

Commonwealth of Kentucky

Title IV-E Waiver Application

February 27, 2014

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Background and Current Initiatives

The Cabinet for Health and Family Services (Cabinet) is the state government agency that administers programs to promote public safety and public health. It is the largest of Kentucky's nine cabinets. The Department for Community Based Services (DCBS) remains the largest department within the Cabinet. DCBS administers the state's array of protective and program support services to families including, prevention activities; services to support family self-sufficiency, child protection, foster care, adoption, adult services; and many others. The Cabinet's structure affords DCBS unique opportunities to collaborate and better coordinate with providers of mental health, developmental disabilities, and addiction services; health care providers of children with special needs; public health; Medicaid services, long-term care providers and aging services; school-based family resource centers; volunteer services; and, income supports, such as child support. DCBS' direct service delivery is provided by nine service regions, which cover all 120 Kentucky counties. Each region, led by a service region administrator, implements the Cabinet's programs and manages resources to meet regional needs. The Cabinet's organizational structure provides an opportunity to maximize resources, leveraging additional funds and evolving the overall child welfare service continuum in Kentucky. The Cabinet also collaborates with other external state agencies and community resources to assist in providing efficient and timely services to families and children.

Several initiatives have recently taken place and have situated Kentucky well as a successful Title IV-E waiver demonstration project site. From strengthening partnerships with key state agencies and community partners for more effective service delivery to revamping the Assessment and Documentation Tool used in child protection investigations/ongoing cases, DCBS is moving in a positive direction to better meet the needs of our families and children. The following paragraphs provide detail on some of the Commonwealth's most critical initiatives.

System of Care Expansion and Redesign

Following careful examination of the system of care for children and youth with behavioral health needs, Health and Family Services Cabinet Secretary Audrey Haynes put forth a charge to redesign the behavioral health service delivery system. In April 2013, members of the major child-serving agencies were convened to identify areas of opportunity and next steps. Shortly after this charge, the Department for Behavioral Health and Developmental and Intellectual Disabilities (DBHDID) was awarded a System of Care Expansion Implementation cooperative agreement from Substance Abuse and Mental Health Services Administration (SAMHSA). Funds from this agreement have supplied the human and fiscal resources necessary to coordinate the various child-serving agency change initiatives to ensure alignment, to facilitate collaborative change efforts, and to realize the overarching goal of ensuring access to an effective, comprehensive, and seamless service delivery system for all children, youth, and young adults and their families.

As a result of the system expansion and redesign effort, multiple change initiatives are underway. Most significant has been the expansion of Medicaid, an amendment to the Medicaid State Plan to include a more comprehensive array of mental health and substance use services, and the opening of the provider network as a means of offering greater consumer choice. Through a Center for Substance Abuse Treatment (CSAT) grant, a comprehensive financial map of behavioral health expenditures for youth 8-21 was completed and will allow Kentucky to track the increase of public resources used to provide behavioral health services and the redeployment of other public financing resources to expand the continuum of behavioral health services and supports. Other significant expansion and redesign efforts include the implementation of evidence-based behavioral health screening, assessment, and

treatment approaches for various populations, including those at-risk of or already involved with juvenile justice and child welfare. Kentucky's Title IV-E waiver affords yet another significant opportunity to align with ongoing efforts to improve the service delivery system for children with or at risk of behavioral health challenges and their families.

Medicaid and Managed Care Organizations

In November 2011, Kentucky moved to a statewide managed care system for Medicaid to improve coordination and quality of care and reduce costs for the state's Medicaid program. Kentucky's Department for Medicaid Services entered into contracts with three Managed Care Organizations (MCOs), which expanded to five in January 2013. These were established under a 1915(b) Waiver. In addition to physical health care, the MCOs are responsible for nearly all community and in-patient behavioral health services for Medicaid eligibles. Limited behavioral health rehabilitative services for Medicaid-eligible children in the custody of or under the supervision of DCBS are carved out of managed care and covered through fee-for-service Medicaid. These services currently include the behavioral health treatment component of residential services and therapeutic foster care services.

Kentucky expanded the behavioral health benefits covered by Medicaid effective January 1, 2014. This benefit expansion included both mental health and substance use disorder services. Also, the Medicaid provider network was expanded to include licensed individual behavioral health practitioners, and eligibility for substance use services was extended from pregnant women and children (through the Early and Periodic Screening, Diagnosis and Treatment benefit) to all Medicaid eligibles.

In addition to these Medicaid-covered services, DCBS pays for acute inpatient psychiatric services if the MCO will no longer pay for the hospital stay because the child does not meet medical necessity criteria and there is no placement available in the community. DCBS also provides some behavioral health services such as intensive in-home services funded with state general funds and Title IV-B funds.

DCBS would use the waiver to enable use of Title IV-E funds more flexibly to provide behavioral health and other services to children and their families to help reduce the number of children coming into child welfare at the front end of the system to prevent deeper system involvement.¹ DCBS understands the need to ensure the availability and accessibility of intensive in-home services, to include substance abuse treatment and parent and youth peer support. DCBS is committed to continuing to work with the Kentucky Department for Medicaid Services to assure that Title XIX and Title IV-E funding are effectively coordinated, to maximize the availability of these critical in-home services. Provision of these services early on would help to reduce the number of children placed in the custody of DCBS.

MCO Pilot Programs

DCBS is engaged, in various degrees of implementation, in pilot programs with three MCOs. One MCO has opened service delivery codes to allow providers in the Community Mental Health Centers to bill the MCO for services such as mobile crisis stabilization. Another MCO is in the proposal stage with two private child care providers. One of these pilots proposes using a lesser restrictive group home-type setting to reintegrate children into the community from inpatient hospitalization. It will be used as a step down program for children. The second of these pilots proposes using effective intensive home-based treatment to address families' dysfunctional behavior in their own environment. This pilot's goal

¹ Harburger, D.S., Zabel, M., & Pires, S.A. (2013). A Good and Modern Behavioral Health System: Redesigning Kentucky's Services and Supports for Children, Youth and Young Adults and their Families, pp 2.

is to improve family functioning to prevent removal as well as successful and safe reunification in cases where the child was already removed from the home. A third MCO, teamed with a private child-placing agency (licensed to provide therapeutic foster care), is engaged in the implementation stage of their pilot with a target of approximately ten children. With the clinical focus on children with escalating behaviors, the provider will utilize interventions designed to deescalate crisis and reduce the likelihood a child will disrupt to a higher level of care, and potentially force movement to a setting outside their home community. The pilot project area focuses on three of the nine service regions; however, the pilot permits services to children outside this area if appropriate for their permanency goal. Within each of the pilots, DCBS pays the daily per diem rate, and the MCO pays for any additional Medicaid covered services outside of the per diem.

Trauma Informed Care

Over the past two years, Kentucky has taken steps to introduce Trauma Informed Care into best practice efforts throughout the Commonwealth. DCBS is focusing on a consultation model that provides accessible, credentialed clinicians to assist frontline staff serving the physical needs and mental health needs of children served by the agency. DCBS has also focused efforts towards an effective mechanism for the monitoring and treatment of emotional trauma associated with maltreatment and removal. The Children's Justice Act (CJA) task force (with both DCBS and DBHDID representatives) is exploring the use of federal 2013 CJA funds to develop regionally based, multi-disciplinary trainings for professionals to provide information on trauma and effective inter-agency cooperation to minimize the effects of trauma in child welfare cases.

DCBS has been engaged in monthly meetings that include representatives from public health systems, early childhood development systems, school systems, mental health systems, correctional systems, physical health systems, disability rights advocates, sexual assault prevention advocates and domestic assault prevention advocates. The committee allows for additional collaboration with community partners as well as offers additional information gathering and distribution. In 2012, expert staff from the Center on Trauma and Children through The University of Kentucky, Center on Trauma and Children/Child and Adolescent Trauma Treatment and Training Institute trained all front line staff in one out of nine regions. The staff were trained on Trauma Informed practice, self-care and Trauma Informed treatment. Additionally, three administrative program management staff from DCBS Central Office became certified trainers in Trauma Informed Care. Eight of the Community Mental Health Centers across the Commonwealth were awarded grants to create Trauma Informed Communities. A series of webinars, conferences, and symposiums have taken place to expand training in Trauma Informed Care. A plan is currently being developed to revise DCBS policies and procedures, standards of practice and intake and assessment forms involving children within the child welfare system as well as foster parents.

START

Part of Kentucky's proposed Title IV-E waiver demonstration project includes expanding the current Sobriety Treatment and Recovery Teams (START) program. START is an attempt to meld what we know about addiction-services treatment, good child welfare practice, and family preservation practice into a model that can work with the special needs of these families. These teams have all of the responsibility that regular intake and social workers have. They provide in-home services and ongoing protective

services. Where indicated, they can take custody and place children out of the home, working with the family on reunification or developing an alternate permanency plan for the children.²

DCBS began investing \$2 million of Temporary Assistance for Needy Families (TANF) Maintenance of Effort (MOE) funds annually into substance abuse initiatives based on Ohio's START program. The funding has been renewed each year since 2007. During 2012 and early 2013, Kentucky also received in-depth technical assistance from the National Center on Substance Abuse and Child Welfare. Additionally, the program received a regional partnership grant (RPG) from the Children's Bureau to fund expansion of the program into Daviess County in 2012. During 2012, because of the substance abuse initiatives and inter-agency rapport during IDTA, DCBS received an invitation from the Division of Behavioral Health to participate in regular meetings to discuss service coordination between community mental health and child welfare.

Reevaluation of START outcomes indicate that children served through the START program enter foster care at a rate (20.9%) that is lower than that for other children interacting with the child welfare agency, but who are not served by START (41% of infants, 38% of children five or younger).

Evaluations of START outcomes indicate that about half the number of children that usually would have ended up in placement will not end up in placement. Specifically, 66% of women and 40% of men achieved sobriety at closure of their child welfare case, including clean drug tests and progress in both Child Protective Services (CPS) and Substance Use Disorder (SUD) treatment, compared with a 37% favorable discharge rate overall for CPS-involved clients served in publicly funded SUD treatment programs. These results reflect a cost offset of foster care expenses for CPS of \$2.52 for every dollar spent on START substance use disorder treatment and family mentors.³

Domestic Violence Initiatives

The Kentucky Domestic Violence Association (KDVA) is a statewide coalition whose membership includes all domestic violence programs in Kentucky. Its purpose is to provide mutual support, information, resource sharing and technical assistance; to coordinate services; and to collectively advocate for battered women and their children on statewide issues. Kentucky is divided into fifteen, multi-county Area Development Districts (ADDs). These districts are used for planning and service provision purposes for a variety of programs. The programs began as safe shelters for victims of domestic violence, but as understanding of the complex issues facing victims of domestic violence continues to grow, domestic violence programs are increasingly committed to providing strong client support services. In addition to providing a safe, secure environment for victims/survivors and their children, programs now also offer a variety of support services to residents and non-residents including: legal/court advocacy, case management, safety planning, support groups, individual counseling, housing assistance, job search and children's groups.

