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A. Access and Visitation Grant Funds

Federal Access and Visitation Grant funds provided to Kentucky are under the jurisdiction of the federal Office of Child Support Enforcement (CSE) and are geared toward facilitating access and visitation of non-custodial parents facing difficulty seeing their children due to issues such as strained relationships with the custodial parent, non-payment of child support, or allegations of domestic violence. In June 2016, the grant transferred from the Department for Community Based Services (DCBS/department) to the Department for Income Support's CSE program.

To educate parents in all 120 Kentucky counties about access to and visitation with their children, CSE collaborated with the Louisville Legal Aid Society (LAS) to establish an Access and Visitation Hotline. A memorandum of agreement (MOA) with LAS began on January 20, 2017.

In April 2017, the hotline began accepting calls. Once operational, publicizing of the hotline occurred through public service announcements, print, media, press releases, and the addition of hotline information to both the CSE and LAS websites. LAS hired an attorney responsible for handling hotline calls. Callers go through an intake process to ensure they meet the guidelines to receive services through LAS.

The attorney captures gender, race, age, reason for calling, and whether the caller is a participant in a IV-D case in their intake database. Race codes have been revised to mirror federal race codes (American Indian or Alaskan; Asian; Black or African American; Hispanic or Latino; Native Hawaiian or Pacific Islander; White; Two or More Races; Data Not Reported, and Other).

Callers are referred to a partnering legal aid program located in the geographical area where they reside. CSE staff receive the above data in addition to data regarding how the hotline served the caller. CSE also requested that the LAS capture the children in common and add the grandparent/legal guardian option in the IV-D case types. Due to increased demands, LAS extended hotline hours to 9 a.m.-5 p.m., Monday through Friday. Previous hours ended at 3 p.m.; however, callers now have two extra hours a day to contact an attorney through the hotline.

During Federal Fiscal Year (FFY) 2023, a total of 1,307 persons contacted the hotline for assistance related to access to and visitation with their child(ren). CSE has paid the LAS $124,324 during Calendar Year (CY) 2023. Since its inception in 2017, the hotline has received a total of 8,291 phone calls, helping citizens of the Commonwealth.

B. Child Victims' Trust Fund Board

In 1984, the passage of House Bill 486 established the Kentucky Child Sexual Abuse and Exploitation Prevention Board (CSAEP) and the Child Victims' Trust Fund (CVTF). Kentucky Revised Statute (KRS) was amended in the 2022 legislative session to change the name of the board to the Child Abuse and Neglect Prevention (CANP) Board (the Board). The Board was codified by KRS 15.905 for the "coordination and exchange of information on the establishment and maintenance of prevention programs." The Board is an autonomous body within the Office of the Attorney General. The organizational structure and duties of the board are set forth in KRS 15.900 to 15.940. Since its inception, the Board has worked tirelessly to support high-quality prevention programs across the Commonwealth.

Assistance for programs has taken many forms, most notably financial support for prevention projects. Grants funded through the CVTF have been awarded to community and professional organizations throughout Kentucky, with technical assistance and operation oversight provided to the recipients. The

Board is increasingly aware of the need for funding prevention programs that engage in community education and enhance public awareness. The Board has historically supported the regional Children's Advocacy Centers (CACs) throughout the Commonwealth by providing supplemental funding for child sexual abuse medical examinations. During the 2022 legislative session, the Department for Medicaid Services (DMS) statute was amended requiring Medicaid to cover sexual abuse medical examinations, allowing more flexibility in funding. The amount of funding expended on medical examinations significantly decreased during State Fiscal Year (SFY) 2023, and no CACs requested reimbursement the first half of SFY 2024.

The CVTF has provided funding for both statewide and regional prevention programs, funding for reimbursement associated with the costs of medical examinations to CACs, and education of professionals at conferences. The Board utilizes five committees to advance specific goals: Marketing and Development Committee, Management Committee, Strategic Planning Committee, Operations Committee, and Policy Committee. The goals of the Board are:

- To promote public and professional education on the nature and scope of child abuse and related issues, indicators, laws, roles, and resources;
- To raise awareness that it is adults' responsibility to provide a safe community for children;
- To reduce the incidence and impact of child abuse by promoting, supporting and/or funding effective programs; and
- To establish procedures to generate and oversee the effective and efficient use of CVTF monies.

KRS 15.925 directs that: "The state board shall by December 1 of each year report to the governor and the General Assembly recommending changes in state programs, statutes, policies, budgets, and standards that will reduce the problem of child sexual abuse and exploitation and child abuse and neglect, improve coordination among government and private agencies that provide prevention services and improve the condition of children and parents or guardians who are in need of prevention program services."

The Board has endorsed and financially supported several programs to reduce child sexual abuse and exploitation, child abuse, and neglect, and improve the coordination among the various agencies, governmental and private, that provide prevention services and improve the condition of children and parents or guardians in need of prevention program services across the Commonwealth. Continued support and funding for these programs and others like it are essential for CANP to reduce the incidence and impact of child abuse and neglect in the Commonwealth.

Consistent with KRS 15.910, the Board is comprised of the following members and their designees if applicable:

- Chairman of the Board, Attorney General, Russell Coleman, Designee: Heather Wagers
- Education & Workforce Development Cabinet, Secretary: Jamie Link
- Cabinet for Health & Family Services, Secretary Eric Friedlander, Designee: Mary Carpenter
- Justice and Public Safety Cabinet, Secretary Kerry Harvey, Designee: Mona Womack
- Kentucky State Police, Phillip J. Burnett, Commissioner, Designee: Captain Bradly Stotts
- Kentucky Youth Advocates: Shannon Moody
- Prevent Child Abuse Kentucky: Jill Seyfred
- Kentucky Court Appointed Special Advocates Network, Inc.: Andrea Bruns
- Children's Advocacy Centers of Kentucky: Caroline Ruschell
- Children's Alliance: Michele Sanborn

- Kentucky Chapter of the American Academy of Pediatrics: Dr. Jamie Pittenger
- Kentucky Association of Regional Programs: Steve Shannon
- Administrative Office of the Courts: Laurie Givens
- Member of the House of Representatives appointed by the Speaker of the House: David Meade
- Member of the Senate appointed by the President of the Senate: Julie Raque Adams

The chart below details the funding for medical exams for SFY 2023:

CAC NAME	# of child sexual assault medical evaluations reimbursed from CVTF funding for 2020-2021	# of child sexual assault medical evaluations reimbursed from CVTF funding for 2021-2022	# of child sexual assault medical evaluations reimbursed from CVTF funding for 2022-2023
Barren River	61	69	2
Buffalo Trace	3	10	4
CAC of the Bluegrass	160	176	108
Cumberland Valley	40	26	13
Family & Children's Place	72	33	13
Gateway	6	22	0
Green River	39	33	35
Hope's Place	20	20	2
Judi's Place	51	57	48
Ky River	13	25	10
Lake Cumberland	64	54	7
Lotus	20	25	7
Northern Ky	0	3	0
Pennyrile	13	15	0
Silverleaf	18	11	5

Please note that the above numbers merely reflect reimbursements made to the CACs utilizing CVTF awards approved by the Child Abuse and Neglect Prevention Board. The actual number of child sexual assault medical evaluations performed by Kentucky's child advocacy centers exceeds the requests for reimbursements made in the current and previous fiscal years. As can be seen from the last three years' grant award funding, Medicaid reimbursement to the child advocacy centers for the true and actual cost of child sexual assault medical evaluations significantly decreased the need for financial assistance from the CVTF.

The Board awarded $133,811.98 for regional and statewide awareness, prevention, and outreach programs for SFY 2023, as follows:

Child Watch Counseling	$26,493.00
Exploited Children's Help Organization	$34,500.00
Family Nurturing Center	$10,000.00
Kentucky Kids on The Block	$37,079.98
Prevent Child Abuse Kentucky	$25,739.00

Child Watch Counseling and Advocacy Center delivered the Totally Awesome Super Important You program to provide child abuse prevention information to children in Western Kentucky, their caregivers, and professionals working within the school system. Programming was presented at 15 schools and the Kentucky Sheriffs' Boys and Girls Ranch, equipping 4,903 children with tools to prevent their victimization. At seven additional schools, 8,353 students received folders and activity books containing information for recognizing and reporting child abuse. Educational materials were also distributed to the students' parents/caregivers and to 661 staff members of the seven schools. Program materials were distributed during a variety of community awareness and outreach events throughout the Western Kentucky region. As a result of The Totally Awesome Super Important You program, six students disclosed abuse and four caregivers requested mental health therapy services to address their children's trauma from abuse.

Exploited Children's Help Organization (ECHO) presented the Transforming Our Communities program to teach children and adults in the Louisville Metro area how to prevent, recognize, and appropriately respond to abuse, bullying, and digital dangers. Through programming provided in school settings, 4,369 children were taught safety rules and the signs of abuse. Adult trainings and presentations on recognizing, reacting, reporting, and preventing child abuse were attended by 336 adults. Child abuse prevention materials were distributed during community outreach events that served 6,291 community members throughout the Louisville Metro area. The Transforming Our Communities program prompted the disclosure of abuse from 233 children and several educational institutions requested assistance in addressing instances of students texting nude photos.

Family Nurturing Center piloted the Monique Burr Foundation's Teen Safety Matters curriculum in Northern Kentucky communities. This comprehensive, evidence-informed prevention education program addresses emotional, physical, and digital safety and teaches students in grades six through 12 how to prevent, recognize, and respond appropriately to child abuse, exploitation, trafficking, relationship abuse, and bullying. Beginning January 1, 2023, staff completed training to become authorized facilitators of the program and contacts were made with middle schools and community partner agencies to schedule programming. Four programs were presented in Northern Kentucky and a total of 25 teens attended the programming. Based on pre- and post-program surveys, 97% of the participants increased or maintained their knowledge after attending the Teen Safety Matters program.

South Central Kentucky Kids on the Block presented puppet performances throughout the state addressing child abuse, cyberbullying, and fire safety. The programming increases children's awareness of the realities of child abuse, cyberbullying, and fire safety by teaching the signs, the ways to protect, and the people children should talk with regarding these issues. Every program includes a specific empowerment exercise teaching children to use their voice. In total, 61 programs were completed throughout the state, serving 9,621 children in grades kindergarten through sixth. Twenty-seven (27) children disclosed abuse because of the programming.

Prevent Child Abuse Kentucky (PCAK) provided several statewide services addressing the primary prevention of child sexual abuse. First, two training of the trainer (TOT) programs were created to allow for service providers to train multi-discipline audiences and peers. In total, four TOT events were held and 76 people were trained to provide the "Are They Good For Your Kids?" curriculum to professionals and community members throughout the state. Second, an online child sexual abuse information center was created using the "Are They Good For Your Kids?" interactive webpage. The landing page for the online information center received 1,935 views during a two-month period and viewers averaged three minutes on the site indicating a 60% viewer increase from the previous year. Third, a Child Sexual Abuse

Prevention Guide was developed, and 551 copies were distributed. Finally, action cards were developed, with 1,400 distributed.

It is important to note that the programming funded during this fiscal year was generally offered from November 1, 2022, to June 30, 2023. This is a period of eight months,[1] which is less than the one-year grant cycle of prevention grant funding from previous years. The delay in awarding funding created challenges for the partner organizations, particularly those organizations that offer presentations through the school system. Despite these challenges, the partner organizations adjusted in ways that allowed the execution of their prevention programming projects and assured that thousands of Kentuckians were provided tools to prevent child sexual abuse and exploitation and child abuse and neglect and to keep kids safe. Their flexibility and determination are evidenced by the commendable results reported above. The Board approved additional grants for PCAK, South Central Kentucky Kids on the Block, Child Watch Counseling and Advocacy Center, Inc., Family Nurturing Center of Kentucky, and Judi's Place for Kids, Inc on November 20, 2023. However, those contracts are still being administered at the writing of this report.

The Board reimbursed $3,500.00 during SFY 2023 and $2,445.00 for conference scholarships. For SFY 2023, the Board awarded medical reimbursement grants for 254 medical exams for child victims to 15 CACs throughout the state. Additional grants were awarded for the focus of prevention of child sexual abuse and exploitation to multiple regional and statewide programs as detailed above. Thousands of children and parents have been the recipients of these prevention efforts. Hundreds of professionals statewide have received training because of this funding.

The Board received technical assistance during SFY 2024 from an outside consultant who assisted with the compilation and assessment of reports and recommendations from multiple sources to assist with strategic planning. This is an ongoing effort. The Board intends to evaluate these efforts once the strategic plan is in place.

C. Children's Advocacy Centers (CAC)

In 1998, Kentucky adopted a statewide CAC network, which provides for one CAC in each of Kentucky's 15 Area Development Districts (ADDs). This regional CAC model ensures that children in every geographic area of Kentucky have access to a CAC. The state model provides a core set of standards set forth in KRS 620.020 and 922 KAR 001:580 and modeled after the standards developed by the National Children's Alliance (NCA). These standards require Kentucky CACs to provide, either directly or as part of a collaborative MOU, the following services: forensic interviews, mental health services, specialized child abuse medical exams, advocacy, court preparation, professional training, and community education programming.

Central to the CAC model is the simple, yet powerful, concept of coordination between community agencies and professionals. This coordinated response to child abuse cases is known as a multidisciplinary team (MDT). CACs, along with the other partner agencies, promote timely and effective systemic responses to child abuse by reviewing investigations, coordinating service delivery, and reaching the appropriate disposition of cases in the criminal justice system. The goals of MDTs in Kentucky, as outlined by the Kentucky Commission on Child Sexual Abuse (KCCSA), include: 1) the safety and protection for child victims of sexual abuse and 2) accountability of the child sexual abuse service

[1] Family Nurturing Center's programming was offered from January 1, 2023, to June 30, 2023, a period of six months.

system. MDT members include child protective services, law enforcement, prosecutors, victim advocates, forensic interviewers, medical providers, mental health providers, and educational professionals.

The state provides a critical base of funding needed to operate the CAC network in Kentucky. As private, independent, non-profit organizations, CACs receive additional funding from grants, individuals, and corporate funding opportunities. CACs are also eligible to receive Medicaid reimbursements for medical exams performed onsite and pursuant to 907 KAR 3.160. CACs may receive $100 for case management services associated with child abuse medical exams from the CVTF.

Children's Advocacy Center Data – CY 2023

Service Category	Number of Services Provided/ Persons Served
New children served	7,483
New caretakers served	4,858
Advocacy services: *court, case management, referrals to services*	116,587
Medical services: *comprehensive forensic medical exam, general exam, follow up exams, referrals for further medical treatment*	656
Forensic services: *forensic interviews by CAC staff, forensic interviews hosted by the CAC for trained child welfare interviewers*	5,943
Mental health services: *individual, family and group treatment, mental health screening*	8,595
New children staffed by KY MDTs	6,066
Total CAC cases seen through KY's MDTs in 2023	38,214
Training programs conducted	2,029
Community partners trained	2,559
Community awareness events	720

CACs in Kentucky continually assess the quality of services available to families and communities through examining Outcome Measurement System (OMS) survey results. Responses from over 2,700 caregivers, investigative partners, and youth surveyed in 2023 demonstrate the critical role CACs play in the investigative and healing processes. These research-based, standardized surveys are supported by the NCA and used at over 800 CACs nationally.

According to the survey results, 99% of caregivers reported that their questions were answered to their satisfaction, and 98% of caregivers reported that the CAC provided them with resources to support their child and respond to their needs in the days ahead. In the words of one caregiver, "The last week has been very difficult for our family. Today at [CAC] my son felt safe and heard. This appointment has helped our family start to heal in the time that we have been here today." Another caregiver stated, "Everyone was friendly, informative and went the extra step to see that the children felt safe and understood the process."

In responses from community partners, 97% indicated that the CAC model fosters collaboration on the MDT, and 97% indicate that the clients served through the CAC also benefit from this team collaboration. 97% agree that CACs provide important resources that improve their ability to work. CACs

participate in MDT case review meetings throughout the Commonwealth and facilitated 70% of case review meetings during 2023. The following comments were provided by community partners.

- "The CAC Center is a life saver for our families that need the services that only they provide locally."
- "I am grateful for the teamwork and effort all members of the MDT show to help children. This is a great way to ensure some continuity of care and making sure everyone is on the same page."
- "Our MDT teams are absolutely amazing and completely essential. When dealing with the types of cases we have, being able to discuss the situations, gather feedback from all entities that are involved, and put plans in place with the same common goal in mind of protection of children... is crucial. Our MDT(s) are extremely beneficial and greatly appreciated. Thank you"
- "The collaboration within the MDT is vital to ensuring that children and families receive a best-practice response to allegations of abuse. The work of the team both during the case reviews and outside of the monthly meeting ensures that children do not fall through the cracks of the system. All disciplines are able to come together, working towards the same end goal and always keeping the child at the forefront of all decisions."

D. Child Care

The mission of DCBS' Division of Child Care (DCC) is to provide leadership in building high quality, community-based access to child care and early learning that enhances health, safety, permanency, well-being, and self-sufficiency for Kentucky's children and families.

DCC strives to fulfill their mission through the following goals:

- Increase available quality child care that is developmentally appropriate, affordable, healthy, and safe
- Provide access to early care and education, and provide support to early care professionals throughout the state
- Engage families and community partners in collaborative decision making for early care and education
- Provide safe child care services which support stability and self-sufficiency of families
- Utilize technological resources to promote the improvement of outcomes in child care
- Expand data collection and management systems that allow for evidence-based management decisions

The Child Care and Development Fund (CCDF) is the principal source of federal funding for DCC initiatives that maintain health and safety standards and improve child quality in child care settings. Direct Temporary Assistance for Needy Families (TANF) dollars are used to fund Child Care Assistance Program (CCAP) benefits on behalf of individuals who receive public assistance. In addition, State General Funds and Tobacco Settlement Dollars are combined with CCDF dollars to fund the CCAP, child care quality initiatives, fitness determinations (background checks), and early care and education professional development. To assure continuation of a program of child care services, the Cabinet must renew the CCDF State Plan every three years. The Cabinet currently operates under the provisions established in the CCDF Plan for FFYs 2022-2024, submitted on 06/30/2021.

DCC is directly responsible for oversight of the CCAP, the tiered quality rating and improvement system, KY All STARS, child care provider professional development, and child care fitness determinations in all

of Kentucky's counties. Child care technical assistance, recruitment, referrals, and licensing are also responsibilities of DCC for the entire state. These functions are contracted to state and community partners and supported by the kynect online portal.

DCC has several mechanisms in place to support collaboration across service programs, which include internal departments within the cabinet. Additional service provider collaboration through meetings and workgroups includes but are not limited to the Governor's Office of Early Childhood, Kentucky Department of Education (KDE), Kentucky Head Start Collaborative, Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), and Department for Public Health (DPH), along with many stakeholder groups.

DCC contracts with the University of Kentucky (UK), Human Development Institute, Child Care Aware (CCA) of Kentucky to provide technical assistance to increase quality in early child care and education facilities and access to high quality licensed type I, licensed type II, and certified providers throughout the state in the areas of health & safety, professional development, quality, and training.

DCC contracts with Western Kentucky University (WKU) for the staffed Family Child Care Network of Kentucky. The purpose of the Family Child Care Network is to recruit new family child care providers, to provide the necessary technical assistance regarding health and safety requirements, professional development, and quality, and to increase access to high quality certified family child care. Family Child Care is often more successful in rural areas throughout the state that cannot financially support large center-based care.

DCC manages CCAP. Children are eligible for child care subsidies if the child has a current protection or prevention case or is in the care of fictive kin. DCC has made regulatory changes to allow CCAP funds to support child care expenses for children in foster care.

During CY 2023, the primary focus of DCC has been to sustain overall child care capacity. DCC increased the CCAP eligibility threshold from 200% of the Federal Poverty Guideline (FPG) to 85% of the State Median Income (SMI) making more children eligible for subsidized care. DCC also created a protected population within CCAP. Anyone who meets CCAP technical eligibility and works in a licensed or certified child care program is eligible to have their entire household income excluded from the CCAP application.

- During CY 2023, a total of 47,136 children and 27,599 families received CCAP benefits. Of the total number of children receiving benefits, there was an average of 2,714 children served as the result of a need for protective/preventive services. Children served as the result of protective/preventive services referrals get placement in safe and healthy environments supporting family unification.
- Total CCAP expenditures for CY 2023 were $220,757,617.39.
- DCC contracts with Child Care Aware of Kentucky (CCA), housed at the UK Human Development Institute, to provide coordination and administration of statewide Kentucky Child Care Resource and Referral (CCR&R) network services. Services provided through the CCR&R regional network include:

    - Eight regional child care administrators, four content area coordinators,
    - One technical assistance specialist health/safety,
    - Four technical assistance quality rating and improvement system (QRIS) specialists,
    - Twenty-one (21) quality coaches,

- Seventeen (17) technical assistance health/safety coaches,
- Eight training coaches, and
- Eight professional development coaches to ensure adequate supply of quality child care programs and services are available in each regional hub covering the ADD.

Through its CCR&R contract work, DCC actively attempts to meet the needs of families, provide referral information to families seeking child care, increase family knowledge of the characteristics of high-quality early care and education services, and increase provider access to training and/or professional development opportunities.

DCC receives consultation and technical assistance upon request to Administration for Children and Families (ACF), Office of Child Care Region IV office and contracted affiliates. DCC staff have also participated in several technical assistance opportunities and Peer Learning Groups (PLGs).

Kentucky Integrated Child Care System (KICCS) helps DCC to manage child care services in Kentucky and contains information on all the child care providers throughout Kentucky that are regulated by the Division of Regulated Child Care. This system processes provider payments for CCAP, as well as helps track licensing and certification requirements for child care providers. This system includes a provider portal for child care providers. Reports are compiled quarterly, annually, and ad hoc for state and federal reporting. Analysis of data reports are used to support decision making, legislative, regulatory, and program improvements.

Effective October 1, 2017, child care assistance program application for eligibility determination transitioned to Benefind, allowing Kentucky's families to easily access public assistance benefits and information 24/7 through an online application and account. Benefind transitioned to kynect during the summer of 2020. The goal of Kentucky's public assistance programs is to build strong families and obtain services such as food, cash, and medical assistance to become self-sufficient. Kynect is also a referral tool used by parents in selecting quality child care.

In 2018, DCC started work with the Kentucky Center for Statistics (KYSTATS) to improve the Early Childhood Profile, which is a cross-agency overview of early childhood education in the state. DCC worked to ensure that accurate and complete information was shared with KYSTATS from all data management partners and that data represented in the report was accurate and easy to interpret. The new and improved report will assist policymakers, practitioners, and the public in making educational and policy decisions.

Utilizing American Rescue Plan Act (ARPA) funding beginning July 2022, DCC launched a regularly updated data dashboard to provide the agency and its partners a snapshot of the child care landscape in Kentucky. Kentucky's child care data is currently stored in many different systems, and it is difficult for DCC leaders to get an integrated view. The dashboard provides users access to high-quality data from various systems and allows DCC leaders to make better decisions leading to a better client experience. This also provides views on program integrity and compliance, as well as point towards areas in the Commonwealth without adequate child care services (child care deserts). This dashboard is accessible to both internal and external partners. The dashboard also includes the following modules: Child Care Provider Dashboard, Provider's Staff Training Dashboard, Kentucky Applicant Registry and Employment Screening (KARES) Dashboard, Self-Service Provider Search Dashboard, and a Family Child Care Network Dashboard. DCC implemented the Brightwheel Platform to be paid for all providers and look forward to reporting on our successes. Overall, the Brightwheel application will help programs with automating

billing and payments, sending messages to staff and families, managing attendance records, streamlining paperwork, monitoring staff, writing lesson plans, and tracking state specific observations.

During CY 2023, Kentucky's CCAP experienced a 18% increase in child enrollment. Families served numbers have increased by 21%. This is a slight decrease for both from last year but continues to show a large swing since the decreases experienced during the pandemic. Child care providers do continue to struggle to recruit and retain staff for the wages they are able to pay. With the current job market, child care staff can easily make higher wages and earn benefits working in competitive markets such as retail and hospitality.

When the COVID-19 pandemic began, national child care policy and advocacy groups projected more than 40% of child care slots would be lost nationwide. DCC received funding from the Coronavirus Aid, Relief, and Economic Security (CARES) Act and the Coronavirus Response and Recovery Supplemental Appropriations (CRRSA) and used those funds to focus on sustaining existing child care programs. Kentucky was awarded $763 million specifically dedicated to child care through ARPA. The largest portion of the funding, over $470 Million was designated for sustainability payments distributed to child care providers throughout the state. The funds were distributed in nine payments totaling $49.6 million per payment cycle.

The second stream of funding, over $293 Million, was slightly more flexible and the federal government designated it for four specific purposes:

- Increasing provider payments
- Improving payment policies
- Increasing wages for early educators and family child care homes; and
- Building the supply of child care for underserved populations

The second funding stream was also dedicated to several much-needed projects:

- Preschool Partnership Grants – This is a collaboration with KDE to support children who qualify for CCAP and children with special needs who receive individual education plan (IEP) services and focuses on social/emotional supports and special education training. Partnering child care programs must be high-quality (Level 3, 4, or 5 STAR)
- Increase CCAP reimbursement rates to the 80th percentile of the current Market Rate Survey
- Address the CCAP benefits cliff effect by providing an additional six months of reimbursement at 50% of typical rate upon graduation from CCAP program. As of December 31, 2023, 9,214 children (5,488 families) have benefitted from this program.
- Make child care employees a protected population for CCAP. Beginning October 24, 2022, any individual who meets CCAP technical eligibility and has verified employment in a regulated child care setting will be eligible to have ALL household income excluded from the CCAP application process. As of December 2023, 3,811 families (6,707 children) had benefitted from this provision.
- Pilot an Infant and Toddler Contracted Slot Project to combat the decrease in programs accepting families accepting CCAP and to increase infant and toddler care for the most vulnerable population. As of December 31, 2023, 28 providers were participating with a total of 415 slots.
- Provide facility repair grants. As of December 31, 2023, 1,255 providers have been approved with over $10,965,128.56 awarded.
- Develop and deliver two training academies for credentialed trainers – one focused on working with children with special needs and the other focusing on director skills. Those who attend are

required to provide these trainings through the state over the course of the next two years. Thirty-seven (37) credentialed trainers completed the Working with Children with Special Needs Trainer Academy and 25 completed the Director and Administrator Trainer Academy.

- Provide funding to the Kentucky Apprenticeship program through the Governor's Office of Early Childhood.
- Provide start-up grants for certified child care homes. Initially these grants were for $2,500, but the amount was increased to $5,000 each. As of December 31, 2023, 78 family child care (FCC) provider grants were issued in 15 different counties.
- Update technology systems and provide new computers to child care programs through the state for enrollment, billing, and other business practices.
- Offer Brightwheel (a child care management system) to all regulated child care providers to alleviate some administrative burden and provide them with tools to run their businesses more efficiently.
- Provider a grant match to open new child care programs through a community partnership. Five grants were awarded.
- Provider a grant match to open new child care programs through an Intergenerational Partnership. Five grants were awarded.

