal resources to conduct robust planning procedures at both the state and community levels. Other states may only be able to examine state level policies. States also may differ in terms of the interest potential state and local partners have in the concept of preventing child maltreatment or in their willingness to operate in a collaborative framework. Regardless of where a state stands on either the "resource" or "interest" continuums, any CBCAP grantee or prevention minded organization can use the framework to advance their prevention activities. Table 2 offers suggested questions and considerations to guide states through determining how best to use this document. As noted in Table 2, states might use the document in one of three ways:

- The tools can be used to improve the state's needs assessment process;
- The tools can be used to craft a state level plan that will provide state agencies and those working with state policies a set of operational guidelines, target outcomes, and a limited list of state policy or legislative changes to pursue; or
- The tools can be used at both the state and community levels to guide the implementation of the state approach in ways best suited to each community's unique needs and resources.

However states use these tools, the process provides an opportunity to bring greater clarity to how child maltreatment prevention is conceptualized and addressed. Those engaged in the process will have the opportunity to collectively reflect on their priorities, identify strategies to achieve these priorities, and establish an evidence base for broadening public and private commitment to this issue.

TABLE 2: QUESTIONS STATES MIGHT CONSIDER WHEN USING THIS DOCUMENT		
Possible Questions	**Possible Directions to Consider**	**First Steps**
We've done dozens of plans over the years, how can we use this document to look at what has already been done?	This document provides a "roadmap" – but there is no one route to get there – simply an overall direction. This framework is intended to help you assess where you've already been to see where you need to go next.	1. Look at the products, outcomes and plans that have already been done 2. Identify commonalities/themes 3. Determine what, if anything, is missing given your understanding of the problem in your state
We have so much variation across our state when it comes to community characteristics and strengths and needs – how do we account for this?	The approach underlying this framework is intended to balance the focus on the local and state level needs. It provides a guide for setting a statewide agenda while letting communities tailor approaches to their own needs.	1. Focus on broad, state-level objectives that will have meaning across all communities 2. Identify one or more strategic messages that resonate with multiple stakeholders 3. Allow each community to articulate the one or two "unique" issues they face and relate these issues to the broader strategic objectives
We already have a lot of partnerships between agencies and organizations. How do we incorporate this approach with existing coalitions?	The processes for determining a vision and sharing data can be powerful in bringing partners together and in leveraging existing partnerships.	1. Bring your current partners to the table 2. Discuss your priorities together 3. Allocate specific tasks/responsibilities for each partner – everyone needs to have a meaningful role to play
We have not really done any planning on this topic before. How will we know where to start?	This toolkit is intended to provide a holistic overview of an all-encompassing approach. You can first begin with small steps in articulating the vision. Remember that it all will not happen overnight but use this as a map to keep moving forward.	1. Bring a small group of critical stakeholders together (health, education, early intervention, major foundations) and determine what specific aspects of the problem you want to address 2. Select one or two "best bets" to move forward

SECTION I: CRAFTING A STATEWIDE PLAN

The CBCAP SLA can play a critical role in guiding the state's response to child maltreatment. This framework provides tools SLAs can utilize in formulating an action plan for state-level stakeholders. SLAs should cast a broad net in initiating this effort, engaging leadership personnel from all key state agencies -- health, education, child welfare, early childhood and other agencies in a position to contribute to the well-being of children and their families. In addition, including parents on the planning team is essential. Over time and to the extent feasible, the planning team can be expanded to include input from other key stakeholders such as representatives of the non-profit sector, business community, law enforcement, and philanthropic community.

Crafting a statewide prevention plan incorporates a series of basic steps, all of which are designed to maximize the benefits, quality and effectiveness of existing efforts and identify the parameters within which local communities will have flexibility in selecting specific innovations to move forward. The basic steps states need to undertake prior to distributing the toolkit to local planning teams include:

- Identifying a **core set of values** to be reflected in all child maltreatment prevention efforts.
- Articulating a **common set of core outcomes and related indicators** which would signal that state and community efforts were indeed successful in preventing child maltreatment and promoting child well-being at the *population level*.
- Identifying a limited set of **program or policy innovations** state agencies or local communities can implement to achieve the plan's target outcomes.
- Developing **implementation teams and (if appropriate and feasible) learning communities** that will support community planning teams advancing one or more common elements identified in the state plan.

Some states will have already accomplished some of these steps as part of other planning initiatives. To avoid duplication of effort, CBCAP SLAs should examine these prior efforts to identify any common themes with respect to best practices, shared outcomes, or potential interventions. Also, consider if these prior efforts have established interagency work groups or have created opportunities for parent participation or input from other stakeholder groups. If such entities exist, they may be important to engage, early on, in the planning process. These groups can serve as a sounding board of early ideas around core values, priority outcomes, and promising strategies.

Earlier efforts in your state which may have application to this planning process might have been supported through various mechanisms both internal and external to the state. In Colorado for

example, the SLA identified several prior plans which provided an initial starting point for building their state plan[1]. In South Carolina, Children's Trust utilized an existing body established as part of a Federal grant from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) grant that brought together state agency leadership, major non-profits and foundations to generate ideas regarding prevention strategies and common outcomes. Table 3 outlines a list of questions states might consider as they review these prior plans to help them identify the most salient elements to consider as they move forward with a plan to prevent child maltreatment.

TABLE 3: QUESTIONS TO CONSIDER WHEN REVIEWING PRIOR PLANS

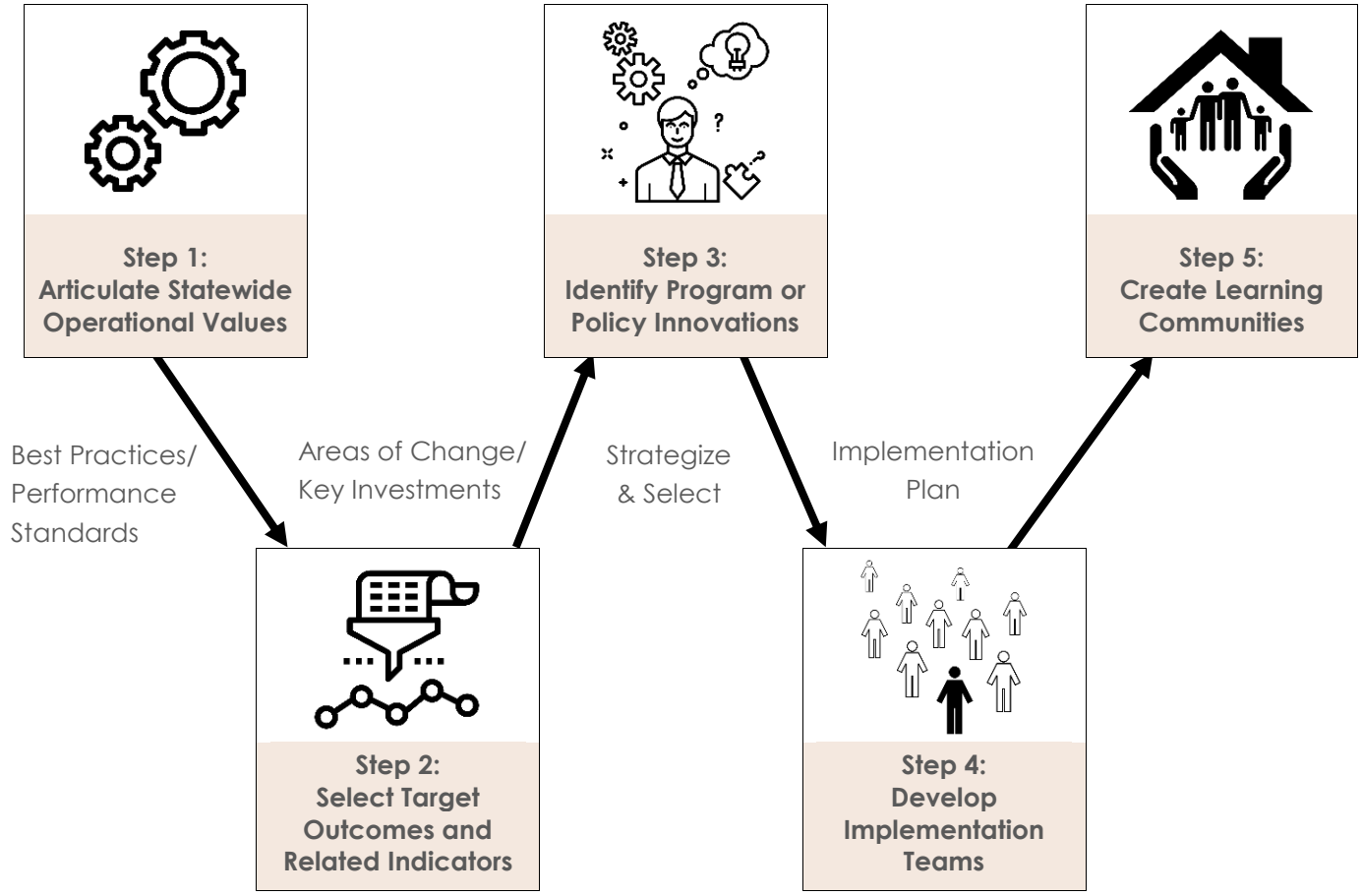
Questions to consider when reviewing prior community plans and profiles:
Goals and objectives • How do the goals articulated in these plans overlap with your proposed objectives? Are there opportunities for collaboration? • Are the necessary data being collected to monitor progress in goal achievement?
Data quality and collection • What is the quality of the existing data used by others to monitor program implementation or outcomes? • How have others utilized these data in the past or how are they utilizing it now? • Can we use these data to determine program quality over time or changes in participant characteristics and service utilization? • Are the structures and agreements in place to share data between/across agencies?
Recommended Interventions • How comparable are planned services/policies to interventions you would like to expand as part of your child maltreatment prevention work? • Are these services being delivered or managed by partners you have engaged in your planning project? What are opportunities these efforts present for further collaboration or alignment?
Implementation Challenges • Which, if any, of the elements in these plans have been implemented? • What have been the major challenges to implementation – lack of staff, too few resources, resistance to organizational change, lack of political/public support, etc.? • Did any of these implementation challenges alter the plan's objectives or proposed interventions? If so, in what way? • What lessons can be learned and applied to your current effort? • What have been the most notable accomplishments of the plan?
Funding • Which funding sources are supporting the reforms recommended in this plan? • Are these funding streams you hope to utilize in the future? • How might other funding sources be leveraged?

[1] These plans include the Colorado Essentials for Childhood Framework developed in 2008; the Colorado Opportunity Project; the state's implementation of the Centers for Disease Control (CDC) Essentials for Childhood Initiative; and implementation of the Strengthening Families Framework supported by the Federal Office of Child Abuse and Neglect.

These earlier efforts can be used to develop an initial list of promising practices or interventions, core outcomes or shared data opportunities, and potential partners you might want to incorporate into this planning process. These earlier efforts also may highlight specific challenges other planners have faced in crafting a more coordinated prevention response. In either case, spending time examining prior work around creating prevention systems in the state or building collective efforts to advance the prevention mission will enrich the activities outlined in this framework.

This section of the framework outlines (graphically depicted in Figure 3) steps CBCAP SLAs can follow in clarifying their operational values, identifying target outcomes and suggested measures, identifying promising interventions, and creating a network of learning opportunities at the state level to foster ongoing monitoring and progress. Those states with the capacity to identify and support local community planning teams also might consider creating virtual learning communities that will facilitate ongoing communication among communities promoting a common innovation or addressing the needs of a specific target population. Such learning communities can be used as a safe place for community planners to share examples of successful implementation efforts as well as raise concerns about approaches that are not going well.

FIGURE 3: STEPS IN THE PLANNING PROCESS



STEP 1: ARTICULATE STATEWIDE OPERATIONAL VALUES

Central to the success of any planning process is finding the sweet spot between establishing a set of common standards and operational guidelines that will move a state toward desired improvements and providing local communities sufficient flexibility to create and own their unique approach to preventing child maltreatment. Planning that allows state and local partners an opportunity to design an intervention or policy that best reflects its particular priorities is critical. Equally important, however, is to identify best practices or performance standards which all agree are essential for maximizing the impacts of any strategy.

A number of factors are often cited in the literature as offering strong potential for improving the quality and consistency of prevention efforts as well as strengthening how diverse state and local agencies can improve the frequency and effectiveness of their working relationships. Our initial review of the literature and work with the pilot sites identified six such operational values that are viewed as strong contributors to improving the quality of both individual programs as well as the infrastructure needed to support them. These include:

- **Monitoring program implementation**: Examine programs not simply from the perspective of outcomes but also with an eye toward more fully understanding the implementation process and the factors that contribute to successful replication. While individual programs and state agencies may differ in their capacity to build effective monitoring systems, paying some attention to both how programs are being implemented in terms of participant enrollment, staff selection and training, and service dosage and duration is essential for determining if investments are being implemented as planned (McCabe Potash, Omohundro, & Taylor, 2012; Durlak and DuPre, 2013; Proctor, Landsverk, Aarons, Chambers, Glisson, & Mittman, 2009).

- **Strengthening the work force**: Create multiple opportunities for direct service staff and supervisors to be trained on common, core practice principles which underscore the importance of cross program collaboration and effective participant service transitions. Such training has been called for across multiple settings from early childhood professionals (Earls, 2010) to home visitors (Tandon, Parillo, Jenkins, & Duggan, 2005). Table 4 outlines a list of potential cross-training topics and sources to support such training.