KDVA in conjunction with the Kentucky Association of Sexual Assault Programs (KASAP) and the Cabinet for Health and Family Services has hosted the annual Ending Sexual Assault and Domestic Violence Conference for the past fourteen years. Held in early December, this weeklong conference includes pre-conferences, plenary sessions, and fifty workshops and attracts over 500 attendees. Sessions cover a wide variety of topics that are appropriate for both novices and seasoned veterans. Sessions at the most recent conference included such diverse topics as "Creating Cultures of Trauma Informed Care" to a

² <http://www.aecf.org/upload/PublicationFiles/start%20child%20welfare%20model.pdf>

³ <http://www.addictionpro.com/article/rebuilding-family-bond?page=show>

plenary featuring an early civil rights leader, Former State Senator Georgia Powers who spoke about the importance of the Violence Against Women Act.

1) Clearly describe the purpose of proposed project. Explain the problem or issue that the demonstration is expected to address. Articulate the hypothesis that will be tested through the implementation of the program evaluation. Describe how the project is innovative and how it will foster improved child and family well-being.

The purpose of Kentucky's Title IV-E waiver demonstration project is to further the state's progress toward the Child and Family Service Reviews (CFSR) outcomes of safety, permanency and well-being of families and children involved in the child welfare system. Specifically, the waiver project will focus on reducing entry rates and length of stay for children 0-9 whose parents have substance use and domestic violence risk factors. The primary interventions for this target population are the creation and implementation of the Early & Specialized Focus on Permanency program (ESFP) and the expansion of the existing START program (as described above).

Kentucky intends to capitalize on the flexibility of funding provided by the Title IV-E waiver to address two of the most prominent issues in the Kentucky child welfare system: substance use and domestic violence. Of the total number of families in Kentucky's child welfare system that had a finding of "substantiated" or "services needed" and also had a child less than 10 years of age, 57% had a risk factor of substance use in calendar year 2013. In this same population, nearly 63% of cases had a risk factor of domestic violence. This data tells us that there is a considerable need in Kentucky's families for help dealing with substance use and domestic violence issues.

Whereas Kentucky currently provides numerous programs and services aimed at strengthening families, there is a need for a more targeted approach focused on prevention and early intervention. Through the waiver, Kentucky aims to reduce the need for out-of-home care (OOHC) placements and shorten the duration of necessary OOHC placements through the initiation of new services, ESFP, which will utilize evidence-based programs and expansion of evidence-informed strategies, START.

The goals of the Title IV-E waiver demonstration project are to: (1) reduce the number of children entering OOHC through the implementation of the ESFP program and expansion of the existing START program and (2) reduce the amount of time children in the target population spend in OOHC through access to the ESFP program. Kentucky's Title IV-E waiver demonstration evaluation will address the program goals mentioned above through the following hypotheses:

Hypothesis 1: By increasing services and expenditures to families experiencing co-occurring child maltreatment and substance use and/or domestic violence through the EFSP program, children ages 0-9 will experience a lower rate of entry into OOHC, shorter lengths of stay for those who require placement in OOHC, and decreased recurrence of child abuse and neglect.

Hypothesis 2: By increasing services and expenditures to families experiencing co-occurring child maltreatment and substance use through the START program, children ages 0-5 will experience a lower rate of entry into OOHC, shorter lengths of stay for those who require placement in OOHC, and decreased recurrence of child abuse and neglect.

Hypothesis 3: Participation in ESFP and START will result in improved family functioning and increased child well-being.

Hypothesis 4: By decreasing the rate of entry in OOHC, decreasing the length of stay for those requiring placement in OOHC, and reducing the recurrence of child abuse and neglect of the target population, expenditures associated with OOHC will decrease.

2) Describe which of the following goals identified in statute that the project is intended to accomplish:

Kentucky's waiver project will accomplish these goals, as identified in statute.

- *Increase permanency for all infants, children, and youth by reducing the time in foster placements when possible and promoting a successful transition to adulthood for older youth.*
- *Increase positive outcomes for infants, children, youth, and families in their homes and communities, including tribal communities, and improve the safety and wellbeing of infants, children, and youth.*
- *Prevent child abuse and neglect and the re-entry of infants, children, and youth into foster care.*

DCBS plans to use its current, though new as of January 2014, assessment tool to identify families with risk factors of substance use and domestic violence. Families in these categories can either be referred to ESFP with children ages 0-9 or START with children ages 0-5 where services are available and appropriate.

The expansion of in-home and community-based services through the creation of ESFP and the expansion of the START program will result in more families receiving substance use prevention and treatment services, more families receiving services (specific to ESFP) related to domestic violence, more families stabilizing with increased family functioning, and decreasing initial and repeat maltreatment. In addition, by providing reunification and aftercare services to families of children returning home, reunifications will not be interrupted resulting in the children/youth returning to care.

3) Identify the target population to be served, including an estimate of the number of children or families who would be served by the proposed project; the estimated number of Title IV-E foster cases involved; demographic information; child welfare status and history and other identified risk factors of the target population (e.g., parental substance abuse).

Through the proposed waiver activities, the target population to be served is children 0-9 years of age who are at moderate or imminent risk of entering OOHC and whose parents have risk factors of substance use and/or domestic violence.

Table 1: CPS Referrals with a Finding of Substantiated or Services Needed, by Age Group and Risk Factor, October 2013 Case Counts

Child Age	Income Issues	Criminal History	Domestic Violence	Drug/Alcohol Issues	Mental Health	Racial Ethnic Cultural Issues*	Serial Relationships
	N=10272	N=9780	N=8661	N=7658	N=5606	N=5090	N=4489
0 - 1	23.3%	22.1%	20.8%	26.4%	22.4%	21.0%	23.1%
2 - 5	23.9%	24.4%	22.5%	23.5%	21.5%	21.2%	22.3%
6 - 12	32.6%	33.0%	33.9%	30.8%	32.6%	33.7%	33.5%
13 - 15	13.8%	14.4%	15.6%	13.3%	15.9%	16.3%	14.4%
16 - 17	6.4%	6.2%	7.2%	5.9%	7.6%	7.9%	6.6%

*As with all child protection practice, cultural issues must be taken into consideration both when assessing and intervening with families at risk of neglect. This could include, but is not limited to, loss or lack of extended family, social, and community supports.

**Cases are impacted by multiple risk factors; therefore, the data includes duplication.

***Data is based on case counts. The data above is for cases that include children who fall within the selected age groups. A case may have children that fall within different age groups; therefore, the data may include additional duplication.

Table 2: Youth under age 10 that had a finding of substantiated services needed with risk factors of domestic violence and substance abuse as of Calendar Year (CY) 2013

Crosstab - Cases that Met Criteria, had a Finding of Substantiated/Services Needed, Had a Child<10, and had Co-Occurring Risk Factors of Substance Abuse/Domestic Violence by DCBS Region, CY 2013								
Age less than 10				SA and DV		Total		
				No	Yes			
Younger Than 10	region	Eastern Mountains	Count	404	361	765		
			% within region	52.8%	47.2%	100.0%		
		Jefferson	Count	742	459	1201		
			% within region	61.8%	38.2%	100.0%		
		Northeastern	Count	452	350	802		
			% within region	56.4%	43.6%	100.0%		
		Northern Bluegrass	Count	704	513	1217		
			% within region	57.8%	42.2%	100.0%		
		Salt River Trail	Count	493	292	785		
			% within region	62.8%	37.2%	100.0%		
		Southern Bluegrass	Count	572	454	1026		
			% within region	55.8%	44.2%	100.0%		
		The Cumberland	Count	487	306	793		
			% within region	61.4%	38.6%	100.0%		
		The Lakes	Count	539	277	816		
			% within region	66.1%	33.9%	100.0%		
		Two Rivers	Count	718	324	1042		
			% within region	68.9%	31.1%	100.0%		
		Total			Count	5111	3336	8447
					% within region	60.5%	39.5%	100.0%

Table 3: Youth under age 10 that had a finding of substantiated services needed with risk factors of substance abuse only as of CY 2013

Age less than 10				SubAbuseOnly		Total	
				No	Yes		
Younger Than 10	region	Eastern Mountains	Count	263	502	765	
			% within region	34.4%	65.6%	100.0%	
		Jefferson	Count	625	576	1201	
			% within region	52.0%	48.0%	100.0%	
		Northeastern	Count	348	454	802	
			% within region	43.4%	56.6%	100.0%	
		Northern Bluegrass	Count	558	659	1217	
			% within region	45.9%	54.1%	100.0%	
		Salt River Trail	Count	446	339	785	
			% within region	56.8%	43.2%	100.0%	
		Southern Bluegrass	Count	455	571	1026	
			% within region	44.3%	55.7%	100.0%	
		The Cumberland	Count	401	392	793	
			% within region	50.6%	49.4%	100.0%	
		The Lakes	Count	505	311	816	
			% within region	61.9%	38.1%	100.0%	
		Two Rivers	Count	678	364	1042	
			% within region	65.1%	34.9%	100.0%	
	Total			Count	4279	4168	8447
				% within region	50.7%	49.3%	100.0%

Table 4: Youth under age 10 that had a finding of substantiated services needed with risk factors of domestic violence only as of CY 2013

Age less than 10 Younger Than 10				DomViolenceOnly		Total
				No	Yes	
region	Eastern Mountains	Count	343	422	765	
		% within region	44.8%	55.2%	100.0%	
	Jefferson	Count	497	704	1201	
		% within region	41.4%	58.6%	100.0%	
	Northeastern	Count	367	435	802	
		% within region	45.8%	54.2%	100.0%	
	Northern Bluegrass	Count	567	650	1217	
		% within region	46.6%	53.4%	100.0%	
	Salt River Trail	Count	364	421	785	
		% within region	46.4%	53.6%	100.0%	
	Southern Bluegrass	Count	451	575	1026	
		% within region	44.0%	56.0%	100.0%	
	The Cumberland	Count	386	407	793	
		% within region	48.7%	51.3%	100.0%	
	The Lakes	Count	381	435	816	
		% within region	46.7%	53.3%	100.0%	
	Two Rivers	Count	436	606	1042	
		% within region	41.8%	58.2%	100.0%	
	Total	Count	3792	4655	8447	
		% within region	44.9%	55.1%	100.0%	