E. Child Support

The Kentucky CSE program is responsible for establishing paternity, child and medical support, and enforcing those obligations. Services are administered locally by contracting officials in each county. Frankfort-based central office staff and regional office staff provide oversight for all 120 counties. The mission of CSE is to contribute to building strong families by establishing and promoting parental responsibility for financial and medical support of children.

Funding for CSE comes from federal grant funds from the Child Support Enforcement - States Program under title IV-D of the Social Security Act, State General Funds, Restricted Agency funds made primarily of state share of Child Support TANF collections.

CSE provides child support services for children placed in child protective services upon the request of the Division of Protection and Permanency (DPP). The total CSE expenses for CY 2023 were $66,796,772.74. The total caseload was 232,414 with 7,633 total foster care cases.

F. Children's Justice Act (CJA) Grant

Children's Justice Act (CJA) grants are provided to assist states in developing, establishing, and operating programs designed to improve:

- The assessment and investigation of suspected abuse and neglect cases, including sexual abuse cases, in a manner that limits additional trauma to the child and child's family.
- The assessment and investigation of cases of suspected child abuse-related fatalities and suspected child neglect-related fatalities.
- The investigation and prosecution of cases of child abuse and neglect, including sexual abuse.
- The assessment and investigation of cases involving children with disabilities or serious health-related problems who are suspected victims of child abuse or neglect.

The CJA grant is comprised of federal funds. The services and programs funded by the CJA are operating and available in various locations throughout the state. CJA task force grants are awarded after being

reviewed and voted upon by the task force. Proposals are required to provide a plan for self-evaluation and thorough reporting prior to the release of funds.

CJA continued to fund Pediatric Forensic Medical (PFM) consultations for DCBS field staff. The task force has allocated $82,500 annually to assist in determinations of abuse and neglect, as well as provide expert testimony as needed. This is a necessary service to field staff, as many communities do not have forensically qualified medical personnel.

The CJA taskforce utilizes a grant award system from a pool of applicants who have developed proposals according grant program instructions. Application instructions clearly outline CJA mandates as well as intended purpose and approved activities.

In 2023, the task force continued to fund an established grantee, the University of Louisville (UofL) Division of PFM, a consultation service consisting of a team of medical professionals headed by a child abuse certified pediatrician. The team consults to determine if there are any medical explanations for a child's reported injuries or circumstances, if those injuries are consistent with what is reported by the caregivers, and if the injuries are either abuse related, medically related, or accidental in nature. The PFM team assists primarily in the investigative process of child protective service cases. In 2023, PFM had a total of 953 consultations; 227 children were admitted to Norton Children's Hospital; 337 youth were seen in Norton Children's Hospital Emergency Department, 38 at Norton Children's Medical Center ED and 53 at Norton Women's and Children's Hospital ED. PFM assisted with 66 near-fatalities and four fatality cases. Of these cases, most of the youth were under four years old.

UK Department of Pediatric Forensics (UK DPF) continues working with registered nurses (RNs) and Licensed Clinical Social Workers (LCSWs) to collaborate with DCBS partners in scheduling trainings, continuing MDT meetings, and solidifying relationships with community partners in existing service regions. MDT meetings include case reviews, coordination of services, and engaging with external partners for resources. This year, the CJA funds have assisted in expanding the program to Cumberland and Eastern Mountain service regions, successfully transitioning services to children and families within growing communities. With the expansion into new regions, UK DPF has served over 600 patients and families, providing interdisciplinary services to victims of suspected child maltreatment. Depending on injuries and presenting concerns, these children and families were also seen for follow-up care with a medical provider and LCSW to coordinate ongoing services.

WKU continues developing and modifying their pilot training program for front line DCBS staff. They have diligently worked to identify and recruit training facilitators as well as completed a training evaluation questionnaire. The program is approximately 50% done with the Institutional Review Board (IRB) approvals, as they are awaiting a letter from the DCBS Commissioner to finalize the process. The evidence-based training modules were completed in 2023, and training locations and logistics should be finalized by February 2024.

UK DPF's project aims to establish MDTs in all DCBS service regions in the UK network, with particular emphasis on expanding into Eastern Mountain. The MDTs include a coordination of services by UK DPF staff (child abuse pediatricians, nurse practitioners, forensic nurses), child protection workers, law enforcement, prosecution, and other criminal justice representatives who evaluate cases of child maltreatment.

The improved communication and collaboration of MDTs can lead to better outcomes for children and families. The trained UK DPF staff are experts in the evaluation and identification of child maltreatment; they consider both the medical evaluation as well as psychosocial elements, and they train others in these skills. Overall, the MDTs and highly skilled UK DPF staff lead to better outcomes for families and child safety, assist in criminal court proceedings, and supply learning opportunities to all members of the team.

WKU received the final grant funds for this year. This project involves the careful creation of evidence-based modules designed to deliver novel content to child welfare workers, which will improve their knowledge and practice skills when working with immigrant and refugee populations. Broadly, the previous phase of the project phase focused on the development of the training modules and recruitment of participants. The second phase will involve the implementation and evaluation of the training protocol. As a benefit of the team's significant research experience, a tailored evaluation plan has been developed.

CJA program has experienced positive growth and expansion during 2023, including adding a new DCBS liaison and UK Program Coordinator. Leaders have been diligently working to increase program goals, objectives, and administrative duties to better serve the child welfare system statewide.

Three primary goals were established for FYs 2023-2024:

1) Recruitment and Transition
    a. Recruit members to vacant positions on the Task Force.
    b. Create a transition plan for members with expiring terms.
    c. Recruit members to positions that will be vacant due to expiring terms.
    d. Update CJA marketing materials, promotional items, and website.
2) Member Support
    a. Provide training sessions, resources, and information to members based on DCBS focal points and Task Force needs.
    b. Acclimate new members to the Task Force
3) Reporting and by-laws
    a. Complete a yearly CJA Task Force Assessment Report
    b. Complete a yearly CJA Grantee(s) Assessment Report
    c. Update and approve CJA by-laws to best service the Task Force

CJA Task Force is excited about upcoming opportunities for continued growth and success. As FYs 2023-2024 goals are met, new clear, obtainable goals and objectives are evolving and taking shape for FYs 2024-2025. For instance, sub-committees will be implemented to enhance efficiency and expand the Task Forces' overall mission. Quarterly reports and bi-annual meetings with supervisors will continue communication improvements and reinforce program direction. The Task Force will also host a member recognition event to highlight those members who have dedicated many years of service. This recognition event will be implemented in 2024 and will continue going forward for those exiting members.

The CJA program also will implement focused reporting to Task Force members. During regularly scheduled meetings, a DCBS representative will report on current challenges facing the child welfare system. Topics will include: Child and Family Services Review (CFSR), fatality/near fatality, high acuity youth (HAY), human trafficking, and youth in foster care/out-of-home care (OOHC). DCBS staff will be able to give the latest information and trends, and also answer any questions task force members may

have. With continued leadership commitment, dedicated task force members and consistent support from child welfare invested partners, the CJA Task Force will see expanding successes.

G. Children's Review Program (CRP)

The Children's Review Program (CRP) is a program with New Vista of the Bluegrass, Inc. and performs its functions under a contract between New Vista and DCBS. The mission of CRP is to support DCBS in its efforts to assure the safety, permanency, and well-being of children committed to DCBS who are placed in OOHC. CRP assigns levels of care (LOC) to children in OOHC; provides direct assistance to DCBS workers in locating, facilitating, and maintaining placements; conducts assessments of children referred for Qualified Residential Treatment Program (QRTP) placement to determine whether such a placement is warranted; and collects, analyzes, and interprets data related to placements and children's outcomes as part of its quality monitoring and assurance responsibilities. CRP maintains a database, which includes children's placement history, level history, diagnosis, and psychotropic medication history, IQ when available, QRTP assessment history, and other child-specific information. CRP provides services to each county of the Commonwealth through CRP staff (Lexington statewide office staff as well as remote staff) who work with DCBS staff across the state.

CRP is funded through title IV-E and State General Funds. CRP has four primary functions: LOC assessment, placement, QRTP assessment, and quality assurance (QA), all of which work toward assuring the safety, permanency, and well-being of children committed to DCBS who are placed in OOHC.

As part of the assessment function, clinical reviewers assigned 10,715 levels (1,982 initials, 6,774 utilization reviews (UR), 694 redeterminations, and 1,265 reassignments) in CY 2023.

As part of the placement function, regional placement coordinators (RPC) assisted in or were involved with 4,983 placements and made 490,472 referrals. Statewide placement office personnel facilitated or were involved in 1,136 conference calls/virtual meetings regarding children with specialized placement or treatment needs during 2023.

As part of the QRTP assessment function, QRTP Assessors completed 729 QRTP referral assessment and recommendation reports during CY 2023. Of the 729 assessments, 682 children were recommended for a QRTP placement, and 47 children were not recommended.

As part of the QA function, CRP maintained data on 9,650 children committed to DCBS at some point in 2023. This is likely an overestimate of the number of actively committed children, as it includes children who have been released from DCBS custody but whose status was not updated in the TWIST data that is integrated into CRP's web application monthly. CRP also maintained program information on 166 private child-caring (PCC) and private child-placing (PCP) programs that operated in 2023 (44 residential treatment programs open at any point during the year; 86 therapeutic foster care programs; and 36 independent living programs). This information is updated on an ongoing and as-needed basis. In addition, during 2023, CRP staff (primarily clinical reviewers, but also QRTP assessors) identified 4,323 quality improvement issues related to the services provided to children while in OOHC.

CRP placement staff participate in UR committees in selected DCBS regions. CRP also has designated staff who work closely with the DCBS Medical Support Team to ensure that all medically complex children are identified and tracked appropriately and that level assignments are as accurate as possible based on both the child's medical needs and behavioral health treatment issues and needs. In several

DCBS regions, CRP is involved in ongoing collaborative meetings between DCBS and PCC/PCP staff (e.g., multiple CRP staff attend the quarterly Southern Bluegrass Quality Care Provider meeting; RPCs and statewide placement staff attend virtual collaborative meetings in the Northern Bluegrass Service Region that occur three times each week, as well as weekly meetings in the Salt River Trail Service Region; RPCs also attend weekly collaborative meetings in Cumberland and The Lakes service regions).

In addition, CRP works closely with the PCC/PCP agencies individually and through their association, the Children's Alliance of Kentucky, to improve outcomes for children in the custody of DCBS. CRP staff attend a Stakeholders Alliance CQI meeting when invited by the Children's Alliance (this did not occur during 2023), which provides an opportunity to plan and track quality improvement activities. CRP representatives also regularly attend the Children Alliance's quarterly OOHC council meetings as community partners. CRP staff also lead a quarterly Quality Outcomes Council for Children meeting that all providers can attend. CRP works collaboratively with the private provider community to update comparative reports and performance indicator data on a quarterly basis. This includes frequent email and telephone contact with providers around the state as part of CRP's effort to encourage accurate reporting of the data contained in these reports. Each program's comparative report provides information on program criteria, characteristics, and services that may be used in helping determine the most appropriate placement for a child. Performance indicator data provides information about placement stability for children in therapeutic foster care and about discharge outcomes for children in residential programs. CRP is in frequent communication with the PCCs/PCPs for issues related to data collection, level assignment, placement, QRTP assessment, and general consultation. For PCC/PCP programs that have questions, are new to the state, or have new leadership, CRP will provide information regarding the expectations of the programs as they relate to CRP. CRP provides orientation training for new agencies or new agency staff during the year on an as-needed basis. During 2023, no orientation trainings were requested or provided. In 2023, CRP staff provided consultation by phone and email to existing programs on an ongoing basis.

CRP posts detailed instructions on the CRP website for completion of the Application for Level of Care Payment (ALP), which is completed by providers at regular intervals regarding the treatment issues of, progress of, and services provided to, children in their care. In 2022, a new ALP was developed, as part of the transition from a five-level system to a three-level system. The new level definitions (amended in 922 KAR 1:360) focus on children's treatment needs, and the new ALP also reflects this focus. Updated instructions for the new ALP are posted on the CRP website. CRP also collaborated with the Eastern Kentucky University (EKU) Training Resource Center (TRC) staff to launch an updated training through Training Resource Information System (TRIS) on how to best complete the new ALP form. This training was made available in September 2023 and a link to the training was added to CRP's website. CRP staff also call or email programs about specific issues related to the completion of the ALP to improve a program's accurate reporting on this form, and meetings with provider leadership at specific agencies are arranged as needed. In addition, during 2023, CRP created a Redetermination Guidelines tipsheet, which was added to the CRP website, to help programs provide the information needed for an accurate redetermination of a level assignment.

DCBS workers continue to utilize a system for notifying RPCs of a placement referral request through an iTWIST Placement Workbasket. RPCs access referral information packets through the workbasket and these packets are then provided to potential placements through the CRP web application. If a referral packet submitted by a DCBS worker is incomplete or is missing important information, the RPC will communicate with the DCBS worker to get a more complete packet of information. When making these

packets available to potential placements, RPCs also provide detailed referral information, which supplements the packet provided by DCBS, and summarizes the child's issues and needs.

Because CRP coordinates placements for children in DCBS custody, including children who have been admitted to psychiatric hospitals and psychiatric residential treatment facilities (PRTFs), it is important that CRP staff maintain relationships with psychiatric hospitals, PRTFs, and managed care organizations (MCOs). CRP tracks children in psychiatric hospitals and some PRTFs through a census report generated by CRP on a weekly basis and updated and returned to CRP by some of the facilities. In addition, CRP continues to supplement the census report by obtaining information from the hospitals, some PRTFs, and from MCOs on an ongoing basis. In order to be proactive in placement efforts, CRP Placement Unit staff communicate information about children's hospitalizations to DCBS workers, with the goal of beginning discharge planning at the time of admission.

CRP provides consultation and assistance on an as-needed basis for a range of DCBS initiatives. Beginning in 2021, this assistance has included QRTP assessments, which identify treatment issues, needs, and goals for children who are placed in, being referred for, or being considered for referral for placement in a residential treatment program. CRP's consultation and assistance also continued to draw on the wide range of clinical expertise among the staff of CRP. This included meeting with DCBS staff and providing data and feedback on child-specific and program-level quality improvement issues that were noted by clinical reviewers during URs or by QRTP assessors during the assessment process. In addition, quality improvement information is made available to each PCC/PCP agency. CRP continues to revise the quality improvement system and data gathering from the ALP as needed to address DCBS concerns related to children in care and to communicate these concerns effectively to the PCCs/PCPs. In consultation with DCBS leadership and based on the new three-level system and cabinet priorities, CRP revised the way several quality improvement categories are identified and tracked. This included adding a reference to trauma-informed care to the *Physical Management and Intervention* category definitions, adding a quality improvement category to track the utilization of involuntary confinement, adjusting the criteria for the categories that track insufficient individual and family treatment services, and strengthening the expectations related to diagnoses reported by providers.

During 2023, CRP continued to work with DCBS on a specialized services ("5S") program for children with high intensity needs. CRP facilitates conference calls/virtual meetings on children being referred to this program and, at the request of DCBS, reviews records of children in this program in order to report to DCBS how well the program is providing the expected services. CRP staff have worked in the past with DCBS staff in the implementation and ongoing assessment of some PCC/PCP pilot programs, including Home of the Innocents CATS Program, Key Assets, and Maryhurst 5S. However, the Home of the Innocents CATS Program closed in early 2022, and CRP did not participate in any meetings regarding the monitoring of the Key Assets or Maryhurst 5S programs during 2023.

CRP routinely convenes conference calls/virtual meetings to discuss and address complex cases, for decision-making on locating placements that best meet the needs of DCBS children, and for clinical consultation. Virtual conferences are also convened to monitor out-of-state placements to thoughtfully plan a child's return to Kentucky, and regular calls occur to support the new placement once the child returns. These conference calls/virtual meetings may involve CRP and DCBS staff along with representatives of state guardianship, Protection and Advocacy (P&A), DBHDID, private providers, school/education personnel, MCOs (primarily Aetna SKY), and/or family members. In most regions, DCBS also implements placement preservation meetings and/or meetings to consider the most appropriate placement referral to request for a child. These are conducted as part of an effort to reduce

the number of placement changes for children by trying to prevent disruptions before they occur and to ensure that referrals to more restrictive placements are warranted. CRP RPCs will continue to support the cabinet in addressing the issues of disruption and placement stability. QRTP assessors also aid in the effort to ensure that referral and placement in a residential treatment program is truly warranted for a child. In addition, clinical reviewers identify quality improvement issues related to placement stability, and a number of these cases are communicated to one of the central office PCC/PCP liaisons each week so that intervention can occur before the child's current placement disrupts. A placement stability report, which identifies all children who have had three or more moves in private foster care within the last 90 days or who have moved within their first month of entering a private foster care placement, is also provided to department leadership monthly to aid in addressing placement stability issues.

During 2023, CRP continued a process started in 2021 of distributing information from central office to RPCs, about children whose placement had given a 14-day notice. This process enabled RPCs to proactively communicate with department staff about the situation. There was a shift to a new process related to 14-day notices in late 2023, when PCCs/PCPs were asked to begin entering these notices into a new PCC tracking portal. Because CRP did not have access to the information entered in this way, DCBS provided a weekly management report that includes 14-day notice information, which is then communicated to RPCs. The information being provided by the PCCs/PCPs tends to be less complete than what was provided under the previous process. Due to the newness of the process, it is not clear that all 14-day notices are being entered into PCC Tracking by the PCCs/PCPs.

In 2023, CRP completed numerous data requests for DCBS (e.g., regarding level changes in programs, referral responses, children in acute psychiatric placements, bed capacity, program discharge outcomes) as well as for the Children's Alliance (e.g., QRTP outcomes, school suspensions in residential care, number of days/levels in foster care) and multiple providers (e.g., referrals to and discharges from specific programs).

For more than ten years, CRP has also served as an internship site for undergraduate psychology and social work students from the UK, EKU, Capella University, and Transylvania University. CRP has always maintained paper charts for children in OOHC but has recently recognized the importance of moving to electronic records to increase the safety, security, and efficient accessibility of case information as CRP carries out its various functions. During 2023, with cabinet approval, CRP began working with Konica Minolta to scan/digitize current records and build a system that will enable digital storage and retrieval of records going forward.

The Children's Review Program's budget for FY 2023 is $4,560,757.46. During 2023, a significant focus of the cabinet continued to be the implementation of the federal Family First Prevention Services Act (FFPSA), including the requirement that children being considered for placement in a QRTP be evaluated within 30 days of admission to determine if congregate care is appropriate. CRP has been completing QRTP assessments since March 2021 and has increased the number of assessments completed each year based on increased staffing and cabinet guidance regarding assessment eligibility criteria. For example, in April 2022, the focus shifted from assessing only those children who were title IV-E eligible and placed in a QRTP to assessing all children placed in a QRTP, consistent with FFPSA legislation. During 2023, changes to the TWIST QRTP Workbasket made it possible for DCBS workers to request a QRTP assessment for any child for whom they completed a Child Needs Assessment and OOHC Referral (DPP-886A form). This added some additional tasks and challenges to the case identification/assignment process (see "Qualified Residential Treatment Program Assessments in Section 5a below, for further information). Although the priority continues to be completing QRTP assessments for those children

placed in QRTPs, as required by FFPSA, assessments for children prior to residential placement or placement referral (e.g., children who are currently in psychiatric hospitals, detention centers, therapeutic foster care, etc.) are completed as assessor capacity allows. Other changes to the QRTP Workbasket included some reorganization and revision of the fields the QRTP assessment report is entered into TWIST.

As part of DCBS' focus on ensuring that children are placed appropriately in residential care, there has been an ongoing effort to have treatment providers, including those from psychiatric hospitals and PRTFs, identify a child's treatment needs at discharge rather than making a placement recommendation. Although there has been less focus on this due to the current challenges related to finding placements, CRP's Placements Unit staff work to support this initiative and integrate this change into placement referral processes when possible.

The cabinet added specific performance indicators to the PCC/PCP agreements in 2019. Although the Kentucky legislature did not approve the cabinet's request in 2020 for funding to pursue performance-based contracting, it is hoped that this performance indicator data will be used to evaluate and potentially reward programs' performance in the future. During 2023, CRP continued working with the PCC/PCPs to assure the accuracy of data collected to measure performance and analyzed the fourth full year of performance indicator data in December 2023. CRP provides raw data on a quarterly basis to the PCC/PCPs so programs can verify the accuracy of the data or make corrections as needed. Finalized performance indicator data was provided to PCC/PCPs each quarter during FY 2023. Each year since FY 2019 has been considered a "hold harmless" year for the PCC/PCPs, and future years will continue to be until the cabinet decides otherwise. This allows PCC/PCPs to better assess where they are on the measures and where they need to make improvements, in anticipation of future performance-based contracting. During the coming year, CRP will continue to analyze performance indicator data in consultation with the cabinet.

CRP has four primary functions: LOC assessment, placement, QRTP referral assessment, and QA, all of which work toward assuring the safety, permanency, and well-being of DCBS-committed children who are placed in OOHC.

Level of Care Assessment: CRP assigns LOC to children as they enter PCC/PCP agencies and as the children progress through the system. Levels are assigned by clinical staff based on definitions provided in 922 KAR 1:360. Information used in the level assignments is provided by the DCBS frontline worker, the PCC/PCP, or through other sources. These levels represent the treatment and service needs of the child.

CY	Total Levels	Initials	Utilization Reviews	Redeterminations	Reassignments
2023	10,715	1982	6774	694	1,265
2022	11,322	2,286	7,141	763	1,132
2021	11,725	2,185	7,619	943	978
2020	12,586	2,123	8,577	924	962
2019*	12,991	2,430	8,529	929	1,103

* The table data has been updated from previous APSRs to reflect a calendar year rather than a fiscal year for 2019.

The number of level assignments has decreased each year from 2019 to 2023 (a 3.9% decrease in 2019, an additional 3.1% decrease in 2020, a 6.8% decrease from 2020 to 2021, a 3.4% decrease from 2021 to 2022, with the number of levels assigned in 2022 compared to 2023 decreasing by 9.5%. Staff who assign levels of care are required to maintain acceptable levels of inter-rater reliability (IRR), which measures the extent of agreement among reviewers when assigning levels. CRP is required to maintain an average IRR of .50 (half a level from the mean) or less. In FY 2023 CRP's IRR was .15.

During the last year, CRP has continued to work to collect IQ scores on children, especially those described as developmentally delayed by DCBS or placement staff. This information is used in determining the most appropriate placement and treatment options for these children. At the time of this report, CRP maintained 791 IQ reports on 566 children committed to DCBS. In 2023, a total of 206 IQ reports (on 186 children) were entered into the CRP database. Please note that some children have more than one IQ report.

CRP has designated staff who work closely with the DCBS Medical Support Section to assure that all medically complex children are identified and tracked appropriately and that level assignments for these children are as accurate as possible based on both the child's medical needs and other issues/behaviors. A Medically Complex Discrepancy Report is provided monthly to the LOC Assessment Unit monthly to aid in this. In 2023, CRP tracked 320 children who were identified as medically complex at some time during the year. The LOC for a medically complex child is based on a medical acuity rating identified by the DCBS Medical Support Section, in addition to the child's treatment needs. New medical acuity ratings were identified for all medically complex children as part of the transition from a five-level system to a three-level system in July 2022. However, due to concerns raised by foster care agencies related to the acuity ratings and the impact on per diem rates, a decision was made by DCBS to review and readjust medical acuity ratings. Discussion of this process began in late 2022, with the anticipation that it would be completed early in 2023 so CRP could adjust levels assigned for these children. Redeterminations for all identified cases based on the new medical acuity rates were processed in January 2023 and CRP worked with the DCBS Medical Support Teams and the CHFS Division of Administration and Financial Management (DAFM) staff to facilitate this process.

CRP communicates with DCBS and PCCs/PCPs on a daily and ongoing basis regarding levels of care and other issues of concern.

Placement: CRP's RPCs are responsible for assisting DCBS staff in locating placements that best meet a child's needs. CRP adds or removes programs as directed by the cabinet. During CY 2023, referrals were stopped or suspended for several programs, and at the cabinet's request, a specified residential substance use treatment program was added as an option for referral. CRP's database identifies placement options based on the child's age, LOC, gender, IQ, and the proximity of the program to the child's home county.

Based on the child's specific needs, children can also be referred based on their medically complex status, specialized population status (pregnant, parenting, at risk for or victim of trafficking), or gender identity. An effort is made to keep siblings together in placement whenever appropriate. CRP staff were involved in 4,983 placements in 2023, a slight decrease from 5,005 in 2022. However, placement coordinators made 33,471 more referrals in 2023 than in 2022, an increase of approximately 7.3%. The average number of referrals made for each placement increased from 91.31 to 98.43, an increase of about 7.8%. There have been significant placement challenges associated with the COVID-19 pandemic like lower residential bed capacity due to staffing shortages or program closures, that have likely

contributed to the increase in the number of referrals made and the average number of referrals needed for each placement found.

CY	# of Referrals	# of Placements with RPC Involvement	Avg. # of Referrals per Placement
2023	490,471	4,983	98.43
2022	457,000	5,005	91.31
2021	345,565	5,873	58.8
2020	251,281	5,573	45.1
2019	360,830	6,898	52.31

CRP provides information to DCBS staff about placement options for referred children, so placement decisions can also be based on the PCC/PCP's ability to provide treatment services for the child's identified treatment needs. CRP maintains information on PCC/PCP programs statewide (including residential treatment, QRTPs, therapeutic foster care, and independent living programs (ILPs)) regarding the evidence-based practices (EBPs) and other services they provide to meet the treatment needs of state committed children. When placement options based on a referred child's age, LOC, etc. are identified, the RPC shares information with the DCBS frontline worker about the types of EBPs and other services each program offers to address the treatment needs of the child being referred. CRP maintains a list of descriptions for the more than 80 EBPs reported as being used at some point by the PCC/PCP programs (48 EBPs are reported as currently being used by 93 programs) and updates these as needed.

Another source of information provided to DCBS staff is the Comparative Report. This report is produced by CRP and updated quarterly for each PCC/PCP and includes information about admission criteria, services provided, staff qualifications, and comparisons to similar programs in various areas including safety and permanency. RPCs request foster families snapshot reports on any foster family considering placement of a child and may request complete home studies on specific families from PCPs at DCBS request. RPCs work diligently to make sure that staff in the individual DCBS regions have available the information needed to make good placement decisions and encourage DCBS staff to use the reports and information that CRP provides when making those placement decisions, especially when there are multiple placement options.

In November 2022, DCBS central office staff initiated virtual Daily Priority Placement Meetings to discuss children currently in (or at risk of being in) nontraditional placement settings (e.g., DCBS offices, hotels, hospital emergency departments). CRP statewide placement staff, as well as the RPC focusing on children in non-traditional placements, join these meetings daily to provide updates on placement searches and other relevant information. During 2023, CRP added an option for non-traditional placements to the child tracking system to more specifically identify when children are in these placements; this will provide the opportunity to begin to gather data related to these placements.