TABLE 4: TRAINING TOPICS	
Potential capacity-building topics:	**Examples of capacity-building support cited in the literature**
Engaging participants	Evidence for training to support optimal participant engagement includes: • A minimum of monthly supervision sessions with targeted attention to issues of family engagement (Ingoldsby, 2010) • Targeted training and professional development to promote engagement, including motivational interviewing and strategies for jointly planning with families (Ingoldsby, 2010) • Support for implementing specific strategies such as a greater focus on parent-child interactions (Knoche et al., 2010) and the use of strategies that involve parents in direct interactions with their child (Peterson et al., 2007)
Using administrative data	Lessons learned when piloting the sharing and use of administrative data (Lee, Warren, & Gill, 2015): • Accessing administrative data can be challenging • Including the state as a key convener of the process from the beginning can help facilitate the process of sharing and accessing key data indicators • Accessing birth certificate data has great potential but can take so long that the data may only be valuable for assessing trends and not for use to target programming during the first year of life

Continuous quality improvement processes	• Driving foundational vision of CQI initiatives: Sound science exists on the basis of which the costs and outcomes of current practices can be greatly improved, but much of this science is unused in daily work -- there is a gap between what we know and what we do • Such systems have been developed at the state level that allow statewide home-visiting programs to use data in real-time to support periodic program reviews at the region and state level (McCabe Potash, Omohundro, & Taylor, 2012). • CQI, which involves cycles of planning, action, assessment, and revision of plans and processes, may facilitate the adoption and integration of evidence-based practices in social service settings. This type of active implementation process values the input of practitioners, managers, and planners in order to make services more relevant, effective, and ultimately sustainable (Aarons & Palinkas, 2007).
Strategic planning	Strategic planning has been recommended and utilized by public agencies. Strategic planning has been identified as an approach that "can be a highly cost-effective tool for creating useful ideas for strategic interventions and for figuring out how to organize the participation and coalition needed to adopt the ideas and protect them during implementation. When not overly formalized, bereft of participation, and obsessed with numbers, strategic planning can be a very effective route to enhanced organizational responsiveness, performance, and accountability." (Bryson, 2004, p. 13)
Cultural humility/competence	Findings from studies examining cultural competence and cultural adaptation of programming demonstrate its importance: • Higher provider cultural competence has been associated with higher goal attainment and satisfaction among participants (Damashek, Bard, & Hecht, 2012) • Cultural adaptations of programming can substantially improve engagement, leading to higher retention and recruitment of families (Kumpfer et al, 2002) • Cultural alterations of curricula and intervention materials, as well as racially-matched staff can help develop trust among participants can lead to high rates of retention, participant satisfaction, and intervention completion (Parra Cardona et al, 2012)

- **Fostering data integration:** Find ways to share information on program participants across institutions and across the life span for purposes of better understanding who is being reached and who is most successfully served. For example, tracking parents and young children who have received home visiting or other early prevention services through administrative child welfare, education and health care records provide one way to track the immediate and long term impacts on subsequent child maltreatment reports, health care status, and early education outcomes. Administrative data also can be used to examine the characteristics and geographic location of families reported for maltreatment or children who struggle in schools or require remedial services. Linking multiple databases allows for a greater understanding of service networks' characteristics and permits administrators and policymakers to see who is served, how they are served over time, what other social service systems they encounter, and what outcomes they commonly experience (Hovmand, Jonson-Reid, Drake, 2007; Jonson-Reid & Drake, 2008). Such data offer critical insights into the characteristics of pre-existing challenges most common among those who require formal and more costly interventions. Figure 4 provides an example of an innovative approach in which to use administrative data to drive program planning.

FIGURE 4: USING ADMINISTRATIVE DATA TO FRAME THE PROBLEM: A CASE EXAMPLE

Western and Central New York Case Study

In 2009, the Community Health Foundation of Central and Western New York commissioned a zip code level analysis of key outcomes in order to guide their work throughout their 8 county jurisdictions. U.S. Census Bureau data was used to examine demographic profiles and key outcomes at the zip code level for the Foundation's target area. The key indicators included:

- Total population,
- Number of births,
- Urban-rural classification,
- Percent of the population five or younger,
- Percent of population over 18,
- Percent of population 65 and over,
- Percent of population non-English speaking,
- Average family size,
- Percent of families below poverty,
- Racial and ethnic composition,
- Educational levels, and
- Employment levels.

In addition to these factors, variation across the service area's 156 zip codes on the key health outcomes was also assessed. These indicators include:

- Teen pregnancy rate,
- Teen birth rate,
- Prenatal care status,
- Low birth weight, and
- Infant death rate.

The analysis yielded a series of maps and figures detailing the demographic profiles of the zip codes in the area. These maps highlighted those zip codes with the poorest performance on the five key outcomes; identified the zip codes with the highest concentration of risk; and the accompanying report examined the community characteristics of specific zip codes that performed differently than expected, given their demographic profiles. The analysis concluded with a discussion about investment opportunities the Foundation might consider in furthering its early childhood goals (Huang, Hart, & Daro, 2010).

- **Incentivizing continuous quality improvement:** Raise the performance bar and set the expectation that program administrators and practitioners alike have a responsibility to find ways to do better, even when they believe they are doing a great job. For the past several years, the early home visiting field has utilized a quality improvement strategy to identify practice changes that will contribute to more robust outcomes with respect to breastfeeding rates, addressing maternal depression, and improve screening rates for early child development delays. In terms of innovations, this effort explored ways to improve participant and engagement rates. See Table 5 which lists resources for building Continuous Quality Improvement.

TABLE 5: RESOURCES ON CONTINUOUS QUALITY IMPROVEMENT (CQI)

Reports and publications on CQI	URL
U. S. Department of Health and Human Services, Health Resources and Services Administration. (2011). *Quality Improvement*	https://www.hrsa.gov/quality/toolbox/508pdfs/qualityimprovement.pdf
Institute of Medicine (US). Committee on Quality of Health Care in America. (2001). *Crossing the quality chasm: a new health system for the 21st century*. National Academies Press.	https://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf
Kohn, L. T., Corrigan, J. M., & Donaldson, M. S. (Eds.). (2000). *To err is human: building a safer health system*. National Academies Press.	http://www.csen.com/err.pdf
National Learning Consortium. (2013). *Continuous quality improvement (CQI): strategies to optimize your practice*. Health Information Technology Research Center (HITRC).	https://www.healthit.gov/sites/default/files/nlc_continuousqualityimprovementprimer.pdf
Institute for Healthcare Improvement. (2003). *The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement.* IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement.	http://www.ihi.org/resources/pages/ihiwhitepapers/thebreakthroughseriesihiscollaborativemodelforachievingbreakthroughimprovement.aspx

- **Family and participant voice:** Listen to those you intend to help and incorporate their thoughts and perspectives into planning and implementation. Across multiple fields there have been efforts to create programs in which clients, participants, or patients have more ownership or say in terms of which services are provided, how they are delivered, and the level of control of information collected or documented. It has generally been believed that such involvement or ownership will foster improved outcomes. Across sectors including child welfare, children's mental health, and psychotherapy there is strong qualitative evidence that parents and children want to be included, feel empowered when included, and that there may be a link between inclusion and increased self-esteem (Fine, Palmer, & Coady, 2007). Strategies for incorporating family and participant voices into the planning process are described later in this report.

- **Policy integration:** Do not implement policy reforms alone when it can be done in partnership with others. This principle applies to work across agencies as well as across sectors (public, private, and nonprofit) (Kania & Kramer, 2011).

While states might elect to expand or omit some of these items or place different priorities on achieving some of these ideas, as a group, these concepts resonated with our pilot sites. They provide a strong foundation on which to launch discussions about the essential characteristics of a robust prevention plan.

In working on this step, it is helpful to consider the principles often identified in relationship to various "collective impact"[2] efforts to address a wide range of social dilemmas. Achieving and sustaining integrated systems requires public institutions—be they focused on health, education, or child welfare—to pool their resources to create approaches that are mutually reinforcing around a shared definition of success (Kania & Kramer, 2011). As state revenues tighten, it is becoming increasingly difficult to justify each agency maintaining its own unique infrastructure. Incentives need to be built into state revenue streams to reward those agencies who design innovative ways to share operational features such as data management; training and staff support services; and quality improvement systems. Strategies that contribute to building strong collaborative efforts include:

- Agreeing on a common agenda representing shared values and a common purpose (not simply a shared agenda which consists of a laundry list of each partner's existing priorities);

- Agreeing on a shared measurement system (you will count outcomes/define success using the same standards and terms);

- Focusing on identifying mutually reinforcing activities (or positive spill-over effects);

[2] "Collective impact occurs when organizations from different sectors agree to solve a specific social problem using a common agenda, aligning their efforts, and using common measures of success." (FSG; see http://www.fsg.org/ideas-in-action/collective-impact).

- Agreeing to continuous and transparent communication and feedback;
- Establishing a "backbone" organization (or in the case of building a state plan, identifying a lead organization that can manage the infrastructure for the collective venture).

With these principles in mind, the planning process should be led by a relatively small group comprised of representatives of the key state partners and stakeholders. Likely members include representatives from the state departments of human services, maternal health, child welfare, education, public benefits and, if such an agency exists in the state, the office of early childhood. Everyone does not need to be at the table to begin, but priority should be given to ensure representation from any department currently investing in preventive services to reduce child maltreatment or promote positive child well-being and family development. The CBCAP SLA should serve as the group's convener unless there is a compelling reason to assign this work to another organization in the state.

In addition to building a collective commitment to these principles among state leadership, the state planning team should solicit input from the general parent population or those families currently utilizing prevention services. The SLAs in both of the pilot states sought input from parents through a general parent survey and a series of focus groups early in the planning process. Using a web-based survey platform, input was solicited from the general parent population on a range of topics including parent familiarity with a range of supportive services found in most communities (e.g., health services, parent education services, child care options, recreational programs for children, family resource centers, faith-based services, etc.); parent assessment of the quality of their community as a place to raise children; the availability of informal supports from families and neighbors; and their own parent practices. (A copy of this survey is included in Attachment B). To augment the responses received from the parent survey, we conducted a series of focus groups around the state with specific sub-groups of parents such as those living in rural or more isolated regions of the state, fathers, and those currently utilizing prevention services. While covering several of the topics captured in the population-based survey, the focus groups allowed for a more in-depth examination of how parents viewed existing services and what gaps they saw in the existing service network. (A copy of the discussion guide used in these groups also is included in Attachment B). Collectively, these two approaches provided the state planning team important insights and influenced their final selection of core outcomes and priority interventions. (A detailed summary of the methodology and key findings from these surveys in the pilot states are available in Daro, Bellamy, Crane, & Phillips 2016; Daro, Seay, and Crane, 2016).

Each of these methods for securing parent input early in the planning process offer unique benefits. In general, a parent survey can be done at a lower cost and offers the potential of securing input from a far greater number of parents than targeted focus groups. While focus groups are more expensive and will involve a fewer number of respondents, this process allows for a more detailed discussion with parents, many of whom may not be inclined to complete an on-line survey. As summarized in Table 6,

states should consider their available resources, capacity to staff and successfully implement either a survey or focus group, and their primary information interests in determine which avenue to pursue.

TABLE 6: PROS AND CONS OF SURVEYS AND FOCUS GROUPS AS DATA COLLECTION TOOLS

Caregiver Surveys		Caregiver Focus Groups	
Pros	*Cons*	*Pros*	*Cons*
Inexpensive and relatively easy to administer	Inflexible instrument; Relies on caregivers' ability to understand and complete	Relatively easy to conduct; Flexible format; Can evolve as new questions or topics arise	Need a well-trained facilitator; Some logistics required; More expensive per participant; Requires a strong facilitator familiar with local culture and norms
Easily accessible for caregivers with internet access; Larger sample size	Difficult to achieve a sample of underrepresented groups; Hard to reach parents without internet	Opportunity to collect data from a specific, curated group; Ideal for brainstorming	Minimal sample size; Convenience sample; Access may be limited by a program "gatekeeper" contributing to potential sample bias
Responses are anonymous; Can be completed at the convenience of respondents	Low variability of sample due to recruitment pathways (internet or organizations); missing data	Allows for clarification of question and response	Low variability of sample due to recruitment pathways; Some lack of community anonymity due to format
Standardized data collection; Easy analysis, particularly using online tools	Missing data; not all responses are required	Richness to data as respondents answer and build on each other's responses	Data analysis is somewhat complex, time consuming and requires a qualitative framework

If the state elects to secure parent input early in the process, survey and focus group findings can then be shared with the planning team. Working collaboratively, this team can then begin their work by reviewing each of the practice principles outlined above or other operational characteristics of high priority to parents as well as members of the group. For each concept, team members should (a) determine if the practice is relevant for their situation and its relative priority with respect to the full

list; (b) identify current examples of how these high priority principles are being addressed within various state agencies as well as examples in which efforts to support these practices were not well received; (c) identify potential strategies for expanding the priority principles within and across state agencies; and (d) flag those areas that may require significant education or systemic change in order to operationalize. Ideas or values which the majority of participants believe will improve prevention practice should not be removed from the list simply because they will be challenging to implement. This group of issues, while challenging to implement, offers you an opportunity to engage in substantive discussions across agency lines and craft a collective action plan to move the state toward implementation.

Each best practice should be accompanied by a set of immediate and long term opportunities for reinforcing the concept. Once the group agrees on their practice principles, they should establish a plan for disseminating these values throughout all governmental agencies. Figure 5 presents a list of possible dissemination options citing the relative advantages and limitations of each as way to reach various stakeholders such as agency managers, legislative leaders, advocates, or business leaders. Efforts also should be made to discuss these values with program managers and direct service providers to identify any barriers that may exist to embedding them into routine practice. Such barriers might include statutory limitations, union contracts, historical perspectives of agency autonomy, or fiscal constraints.

FIGURE 5: POSSIBLE DISSEMINATION OPTIONS FOR STAKEHOLDERS

Publications

Briefs, Memos, Reports, Toolkits

Target Audience: Providers, Agency Staff, Legislators, Consumers, Academics

Pros: Can Convey Complexity

Cons: Costly, Limited Reach

Social/Web-based Media

Media Campaigns, News Stories

Target Audience: Families, Practitioners, Partners

Pros: Affordable, Engaging, Likely to be Read, Accessible

Cons: Format Restrictions, Oversimplification of Complex Issues

Direct Outreach

Advocacy, Legislative Testimony, Town Hall Meetings

Target Audience: Public, Community Leaders, Legislators, Businesses

Pros: Targeted Messaging, Partnership-building

Cons: Costly, Limited Reach

Once the group agrees on the importance of certain practice principles and on the need to expand their use across agencies, efforts should be made to "institutionalize" the values into standard practice.

For example:

- The values can be reinforced through the state's procurement process – collaboration and data sharing can be built into requests for proposals or contracts.
- The values can be reflected in legislative mandates.
- The values can be reinforced through conversations and awareness building with thought leaders and community decision makers (including business leaders)
- The values can be reflected in training offered to direct service staff as well as program managers.
- The values can be required talking points in relevant state reports.
- The values can be used to organize reporting systems or define measurement tools or reporting requirements.

As noted above, high priority operational values with significant implementation barriers should be allocated to a small task force to determine how to best advance their spread across state agencies. Figure 6 presents one example of how state leaders overcame barriers to integrating these values into ongoing state level work in the context of juvenile justice.

FIGURE 6: EXAMPLE OF STATE LEVEL VISION AND PLANNING PROCESS

Case Study: Safe Communities Successful Youth: A Shared Vision for the New York State Juvenile Justice System

In 2010, New York State embarked upon a process to create a more well-coordinated juvenile justice system aimed to achieve a well-defined set of community level and youth level outcomes. A number of factors drove the success of this initiative including a clear and well-articulated vision shared by all stakeholders, which included four guiding principles: fairness, effectiveness, safety, and accountability. In order to address the need for a more well-coordinated system four strategies were employed. The first was the creation of a support structure at the state level tasked specifically with measuring progress.

This support structure was supported by local interagency advisory teams to provide recommendations to the state. All stakeholders worked together towards defined performance based measures and a data coordination team guided data sharing within and across agencies at the state level. This shared data system creates the foundation for a comprehensive assessment and measurement protocol through which juveniles will be offered a continuum of options for all levels of risk so that low-and moderate-risk youth can be treated in their communities and only high-risk youth need incarceration.

This new comprehensive and integrated system, based on a set of shared principles and shared vision, will allow for the reliable assessment of risk while diverting youth from the system when appropriate. This project is still in its early stages of development and implementation and therefore does not yet have demonstrated outcomes. However, they are a strong case study demonstrating the ability to bring together a diverse set of stakeholders in a complex system and move in a common direction.