Table 5: Youth Currently in OOHC by Age. Point-in-time data from approximately April 2013

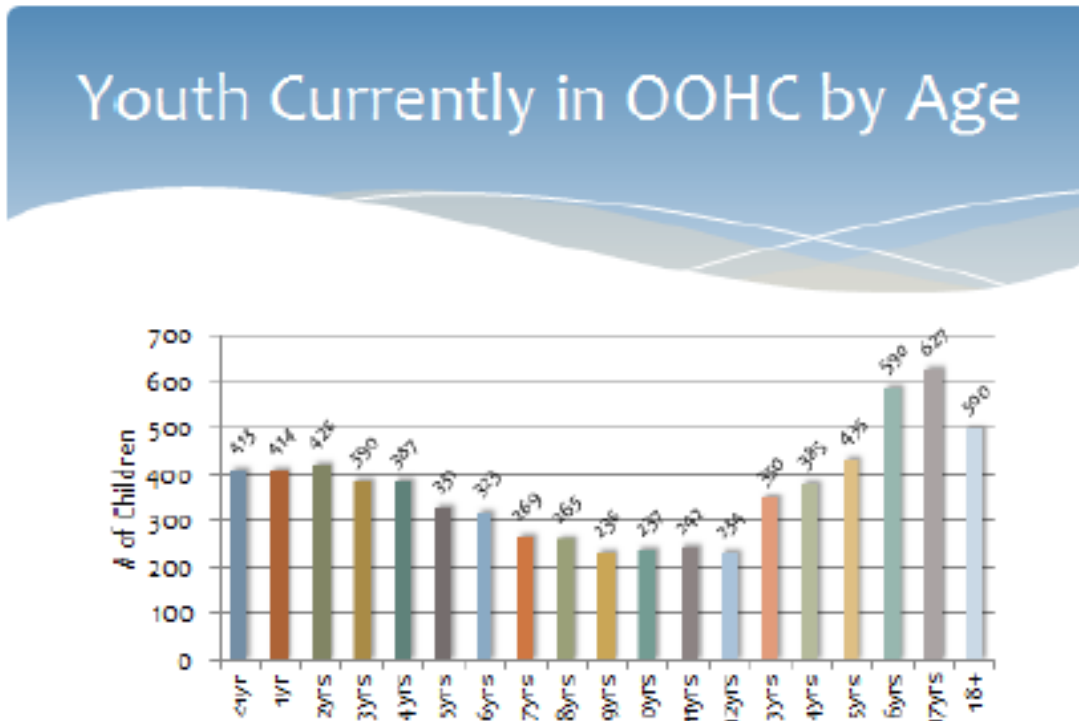


Table 6: Of the children 0-9 years old with Substance Abuse or Domestic Violence identified risk factors, the number that entered out of home care (OOHC) for CY 2013

Risk Factor	Number	Percentage
Total families with children age 9 and under with DV and/or SA risk factor	6,773	
Families that had a child enter out of home care	1772	26.1%
Families with only SA risk factor identified that had a child enter OOHC	1040	58.7%
Families with only DV risk factor identified that had a child enter OOHC	1166	65.8%
Families that have SA or DV risk factor have a child enter OOHC	1455	82.1%
Families that have co-occurring SA and DV risk factor have a child enter OOHC	1068	60.3%

As of January 5, 2014, there were 7,373 children in OOHC (TWIST, TWS-W058). This has risen from 6,940 in June 2012 (TWIST, TWS-W058). Factors that contribute to the increase in the OOHC population include older children languishing in OOHC as result of increasingly complex needs, an increase in the number of children exiting that re-enter, and an increase in first time entries (data from Casey Family Programs).

DCBS data indicates that the majority of children within this group (ages 0-9, SA as condition present at time of OOHC) experienced one removal episode (96.4%). Length of stay was accounted for by looking at patterns of entries and exits over the last five years. This was necessary because many of the children who entered OOHC in CY 2013 have not yet exited. Based on the average lengths of stay of prior entry cohorts, the duration trends for children with characteristics matching the target population group fell within the following timeframes:

Table 7: Average Duration by OOHC Entry Cohort for the Past Five Years (2009-2013)

Average Duration by OOHC Entry Cohort		
Duration Groups	Less than 1 month	20.30%
	1-2 Months	8.65%
	3-6 Months	16.47%
	7-9 Months	11.15%
	10-12 Months	6.67%
	Over 12 Months	36.77%

DCBS believes with readily accessible preventative services, children may be diverted from coming into care and expects time to reunification to decrease.

DCBS anticipates serving approximately 20% of the families each year with youth ages 0-9 who have substance use or domestic violence referrals.

DCBS anticipates that the number of Title IV-E eligible children served will reflect the current eligibility rate of Kentucky which is 43%.

4) Identify the geographic area(s) in which the proposed project will be conducted.

ESFP will be conducted statewide. START will be expanded to certain counties following an assessment of need and available resources.

5) Clearly describe the service intervention(s) the Title IV-E agency intends to implement under the demonstration. Indicate whether the proposed interventions are evidence-based or evidence-informed. Describe why the proposed intervention(s) were selected to meet the needs of the identified target population.

Early and Specialized Focus on Permanency (ESFP)

In examining the target population closely, it became evident that the current in-home and community based preventative services available do not fully address the needs of the target population due to diversion and Family Preservation Program (FPP) not allowing for families with substance use or domestic violence issues. In order to serve the target population of children ages 0-9 whose parents have identified risk factors of substance use and/or domestic violence, and as a result the children are at imminent or moderate risk of removal, DCBS intends to implement ESFP. By increasing services and expenditures to families experiencing co-occurring child maltreatment and substance use and/or domestic violence through the ESFP program, children ages 0-9 years will experience a lower rate of entry into OOHC, shorter lengths of stay for those who require placement in OOHC, and decreased recurrence of child abuse and neglect. ESFP will be an expansion of what is currently offered through in-home and community based preventative services.

ESFP focus will be on prevention of OOHC and the reduction in length of stay for those children who may be placed. DCBS intends to require a minimum of two evidence-based practices (EBPs) that address substance use and domestic violence. At this time, those EBPs have not been identified; however, DCBS intends to seek technical assistance in order to identify those interventions as soon as possible. Current FPP/diversion providers are offering EBPs such as, but not limited to, the following: Active Parenting (AP) NOW, AP Teen, (Brief) Strategic Family Therapy, Cognitive-Behavioral Therapy, Dialectical Behavior Therapy (DBT), Homebuilders Model, Motivational Interviewing, Nurturing Parenting Programs (NPP), Parent-Child Interaction Therapy (PCIT), Seven Challenges, Solution-Focused Therapy, Systematic Training for Effective Parenting (STEP), and Trauma-Focused Cognitive Behavior Therapy (TF-CBT). DCBS will do further research to determine the interventions that support trauma informed care and that best meet the needs of substance use and domestic violence affected families in Kentucky, including but not limited to those services already provided either by DCBS or other community partners within Kentucky. Some of these programs are described further in section 11, other initiatives. These services will be coordinated between the DCBS case manager and the ESFP contracted provider. Once those interventions have been identified, DCBS will meet with the current FPP/diversion providers across the Commonwealth to determine whether those identified are EBPs that the providers could implement and

provide. Once interventions that are a good fit for the children and families are chosen, DCBS will go through the process to contract with providers to provide services.

The information and data below supports the decision to create ESFP.

In-Home and Community-Based Preventative services currently provided by DCBS:

Kentucky’s DCBS currently provides an array of In-Home Services (IHS) through contracted providers. Kentucky’s IHS are aimed at keeping families together and safe and range from Intensive Family Preservation Services (IFPS), which targets families at imminent risk of their children entering OOHC, to *Community Collaboration for Children (CCC)*, which provides IHS and community based services to low-risk families for the promotion, development and support of parenting skills. Through the Title IV-E waiver, Kentucky plans to expand the availability (through contracts with providers) and usage (through early identification of appropriate families via the new front-end assessment, and through education and training of staff) of IHS.

Kentucky’s FPP refers to an array of short-term crisis intervention and support services programs based on the Homebuilder’s Model intended to prevent unnecessary placement of children, maintain children safely in their home and facilitate the safe and timely return home for children in placement. FPP providers intervene within 72 hours of a DCBS referral and are available 24/7 to work with the family. Providers teach skills, promote and model positive parenting, and connect families with community services. To qualify for FPP services, families must (1) be at imminent risk of having children placed in OOHC, or (2) have a child in OOHC who will be returning home. The following table provides a brief description of the three types of FPP services currently provided throughout Kentucky.

Table 8: Family Preservation Programs

FPP Service	Duration	Intensity	Conditions/Limitations
Intensive Family Preservation Services (IFPS)	Average 4-6 weeks	8-10 direct service hours per week	Imminent risk of removal from home
Family Reunification Services (FRS)	Average 6-17 weeks	3-8 direct service hours per week	Child returning home within 15 month period
Families And Children Together Safely (FACTS)	Average 4-27 weeks	3-8 direct service hours per week	Risk of removal or child in OOHC to be reunified

The following Family Preservation Program data for January 1, 2012 through December 31, 2012 shows the number of families and children who received services during the year.

Time-Limited Reunification (FRS):

- 258 families accepted
- 219 families completing services
- 385 children to be reunified
- 335 out of 385 children safely returned to home (87%)

Families and Children Together Safely (FACTS) Preservation

- 683 families accepted
- 590 families completing services
- 1,210 children at risk
- 1,140 of 1,210 children at risk remained safely in the home (94%)

Families and Children Together Safely (FACTS) Reunification

- 112 families accepted
- 85 families completing services
- 164 children at risk
- 150 of 164 children at risk remained safely in the home after reunification (91%)

Prior to service, families served are evaluated using the North Carolina Family Assessment Scale (NCFAS). Families are evaluated using the NCFAS following completion of family preservation/reunification services. Analysis of NCFAS data continues to indicate that interventions positively impact family functioning.