CRP statewide placement staff, in addition to the RPCs, are frequently involved in conference calls and virtual meetings with DCBS staff and others to determine the most appropriate placements and services for children. During 2022, RPCs began reaching out to residential treatment facilities and therapeutic foster care agencies when there had been no placement acceptances for a referred child, to request that the child be reconsidered for placement with an enhanced rate developed by DCBS to cover specialized treatment needs. This practice was discontinued in May 2023 at the direction of the cabinet due to system-wide rate adjustments for providers.

CRP routinely convenes telephone conference calls/virtual meetings to discuss and address complex cases, for decision-making on locating placements that best meet the needs of DCBS children, and for clinical consultation with DCBS Clinical Services Branch staff. In 2023, CRP staff were involved in approximately 1,136 conference calls. This is a 42.7% increase from the 796 conference calls CRP staff were involved in, in 2022. A large part of this increase is due to the inclusion of the Daily Priority Placement Meetings in the count of conference calls/virtual meetings. However, this does not account for all of the increase; there were nearly two more virtual conference meetings each week of 2023 compared to 2022, on average. Some of this increase may also be due to changes in processes. For example, some additional virtual meetings were scheduled by high acuity specialists and others were scheduled by regional staff to check on a child's progress while at Peace Hospital. For virtual meetings about children aged 16 and over, independent living coordinators may be invited to participate to ensure the region follows appropriate steps to prepare children for aging out of the system. Guardianship staff are invited to participate in conference calls/virtual meetings about youth over the age of 18 who may need these services as they get closer to aging out of the DCBS system.

During 2022, the head of the Placements Unit began taking part in an initiative focused on transitioning children to community-based placements who are currently in residential care and who have been assigned a Level 2; CRP's focus in this effort is on communicating with DCBS regional staff to facilitate a child's move to a less restrictive placement option. During 2023, meetings about this population moved from a monthly to a quarterly schedule.

Because of the number of children and the complex treatment needs of children in DCBS custody who are placed in psychiatric hospitals and PRTFs, it is important that CRP staff maintain relationships with psychiatric hospitals, PRTFs, and MCOs. Aetna SKY became the health insurance provider for the majority of children in OOHC in January 2021, therefore, CRP works most often with Aetna SKY staff but communicates with other MCOs on an as-needed basis. CRP tracks children in psychiatric hospitals and PRTFs through a census report generated by CRP to be updated and returned to CRP by the facilities on a weekly basis. In addition, CRP supplements the census report with information obtained in other ways about hospital and PRTF admissions (e.g., from Aetna communications) on an ongoing basis. This allows placement efforts to be proactive, with the goal of beginning discharge planning for a child at the time of admission to a hospital or PRTF. CRP also maintains and utilizes lists of children who have specialized placement or treatment needs (e.g., are being referred out of state or to the 5S program; are in a detention setting) and/or are in hospitals or PRTFs, to effectively communicate with DCBS Clinical Services Branch staff on challenging cases. CRP updates these lists as needed. These lists are also used to track children who are at risk for disruption or decertification or whose services have already been decertified by the MCO at their current placement. Decertification was not an issue while Kentucky was under a state of emergency, but during 2023 this process began again for children in inpatient substance abuse programs. Decertification has not been reinstated yet for psychiatric hospitals or PRTFs.

CRP maintains a database of PCP medically complex foster homes (homes in which the foster parents are trained to care for children with significant medical needs) to assure appropriate placement referrals for medically complex children. There are currently 148 homes designated as medically complex. CRP monitors the DCBS PCC tracking system for medically complex foster homes. If a foster home is no longer listed as medically complex in the PCC tracking system, it is removed from the CRP list. CRP also provides a monthly report to DCBS identifying medically complex children placed in non-medically complex homes.

RPCs refer to supervised and scattered site ILPs as appropriate. In 2022, DCBS also began allowing DCBS-committed youth attending college to reside in a dorm, with a specified set of support services provided by an independent living program. The CRP database provides a list of ILP providers by county and region. CRP's Comparative Report provides additional information about each resource. Currently, CRP lists 11 agencies with 35 separate programs licensed to provide ILP services to state-committed children.

CRP staff are actively involved in transitioning children who have been placed in out-of-state (OOS) treatment programs back into placement in Kentucky. CRP convenes conference calls as appropriate with DCBS staff, current OOS treatment providers, and others as needed, while the child is in the OOS placement, again approximately one month after the child's return, and then at ongoing regular intervals as needed to support and maintain the placement. The number of children in OOS placement had been gradually increasing. After a significant jump in 2018, the number of children placed in an OOS program sometime during the year leveled out in 2019. There were 25 children placed in OOS placement in 2020, compared to 31 in 2019. Although there was a decreasing trend in 2020 and 2021, with 25 children placed OOS sometime during 2020 and 19 children placed OOS in 2021, the number increased to 25 in 2022, and was up to 55 for CY 2023. (see table below).

The number of children in OOS placement at the end of 2023 was 38, which is a significant increase from 2022, when there were 15 children placed in OOS treatment programs at the end of the year. The increase in the number of OOS placements seems to be a direct result of the decrease in the number of available residential and PRTF beds in Kentucky. The number of residential program beds decreased from 966 at the beginning of 2023 to 578 at the end of the year, a 40.2% decrease. CRP does not have access to data about the number of PRTF beds. An additional column was added to the table below in 2022 to begin tracking the number of referrals made for OOS placements each year, based on staff reports that this number has also increased significantly. Not all OOS referrals lead to placement. Each referral made for an OOS placement involves CRP staff gathering and summarizing information about the referred child, as well as collecting clinical documentation (IEPs, psychological evaluation reports, treatment plans, etc.) that is often required by OOS treatment facilities. In 2023, 91 children were referred for OOS placement, compared to 71 referrals in 2022. This represents a 28.2% increase. DCBS leadership anticipates that the number of children referred to and placed in OOS treatment programs will remain at or above the current level until such time as Kentucky has developed the resources sufficient to meet these children's needs.

Number of Children Referred for OOS Placement by CY

CY	# Children OOS During the Year	# of Children OOS at End of Year	# of Children Referred for OOS Placement
2023	55	38	91
2022	25	15	71
2021	19	4	
2020	25	8	
2019	31	10	

CRP staff work closely with DCBS to address the needs of the developmentally and intellectually disabled populations especially as they begin to age out of the system to assure a smooth transition to the adult system. CRP staff may at times work with supports for community living (SCL) programs to have them consider placing these youth under an individual placement agreement until SCL funding is available for

the youth at 20.5 years of age. This may serve to reduce the number of transitions for the youth. SCLs include both family settings and staffed residences. CRP has compiled a list that identifies which SCLs fall into each category and made this list available to the cabinet, as youth may be more suited to one kind of SCL than the other. However, referrals have generally been made to both SCL types over the past year due to decreased SCL capacity during the COVID-19 pandemic.

From 2015 to 2017, the number of youth utilizing SCL services remained stable. However, in 2018, the number increased significantly to 92 DCBS youth being placed with an SCL provider sometime during the year and 74 DCBS youth being placed with SCL providers at the end of the year. The number of DCBS youth in SCL placements continued to increase between 2019 and 2021 (see table below). In 2022, although the number of youth in SCL placements sometime during the year decreased to 101, compared to 111 in 2021, the number of youth placed with SCL providers at the end of the year was slightly higher than in 2021, 70 compared to 66. In 2023, the number of youth placed in an SCL during the year rose slightly (from 101 to 106) and the number of youth in SCL placement at the end of the year remained approximately the same (71 youth in 2023 versus 70 youth in 2022).

Calendar Year	# Youth in SCL During the Year	# of Youth in SCL at End of Year
2023	106	71
2022	101	70
2021	111	66
2020	104	75
2019	105	74

DCBS worked during 2023 with one agency, Maryhurst, that has a specialized 5S residential program for children with high intensity needs. CRP has continued to be involved in helping determine children's appropriateness for placement in this specialized-services program and has facilitated conference calls/virtual meetings to discuss related referrals and placements. CRP staff also review the records of this program to determine if agreed-upon services have been provided. During 2023 CRP completed 152 service reviews for the Maryhurst Specialized Services Program. Service reviews are completed on a quarterly basis for each youth in this program. In 2023, there were 81 children who resided in Maryhurst. It was decided in 2020 that the individual reviews no longer needed to be sent to the programs or to DCBS, and since then the aggregate reports have been available each quarter to both DCBS and to Maryhurst through the CRP web application.

CRP communicates with DCBS and the PCC/PCPs on a daily and ongoing basis regarding placement referrals for children, clinical consultation, and other issues of concern. During 2023, providers requested the ability to view rejected referrals in the CRP placement referral system. This was already available to PCC/PCPs, but not all providers were aware of this capability. CRP revised the instructions that are available to providers on the web application. CRP also added the ability for providers to view the rejection reason they chose for these cases.

QRTP Assessments: In March 2021, CRP began completing QRTP assessments for youth in the custody of DCBS who had been referred for residential care, and this function continued in 2023. The QRTP Assessment Unit reached full staffing levels during 2023, with 12 full-time assessors and one part-time assessor. Although the primary focus is on meeting federal FFPSA requirements to assess children who have been placed in a qualified residential treatment program before their 30th day of placement, CRP expanded beyond this focus in 2023. As assessor capacity has allowed, QRTP assessments were

completed for children prior to residential placement or placement referral (e.g., children who are currently in psychiatric hospitals, detention centers, therapeutic foster care, etc.). QRTP assessors completed 729 QRTP Referral Assessment and Recommendation reports between during CY 2023, an increase of 22% (131 assessments). Of the 729 assessments, 682 (93.6%) children were recommended for a QRTP placement, and 47 children (6.4%) were not recommended. Of the 729 assessments completed, 210 (28.8%) were reassessments (i.e., an assessment of a child for whom a previous QRTP assessment had been completed); this was a significant increase from the 13.5% percentage of reassessments completed in 2022. Reassessments occur when a child disrupts their current QRTP placement and is referred for placement with another QRTP, when a DCBS administrative decision about placement is made (e.g., program closures), or when a child has stepped down from a QRTP placement (for example, to a therapeutic foster care home) but then is referred again for residential treatment due to escalating behavior and treatment needs.

A portion of time spent completing assessments is Medicaid-billable, and 556 of the QRTP assessments completed in 2023 (76.3%) were able to be billed to Medicaid. This is at about the same level as the percentage of assessments that were able to be billed to Medicaid in 2022 (73.6%). The Medicaid-billable time in 2023 represents more than 3600 hours of records review, interviews, and assessment tool scoring (a little less than 6.5 hours per billed assessment on average). Revised DMS guidelines related to QRTP assessments were provided in final form in August 2023. The guidelines identified that activities including clinical decision-making, treatment planning, and preparation of the report were billable, and CRP was able to begin implementing these guidelines in November 2023. Inclusion of these activities will likely increase the number of QRTP assessments that meet the five-hour minimum requirement for billing, but the impact will not be clear until data is available for the CY 2024.

CY	# Assessments Completed	# Assessments Recommending QRTP	# Assessments Recommending Against QRTP
2023	729	682	47
2022	598	552	46
2021	168	162	6

QRTP assessors identify QI issues as needed, based on information gathered during the assessment. QRTP assessors also make maltreatment reports to DCBS as required. During 2023, assessors brought 20 reports of potential maltreatment to DCBS' attention, through reports to the child abuse reporting hotline or online reporting portal.

The TWIST QRTP assessment workbasket was made available to CRP in 2021, to identify children who have been placed in a QRTP and allow CRP a means for entering QRTP Referral Assessment and Recommendations reports into TWIST. Due to ongoing issues with the functionality of the workbasket, however, not all QRTP assessments completed are able to be entered in TWIST. To address this, CRP emails QRTP reports and CANS assessment summaries to DCBS workers, in addition to utilizing the QRTP workbasket whenever possible. A significant shift in the workbasket's functions occurred early in 2023. The workbasket now allows DCBS workers to request a QRTP assessment for any child for whom they have completed a Child Needs Assessment and OOHC Referral (DPP-886A form); the workbasket no longer lists cases based on the child's placement in a QRTP. As noted previously, CRP continues to focus on completing QRTP assessments for those children placed in qualified residential treatment programs, as required by the FFPSA, utilizing placement information from multiple sources. Additional

assessments, including for appropriate cases identified through the workbasket, are completed as assessor capacity allows. DCBS standards of practice (SOP) directs workers to request a QRTP assessment if a child is "being considered or referred for residential treatment, or if the youth is placed in a residential treatment program." However, because not all DCBS workers may be familiar with these guidelines, not all requests made for QRTP assessment are appropriate (e.g., cases are identified in the Workbasket when the child is too young for QRTP placement or when the worker is considering placement only in a therapeutic foster home). There also continue to be challenges related to CRP's ability to enter QRTP assessment reports into iTWIST because entry relies on the DCBS worker making an initial request for an assessment through this system. CRP continues to email QRTP assessment reports to DCBS workers, to ensure that the report is available for court processes, etc., whether or not the case has been listed in the workbasket. CRP created a QRTP assessment fact sheet with DCBS input, to help educate DCBS workers about the assessments and assessment process.

To comply with the federal requirement that assessments be completed within 30 days of a child's placement in a QRTP, staff in the QRTP Assessment Unit work diligently to identify children placed in these programs as well as the accurate date on which the children were admitted. Although DCBS workers and providers are expected to enter placement information promptly into TWIST/PCC Tracking, timely and accurate placement information is not always available to QRTP staff. As a result, there are multiple efforts by QRTP staff to accurately identify children who require assessments, including by monitoring anticipated placements through regional placement coordinator documentation, tracking children placed utilizing post-adoption placement stabilization services (PAPSS) funds so a QRTP assessment can be initiated at the appropriate time, and daily communication with DCBS workers and PCC staff. Numerous web application additions also aid in the effort to identify and track QRTP assessment cases.

Gathering comprehensive information for each QRTP assessment is a priority for the QRTP Assessment Unit and staff have worked to navigate barriers related to cooperation from providers and other agencies in providing information and scheduling interviews when requested. QRTP Assessment Unit staff have worked to educate providers and DCBS frontline staff about the QRTP assessment process and goals and to smooth the release of information process. Due to the number of children whose treatment histories include admission to a psychiatric hospital, QRTP staff also began efforts at the end of 2022 to develop relationships and information-sharing processes with psychiatric hospitals around the state.

Quality Assurance: CRP receives quarterly or semiannual reports from the PCC/PCPs regarding each child in their care. Through these reports CRP can monitor some aspects of service provision by the PCCs/PCPs. As CRP's clinical reviewers review these reports as part of the level assignment process, they also note any concerns about issues including the child's safety or the services he/she may or may not be receiving. Although the majority of quality improvement (QI) issues identified are recorded by clinical reviewers as part of URs, QI issues can also be identified by clinical reviewers based on information provided to CRP for a child's reassignment level or as part of a redetermination request. Since the implementation of QRTP assessments, concerns identified during the assessment process have also been documented as QI issues. QI issues are also tracked at a program level, and a frequency report is provided to DCBS monthly. Depending on the seriousness of the concern, it may be reported in detail to DCBS. Throughout 2023 these specific issues of concern have been emailed on a weekly basis to DCBS. In 2023, 619 specific QI issues were sent to DCBS (about 11-12 cases each week, on average). Clinical reviewers also identify systems and program-level concerns to bring to the cabinet's attention (e.g., concerns related to child progress and services) or track concerns identified by the cabinet.

QI information has been available to the PCC/PCPs online through the CRP web application since 2014. With online access, PCC/PCP staff can readily review any issues that have been noted about their programs and utilize the information for program improvement purposes. CRP identified 3,924 issues in 2019, 3,645 issues in 2020, 2,901 issues in 2021, and 2,929 QI issues in 2022. In 2023, 4,323 QI issues were recorded. A portion of these QI issues are considered non-program issues (i.e., the concern identified is not associated with any one program or provider, as for example, when a placement stability-related QI issue is identified for a child who has moved multiple times among multiple agency's therapeutic foster homes).

QI data is most meaningful when considered as a percentage of the total number of URs completed for which a program-related QI was identified. In 2023, a program-related QI was identified for 2,788 of the URs completed (41%). The majority of the time (67%), a single QI issue was identified for a particular UR. However, multiple QI issues are sometimes identified for a single UR. In 2023, two QI issues were identified 26% of the time, and three or more QI issues were identified about 7% of the time. The number of QI issues identified overall remains consistently high, even though the PCC/PCPs have access to the information and are encouraged to use it for their own QI purposes. There are multiple explanations for the particularly high total number of QI issues identified in 2023, including changes in cabinet guidance about how some QI issues should be tracked (see Section 5b, below, for further discussion.) CRP continues to monitor and adjust the system as necessary. For example, in 2023, CRP created a frequently asked questions (FAQ) resource that was provided to programs for which two or more QI issues had recently been identified in the category of Psychiatric Treatment, in an effort to increase programs' ability to document psychiatric services accurately on the progress reports they submit to CRP as part of URs.

Calendar Year	# QI Issues Identified	# URs	% URs With Identified QI Issues	# URs With at Least One Identified Program-Related Issue
2023	4,323	6,774	41%	2,788
2022	2,929	7,141	41%	
2021	2,901	7,619	38%	
2020	3,645	8,577	42%	
2019	3,924	8,529	46%	

DCBS has a tracking system for children in private foster care, residential, and independent living placements. CRP receives a weekly download from DCBS which is integrated into the CRP system to ensure that placement information is as current and accurate as possible. Reconciliation requires review of information in TWIST or communication with PCC/PCP staff for each of the cases that have discrepant information. There are ongoing efforts to have providers accurately record placements (e.g., moves/placements vs. respite placements for PCPs). In 2019, 16,706 records were reconciled, 15,688 in 2020, 16,063 in 2021, and 15,938 in 2022. In 2023, 16,207 PCC tracking records were reconciled with information in the CRP web application.

During 2023, CRP completed numerous data requests for DCBS (e.g., regarding level changes in programs, referral responses, children in acute psychiatric placements, bed capacity, specific program discharge outcomes) as well as for the Children's Alliance (e.g., QRTP outcomes, school suspensions in residential care, number of days/levels in foster care) and multiple providers (e.g., referrals to and discharges from specific programs).

CRP made several database and web application changes in 2023 to make information more available to central office staff or to make data more usable or secure. In early 2023, all users of the CRP web application were required to change their password to meet new security requirements. On the CRP web application page that lists the children in each residential, foster care, or independent living program, a program total number was added. Several changes to the web application page related to children with specialized placement or treatment needs were made, based on central office requests (e.g., a date-of-birth field was added, categories were reorganized, and information such as the date of last referral was added for each case). Summary analytics related to referrals and placements (e.g., total number of referral episodes, total number of psychiatric hospital placements) were added to every child's record and are now available for both CRP staff and central office staff.

CRP responds to numerous data requests throughout the year from DCBS and from providers. In addition, CRP provides reports on a yearly, quarterly, monthly, and weekly basis. The following reports are sent to designated DCBS staff on a yearly basis:

- Performance Indicators for PCCs/PCPs

CRP provides the following reports to designated DCBS staff on a quarterly basis:

- Comparative Report
- Foster Parents Who Have Changed Agencies
- Referral Responses Report
- Medically Complex Homes and Placements Report
- PCC Foster Care Homes with No History of Placement or No Current Placement
- EBPs Currently Being Used By PCC/PCPs
- Total Number of In-Progress QRTP Assessments for the Quarter/Year
- Total Number of QRTP Assessments Completed for the Quarter/Year
- Total Number of Youths Recommended for QRTP for the Quarter/Year
- Total Number of Youths Not Recommended for QRTP for The Quarter/Year

In addition to these required quarterly QRTP reports, additional information is provided each quarter, providing data related to assessments that were not completed.

CRP provides the following reports to designated DCBS staff on a monthly basis:

- PCC Foster Home Occupancy Rates by Region
- PCC Foster Home Occupancy Rates by Program
- PCC Foster Home Occupancy Rates by County
- PCC Foster Home Occupancy Rates by Region and County
- Empty PCC Foster Homes
- PCC Foster Care Medically Complex Foster Home Beds
- Medically Complex Youth with Medically Complex Rating
- Medically Complex Census
- Private Medically Complex Foster Parents By Program
- Private Medically Complex Foster Parents By Region
- Medically Complex Children in Residential Care
- Medically Complex Children in Non-medically Complex Homes
- PCC Compliance Reports
- Private Care Capacity and Occupancy Dashboard

- Placement Stability Reports (one identifying children who moved from a PCP foster home within 30 days of their commitment, and another showing the number of children with three or more placement moves in PCP foster care within the previous 90 days)
- Residential Length of Stay Report
- Youth Medication Report
- Monthly Activity Dashboard (includes current and trend data related to CRP's assessment, placement, and quality assurance functions)
- SCL Program Contact Information
- Referral Data (including child demographics and referral specifics)
- Projected Discharge Date from Residential Report
- Children's Residential Level of Care

CRP provides the following reports to designated DCBS staff on a weekly basis:

- QRTP Report (sent to DAFM)
- Regional QRTP Reports

CRP communicates with DCBS and/or PCCs/PCPs on a daily and ongoing basis regarding data collection and other issues of concern. In the last year, the number of level assignments decreased 5.4% compared to the previous year (11,322 level assignments in 2022 and 10,715 in 2023, a decrease of 607, or 40.2%). This continues a trend that began in 2019. There were fewer levels assigned for all categories other than Reassignment levels (those assigned when a child's level has expired, for example, due to re-entering the out-of-home care system); the number of Reassignment levels increased from 1,132 in 2022 to 1,265 in 2023. DCBS data does indicate a generally decreasing trend for the number of children in out-of-home care over the last years (there were 9,038 children in care at the end of 2019, 9,193 at the end of 2020, 8,998 at the end of 2021, 8,437 at the end of 2022, and 8,060 at the end of 2023). It may be that there has been an increase in the number of DCBS foster care or relative and fictive kin placements over these years, and these types of placements do not require a level of care. An additional explanation for the decrease in the number of levels assigned relates to the trend that started in 2020 of decreasing numbers of children placed in residential care. The decrease in the number of children in residential care that started in 2020 continued in 2023, with 556 children in residential placement at the beginning of the year and 487 children placed in residential treatment programs at the end of the year. UR levels for children in residential placements occur every 3 months, while levels for children in therapeutic foster care occur at 6-month intervals. A higher proportion of children placed in therapeutic foster care compared to residential treatment programs from one year to the next would thus lead to fewer UR levels assigned. This explanation is consistent with the decrease from 2022 to 2023 in the number of UR levels assigned (from 7,141 to 6,774).

Some of the decrease in the number of children placed in residential treatment programs is likely related to the ongoing focus by DCBS on ensuring that children referred to and placed in residential care truly require the structure and services of those programs (i.e., FFPSA goals and QRTP assessment implementation). Based on the QRTP assessments completed in 2023, the majority of children placed in a residential program were determined to be appropriate for that placement (93.6% of children assessed were recommended for residential placement). There was also a significant decrease in residential capacity of 388 beds due to programs closing and to a decreasing number of beds available in individual programs. Some of this decrease was due to the ongoing impact of pandemic-related staffing issues. It is also likely the some of the decrease in residential beds occurred due to providers' awareness of DCBS' long-term focus on decreasing the number of children in residential programs.

CRP continued to support DCBS leadership over the past year in their efforts to decrease the number of children moving from placement to placement with little to no stability. As noted in the list of reports in the previous section, CRP has continued to provide two reports related to stability to the cabinet on a monthly basis: one identifies children who moved from a PCP foster home within 30 days of their commitment; the other identifies the number of children with three or more placement moves in PCP foster care within the previous 90 days. DCBS has continued to follow up on cases identified in these reports. Placement stability is also one of the QI categories, and individual cases identified as particularly concerning based on the child's age, number of moves, etc. are sent to a designated central office staff for follow-up as needed. QI data and performance indicator data for therapeutic foster care programs provide individual programs with information about placement stability and additional avenues for potential improvement in this area. Stability in residential care can be an issue as well. In 2023, 28.8% percent of the QRTP assessments completed were reassessments (i.e., assessments for children who had a prior QRTP assessment). These reassessments often occurred due to the child disrupting their current QRTP placement. It will be important to continue to track trends related to reassessment cases going forward.

The number of conference calls/virtual meetings about children with complex placement and treatment needs continues to increase (1,136 calls/meetings, including Daily Priority Placement Meetings, during 2023, or more than 20 calls on average per week). The large number of complex cases and the decrease in placement options drive the need for the high volume of calls. Although finding placement/treatment options for these children is the primary focus of the majority of the conference calls/virtual meetings, they are also convened to address questions or to reach consensus regarding placement or treatment recommendations and to explore ways to prevent disruption or assure successful transitions. In addition, as noted previously, DCBS central office staff initiated daily virtual meetings in November 2022 to problem-solve situations where children were placed in nontraditional placement settings (e.g., DCBS offices, hotels, hospital emergency departments); these daily meetings have continued in 2023. The regular occurrence of these non-traditional placements is another indication of the challenges and stresses of the out-of-home care system currently.

Despite a decrease in the number of placements made in 2023, the number of placement referrals made, as well as the average number of referrals per placement, far surpass the pre-pandemic level. The continued increase in the average number of referrals made per placement compared to last year likely reflects the ongoing impact of the pandemic (on staffing and thus program capacity and waitlists for placement) and the need for RPCs to refer children to a broader range of placement options and to refer them multiple times in order to find placement. The trend identified last year of more children being placed in OOS treatment facilities continued and escalated (with 38 children placed OOS at the end of 2023, compared to 15 children in 2022). As noted previously, this trend is likely a reflection of the decreased in-state placement options (for both residential programs and PRTFs) for children with particularly complex treatment issues and needs.

It is difficult to compare this year's QI data to previous data, given the substantial changes made at the beginning of 2023 in how issues in some categories were tracked. The significant increase in the number of QI issues identified in 2023 (increasing from 2,929 QI issues in 2022 to 4,323 issues in 2023) may be attributable to a range of factors. First, per the cabinet's request, a new QI category (involuntary confinement) was added. Second, higher expectations regarding the number of individual therapy sessions for children in therapeutic foster care assigned a Level 3 were included in the PCC agreement in 2022, and provider progress reports that would reflect this change began being received by CRP in 2023.