Source: http://collectiveimpactforum.org/sites/default/files/Safe%20Communities%20Successful%20Youth%20Full%20Version.pdf

STEP 2: SELECT TARGET OUTCOMES AND RELATED INDICATORS

For any plan to be effective, everyone needs to agree on the final destination. Preventing child maltreatment is the ultimate goal. In some instances, logic models are built to clarify not only the goal, but also the specific strategies that will be used to meet the goal. Distinct from logic model development, our planning process asks states to focus on the outcomes they want to achieve and allows for flexibility at the community-level to determine how to get to the ultimate outcome based on specific community resources and challenges. Central to achieving this goal is promoting a set of improvements in a number of domains, many of which will involve strengthening protective factors (resilience, competence, social connection, physical health, cognitive development) as well as minimizing risk. While there are myriad ways to frame these important areas of change, our pilot work identified four areas which state leaders found most salient:

- **Child well-being and achievement:** Maximize developmental potential of all children
- **Adult well-being and achievement:** Provide parents the support they need to succeed
- **Consistent, high quality caregiving by all those responsible for meeting the needs of children (parents, foster parents and child care providers):** Insure all caregivers nurture positive child development
- **Safe, stable and supportive neighborhoods:** Create a context that supports collective responsibility for children

To maximize the ability of these types of broad outcome domains to inform the development of the plan, it will be critical to identify a ***limited set of indicators*** in each domain (see Attachment C for a detailed list of suggested indicators). In selecting specific indicators, the planning team will want to engage a range of stakeholders including those familiar with the technical aspects of data development and data use; policy makers responsible for reporting the impacts of key investments; and direct service providers responsible for augmenting existing data systems with information obtained directly from program participants. For each of these outcome domains, a list of suggested indicators need to be

identified along with how these indicators might be defined at the population level. Figure 7 details Colorado's use of existing data sources and surveys to track each outcome domain.

Table 7 illustrates the issues and level of detail the planning committee will want to consider when finalizing their list of recommended outcomes. We would suggest that the planning team recommend tracking between **two to four indicators** for each outcome domain.

FIGURE 7: EXAMPLE OF STATE LEVEL INDICATOR SELECTION

Case example: Colorado's use of existing data sources to track outcomes

In an effort to track outcomes across four agreed-upon domains, Colorado utilized existing data sources such as statewide administrative data and items in current statewide parent surveys to track trends over time. The following are examples of such indicators that align with the four outcome domains and their sources:

Child Well Being and Achievement

- "During the past 12 months, did a doctor have you fill out a questionnaire about specific concerns or observations you may have about your child's development, communication, or social behaviors?" **(Colorado Department of Public Health and Environment - Colorado Child Health Survey)**
- Percent of children K-3 who have a significant reading deficiency **(Colorado Department of Education data)**

Consistent High Quality Caregiving

- In what position do you usually put your child down to sleep? **(Colorado Department of Public Health and Environment - Pregnancy Risk Assessment Monitoring System)**
- Percentage of professionals in PDIS working directly with young children achieving at each level of the Early Childhood Professional Credential **(Colorado Department of Human Services – Colorado Shines data)**
- Annual incidence of physical abuse, sexual abuse, emotional abuse, etc. **(Colorado Department of Human Services – TRAILS data)**

Caregiver Well Being and Achievement

- "At any time during your most recent pregnancy or after delivery, did a doctor, nurse, or other health care worker talk with you about 'baby blues' or postpartum depression?" **(Colorado Department of Public Health and Environment - Colorado Child Health Survey)**
- "Since [CHILD'S NAME] was born, how often has it been very hard to get by on your family's income – hard to cover the basics like food or housing? Would you say very often, somewhat often, often, rarely, or never?" **(Colorado Department of Public Health and Environment - National Children's Health Survey)**

Safe and Supportive Neighborhoods

- "Now, for the next four questions, I am going to ask you how much you agree or disagree with each of these statements about your neighborhood or community:
  - 'People in my neighborhood help each other out.'
  - 'We watch out for each other's children in this neighborhood.'
  - 'Is there someone that you can turn to for day-to-day emotional help with (parenthood/raising children)?' **(Colorado Department of Public Health and Environment - Colorado Child Health Survey)**

TABLE 7: ISSUES TO CONSIDER DURING THE PLANNING PROCESS	
Issues	**Considerations**
Data Sources	• The presence of intervention programs in a community will drive the extent to which program-level data is available. If programs routinely document the characteristics of their participants, participant experiences in the program (duration and dosage), and service outcomes, you will be able to track changes in these indicators over time to assess any improvements as a result of changes in practice standards or increased agency collaboration. • The data infrastructure and commitment to data sharing across agencies and institutions will influence whether community data, national data, state-level data, or program data can be included.
Proximal versus distal outcomes	• The vision and scope of the plan will influence the selection of distinct outcomes and associated indicators; for example, if the state or community is primarily interested in young children ages 0-8 then anticipating change in events that occur much later in a child's development, such as improved high school graduation rates, may be less critical. If such measures are included, it should be clarified that change in these areas will not occur until the cohort experiencing an early reform reach high school. • A mix of both shorter and longer-term outcomes is recommended; while longer term outcomes may or may not be included in the overall vision, it is recommended that near-term outcomes (ex. process measures in addition to outcome measures) be selected so that earlier progress can be tracked.
Consider a broad array of population or community indicators	• Many factors contribute to a healthy community or one which offers families a degree of support and stability. If the plan is designed to improve the context in which families live, a range of safety, economic and quality of life indicators might be considered for tracking. A variety of sources can be used to assess community quality including economic indicators maintained by the commerce department or safety indicators tracked by law enforcement. • Additionally, the availability of social services and educational resources may be available through state social service agencies as well as community organizations such as the United Way, churches, and advocacy groups. Selection of such indicators should be driven by the vision and the array of partners involved.
Data Quality	• Data may be excluded if it is of poor quality (high level of missing data, poor reliability or validity). However, the planning team may recommend examining less than perfect data as a strategy to drive the conversation about how to improve data quality.

Starting with a limited number of indicators improves the odds of maintaining a data system of high quality and reducing data collection burden among participating groups. Additional areas of interest can be added as agencies become more familiar with and implement the process. Once finalized, these outcomes and related indicators can be used to guide the state plan as well as inform planning efforts at the community level as discussed in Section II.

STEP 3: IDENTIFY PROGRAM OR POLICY INNOVATIONS

Once core outcomes have been identified, the planning team should consider identifying a small number of interventions or policy reforms that align well with one or more of the plan's target outcomes. In selecting this list of options, priority consideration should be given to those programs with evidence of effects. In recent years, several web-based resources have been established which offer comprehensive assessments of prevention models and strategies in terms of their implementation rigor (staff qualifications, target populations, service content) and empirical evidence. Rating systems commonly used by those seeking to identify promising prevention programs include:

- Home Visiting Evidence of Effectiveness – HOMVEE (http://homvee.acf.hhs.gov/)
- California Evidence-Based Clearinghouse for Child Welfare (http://www.cebc4cw.org/)
- What Works Clearinghouse (http://ies.ed.gov/ncee/wwc/)
- Substance Abuse and Mental Health Clearinghouse (http://www.samhsa.gov/capt/tools-learning-resources/what-works-clearinghouse)
- Social Programs That Work (http://evidencebasedprograms.org/)
- Evidence-Based Practice Directory (https://www.friendsnrc.org/evidence-based-practice-in-cbcap/evidence-based-practice-directory)

To help structure the consideration of the wide ranging alternatives offered in these sites as well as other program directories, we have organized interventions and policies into four major practice streams, which are briefly described below. These and other promising strategies are discussed at length in the accompanying literature review *Planning to Prevent Child Maltreatment: Strategies to Support an Integrated Child Maltreatment Prevention Framework* (Karter & Daro, 2016). This can be accessed at http://www.chapinhall.org/research/report/planning-prevent-child-maltreatment.

- **Strengthening individual child and parent skills and well-being**: these strategies focus on identifying and supporting individual participants with the goal of promoting physical, cognitive and emotional well-being. Individual strategies may focus on altering behaviors, attitudes or skills. Programs captured under this heading include the following.
    - ***Early home visiting programs*** have demonstrated positive impacts in several domains, including preventing initial and subsequent child maltreatment; reducing the use of harsh punishment; improving parental capacity and use of positive parenting practices; and promoting healthy child development.

- ***Parenting education programs*** have been effective at teaching parents emotional communication skills; helping them acquire positive parent-child interaction skills; and giving them opportunities to demonstrate and practice these skills while observed by a service provider.

- **Changing organizational culture and workforce practice**: these strategies focus on altering the standard operating procedures within existing organizations (such as eligibility criteria, service flow, service options), as well as efforts to educate and improve the capacity of individual providers. Approaches captured under this heading include the following.

  - ***Strategies to increase an organization's use of evidence*** include leadership that supports a learning culture and evidence-based practice (EBP), the presence of an organizational EBP champion, partnerships and organizational linkages with researchers, and access to technology.

  - ***Differential response models***, typically discussed as a change in the structure of child protective services response, can also be applied to prevention services. The concept of conducting a careful assessment of a family's needs to ensure the best and most appropriate type and intensity of assistance offers a rational way to allocate services and refer families to the most appropriate assistance for their specific situations.

- **Fostering service collaboration and community efficacy**: these strategies focus on building coalitions among organizations within a given community or strengthening the collective efficacy of community residents. Potential strategies include:

  - ***Standardized data collection and information exchange*** allows community providers to learn more about the families they serve, coordinate the provision of services, and strengthen the community supports available to families.

  - ***Partnerships with libraries or similar public community centers*** are an effective way to support an early learning community to assist parents in accessing appropriate information on child development and child management.

- **Influencing policy and legislative change:** these strategies include advocacy efforts targeting public policies that shape the broader social service system or seek to extend public funding streams to support services for families and deepen community resources. Specific examples include:

  - Informing policy and agenda setting around the complex issues at the focus of child maltreatment prevention requires ***effective advocacy***. Successful advocates link specific

policy recommendations to documented trends and real conditions and present information on costs and outcomes of interest to policy makers.

- ***Innovations in federal and state funding*** can have a significant impact on prevention. These innovations include flexible funding for the integration of social and educational services during medical care, flexible spending grants that allow states to fund prevention programs without requiring them to spend down funds available for foster care, or expansion in the eligibility and provision of concrete supports.

Depending on the resources available in the state, the planning team should identify a small set of interventions (three to four) which they believe represent good investments or "best bet" for the state. These decisions should be influenced by the quality of the evidence (planners should look for interventions that have demonstrated that they can impact the outcomes of highest interest to the planning team); the ability of a program to complement or build upon efforts already underway in the state; and the ability of a program to address an unmet need or underserved population and/or geographic area.

Once the planning team has vetted the full range of promising interventions, they will need to limit the list to three to four strategies within each domain. This number of strategies will offer sufficient choice to those charged with implementing the plan but will avoid diluting potential impacts if individual communities invest in too varied a set of interventions. Given too much choice, local planning teams may elect to pursue strategies that focus on outcomes not central to the plan or implement too many programs to insure high quality implementation and monitoring. In selecting a narrow set of implementation options, the state planning team should give higher priority to strategies that are already operating in the state or have strong replication support services. Other considerations should include the feasibility of the idea (does the state have the sufficient resources to staff and support the effort over time) and a strong champion for the idea within state leadership or legislative bodies. It will be important to have willing and enthusiastic leaders to monitor ongoing implementation and problem solving.

STEP 4: DEVELOP IMPLEMENTATION TEAMS

Moving from planning to action will require states to develop an implementation plan. For some states, implementation efforts will focus on mobilizing state leaders to embrace two or perhaps three of the ideas emerging from the plan. For example, a state may wish to support a joint training project that will strengthen the skills of all those working with young children. In other states, the initial focus might be on extending early home visiting to all Medicaid recipients. In other states, the goal may be creating a more integrated data system. What the state elects to do first is far less important than having a clear implementation plan for achieving it. Scholars examining the implementation process repeatedly

underscore the importance of identifying the specific challenges one faces in successfully moving from an idea to a program (Aarons, Hurlburt, & Horwitz, 2011; Aarons et al., 2012; Proctor, Powell, & McMillen, 2013; Proctor et al., 2011). A comprehensive implementation plan will address the following issues:

- **Planning strategies**: identifying specific activities to insure full participation by key state and local partners in developing core practice principles and outcome indicators, generating opportunities of key partners to work together in implementing and monitoring all aspects of the plan, identifying key leaders and advocates at the state and local levels to promote the plan and create a context that will foster shared ownership of the plan.

- **Education strategies**: planning activities to inform legislators, program providers/advocates and parents of the framework, its core values, targeted outcomes and roles various state and local actors can play in strengthening the child maltreatment prevention response.

- **Finance strategies**: identifying existing and potential new sources of support for specific elements in the plan, including public investments, private philanthropy and community buy-in among the voluntary selector. Equally important will be expanding incentives and eliminating disincentives for potential participants, providers and agencies to contribute to the collective outcomes.

- **Restructure strategies**: identifying the extent organizational change or realignments in staffing plans, record keeping systems, or agency activities may be needed to implement specific elements of the plan and creating a system for communicating and achieving change among all relevant parties.

- **Quality management strategies**: identifying strategies that agencies as well as local service providers can implement to improve the service delivery process, paying particular attention to efforts that will encourage the collection and use of data on program participants, service experiences and initial outcomes in a time sensitive manner.

- **Policy strategies**: identifying changes that may be required in existing policies or authorizing legislation to promote the plan's core operating values and principles and enhance the ability of the system to achieve the plan's core outcomes

Following the process used to identify the plans' operational priorities, the planning team should (a) identify its highest priority projects; (b) identify the specific implementation barriers facing the expansion of the idea; (c) develop a specific work plan and related time frame to overcome the implementation challenge: and (d) identify a lead agency/individual to monitor the implementation process.

Table 8 describes how using an implementation science framework can guide implementation priorities.

TABLE 8: IMPLEMENTATION ISSUES TO CONSIDER			
Strategic Area	**Potential Questions**	**Elements to Consider**	**Conditions Facilitating Action**
Planning strategies	Do we have all the pieces in place to implement our change ideas?	• Current workforce capacity to meet workforce demands related to recommended strategies. • The capacity of local service networks to support recommended innovations. • A sufficient level of need to insure a robust flow of participants.	• Training and skill-building plans. • Organizational support and interest in adopting innovations. • Increased attention and sense of urgency to address child maltreatment.
Education strategies	How do we get our message out?	• Public awareness and support for the change. • Interest among elected officials. • Understanding and support for the idea among agency managers and front line workers.	• An existing public awareness campaign complementary to your objectives. • Champions at key leadership and administrative levels.
Finance strategies	How do we secure adequate fiscal resources to implement the plan?	• The ability of current funding levels to cover the cost for innovation. • The level of interest in the plan and its priorities among private philanthropy. • The potential for volunteer support and in-kind contributions to fill resource demands.	• New funding streams available within the public sector. • Local foundations launching a new initiative that complements the plan.