Table 9: Percent of Families (Completing Services) Scoring Adequate or Better on NCFAS Scale for Families 2012

	FRS		FACTS Preservation		FACTS Reunification	
	Intake	Closure	Intake	Closure	Intake	Closure
Environment	46.4%	71.9%	34.1%	61.8%	45.9%	71.3%
Parental Capability	17.1%	71.9%	11.1%	58.7%	9.4%	60.0%
Family Interactions	53.1%	81.3%	50.5%	74.6%	52.9%	79.7%
Family Safety	28.9%	77.3%	34.6%	76.4%	28.2%	80.0%
Child Well Being	44.5%	75.7%	37.5%	68.8%	41.2%	76.3%
Caregiver/Child Ambivalence	84.4%	92.5%			79.2%	92.3%
Readiness for Reunification	73.7%	86.1%			72.2%	87.7%

DCBS' **Diversion Program** was instituted in 2005 to provide intensive, long-term (four months with the possibility of two one-month extensions) IHS for children ages 10-17. The goal of the Diversion Program is to safely maintain children in the home where there is an imminent risk of removal or assisting in safely reuniting children with their family and community. Diversion service begins with an intense clinical assessment of the family within 96 hours of DCBS referral. The assessment is conducted by a professional with at least a Master's Degree in social work or similar field. A wrap-around service delivery approach, including intervention and treatment plans, is then implemented. During 2011-2012, Diversion was available in all nine DCBS Service Regions, but only in 48 counties.

Community Collaboration for Children (CCC) is a program funded through the federal Community Based Child Abuse Prevention (CBCAP) grant which provides community based services to low risk families. The purpose of CCC is to promote, support and develop parenting skills through parent education and resources to families at risk of child abuse and neglect. CCC programs and services are located in each region across the state. Both CBCAP and Promoting Safe and Stable Families (PSSF) (Title IV-B, subpart 2) funds are used for developing, operating, expanding, and enhancing community-based and prevention-focused programs. Through the use of regional networks these programs are designed to strengthen and support families to prevent child abuse and neglect. Funds are used to support network prevention activities that are accessible, effective, culturally appropriate, and build upon existing family strengths. Available services include supervised visitation (PSSF only), intensive in-home services, and family team meeting facilitation. Regional based leadership participates in regional network meetings and makes determinations regarding services based on locally identified needs. Network membership is formed from a community collaborative, and their memberships include representatives from the department's regional leadership, CCC service providers, early childhood councils, family resource and youth service centers (school-based resource centers), community leaders, and local citizens including parents who receive department interventions and services. Regional meetings occur at least five times per year and incorporate a review of program data reports.

During 2012 the CCC program served a total of 1,379 cases including approximately 3,106 adults and 4,232 children through multiple services including in-home services, supervised visitation, and facilitated family team meetings.

START Program Information and Plan to Expand

To meet the needs of the population of children ages 0 to 5 whose parents have substance use risk factors, Kentucky will expand the current START program. The START program is active in only part of the state, and the Title IV-E waiver will allow for the program to expand to additional target areas. Through the implantation phase of this waiver project, DCBS will complete an assessment of need and resources across the Commonwealth, to determine where START will be expanded.

The START program is an intensive intervention model for substance abusing parents and families involved with the child welfare system that integrates addiction services, family preservation, community partnerships, and best practices in child welfare and substance use treatment. The program aims to address systems issues that result in barriers to families being able to access services in a timely manner. It requires an approach to service delivery that involves cross-system collaboration and flexibility to meet the unique needs of this population.

START is based on the successful and nationally recognized START program in Cleveland, Ohio. Kentucky has modified and evolved the model to fit the needs of Kentucky families. While Daviess County has been awarded federal funding to implement START, state funding is being used to fund the program in three other counties in KY: Kenton, Jefferson and Boyd. A fifth site in rural Martin County had federal grant funding for five years and is now shifting to a less intensive model.

The key components of Kentucky's START program are:

- The pairing of a specially trained Child Protective Services (CPS) worker and a Family Mentor to share a caseload of families with the co-occurring issues of substance abuse and child maltreatment where at least one child is 3 or younger; Jefferson serves families who are referred due to the birth of a drug affected infant;

- The Family Mentor brings real-life experience to the team because they are a recovering person with at least 3 years sobriety and previous CPS involvement. She/he is rigorously screened and intensively trained and supervised to provide START clients with both recovery coaching and help in navigating the CPS system;
- Reduced caseloads for the START team of 12- 15 families per worker/mentor pair;
- 12 basic tenets outline the program philosophy and collaboration;
- Program fosters integration between CPS, substance abuse treatment providers and other community partners by addressing differences in professional perspectives that have resulted in fragmentation of services;
- A service delivery model that is more frequent, intense and coordinated, seeking to intervene quickly upon receipt of the referral to CPS;
- Quick access to substance abuse treatment, close collaboration among CPS and service providers, and shared decision-making among all team players, including the family;
- The use of TANF funding to pay for substance abuse treatment in Kenton, Jefferson and Boyd;
- Collaboration with community partners, substance abuse providers, the courts, and the child welfare system dedicated to building community capacity and making START work;
- Sober parenting supports that include flexible funding for meeting basic needs such as housing, transportation, child care and intensive in home services;
- A holistic assessment for all clients, addressing substance abuse, mental health, domestic violence, and intellectual ability, and;
- Extensive program evaluation to indicate and document the program achievements and weaknesses. Evaluation findings are used to empower program improvements.

In addition, each regional community mental health center has adopted one or more EBP for delivering treatment. Examples of EBPs include motivational interviewing (Miller & Rollnick, 2002), the Matrix Model program (Rawson, Obert, McCann, & Ling, 2005), or Seeking Safety therapy (Najavits, 2002). Specific objectives are to reduce recurrence of child abuse/neglect, provide comprehensive support services to children and families, provide quick and timely access to substance abuse treatment, improve treatment completion rates, build protective parenting capacities, and increase the county, region and state's capacity to address co-occurring substance abuse and child maltreatment. Kenton and Jefferson counties began serving families in October of 2007 and Boyd County began serving families in January of 2010. Daviess County began serving families in May of 2013.

6) Identify the time period in which the project will be conducted.

DCBS will implement within a year of finalizing terms and conditions. The demonstration is proposed for five years (20 fiscal quarters).

7) Outline the specific outcomes on which the Title IV-E agency expects the demonstration to have an impact, including outcomes relating to safety, permanency, and well-being. The Department expects all child welfare demonstrations to include specific measures assessing both family capacity to

provide for children’s needs and child functioning in the well-being domains. In addition, the Department expects that demonstrations will measure not only the achievement of permanency, but appropriate post-permanency measures, such as whether children re-enter care, whether adoptions or guardianships disrupt or dissolve and any other pertinent information on how children and families fare after discharge from foster care.

Outcomes of safety, permanency and well-being will be impacted by the waiver project activities.

Safety:

Repeat maltreatment—families receiving services through the waiver will receive intensive in-home services and community-based services, which will lead to more stability, improved family functioning and as a result, repeat child maltreatment will decrease. Decreased child maltreatment will be measured through the number of subsequent substantiated investigations experienced by families who received services through the waiver (during service provision and after case closure).

Permanency:

Fewer children entering OOHC—families receiving services through the waiver will receive intensive in-home services and community-based services, which will lead to more stability, improved family functioning, and as a result, more children will be able to remain in the home than if services were not provided. Permanency will be measured through the number of children receiving services entering OOHC while services are being provided and after case closure.

Fewer children re-enter OOHC—families receiving services through the waiver will receive intensive in-home services, community-based services, and reunification services if a child is already in OOHC placement or is placed in OOHC during the provision of waiver services. As a result of services, families will have increased stability, improved family functioning, and children who have experienced an OOHC placement will re-enter OOHC at a decreased rate. Permanency will be measured by the number of re-entries into OOHC for children who have received services through the waiver once services have concluded.

Well-Being:

Shortened length of stay (LOS) in OOHC—families receiving services through the waiver will receive intensive in-home services and community-based services, which will lead to more stability, improved family functioning, and as a result, children who are currently in OOHC during service provision will be able to return home sooner than if services were not provided. LOS will be measured by calculating the average number of days spent in OOHC for children who receive services and were either removed during service provision or who were already in OOHC placement and received reunification services.

Family functioning—families receiving services through the waiver will increase their levels of family functioning as measured by domains of the NCFAS and potential other measures before service provision, during service provision, and at the conclusion of service provision. Indicators of family functioning include parental capabilities, family safety, child well-being, family health, caregiver/child ambivalence, etc.

Recovery—Adults receiving substance abuse treatment services through the waiver will have increased rates of recovery as demonstrated through drug screen results and progress on case goals.

8) Describe the evaluation design the Title IV-E agency proposes to employ. Provide a justification of why the proposed approach is the most rigorous and appropriate approach to evaluation that will enable the Title IV-E agency to accurately determine the impact and effectiveness of the program intervention(s).

Evaluation of Kentucky's Title IV-E waiver demonstration project initiatives will serve multiple purposes throughout the course of the waiver period and beyond. First, evaluation efforts will guide early decision making through the assessment of agency capacity/readiness, monitoring of program implementation, and informing of program improvements as ESFP and START are being implemented. Second, evaluation efforts will examine program effectiveness by defining and measuring anticipated program outcomes as well as identifying factors associated with positive outcomes. Lastly, evaluation efforts will provide information on program costs and long-term cost savings realized through the achievement of anticipated outcomes.

The START and ESFP programs will be evaluated using several methodologies designed to best address program objectives and corresponding hypotheses. The project evaluation will consist of three major components: (1) Outcomes, (2) Process/Implementation, and (3) Cost analysis. The following hypotheses will be addressed through the project evaluation:

Hypothesis 1: By increasing services to families experiencing co-occurring child maltreatment and substance use and/or domestic violence through the EFSP program, children ages 0-9 will experience a lower rate of entry into OOHC, shorter lengths of stay for those who require placement in OOHC, and decreased recurrence of child abuse and neglect.

Hypothesis 2: By increasing services to families experiencing co-occurring child maltreatment and substance use through the START program, children ages 0-5 will experience a lower rate of entry into OOHC, shorter lengths of stay for those who require placement in OOHC, and decreased recurrence of child abuse and neglect.

Hypothesis 3: Participation in ESFP and START will result in increased family functioning and increased child well-being.

Hypothesis 4: By decreasing the rate of entry in OOHC, decreasing the length of stay for those requiring placement in OOHC, and reducing the recurrence of child abuse and neglect of the target population, expenditures associated with OOHC will decrease.

Outcome Evaluation Design (Part A):

ESFP: A quasi-experimental design using a comparison group will also be conducted to test the effects of the ESFP program as compared to usual DCBS services. Primary data will be collected and secondary data reviewed from families participating in the ESFP program as well as a group of comparison families who are ESFP-eligible but do not receive services through this program. Methods for identifying comparison families with similar key characteristics will be decided once ESFP has been further defined and program implementation (regional vs. statewide rollout) is determined.