Third, based on cabinet guidance, CRP revised the way several QI categories were identified and tracked (e.g., strengthening the criteria for the categories that track insufficient individual and family treatment services, and raising the expectations related to diagnoses and provider credential documentation). Given the size of the increase in the number of QI issues in 2023, there are likely additional factors that impacted programs' provision of services, including lack of familiarity with the new requirements, as well as staffing turnover and shortages (which may impact training, experience level, and quality of documentation). It is also possible that QI issues in one area contributed to increased issues in another area (for example, providing insufficient therapy services may have led to increased placement disruptions/placement instability). Finally, children placed in OOHC during 2023 may have presented more challenging and complex treatment issues than in the past (reflecting the negative impact of the pandemic on children's mental health that has been noted for the wider population), and this may have exacerbated existing staffing issues, placement stability challenges, etc. It is hoped that an ongoing focus by DCBS on PCCs and PCPs providing treatment services that are commensurate with children's needs (including providing family therapy when children are in OOHC), coupled with intervention by DCBS staff regarding specific child concerns identified by CRP, stabilization of staffing issues, and increased awareness and effort by individual programs to improve services provided to the children in their care will lead to fewer QI issues being identified over time.

Trends in QRTP assessment data include a continuation of the high proportion of assessments completed that recommended QRTP placement and an increase in the proportion of reassessments completed. As in previous years, the high percentage (93.6%) of assessments that recommended QRTP placement reflects appropriate referral requests by DCBS workers—i.e., children who are being considered for, referred for, or placed in residential treatment are typically assessed to have treatment needs that require the intensity of treatment and supervision services provided by those programs. The requests for QRTP assessments that result in a recommendation against QRTP placement are likely to be related to current challenges in the OOHC system. Finding placement for children has continued to be extremely difficult due to decreases in placement options and to associated gridlock in the system. DCBS workers may more often be requesting referrals to multiple kinds of placements, including residential, due to their understanding of these placement challenges. As noted last year, it is not clear how the increased proportion of QRTP reassessments should be interpreted, since the number of potential reassessments necessarily increases over time as the total number of completed assessments increases. It is possible that more reassessments of children moving from one residential program to another are occurring due to the difficulty of managing children's challenging behavior and providing the intensity of services needed for these children when there are staffing shortages and challenges in retaining experienced staff.

During 2023, CRP made some additional data available to DCBS central office staff and to providers through the web application (e.g., making summary analytics related to referrals and placements available to DCBS for all children in OOHC; adding rejection reason data to provider response page of the referral system). A continuing focus of 2024 will be to further enhance web application processes to provide information more readily and effectively to CRP, providers, and DCBS Clinical Services Branch staff. This may include adding information to the web application related to children who are placed in, or at risk of being placed in, non-traditional settings. CRP will also continue to expand the use of electronic communication and reporting where appropriate. Although CRP still accepts faxes from DCBS, PCCs/PCPs, and treatment facilities as needed, documents are rarely faxed out by CRP. In addition, CRP staff encourage DCBS workers and PCC/PCP staff to utilize email whenever possible.

The iTWIST LOC, placement, and QRTP Workbaskets allow DCBS workers to submit documents to CRP more efficiently and provide a mechanism for communication from CRP to the DCBS worker through the pend back function when documentation submitted is not sufficient in some way. With few exceptions, DCBS workers seeking an initial LOC assignment for a child utilize TWIST to submit this request and the Placement Workbasket is being used for the majority of placement referrals. However, as noted previously, DCBS workers are not routinely utilizing the QRTP Workbasket as envisioned to request QRTP assessments. Although RPCs regularly use the pend back function in the Placement Workbasket to identify to DCBS workers the areas of the DPP-886A form where additional information is needed, this function is rarely utilized in the other workbaskets. The QRTP Assessment Unit staff typically pend back assessment requests when no explanation of why a QRTP assessment is needed has been provided, and parameters for use of this function in the LOC have not yet been established. CRP will continue working with unit staff and the cabinet to utilize the pend back function as effectively as possible. Changes to the QRTP Workbasket in 2023, as described previously, now provide DCBS workers the opportunity to request a QRTP assessment for any child for whom the DCBS worker has completed a DPP-886A form. CRP will continue to provide feedback about changes to the QRTP Assessment Workbasket that would allow DCBS workers and CRP staff to utilize the workbasket most effectively (e.g., ensuring that requests for QRTP assessments are appropriate and that required materials such as signed consent for the assessment, documentation of commitment status, and approval memos for young children, are included.)

High-quality and complete information about children is critical to all of CRP's functions, and CRP works in multiple ways to improve the information received. In the coming year, CRP will continue to provide guidance to DCBS staff and providers when appropriate about the type of information to include in submitted documentation to assure the most accurate level assignment, appropriate placement, or well-informed QRTP assessment. QRTP Unit staff will continue to work on developing relationships with QRTP and therapeutic foster care staff, as well as psychiatric hospitals and other treatment facilities, to increase responsiveness to requests for treatment records and staff interviews during the QRTP assessment process.

CRP will continue to work toward revising the Provider Capacity and Occupancy Dashboard and making it available to providers in the coming year through the CRP web application, as possible in consultation with the cabinet; other web application changes and additions are higher cabinet priorities at present. CRP will revise the CRP Monthly Activity Dashboard as needed in consultation with the cabinet (e.g., adding data related to QRTP assessments).

Performance Indicator data for FY 2023 was analyzed, and a report was sent to programs and agencies as well as to DCBS central office staff. CRP will continue to evaluate performance indicator data in preparation for possible performance-based contracting in the future.

CRP will continue to collect and report QI issues and encourage their review by the PCC/PCPs in order to help inform programs of treatment/service issues. CRP will continue to revise the QI tracking system as needed in consultation with DCBS leadership and provide QI data to the cabinet to help identify system-wide patterns and issues (e.g., insufficient individual and family-focused treatment services being provided, outdated diagnoses being listed for children) and to complement the cabinet's reviews of QRTPs. CRP will continue to work with the cabinet to meet any other data needs in this area. CRP may also develop additional tip sheets, similar to the one developed for documentation of psychiatric services, to assist PCCs/PCPs in providing accurate information in the documentation they submit for URs. It is anticipated that the number of specific cases sent to DCBS each week will decrease over the

coming year due to new guidance from central office (e.g., no longer sending placement stability QI issues as it has been decided that regional staff are monitoring these cases sufficiently.)

CRP has continued to assess the information collected from PCCs/PCPs related to the EBPs utilized. This EBP information is provided to DCBS workers to help them make informed placement decisions. CRP has previously revised the way EBP information is reported in the CRP web application and would like to make additional changes to increase the usefulness of the information. For example, CRP would like to distinguish EBPs that are utilized for treatment issues that are common for children in OOHC (e.g., defiant behaviors, trauma-related issues) versus those utilized for less common treatment issues (e.g., psychosis, eating-related issues). No changes to the EBP information have been made at this time, but they remain under consideration. Any changes made in the coming year will be made in consultation with the cabinet.

CRP will continue to adapt workflows and procedures to support DCBS initiatives and pilot programs (e.g., Key Assets or any new pilot programs identified). CRP will continue to identify additional ways to assist and support DCBS in addressing placement-related issues (e.g., the increasing number of children referred for and placed OOS, exploring after-hours placement assistance, and providing information and data related to children with complex placement and treatment needs, to better understand the placement needs and challenges related to this population and to inform associated planning and decision-making, improving placement processes, etc.). CRP will continue to adjust the referral process as needed to align with cabinet priorities. For example, CRP will revise the referral narrative format per DCBS central office guidance, to provide a broad overview of a child's trauma history and contextualized treatment needs (rather than specific details and behavioral descriptions) and to integrate the child's voice into the narrative where possible.

The changes in the QRTP Workbasket allow DCBS workers to easily refer a child for a QRTP assessment, consistent with DCBS' vision that QRTP assessments will, over time, guide referrals and placements being made. CRP will continue to work with DCBS to educate DCBS workers in making appropriate referrals, using approved referral processes consistently, and providing timely and accurate information about children's placements. The QRTP Unit will continue to expand beyond completing federally required QRTP assessments of children placed in residential treatment programs to complete assessments on children earlier in the referral/placement process as often as possible. Although there are current, significant challenges in the OOHC system (e.g., decreased capacity, limited therapeutic foster care options for teenagers, particularly those with complex trauma and associated behavioral and emotional challenges), it remains a DCBS goal to decrease both the length of stay in residential treatment programs and the need for additional residential placements for an individual child, and for the number of successful and stable step-downs from residential programs to increase. It was intended that the QRTP assessment reports would serve to jump-start and guide the treatment provided to children in residential treatment programs. However, it appears from anecdotal feedback that DCBS workers are not yet routinely providing a copy of the most recent QRTP assessment report to children's QRTP treatment teams, so the potential impact of the assessments cannot be currently examined. Cabinet approval was given in early 2024 for CRP, rather than the DCBS workers, to provide copies of the QRTP assessment reports to children's treatment providers, and this process change has been implemented. Recent guidance provided by the DMS regarding billable activities that are part of the QRTP assessment process is expected to increase the number of assessments that can be billed.

CRP actively supports the cabinet's focus on assuring the safety, permanency, and well-being of DCBS-committed children who are placed in OOHC and will continue to do so in the coming year, through

CRP's LOC assessment, placement, QRTP assessment, and QA functions. CRP will continue to communicate with and work with DCBS to meet other needs as they arise in 2024.

H. Community Collaboration for Children (CCC), Community-Based Child Abuse Prevention (CBCAP), and Promoting Safe and Stable Families (PSSF)

Community Collaboration for Children (CCC) is funded by Promoting Safe and Stable Families (PSSF) and the Community-Based Child Abuse Prevention (CBCAP) program, including ARPA. PSSF funds are used exclusively for direct services. CBCAP funds are used for direct services, the regional network, and other initiatives such as child abuse prevention awareness, especially in April. Both CBCAP and PSSF funds are used to develop, operate, expand, and enhance community-based and prevention-focused programs. Two direct services are currently provided through these funding streams: in-home based services (IHBS) and parent engagement meetings (PEMs).

IHBS are available in every county across the state. This service targets low-risk families, such as families who have children with disabilities, teenage parents and parents who are young adults, parents with disabilities, young children, low incomes, and any family in need of assistance. IHBS are short-term, home-based services geared to develop, support, and empower the family unit. IHBS teaches parent education, child-development, problem-solving skills, appropriate discipline techniques, and how to be self-sufficient by coordinating available community resources.

PEMs have the same target population. PEMs are currently available in 14 counties statewide. PEMs bring families, agencies, and community partners together to resolve issues that exist within the family. Facilitators ensure an objective discussion of issues and explore resources. Referrals are accepted from school systems. PEMs target school-aged children (ages five-11) who are at risk of educational neglect. In 2023, 1,192 families received PEM services and 85% of those cases were diverted from becoming involved with Kentucky's child welfare agency.

CCC's IHBS are provided in each county across the state. CCC is divided into 17 service areas, comparable to ADDs, and the service areas cover all 120 counties. CBCAP exclusively funds the regional networks located in each of the CCC service areas across the state. A regional network is a community-based collaborative including community partners, child welfare, and parent representatives within each service area whose members meet at least five times per year. The regional network provides collaboration and support to CCC service providers, and the members share regional resources as well as discuss child abuse prevention in local communities. Regional needs assessments are completed yearly to determine the goals for each network. Data is shared by partners and presented at network meetings. These collaborations are a unique component of the program and fulfill the statewide network requirement of the CBCAP grant.

In 2023, IHBS served 424 families with 935 children. CCC provided these statewide according to the state's in-home services continuum. Services were designed to develop, support, and empower the family through teaching appropriate discipline, child development, and problem-solving skills; assisting parents to advocate for themselves; and coordinating community resources. CCC utilizes evidence-based curricula for all in-home services provided to families.

CCC is committed to recognizing the importance of parents throughout the program. The initial level of parental involvement is within the in-home services as they are the most important element within their family. Upon completing in-home services families have the tools necessary to be self-sufficient and have a stronger connectivity of resources within their communities. Parents with lived experience are

offered an opportunity to serve on their local regional networks as a voice for their communities. Once parents serve on their local networks, they are granted an opportunity to be on the statewide Parent Advisory Council and may serve on the National Parent Advisory Council. The current CCC parent leader is serving in this capacity.

CCC is included among the services essential to achieve the outcomes in Kentucky's CFSP. Kentucky conducts quarterly CFSP stakeholder continuous quality improvement (CQI) meetings including community partners, providers, child welfare staff, and parents. These meetings allow interagency collaboration on the state's CFSP. CCC staff, CBCAP state leads, and parents from across the state participate in the CFSP stakeholder CQI meetings.

DCBS representatives provide CFSP and PIP updates at local regional network meetings. The DCBS representatives allow community partners and parents a chance to provide their input related to services and how those may improve. DCBS staff are available to meet with participants, privately if requested. Statewide and regional data is provided during network meetings to inform participants on trends and assist in the identification of potential areas for training and outreach.

IHBSs and PEMs are coordinated separately from the regional networks. However, reporting on the status of services, client needs, trends, and counties served occurs at regional network meetings. Regional networks use available funds to meet the needs of clients in each region throughout the state by providing opportunities such as parenting education, access to training and other resources, as well as local community initiatives targeting prevention of child abuse and neglect.

CCC in-home services will continue statewide. In-home services continue to be the most effective and in demand services for prevention of abuse/neglect. Regional network collaborations continue to be critical. As funding limitations increase for families, creative solutions as well as decreasing duplication of services are needed. PEM programs will continue in 21 counties, with continued efforts to identify additional funding sources for program expansion. Funds from ARPA will be used to sustain the PEM expansion, decrease wait lists, and to provide concrete supports to families in each region in CY 2024 and beyond.

In-home services continue to be the most effective and in demand services for family stability and prevention of child welfare involvement. Regional network collaborations continue to be critical, as with funding limitations, creative solutions as well as decreasing duplication of services are needed. PEM programs will continue to expand, with continued efforts to identify additional funding sources for program expansion.

Referrals can come from any source such as community partners, family, friends, and child welfare referrals that do not have a previous or current substantiation or an ongoing case. Self-referrals are also accepted. CCC services are free and available to any family with children in their custody including race, color, religion, gender, sexual orientation, national origin, disability, or age. This may include both relatives and non-relatives. Each in-home service worker makes appropriate referrals to local resources, as family needs are identified and currently unmet.

CCCs always accept referrals from any group in the state which includes but is not limited the following:

- Children with disabilities;
- Teenage parents and parents who are young adults;
- Parents with disabilities;

- Single family households;
- Families with young children;
- Low-income families/families in poverty;
- Families who are struggling with safety and well-being issues;
- Children who are truant or exhibiting concerns in a school system;
- Grandparents or caregivers raising children;
- Homeless families and those at risk of homelessness;
- Adult former victims of child abuse and neglect or domestic violence; and
- Unaccompanied homeless youth.

The prevailing service delivery trend is adequate affordable housing. The homeless population is rising and there are few if any options that families can afford so we are serving homeless families in the best way possible with the limited resources available. Additional trends affecting families include but are not limited to economic issues/availability of employment and resources, limited childcare, increases in costs for food. All of these are contributing factors for barriers experienced by many of the families receiving CCC services.

I. Community Services Block Grant (CSBG)

The mission of the Community Services Block Grant (CSBG) is to reduce and eliminate poverty by providing opportunities for education, technical training, and employment that will improve living standards among those with low income and provide the client with dignity and self-respect. Efforts to promote self-sufficiency for CSBG clients aim to reduce the burden of dependency. The CSBG program is federally funded through the United States Department of Health and Human Services (HHS), ACF, Office of Community Services, and Division of State Assistance.

CSBG services are available statewide in all 120 counties. Services are available through all 23 Community Action Agencies (CAAs) for clients who meet eligibility requirements of 125% at or below the FPL. CSBG funds are allocated through CHFS. CHFS is responsible for administration, oversight, and allocation of the CSBG funds to eligible entities within Kentucky. The CAAs and DCBS service regions work in partnership to provide services, which complement the common mission and outcomes, to prevent child maltreatment, to promote quality foster care and adoption services, and to assist vulnerable adults or low-income families. Both parties have a joint referral mechanism to identify and address the vital service needs of the CAAs geographic area and prevent the duplication of services. The CSBG Program is federally funded through the HHS, ACF, OCS, and Division of State Assistance. The CARES Act was signed into law March 27, 2020, granting the state of Kentucky an additional $16.8 million in CSBG funding. CARES funds have been divided proportionately to CAAs and will be used to address a variety of needs created by the COVID-19 pandemic including, but not limited to rent/mortgage and utility assistance payments, grocery vouchers, employment related assistance, and medical assistance (copays, transportation, personal protection equipment (PPE), etc.). The funds expired December 29, 2022.

CHFS filed an ordinary and emergency regulation change for 922 KAR 6:010 on May 21, 2020, in response to HHS' CSBG Information Memorandum (IM) 2020-157, authorizing states to, "revise the income limit for eligibility ceiling from 125 to 200 percent of the FPL for CSBG services furnished during fiscal years 2020 and 2021, including services furnished with the state's regular CSBG appropriations during those years," via the CARES Act.

The CR passed with language extending the use of the 200% FPL for CARES and CSBG FYs 2021-2023 funds released during the CR. On January 6, 2023, the OCS released a notice regarding the 200% FPL Provision for CSBG eligibility. Per the Consolidated Appropriations Act, 2023 (P.L. 117-328) and section 673(2) of the CSBG Act, states may revise the poverty line not to exceed 125 percent of the official poverty line otherwise applicable under the CSBG Act by substituting "200 percent" for "125 percent" for CSBG and CARES funding during FFYs 22-23. Congress passed a CR to keep the FPL at 200% until February 2, 2024.

Each CAA has a tripartite board that fully participates in the development, planning, implementation, and evaluation of the program serving that geographical area. The tripartite board must be composed of one-third democratically elected representatives of low-income individuals or families who reside in neighborhoods being served; one-third elected officials holding office at the time of their selection, or their representatives; and one-third of the board must be chosen from "business, industry, labor, religious, law enforcement, education, or other groups and interests in the community served". The tripartite board must operate in accordance with KRS 273.437 and KRS 273.439 (2). Governing boards and community action boards adopt written bylaws that include: the purpose of the CAA; duties and responsibilities of the board; number of members on the board; qualifications for board membership; types of membership; the method of selecting a member; terms of a member; offices and duties; method of selecting a chairperson; a standing committee, if applicable; provision for approval of programs and budgets; the frequency of board meetings and attendance requirements; and provision of official record of meetings and action taken. The board meeting minutes are provided to CHFS, per the master agreement between the agencies. After approval by the board and signature of a board's designed official, the minutes are sent to a specialist at DCBS, each board member, and the executive director.

Pursuant to KRS 273.441 (1) (e), each CAA collaborates and encourages business, labor, and other private groups and organizations to work together to encourage support of community action programs in order to provide additional private resources and capabilities.

Community Action for Kentucky (CAK) provides technical assistance and training to the CAAs, a contract agent on behalf of CHFS. Additionally, CHFS offers technical assistance as needed and annual training to the CAAs to aid them in the preparation of their CSBG annual plan and budget proposals. CAK has provided training to the CAAs on case planning for CSBG services.

CAAs submit an annual plan and budget proposal to CHFS. Each plan outlines CAAs' efforts to appropriate funds, efforts, and services to low-income families in their communities. The plan requires a needs assessment process so the agencies can determine how to prioritize the domains outlined by module 2 of the annual report. The plan and budget proposal also set forth a budget in accordance with 42 U.S. C. 9907. The funds are distributed to the CAAs by CHFS in accordance with 922 KAR 6:045. Each CAA is required by 42 U.S.C. 9917 to implement Results Oriented Management and Accountability (ROMA). Results-management reporting impacts the way agencies document the results of their efforts. This tool is used in planning, organizing, directing, and self-evaluation. ROMA focuses on three broad areas: family, agency, and community.

The Commonwealth directs and manages the CSBG Program and the administering of funds to the eligible entities in accordance with the Act 42 U.S. C. 9901 et seq., the applicable KRS in chapters 45 and 273, and the applicable Kentucky Administrative Regulation (KAR) in Title 922 Chapter 6.

OCS has enhanced the CSBG network's performance and outcomes measurement system for local eligible entities identified in the CSBG Act as ROMA Next Generation (NG). This will improve the tracking and accountability measures reported by the CAAs and CHFS.

New goals have been implemented for ROMA NG, based on the theory of change. The following are the new community action goals:

- Individuals and families with low-income are stable and achieve economic security.
- Communities where people with low incomes live are healthy and offer economic opportunity.
- People with low incomes are engaged and active in building opportunities in communities.

CAAs collect data utilizing the CSBG expenditures domains and the National Performance Indicators (NPIs) which are part of the annual report, module two through module four. CSBG funding during the reporting period should be identified in the domain that best reflects the services delivered and strategies implemented. The CSBG expenditures domains listed in module two, section A are as follows: employment, education and cognitive development, income infrastructure and asset building, housing, health/social behavioral development (including nutrition), civic engagement and community involvement, services supporting multiple domains, linkages, and agency capacity building. The CAAs submit the ROMA NPI reports to CAK on a quarterly basis. CAK submits the cumulative reports to the state at the end of the SFY.

To meet the requirement of Performance Measurement under Section 678E(a)(1)(A) of the CSBG Act, CHFS submits Modules I-IV of the CSBG Annual report through the Online Data Collection operated by ACF in pursuant of CSBG IM-152. The CSBG Annual Report replaces the CSBG IS Survey. The four modules include (1) State Administration, (2) Agency Expenditures, Capacity, and Resources, (3) Community Level, and (4) Individual and Family Level. The modules "outline accountability and reporting requirements, including the establishment of a performance measurement system through which states and eligible entities measure their performance in achieving the goals of their community action plans." Module I is completed by the cabinet and modules II-IV will be completed by CAK, reviewed, and then submitted by the cabinet. The complete Annual Report will be submitted to the federal government by March 30, 2024.

DCBS completes biannual block grant status reports on CSBG for the state legislature in January and July. The status report reflects activities completed in the past six months such as expenditures, objectives, achievements, authorized changes, and evaluation of results. CHFS performs monitoring of the CAAs to determine the agencies' compliance with applicable federal and state regulations and statutes, programmatic and financial requirements, and the agencies' adherence to the CSBG plan and budget proposal. DAFM performs monitoring for the CAAs' activities at the DCBS level. Monitoring is conducted on the calendar year. Each agency will be monitored at least once every three years. Depending on the findings of the monitoring, the CAAs may be required to submit a plan of corrective action. The CAAs are also subject to audit requirements per CFR Part 200, Subpart F. CHFS, in cooperation with CAK, also monitors each of the 23 CAAs annually for the CSBG Organizational Standards in accordance with IM-138.

J. Court-Appointed Special Advocates (CASA)

Kentucky CASA Network, Inc. (KCN) is the state association for court appointed special advocate (CASA) programs. CASAs are trained volunteers, supervised by CASA programs, appointed by a judge to represent the best interests of dependent, abused, and neglected children in court. KCN assists in the development of new local CASA programs, monitors practices and policies of local CASA programs, and

provides technical assistance to local CASA programs. KCN collects data from local CASA programs pertaining to the numbers of volunteers trained and children served. While the KCN does not administer the direct service of CASA programs, for CY 2023, the KCN partnered with new local programs to build capacity through training and technical assistance to further their capacity to deliver direct service statewide. In 2023, the KCN creating one new CASA program, CASA of the Gateway Region that will serve Rowan, Bath, Menifee, and Montgomery counties.

KCN is a statewide association. In 2023, there were 94 counties served by 23 local CASA programs. KCN works with local family courts, or district courts if there is no family court, to establish local CASA programs in unserved areas. KCN collaborates with local CASA programs across the state. One member represents local CASA programs on the KCN board of directors. KCN staff regularly communicate with local CASA programs through newsletters, conference calls, and email. KCN problem-solves with local CASA programs about matters affecting programs individually and as a group. KCN and local CASA programs have collaborated on grant requests, and KCN provides joint training opportunities for local CASA programs. The KCN has two standing workgroups that began in 2023, The Volunteer Recruitment Workgroup and The Performance Measurement/Data Workgroup. The KCN provides significant training and holds two signature training events twice a year: Volunteer Coordinator Training and a Training of Facilitators (TOF). In 2023 KCN launched a new Board Governance Initiative which focused on providing strategic planning mini grants to interested Kentucky CASA Programs and created a Board Member Handbook.

KCN collaborates with various other local and statewide organizations, including but not limited to the DCBS, AOC, Kentucky Youth Advocates (KYA), the State Interagency Council (SIAC), Supporting Kentucky Youth (SKY) Governance and Training Task Force, and local family courts. Bloom Kentucky is a new partner organization aimed at ending Adverse Childhood Experiences (ACEs). The Bloom Kentucky initiative is focused on policy change to divert and lessen the impact of childhood adversity. KCN staff serve on several statewide advisory committees and workgroups which include the Child Abuse and Neglect Prevention Board, CJA, Judicial Commission on Mental Health Workgroup/dependency neglect and abuse (DNA) subgroup and the Judicial Engagement Workgroup. KCN also works collaboratively with the state association for CACs and other service providers in conference calls and meetings, participating in trainings, information, and data sharing.

Statewide, CASA programs served 3,472 children with 1,211 assigned CASA volunteer advocates. There were 289 new CASA volunteers trained in 2023. KCN also worked to provide expansion services with new membership in Jackson, Magoffin, Leslie, Letcher, Butler, Ohio, Hancock, Allen, and Simpson counties.

During CY 2023, KCN provided/facilitated over 40 virtual and in-person training opportunities for local CASA program staff and board members. These trainings focused on board governance, new executive director training and onboarding, volunteer recruitment and retention, sustainability planning, new processes by DCBS on the new Structured Decision-Making® (SDM) model, performance measurement and diversity, equity, and inclusion (DEI). In addition, webinars that specifically targeted best practices around facilitating pre-service training were new for 2023.

The KCN hosted the first large in-person conference post-COVID attended by 350 people to include volunteers, staff board and community members. The conference had 12 breakout sessions and included a judges panel and the opening motivational keynote speaker Ashley Rhodes Courter.

Kentucky saw a 48% reduction in child victims of maltreatment from 2018 to 2022, according to the latest federal data from the Children's Bureau (CB). Much of this can be attributed to DCBS rolling out a new tool as part of implementing the SDM® model for case acceptance criteria. DCBS has also rolled out alternative response (AR) which prioritizes a community response with services to families prior to involvement in the court system. The move to identifying families in need of services and diverting from court involvement are resulting in cases that do come to court being more severe in nature with cases lasting longer.

The KCN adopted growth plan in January 2022 that covers the years 2022-2024 and includes increasing the CASA program footprint to be active in 100 Kentucky counties by mid-2024. As of February 2024, CASA is on target to meet this goal currently serving 94 counties. In January 2024, the KCN also adopted a new three-year strategic plan which looks to build out the network so that every Kentucky county is covered by CASA by 2027.

Barriers to increasing the CASA footprint are the high number of counties in Kentucky, which can make sharing resources more complicated, and maintaining local organizers' full engagement through the process of establishing a CASA program and expanding into new counties to create regional programs. Community support can be a barrier to establishing and creating new local programs and boards as can be apprehension and judicial interest on having CASA in a particular jurisdiction. While not as large as barrier as it was ten years ago, some judges are unfamiliar with the positive impact of CASA advocacy and can be reluctant to introduce a new program into their courtroom.