Restructuring strategies	What organizational or institutional changes are needed to build an appropriate interagency infrastructure?	• Current data sharing agreements and barriers. • Status of interagency collaboratives and levels of engagement. • Historic barriers to collaboration.	• New interagency task force being formed on related topic. • New institutional alignments being proposed that complement your objectives. • New data systems in process.
Quality management strategies	What is the best way to monitor and manage quality?	• Existing CQI plans at state level. • Quality Rating systems in for child care or other provider systems. • Level of agency buy-in to CQI.	• Pending legislative requirements to implement CQI systems. • Funding requirements to monitor program quality and implementation.
Policy strategies	Are there legislative barriers that will limit participant access or program expansion?	• Current authorizing legislation for key organizations. • Current eligibility criteria for basic need programs. • Statutory limits on public investments/taxing structure.	• Changes in Federal policy that might open up new funding streams or change eligibility. • Change in political leadership.

STEP 5: CREATE LEARNING COMMUNITIES

Sharing the plan with all stakeholders is the final step. States will differ in their capacity to disseminate the plan and to create the infrastructure required to seed the concepts across all communities in the state. Based on their capacity, CBCAP SLAs should play a lead role in disseminating the plan to key stakeholder groups through a variety of strategies including virtual webinars, statewide conferences, or web-based technologies. In some instances, the dissemination plan and expectations regarding implementation will be narrowly focused on one or more state-level reform strategies such as expanding funding for a particular service or facilitating administrative data sharing agreements. States adopting this approach may place priority on educating the leadership of the relevant state agency or legislative body on the plan's content and rational for selecting the specific reform or policy change, working with these key stakeholders to achieve change. In other instances, the SLA will have sufficient resources to develop a more comprehensive dissemination plan including statewide public awareness plans as well as strategies to inform and engage local community advocates as well as the general public.

For those able to support local implementation efforts, states will need to develop an infrastructure that can assist local stakeholders in using the plan to guide their efforts. Attachment D is an example of

how Colorado shared the results of their statewide planning process with their local community implementation teams. Each community will implement these core operational values and indicators in unique ways. To maximize the learning across the state, SLAs should facilitate learning communities that will draw together representatives from local partnerships. Such learning communities can be organized around implementing common interventions, targeting a specific subpopulation, or addressing specific factors contributing to elevated levels of maltreatment. In others cases, alignment may occur across organizations working in a specific region of the state. Once established, the SLA can coordinate and promote these learning communities in the following ways:

- Provide each local implementation team with an historical overview of the state's response to child maltreatment prevention including any relevant legislation, administrative structures or prior planning efforts. A tool to examine historical trends at the national level is referenced in Attachment E.
- Provide an overview of current planning work to stakeholders and implementation teams. An example PowerPoint for presenting agreed-upon foundational principles, core outcome domains, and survey and focus group findings is provided in Attachment F.
- Provide each local implementation team with initial profiles of the families and state-supported resources within their local community. These descriptive variables would be drawn from existing sources, many of which provide information at the county or, in some instance, sub-county levels. Potential sources for developing such a profile might include the U.S. Census, state health department records, school performance information and student characteristics, and child welfare data. There are many existing data sources that may be utilized and are easily-accessible. Such national level data sources can provide a snapshot of your state, city, or community and also offers the opportunity to create a common visual around which community stakeholders can identify shared concerns or unique strengths. Examples of such resources are shown in Table 9.

TABLE 9: DATA RESOURCES

National level resources to consider:	URL or contact info:
United States Census Bureau website	www.census.gov
American FactFinder website	www.factfinder.census.gov/faces/nav/jsf/pages/index.xhtml
Child Death Review Data	www.childdeathreview.org
National Violent Death Reporting System [NVDRS]	www.cdc.gov/violenceprevention/nvdrs
National Child Abuse and Neglect Data System [NCANDS]	www.acf.hhs.gov/cb/resource/about-ncands
National Survey of Family Growth [NSFG]	www.cdc.gov/nchs/nsfg

Annie E. Casey's Kids Count	www.kidscount.org
Pregnancy Risk Assessment Monitoring System [PRAMS]	www.cdc.gov/prams
Maternal and Child Health Bureau at the Health Resources Services Administration	www.mchb.hrsa.gov/mchirc/chusa
Children's Bureau of the Administration for Children and Families	www.childwelfare.gov/systemwide/statistics
The Forum on Child and Family Statistics	www.childstats.gov
Child Trends Data Bank	www.ChildTrends.org
Behavioral Risk Factor Surveillance System	www.cdc.gov/brfss

- Access the descriptive information on families and available resources included in state needs assessments completed for the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Initiative; Title V needs assessment for inclusion in a state's Maternal and Child Health Services Block Grant application; and Collaborative Needs Assessment Strategic Plan periodically required by the Head Start Collaborative Office. Also, the state's Annual Kids Count data report funded by the Annie E. Casey Foundation will list specific indicators and data sources which may be available at a sub-state level. Some states also may have access to descriptive information generated as part of their Project LAUNCH, Reach for the Top, and other federal or state grants that require documentation of existing services and unmet need estimates. One example of what this type of summary might look like is included in Attachment G.

- Create a web-page dedicated to this effort which would include, among other features, an interactive map, illustrating the membership of the local community teams and the activities each are promoting. The webpage also might support an interactive blog where individual community planning teams could post their initial implementation success stories or post challenges they are facing. To further promoted information, the CBCAP SLA might host a series of webinars on topics of high interest across the state which could be logged on the website for future reference. Also, as state or local planning teams develop new tools, these tools could be available on the webpage with a set of interactive instructions. Examples of this type of page are included in Table 10.

- Promote the ongoing work of the individual learning collaboratives. The CBCAP SLA could host "virtual" meetings of the group on state conference call lines.

TABLE 10: INFORMATION RESOURCES WEBSITE EXAMPLES

Website examples
The Recovery Program Transformation & Innovation Fund (RPTIF) is a collaborative initiative designed to support and enhance services for addictions treatment and recovery support in South Carolina. Their website houses a dedicated space for grantees to share resources with one another: http://rptif.cosw.sc.edu/

The Virginia Board for People with Disabilities engages in advocacy, capacity building, and systems change activities that contribute to a coordinated consumer and family centered and directed, comprehensive system of services, individualized supports, and other forms of assistance that enable individuals with disabilities to exercise self-determination, be independent, be productive, and be integrated in all facets of community life: https://vaboard.org/

The **Robert Wood Johnson Foundation** houses information for all of its grantees, including a collection of resources for RWJF-supported researchers, and for evaluators who are assessing RWJF programs. These are housed here: http://www.rwjf.org/en/library/collections/resources-for-researchers-and-evaluators.html

- Hold state conferences once or twice a year in which members from multiple learning communities gather for common training or to share innovations across communities. During these meetings community implementation teams could be introduced to various methods of insuring continuous quality improvements, such as Collaborative and Innovation Improvement Networks (COIIN) supported by the Institute for Healthcare Improvement (www.ihi.org). Most recently, the concept has been applied to improving early home visiting programs for new parents. See Figure 8.

- Provide on-site technical assistance on enhancing data quality through improved measurement specifications, more consistent and complete data entry, improved rigor in system design. Such training also should address issues of data use. Attachment H provides an overview of the data use strategies commonly cited in data sharing arrangements between administrative entities and local non-profit organization

FIGURE 8: EXAMPLE OF TOPICS TO BE INCLUDE IN STATE LEVEL TRAININGS

Using Quality Improvement Efforts to Enhance Early Home Visiting

The Maternal and Child Health Bureau's (MCHB) Division of Home Visiting and Early Childhood Systems has launched a Home Visiting Collaborative Improvement and Innovation Network (HV CoIIN) through a three-year cooperative agreement with Education Development Center, Inc. (EDC). The HV CoIIN, using the Institute for Healthcare Improvement's Breakthrough Series Model, aims to improve critical outcomes for families. It brings together teams from local home visiting service agencies across 11 states, and one non-profit grantee to seek collaborative learning, rapid testing for improvement, sharing of best practices and building of QI capacity.

The Health Resources and Services Administration, in cooperative agreement with Education Development Center, are working to improve outcomes for families targeting four program outcomes.

The HV CoIIN provides working technical documents developed by faculty experts and stakeholders that establish a common vision and mission for each of the topic areas. For each topic a charter was developed which clearly identifies the gap between what we know works and what is happening on the ground, the SMART AIM the collaborative is trying to accomplish,

process aims and accompanying measures, and roles and expectations of participation. Each team signs the charter. Initial topics explored include:

- Breastfeeding
- Developmental promotion, early detection and intervention
- Family engagement
- Maternal depression

Information on the strategies examined to support performance in these areas is available at: **http://hv-coiin.edc.org/aboutmeasure**.

SUMMARY OF SECTION I

This section has provided guidance and resources on Crafting a Statewide Plan. Specifically, the toolkit guides state planners through a series of steps to clarify key operational values, identify specific programmatic and system objectives and develop an implementation plan for advancing those interventions or policy changes in a manner that offers the strongest probability for achieving the plan's outcomes.

Below we provide a checklist for the state leadership team to monitor their progress and offer strategies as to how the state can best communicate its decisions to local implementation teams. This is provided in Table 11. Additionally, in Figure 9 we have provided a set of issues to watch out for as state teams embark upon this work.

TABLE 11: CHECKLIST TO MONITOR PROGRESS

Checklist	Suggestions for moving activities forward
Step 1: Identify a core set of values	• Provide each planning team member with an historical overview of the state's response to child maltreatment prevention. • Solicit input from parents and other key stakeholders on their perceptions of priority items.
Step 2: Select target outcomes and related indicators	• Provide each local planning team with initial profiles of the families and state-supported resources within their local community. • Consider outcome domains relevant across multiple initiatives and agencies.
Step 3: Identify program or policy innovations	• Examine evidence-based and promising programs and policies that have worked in similar states or jurisdictions. • Consider the potential of scaling-up high priority strategies already being implemented in the state.
Step 4: Develop implementation teams	• Identify areas already undergoing change and consider ways to use the momentum to facilitate early implementation of priority strategies. • Support the work across implementation teams by holding "virtual meetings" via conference call.
Step 5: Create learning communities	• Support learning communities by developing a website that allows local planning teams to share tools and resources with one another. • Hold state conferences so that learning communities can participate in training together and share ideas, progress, and resources. • Provide on-site technical assistance.

FIGURE 9: THINGS TO WATCH OUT FOR GOING FORWARD

Issues to consider:

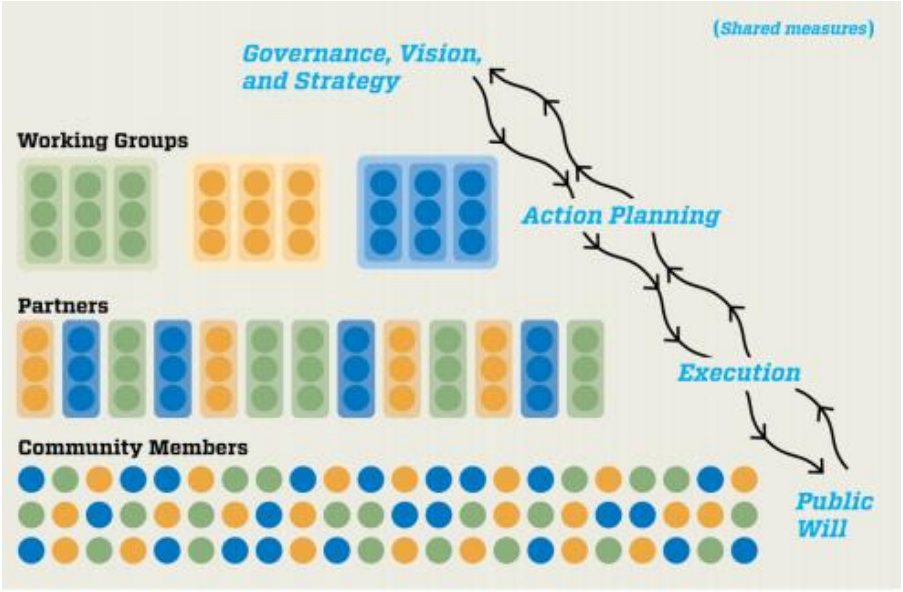
- Anticipate changes in political leadership and build relationships, formulating contingency plans as necessary.
- Work in partnership with other states to gather ideas, align efforts and share success stories.
- Align efforts with other partners within the state as much as possible. There may be unanticipated alignment that could be leveraged for marketing and publication efforts, advocacy efforts, etc.
- Remain open to adjusting your priorities when new opportunities emerge. If an initial course of action proves difficult, regroup and consider an alternative approach.
- Share your success stories. Be sure state leadership as well as the general public are aware of your efforts and the gains you achieve.

SECTION II: COMMUNITY PLANNING

All plans, like all politics, are best realized at the local level. While state leaders can offer a general framework for shaping an effective practice and policy response to child maltreatment, the ability of any plan to touch the lives of families requires that community leaders tailor the plan to fit local realities. In some instances, this "tailoring" process will be minimal and involve introducing a state recommended approach into the existing community service portfolio. In other instances, communities may want to convene local stakeholders to present the state plan and local organizations may integrate the plan's core practice principles into the way they do business. In other instances, the state's target outcomes may provide new insights for program managers on how to shape their evaluation plans and data management systems. Each of these strategies offer meaningful ways to enhance local child maltreatment prevention efforts particularly for communities with limited abilities to engage in a more comprehensive planning process.

For those communities that do have sufficient resources, leadership and interests in the planning process the state plan can provide a spring board for engaging in a comprehensive assessment of current local conditions, outlining an approach for improving conditions, and tracking the impacts of these reforms on the well-being of children and their families.