Demographic and descriptive data will be collected at the family, parent/adult and child level for families referred to the ESFP program. Data will be entered into the in-home services database (web-based data collection system) by contracted providers. Basic demographic and descriptive data including age, gender, race, education level and employment for family members in addition to other

pertinent data including adult court involvement and substances abused (if relevant) will be collected. Data related to services received including date of referral to ESFP, date of initial family team meeting, and services provided during ESFP will be collected.

ESFP Outcomes

Tracking and analysis of short and long-term outcomes of the ESFP program will take place throughout the waiver period (five years) at a minimum. Family functioning, child well-being, recovery (if applicable), safety and permanency will be included in this part of the evaluation. The following table describes outcomes and potential methods of measurement/tracking for the ESFP program as of this stage in the ESFP program development.

ESFP Outcome	Definition	Instrument/ Documentation Tool
Family Functioning and Child Well-being	1. Ten domains of family functioning: Environmental, Parental Capabilities, Family Interactions, Family Safety, Child Well-being, Social/Community Life, Self-Sufficiency, Family Health, Caregiver/Child Ambivalence, and Readiness for Reunification	<i>North Carolina Family Assessment Scale (NCFAS)—General and Reunification</i>
Recovery (if applicable)	1. Ratings based on drug screen results, attendance at recovery supports, progress/attendance in treatment, and progress on CPS goals. Monthly progress rating used to describe treatment and progress toward outcomes.	In-Home Services Database; Behavioral Health Provider Case Data
	2. Severity of parental drug and alcohol abuse	<i>Addiction Severity Index, Self-Report Form (ASI Self-Report Form; McLellan et al. 1992)</i>
Safety and Permanency (Child Custody Status)	1. Child living/custody situation	In-Home Services Database/verified through TWIST
	2. If child placed in OOHC, placement type	TWIST
	3. If child placed in OOHC, length of time between placement and reunification	TWIST
	4. Subsequent reports of child abuse/neglect	TWIST

START: A quasi-experimental design using a comparison group will also be conducted to test the effects of the START program as compared to usual DCBS services. At this time, referrals to the START program exceed the agency’s capacity to serve. Current Kentucky START evaluators found that for each family accepted into the START program, another START-eligible family is turned away due to limited program capacity; in some existing START sites, two START-eligible families are turned away. This provides an ideal comparison group for a quasi-experimental design. This design allows for a rigorous evaluation in

that the only theoretical differences between START and comparison group families will be whether program space existed in the START program at the time of the referral. In addition, a similar quasi-experimental design using a comparison group is underway at another START site (Davies County), which is part of the Children’s Bureau’s multi-site Regional Partnership Grant Round II (RPG II).

All families who are eligible for START, regardless of whether there is space available at the time of referral, will be invited to participate in the evaluation. For the outcome evaluation, primary data will be collected from START program participants as well as comparison families who are START-eligible but unable to receive services due to program capacity. Both groups will complete measures assessing family functioning, child well-being, and recovery. Additionally, secondary data will be used to assess safety and permanency.

Demographic, descriptive, and service data will be collected at the family, parent/adult and child level. These data will be entered into the START Information Network (START_IN), a web-based data collection system. START_IN was previously developed by Kentucky’s START team and is currently used by all START sites in Kentucky. In addition to basic demographic and descriptive data, START_IN is used to collect other pertinent data including date of referral to START, date of initial family team meeting, court involvement, substances abused, services provided during START, and behavioral health treatment received.

START Outcomes

Tracking and analysis of short and long-term outcomes will take place throughout the waiver period (five years) at a minimum. Specifically, START program objectives related to improving family functioning, child well-being, recovery, safety and permanency will be included in this part of the evaluation. Long-term safety and permanency outcome data will be tracked and analyzed at specified intervals—6, 12 and 24 months after case closure. Pre/post comparison of outcomes will be conducted. The following table describes START outcomes and potential methods of measurement/tracking.

START Outcome	Definition	Instrument/ Documentation Tool
Family Functioning	1. Ten domains of family functioning: Environmental, Parental Capabilities, Family Interactions, Family Safety, Child Well-being, Social/Community Life, Self-Sufficiency, Family Health, Caregiver/Child Ambivalence, and Readiness for Reunification	<i>North Carolina Family Assessment Scale (NCFAS)—General and Reunification</i>
	2. Primary caregiver depression	<i>Center for Epidemiologic Studies-Depression Scale, 12-Item Short Form (CES-D; Randolff 1977)</i>
Recovery	1. Ratings based on drug screen results, attendance at recovery supports, progress/attendance in treatment, and progress on CPS goals. Monthly progress rating used to describe treatment and progress toward outcomes.	START_IN; Behavioral Health Provider Case Data
	2. Severity of parental drug and alcohol abuse	<i>Addiction Severity Index,</i>

		<i>Self-Report Form (ASI Self-Report Form; McLellan et al. 1992)</i>
Child Well-Being	1. Trauma experienced by young children (ages 3-12)	<i>Trauma Symptoms Checklist for Young Children (TSCYC; Briere et al. 2001)</i>
	2. Behavior and emotional and social functioning of children (18-60 months)	<i>Child Behavior Checklist—Preschool Form (CBCL; Achenbach and Rescorla 2000)</i>
	3. Children’s sensory processing abilities and profiling the effect of sensory processing on functional performance in child’s daily life (Birth to 36 months)	<i>Infant-Toddler Sensory Profile (ITSP; Dunn 2002)</i>
Safety and Permanency (Child Custody Status)	1. Child living/custody situation	START_IN/verified through TWIST
	2. If child placed in OOHC, placement type	TWIST
	3. If child placed in OOHC, length of time between placement and reunification	TWIST
	4. Subsequent reports of child abuse/neglect	TWIST

Process/Implementation Evaluation Design (Part B):

The purpose of process evaluation is to determine the following: (1) Is the program being implemented as intended?; (2) Have any feasibility or management problems emerged?; (3) Why is the program not (or no longer) achieving expected outcomes? (GAO-12-208G, Designing Evaluations: 2012 Revision).

Evaluating the processes and implementation of waiver strategies is critical as organizational and systems-level factors can greatly impact anticipated outcomes (Ferguson, 2012; Durlak & Dupre, 2008). Process evaluation will occur throughout the life of the demonstration project and focus on critical factors known to affect successful implementation (organizational readiness for change, staff development/training, interagency collaboration, EBP strategy implementation fidelity, etc.)

Focus groups, interviews, surveys, and fidelity assessments will be used to collect data from DCBS staff, agency partners and providers prior to the implementation of the waiver activities and again at key points during the roll out process. When applicable, regression analysis will be used to determine the effect of organizational and systems-level characteristics on implementation and outcomes. Findings from the process evaluation will be used for programmatic decision-making, informing program improvements, making necessary changes, etc. as the waiver activities are implemented across the state.

The following questions will be addressed through the process evaluation:

1. *What critical actions need to happen for the demonstration project to be successful? (development of project implementation plan)*
2. *What barriers exist to successful implementation? How can these barriers be addressed?*
3. *What progress is being made/are we adhering to the project implementation plan?*
4. *What actions do we need to take to insure successful project implementation?*

Development Phase Questions:

- What is the current behavioral health, in-home services, and community based service availability/capacity? What is the need for these services in each county/region?
- What barriers (potential barriers) exist to successful program implementation?
- How well are agencies currently collaborating toward client outcomes—Interagency collaboration will be measured via cross-sectional survey design prior to waiver activity implementation and periodically throughout the waiver period (before, halfway through, upon completion of demonstration project)
- What current processes and operating procedures are critical to the implementation of the waiver project activities? Baseline information on current policies, procedures, programs/services contracts process; referral processes, etc. Do these need to be revised? Do new SOP's, standards, etc. need to be written to support waiver initiatives?
- What training is necessary to prepare staff for waiver project activities? Are staff sufficiently trained on new programs/processes and how to use—measure training effectiveness with pre/posttests.

Implementation Phase Questions:

- Are we on target with the goals/deadlines of our implementation plan?
- Are the key processes and procedures employed by ESFP and START effective in meeting anticipated outcomes (e.g., is referral process, service delivery, interagency collaboration)?
- What services are being provided/received by program participants (START and ESFP)? Are the services being provided meeting client needs and resulting in positive outcomes?
- Are we capturing all necessary data in the correct format?
- Is data being entered correctly into program databases/SACWIS?—quality assurance of data
- Are we adhering to best practices in change management?
- Are programs being implemented with fidelity? Are the programs/services being implemented as intended--according to EBP specifications?
- What are staff and client reactions/perceptions of the new waiver programs/processes?
- How can we improve?

The table below outlines several processes which will be evaluated and potential instruments/methods for measurement (*this is not an exhaustive list and will be added to/ revised as the project details are decided*):

Process	Instrument/Method
Organizational Readiness for Change/Organizational Climate	Scales from <i>TCU Survey of Organizational Functioning</i> (Lehman, Greener, & Simpson, 2002) and <i>Dimensions of Organizational Readiness</i> (Hoagwood, 2005) administered to DCBS staff, community partners and service providers. Focus groups with DCBS staff, community partners and service providers
Staff Training	Criterion-based pre/post tests
Interagency Collaboration	<i>Wilder Collaboration Factors Inventory</i> (Mattessich, Murray-Close & Monsey, 2001) Focus groups with DCBS staff, community partners and service providers
Client Satisfaction	Surveys, interviews, focus groups including questions related to satisfaction with services provided

Cost Analysis (Part C):

An important part of any program evaluation is an in-depth analysis of cost effectiveness. Data will be provided by ESFP and START program staff, the Division of Administration and Financial Management (DAFM), behavioral health providers and other applicable community partners. The following questions will be addressed through the cost analysis part of this evaluation:

1. What is the start-up cost associated with the ESFP and START programs?
 - ESFP/START Program Staff time (salaries and benefits)
 - Operating expenses
 - Travel
 - Staff training
2. What are the ongoing costs associated with the ESFP and START programs/average cost per case?
 - ESFP/START staff time (salaries and benefits)—program administrators, supervisors, social workers, mentors (START only)
 - Average caseload
 - Staff training
 - Operating expenses
 - Travel
 - Behavioral health services/mental health services cost data

- Drug testing
 - Support services to families (concrete services/flex funds)
3. What cost savings are realized through the reduction of OOHC placements of children achieved by each program?
 - Rate of placement in OOHC for children receiving ESFP or START services versus rate of placement in OOHC for those in comparison group
 - Average per diem costs
 4. What cost savings are realized based on the decreased length of stay in OOHC achieved by each program?
 - Average length of stay for those receiving ESFP or START versus comparison group
 - Average per diem of comparison group entering OOHC versus level of care of those children receiving ESFP or START services.