Volunteer recruitment nationwide has decreased since the easing of the COVID pandemic. This has been more pervasive in a volunteer program like CASA, which seeks a multi-year commitment and intense training. Additional barriers are around workforce development and staff recruitment and retention. When there is staff turnover there tends to be more turnover with volunteers who oftentimes develop trusting relationships with their supervisors.

K. In-home Services and Family Preservation and Reunification Services Program (FPRS)

The Family Preservation and Reunification Services Program (FPRS) describes an intensive, in-home crisis intervention resource using approved EBP models. The primary goal of the services is to support the cabinet's efforts to ensure safety, permanency, and well-being of children by preventing unnecessary placement of children in OOHC, facilitate the safe and timely return home for a child or youth in placement, as well as enhance protective and parental capacities of caregivers.
FPRS services are funded through multiple funding streams:

- State General Funds
- Title IV-B Subpart 2 Funds (PSSF)
- TANF funds
- Title IV-E funding

The FPRS service array includes Family Preservation Services (FPS) – for families with children at moderate to imminent risk of out-of-home placement and Family Reunification Services (FRS) – to help children in OOHC return to their families. FPRS ranges from intensive short-term four to six-week interventions, to moderate-risk interventions, lasting three to six months. FPRS service intensity ranges from three to ten hours of direct contact occurring in the home. Intensive services require smaller caseloads of two to four families at a time to ensure the intensity level needed is met, and moderate-risk level intervention programs serve a caseload of up to six families at a time. FPRS programs serve children 17 years of age and younger. All FPRS programs utilize EBPs and an in-home intervention using

a strengths-based and trauma-informed (TI) approach to working with families. Families served are evaluated at intake, closure, and interim for services extending beyond 45 days using the North Carolina Family Assessment Scale (NCFAS) and other evidence-based clinical assessments. This provides a comprehensive assessment of family functioning and determines service needs.

Eligible families are referred by a DCBS social service worker and referrals are screened and approved by a designated DCBS regional staff person. Lower scores on the NCFAS form the basis for goal development using evidence-based intervention strategies with a scientific rating of well-supported, supported, or promising by the Title IV-E Prevention Services Clearinghouse. FPRS services are available statewide in all 120 Kentucky counties through contracts with non-profit agencies.

Networking: Regional management teams comprising DCBS staff, including the person responsible for screening all family preservation and reunification referrals and the service region administrator (SRA) or designee; the FPRS program director/supervisor; and agency designee, determine any specialized FPRS services and provide ongoing oversight of the services. FPRS specialists and supervisors may participate in school-based meetings, coordinate mental health services, and locate both hard and soft resources such as housing, counseling, and parenting classes. FPRS also networks with community partners that include but are not limited to domestic violence shelters, family team meetings (FTMs), drug task force, IMPACT, mental health services, CACs, health departments, and community partnerships such as housing programs and faith-based services.

FPRS services provide a wide variety of family centered and strength-based services for children and families that include a comprehensive family assessment and use of evidence-based cognitive and behavioral change strategies, crisis intervention, parent education programs, and family and youth support services. Additionally, FPRS specialists are available to families 24 hours a day, seven days a week.

A percentage rate of 80% or more of children remaining in the home indicates that services were successful. During CY 2023 there were 1,918 families with 3,977 children at risk of OOHC placement or reunifying from foster care participating in one of the family preservation program (FPP) services, and 3,519 of those children were reunified with their families or remained home safely at closure indicating an 88% success rate.

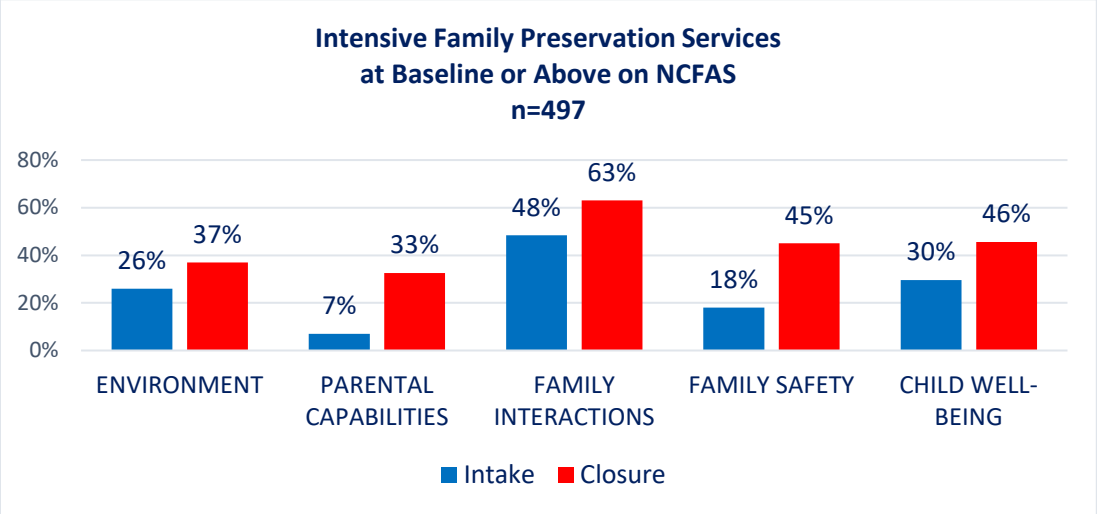
Families and children who have completed FPRS services are also followed-up with at three, six, and 12 months to determine if the child who was at risk of placement (or was reunified) remains in the home. The six month follow up contact is a face-to-face visit with the family and child if possible and includes a review with the family of the maintenance of safety and family functioning goals.

Follow- up Activity Completed CY 2023

Six Month Follow-Up	**All FPRS**
# Children at Risk with Follow-Up	1,258
# Children at Risk in Home at Follow-Up	1,097
% of Children at Risk in Home at Follow-Up	87%
12 Month Follow-Up	**All FPRS**
# Children at Risk with Follow-Up	39
# Children at Risk in Home at Follow-Up	37
% of Children at Risk in Home at Follow-Up	95%

Families served are evaluated at intake, closure, and at interim for services extending beyond 45 days using NCFAS and other clinical assessments. This provides a comprehensive assessment of family functioning and determines service needs. The NCFAS comprises five domains for preservation and seven domains for reunification which are measured on a six-point rating scale. Rating scores and change scores measure the family's capacity to provide for the child's needs and the lower scores form the basis for goal development. Improved closing scores can indicate increased parenting capacity in areas such as supervision, discipline of children and improved family communication and problem solving.

In the chart below, outcomes for families completing preservation services with an evaluation placement risk of imminent risk (represented by "n") during CY 2023, are evaluated by showing the overall change in the percent of families who scored at or above baseline in each of the five categories at intake and closure.



The chart above shows significant improvement made by families in the domains of Parental Capacity, Family Safety, and Child Well-being at the completion of FPRS services. Parental Capabilities domain is one of three domains where families referred to the FPRP usually experience low scores ranging from moderate to serious problem. Conversely, these domains normally see the greatest gains at closure. Comparison of the intake and closure scores reveal that greater gains were made in Parental Capabilities (26%), Family Safety (27%) and Child Wellbeing (16%). An increase in scores in parental capabilities normally correlates to an improvement in scores in family safety and child wellbeing. This shift in NCFAS scores indicates that incremental and impactful improvements can be measured during the Intensive Family Preservation Services (IFPS) intervention.

DCBS implemented the FFPSA of 2018 (Public Law 115-123), allowing title IV-E funding to be utilized for prevention services to families of children at imminent risk of entering foster care. Through Family First, funding will be available for TI, evidence-based mental health prevention and treatment services, substance use/misuse prevention and treatment services, and in-home parent skill-based programs listed in the Title IV-E Prevention Services Clearinghouse. As of CY 2022, Motivational Interviewing (MI) was approved for use in all three categories on the Title IV-E Clearinghouse.

In CY 2022, Kentucky awarded FPRS contracts due to a request for proposals, which included increases to flexible funding available to meet familial concrete needs from $500 to up to $1,000 per family, and to add 25% more in additional funding to serve additional families. Future directions include assessment of expanding FPRS to include funding to impact recruitment and retention of provider staff through salary increases ensuring a competitive rate to optimize the use of expansion funding and serving families. The cabinet will continue to assess the statewide implementation of IV-E EBPs for in-home services (IHS) provision and provider readiness for capacity building and growth.

- The following IV-E EBPs are approved for use with family preservation and reunification services statewide: Functional Family Therapy, Homebuilders Model, MI, Multi-systemic Therapy (MST), Parent-Child Interactional Therapy (PCIT), and Trauma-Focused Cognitive Behavioral Therapy. Kentucky continues to explore the use of High-Fidelity Wraparound and other EBPs to expand the in-home services continuum.
- All FPRS programs currently report their data online using the IHS Activities Data Collection tracking system and the KY TWIST Invoicing Portal. The data collected informs evaluative efforts.
- Interim checks matching data from the monthly reports submitted online are helping providers and central office improve both data entry and the quality of administrative data. This has greatly improved the consistency of statewide data.
- The data collected is used to closely monitor service provision and to evaluate overall program improvement and quality assurance.

Sivic Solutions Group (SSG) continues to provide consultative and technical assistance to Kentucky in implementing Family First. Chapin Hall has helped Kentucky develop CQI processes to ensure EBPs model fidelity and follow federal requirements for Family First.

A key tenet of FPRS is to ensure that services to families and children are delivered in a TI manner that is also responsive to cultural, racial, ability, economic, social, spiritual, and gender differences among clients, with a focus on building up family strengths. The implementation of FFPSA and increased funding for prevention services, gives the state the opportunity to expand the array of services and build capacity to continue to serve kinship caregivers. increase our focus on the challenges and needs of underserved families caring for lesbian, gay, bisexual, transgender, queer, intersex, asexual, plus (LGBTQIA+) children. Kentucky has to opportunity assess needs to identify service gaps, and to explore evidence-based programs that specifically target this underserved population. In addition, PSSF funds will go towards statewide provider training to ensure providers incorporate specific standards, policies and practices that reflect and promote the equitable treatment, inclusivity, support, and advocacy for clients in underserved populations.

L. Early Childhood Mental Health Initiative (ECMH)

The Early Childhood Mental Health (ECMH) program promotes the social and emotional growth of Kentucky's children birth through age five by emphasizing the importance of nurturing relationships in multiple settings. There are 15 regions with ECMH specialists across the state located at regional community mental health centers (CMHCs). Specialists provide consultation to early care and education settings, direct interventions to children and families identified as having social-emotional concerns, and training for early childhood professionals on social-emotional wellness and dealing with challenging behaviors. Additionally, the ECMH specialists serve as a resource for their own CMHC. A key goal of this program is to build capacity of mental health clinicians to work with the birth through five populations.

Program-funded opportunities for professional development are presented statewide on early childhood mental health topics to ECMH specialists. These trainings are at no cost and clinicians receive continuing education units, which can apply to licensure requirements. Building the capacity of early care and education professionals supports the program goal to decrease the number of children expelled from early care and education settings. This program is operational statewide and initial funding is through state dollars, specifically Phase I Master Tobacco Settlement dollars. Clinical services provided to children and families through CMHCs are billed to Medicaid and private insurance.

Many ECMHs are members of CECCs and some hold office within their perspective councils. The primary goal of all CECCs is to build innovative, collaborative partnerships that promote school readiness for children and families by bringing local partners together, identifying local needs, and developing strategies to address those needs. As members of CECC, ECMHs assist with a variety of efforts including training community and family partners, needs assessment, grant writing, and resource sharing. ECMHs also participate in other community groups on a regular basis such as RIACs and District Early Intervention Committees (DEICs).

In addition to direct services provided to young children and their families, ECMH specialists conducted 2,670 hours of consultations hours of consultation to: parents/guardians, child care, CMHCs, primary care providers (PCPs), child care health consultation, recovery centers, Head Start programs, public and private preschool programs, public and private schools, Kentucky Early Intervention System (KEIS), the HANDS Program, KY Impact, and the Interagency Council. ECMH specialists provided 106 trainings to a variety of early care and education personnel and other stakeholders. Finally, they participated in 1,133 hours of early childhood meetings including CECCs, DEICs, CCC regional networks, and Family Resource Youth Services Centers (FRYSCs). ECMH Specialists provided 3,418 total hours of direct billable service.

M. Education, Accountability, and Change (EAC), previously Batterer's Intervention Program (BIP)

On January 1st, 2018, the Education, Accountability, and Change (EAC), previously known as Batterer's Intervention Program (BIP) Certification Program was moved from the department to ZeroV. ZeroV now administers the state's EAC Certification Program as the cabinet designee, enrolling providers, conducting training, and maintaining the provider list. ZeroV also accepts grievances regarding EAC providers and monitors complaints about EAC practices if any are received.

In May 2022, CHFS awarded ZeroV an annual allocation of $300,000 to support the EAC program. This allowed ZeroV to hire a senior program specialist, and purchase Client Progress Online (CPO) database software. ZeroV has recently welcomed a Leadership staff who works to coordinate the EAC program. Three additional staff work to support this program.

Batterer intervention services are funded through the cabinet to allow for a meaningful investment in services to people who use violence to control their partners. Services are provided to court-ordered attendees; however, there is variability in the practice across the state whether it be the courts, DCBS, or other referral sources. In many unserved counties, judicial practice does not include mandating domestic violence offenders into EAC. The funding awarded to ZeroV by CHFS has helped the coalition correct the lack of information provided about EAC causing survivors, attorneys, and potentially judges not to fully understand the advantages of the program. This funding allows ZeroV to provide more information and aids in the creation of new practices, including the purchase of a statewide subscription with Webware, LLC, the developer of the CPO software, which tracks the progress of a participant through EAC course products. The funding also allows more training opportunities for EAC providers,

domestic violence program staff, and other community referral sources/partners. CPO functions similarly to the state driving under the influence (DUI) system.

CPO will collect the data that ZeroV collects on behalf of CHFS annually. This data includes the amount of people served, their socioeconomic status, race, and age. It also provides information about referral source and the reason for referral. CPO will also allow ZeroV to closely monitor and audit (if need be) EAC providers in real-time. CPO allows referral sources such as DCBS and the court system to monitor the progress and attendance of EAC clients. ZeroV hopes that CPO will allow for more complete data, will improve access to statistics, and will allow providers to gather their statistics and submit them to ZeroV. CPO will allow ZeroV to have a more complete look into what populations are being served and how they are being served. CPO was implemented in the last half of 2022, therefore, ZeroV used the annual report form to have providers submit this information.

There is at least one certified EAC provider offering services in 33 counties of the Commonwealth. In the eastern and southeastern parts of the state, unserved counties largely correspond with counties underserved in many other service categories. Even though the program has been in existence since 1998, there has never been an opportunity for the community of providers (300 certified, 100 active) to contribute to the work of addressing and potentially preventing domestic violence occurrences in such a critical role. The funding awarded to ZeroV by CHFS allowed the coalition to hire staff to focus attention on strengthened skills (including improved access to training) so providers can step into this pivotal role is of vital importance.

Survivors who have a partner participant in EAC may experience misinformation or a lack of information about their rights. When survivors, judges, or attorneys do not understand what EAC is, the regulations surrounding the program, or what value certified providers add to these cases, there is a risk that batterers may be placed in an inappropriate or unregulated program such as anger management, which does not hold the batterer accountable for the actions they have committed. In economically disadvantaged counties, the absence of public funds to subsidize or offset the cost to individuals further exacerbates issues around recruiting and retaining batterer intervention providers/programs in specific locations. A list of batterer intervention providers and the cities they serve may be found on the ZeroV website.

Certified providers provide individualized treatment and have the capacity to address issues relevant to children exposed to domestic violence, parenting after violence, abusive head trauma, and managing conflict without violence. Certified providers also assess for possible substance use disorder and mental health disorders.

In early 2021, ZeroV created a virtual certification process to train new providers. In 2023, ZeroV's EAC provider certification training was held three times. This training is the virtual equivalent of the training that corresponds with the regulations stated in 922 KAR 5:020. Making the EAC Certification training virtual has allowed more practitioners to have the option of participating long-distance without interruption to their schedule. Subsequently, ZeroV determined that learning management software, Moodle, was not user-friendly and did not allow us to hold trainees accountable. In late 2022 and early 2023, ZeroV set out to find better learning management software and landed on Litmos. With Litmos, the agency can monitor how much time trainees spent on each section of the module and better understand who completed all the work for the module and who did not. ZeroV started using Litmos for the EAC Certification Program in June of 2023.

Near the end of 2022, ZeroV used funds from CHFS to purchase Client Progress Online (CPO) to collect data from providers, monitor providers, and investigate grievances. During CY 2023, ZeroV staff worked to train providers and help them actively use CPO. Some pushback was received from providers; however, the agency is actively working to continue implementing CPO uniformly across the state. ZeroV meets individually with providers to facilitate walk-throughs of the system and address questions or concerns.

ZeroV staff and Kilen Gray (Creative Spirits), an EAC service providers in Louisville, serve as the training faculty for EAC certification training. Kilen Gray focuses on hegemonic masculinity, how society sends messages that cause gender roles to be seen in a specific way and discusses how gender roles can get in the way of healthy relationship dynamics in groups. ZeroV staff discuss the specifics of EAC service provision and the needs of the EAC participants through live modules on the basics of domestic violence, the provision of EAC services to court-ordered offenders, legal remedies for survivors, and the EAC regulation, which details the legally required components of both certification and provision of services. The certification training is comprised of a series of podcasts, readings, and a test.

In addition to administration and training, ZeroV maintained the following in support of the EAC program during CY 2023:

- A provider site, Associations Management Online (AMO) that manages the certification records of a provider, maintains the provider list, contact information for providers, and allows for registration of the EAC certification training. Referral sources and the public can search the certified providers list or locate providers in their area at https://members.zerov.org.
- Implemented and maintained CPO and provided technical assistance to new and established users.
- Trained 31 providers to use CPO.
- A list of currently certified EACs shared with the Administrative Office of the Courts (AOC) and to CHFS quarterly.
- Created and distributed guidance on issues such as when a provider can bill insurance for EAC services, informational handouts that provide an overview about EAC to judges and DCBS workers making referrals, the regulatory exclusion of anger management services, and guidance for ensuring that only Kentucky-certified EAC providers are offering telehealth services.
- Provided community education to referral sources that offers an overview of what the program is and how it should be used.
- Provided technical assistance to EAC providers and referral sources across the state.
- Processed 60 certification renewals.
- Ensured that no one is practicing EAC services without being certified through the state.
- Handled two grievances about EAC providers.
- Provided quarterly EAC Certification training in March, June, and September. A December training was canceled due to a lack of registrants.
- Educated the Child Fatality and Near Fatality Review Board members about the EAC program.
- ZeroV began work on a recruitment strategy to increase the number of certified EAC providers across the state.
- Responded promptly to requests from DCBS for data regarding providers and program participants.

The EAC program continues to struggle with provider data collection compliance. CY 2023 data shows EAC attendance remains steady.

Calendar Year	Number of Participants
2023	1,212
2022	1,245
2021	1,044
2020	818
2019	2,973

Education, Accountability, and Change (EAC): CY 2023				
Category	**Male**	**Female**	**Other**	**Total**
Batterers Assessed*	951	134	0	1,085
Civil/Domestic Violence Order (DVO)	522	63	0	585
Criminal/Post-Conviction	654	54	0	708
Diversion	40	7	0	47
DCBS	203	54	0	257
Self-Referred	35	5	0	40

*Referral sources are not exclusive categories, and a single batterer may be referred by more than one referral source

EAC providers specifically struggle with:

- The change of staff at ZeroV. The agency's former COO resigned in July to explore other opportunities and growth, taking 20 years of knowledge and relationships along. The EAC Team has worked tirelessly to build and strengthen relationships with providers and fill that gap. Adding a Team Leader with knowledge and experience as an EAC provider is expected to be an invaluable asset to the program.
- Most EAC providers are very small-practice practitioners and struggle with managing their own practices. Maintaining the program's administrative structure is difficult, as it requires consistently documenting attendance for 30 weeks and reporting routinely to the courts/DCBS.
- The implementation of CPO. ZeroV has received pushback from providers who do not want to implement CPO. Some providers have their own systems in their practice and do not want to use CPO.

Throughout 2023, ZeroV offered technical assistance to providers when needed. Technical assistance topics included: collaboration, shifting to virtual service provision, service requirements, changes in regulation, guidance regarding insurance billing for EAC, education on differences between EAC and anger management, how to inform judges about EAC, and other topics as requested.

2023 statistics:

- Average assessment cost: $67.00
- Average cost per group session: $25.00
- Total participants referred for SUD outpatient treatment services: 157
- Total participants earning less than $30,000 per year: 899

- Participants who identified as Asian, Hispanic, or African American: 497
- Participants ranged 18-29 in age: 369

During CY 2023, four providers surrendered their licenses and several others, including one of the biggest providers (400-600 participants a year) in Louisville, the largest city in the state stepped away from practice, therefore there were decreases in numbers of participants served. ZeroV is committed to increasing the number of providers across the state and with recruitment efforts already underway, expect to have an increase in participants for CY 2024.

N. Family Assistance Short Term (FAST)

On June 5, 2023, the Family Assistance Short Term (FAST) program replaced the Family Alternatives Diversion (FAD) program. Payment amounts for FAST increased from up to $1,300 to up to $2,600 within a three-month period. Families can re-qualify for FAST benefits every 12 months. The 12 months ineligibility period is calculated from the last FAST payment issued. There is no limit to the number of times an individual can receive FAST.

The FAST Program is a new, short-term cash assistance program that can be an alternative to ongoing Kentucky Transitional Assistance Program (KTAP) benefits. The FAST program promotes an expanded eligibility criteria and individuals do not have to be KTAP-eligible to receive FAST assistance; FAST eligibility has its own application and eligibility criteria. One or more checks with a combined total of up to $2,600 may be issued to resolve short-term needs within a three-month period. Income is based on the 100% FPL, which widens the income limits for individuals and increases eligibility. FAST is administered statewide and is funded by title IV-A and TANF.

FAST eligibility has its own application and eligibility criteria. The FAST program promotes an expanded eligibility criteria and individuals do not have to be KTAP-eligible to receive FAST assistance; FAST has quicker prescreening and processing due to an enhanced eligibility screening tool.

Families eligible for FAST may receive up to $2,600 to pay for verified short-term needs. The types of benefits provided include assistance with transportation, childcare, shelter, utility costs, or employment related expenses. FAST has a three-month eligibility period and is not considered cash assistance. Therefore, FAST does not count toward the 60-month lifetime receipt of TANF cash assistance. FAST may not be received more than once in a 12-month period and there is no limit to the number of times an individual can receive FAST. Receipt of FAST payment excludes the benefit recipient from receiving on-going KTAP benefits for 12-months unless non-receipt would result in abuse or neglect of a child or the parent's inability to provide adequate support due to the loss of employment through no fault of the parent. In addition to being determined eligible for FAST, additional services or referrals should be offered including SNAP, Medicaid, childcare assistance, child support, and employment services.

During CY 2023, an average of 11 families per month received a FAST payment. The average monthly payment per family was $1,417.41. In CY 2023, FAST totaled 131 cases statewide, an average of 11 cases per month and expenditures of $185,680.95. The number of FAST cases continued to increase from 19 cases in 2022 to 131 in 2023. Over 80% of the families received payments in the last 6 months of 2023 after the benefit amount was increased from $1,300 to $2,600. Income is based on the 100% FPL, which widens the income limits for individuals and increases eligibility. It is thought the cases will continue to increase.

O. Family Resource and Youth Service Centers (FRYSC)

The FRYSC initiative was established by an act of the Kentucky General Assembly in 1990. The authorizing legislation indicates that the purpose of the local FRYSCs is to enhance students' abilities to succeed in school. The legislation further clarifies the role of FRYSCs as focusing upon the non-academic barriers to education. The FRYSCs accomplish their mission through a comprehensive assessment of needs of students, families, school personnel, and community partners. Their primary role is to serve as brokers of existing services as needs may indicate. They also are to work to identify gaps in and barriers to services as they assist students and their families. FRYSCs collect local data in KDE's Infinite Campus system. Services are funded through state general fund dollars as part of the state's KDE budget. The Division of FRYSCs in CHFS provides state-level support and administrative coordination.

The Division of FRYSC developed the following mission statement that encompasses the work of the initiative:

- Early learning and successful transition into school
- Academic achievement and wellbeing while in school
- Graduation and transition into adult life

At the state level, the Division of FRYSCs conducts a minimum of three regional information-sharing meetings with local staff annually. Local FRYSC programs are in 1,217 of Kentucky's nearly 1,250 public schools. There is at least one program in all 120 of Kentucky's counties. This initiative is a part of educational reform legislation that calls for centers to be established in or near schools where 20% or more of the school's enrollment qualifies for free school meals. Local FRYSCs have consistently worked to either connect with or initiate local collaborative partnerships to identify current resources and expand existing networks. FRYSCs staff attend local inter-agency councils and vision groups, as well as other collaborative meetings. They are also statutorily required to be a part of local early childhood councils. The local FRYSCs are also involved in numerous community groups that focus of specific issues such as substance abuse, mental health counseling, physical health issues, and numerous others. Each local FRYSC is required to have an advisory council that involves community partners, parents, and school staff. Some communities have Kentucky Integrated Delivery System meetings, which serve as a collaborative effort to case conference regarding specific needs. Many local FRYSCs are involved in writing grants to fund initiatives through their local centers.

Family resource centers serve children under school age and in elementary school and coordinate:

- Preschool child care
- After-school child care
- Families in training
- Family literacy services
- Health services and referrals

Youth services centers serve students in middle and high school and coordinate:

- Referrals to health and social services
- Career exploration and development
- Summer and part-time job development (high school only)
- Substance abuse education and counseling
- Family crisis and mental health counseling

P. Family Violence Prevention Funds

The Family Violence Prevention and Services Grant is administered for CHFS, which contracts with ZeroV for implementation. ZeroV subcontracts with 15 domestic violence programs, also referred to as designated program members (DPMs) in the 15 ADDs across the state for direct service implementation regionally. The domestic violence programs provide shelter and related services to victims and their dependent children and are geographically distributed to be no more than 60 miles in distance from any state resident. The mission of ZeroV is to abolish the social conditions and systems that spark, enable, and amplify interpersonal violence, and to create communities where all Kentuckians can live and thrive in safety and peace. Funding for ZeroV comes from the Family Violence Prevention and Services Grant (FVPSG), the state general funds, TANF, Kentucky Trust and Agency, and Social Services Block Grant (SSBG).