FIGURE 10: HOW THE STATE LEVEL AND COMMINITY LEVEL WORK INFORM ONE ANOTHER



Sources: Phillips & Splansky Juster,, 2014; Hanleybrown, Kania, & Kramer, 2012

As noted in the collective impact literature and illustrated in Figure 10, the process of improving community conditions for meeting the needs of children and adequately supporting parents is an iterative process, with the various steps and individual tasks embedded in the planning process building on each other and interfacing with the work that has been completed at the state level. Hanleybrown, Kania, and Kramer (2012) note, "the real work of the collective impact initiative takes place in these targeted groups through a continuous process of 'planning and doing,' grounded in constant evidence-based feedback around what is or is

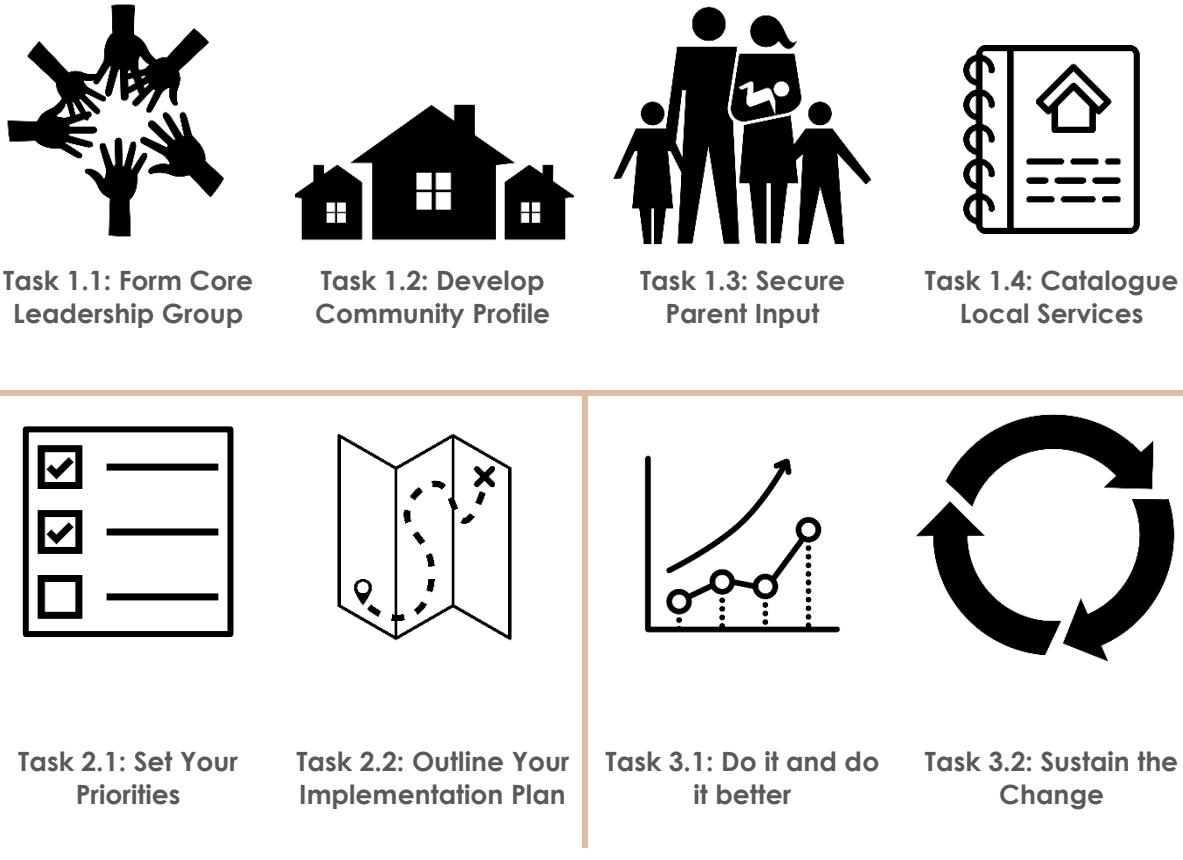
not working." The success of the entire process relies on how well the working groups can leverage their shared vision and strategic goals into a collection of actionable steps.

This section of the framework provides local communities specific steps they can follow in applying the concepts and suggested action items raised in the state plan to their specific situation. These steps are divided into three broad areas:

- **Framing the scope of the local plan** (selecting your leadership team, developing a picture of your community's demographic, health, and economic parameters, securing input from parents, and cataloging local service options).
- **Planning specific action steps** (setting your priorities and outlining an implementation plan).
- **Monitoring your progress** (developing strategies to insure continuous quality improvement and sustaining change over time).

These phases are organized under the steps illustrated in Figure 11.

FIGURE 11: TASKS IN THE COMMUNITY LEVEL PLANNING PROCESS



STEP 1: FRAMING

TASK 1.1: FORM CORE LEADERSHIP GROUP

The first step in tailoring the state plan to your community will be to identify a lead organization and team who will be responsible for moving the plan forward. Initially, this group may be relatively small, consisting of those engaged in local child maltreatment prevention or family support efforts. In many communities, this group might consist of those managing larger, non-profit organizations that focus on family issues; local advocacy organizations that support expansion of children and family services; public agency managers directing public health, child welfare, and primary and secondary education; and civic leaders who have an interest in child maltreatment prevention. It also will be important to identify a lead organization who can provide some in-kind support for this effort in terms of hosting meetings and facilitating communication among group members.

At the framing stage, the primary tasks of this group would be the following:

- Review the goals and values presented in the state plan.
- Identify team leaders to develop a general profile of the community. Specific tasks include examining any summary or descriptive data provided in the state plan on your community, noting the ways in which your community differs from other parts of the state; augmenting these data with more detailed information maintained by local public agencies such as the health department, school districts, and welfare agencies as well as information cataloged by non-governmental agencies such as the local United Way or the Chamber of Commerce.
- Identify team leaders to secure parent input. Specific tasks include reviewing any parent survey or parent focus groups conducted by the state to determine which issues are most relevant to further explore in your community; *if parent input was not systematically collected at the state level*, outlining your specific questions and determining how best to obtain parent response; developing a plan for data collection and analysis; and sharing results with local residents. The team also will need to think through needs such as resources to include families including interpreters, refreshments, transportation and other costs that can support participation and feedback.
- Identify team leaders to document available services and resources. Specific tasks include examining any summary or descriptive service data provided in the state plan relevant to your community, noting key variations in the types or level of services available in your community versus other parts of the state; augment this information with services provided by members of your leadership team; review existing lists of community resources maintained by the United

Way or other similar organizations; ask key stakeholders (such as members of the faith community, library staff, community service centers staff, etc.) to augment your list with other supports they provide families and children; and compiling the list and share with the full leadership group.

Dividing the group into smaller task forces offers a way to move forward on multiple tasks in a timely manner. While communities may elect to do each of these tasks sequentially, doing them simultaneously will generate opportunities for engaging a greater number of residents, particularly if the teams expand membership beyond the core leadership team.

TASK 1.2: DEVELOP A COMMUNITY PROFILE

The first place to start is to develop a descriptive profile of your community. Building on the local descriptions the state will have provided you, use additional local information to enhance your understanding of the basic demographics of your community (e.g., the number of residents, children, households and the trends in these numbers; racial composition, paying particularly attention to those groups that are increasing in number; economic profile of both the residents and the community as a whole (e.g., is unemployment increasing or decreasing, are new industries coming into the community, overall economic "health" of the community); common health indicators (e.g., infant mortality/morbidity, adult health trends, smoking, accident rates, suicide both adults and youth) and child maltreatment reports, confirmations, and foster care trends. Advocacy organizations collect and compile data on different indicators that may also be readily available. See Table 12 for examples of indicators to use in creating a community profile.

In addition to the state and local government statistics that may be available, consider collecting any trend data maintained by private organizations such as hospitals (changes they may be seeing in birth rates, emergency room usage and patterns, families lacking insurance, etc.) as well as the membership trends among local churches and civic organizations. Such information can help you better understand emerging issues among residents that may not yet have hit the public "statistics". See Table 13 for examples of community profiles that may be readily available to you. These may also serve as guides for how this information may be presented for your community.

Once you have collected this information, it will be important to display the data in a manner that is engaging to the average reader. Few people are likely to wade through detailed reports filled with statistics they may or may not fully understand. Examining trends and compiling data in a "user friendly" manner are important steps in this process.

Several on-line tools are listed in Attachment I which can assist in making data easier to present, disseminate and consume. For example, data visualization tools allow multiple variables to be depicted

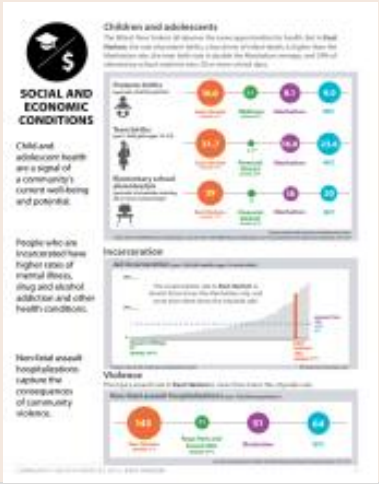
at the same time and display changes and trends in health status and disparities over time within and between communities.

Figure 12, taken from the Kids Count Data Report, illustrate current levels and trends on a variety of indicators. This type of information can be particularly important in helping communities focus on populations in greatest need or identify those specific needs which are not currently being addressed.

TABLE 12: RESOURCES FOR COMPILING COMMUNITY LEVEL DATA

Suggested resources for compiling data in your community
Vital statistics • Birth and death records (births to teen mothers and child homicide deaths among children under 5 years of age) • Child fatality review records
Health data • Hospital emergency department or discharge data • Prenatal care coverage, month initiated, and services included (e.g., are pregnant women being screened for depression, exposure to partner violence, or substance abuse; if they are, are they being referred to evidence-based services, if they are, what percent of those referred actually receive the service) • Coverage and dosage of well-baby visits and services offered for all children and for children at risk or with developmental problems • Coverage of family planning services
Criminal justice data • Police reports of events or arrest records especially for partner violence • Programs offered to incarcerated parents (e.g., parenting or problem solving skills training)
Child protection and welfare data • Reports to child protective services, substantiated reports of abuse and neglect, or out of-home placements (number and geographic location) • Services provided to parents and children reported • Length of wait list for early child care and education programs such as Early Head Start • Length of wait list for child care subsidies • Number and location of families receiving TANF, SNAP, etc.
Educational data • Length of wait list for pre-K program such as Head Start • Sex education programs being used in schools (e.g., are they evidence-based?
Demographic data • Children living in poverty (number, proportion, and location) • Parents unemployed (number, proportion, and location)
Source: Centers for Disease Control and Prevention

TABLE 13: EXAMPLES OF COMMUNITY PROFILES

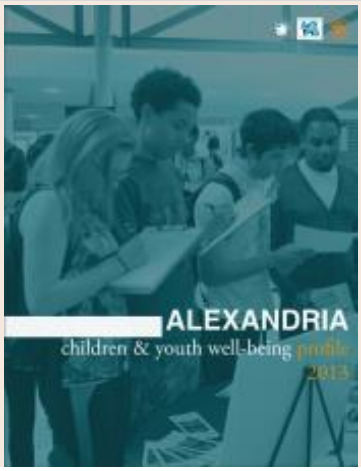


NYC Department of Health Community Profiles
Health profiles by community area

- **Example URL:** www1.nyc.gov/assets/doh/downloads/pdf/data/2015chp-bx4.pdf
- **Contains:** Demographics, health outcomes, social and economic conditions, neighborhood conditions, health behaviors, and environmental characteristics
- **Pros:** Comprehensive, graphic presentation
- **Cons:** Somewhat lengthy at 16 pages

Illinois Action for Children
Child care and early education profile by legislative district

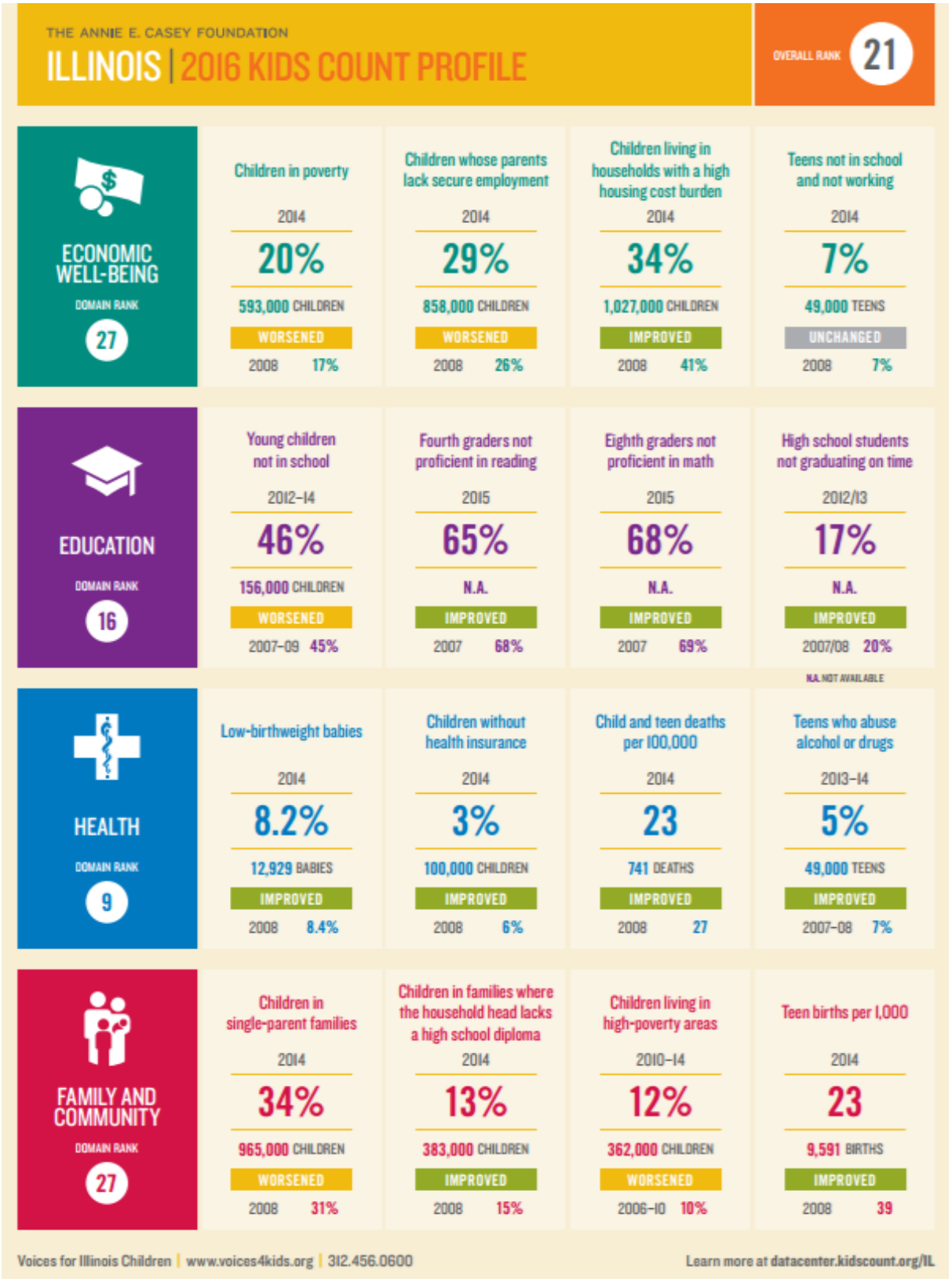
- **Example URL:** www.actforchildren.org/wp-content/uploads/2016/01/2016-IL-Congressional-District-4.pdf
- **Contains:** Total population, number of child care options, total cost of childcare, etc.
- **Pros:** All findings presented graphically with short text summary
- **Cons:** Text-heavy, small print



Alexandria Youth Wellbeing Profile: Comprehensive profile including safe environment, school readiness, resilience, etc.