Evaluation Team

Kentucky's Title IV-E waiver demonstration project evaluation will be conducted by a team of independent evaluators with expertise in quantitative and qualitative evaluation methods, data collection and management, analysis, and report writing. The evaluators are from Eastern Kentucky University and University of Louisville with a third evaluator to be determined.

This evaluation team will employ the principles of empowerment/participatory evaluation (Dugan, 1996; Secret, Jordan & Ford, 1999) with an emphasis on stakeholder engagement in the design, implementation and interpretation of evaluation results. The evaluation team will work closely with key stakeholder groups (primary intended users) including DCBS leadership, DCBS program staff, DCBS Information and Quality Improvement (IQI) staff, providers, community partners, etc. Best practices in evaluation, program evaluation standards and ethical standards will be adhered to throughout the evaluation process and all evaluation activities.

9) Provide an estimate of the costs or savings of the project, along with a description of the basis for projecting that the project would be cost-neutral overall.

KY DCBS is currently identifying key details for demonstration interventions, such as the specific EBPs to be used under ESFP and the geographic regions in which START will be expanded. However, there is currently enough information available to create an estimate of cost for each intervention.

ESFP cost information shows that the agency will see a dramatic savings through this intervention. Each ESFP child is anticipated to incur a cost of \$287.04 per month; this is an estimate based on current FPP services contracted to private providers. This cost includes the use of the chosen EBPs that will make up the ESFP program for families with substance use and/or domestic violence risk factors. The average length of an ESFP case is expected to be 4 months. Therefore, the average cost per child will be approximately \$1,148.

The children that participate in the ESFP program will be in-home children. If not for their participation in ESFP, the majority of the children would be placed into OOHC. The anticipated cost of the children not participating in the ESFP program is anticipated to be \$1,924. Based on current estimates, DCBS

plans to serve approximately 1,300 families per year with ESFP bringing a total estimated cost savings to approximately \$2.5M annually.

Using cost information gathered from DCBS' current START sites, DCBS anticipates each START child to cost approximately \$514.50 per month, assuming an average of 1.8 children per family. This annual cost includes costs of the family mentor, behavioral health treatment, and travel costs. The average length of a START case is anticipated to be 14 months. Therefore, the cost per child will be approximately \$7,203 in year one and \$6,482 in years two through five; both of these estimates represent the cost of the life of the case, not just one year (average case length is 14 months).

Comparing that cost to the cost a child would have incurred without the START intervention, current estimates show START as being more cost effective. The average child who meets the criteria of START, but does not participate in START, is anticipated to cost approximately \$8,133 through the life of the case, when considering placement and case management expenses. Additionally, DCBS foresees that those families participating in START will have a lower rate of return into care – an additional savings to the agency.

DCBS will continue to gather detailed cost information and couple that with the anticipated number of children expected to be served by both ESFP and START in order to achieve cost neutrality.

10) Present a reliable method of measuring and ensuring Federal cost-neutrality over the course of the demonstration.

DCBS wishes to cap the Title IV-E foster care maintenance and foster care administration payments received by the Commonwealth of Kentucky at a mutually agreed upon level over the course of the demonstration project based on the projection of what the Commonwealth would have received in the absence of the demonstration. During the last three years, the amount of Title IV-E claimed has increased as the overall number of children coming into the foster care system has increased. The Commonwealth has clearly been impacted due to the restrictions of the 1996 AFDC income limits as Title IV-E eligibility rates have gone down. The challenge of negotiating a capped allocation at this time comes with the continued rise in the number of children in the foster care system, as well as some missed opportunities to claim Title IV-E reimbursement in recent years. However, to ensure that we are at the maximum earnings that we can be, an intense Title IV-E revenue effort will be completed in the coming months.

During the last three fiscal years, the Title IV-E growth has increased by 4% in Federal Fiscal Year (FFY) 2012 and 3% in FFY 2013 clearly demonstrating that it is imperative that considerations be made for the necessity to include both caseload and cost triggers. The following chart shows the trend over the last three years of Title IV-E claims including prior quarter adjustments made in the respective year.

Table 10: Federal Claims for FFY 2011 through 2013

Federal Claims - Maintenance and Administration			
	2011	2012	2013
Maintenance	\$ 20,801,168.00	\$ 21,729,018.76	\$ 22,515,888.87
Administration	\$ 11,126,175.00	\$ 11,495,234.00	\$ 11,566,413.50
Total	\$ 31,927,343.00	\$ 33,224,252.76	\$ 34,082,302.37

At this time we believe that capping the FFY 2013 is essential for Kentucky entering into a capped allocation, with the understanding that the negotiations must include triggers that we would provide for increased funding over the life of the Title IV-E waiver to reflect increases in funding that would have occurred in the absence of the demonstration. While we believe that the identified interventions will address the issue of an increasing foster care population, we also believe that due to the growing substance use problem within our state, and the risk it poses to children, that short-term placements may continue to be a necessity to keep children safe.

11) Describe any similar project already underway in the State or tribal service area that is supported by State, tribal or private foundation funds and how these activities will be affected if the Title IV-E agency is approved to undertake the demonstration. If the child welfare waiver demonstration is intended to be operated in conjunction or collaboration with other relevant Federal initiatives (e.g. title XIX (Medicaid) State Plan Amendments and/or waivers in Medicaid or other programs, provide information on these associated collaborative activities. Explain to what degree (1) the proposed collaboration can be accomplished through coordination within the other program's existing authority or a plan amendment; or (2) whether coordinated activities will require approval of waivers in another program.

Performance-Based Contracts for Private Providers

Over the next two years, DCBS intends to shift to performance-based contracting (PBC) for continuum of care services provided by private agencies. A facilitator has been identified and funded by Casey Family Programs to assist DCBS and the private providers to collaborate in planning, piloting and implementing the project. The project is based on findings and best practices identified and set forth by the National Quality Improvement Center on the Privatization of Child Welfare Services.⁴ Using a collaborative planning model which is also consistent with the Building Bridges Initiative model to engage private providers and other stakeholders in the development of a comprehensive service system designed to meet the needs of children and families in the child welfare system, DCBS will assess system readiness; install a collaborative planning structure; use this structure to develop, pilot and implement performance based outcome measures to ensure shared accountability for outcomes. Hence, implementing PBC into Kentucky's child welfare system will bring a higher level of accountability and encourage and promote innovative and cost-effective service delivery among providers. Performance-based contracts (PBCs) will allow DCBS to provide fiscal incentives and/or penalties for achievement of identified outcomes related to safety, permanency, and well-being.

While the PBC initiative is in the very beginning stages of planning and design, DCBS and the PBC facilitator have engaged in preliminary discussions with private providers and Children's Alliance, who have voiced support for this change. The project is expected to foster a collaborative working relationship and culture between the public and private sectors which is critical for the successful implementation of the Title IV-E waiver. As DCBS increases its focus on prevention and timelier reunification, Kentucky's providers will need to also buy-in to this framework. PBC will be aimed at

⁴ National Quality Improvement Center on the Privatization of Child Welfare Services. (March, 2011). *Performance Based Contracts and Quality Assurance Systems: Final Report*. Retrieved from http://library.childwelfare.gov/cwig/ws/library/docs/gateway/Blob/76136.pdf?w=NATIVE%28%27SIMPLE_SRCH+p+h+is+%27%27Performance+Based+Contracts+and+Quality+Assurance+Systems%27%27%27%29&upp=0&rpp=25&order=native%28%27year%2FDescend%27%29&r=1&m=1.

encouraging better outcomes for children while also helping DCBS to reduce placements in expensive OOHC programs, which will be vital to the financial feasibility of Kentucky's waiver project.

Project SAFESPACE

Project SAFESPACE (Screening and Assessment For Enhanced Service Provision to All Children Everyday) is a collaborative initiative of the Commonwealth's public child welfare, behavioral health and Medicaid agencies, the court system, and a public university who have a history of working together to enhance child welfare services to children and families. Project SAFESPACE service delivery is expected to start in January 2015. This federally funded project addresses the need to better provide behavioral health services to children in Kentucky's child welfare system. Primarily in rural areas, access to behavioral health services for children and families is limited. The child welfare population is not systematically screened for behavioral health needs. Children in OOHC receive services provided in absence of a functional assessment to drive treatment, and the level of evidence-based treatment is limited.

Project SAFESPACE focuses on the following goals:

- 1) Use interagency collaboration to redesign the system of behavioral health services for children served by the child welfare system;
- 2) Reconfigure infrastructure, and inter- and intra-agency procedures to support a flexible evidence-based service array based on universal screening, functional assessment, outcome-oriented case planning , and evidence informed treatment;
- 3) Implement universal screening of children in out-of-home care regarding behavioral health needs in the Department for Community-Based Services;
- 4) Implement functional assessment of children in out-of-home care in private child caring agencies and community mental health centers;
- 5) De-scale ineffective practices, as agency capacity for implementing evidence based interventions grows; and,
- 6) Improve the social and emotional well-being of children in out-of-home care.

The project will include a process, cost, and outcome evaluation. The project will have a national evaluation and should strengthen public/private partnerships for long term project sustainability.

The target population for the project is children ages 6-18, with expansion to all children entering OOHC by the end of the five-year funding cycle. It is anticipated that there may be overlap between children receiving SAFESPACE and waiver services.

Standardized universal screening and functional assessment tools will be selected and used in conjunction with the DCBS front line staff's assessment tool which workers use to identify protective and risk factors present in the family. The combination of assessments will guide workers in making appropriate referrals to necessary community and in-home services including crisis intervention, behavioral health counseling, substance abuse treatment programs, etc. Furthermore, the assessment tools should drive treatment towards providers that use evidence-based practices. With more families being identified on the front end as being in need of services, more families will receive evidence-based treatment, services, and case planning, and the rate of children being placed in OOHC should decrease, which is in line with the waiver goals.

New Assessment and Documentation Tool for Child Protection

Throughout CY 2012-2013, DCBS researched, designed, tested, and finally, implemented a new documentation tool for the assessments completed by their social services workers. This was done in attempt to have a more effective, accurate tool to assess maltreatment findings and risks of future harm. In addition to risk factors, the new tool includes the five categories of “protective factors” which serve as the foundation of the Strengthening Families approach (Center for the Study of Social Policy, U.S. Department of Health and Human Services, Administration for Children and Families). For each protective factor, the focus is on helping parents identify and build on their own strengths and on empowering them to identify the best strategies to help them enhance their parenting capacity. The five protective factors are nurturing and attachment; knowledge of parenting and of child/youth development; parent resilience; social connections; and concrete supports for parents.