2023 Programing Additions and Highlights: Transportation to services is a barrier in many of the regions. Several shelters have obtained grant funds to begin mobile advocacy units to serve survivors with barriers to transportation. ZeroV utilized flexible funding to provide practical support to survivors of domestic violence. Flexible funding is supported by grants and private donations. During CY 2023, over $22,000 was spent on providing practical supports to survivors, including help with automobile expenses, such as covering car insurance, repairs, and payments to help overcome the transportation barrier. Nearly $2,000 was specific to vehicle related expenses. Other flexible funds payments went to cover utility assistance, moving/relocation fee assistance, rent/security deposits, and household items and groceries for survivors of domestic violence. ZeroV provided these funds to survivors of violence on behalf of the designated program members. During CY 2023 ZeroV worked with the DPMs on ensuring that the DPMs have enough local flexible funding to support survivors of domestic violence, due to the overall decrease in available flex funds from ZeroV.

Housing is a top priority, and ZeroV administers three housing-specific grants that provide rental assistance to survivors totaling nearly $3 million in housing funds. ZeroV also operates 84 units of tax credit housing.

In 2023, 128 people began the EAC certification process, with 31 domestic violence advocates completing Level 1 Certification. Level 1 Certification is a cumulative 30-hour training offered by the ZeroV to all DPM staff/advocates. This training educates domestic violence advocates and staff on how to best serve survivors of IPV; such trainings offered are the intersectionality of substance use disorder and domestic violence, child advocacy, and legal basics (such as confidentiality).

100% of ZeroV designated program members have language access policies in place. Language access policies include provisions for accessing certified American Sign Language (ASL) interpreters 24 hours a day, 365 days per year. ZeroV continues to provide technical assistance as they update those policies and practices to account for the virtual delivery of services.

ZeroV continued to fund a position designed to address substance use/mental health issues in member programs. The position continues to provide training, technical assistance, product development, and systems advocacy related to substance use, mental health, and systems involvement. ZeroV continues to seek options for addressing substance use disorder and mental health conditions within domestic violence shelter advocacy work and is working to build health equity into all aspects of ZeroV's work.

In October 2022, ZeroV signed an MOU with Pacific Institute for Research and Evaluation (PIRE), to conduct research on two project areas, which includes understanding the impact of the COVID-19

pandemic on domestic violence programming and alternatives to congregate shelter options. PIRE is an independent, non-profit organization focused on merging scientific knowledge and research-based practices to create solutions that improve the health, safety, and well-being of individuals, communities, and nations around the world. Staff at PIRE have worked closely with staff at ZeroV to create and administer surveys designed for domestic violence survivors and staff at ZeroV designated program members. The purpose of this research is to discover how domestic violence designated program members services can be improved in the event of an infectious disease pandemic and how to redesign the physical environment to better meet the needs of survivors. PIRE has created a Community Advisory Board made up of people with lived domestic violence experience. This board has reviewed and commented on the survey tools. Research will wrap up in early 2024 and ZeroV will utilize the findings to implement improved services to survivors and discuss altering the physical environments.

In 2023, ZeroV successfully migrated all data and all DPMs to a uniform database for client service recording and reporting, Vela. ZeroV successfully onboarded all member programs across the state to an online database. This move will help advocates be able to collect and report demographic and service data in a more accurate and TI manner, and also standardizes those processes across the state, as well as with other users nationally. ZeroV now also has the ability to view de-identified data and pull aggregate reports across the state in real time.

In 2022, ZeroV finalized a salary survey of the 15 designated program members. The salary survey reviewed position descriptions and salaries for 464 workers at the designated program members, then grouped those positions into categories, and finally determined some simple descriptive statistics for each category as well as for each program. The salary survey compared the mean and median salary for each category of worker to several different state living wage measurements. Additionally, to obtain more local level data, each program's results were compared to living wage measurements for their specific counties. Based on the results of this, ZeroV was able to demonstrate that most workers were paid significantly less than a living wage, no matter where they lived in the state. With this data, ZeroV was able to secure additional general funding from the state with the purpose of raising the wages of advocates at designated program members. Early analysis has shown that with this increased funding, which was used to improve advocate wages, and there has been a reduction of overall staff turnover at the DPMs. ZeroV and its designated program members are committed to raising the salaries of staff to a regional living wage and move staff out of poverty and increase services to survivors of domestic violence.

DOVES of Gateway, a designated program member in Morehead, Kentucky, is committed to raising staff salaries and increasing benefits to staff, such as providing affordable health insurance. Affordable health insurance and a living wage will help staff to move out of poverty, which has been identified as a structural issue that ZeroV and designated program members such as DOVES are committed to eliminating. Offering health insurance increases prevention and treatment efforts in keeping staff safe from catching and spreading COVID-19 to survivors of domestic violence. The staff have had concern about the financial burden of going to the doctor for medical care and preventative services without the support of a living wage and affordable health insurance. FVPSA funding helps to cover the cost of affordable health insurance for DOVES employees and healthy staff can show up and serve survivors; it increases the quality of life for staff, including not having to work multiple jobs and being able to access prevention and treatment services.

Safe Harbor, a designated program member in Ashland, Kentucky, runs a pet kennel program. Pets are considered part of the family and Safe Harbor wanted to remove animal care as a barrier to survivors

seeking services. During the intake process, when a survivor calls the shelter, the call taker will ask the survivor if they have a pet that needs care while the survivor is in shelter. Depending on space available, Safe Harbor can house dogs, cats, and even rabbits. Funding that Safe Harbor receives pays for animal food, shelter, and vetting of the animals. Safe Harbor will also connect the survivor with veterinary services and spay/neuter clinics to provide comprehensive animal care to the survivors' pets. Safe Harbor wants to ensure survivor safety as well as pet safety during the stay at the shelter. Safe Harbor staff understand that pets can be part of the domestic violence dynamic, and many times pets are used to manipulate the survivor, or pets can even experience harm as well. Providing kennel services is another way shelter programs are removing barriers for survivors in seeking safety services.

ZeroV continues to provide technical assistance for COVID-19 challenges that have arisen with our programs, stemming from the pandemic. For example, ZeroV has researched answers to questions about use of funding sources, working to ensure shelter staff, as front-line workers, are provided access to vaccines, COVID-19 testing, mobile health unit services, and helping to disseminate donations and large purchases of personal protective equipment. In addition, many designated programs members are utilizing ARPA FVPSA funds to supply hotel vouchers for survivors to ensure social distancing. Programs are also partnering with local health agencies, such as local health departments, to provide testing and vaccine access to survivors who utilize shelter services. Staff at ZeroV stay abreast on current events and trends to provide technical assistance to designated programs members on COVID-19 mitigation related services and activities. This funding will end in mid-2025.

Funding supports designated member program personnel expenses, affording staff the time and expertise to continue to invest in community partnerships. Each designated member program has identified a local health agency to engage with utilizing COVID-19 mitigation funding; many collaborations include agency staff participation on task forces and meetings, community referrals, and access to supplies such as PPE, vaccines, and rapid tests. These partnerships may differ from region to region and have led to cross referrals and improved overall services to survivors, such as access to vaccines and testing. Survivor services are strengthened through direct access to PPE, vaccines, testing, and cleaning supplies, which is provided by community health agency collaborations. Without access to these supplies, COVID-19 mitigation in congregate shelter would be undermined and survivor health and wellbeing would be compromised.

Selected statistics:

- 2,965 people served through emergency shelter services
- 4,638 people received group or individual counseling services
- 12,139 survivors received non-residential services through 15 member programs
- 947 men received domestic violence services through programs
- 1,742 children received services from programs
- 1,765 survivors who identified as African American, 875 who identified as Hispanic/Latino, 70 who identified as Asian, 66 who identified as American Indian/Alaskan Native, and 20 who identified as Native Hawaiian/Other Pacific Islander received domestic violence services from ZeroV programs
- 297 survivors identified as LGBTQIA+ received services
- 273 survivors had limited English proficiency (LEP)

Q. Health Access Nurturing Development Services (HANDS)

The Health Access Nurturing Development Services (HANDS) program is a voluntary home visitation program for new and expectant parents. Any parent expecting a new baby and residing in Kentucky is eligible. Services can begin during pregnancy or any time before a child is three months old. Families begin by meeting with a HANDS parent visitor who will discuss any questions or concerns about pregnancy or a baby's first years. Based on the discussion, all families will receive information and learn about resources available in the community for new parents. Some families will receive further support through home visitation. HANDS is supported by federal Medicaid and state Tobacco Funds and operates statewide as a free service program. The program is housed in the local health departments in all 120 counties in Kentucky.

The primary goals of the HANDS program include:

- Positive pregnancy outcomes
- Optimal growth and development
- Children live in healthy, safe homes and
- Families make decisions that enhance long-term independence over meeting short term or immediate needs

R. Kentucky Children's Health Insurance Program (KCHIP)

The Kentucky Children's Health Insurance Program's (KCHIP) mission is to promote responsible partnerships between families and community agencies to establish and maintain access to health insurance for Kentucky's eligible children and pregnant and postpartum individuals. A statewide program, KCHIP collaborates with various organizations and agencies to ensure quality access to care for enrollees. KCHIP contracts with DCBS and kynect to determine eligibility for potential enrollees. KCHIP also works closely with local health departments to provide age-appropriate screenings and with DPH to provide vaccines for enrolled children.

All KCHIP enrollees receive a benefit package that provides comprehensive coverage to meet children's physical and mental health needs. KCHIP covers health check-ups, screenings, prescriptions, medications, immunizations, physician office visits, hospital care, mental health, allergy injections, substance abuse, and other medically necessary services. Additional information about KCHIP may be accessed at https://kidshealth.ky.gov and information on other Medicaid programs can be found at https://chfs.ky.gov/agencies/dms/Pages/default.aspx.

KCHIP is funded with title XXI and state general funds. Services are available statewide. KCHIP uses quality standards, performance measures, and information and quality improvement strategies to assure high-quality care for KCHIP enrollees. Data is collected to maintain fiscal resources and proper administration.

Per ACA requirements, children below 138% FPL (P5 status codes) in the KCHIP Expansion Program were transitioned into Medicaid effective 1/1/2014. Children below 213% FPL were transitioned into Medicaid Expansion effective 7/1/2022. Per FY 2022 preliminary reports, CMS 64 EC-21E (expansion) and CMS -21E (KCHIP), 116,118 children were served during FY 2022. KCHIP operated within its forecasted expenditures, averted the elimination of any services and increased enrollment levels without instituting a waiting list, lowering eligibility, or reducing benefits.

As per DMS' contract, MCOs must implement and operate a comprehensive Quality Assessment/Performance Improvement (QAPI) program that assesses, monitors, evaluates, and

improves the quality of care provided to its members. The MCOs must provide QAPI program status reports to DMS quarterly. The QAPI program is reviewed annually for effectiveness with a final report submitted to DMS. The MCOs are required to implement steps towards improving performance goals for the Kentucky Outcomes Measures and Healthcare Effectiveness Data and Information Set (HEDIS) measures. The MCOs conduct annual surveys of member and providers' satisfaction with the quality of services provided and their degree of access to services by participating in the Consumer Assessment of Healthcare Provider and System (CAHPS) Survey.

Results of the MCO 2023 CAHPS surveys indicate that overall utilization of health services by KCHIP recipients remains high, access to needed care and specialized care do not appear to be major problems for KCHIP recipients, recipients are largely satisfied with their experiences of care, and evaluations of health care providers, health services, and KCHIP-related health plans are generally positive. MCOs have identified areas for improvement, such as improved follow-up instructions given to patients. These measures are reviewed, and results are analyzed by DMS staff.

In 2022, legislation authorizing 12-month postpartum coverage passed at the federal and state level. Therefore, eligible pregnant and postpartum women will be in enrolled in KCHIP for applicable coverage to improve birth outcomes. Additionally, children under age 19 who previously received Type of Assistance (TOA) CHIP, will now receive TOA CHEX, providing coverage of early and periodic screening, diagnostic, and treatment (EPSDT) special services and non-emergency medical transportation to a greater number of children.

During the reporting period, Kentucky continued to coordinate with a statewide managed care system to expand outreach efforts and continue to increase awareness of the program at the community level. Eligibility passive renewal process was instituted in July 2015, which allowed eligibility to be recertified electronically via a match with the federal hub. Therefore, increases in enrollment trends are expected to continue with Medicaid Expansion and for pregnant and postpartum coverage through KCHIP. KCHIP's ongoing goals are to continue to increase retention efforts, increase the current level of outreach through targeted promotional campaigns, and to continue to increase enrollment including for pregnant and postpartum individuals.

S. Kentucky Education Collaboration for State Agency Children (KECSAC)

KECSAC is a statewide collaborative that works with state agencies, school districts, and local programs to ensure that state agency children (SAC) receive a quality education comparable to all students in Kentucky. SAC are all children and youth placed in programs contracted, funded, and/or operated by the Department of Juvenile Justice (DJJ), CHFS, and DBHDID.

All monies come from State General Funds. During the 2022 legislative session, KECSAC received the largest financial allocation in the history of the program. The new allocation for educating state agency children is $11,000,000 for the first year of the biennial budget and $12,500,000 for the second year. During 2023 $10,179,571 (92.54%) from the State Agency Children's Fund (SACF) was distributed directly to programs through a memorandum of agreement with the districts. KECSAC distributes the SACF to the districts on a per child basis through an MOA with 93% of KECSAC funds going directly to districts.

KECSAC is committed to the belief that all children can learn and have a right to quality education. KECSAC protects and assures this right by accessing resources and providing support to programs that educate SAC. Those children who do not receive a quality education cannot realize their greatest

potential. KECSAC believes these goals are achieved through the process of interagency collaboration. To accomplish the mission, all members of this statewide partnership must exemplify and publicly promote collaborative relationships with partners and other associates. KECSAC provides facilitation services and mediation support to districts and programs when needed to settle disputes between school districts and programs. A quarterly newsletter, *The Collaborative*, is published by KECSAC to include annual census report, annual program directory, and quarterly and annual progress reports. Also included is the task of reviewing and recommending revisions to KECSAC regulations and statutes.

KECSAC staff meet quarterly with the Interagency Advisory Group, which consists of the following collaborative partners: DJJ, DCBS, DBHDID, and KDE. In 2022, KECSAC ended its long-time partnership with EKU as the agencies' fiscal agent and began a partnership with the Kentucky School Boards Association now serving in that role. The relocation of the program and new partnership required a legislative change (during the 2022 session) related to how KECSAC operates. An amendment to HB 194 was presented and unanimously passed which expanded the options of where and how KECSAC could be administered.

Agencies Serving SAC: KECSAC distributes the SAC's fund to programs that serve SAC in educational settings. The funds must be used by educational programs in state educational districts to provide smaller student to teacher rations (10:1) and to provide extended school days during the academic year. An additional 33 educational days are required to receive SAC funds. 64% of all state agency children received educational services while living in one of 33 programs contracted by DCBS.

• DBHDID	• 2% (29)
• DJJ Contracted	• 14% (208)
• DJJ Owned	• 20% (638)
• DCBS	• 64% (839)

KECSAC-funded state agency educational programs provide funding to students between the ages of five and 21. The current average age of youth in KECSAC funded programs is 14.6 years old. The largest age group of SAC in DCBS contracted programs is 17-year-olds with 21.8% of the population, followed by 15-year-olds with 17.4%. The majority (67%) of DCBS KECSAC students are male. A significant number of DCBS children, 35.6%, are diagnosed with an emotional behavioral disability. Other health impairment is the next highest category at 25%. Mild mental disability comes in third with 13.6%. Most children served in KECSAC programs, 67% identify as White. Black or African American is the second highest race category with 22.1%, which is an overrepresentation of this population.

Educational Disabilities of State Agency Children		
IDEA Category	***Count***	***Percentage***
Autism	39	6.2%
Developmental Delay	9	1.4%
Emotional Behavioral Disability	223	35.6%
Functional Mental Disability	25	4%
Mild Mental Disability	85	13.6%

Multiple Disabilities	22	3.5%
Other Health Impairment	157	25%
Specific Learning Disability	54	8.6%
Speech/Language Impairment	5	0.8%
Traumatic Brain Injury	8	1.3%
Total	**627**	**100%**

Currently, KECSAC operates 71 educational programs in 46 school districts across Kentucky. Thirty-four (34) of these programs contract with DCBS. Program improvement specialists use a tool, which aligns with Kentucky's standards and indicators, to audit the educational services provided the youth in state care. Specialists observe classrooms, review prepared evidence, as well as interview the school administrator, program administrator, teacher, and students. If needed, recommendations for improvement are communicated to the program and a follow-up visit is scheduled. Attention is also paid to progress made from the previous year's report to ensure programs are continuing to meet standards and improve curricula. Every program is visited at least once per year to ensure youth are receiving a quality education.

The number of children and youth being served in department programs has slightly decreased, while students in DJJ programs have increased. As predicted in the previous two years, it is possible that the implementation of the QRTP process may have contributed to the decrease in the number of children being served in DCBS programs. DCBS-committed children and youth continue to be served in KECSAC programs; however, current barriers exist due to staffing shortages in the programs, which has led to some programs shutting down.

In addition to providing the funding for educational programs that serve SAC, KECSAC also provides training to educators and administrators in the programs. Annually, KECSAC provides professional development opportunities for educators through their at-risk conference, KY Alternative Education Summit, and the New Educators Training. Professional development events are free to KECSAC program members and consistently rank very well in evaluations from attendees.

T. Kentucky Partnership for Families and Children, Inc. (KPFC)

Kentucky Partnership for Families and Children, Inc. (KPFC) is a statewide, non-profit, family organization founded in 1998. A family organization is an organization that has 51% or more parents/primary caregivers raising children with behavioral health challenges. KPFC has nineteen employees; approximately 74% of the staff is parents that have raised, or are raising, children with behavioral health challenges and approximately 26% of the staff are adults that received services for children's behavioral health disabilities under the age of 18. KPFC supports five different programs: transitional-age youth leadership; family and youth peer support specialists; family and youth network building; regional peer support centers; and training for parents, teens, and provider partners. KPFC partnered with DBHDID and DCBS on Kentucky's System of Care FIVE (SOC V) grant that focused on expanding and strengthening Kentucky's services and supports for families involved with child welfare services which have at least one child diagnosed with a serious emotional disability.

KPFC staff, parent leaders, and transitional-age youth leaders participate on multitude of state level and regional level committees:

- SIAC Subcommittees
- CJA Task Force
- System of Care FIVE Grant Management and Implementation Team
- Kentucky Partnership for Youth Transition
- Transition Age Youth Launching Realized Dreams (TAYLRD)
- Kentucky Interagency Transition Committee
- Kentucky Behavioral Health Block Grant Council
- Strengthening Families Leadership Team
- Youth Thrive Leadership Team
- Statewide Prevention Collaborative
- Lived Experience Authentically Driven in Kentucky, and many others

KPFC staff, parent leaders, and transition-age youth leaders also provide the following trainings/workshops across the state for professional groups as well as for foster/adoptive parents and teens: Reactive Attachment Disorder (RAD), Surviving Challenging Behaviors, Better Understanding ADHD/bipolar disorder/etc., Bridges Out of Poverty, Scarcity Mindset, and Youth Mental Health First Aid.

KPFC's board consists of over 51% parents and agency representatives from child welfare, courts, education, private child care, etc.

KPFC receives funds from DBHDID and fees for service for training, fundraising, and donations. KPFC services are available statewide. KPFC accomplished the following in 2023:

- Monthly e-newsletters disseminated to 2,300+; open rate averages around 45%
- Wednesday webinars: 200+
- Children's Mental Health Awareness Day: 100+
- Resource requests: 500+

KPFC has six Peer Support Centers which consists of ten family and/or youth peer support specialists. These ten specialists served 467 parents and young people with 62% being families with child welfare involvement. Those families with child welfare involvement received 5,305 services which included: peer support, Nurturing Parenting classes, resource linkages, SMART Recovery, virtual support groups, attending team meetings, and leadership development.

KPFC Peer Support Centers

2023 Referrals	SOC FIVE/DCBS involved	Non-SOC FIVE
467	290	177

Services	All KPFC Customers	SOC FIVE Customers
Peer Support	5,094	3,525
Nurturing Parenting	950	709
Resource Needs	564	327
SMART Recovery	496	368

Support Group	340	255
Team Meetings	90	45
Training/Leadership Development	87	76
Total	**7,621**	**5,305**

A theme that emerged during 2022 is the emphasis on families of origin being included on system and program level decision-making. The former DCBS Commissioner created a trusted advisors group which consists of families who received DCBS services. During 2022 Kentucky System Experience At the Table (KY SEAT) began an advisory council to DCBS. The CFSP Stakeholder CQI meeting facilitator has put together a group of birth, foster, and adoptive parents to provide input and guidance during the CFSP Stakeholder CQI meetings. These meetings continued throughout 2023.

KPFC has intentionally worked with DCBS administration as well as frontline workers to understand the importance and benefits of peer services. The data shows that this is increasing as we continue to build this partnership between KPFC and Kentucky's child welfare agency.

KPFC partners with DCBS by establishing intentional guidelines for DCBS regions which are early implementers of community and alternative responses. Community Response (CR) is a resource or service for a family when a report regarding a child under the age of 18 has been made to DCBS but does not meet acceptance criteria for a child maltreatment assessment. Alternative Response is a family-centered and strengths-based approach to child protection allowing the cabinet to better match responses to reported concerns in the community. KPFC can provide Peer Support Center services to any parent who is referred regardless to which DCBS region the parent resides in. The intentional guidelines and processes that are being established for the specific regions around CR and AR is to help DCBS staff better understand what KPFC Peer Support Centers can offer:

- Peer support
- Nurturing Parenting classes
- Resource linkages
- SMART Recovery and SMART Recovery Family & Friends
- Virtual support groups
- Attend team meetings as requested by customer (family/youth), and
- Leadership development

Some barriers for KPFC include the inability to bill Medicaid, the need for additional office space in locations across the state, finances for peer support positions, and building alliances with service providers and community members.

U. Kentucky Strengthening Families (KYSF)

Kentucky Strengthening Families (KYSF) Initiative represents a multi-disciplinary partnership made up of national, state, local, public, and private organizations dedicated to engaging families, programs, and communities in building six research-based Protective Factors. Supporting families is a key strategy to enhance child development, increase family strengths and reduce the likelihood of child abuse and neglect. All families experience times of stress, and research demonstrates that children grow and learn

best in families who have the supports and skills to deal with those times. Supporting families and building skills to cope with stressors can increase school readiness and reduce the likelihood abuse will occur in families. KYSF uses a nationally recognized strategy, Strengthening Families: A Protective Factors Framework, coordinated nationally by the Center for the Study of Social Policy. KYSF can help programs working with children and families to make informed decisions on ways to support parents to build their Protective Factors that enable children to thrive.

The vision of KYSF is that all Kentucky children are healthy, safe, and prepared to succeed in school and in life through families that are resilient, supported, and strengthened within their communities. The mission of KYSF is to strengthen families by enhancing protective factors that reduce the impact of adversity and increase the well-being of children and families through family, community, and state partnerships. KYSF is supported by the Governor's Office for Early Childhood through funds from the Race to the Top/Early Learning Challenge Grant and the Tobacco Settlement Dollars administered by DPH. In June 2021 the KYSF Initiative received CRRSA funding from DCC to help support child care professionals during the COVID-19 pandemic. This grant ended June of 2022.

Family Thrive (across the lifespan) Protective Factors

- Parental Resilience: Families bounce back
- Social Connections: Families have friends that can count on
- Knowledge of Child Development: Families learn how their children grow and develop
- Concrete Support in Times of Need: Families get assistance to meet basic needs
- Social and Emotional Competence of Children: Families teach children how to have healthy relationships
- Nurturing and Attachment: Families ensure children feel loved and safe

Kentucky Youth Thrive (Ages Nine-26)

- Youth Resilience-Youth bounce back when life presents challenges
- Social Connections-Youth have genuine connections with others
- Knowledge of Adolescent Development-Youth Understand-Youth understand the science of their development
- Concrete Support in Times of Need-Youth find resources and support in their community that help them
- Cognitive, Social, and Emotional Competence-Youth know how to communicate their thoughts and feelings effectively

The overarching goal of the Family Thrive framework is to achieve positive outcomes by mitigating risk and enhancing healthy development and well-being of children and youth. These guiding premises provide the foundation for Family Thrive and Kentucky Youth Thrive.

Two regional leadership teams were created in 2018: one in northern Kentucky and one in western Kentucky. Representatives from over 20 partner organizations, departments, and agencies make up the leadership team. The regional team membership is representative of similar partners as the state team. A third regional team formed in Floyd County in June 2019. All regional teams are securing grant funding for projects related to KYSF. These teams meet bi-monthly and representatives from the regional teams attend the state meeting.

Currently, there are 387 master trainers for Family Thrive. KYSF activities were significantly impacted by the COVID-19 pandemic. Leadership team meetings and trainings were held virtually with fewer participants than in the past. Other activities were suspended because of the pandemic restrictions. The KYSF leadership team worked diligently to transition to online trainings and meetings to continue working on goals such as revising current training material, updating, and launching a new online KYSF Initiative course, developing a provider café model and Trauma-Informed Care and Resiliency Training for child care professionals, and revamped the overall purpose and function of the KYSF State Leadership Team meetings. Protective Factor Surveys and Café evaluations for Parents and Youth are being collected in the regions.

KYSF is a statewide, long-term initiative, with ten-year goals. The proposals for the future for KYSF include:

- Expansion of regional teams
- Training specific to regions
- Regional summits
- Parent and Youth Café expansion
- Social media presence
- Increase the use of Zoom post-pandemic to reach more individuals and communities
- Leadership team working on strategic planning

The state KYSF team collaborated with epidemiologists to create a statewide KYSF Initiative evaluation system on Redcap. This launched in July 2023. KYSF is currently trying to increase statewide participation in this evaluation process. The statewide evaluation system will also capture trainer-specific data, including number of trainings, number of participants, positives outcomes and potential barriers for implementation that the state KYSF team can address.

V. Kentucky Strengthening Ties and Empowering Parents (KSTEP)

The cabinet implemented KSTEP to address parental substance abuse that places child safety at risk. This program was designed to be a resource to prevent unnecessary removals of children and to reduce the number of children in OOHC. Goals of the KSTEP program are to (1) reduce the need for out of home care (OOHC) placements, (2) shorten the duration of any necessary OOHC placements, (3) reduce repeat maltreatment, and (4) increase well-being of families by enhancing caregivers' capacity to care for children and maintain them safely in their own homes. To achieve the above goals, the KSTEP program integrates evidence-based substance use disorder (SUD) treatment and intensive in-home services and child welfare practice to address parental substance abuse. The program places emphasis on quick access to services, the removal of barriers, and increased collaboration occurring between DCBS, and community partners, to assist families.

During CY 2023, KSTEP serviced 586 families and 1,233 children. Three-hundred sixteen (316) cases closed in 2023, and 121 of those cases closed due to successful completion, five cases closed due to alternative permanency being established, 29 cases closed due to assessment only, 25 cases closed due to the family choosing to leave services prior to completion, 78 cases closed due to the family being unable to meet program requirements, eight cases closed due to the family moving out of the service area, 23 cases closed with the reason cited as "other" (reasons included non-compliance, family being unable to meet program requirements, clients participating in long term treatment or incarceration), and 27 cases have no text provided for closure reason. The KSTEP program is designed to serve families for six to eight months, but services can be extended by approval of the KSTEP administrator.