- **Example URL**: www.alexandriava.gov/uploadedfiles/dchs/info/youthwellbeingprofileweb.pdf
- **Contains:** Teen pregnancy, school readiness, resilience, mental health, substance use, etc.
- **Pros:** Detailed, specific information provided
- **Cons:** Very long, at 44 pages

FIGURE 12: EXAMPLE OF A PROFILE WITH MEANINGFUL GRAPHIC REPRESENTATION



TASK 1.3: SECURE PARENT INPUT

As noted in the previous section, it will be important to incorporate the voice of the parent into your planning process. While conducting statewide parent surveys or focus groups often represent a significant financial investment, securing parent input at the community level often can done with limited resources. Online survey software or websites, such as Survey Monkey, Formstack, or Google Forms, offer a relatively inexpensive but reliable platform to secure parent input on a limited set of issues. In many cases, these issues will mirror the topics that are of interest to those conducting statewide surveys such as how parents use the resources in their community; the extent to which they view their community as a safe and supportive place to raise their children; the extent to which they offer support or access support from friends and neighbors; and the issues that most concern them about having the support they need to raise their children. When conducted at a local level, the content of these survey questions can be less generic and more specific – local surveys can ask parents if they are familiar with or have used Program X rather than simply asking if they have attended a parent education class. While the level of detail available through online survey methods is limited, the strategy can provide an important lens for learning how consumers view the utility and quality of local service options. Attempt to secure a broad range of participants (with representation from all socio-economic strata and all sections of the community). Care should be taken in interpreting the results if the survey sample omits certain groups.

To tap into hard to reach populations or obtain greater detail, focus groups with parents may be a particularly important strategy to utilize at the community level. Such groups can be organized by neighborhood agency or community block group, be hosted by local community organizations such as a local church, child care center, public library or a parent group at the local elementary school. Local health providers or community service programs also could offer an opportunity for their participants to share their ideas. As with the parent survey, these groups can focus on service utilization, quality, and unmet needs. Unlike a survey, however, focus group discussion offers the opportunity to secure rich, descriptive information on a parent's experiences and how best to improve the community context. Tips for conducting data collection efforts are shown in Table 14.

Local planning teams should discuss their proposed approach and desired outcomes with local government agencies that may have conducted this type of research or consult with local academic partners. Those with access to local colleges/universities should reach out to faculty members with experience in survey research and may be in a position to lend their expertise to these efforts and potentially provide student resources for the collection and/or analysis of the results.

TABLE 14: TIPS FOR MAXIMIZING PARTICIPATION IN SURVEYS OR FOCUS GROUPS
Tips for maximizing Survey response rates:
• **Provide Notification.** Potential respondents should be made aware of the upcoming survey in advance. This can be done through email, phone, or newsletters as a way to draw attention to the purpose for the survey and the potential benefits of the survey results. Consider the role community partners and schools can play by including survey links in their communications to parents. • **First Impressions are Important**. Make sure that the survey itself contains clear instructions for completion and contact information for any assistance. It is also important that your questions are simple, direct, and contain only a few open-ended questions. You only have one opportunity to make a good first impression. • **Accessible**. Make sure that the survey is accessible for all potential respondents. Some examples of this include assuring that the online survey can be accessed via a person's phone and if your survey population is likely to include people whose first language is not English, include translated content or information on where they can obtain a translated copy of the survey. • **Follow-up.** Monitor the responses and coordinate reminder notifications about completing the survey. It's best to include a link directly to the survey in each reminder.
Tips for maximizing involvement in Focus Groups:
• **Planning**. Participants should be notified of the date and time of the focus group well in advance. Additionally, send reminder notifications to participants ahead of the focus group date. • **The Role of the Moderator**. A good moderator for your focus group plays a critical role in the responses and involvement of participants. They guide the group in a structured discussion while assuring that all participants are comfortable in expressing their own opinion. • **The Power of Food**. If budgeting allows, provide refreshments and snacks. This small incentive goes a long way in generating participation. • **Accessible**. Provide language assistance if needed.

TASK 1.4: CATALOGUE LOCAL SERVICES

The goal of this task is not to list every possible service in the community but rather to highlight the primary providers and sources of support that are found within the community. Again, the SLA will have provided the local planning team an initial list of state level investments in the plan's strategic services areas and some indication of the number of families being reached through these mechanisms. The challenge for the community planning team is identifying the specific providers offering these services at the local level and determining the capacity and quality of these options. While no community should expect to launch expansion in all of the areas identified in the state plan, familiarizing the local planning team

with an array of options currently being offered is a good first step in learning what might be possible within the context of the service options prioritized in the state plan.

"High priority" interventions that should be included in this scan would be those with a strong connection to improving the plan's core outcomes. For each intervention, the local planning team should document the intervention's eligibility criteria, current capacity, and potential for expansion. Common providers of key prevention services targeting children and their families include local offices of state-funded agencies (e.g., public health offices, state employment services, WIC offices); prevention services supported by municipal public agencies such as libraries, parks and recreation programs, community centers, and schools; and prevention services supported by non-profit organizations such as churches, YMCA, etc.

STEP 1 SUMMARY

The final products generated by all three of these "framing" efforts – community profiles, parent surveys, and service listings -- should allow the local planning team to address the following questions:

- What are our strengths in terms of human resources as well as programmatic resources?
- What are our biggest gaps – what do families want and need that we are not able to provide?
- What gets in the way of our community doing better in addressing these needs?

STEP 2: PLANNING

This step involves two stages – setting priorities and crafting an implementation plan.

At this step in planning, your key planning group needs to focus on:

- Pulling out the key lessons learned from your parent survey, focus groups and service scan.
- Set priorities and engage the necessary stakeholder to implement each of your core ideas

TASK 2.1: SET YOUR PRIORITIES

The descriptive information on the community, the perspectives and priorities of parents, and the current service network provides the leadership group important information for determining the community's strengths and promising areas for investment. Strengths can be found in the attitudes and skills of parents in identifying and accessing needed resources; in a strong network of local service providers; or in a key community leader or organization. Consideration should be given to how local resources might be augmented with new programs; how local resources might be shifted to more promising investments; how outcomes might be strengthened if local organizations combined their efforts in certain ways or shared infrastructure or

"back office" functions (staff training needs, financial report, data management systems); or how outcomes might be improved if local programs altered their target populations or adapted their delivery system. The first question to ask in all of these discussions is "how can we make these resources stronger – can we make the context more responsive to what we want to accomplish".

Second, look at each gap and ask yourself if the gap is significant – is there a key service or particular resource families in your community need that is not currently available or available to only a limited degree? Is there a gap in collaboration -- does it block programs from working together? Whatever the gap or limitation, you should outline the possibilities for filling it and outline the resources it will take to accomplish this task. If you cannot envision how you would fill a gap, what other options are available to you? How can you minimize the impact this shortage has on accomplishing your overall goals?

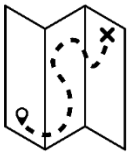
Once you have identified your candidate list of options you might implement in order to strengthen your response or minimize your gaps, you will need to evaluate the feasibility and promise of each candidate strategy. Factors to consider in this vetting process include:

- Ease of implementation – take advantage of "low hanging fruit."
- Potential cost for not addressing it – is this is a big problem that will seriously impede access to important supports or create a negative context in the community? If not, focusing on this problem first may not result in notable gains on core outcomes. This may be an issue you could assign to one organization rather than focus your collective energy on it.
- Interested actors – was this a major concern for parents or something they would use if it was available? Is there an agency/key stakeholder that wants to take this one? If you have highly motivated potential users and/or someone willing to take up the challenge, you should take advantage of this momentum.
- Funding sources or other partners – ideally, you should have a number of organizations willing to champion the idea within their own leadership as well as with their funders. Also, consider any possible support you might be able to secure from the state or non-local governmental or private sources.
- Sustainability – start thinking now about how you will keep the change going.
- Monitoring – how easy will it be to monitor implementation and impacts? What can be built into the plan to insure that your key process and outcome indicators are reliability collected, carefully monitored, and fed back into the decision making process.

You should select no more than three to four ideas to promote at any one time – if you finish one of them sooner then you anticipated, take on another issue. Focusing on too many innovations at one

time can dilute your resources and, potentially, dilute your impacts. It is better to do a few things well then to partially implement a dozen ideas, no matter how good they are.

TASK 2.2: OUTLINE YOUR IMPLEMENTATION PLAN



For each of your top priorities, develop a plan for implementation. Following a process similar to the one recommended for state planners in Section I, this implementation plan should include the following elements:

- Someone to lead the effort – what specific organization or individual will be responsible for each initiative or idea? Responsibility for a new activity can be shared across agencies but one agency needs to be given *lead responsibility* and authority to move forward.
- Specific target user – who will most benefit from the effort and how will you engage your target population? Focus on establishing referral networks that will identify and engage those who you most need to reach.
- Staffing and management issues – does the lead organization have the existing staff capacity to take on this effort? If not, what additional staff are needed and how will the new program fit within the organization's existing management structure?
- Budget and funding sources -- remember some things can be accomplished with minimal dollars but all change requires some resources. What resources are available to support the effort and what additional resources are needed? Who is in the best position to provide these resources?
- Monitoring plan – identify data you will need to insure continuous quality improvement. Who will be responsible for collecting and analyzing these data?
- Time frame – what are your immediate, mid-point and distal milestones and when do you anticipate reaching them?

STEP 2 SUMMARY

The final product generated by these all of these "planning" efforts should be a fully vetted list of candidate strategies that will allow the local planning team to address the following questions:

- What are our top priorities for moving forward?
- Does each idea have at least one champion and "organizational" home that can incubate it?
- How will I inform the community of the plan and secure buy-in from all parts of the community?

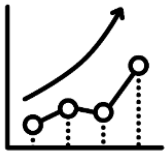
STEP 3: ACTION

This step requires the implementation of the plan, a system to monitor collective progress, and strategies to use data to guide changes.

At this step in planning, your key planning group needs to focus on:

- Transitioning responsibility for implementation and ongoing quality improvement to a specific set of stakeholders for each key objective.
- Design a strategy to secure data to monitor progress on your population level outcomes.
- Develop a strategy to promote community awareness and sustain collective commitment to the change –keeping the plan alive.

TASK 3.1: DO IT AND DO IT BETTER



As you move forward in implementing each idea, assess the extent to which your efforts are reaching the intended audience and are achieving your short term outcomes. If you are implementing a specific intervention or altering an existing direct service program, be aware of who you are engaging and who you may be leaving behind. Be sure you continue to secure input from users to make sure your effort remains on target. If your goal is to extend the message of prevention to a broader segment of the community, monitor who you are engaging and how specifically they are reacting to your message. Are they changing their program focus? Are they more visible in advocating for prevention services? Are they acting in ways to personally support children and their families as evidenced by increased volunteer hours or an increase in donations to non-profit organizations? Be aware of intended and unintended consequences – sometimes changes in a community service network or leadership can alter the context in ways you did not anticipate. Some of these unanticipated outcomes will be positive and advance your objectives. Others may create new challenges or require you to alter your priorities. To maximize the impacts of positive change and minimize the impacts of negative change, it will be important for the steering committee to maintain close communication with all of those working on implementing the plan's priorities.

TASK 3.2: SUSTAIN THE CHANGE

Periodic updates will be essential in keeping the plan "alive". This will be the most important job of the leadership committee. If elements are completed, go back to your list of priorities and select additional elements. Update the community on your progress. Demonstrate change on the outcomes through benchmark reporting and public forums open to all residents. Also consider providing the community periodic updates on the plan and your progress through press releases distributed through the local press and community newsletters as well as agency websites.

STEP 3 SUMMARY

The final product generated by both of these "action" steps should be an infrastructure that will allow you to successfully implement your target priorities, monitor your progress, and continuously improve your performance. You will be able to address the following questions:

- Are our strategies engaging the appropriate target population and achieving the change in participants that we expected?
- Are we seeing improvement in our core population level outcomes?
- Are new issues emerging that we need to address?
- What planning and implementation lessons can we share with others in our learning community?

SUMMARY OF SECTION II

This section has provided guidance for local communities in tailoring state child maltreatment prevention plans to fit local conditions. In terms of initial steps, this section provided suggestions on how community leadership teams might document the key demographic aspects of their community, obtain input from local residents on the challenges they face in meeting their parenting responsibilities, and summarize the local service network. Building on this information, community planning teams can thoughtfully select their priority interventions and build solid implementation strategies for moving these priorities forward. Finally, the section underscores the importance of crafting a strong quality improvement system and sustainability plan.

As with the state plan, it will be important for local communities to monitor their progress overtime and remain open to making mid-course adjustments if their initial implementation plans cannot be operationalized. Effective plans are ones that evolve and change over time. Plans, like families, are impacted by such things as changes in a community's economic conditions, by the introduction of new populations, and by variations in public and private funding levels. As such, reaching a plan's desired outcomes will require continuous attention to how resources are being allocated.

SECTION III: RESOURCES

ATTACHMENT A: COLORADO AND SOUTH CAROLINA PLANNING PARTNERS

Both pilot states, Colorado and South Carolina, had a number of partners engaged throughout the child protection framework planning process that provided their expertise, insight, and knowledge in supporting the state's response to child maltreatment and improving the lives of children and families. Some of these important partners are highlighted below:

Colorado Partners	South Carolina Partners
Colorado Office of Early Childhood; Colorado Child Maltreatment Prevention Unit; SafeCare Colorado; Promoting Safe and Stable Families, Office of Early Childhood; Early Intervention Colorado; Early Childhood Councils; Community Centered Boards; Essentials for Childhood; Strengthening Families Network, Early Childhood Mental Health Unit, Home Visiting Unit; Head Start; State Prevention Steering Committee; Invest in Kids; Lutheran Family Services; Jeffco Prosperity Project; Qualistar - Child Care Resource and Referral; Prevent Child Abuse Colorado; Colorado Alliance for Drug Endangered Children; Mile High United Way; Paddington Station Preschool; A Kids Place - CASA and CAC in Weld County; Savio House; Military networks; Colorado Children's Campaign; Action for Healthy Kids Network; Colorado State Parent Teacher Association; Family Leadership Training Institute; Evergreen Parks and Recreation; Fatherhood Coalition; and Early Childhood Colorado Partnership.	Children's Trust of South Carolina; University of South Carolina (Department of Social Work, Department of Psychology); South Carolina Department of Social Services; South Carolina Department of Social Services State and Regional Offices; Joint Council on Children and Adolescents; Department of Alcohol and other Drug Abuse Services; Department of Health and Environmental Control; Department of Health and Human Services; Department of Juvenile Justice; Department of Mental Health; Blue Cross Blue Shield Foundation of South Carolina; The Duke Endowment; Family Connection of South Carolina; Federation of Families of South Carolina; National Alliance on Mental Illness (NAMI); Palmetto Association for Children and Families; Tidwell and Associates; Family Corps; A Children's Place; East Point Academy; Lee County First Steps; Midlands Fatherhood Coalition; United Way of Midlands; and parents and community service providers in Aiken, West Columbia, Columbia, Charleston, Darlington, Florence and Marion Counties.

ATTACHMENT B: DATA COLLECTION TOOLS

PARENT SURVEY

Community Supports

We are interested in learning more about how the supports and resources parents often find in the communities in which they live can help them care for their children. These first few questions ask about the resources available in your community.