The new Assessment and Documentation tool helps capture all the work being completed by DCBS. A benefit of the new assessment tool is that it has streamlined the process of documentation. Workers can take the “worksheet” into the field with them to use as a guide, and then have all the information they need to input in the system when they return to their offices. In addition, the use of this tool may assist in early identification of the families that would be appropriate referrals for waiver services.

The new Assessment and Documentation Tool is used by DCBS staff and was incorporated into Statewide Automated Child Welfare Information System (SACWIS), The Worker’s Information SysTEM (TWIST), in January 2014.

Batterer Intervention

In 1998, KRS 403.7505 authorized the Cabinet to promulgate regulations to create a batterer intervention provider (BIP) certification program for mental health professionals (920 KAR 2:020). Batterer intervention is a 28-week psycho-educational group program that helps the batterer be accountable for their behavior and to make non-abusive choices in the future. The primary mission of BIP is to maximize safety for victims of domestic violence, prevent children from further exposures and to hold perpetrators accountable for their abusive choices through the provision of quality intervention services to domestic violence batterers. The program is also intended to provide for an organized referral resource for KY court system. BIP is one piece of a coordinated community response involving law enforcement, DCBS, health care professionals and correctional facilities and others.

The BIP certification process is housed in the DCBS, Division of Protection and Permanency, Family Violence Prevention Branch. There are currently 121 certified providers working in 56 counties. In some communities, judges do not order people into BIPs, and this has resulted in certified providers that no longer provide service. Over 3500 batterers were served in Kentucky last year. There is no public funding for this program at the state level, therefore the providers must collect fees from their clients to sustain these services.

DCBS envisions using this program along with ESFP to ensure that appropriate services are being offered to the offending parent to decrease the risk of repeat maltreatment.

Medicaid Expansion – Substance Use and Mental Health

Due to Kentucky’s implementation of the Affordable Care Act, more individuals across the commonwealth will be covered by Medicaid due to expansion of coverage for substance use and mental health services. In October 2013, Kentucky submitted a state plan amendment to expand Medicaid to

cover substance use and mental health. The state plan amendment (13-022) was approved on December 30, 2013, with an effective date of January 1, 2014.⁵

This amendment includes treatment services for substance use disorders and mental health disorders. The services covered under this plan (section 4) include:

- a) Screening
- b) Assessment
- c) Psychological Testing
- d) Crisis Intervention
- e) Mobile Crisis
- f) Residential Crisis Stabilization
- g) Day Treatment
- h) Peer Support
- i) Parent/Family Peer Support
- j) Intensive Outpatient Program (IOP)
- k) Individual Outpatient Therapy
- l) Group Outpatient Therapy
- m) Family Outpatient Therapy
- n) Collateral Outpatient Therapy
- o) Partial Hospitalization
- p) Service Planning
- q) Residential Services for Substance Use Disorders (Substance use only)⁶
- r) Screening, Brief Intervention and Referral to Treatment (SBIRT) (substance use only)
- s) Medication Assisted Treatment (substance use only)
- t) Assertive Community Treatment (mental health only)
- u) Comprehensive Community Support Services (mental health only)
- v) Therapeutic Rehabilitation Program (mental health only)

With the approval of this state plan, DCBS will need to work with DMS to clarify how Medicaid and the Title IV-E waiver capped allocation funding streams can be most effectively coordinated, particularly for substance use and mental health treatment services.

12) Provide an accounting of any additional Federal, State, tribal, and local investments made, as well as any private investments made in coordination with the Title IV-E agency, during the past two fiscal

⁵ <http://chfs.ky.gov/dms/State+Plan+Amendments.htm#2013>

⁶ <http://chfs.ky.gov/NR/rdonlyres/49B44BF3-31B1-4C72-AC2F-C6F2299F7C1D/0/KY13022ApprovalLetter179andPlanPages2.pdf>

years to provide the service intervention(s) that the applicant intends to undertake through the waiver demonstration.

See attached Accounting of Investments form.

13) Provide an assurance that the Title IV-E agency will continue to provide an accounting of that same spending for each year of the approved demonstration project.

DCBS will comply with all fiscal reporting requirements for a waiver demonstration project.

14) Identify the statutory and regulatory requirements under Titles IV-B or IV-E of the Act for which waivers will be needed to permit the proposed project to be conducted.

Waivers of the following provisions of the Social Security Act and Program Regulations as outlined in the terms and conditions for the proposed demonstration project include the following:

- Section 472 (a): Expanded Eligibility: To allow the State to expend Title IV-E funds for children and families who are not normally eligible under Part E of title IV of the Act as described in the Terms and Conditions.
- Section 474(a)(1): Expanded Claiming: To allow the State to claim at the Federal medical assistance percentage any allowable expenditures of foster care maintenance payment cost savings.
- Section 474(a) (3) (E) and 45 CFR 1356.60(c) (3): Expanded Services: To allow the State to make payments for services that will be provided that are not normally covered under Part E of title IV of the Act; and to allow the State to use Title IV-E funds for these costs and services as described in the Terms and Conditions, Section 2.0.

15) Address whether/how the demonstration will affect the Title IV-E agency's automated child welfare information system.

The Worker's Information SysTem (TWIST) is Kentucky's State Automated Child Welfare Information System (SACWIS). TWIST, a client server application, collects data on referrals of maltreatment (including victim/s and perpetrator/s, issues of safety and determination on the referral), a child's entry into and exit from out-of-home care, plans for services and permanency, court activities, Title IV-E determinations, contacts and ongoing case management activities including adoption activities (placement and finalized adoptions). Regular meetings are held between TWIST management and department management through the structure of the TWIST Steering Committee to discuss issues from local and regional staff; federal, statutory, and regulatory changes; and new protocols and practices that impact the capturing and analysis of data. In these meetings, work is prioritized and scheduled for future implementation.

DCBS anticipates needing additional TWIST screens to capture waiver activities. The newly captured data will be used to create Title IV-E waiver reports. DCBS will meet with TWIST management moving forward to implement any needed change.

16) Provide a narrative description of the Title IV-E agency's capacity to effectively use the waiver demonstration authority under Section 1130 of the Act to conduct a demonstration project by identifying changes the Title IV-E agency has made or plans to make in policies, procedures, or other

elements of the agency's child welfare program that will enable the Title IV-E agency to achieve the goal or goals of the project.

Division of Administration and Financial Management (DAFM)

The Division of Administration and Financial Management (DAFM) is composed of the DCBS budget and fiscal staff, in addition to the Resource Management Section. DAFM is responsible for the department's financial management and budget activities. DAFM also assumes oversight of policy, administrative regulations, state plans and contract monitoring functions. The DCBS Budget staff is responsible for the compilation and submission of the biennial budget for DCBS programs; monthly monitoring of financial activity; budget modifications and realignments; and contract funding verification. In addition, budget staff prepares fiscal impacts to proposed legislation and changes in regulations and state plans.

Coordinated and Collaborative Implementation Planning

A large part of the Title IV-E waiver project's success lies in the actual implementation. DCBS recognizes the importance of drawing upon best practices from lessons learned in implementation science in bringing project such as this waiver to scale. Therefore, we intend to not only review the waiver reports filed by other states who have preceded Kentucky in this effort, but to also use the work of Fixsen and his colleagues to guide the development of a formal implementation plan.⁷ This plan will identify and address core drivers such as staff selection, supervision/coaching, and training; quality assurance; program evaluation and monitoring; and facilitative administrative supports that are essential key components for long-term sustainability of this demonstration project. As part of the implementation planning process it will be necessary for DCBS to coordinate and align all reform efforts underway (e.g. System of Care, Project Safespace, and performance based contracting) to ensure necessary policies, regulations and procedures are changed when appropriate to support these efforts.

As this demonstration project will require significant organizational change, Kentucky will look to best practices in child welfare and human services related to implementing change. Casey Family Services' (2011), *Learning While Doing in the Human Services Sector: Becoming a Learning Organization through Organizational Change*, 12 strategies for developing and strengthening learning organizations will be used as a resource in the development of DCBS' Title IV-E waiver project implementation plan. Particular attention will be paid to the following recommendations related to sustainable organizational change:

- Use of pilot programs (when appropriate) to prepare for organizational change
- Establish procedures for implementing change and encourage staff to work together to reach outcomes
- Provide frequent progress reports
- Establish measurable, public timelines; monitor and revise support plans
- Assess baseline conditions relevant to the changes to be implemented
- Share assessment findings with staff and explain how the proposed changes relate to outcomes

⁷ Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M. & Wallace, F. (2005). *Implementation Research: A Synthesis of the Literature*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).

- Outline DCBS' "three-tiered" structure for change—(1) clinical model involving service participants, (2) program model involving staff, and (3) DCBS' business model.
- Share the three-tiered structure for change with staff; work with staff to identify any potential conflicts between the levels; plan how the organization can address these potential barriers to change.
- Solicit frequent feedback from all organizational levels
- Engage early adopters who embody the change
- Develop and implement a comprehensive training plan for all administrators, supervisors and staff; implement a coaching model; provide ongoing support to staff and supervisors
- Develop a communication plan to facilitate regular, comprehensive information sharing with all stakeholders.
- Clarify the role of consultants; establish exit strategies for consultants that will empower existing supervisors
- Identify ways to integrate new values and practices into the existing culture
- Engage stakeholders in the evaluation design; share data in a timely manner; establish and monitor data dissemination plans that target specific audiences
- Identify and engage internal and external partners who could have impact on the success of the change effort.

Kentucky currently has the capacity to implement and sustain the demonstration project considering its strong workforce, leadership and strategic partnerships.

Training

For over 30 years, DCBS has partnered with Kentucky's higher education system to provide quality training and program support services through an entity called the University Training Consortium (UTC). The UTC is a unique human services agency/public university collaborative that provides quality training and professional development support and delivery for the Kentucky Cabinet for Health and Family Services' DCBS. The UTC provides a continuum of training and professional development programs targeting DCBS employees at all stages of their careers. From pre-employment programs to advanced seminars for veteran staff, Kentucky's professional development system rests solidly on the principles of adult learning, occupational analysis, competency-based curricula, reinforcement of learning, and continuous program evaluation.

Employee Training and Development:

DCBS has in place a competency-based training program for all new staff in all program areas. The curricula are based upon job/task analysis and are evaluated at a number of levels. The training is delivered using a variety of methods from traditional classroom to web-based instruction. Curriculum is designed using an instructional development technique that ensures transfer of theory into practice. This area is also part of the Credit for Learning program that is currently awarding graduate (Protection & Permanency Academy) and undergraduate credit (Family Support's Supplemental Nutrition Assistance Program) for successful completion of the basic training.