The average cost per child served in KSTEP programs in CY 2023 was $7,010.62. The current average cost per child in OOHC is $69,353.41. By utilizing programs like KSTEP that prevent children from entering OOHC, there is a cost savings of $62,342.79 per child by utilizing programs like KSTEP that prevent children from entering OOHC.

To assess the program impact of KSTEP, primary data and secondary data are collected, analyzed, and reported. Primary data is collected from KSTEP families at multiple intervals throughout the life of the KSTEP case and includes family level and individual level assessments, (e.g., NCFAS, Adaptive Stress Index, Parental Stress Index). Secondary data, including case management/service delivery activities documented in the KSTEP database and outcomes including repeat maltreatment and placement in out of home care documented in TWIST, are also collected.

NCFAS is administered to KSTEP families by the private providers upon entry into KSTEP, then around the mid-point of the KSTEP services (usually three to four months into the service cycle), and upon completion (usually at the end of eight months). The ASI is administered to primary caretaking adults (indicating substance misuse) residing in the home at the time the case is accepted to KSTEP by the contracted service providers. The ASI is administered upon entry into KSTEP, three to four months after entry into KSTEP, and at the conclusion of the eight-month KSTEP service period. Similarly, the PSI is administered to all primary caretaking adults residing in the home at the time of the maltreatment report is substantiated by contracted service providers. The instrument is administered at the outset of acceptance in KSTEP, at the end of the fourth month in KSTEP, and at the conclusion of KSTEP services. All individuals involved in collecting primary data, no matter the measure, are trained in appropriate data collection procedures. Data collection occurrences are expected to take between one and two hours, however, times may vary depending on factors such as the size of the family, etc.

Evaluation of KSTEP outcomes based on the above assessments focused only on the KSTEP cases and their pre-post growth. Data were analyzed using statistical software, such as International Business Machines (IBM) Statistical Package for the Social Sciences (SPSS) software, including repeated measure mean comparisons across different administrations of the tests, and descriptive analyses for some KSTEP families.

During CY 2022 KSTEP program administrators worked with DCBS contract monitors to develop a new targeted case monitoring tool for KSTEP providers. This new tool has been used to guide program performance improvements. DCBS also completed quarterly case reviews for fidelity monitoring of EBPs. DCBS provides feedback and action steps for providers to improve service delivery. The KSTEP evaluation outline has been drafted for submitting the Family First state plan amendment.

W. Low Income Home Energy Assistance Program (LIHEAP)

The mission of the Low-Income Home Energy Assistance Program (LIHEAP) is to provide energy assistance benefits to eligible low-income families at or below 130% of poverty. Heating subsidy began November 7, 2023, and ended December 16, 2023. Income limits were adjusted to 130% of the federal poverty level. Eligible applicants received assistance with energy costs through subsidy and crisis components. Subsidy aided all eligible households and crisis aided eligible applicants experiencing an energy crisis, identified by a past due notice, termination notice, or final notice. These programs provide services and benefits to improve the quality of life for young children and vulnerable adults, making their home a healthier environment in which to live.

LIHEAP is federally funded through the ACF OCS Division of State Assistance. LIHEAP services are available statewide in all 120 counties. CHFS disperses funds to Community Action Kentucky (CAK), who then distributes to the 23 CAAs across the state. Clients meet eligibility requirements based on 130% FPL for 2023, for summer cooling subsidy and spring subsidy; and 130% FPL for heating subsidy and crisis.

Technical assistance and training are provided to the CAAs by CAK, a contract agent on behalf of CHFS. Fall and spring training are hosted by CAK for the CAAs and appropriate staff at CHFS.

CAK collects data included in the household report and performance measures report and submits it annually to ACF on behalf of CHFS. The household report includes information regarding the number of households served in crisis and subsidy. It also details the number of households weatherized through the weatherization program. It offers details of the number of households by poverty level, vulnerability of the household, including how many households have children aged two and under, between three and five years old, and whether a household includes a member who is 60 and over or who has a disability. The performance measures report provides information pertaining to the energy burden households carry in relation to the main type of their heating source. The number of homes having energy restored and the number of households preserving their heating source upon receiving LIHEAP are also reported.

The state plan is submitted annually to HHS. The plan shows Kentucky's planned use for the allotment received. Components of LIHEAP are subsidy and crisis and are used between November and March. Outreach is one of the areas covered in the state plan to develop measures on how to let the public know about LIHEAP and its benefits.

DCBS completes half-year block grant status reports on LIHEAP for the state legislature in January and July. The status report reflects activities completed in the past six months, (i.e., expenditures, objectives, achievements, authorized changes, and evaluation of results). Categories include but are limited to types of fuel and vulnerable household members.

A program compliance review is conducted by CAK for each agency a minimum of one time during the contract period. It is the agency's responsibility to be available for and have documentation for CAKs review. Desk reviews are conducted for agencies without findings from last year's monitoring. Remaining agencies are monitored on-site.

Goals for LIHEAP are measured, in part, by the number of Kentucky's most vulnerable citizens served. In SFY 2023, 70,563 households were served in heating subsidy; 46,971 households were served during the spring subsidy component. Crisis component households served totaled 71,961 for winter crisis and 58,286 in the summer crisis component of LIHEAP. Summer subsidy households served totaled 58,286. Four hundred thirty-three (433) households were served by weatherization.

X. Michelle P. Waiver Program

The Michelle P. Waiver (MPW) is a home and community-based services (HCBS) waiver under the Kentucky Medicaid program developed as an alternative to institutional care for individuals with intellectual or developmental disabilities (IDD). It was designed so that people who were placed in institutions could return to or remain in their communities. The MPW allows individuals to remain in their homes with services and supports. Adults and children alike are eligible for the program if the meet the criteria for eligibility. To qualify, recipients must have intellectual or developmental disabilities that

meet the requirements for residence in an intermediate care facility or a nursing facility. Recipients must also meet level of care and Medicaid financial eligibility requirements.

MPW services include:

- Case management
- Adult day training
- Supported employment
- Community living supports
- Behavior supports
- Occupational therapy
- Physical therapy
- Speech therapy
- Respite
- Homemaker service
- Personal care
- Attendant care
- Environmental/minor home adaptation
- Adult day health care

The MPW came about because of a class action lawsuit filed by P&A, on behalf of several persons with disabilities living at home with elderly parents who were not receiving the Medicaid services they needed. P&A is a state agency whose mission is to protect and promote the rights of Kentuckians with disabilities through legal-based individual and systemic advocacy and education. Clients were on waiting lists to obtain placement in a residential program, however, the wait was indefinite. At that time, the only way someone could receive certain services was if they were housed in a facility.

The court determined that under the Americans with Disabilities Act (ADA), each state is required to provide services to people in their community and they should not be forced to live in an institution to get the services they needed. The settlement resulted in:

- The funding for intellectual and developmental disabilities being doubled.
- A total of $27.5 million dollars for SCL services.
- A total of 15.2 million dollars for crisis stabilization services.

Additional money was allocated for services in the community:

- Three million dollars for the Hart Supported Living Program.
- A 75% increase in the funding of family care homes and adult foster home to encourage new homes to open.

SCL providers are agencies licensed and/or certified with Medicaid, to provide services to people with intellectual and/or developmental disabilities. SCL providers offer MPW services.

DMS changed the process for receiving services for occupational (OT), physical (PT) and speech-language therapy (ST) in the MPW program for members under the age of 21. The EPSDT benefit provides medically necessary therapy services. DMS sent a letter to all providers on October 1, 2012, informing them of the change. The department expanded the provider network for participant directed service delivery to any willing and qualified provider.

DMS is focused on transforming 1915(c) HCBS waiver coverage and enhancing service quality throughout the Commonwealth. This includes:

- DMS was granted additional slots for MPW in the 2022-2024 biennial budget and plans to request additional MPW slots during the 2024 General Assembly when lawmakers consider the 2024-2026 biennial budget.
- DMS is currently conducting a feasibility study to determine if it is possible to add a new 1915(c) HCBS waiver for children with severe emotional disturbance, intellectual disabilities, and related conditions, including children with autism spectrum disorder (ASD).
- DMS recently completed a rate study focused on developing a sound payment and rate-setting methodology for 1915(c) HCBS-based on reasonable and necessary provider costs. The results of the study and an impact analysis are with CHFS executive staff for decisions about implementation.

Additional funding for 1915(c) HCBS waivers will be needed to move forward with these initiatives in the future.

During CY 2023, there were 10,135 unique members who had a paid claim for MPW services. There were 4,195 active members under the age of 21 and 5,950 active members 21 and over.

Y. Multidisciplinary Commission on Child Sexual Abuse

The Kentucky Multidisciplinary Commission on Child Sexual Abuse (KMCCSA), staffed by the Office of the Attorney General (OAG), is tasked with preparing and issuing a model protocol for local MDTs regarding investigation and prosecution of child sexual abuse and the role of the CACs on MDTs (KRS 431.660). In addition, KMCCSA reviews and approves protocols prepared by local MDTs. They are responsible for advising local MDTs on the investigation and prosecution of child sexual abuse. KMCCSA seeks funding to support special projects relating to the operation of local MDTs. They receive and review complaints regarding local MDTs and make appropriate recommendations. KMCCSA also makes recommendations to the Governor, Legislative Research Commission (LRC), and Kentucky Supreme Court regarding any changes in state programs, legislation, administrative regulations, policies, budgets, and treatment and service standards which may facilitate effective intervention of child sexual abuse cases and the investigation and prosecution of perpetrators of child sexual abuse, and which may improve the opportunity for victims of child sexual abuse to receive treatment.

MCCSA meets bi-monthly via virtual platform and provides guidance to the statewide county teams. KMCCSA shall be composed of the following members: the DCBS commissioner or designee, the DBHDID commissioner or designee; one social service worker who is employed by DCBS to provide child protective services, who shall be appointed by the CHFS secretary; one therapist who provides services to sexually abused children, who shall be appointed by the CHFS secretary; the commissioner of the Department of Kentucky State Police (KSP) or a designee; one law enforcement officer who is a detective with specialized training in conducting child sexual abuse investigations, who shall be appointed by the secretary of the Justice and Public Safety Cabinet; one employee of AOC appointed by the Chief Justice of the Supreme Court of Kentucky; two employees of the OAG who shall be appointed by the Attorney General (AG); one Commonwealth's attorney who shall be appointed by the AG; the commissioner of KDE or a designee; one school counselor, school psychologist, or school social worker who shall be appointed by the commissioner of KDE; one representative of a CAC who shall be appointed by the Governor; one physician appointed by the Governor; and one survivor of a sexual offense or one parent of a child sexual abuse victim who shall be appointed by the AG. Appointees shall

serve at the pleasure of the appointing authority but shall not serve longer than four years without reappointment.

KMCCSA shall elect a chairperson annually from its membership. KMCCSA will review the MDT protocol to ensure the protocol is meeting best practice standards and has identified all current and pertinent legislation. KY AG Russell Coleman has appointed Heather Wagers, Executive Director of Kentucky OAG to lead the Office of Human Trafficking and Child Abuse Prevention and Prosecution.

In 2021, KMCCSA rolled out its latest model protocol and asked that all local MDTs to submit a revised local protocol. Since then, KMCCSA has reviewed and approved the protocols from nearly all local multidisciplinary teams. Although the statewide model protocol was designed under the lens of child sexual abuse cases, MDTs across the state have widened their scope to include the review of additional abuse types. The data highlights that a growing 20% of cases are physical abuse cases benefiting from the MDT model in Kentucky.

Local MDTs are mandated by KRS to exist in each county. Each local MDT is charged with completing and submitting the mandatory data collection tool by the end of January each year. In turn, KMCCSA is responsible for compiling and adopting an annual report reflecting the work of KMCCSA and local MDTs. The model protocol requires teams to meet on a monthly basis. Some counties have a very small number of cases that require a team response; however, the Commission encourages a minimum of monthly meetings to stay connected to the other individuals and agencies involved in the investigation of child abuse. Non-case review time can be used to go over administrative updates, cross-training, and networking. The Commission appreciates the 111 counties meeting monthly throughout 2022 in Kentucky.

Local MDTs continue to update their protocol to the newly revised model that was effective January 2021. The commission finalized the updated model protocol to ensure that all Local MDTs can have access to start utilizing the new updated model. The Commission will review the MDT protocol to ensure the protocol is meeting best practice standards and has identified all current and pertinent legislation.

Kentucky Multidisciplinary Commission on Child Sexual Abuse has no monies per se. KY OAG pays for administrative fees incurred when this board meets.

Z. Office for Children with Special Health Care Needs (OCSHCN)

The Office for Children with Special Health Care Needs (OCSHCN) provides gap-filling specialty and subspecialty pediatric care to medically underserved children and youth with special health care needs (CYSHCN), as well as enabling public health services statewide. Created in 1924 by the state legislature to provide treatment to children with orthopedic conditions across the state, OCSHCN's clinical services have since expanded to include treatment and care coordination for a variety of severe and chronic conditions. The agency endeavors to create a comprehensive, quality system of care for Kentucky's CYSHCN, which are defined as children birth to age 21 who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who require health and related services of a type or amount beyond that required by children generally. In addition to administering the state's Title-V children with special health care needs medical services program, OCSHCN provides special services to address health care needs of children involved with the child welfare system and a population-based early hearing detection and intervention (EHDI) program to ensure the assessment of hearing in newborns statewide.

OCSHCN's mission is to enhance the quality of life for Kentucky's CYSHCN through direct service, leadership, education, and collaboration. Services are family-centered and community-based with access to specialty providers coordinated through 11 regional offices and four satellite clinics. The agency's website is https://www.chfs.ky.gov/agencies/ocshcn, where a directory of services and provider lists programs available in all areas of the state. OCSHCN provides services for the following: audiology services (EHDI, hearing screener program, hearing aid services, and Kentucky Early Intervention Service Provider), clinical services (ASD, cardiology, cerebral palsy (CP), cleft lip and palate, craniofacial anomalies, neurology, telehealth, ophthalmology, orthopedics, otology, scoliosis, and transitioning to adulthood), supplemental services or care coordination (case management, social services, nutrition, PT, OT, ST, and language interpretation), additional diagnostic and treatment services (First Steps point of entry and hemophilia treatment centers), family support services (family to family health information center and Spanish-speaking support groups), and provider support for ECHO Autism.

OCSHCN also collaborates with DCBS regarding foster care support. Funding for OCSHCN services originates from various sources, including state general funds. Those sources are the Title-V Maternal and Child Health Block Grant (supports the specialty clinic program), CDC grants (support hearing screening and transitions), and third-party reimbursement/agency receipts (supports medical care).

OCSHCN services are available statewide. As a public agency within CHFS, OCSHCN shares a statewide parent organization with DCBS, DMS, DPH, and other important social service and health programs. Over the course of 100 years, OCSHCN has developed formal and working relationships with a variety of programs providing services to children. In addition to direct care provided in specialty clinics, children with eligible diagnoses may receive care coordination services from registered nurses.

Depending on the individual needs of the child, this may involve varied activities such as:

- Advocating and helping patients and families understand their current health status and educating them on what they can do to improve it
- Linking families with resources and providing cohesion among other professionals of the health care team to accomplish goals efficiently and effectively
- Attendance at school meetings; and
- Home visits for individual health planning meetings with DCBS frontline staff.

OCSHCN employs family consultants and social workers who assist families to access outside services or help with overcoming barriers to optimum care. A family-to-family health information center program places parent-organized resource centers within OCSHCN clinics and establishes a network of parents who provide peer support. Critical partnerships exist with the Home of the Innocents, a PCC facility where Louisville therapy staff (physical, occupational, and speech therapy) have access to a state-of-the-art therapy pool. Universities provide expertise by way of administering the Lexington and Louisville Hemophilia Treatment Centers (HTCs). Several specialty providers have become active with OCSHCN due to their affiliations with Kentucky's teaching hospitals. In addition, the Louisville OCSHCN office is a point of entry for Kentucky's Early Intervention Program's Kentuckiana Regional Planning & Development Agency (KIPDA) Region.

Through a formal needs assessment process pursuant to the Maternal & Child Health Title-V Block Grant, agency strategic planning, and ongoing interagency communication, OCSHCN works with state, local, and regional medical providers to ensure that services are available to meet the needs of all Kentucky CYSHCN. In addition to involvement on a case level, several OCSHCN staff are active on boards

and councils, such as the Kentucky Council on Developmental Disabilities, SIAC for Services and Supports to Children, and Transition-Age Youth, each of which further the agency's mission. OCSHCN also receives input from formal stakeholder advisory groups of youth and parents.

EHDI Program: Kentucky's EHDI Program oversees hearing screening at birth hospitals that deliver more than 49,000 births annually across the state. Ninety-nine percent (99%) of all live births received a newborn hearing screening prior to discharge. In addition to providing technical assistance to hospital hearing screening programs, EHDI program staff work with clinical audiologists and Part C providers to ensure that infants not passing their hospital based newborn hearing screening are able to receive diagnostic assessment of hearing and, if necessary, appropriate early intervention. An MOA with First Steps created a collaborative agreement with Part C to provide audiologic evaluation for all First Steps-eligible infants and toddlers prior to onset of First Steps services, and a separate MOU with DCBS provides for OCSHCN to fulfill the role of primary audiology provider for children in the custody of DCBS. The EHDI program sends letters to each infant's primary care physician informing them of the infant's risk of hearing loss, as well as when infants are diagnosed with hearing loss.

Other Programs/Initiatives:

HTCs: HTCs in Lexington and Louisville assists with factor products and other related medications needed to manage bleeding episodes. Each case is individual and must be reviewed before any determination can be made. Families needing assistance complete an application process and must meet eligibility criteria.

Transition Program: OCSHCN's transition program continues helping young people move from school to work, pediatric to adult health care, and living at home to independent living. OCSHCN nurses and social workers utilize an age-appropriate transition checklist to work closely with young people and their families to help them plan. OCSHCN nurses, social workers, and family consultants help families find resources, facilitate communication, and support parents as they seek services for their children and youth. OCSHCN nurses work with youth and families, in collaboration with local adult providers, to assist youth to transfer to an adult health care provider when the youth is ready to transfer.

Parent and Youth Involvement: The Youth Advisory Council (YAC) is comprised of youth from across the state with a variety of physical and mental disabilities. Most of the council members receive services from OCSHCN. This diverse group provides youth with disabilities a voice.

The Parent Advisory Council (PAC) is comprised of parents of children with disabilities. Most of the council members have children that have received services from OCSHCN. This is a diverse group representing several regions of the state and provides a means for parents to provide input into OCSHCN's services.

OCSHCN's Family to Family Health Information Center initiative has created a network of families trained to support other families, encourage families to become involved in efforts that will lead to reduced barriers to care, and build family capacity to make informed choices and be involved in decision making at all levels.

Data: During CY 2023, OCSHCN provided specialty medical services to 6,973 patients. Of the total number of patients seen, 73% had Medicaid/KCHIP, 22% had private insurance, and 5% had no

insurance. OCSHCN accepted 2,929 new patients, permanently discharged 353 over age patients, but 5,149 were eligible to return; 36,831 visits were recorded.

During CY 2023, OCSHCN's EHDI program received 48,432 hearing screening report forms. Failing the newborn hearing screening is considered a risk factor for hearing loss, according to the Joint Committee on Infant Hearing. Of the infants screened, 1,716 failed on one or both ears. The total number of infants that passed the hearing screen was 46,611. The data is reasonably consistent to patients served in previous years.

OCSHCN leadership continues to feel that the partnership with DCBS is a vital one and remains consistent with OCSHCN's mission. As a Title-V Maternal and Child Health services agency, OCSHCN prepared a five-year needs assessment in 2020, results of which guide the direction of services, especially regarding any new or expanded programs. Priorities for the years 2020-2025 include transition to adulthood, improving access to care and services, ensuring adequate insurance coverage, and enhancing agency data capacity. Considering Kentucky selected transitions services as a title-V national performance measure, emphasis is placed on ensuring services for youth health care transitions to adult care in the child welfare area.

AA. Supporting Kentucky Youth (SKY)

Supporting Kentucky Youth (SKY) is a single statewide MCO managed by Aetna Better Health of Kentucky. SKY offers evidenced-based trauma-informed practices and wraparound service provision to approximately 28,000 members in all 120 counties and all nine service regions in the department. Children and youth in foster care, OOHC, children receiving adoption assistance, dually involved youth, former foster care youth, and Medicaid eligible DJJ youth will be enrolled with Aetna for Medicaid coverage. In addition to covering Medicaid benefits, SKY provides a high touch approach to care management that helps families navigate systems and make it easier for them to get the resources they need. The SKY program offers enhanced benefits to support members to include a care coordination team assigned to each member enrolled to ensure access to primary care, behavioral health services, dental care, specialty care, wraparound services, and social support services. The LOC management services provided by the care coordination teams are tailored to meet the needs of each individual SKY member.

The team also provides the following services:

- Assist with locating providers and obtaining appointments as needed
- Expedite the scheduling of appointments for assessments
- Assist with the coordination of covered transportation services
- Arrange community supports for members and referrals to community-based resources as necessary

SKY collaborates across the Commonwealth in terms of resources and service provision to members and stakeholders on a consistent and continual basis. Aetna has long standing relationships with the healthcare community and SKY has insurged the addition of additional partnership in the child welfare specific arena as well. Daily reports and data are shared between DCBS, DMS, and SKY daily to ensure children in OOHC are communicated as efficiently as possibly as not to create gap in coverage service. Additionally, this assists in insuring that children in care show as actively enrolled to pay and coordinate their medical claims. Daily information specifies the status of a child's placement to ensure ongoing health coverage as well. Routine contact for collaboration is established. There is a monthly Command

Center meeting facilitated by DCBS and includes divisions and departments across the cabinet, the Office of Administrative and Technology Services (OATS) for technical applications and assistances, and Aetna Better Health of Kentucky. This group keeps the cabinet apprised of information, education, and changes to SKY for widespread sharing across organizational responsibilities and community partners.

The CORE group includes the following groups: Infrastructure and Technology, Medically Complex Population, Practice and Policy, Training, Communications, and DJJ Youth. These groups range in cadence from weekly, monthly, and ad hoc dependent upon need. SKY hosts various connector, data sharing, and inclusive meetings which have a quarterly Governance Council with department and cabinet-wide representation, as well as ad-hoc, a Training Collaborative charged with meeting training gap needs across stakeholder groups, a formal partnership with Kentucky Youth Advocates (KYA) to bring stakeholders together. KYA currently partners with Casey Family Programs and serves on several FFPSA initiatives. SKY also provides Advisory Council meetings to offer a voice and inclusion from varied roles across the collaboration. SKY team members work shoulder to shoulder with department and DJJ staff at a frontline case management level as well for heightened collaboration and a true teamwork mentality. The SKY care case managers visit youth in congregate care settings monthly and ideally attend with the DCBS social worker. SKY has provider meetings in which the department collaborates on reduction of barriers and insuring supports to remediate gaps in service coverage. This directly speaks to service array and problem-solving around service deserts and offering choice of treatment and service provider when able to consumers. Communication is frequent and active. It is a true partnership in which collaboration is encouraged, supported, and tangible.

Goals for the Kentucky SKY program include improving the quality of care and health care outcomes for program enrollees. The program's mission is to:

- Achieve safety and permanency for children.
- Reduce psychotropic medication use.
- Improve health outcomes.
- Incorporate youth voice and choice.

Program goals for SKY include the following:

- Improve member satisfaction with the health plan to be greater than or equal to 4 stars on the CAHPS survey.
- Improve Weight Assessment, Counseling for Nutrition and Physical Activity, and Referrals for Overweight and Obesity Management in Children and Adolescents.
- Reduce overprescribing of psychotropic medications and increase appropriate metabolic monitoring for those prescribed certain medications.
- Return children from long-term out-of-home placements to their families, specifically those children placed out of state or in residential care.
- Build a family meeting culture through utilization of collaborative family engagement and family finding frameworks that promote healing.
- Ensure that each child has a care plan that incorporates at least two community-based resources and supports.
- Implement care management and provider programs to address delivery and access to care in the least restrictive setting.
- Provide accessible and in-depth education, insight, and opportunity to bolster stakeholders' expertise in serving the SKY population.

Aetna Better Health of Kentucky has dedicated staff with experience working in child welfare and will conduct the following key functions to help achieve these goals:

- Development of a statewide provider network for the Kentucky SKY populations with 24-hour emergency access and crisis services.
- Provision of comprehensive care coordination for enrollees inclusive of:
- Assigning each enrollee to a primary care provider and a dentist.
- Conducting required assessments to determine enrollee needs.
- Assigning care coordination teams to support enrollees in receiving the needed services.
- Collaborating with CHFS agencies and health care providers to share health records and to reduce duplication of services.
- Provision of access to TI services, including physical health, mental health and substance use disorder treatment, dental care, social services, and wraparound services.

Aetna Better Health of Kentucky has the following supportive programing and initiatives to help reach previously noted goals.

- High Fidelity Wraparound: Members stratified in the complex tier of care management for behavioral health reasons, receive family driven, team-based planning and supports and services by a certified High Fidelity Wraparound care manager.
- Journey to Independence: Transition-age youth receive youth-driven interdisciplinary care team meetings aimed to develop formal transition plans and to support the youth entering adulthood.
- Family Finding: A workshop-based approach focused on equipping system partners with tools to search and engage family members and fictive kin for members.
- Peer Support Services: Certified peer supports serve members, foster parents, legal guardians, and adoptive/fictive/kinship providers to render additional supports and services from individuals with lived experience.
- Charting the LifeCourse: A member-centric care planning tool to assist our members in identifying and reaching their life aspirations.
- Helping Everyone/Each Other Reach out (HEERO): A workshop-based approach focused on youth supporting each other from a capabilities (not deficits based) perspective to build lifelong, sustainable networks of support.
- Behavioral Health Discharge Program: Members and hospital-based facilities have access to a dedicated licensed behavioral health professional to streamline care coordination, transition, and discharge planning.
- Social Determinants of Health: Care managers/coordinators work in close partnership with community-based organizations to obtain and coordinate resource and services for members.
- Psychotropic Polypharmacy Initiative: Identifies and reduces the number of members who meet criteria for high-level psychotropic polypharmacy, reduces overprescribing, increases appropriate monitoring, and increases education and outreach on polypharmacy, medication management and informed consent.
- Child & Adolescent Nutrition and Wellness Initiative: Identification of members at risk for diagnosis of obesity/overweight and provision of tailored care coordination, referrals to weight management specialist, value-added benefits and member and family education to enhance nutrition and wellness.
- Prioritizing Risk, Engagement and Prevention Initiative: Identifies risking or at-risk SKY members in behavioral health or physical health crisis, prioritizes those members based on criteria,

deploys appropriate interventions to engage the member, assures the member is wrapped up tin the appropriate level of services and supports and works to prevent further escalation or crisis.