1. Communities often have organizations that support families. Please indicate if you are familiar with and if you have used the following organizations or institutions in your community. (Please circle all that apply)

	Are you familiar with the organization?		**Have you used the organization?**	
	YES	NO	YES	NO
Religious or faith organizations				
Hospital/urgent care clinics				
Primary care doctors or pediatricians				
Neighborhood watch organization or resident, tenant or homeowner's association				
Parent organizations that work with schools like the Parent Teacher Association (PTA) or school improvement councils				
Sport or recreational programs for children and youth (e.g., Little League, scouting, music/dance programs)				
Programs for pre-school children (2-4 years of age)				
Center-based child care				
Libraries				
Parenting education/support programs				
Home visiting programs				
Family Resource Centers				
Respite or emergency care for young children				

2. Please indicate the extent to which you agree with the following statements.

	Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**	**Don't Know**
I can generally get to where I need to go in my community.					
I feel safe in my neighborhood.					

My community is overall a clean, well-kept community.					
People generally can find work in or near my community.					
I can find help with childcare in my community when I need it.					
I am very satisfied with my neighborhood as a place to live.					
My community has educational opportunities for children.					

3. People have different ways of describing their community. How well do the following statements describe people in your community?[3]

	Not at all	**Some what**	**Mostly**	**All of the time**	**Don't know**
If I had an emergency, even people I do not know in this community would be willing to help.					
People here know they can get help from the community if they are in trouble.					
People can depend on each other in this community.					
My friends in this community are a part of my everyday activities.					
Living in this community gives me a secure feeling.					
This is a very good community to bring up children.					

4. From time to time, people in communities often offer help to each other to deal with simple issues around parenting. In the past 30 days, have you helped a neighbor or friend by:

	No	**Once**	**More than Once**
Taking care of their child(ren) on a regular (e.g. weekly or daily) basis?			
Taking care of their child(ren) when something is unexpected?			
Running an errand for them, helping them shop, giving them a ride somewhere, or helping them around the house with a chore/repair?			
Lending them things like money, tools, food, or clothing?			
Giving them some advice or information about raising child(ren)?			

[3] Questions 2 and 3 adapted from the American Family Assets Study (Search Institute)

5. Now thinking about this in terms of help you might have needed, in the past 30 days, have you asked a neighbor or friend to:

	No	Once	More than Once
Look after your child(ren) on a regular basis (e.g. weekly or daily)?			
Look after your child(ren) when something unexpected happened?			
Run an errand for you, help you with shopping, give you a ride somewhere, or help you around the house with a chore or repair?			
Lend you things like money, tools, food, or clothing?			
Give you some advice or information about raising your child(ren)?			

Family Supports

Thinking about your own family, the next few questions ask about how families can help each other support and care for their children.

6. Many families have a number of strengths as well as challenges. From the statements listed below, please indicate how well each characteristic describes your family.

	Rarely	On occasion	Most of the time
In my family, we talk about problems.			
In my family, we take time to listen to each other.			
My family pulls together when things are stressful.			
My family is able to solve our problems.			
My family can consistently meet our basic material needs (e.g., food, clothing and shelter).			
My family enjoys spending time together.			
Members of my family are emotionally and physically healthy.			
My family is able to find resources in the community when we need them.			

7. Raising children can be challenging. Please indicate how often each statement applies to you in thinking about the relationship **with your youngest child living in your home.**[4]

	Rarely	**On occasion**	**Most of the time**
I know how to help my child.			
I believe my child misbehaves just to upset me.			
I praise my child when he/she behaves well.			
When I discipline my child, I lose control.			
I am happy being with my child.			
My child and I are very close to each other.			
I am able to soothe my child when he/she is upset.			
I spend time with my child doing what he/she likes to do.			
I know what to expect from my child as he/she grows and develops.			

General Description

This final set of questions will help us understand a bit more about you.

8. In what year were you born? _____

9. Please specify your gender: Male ____ Female____

10. Which Ethnicity/Race best describes you? (please select all that apply)
    ____African American or Black
    ____American Indian/Alaska Native
    ____Asian American
    ____Hispanic or Latino American
    ____Caucasian/White
    ____Other: _____

11. What is your highest level of education?
    ____Less than high school
    ____High school graduate/GED
    ____Some college/post-secondary school/ Technical School
    ____College graduate
    ____Graduate Degree(s)

[4] Questions 6 and 7 revised from the Protective Factors Survey, http://friendsnrc.org/jdownloads/attachments/pfs_revised_2012.pdf.

12. What is your estimated Household Income?
    ____Under $10,000
    ____$10,000 to $29,999
    ____$30,000 to $49,999
    ____$50,000 to $74,999
    ____$75,000 or over

13. How many children under age 18 are currently living with you? _____

14. What is the age of the youngest child currently living at home? _____

15. Do you share caregiving responsibilities for your child(ren) with another adult on a regular basis?
    ____ Yes
    ____ No

16. Have you, or other adults who share caregiving responsibilities for your child(ren), ever served in the U.S. military?
    ____ Yes
    ____ No

17. Please list the ZIP Code in which you live: _____

Thank you so much for your time.

FOCUS GROUP GUIDE

Child maltreatment Prevention Planning: Parent Focus Groups		
Internal goals to be covered in focus groups: (a) identify what parents see as most valuable in meeting the needs of their children and how they use these resources; (b) comment on 4-6 "high value" innovations identified by the state planning team or state leaders to determine parent interest in the ideas, their likelihood to use them, any barriers they perceive in accessing them, and their potential impact; and (c) testing the prevention values or "pillars" outlined in the draft plan to see if some of these concepts resonant with families.		
INTRODUCTION		
Introduction	Hi. I appreciate all of you taking the time to talk with me today. My name is _____. We are interested in learning more about the supports and resources available to you in your community and how these resources help you to care for your children or help you to be a better parent. I'm excited to hear your thoughts on this topic. Please feel free to share your thoughts even if you think they are different from what others might say. We want to hear lots of different ideas. Today I have _____ with me. He/she will be taking notes and helping to make sure we don't miss any of the important things that you say. As I mentioned in obtaining your consent I am tape recording our discussion because we don't want to miss any of your comments.	
Domain of Interest	**Primary Question**	**Suggested Follow-Up Questions**
Community Resources and Supports		
1. *Community Formal Support*	***Comment:*** I would like to start off by talking about what you see as valuable supports in meeting the needs of your children. I want to ask you about the resources available in the community in which you live and how these are used.	A. How often do you use these resources? B. How have they been helpful to you? C. Have you recommended any of these resources to others in your community?

	Questions: What do you see as the most valuable organizations, services, or programs in your community that support your efforts in raising your children?	
2. Community Informal Support	***Comment:*** From time to time, people in communities need to give and receive help in order to deal with simple issues around parenting. ***Question:*** Are individuals in this community generally willing to help others that are in need? What are your personal experiences with this?	A. How often and in what ways have you helped neighbors or community members with simple issues around parenting [watching someone's child, lending items, helping with errands, giving advice]? B. Are there any reasons one might not offer help to a neighbor or someone in the community? C. Have you ever called on a neighbor or community member when you needed help in your community? If so, in what ways? D. Are there any reasons you might not ask for help from a neighbor?
Possible Innovations		
3. Community Innovations	***Comment:*** We would like to get your thoughts on new ideas about supports for parents. I am going to tell you about a couple of these, and I would like to get your reaction to each one. First….: 1. The state is thinking about creating a new information sharing system for service providers to help them get the right kind of services to the right families. For example, a family might be referred to child welfare for services, but they may not need that type of service. So, child welfare may share information about that family with a Family Resource Center or home visiting program or somewhere else. 2. Another new idea for a service is the "Parent Café". In this model, parents meet together in small groups, maybe once a month or every other week.	A. For each issue ask: • What do you think of the idea? • How likely would you be to use this resource or recommend it to others? • What barriers do you see in using this resource?

	One parent "hosts" the group and provides a little bit of information on a specific topic, like discipline, or picky eaters, and then the rest of the time is more informal discussion. 3. Do you all have ideas about how parents might take more of a leadership role in services? 4. Any other new ideas about what services you would want or need in your community. ***Question:*** What are your initial thoughts on each of these ideas?	• What do you see as the most positive aspect of this idea? • What concerns do you have about this resource? • Do you have any ideas about how we could improve on this idea?
Characteristics of Prevention Plans/Core Values of Practice		
4. Family and Participant Voice	***Comment:*** All of us have to get help sometimes. We are interested in how programs can make families feel more welcomed and involved when they seek out support. ***Questions:*** Who can tell me about a time when they had a really good experience getting help from a program or service in the community in which you live? During that process, did the service provider ask your opinion about what specific help you would get or what you wanted from the program?	A. How important is it for you to be able make decisions about what services you will receive and the issues you work on? B. When you think about the people that helped you, what were some of their qualities that contributed to your having a positive experience? What types of people do you think are most effective at offering help to families like yours?

OTHER THOUGHTS		
5. Other Thoughts	*Comment:* We have talked a lot about communities and parenting today but I am sure there are topics I did not cover. *Question:* Is there anything else that that you would like to mention today?	
CONCLUSION OF FOCUS GROUP		
Conclusion	**[When a student is taking notes, I will say this.]** Because I want to ensure that we capture everything you said, I would like to ask _____ if there are any topics that we need to follow-up on before we conclude the focus group. *[_____: probe for further clarification on points that were unclear or need follow-up]*. That brings us to the end of our time together. I want to thank you for your time. We'll be looking at the information you and others have given us and utilizing it to develop a plan to improve supports and resources for families in your state. **Thank you again for making time for this today! Your voice is important!**	

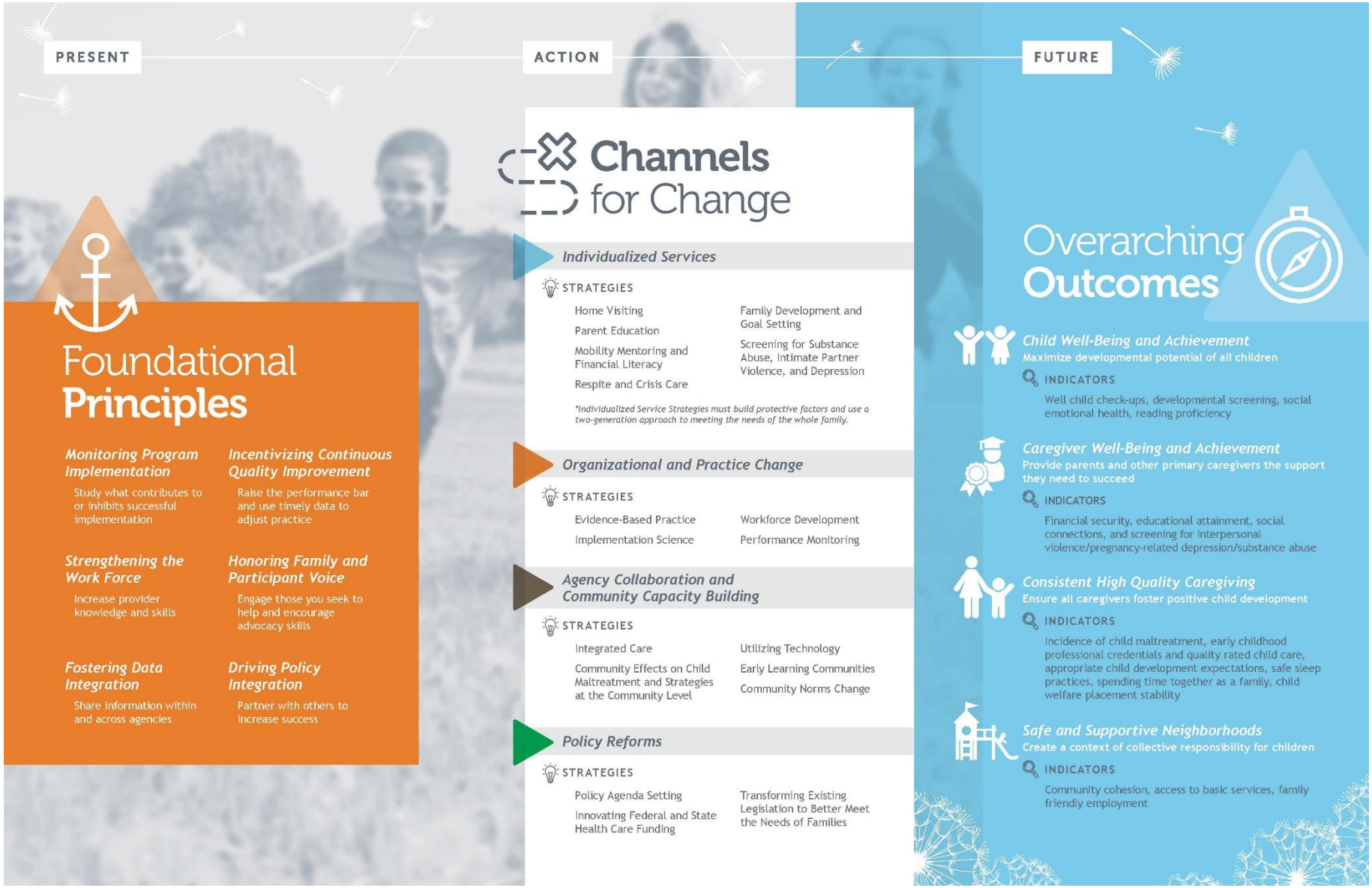
ATTACHMENT C: EXAMPLES OF INDICATORS THAT CAN BE USED FOR STATE AND PROGRAM LEVEL PLANNING

Example Indicators				
Domain	**Measure**	**Level**	**Source**	**Related indicator(s)**
Child wellbeing and achievement	Child health	Program participant	Program data (self-report)	Number and percent of children who received their last well visit; Number and percent of children with a reported medical home; Number and percent enrolled in health insurance
		State or municipality	Immunization registry; Medicaid data	Number and percent of children with up to date immunizations; Number and percent of students with a medical record on file; Percent of children enrolled in Medicaid or other state health insurance plan;
	Child safety (exposure to toxins, smoking and lead)	Program participant	Program data (self-report)	Percent of children living in smoke-free homes; Percent of mothers enrolled in programs who quit smoking or tobacco use following program enrollment
		State or municipality	Health department data	Proportion of children ages 1–5 with blood lead greater than or equal to 5 µg/dL
	Child education & development	Program participant	Program data (self-report); Individual medical record data	Percent of children who are screened and referred for follow-up evaluation and intervention; Percent of patients or students who meet developmental milestones
		State or school district	School administrative data	Percent of children on grade level; Percent of children without behavioral or discipline infractions; Percent of children who are not truant; Percent of children who do not repeat grades
Adult wellbeing and achievement	Maternal mental health and wellbeing	Program participant	Program data (self-report)	Percent of mothers screened and referred for follow-up evaluation and intervention
		State	Behavior Risk Factor Surveillance System Survey (BRFSS)	Percent of adults who have 4 or more Adverse Child Experiences