In order to maintain a learning organization able to respond to changing needs, learning must continue after employees have been on the job. The practices involved in working with the poor, the elderly, families and children change with time. New laws, federal procedures and changing information demand that all staff continue to maintain and improve their skills. The ongoing training program is also competency-based and designed to ensure that tenured staff maintain an up-to-date skill and knowledge base in order to do their job. Specialized trainings are also developed and delivered in response to specific needs identified within the regions.

Training and Program Support Services:

The UTC also provides an extensive system of training and program support services. Training and professional development support services provided through the UTC are efficient, user-friendly and incorporate the most recent technological advances in the field. UTC staff includes experts in key areas necessary for the provision of all aspects of effective training support services including instructional design, multimedia, distance learning, programming, and database construction/management.

The Training Records Information System (TRIS) provides online access to training activities and information, support, management reports, and programming. TRIS provides comprehensive data for customized and special reports for DCBS. The system provides aggregate data on training hours, training participants, and budgetary information in relation to training events, training needs assessment, prerequisite notification, demographics and other related information. The TRIS team also provides programming services. DCBS-TRIS, Early Care and Education (ECE)-TRIS and Foster and Adoptive Parent (FAP)-TRIS are customized training tracking systems that require programming services. Team members in this area provide server administration, database administration, database design, report development, needs analysis, and general programming services.

The Curriculum Media Group (CMG) assists with the development, delivery and coordination of programs within the continuum of training and professional development. CMG staff work closely with trainers and managers to design, produce and distribute instructional, training and multimedia products. The staff also develops products for DCBS for use in public relations, information and education regarding services offered by DCBS. CMG is capable of producing videos, web-conferencing, and computer-based training that can be delivered via the internet or on CD-ROM or DVD. CMG staff coordinates sites, actors/voice-overs, and equipment when necessary.

An integral part of the Training System's success is the Regional Training Coordinator (RTC) position located in each of the states' nine regions. RTC's serve as liaisons between DCBS regional management, field staff and/or Central Office staff and the DCBS Training Branch. RTC's are responsible for conducting training at the regional level, coordinating activities for regional training events (e.g., securing training site/equipment, arranging lodging, notifying participants of training events, and facilitating training registration and close-out function with TRIS office) and providing facilitation services to DCBS regional management. By providing training services at the regional level through the RTC's, the Training System is able to deliver cost-effective (reduced travel costs for staff to attend training) specialized training to meet the regions' needs.

Facilitation

The Facilitation Center at Eastern Kentucky University provides facilitation services supporting collaborative approaches to planning, problem-solving and management, through the use of a guided participatory model of decision making. The Facilitation Center aids DCBS in designing meetings and the planning process. They also conduct Developing a Curriculum (DACUM) occupational/job analyses for

DCBS worker groups for use in needs assessment and curriculum development. The Facilitation Center provides training in strategic planning, meeting management, effective conflict resolution and mediation.

Evaluation Services

Measuring training effectiveness and performance improvement within a learning organization is paramount for a comprehensive professional development and training system. In order to provide the framework for a multi-level human services evaluation plan for training evaluation, DCBS, through the contractual services of the UTC, has utilized an expanded version of the four level Kirkpatrick model promoted by the American Humane Association to evaluate DCBS competency-based training curriculum and transfer of learning.

Continuous Quality Improvement

In Kentucky, the Continuous Quality Improvement (CQI) process is designed to empower staff in leading the agency toward improved quality through three fundamental processes.

1. Building knowledge through data and reports on how each individual's and each group's performance contributes to achieving outcomes for families and children and then creating action plans for improvement.
2. Structuring and leading staff in identifying barriers and best practices, and implementing solutions at the local team, county, regional or state level that will enhance service delivery and achieve improved outcomes.
3. Implementing a case review process and using the reviews at the team level for coaching and mentoring, and at the regional level to identify trends, best practices, and needs for practice improvements.

CQI is a *process*, not an event, by which all staff (front line and support staff to management and leadership) are involved in evaluating the effectiveness of services provided to customers of DCBS. The DCBS CQI process involves: the examination of internal systems, procedures and outcomes; and the examination of relationships and interactions between DCBS and other stakeholders.

1. CQI evaluates the effectiveness and efficiency of services provided.
2. CQI determines whether services meet predetermined expectations of quality and outcomes.
3. CQI attempts to correct observed deficiencies identified through the CQI process.
4. CQI is intended to be a process that is creative, inclusive, recurring, empowering, structured, solution-focused, action-oriented, common-sense driven and efficient.

Through the CQI process, problem issues can be addressed by those most directly affected by and knowledgeable of the need and the possible solutions. CQI teams are *decision-making teams*. CQI meetings result in the identification of needs, goals, available resources and the strengths of the program, the staff and community partners. Areas needing improvement are identified and discussed, action plans are developed and strategies are implemented to improve service delivery. While CQI focuses on solving issues in Protection and Permanency (P&P) and Family Support, CQI team members should remain mindful that those issues have implications throughout the broad spectrum of public and private child-centered services. CQI teams are expected to implement local action plans to resolve most issues they identify. Unresolved issues are advanced to the Regional CQI team for possible resolution.

CQI specialists develop, prepare and disseminate to CQI teams the data and other information needed to support data-informed decisions. CQI specialists also facilitate action and improvement by:

- assisting, as needed, in the conduct of local CQI meetings and case reviews;
- coordinating, facilitating and recording regional CQI meetings;
- serving as a liaison between management and staff; and
- mentoring and guiding staff toward the use of best practices.

Beyond their direct service to CQI teams, CQI specialists act in other ways to advance the core mission of service improvement as follows:

- coordinating the implementation of special initiatives and projects;
- advocating for statewide system changes that will improve results;
- gathering ideas from staff, synthesizing these and presenting them to management; and
- reading and displaying trends, anticipating barriers and identifying strengths.

17) Identify the steps taken to assure county, local, Tribal and/or judicial cooperation as required by the project. Supply a copy of letters or memoranda of agreement between the Title IV-E agency and any county, municipality, Tribe or tribal organization, foundation, private agency or any other governmental organization that is to be a participant in the child welfare demonstration project.

Please see attached letters of support from other state agencies and community partners.

18) Describe how the proposed project responds to the findings of the State's Child and Family Service Review and how it will affect implementation of the State's CFSR PIP.

Kentucky has successfully completed its PIP. The PIP was completed in the spring of 2013.

19) Describe any court order in effect anywhere in the State by which a court has determined that the State's child welfare program failed to comply either 1) with State child welfare laws or 2) with title IV-B, Title IV-E or the U.S. Constitution, along with an analysis of whether the proposed demonstration project would have any effect on any such court order, and if so, how.

There are no court orders in effect in Kentucky whereby a court has determined that the child welfare program failed to comply with the state's child welfare laws or with Title IV-B, Title IV-E, or the U.S. Constitution. However, as of May 2013, DCBS is under a settlement agreement as a means to end a twelve year lawsuit that originated when a family alleged that a private provider, with whom DCBS has a placement agreement, was proselytizing youth. DCBS is putting additional policies and provider requirements in place in attempt to prevent any further concerns around proselytizing. These additional policies and requirements will be in place by July 2014. The proposed demonstration project would not impact the settlement agreement.

20) Describe methods used to obtain public input, a summary of comments received and how public input shaped the development of the proposal.

DCBS formed a Waiver Exploratory Advisory Committee (WEAC) to engage community stakeholders in the waiver decision-making process. Stakeholders included agencies such as Department for Behavioral

Health and Developmental and Intellectual Disabilities, Administrative Office of the Courts, Department for Medicaid Services, Children's Review Program, Prevent Child Abuse Kentucky, Kentucky Youth Advocates, and Children's Alliance. DCBS met with the stakeholders and presented data regarding Kentucky's current out-of-home care population, services being rendered, and outcomes related to permanency. DCBS also used the Statewide Strategic Planning Committee for Children in Placement as a forum to seek feedback regarding this project. This committee includes many of the same members as the WEAC; however, it also encompasses many more community stakeholders, including Department of Education, Department of Juvenile Justice, a family court judge, a foster parent, a youth formerly in care, a State Representative, and a Senator.

DCBS met with the WEAC on January 30, 2014, to share the waiver application draft. DCBS posted a copy of the waiver application on the DCBS webpage for public review from February 3 through February 17, 2014. The public had the ability to submit comments electronically during this time period. All comments were reviewed and changes were made to the application as appropriate.

21) Provide an assurance that the Title IV-E agency provides health insurance coverage for all special needs children for whom the Title IV-E agency has entered into an adoption assistance agreement (including those not supported by Title IV-E funds).

The Cabinet for Health and Family Services provides health insurance coverage in accordance with KRS 199.555(2). "State-funded adoption assistance" is for children with special needs. A special needs child is defined as "a child which the state has determined cannot or should not be returned to the home of the child's parents; and (b) A child which the state has first determined: 1. That there exists a specific factor or condition the existence of which leads to the reasonable conclusion that the child cannot be placed with adoptive parents without providing adoption assistance under his section or medical assistance under Title XIX; and 2. That except where it would be against the best interests of the child because of such factors as the existence of significant emotional ties with prospective adoptive parents while in the care of these parents as a foster child, a reasonable, but unsuccessful, effort has been made to place the child with appropriate adoptive parents without providing adoption assistance under this section or medical assistance under Title XIX.

22) Identify which of the Child Welfare Program Improvement Policies identified in section 1130(a)(3)(C) of the Act the Title IV-E agency has implemented or intends to implement within three years of the date on which the Title IV-E agency submits its application or two years after the Department approves the demonstration (whichever is later). At least one of the child welfare program improvement policies to be implemented must be a policy that the Title IV-E agency has not previously implemented as of the date on which it submits an application to conduct the demonstration project. (See "Requirement to Implement Program Improvement Policies" section on pages 12 - 14 of this IM.)

Kentucky will be implementing the following Child Welfare Program Improvement Policies, as identified in section 1130(a)(3)(C) of the Social Security Act.

The new policy that DCBS will implement is as follows:

- 5) Limiting Use of Congregate Care: The development and implementation of a plan that ensures congregate care is used appropriately and reduces the placement of children and youth in such care.

The following policy includes a new component as well as an expansion of an existing program:

10) Establishment of Specific Programs to Prevent Foster Care Entry or Provide Permanency: The establishment of one or more of the following programs that are designed to prevent infants, children, and youth from entering foster care or to provide permanency for infants, children and youth in foster care:

- A comprehensive family-based substance abuse treatment program.
- A program under which special efforts are made to identify and address domestic violence that endangers infants, children, and youth and puts them at risk of entering foster care.