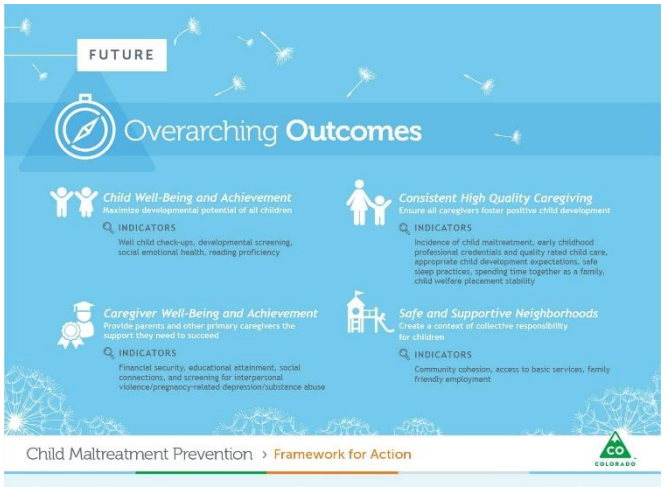
	Maternal reproductive health and family planning	Program participant	Program data and/or medical records	Percent of mothers who receive a postpartum visit with a health care provider within 60 days following birth
		Municipality or state	Vital statistics/birth certificates	Percent of mothers who have an interbirth interval of at least 18 months
Consistent, high quality caregiving	Licensed childcare settings	State or municipality	Human services administrative data	Number and percentage of child care settings that are licensed
	Availability of affordable childcare	State or municipality	Child welfare administrative data	Number and percentage of child care settings that are affordable
	Availability of licensed foster care parents	State or municipality	Child welfare administrative data	Number and percentage foster parents that are licensed
Safe, stable, supportive neighborhoods	Tobacco-free environments	State or municipality	Housing administrative data; state and local policy data	Number and percentage of public and low-income housing that are "smoke free"; Coverage of policies for tobacco-free parks, restaurants, etc.
	Food insecurity	State or municipality	US Census, Current Population Survey	Proportion of parent/guardian population reporting that at some time during the year one or more children were hungry, skipped a meal, or did not eat for a whole day because the household could not afford enough food
	Crime and violence	State or municipality	Justice or police department administrative data	Incidence of crime; Incidence of violent crime in the community

ATTACHMENT D: EXAMPLE STATE PLANNING FRAMEWORK

Example of Colorado's Framework presented as a tri-fold brochure


PRESENT
ACTION
FUTURE
Foundational Principles
Monitoring Program Implementation
Study what contributes to or inhibits successful implementation
Incentivizing Continuous Quality Improvement
Raise the performance bar and use timely data to adjust practice
Strengthening the Work Force
Increase provider knowledge and skills
Honoring Family and Participant Voice
Engage those you seek to help and encourage advocacy skills
Fostering Data Integration
Share information within and across agencies
Driving Policy Integration
Partner with others to increase success
Channels for Change
Individualized Services
STRATEGIES
Home Visiting
Parent Education
Mobility Mentoring and Financial Literacy
Respite and Crisis Care
Family Development and Goal Setting
Screening for Substance Abuse, Intimate Partner Violence, and Depression
*Individualized Service Strategies must build protective factors and use a two-generation approach to meeting the needs of the whole family.
Organizational and Practice Change
STRATEGIES
Evidence-Based Practice
Implementation Science
Workforce Development
Performance Monitoring
Agency Collaboration and Community Capacity Building
STRATEGIES
Integrated Care
Community Effects on Child Maltreatment and Strategies at the Community Level
Utilizing Technology
Early Learning Communities
Community Norms Change
Policy Reforms
STRATEGIES
Policy Agenda Setting
Innovating Federal and State Health Care Funding
Transforming Existing Legislation to Better Meet the Needs of Families
Overarching Outcomes
Child Well-Being and Achievement
Maximize developmental potential of all children
INDICATORS
Well child check-ups, developmental screening, social emotional health, reading proficiency
Caregiver Well-Being and Achievement
Provide parents and other primary caregivers the support they need to succeed
INDICATORS
Financial security, educational attainment, social connections, and screening for interpersonal violence/pregnancy-related depression/substance abuse
Consistent High Quality Caregiving
Ensure all caregivers foster positive child development
INDICATORS
Incidence of child maltreatment, early childhood professional credentials and quality rated child care, appropriate child development expectations, safe sleep practices, spending time together as a family, child welfare placement stability
Safe and Supportive Neighborhoods
Create a context of collective responsibility for children
INDICATORS
Community cohesion, access to basic services, family friendly employment

Example of Colorado's Framework presented as a PowerPoint Deck



ATTACHMENT E: HISTORY OF MALTREATMENT PREVENTION

Children's Bureau Timeline

Use this interactive timeline to explore the Children's Bureau's rich history, decade by decade. Learn about the key political and social events that influenced the development of today's Children's Bureau and shaped the evolution of child welfare in America.

1994 1995 1996 1997 1999 2000 2001 2002 2003 2005 2006 2008 2009 2010 2011 2012

National & World Events

First "orphan train" heads West.

1854-1929

From 1854 through the early 1930s, approximately 200,000 orphaned or abandoned children from Eastern cities were transported by train to new families in other parts of the country. Organizations such as Charles Loring Brace's Children's Aid Society in New York hoped that these children would benefit from living in family homes, where they could receive a good education and training in wholesome work. With the help of the Children's Bureau, the trains eventually were replaced by foster care and adoption practices that promised greater safety and permanency for children.

- National Orphan Train Complex

Orphaned or abandoned children in search of new families traveled west on trains like this one to Kansas, c. 1900. (Kansas State Historical Society)

Website: https://cb100.acf.hhs.gov/childrens-bureau-timeline

ATTACHMENT F: EXAMPLE OF POWERPOINT FOR PRESENTING PROCESS TO STAKEHOLDERS AND PLANNING TEAMS

Source: Chapin Hall at the University of Chicago.
http://www.chapinhall.org/sites/default/files/documents/Example%20PPT%20for%20Presenting%20to%20Stakeholders%20and%20Planning%20Teams.pdf

ATTACHMENT G: EXAMPLE OF COMMUNITY NEEDS ASSESSMENT

MISSOULA

Maternal, Infant, and Early Childhood Home Visiting (MIECHV): 2013 County Profile

MIECHV Risk Indicators (indicators for which the county has higher risk than the state are in bold)

Indicator	Missoula	Statewide
Premature/preterm births (% before 37 completed weeks), 2008-2011[1]	8.8	9.5
Low birth weight births (% <2,500 grams), 2008-2011[1]	6.9	7.3
Infant mortality rate (per 1,000 live births), 2008-2011[1]	5.1	6.1
Under age 18 in poverty (%), 2011[2]	19.4	20.9
Crime rate† (per 100,000 people), 2012[3]	**2,767**	2,149
High school dropout rate (%), 2010/2011 school year[4]	2.4	4.3
Unemployment rate (%), 2012[5]	5.9	6.0
Child abuse (substantiated) rate (per 10,000 children <18 years), 2011[6,8]	18	29
Domestic violence rate† (per 10,000 women 15-44 years of age), 2011[3,8]	**336**	239
Teens who reported ever smoking cigarettes (%), 2012[7]	26.1	31.1
Teens who reported binge alcohol use in last two weeks (%), 2012[7]	**20.5**	20.2
Maternal smoking during pregnancy (%), 2008-2011[1]	12.8	16.6

Additional Risk Indicators

Indicator	Missoula	Statewide
Teen (15-19) birth rate (per 1,000 women 15-19), 2008-2011[1]	18.1	35.5
Births to women without a high school education (%), 2008-2011[1]	7.1	13.4
Deliveries paid for by Medicaid (%), 2008-2011[1]	32.2	33.1
Deliveries for which mother had WIC (%), 2011[1]	32.7	32.7
Deliveries for which newborn was not being breastfed at discharge (%), 2011[1]	6.5	11.7
Prenatal care initiated after the first trimester or not at all (%), 2008-2011[1]	22.2	25.3

* Does not meet standards of reliability or precision.
** Fewer than five. Withheld to prevent possible reidentification.
† Crime and domestic violence rates were derived from a different database than that featured in the 2011 MIECHV Profiles.

Please refer to "MIECHV Indicators by Domain" and "MIECHV Models by Domain" to assist you in determining the domains where your community has the greatest need and the models that show evidence of effectiveness in those domains (available at: http://www.dphhs.mt.gov/publichealth/homevisiting/miechv.shtml).

For more information about evidence-based home visiting models, visit http://homvee.acf.hhs.gov and the model-developer website.

Population (2011)

Live births[1]	1,211
Births to American Indian women[1]	50
First births[1]	549
Births to women under 21[1]	87
Births to women with less than 12th grade education or no GED[1]	72
Medicaid-paid deliveries[1]	389
First births with deliveries paid by Medicaid[1]	189
Estimated children 1 through 2 years[8]	2,422
Estimated children 3 through 4 years[8]	2,602
Medicaid participants under 1 year[1]	628
Medicaid participants 1 through 2 years[1]	1,347
Medicaid participants 3 through 4 years[1]	1,335

Data sources:
1. Montana Department of Public Health and Human Services (MT DPHHS), Office of Epidemiology and Scientific Support.
2. U.S. Census Bureau, 2011 Poverty and Median Income Estimates (http://www.census.gov/did/www/saipe/data/statecounty/data/2011.html).
3. Montana Board of Crime Control (http://mtibrsrp.mt.gov/public/Browse/browsetables.aspx).
4. Montana Office of Public Instruction.
5. Montana Department of Labor and Industry, Research and Analysis Bureau, annual, non-preliminary unemployment rate (http://www.ourfactsyourfuture.org/cgi/dataanalysis/AreaSelection.asp?tableName=Labforce).
6. MT DPHHS, Child and Family Services Division.
7. MT DPHHS, Addictive and Mental Disorders Division, Prevention Needs Assessment.
8. National Center for Health Statistics, U.S. Census Estimates, Vintage 2011 (http://www.cdc.gov/nchs/nvss/bridged_race.htm).

Prepared by the Maternal and Early Childhood Home Visiting Section, Family and Community Health Bureau, Montana Department of Public Health and Human Services.
Contact: Dianna Frick, Section Supervisor, dfrick@mt.gov, 406-444-6940.

Source: Montana MIECHV County Profiles, http://dphhs.mt.gov/Portals/85/publichealth/documents/homevisiting/documents/countyprofiles2013/Missoula.pdf

ATTACHMENT H: EXAMPLE OF DATA USE AGREEMENT LANGUAGE

Data-sharing agreements are central for partnerships between administrative entities and local non-profit organizations. The agreement outlines how and with whom data will be shared, information on data security, and communication about findings. Below highlights some commonly used strategies in developing a data sharing agreement as well as the key elements included in any data sharing agreement.

Successful data sharing agreement strategies:

- Determine what data is available and outline the data flow and processes.
- Outline any privacy considerations including understanding any privacy protections, security requirements or consent requirements.
- Verify if there is a data sharing agreement in place currently and adapt any existing agreements where appropriate.
- Ensure that all agreements have a specified purpose, identify the data that will be shared, and discuss destruction of data.
- Make data sharing sustainable and equitable.
- Utilize available resources (i.e., available federal or state data).

Key Elements in any Data Sharing Agreement:

General introduction: This introduction would include the various organizations and agencies that are involved in the agreement. It would also detail the reason for the agreement and how the data will be used.

Data content and the transmission of data: The specifications of how the data will be transmitted, including the file format, method for transmission, and the frequency of data delivery are important aspects to include in the agreement. The specific data fields and the time period that the data represents are important to highlight as well as any agency disclaimers that will release the agency from any liability from incorrect data.

Release of data and analysis: This includes information on any data security requirements around the handling of the data. If appropriate, the date for which the data should be destroyed or returned should be indicated. Information on the release of data analysis and the proper citation of the data source or if any disclaimer is required on reports should be included.

Contractual issues: It's important to include contractual information about the agreement in place, the process for any necessary amendments to the agreement, and reasons for which the agreement can be ended by either organization.

ATTACHMENT I: USEFUL ONLINE TOOLS FOR DATA ANALYSIS AND PRESENTATION

There are a number of useful tools available that are helpful to both analyze and present data in easy, efficient ways. The table below lists a number of such websites with a simple description of their features.

Type of Resource	Website	Purpose
Infographics	Canva, Piktochart, Easel.ly	• Online tools for creating brochures, presentations, briefs, flyers, and more based on free templates provided • Create within the online tool or in an app for tablets • Graphics can be uploaded • Many features and templates for free, others for minimal cost
	Infogr.am	Similar to the tools above but an Excel-style spreadsheet allows data to be customized in the online tool itself
	Google developers	Create charts and graphs for your website
Dynamic tools to show data trends	Gapminder Motion Chart, Google Motion Charts Gadget	Tools that can be used to create a dynamic chart to explore several indicators over time

ATTACHMENT J: COMMUNITY LEVEL APPROACHES

The following table provides a list of examples of interventions states have used to promote child well-being, maximize adult well-being, etc.

Objective	Interventions used
Promote child well-being	• Family support services • Home visiting • Safe sleep programs • Shaken baby prevention • Home safety checks • Fatherhood programs • Early Intervention • Child daycare/Head Start/Early childhood education • WIC • Parent education and training • Lead screening • Referral to child welfare agency • Referral for primary or specialty medical care • Referral for mental health counseling
Maximize adult well-being	• Assistance with employment and housing • Referral for primary or specialty medical care • Referral for mental health counseling • Referral for substance abuse treatment • WIC • Intimate Partner Violence Prevention
Improve the capacity of all caregivers to meet the safety and developmental needs of children	• Day care licensure • Registered family day care licensure • State-mandated training for child care professionals
Creating safe, stable and supportive neighborhoods	• Community Violence Prevention Programs • Stable housing programs • Hospital licensure • Teen pregnancy prevention • Child sexual abuse prevention

Source: Education Development Center, 2009

ATTACHMENT K: ADDITIONAL PLANNING FRAMEWORKS AND RESOURCES

Frameworks for planning

- Centers for Disease Control and Prevention. (2016). *Preventing Child Maltreatment Through the Promotion of Safe, Stable, and Nurturing Relationships Between Children and Caregivers.* Available at: http://www.cdc.gov/ViolencePrevention/pdf/CM_Strategic_Direction--Long-a.pdf

- Institute for Healthcare Improvement. (2016). *100 Million Healthier Lives: Program Brief – Approach to Equity, Concept Paper.* Available at: http://www.100mlives.org/wp-content/uploads/2016/11/100-Million-Healthier-Lives-Equity-Concept-Paper-11-10-16_Fall-Gathering-Final.pdf

- RAND. (2016). Getting to Outcomes for Home Visiting. Available at: http://www.rand.org/pubs/tools/TL114/manual.html

Prevention resources

- Department of Health and Human Services, Office of Child Abuse and Neglect. (2003). *Emerging practices in the prevention of child abuse and neglect.* Available at: https://www.childwelfare.gov/pubPDFs/emerging_practices_report.pdf.

- Child Welfare Information Gateway. (2011). *Child maltreatment prevention: Past, present, and future.* Available at: https://www.chapinhall.org/sites/default/files/publications/cm_prevention.pdf

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