Aetna has developed collaborative relationships with stakeholders who support the Kentucky SKY population. The MCO provides communications and training to providers, law enforcement, the judicial system, advocates, and other stakeholders to assure understanding of the Kentucky SKY program and services and their roles in supporting enrollees to obtain needed services and to achieve improved outcomes. Since 2021, 31,000 stakeholders in the state have received trainings through the SKY Training Collaborative.

The cabinet's TWIST team has developed a shared SKY module accessible by both SKY and DCBS. DCBS and DJJ work collaboratively together with SKY to aid in ensuring children entering OOHC have support and services available to meet their holistic health care needs. A care team, inclusive of nursing staff for both DCBS and SKY, is in place that supports children needing specialized or unique services regarding medical challenges. DMS is in an integral part of the continual communication and helping to vet through technical and contractual processes and needs.

To best serve the members of this population, Aetna SKY has an expansive offering of care management assessments and programs that reveal the strengths and needs of enrollees and support them in achieving permanency. Additionally, Aetna SKY offers an Autism Spectrum Training Series each year to increase provider and caregiver knowledge of autism and the treatment of autism. SKY is committed to building a family meeting culture through utilization of collaborative Family Finding engagement and Family Finding framework that promotes healing. Additionally, SKY ensures that Transition Age Youth are engaged in Charting the LifeCourse and transition to adult milestones discussions. In 2023, SKY was able to increase engagement in all programs.

The SKY Program strategy produced multiple positive outcomes in 2023. The Aetna SKY team operates with a CQI philosophy, making data-driven decisions based on the current needs of the population.

Key Accomplishments based on program priorities:

- The Aetna quality team worked with the department to create HEDIS gap in care reports for children in out of home care to be utilized by front line staff.
- The SKY quality team improved systems for tracking non-HEDIS measures related to child welfare system transformation.
- The SKY quality team improved psychotropic polypharmacy reporting and programming based on up-to-date research and collaboration with DCBS' medical director.
- Identified and addressed barriers to service delivery to address special health care needs of members and deployed interventions to improve barriers.
- Improvement in rate of out of state placements that were returned to in-state placements.
- Improvement in rate of out of state referrals that were diverted in in-state placements.
- Identification of rising, moderate, and critical risk members that need increase in supports and services and implementation of individualized interventions.

Analysis of data revealed the following barriers related to special needs of SKY population:

- High utilization rates of psychotropic polypharmacy among SKY members.
- High levels of members who meet criteria for high-risk obesity as defined by Kentucky DMS

- High utilization of emergency department among SKY OOHC members experiencing behavioral health related crises.
- High utilization of inpatient hospital behavioral health services among out-of-home care members due to system placement constraints in residential treatment and foster care; and due to prior authorization liberalization.

Continued monitoring and CQI efforts will produce further recommendations for improvements and celebrations for meeting outcomes and goals for the SKY Program and overall collaboration statewide.

BB. Prevent Child Abuse Kentucky (PCAK)

Prevent Child Abuse Kentucky (PCAK)'s mission is in collaboration with our partners, to prevent the abuse and neglect of Kentucky's children through advocacy, education, awareness, and training. PCAK seeks to build a safer Kentucky, strengthening families two generations at a time, by increasing awareness of child maltreatment through sustainable statewide partnerships. PCAK utilizes a network of partners, professionals, and volunteers to engage in the prevention of child abuse and neglect and develop effective prevention strategies and programs throughout the Commonwealth. Through the various community-based programs, parents and children are afforded the opportunity to learn and create a positive attitude toward their differing roles. With this knowledge, the cycle of child abuse can be broken; the aspects of abuse can be identified, treated, and prevented; and parents and children can develop and maintain open, warm, and loving relationships.

On January 1, 1987, PCAK was created through a merger of Parents Anonymous of Kentucky and the Kentucky Chapter for Prevention of Child Abuse. These two statewide agencies were formed in Kentucky in 1977-1978 and had been active as pioneers in the child abuse field since their creation. The merger resulted from a desire to combine the primary, secondary, and tertiary prevention aspects of the two autonomous agencies. This merger created the Kentucky Council on Child Abuse, and the board of directors approved the name change to PCAK in April 1999. PCAK is affiliated with Prevent Child Abuse America, headquartered in Chicago. The agency is statutorily funded utilizing a portion of state birth certificate fees (KRS 213.141).

PCAK works closely with CHFS personnel to ensure the goals and services provided under its programs are aligned closely with the overall CFSP. All subcontractors, who are local community agencies, are required to implement evidence-based parent education and support group services. All subcontractors are required to have a process to receive referrals from the state child welfare agency and serve families at risk. PCAK subcontracts, through annual requests for proposal, with programs serving parents in each of the nine service regions. The state office of PCAK provides the administration, coordination, training, maintenance, evaluation, and enhancement functions necessary to allow the evolution of viable child abuse prevention options for families. PCAK conducts a variety of outreach programs (Kids Are Worth It! ® Child Abuse Prevention Conference; self-help, parent education, and support groups; educational workshops and institutes; 1-800 CHILDREN parent support resource; Partners in Prevention; Child Abuse Prevention Month; Awareness Tools; Parent Engagement/Fatherhood and Lean On Me Kentucky initiatives) throughout the year. Each activity is reported separately below.

PCAK Kids Are Worth It! ® Statewide Child Abuse and Neglect Prevention Conference: Kids Are Worth It!® (KAWI) Conference is a statewide child abuse and neglect prevention conference. The conference focuses on child abuse and neglect issues across the prevention continuum from primary prevention through permanency planning for youth in care. The conference meets the training, continuing education, programmatic, and networking needs of a broad, multidisciplinary audience. Workshop,

plenary, and networking sessions offered provide participants with information and tools to promote and support best practice. Participants learn of new resources, obtain new skills, receive information to enhance existing skills, and are provided networking opportunities to improve relationships and collaboration with colleagues working within or in support of the child welfare system.

The conference is funded through CBCAP, grants, sponsorships, and private/corporate donations. The conference is planned collaboratively between PCAK staff and a diverse advisory committee representing a variety of disciplines (including legal, public health, mental health, substance abuse, community services, medical, and law enforcement). This committee also represents varieties of geographical regions across the state. The KAWI Conference provides a unique training opportunity to both staff and service providers within the child welfare system. State and national experts provide high quality, state-of-the-art workshops, and plenary sessions relevant to the broad audience providing a variety of services to children and families. Care is taken to ensure all material presented are relevant to participants regardless of geographic location within the state.

The 27th Annual KAWI conference was held at the Galt House in Louisville, KY on September 11-12, 2023. This function was attended by 730 individuals. Participants were able to attend up to six workshops from a selection of 37 offerings, two keynote sessions, and 42 exhibits. Participants from 86 counties (identified in the Kentucky map below), across all nine department service regions were present, representing 72% of Kentucky counties.

2023 KAWI Participant Representation Map

Participants were provided the opportunity to complete an overall conference evaluation. In efforts to "go green" PCAK provided evaluations electronically through Survey Monkey and had a 24% response rate, indicating room for improvement. Respondents who indicated they were either *Extremely Satisfied* or *Satisfied* are represented by the percentages below:

Conference Participant Experience Ratings	2019 Overall Responses	2020 Overall Responses	2021 Overall Responses	2022 Overall Responses	2023 Overall Responses
a. Conference as a whole	100%	95%	96%	94%	91.41%
b. Registration process	98%	94%	94%	97%	96.06%
c. Workshop choices	96%	94%	95%	87%	85.94%
d. Keynote sessions	96%	92%	95%	85%	80.32%
e. Networking opportunities	96%	N/A	N/A	N/A	89.68%

As a result of attending the conference:	2019 Overall Responses	2020 Overall Responses	2021 Overall Responses	2022 Overall Responses	2023 Overall Responses
a. I am better prepared to prevent child abuse and neglect.	96%	94%	92%	100%	91.40%
b. I learned of a new resource, which will assist me in my work to improve outcomes for children and families.	96%	95%	97%	94%	92.91%
c. I learned a new skill, which will assist me in my work to improve outcomes for children and families.	96%	95%	96%	97%	90.62%
d. I was able to network with community partners.	91%	N/A	N/A	N/A	89.85%

Open-ended responses were solicited on the overall evaluation in addition to individual workshop evaluations. When asked what aspects of the conference were most beneficial, respondents indicated the following:

- *"I loved the workshop options and the area where all booths were set up."*
- *"Terrific presenters and opportunities to network."*
- *"The Poverty Simulation and the Internet Crimes Against Children were AMAZING classes, the presenters were well prepared, and I left with ideas and tools to help my community."*
- *The speakers were all very informative and friendly towards the topics and other perspectives and experiences. Speakers all did a great job at answering questions and engaging with attendees."*

- *"This is the best conference for networking. I always meet new people that help support the work I do daily."*
- *"Child deaths and trauma classes were amazing. Anyone should take those regardless of if you are in a field directly with kids or have kids of your own. Wonderful information."*
- *"Workshops and presenters were wonderful and informative! Exhibits/community partners with brochures and info sheets is a major benefit, not only to myself but my coworkers/team who I will be able to share resources with."*

Open ended responses also provided opportunities for growth:

- *"My biggest suggestion would be a better venue. The parking was terrible, rooms had an odor and there were issues with the elevator being overcrowded."*
- *"The Galt House, while wonderfully located, left much to be desired from a facilities standpoint."*
- *"Great job putting this together. There were a few sessions where the presentation did not meet the description. I may have chosen differently if I had known."*

Media Participation: Three television stations attended the Kids Are Worth It! Conference, resulting three media spots highlighted below:

'Kids Are Worth It' conference aimed at preventing child abuse in Kentucky--WHAS
Kentucky's governor pledges more money for child abuse prevention, social worker salaries if re-elected--WDRB
'Kids Are Worth It' conference in Louisville held to protect kids, prevent child abuse--WLKY

Other media:

Three Rivers HANDS team meets with Governor Beshear—Falmouth Outlook
Kids Are Worth It: PCA Kentucky Hosts Successful Prevention Conference (PCAA Newsletter)

Self-Help, Parent Education, and Support Groups: Services are available in every service region and served 68 of 120 counties in the state in 2023. Subcontractors are required to utilize the evidence-based Nurturing Parenting curricula along with administration of the parallel Adult-Adolescent Parenting Inventory (AAPI) pre and post-test. The utilization of a single curriculum enhances programmatic consistency across service providers and strengthens program evaluation through universal use of the AAPI. PCAK maintains a single account with provider satellites for providers to enter their AAPI data, which allowed for collection and data analysis. Currently, one PCAK staff member is a trained facilitator of Nurturing Parenting and Parent Café to enhance self-help work. Programmatic, training, and evaluation changes continue to encourage integration of the protective factors' framework into service delivery. Furthermore, providers are required to administer a drug and alcohol-screening tool to all participants at intake. Majority of the providers use UNCOPE. As part of service delivery, each provider offers an education component on child welfare, from investigation to case resolution. Subcontractors are asked to distribute the child welfare agency's child removal handbook, When Your Child is Removed from Your Care, and parents are asked to complete the child welfare agency's Customer Satisfaction Survey.

The content delivered each week of the parent education sessions and/or support group is designed to provide parents with skills relevant to healthy parenting, while encouraging permanency and well-being within the family structure. PCAK collects attendance and referral data from each subcontractor monthly during each SFY. An analysis of the CY records reflects 971 families began a parent education

and/or parent support program with one of the 15 providers during 2023. In this period, PCAK subcontractors provided 9,830 duplicated incidents of service through Parent Education Classes and/or Parent Support Groups.

PCAK staff utilize a two-prong approach to measure program impact. For several years, the program has been evaluated through a retrospective survey collected from participants at program completion. Questions on the survey instrument focus on demographic data, as well as parenting skills gained while attending the program and how the individual feels about him/herself afterwards. Program participants are clearly told their answers will not have any impact on an individual's personal situation. This self-report tool has consistently shown positive program impact.

In 2023, PCAK's partnership continued with The Center for Family and Community Well-Being at UofL to conduct a comprehensive evaluation of outcomes across multiple domains. The evaluation includes analysis of the AAPI pre and post-test data collected, as well as data collected from the PCAK generated Parent Education Survey. The AAPI is a tool used to measure the effectiveness of PCAK's parent education programs. Based on the known parenting and child rearing behaviors of abusive parents, responses to the inventory provide an index of risk for behaviors known to be attributable to child abuse and neglect. The AAPI is universally recognized as a valid and reliable tool used to assess parenting attitudes, knowledge, and history.

The AAPI includes both a pre and post-assessment. The pre-test collects data to determine the program participant's entry-level capabilities. The post-test data is collected at the completion of the program to determine level of growth and future intervention needs of the family.

The information gained through this assessment includes:

- Knowledge: What do parents know about appropriate parenting practices?
- Attitudes: What attitudes do parents have about raising children?
- History: What childhood history do parents and teens have that affects their parenting?

Responses to the AAPI provide an index of risk in five specific parenting and child rearing behaviors:

- Construct A - Inappropriate Expectations of Children
- Construct B - Parental Lack of Empathy Towards Children's Needs
- Construct C - Strong Parental Belief in the Use of Corporal Punishment
- Construct D - Reversing Parent-Child Family Roles
- Construct E - Oppressing Children's Power and Independence

Parents who score "high risk" in the constructs measured by the AAPI are at greater likelihood of abusing their children.

The final report submitted to the cabinet in December 2023 noted the following outcomes:

- The most common demographics of Parent Education participants are white women ages 25-34 with a high school education or above.
- 99.5% of respondents shared their facilitator/ leader was "really helpful" or "helpful" to them.
- 67.98% of Program participants report their minor children live with another caregiver.
- Program participants reported several positive changes to their parenting styles, notably, having expectations that are age appropriate for their children, reacting calmly when their child did the thing that upsets them most, handle conflict in a healthy way, listen to their children,

understand their children's behavior, deal with stress in a healthy way, set rules and limits, and following through with rules and limits.

In 2023, PCAK's Annual Provider Meeting was held in-person for the first time since before the Covid-19 pandemic. During this educational opportunity specifically created to address the needs of our Parent Education Providers, attendees received the following training:

- Healthy Outcomes for Positive Experiences (HOPE 101)
- Lean On Me Kentucky
- Evaluation and Data Collection
- Advocating for a Healthier Kentucky
- Looking Forward to the Future

PCAK Educational Workshops and Institutes: PCAK provides educational offerings to requesting groups statewide, focusing on issues impacting local communities and actively engaging the community in preventing child maltreatment. Activities are supported through CBCAP funds, PCAK general funds, grants, private donations, training honoraria, and corporate giving. PCAK offers specialized trainings, train-the-trainer workshops, and continuing education credit for participants. Curricula on a variety of child maltreatment related topics are available and each audience participates in an individualized learning experience. PCAK has expanded its training offerings, now providing the following workshop topics:

Abusive Head Trauma: HB 285, legislation passed during the 2010 General Assembly, mandates and encourages education on the identification and prevention of abusive head trauma. Check with us to see if your profession is part of the mandate, or whether you and your colleagues are merely encouraged to receive this training. In partnership with experts in child maltreatment, PCAK has developed curricula to meet the needs of a variety of professionals impacted by this legislation. Train the Trainer workshops are also available.

Are They Good for Your Kids? Child Sexual Abuse Prevention: Child sexual abuse is preventable when adults educate themselves and take precautions to keep children safe. This workshop highlights PCAK's *Are They Good for Your Kids?* Campaign and resources and teaches participants how to prevent child sexual abuse in their spheres of influence. The workshop will cover grooming behaviors, healthy child sexual development, and will provide school personnel actionable steps to take to keep kids safe. Train the Trainer workshops are also available.

Data and Messaging Training: This training focuses on uniting providers in Kentucky to use evidence-informed messaging grounded in social norms science to discuss child maltreatment. Participants will understand how current child abuse research informs audiences and learn ways to re-frame messages regarding child abuse prevention.

Engaged Fathers: Improving Outcomes for Children: Fathers are instrumental in the healthy growth and development of children. This workshop reviews research on the positive and negative outcomes which are directly influenced by the involvement of fathers in children's lives. Attendees are provided with tools to assess the "father-friendliness" of their organizations and service delivery models. Discussion surrounds changes in practice which, when instituted, may impact the engagement of fathers in the lives of children.

Family Thrive: The overarching goal of the Family Thrive framework is to achieve positive outcomes by mitigating risk and enhancing healthy development and well-being of children and youth. The guiding premises provide the foundation for Kentucky Strengthening Families and Kentucky Youth Thrive. This approach can be used in any setting serving families, youth, and children typically without making huge changes in daily practice.

Internet Safety: The Internet Safety training provides strategies to educate, monitor and communicate internet safety. Because of this training, participants will understand risks and learn how to keep children protected both from unsafe material as well as from predators who are unyielding in their efforts. This training has been designed to support parents and other caregivers in their efforts to assure the safety of children in their care.

Lean On Me Kentucky**:** This training will introduce the initiative Lean On Me Kentucky, the context of neglect and supporting families in our state, along with what primary, secondary, and tertiary child abuse prevention means. Participants will learn primary prevention strategies to help families prior to system involvement and learn ways to become a community supporter.

The Power of Parent Engagement in Healthy Community Outcomes: It's no secret that children and youth have better outcomes when caregivers and parents are involved, not only in the household but in schools, child welfare organizations and more. During this session, participants will learn strategies to build and sustain meaningful and effective parent partnerships from daily interactions with parents to engaging caregivers through board leadership and more.

Positive and Adverse Childhood Experiences: Strategies for Supporting Families and Children: Fifty-nine percent of Kentuckians report experiencing at least one adverse childhood experience, such as child maltreatment. These traumatic events can have a negative impact on the health and social wellbeing throughout someone's lifespan. In a safe, stable, and nurturing environment, children can adapt and build resilience in response to these negative experiences. This workshop will explore current research regarding the impact of toxic stress, evidence informed practices designed to mitigate the effects of toxic stress on children and strategies for supporting families.

Poverty and Neglect: Understanding the Difference and Supporting Families and Children Living in Poverty**:** During the 2022 Legislative Session, the General Assembly changed the definition of neglect in KRS to better reflect the difference between poverty and child neglect. This workshop not only explores the difference between poverty and neglect but helps service providers understand primary prevention or ways to support families prior to CPS involvement. Attendees will also learn ways to communicate messaging to their colleagues and community members that encourage supporting families and preventing maltreatment from ever occurring.

Poverty Simulation from the Child Welfare Lens**:** With funding from Prevent Child Abuse America, PCAK worked with the University of Louisville, Center for Family and Community Wellbeing to develop the first-of-its-kind simulation offering a deeper understanding of poverty and the child welfare system. This project represents a primary prevention effort, as it enables providers and others to understand and respond to families experiencing poverty in a different

manner. Moreover, this simulation raises awareness of unconscious biases that impact interactions with lower-income populations, thereby leading to improved engagement, effective service provision, and more positive outcomes. Piloted in July 2023, this simulation was offered to PCAK Partners in Prevention, DCBS leadership and offered at the Kids Are Worth It! Conference.

Protecting Your Children: Advice from Child Offenders: Using film clips of interviews with various types of sex offenders, participants will understand the techniques perpetrators use to target, seduce, and exploit children. This workshop will challenge common misperceptions about children's ability to protect themselves and promote the idea that all adults must be informed and take an active role in promoting child safety. Participants will learn effective prevention strategies for use in a variety of settings.

Protocol for Youth-Serving Organizations, Colleges & Universities: How Do You Keep Children and Youth Safe While Under Your Supervision**:** Summer camps, colleges/universities, athletic organizations, the faith community, and other youth-serving organizations all have a duty to ensure the children and youth they serve are safe while under their care. This training is suitable for athletic personnel, Title IX administrators, summer camp counselors/staff and others. The training covers topics including recognizing & reporting child abuse, strategies for screening and selecting employees and volunteers, strategies for ensuring safe environments and others. A planning tool for organizations is included in the training.

QPR Gatekeeper Training**:** Question, Persuade, and Refer (QPR) are three simple steps anyone can learn to help save a life from suicide. The QPR mission is to reduce suicidal behaviors and save lives by providing innovative, practical, and proven suicide prevention training. Just as people trained in CPR and the Heimlich Maneuver help save thousands of lives each year, people trained in QPR learn how to recognize the warning signs of a suicide crisis and how to question, persuade, and refer someone to help.

Recognizing, Reporting and Preventing Child Abuse and Neglect**:** Through lecture, video, injury identification and group work, attendees are prepared to recognize, report, and prevent child abuse and neglect within their role as child and/or family-serving professionals. This workshop reviews Kentucky mandated reporting laws, definitions of abuse and neglect, what to expect after a report has been made to the authorities and outlines specific action steps which prevent child maltreatment.

Reinventing Our Messages: Promoting Action for the Prevention of Child Sexual Abuse: The way we talk about social problems affects how people understand their causes and solutions. Each of us has beliefs and values we use to help us decide the meaning of messages received. Intentional framing is needed to understand complex issues and build support for programs and policies. Research and analysis have shown Prevent Child Abuse Kentucky there is work to do in how we frame child sexual abuse and its prevention. We want our messages to promote action and move individuals to intervention and prevention. This workshop will summarize the work already completed around reframing child sexual abuse messaging in Kentucky, as well as the importance of adequate message frames moving forward. Participants will leave with an

understanding of proper framing for difficult topics, and the tools to create new appropriate messages for difficult social issues, specifically child sexual abuse.

Resilience**:** Participants will screen a 60-minute documentary produced by James Redford. This documentary summarizes the science behind the ACEs Study and provides an in-depth look at how toxic stress can trigger hormones that wreak havoc on the brains and bodies of children, putting them at a greater risk for disease, homelessness, and early death. Resilience, however, also chronicles the dawn of a movement determined to fight back. Trailblazers in pediatrics, education, and social welfare are using cutting-edge science and field-tested therapies to protect children from the insidious effects of toxic stress. A question-and-answer session will follow the film, allowing participants the opportunity to bring this national movement into a local context for implementation.

Stewards of Children**:** PCAK staff is credentialed by the Darkness to Light organization as an Authorized Facilitator of the Stewards of Children curriculum. Stewards of Children is an evidence-based workshop, documented to "increase knowledge, improve attitudes and change child-protective behaviors." The two-to-three-hour workshop is conducted in small group settings and is geared toward all adults interested in preventing child sexual abuse.

The Connection Between Intimate Partner Violence and Child Maltreatment: Intimate Partner Violence (IPV) impacts the entire family and is found in approximately 55% of KY households with substantiated cases of child maltreatment. Attendees will learn about common dynamics of IPV, how children are impacted by the violence and techniques for preventing child maltreatment when working with families impacted by IPV.

Trauma-Informed Care**:** Traumatic events can have a significant impact on an individuals' health and life, and can lead to a sense of powerlessness, fear, hopelessness, and a constant state of alertness within an individual. TI care is an approach to engaging people that recognizes the potential presence of trauma symptoms and acknowledges the role that trauma may play in an individual's life. When a human service agency becomes trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the lives of individuals.

Tools for Supporting Families Impacted by Shift Work**:** Shift work refers to any inconsistent work schedule or work schedule outside of 7 a.m. – 6 p.m. It is important for service providers to understand the unique challenges experienced by families impacted by shift work, and how to support them. This training identifies primary prevention, ways to strengthen families living with a shift work schedule and determines future areas in need of improvement when focusing on this work.

Understanding Typical Child Development**:** A Tool to Prevent Child Sexual Abuse: Understanding typical child sexual development is critical to keeping children safe. Often parents do not understand when and how to discuss sexual abuse. Training participants will understand the typical stages of child development and learn how to help caregivers talk to their children about healthy sexual development as a tool to prevent child sexual abuse.

Working with Families in Substance Use Recovery**:** Substance use is commonly present in cases where child maltreatment has been substantiated. Through lecture and group work, attendees will become familiar with the continuum of prevention, the connection between substance abuse and child maltreatment, and specific techniques to prevent child maltreatment in families impacted by substance use.

Online trainings:

Electronic Crimes Against Children: How to Educate, Monitor, and Communicate Internet Safety: Whether you are a professional working to protect children or are a parent, this presentation will provide insight into how perpetrators groom children online and what parents and caregivers can do to keep kids safe. This training was conducted and current as of May 2019. As technology quickly evolves so do the statistics and electronics utilized by youth. As such, we will work to update this training annually. Special thanks to our presenter, Major Jeremy Murrell with KSP.

No Hit Zone**:** Prevent Child Abuse Kentucky is proud to be an official No HIT Zone. No HIT Zones are a proactive way to promote, calm, safe and caring environments where violent behavior is not tolerated. It not only provides public notice that hitting is not acceptable in the identified No HIT Zone property but provides training to staff and volunteers on addressing situations in which adults are using physical discipline with children or need to de-escalate a situation which may lead to violence. Special thanks to our presenter, Dr. Kelly Dauk, National No HIT Zone Committee member and PCAK Board Member.

Trauma-Informed Practice for Attorneys**:** A TI approach in legal practice can reduce re-traumatization of victims, provide recognition on the role trauma plays in the lawyer-client relationship and provide legal professionals with the opportunity to increase connections to their clients and improve advocacy. When children who have experienced trauma receive support and advocacy early on, the cycle of abuse and neglect can be prevented for the next generation. Special thanks to our presenter, Laken Albrink, Assistant Professor of Legal Studies at Morehead State University.

Understanding Typical Child Development**:** A Tool to Prevent Child Sexual Abuse
Understanding typical child sexual development is critical to keeping children safe. Often parents do not understand when and how to discuss sexual abuse. Training participants will understand the typical stages of child development and learn how to help caregivers talk to their children about healthy sexual development as a tool to prevent child sexual abuse.

PCAK will continue to provide educational workshops and institutes to the public as requested. Additional PCAK staff are being trained as workshop presenters. As new workshops are developed at the request of participants, PCAK's listing of workshop topics continues to increase, and is always shared on them PCAK website: https://www.pcaky.org/trainings. As communities become more aware of PCAK workshops and educational offerings as a resource for preventing child maltreatment, PCAK receives greater numbers of requests.

PCAK collaborates with DCBS and other key stakeholders to ensure workshops and institutes serve as high quality professional development venues, applicable to the needs of diverse audiences. PCAK workshops and institutes are strategically located to ensure child maltreatment prevention education is accessible to audiences statewide through in-person and virtual means. Considering COVID-19, PCAK was able to shift and provide trainings through virtual platforms. PCAK promotes trainings through networking and engagement of community partners. Invitation listings are developed based on the target audience and region of the state in which it will be located. Partners instrumental in announcing events include DCBS, DPH, DBHDID, DCC, FRYSCs, and well as other locally based entities. PCAK utilizes web-based advertising including the website, electronic newsletters, and social media (Facebook, X).

Workshops and institutes, which are specific to one discipline, include a segment on the importance of a multi-disciplinary approach to prevention. PCAK provides workshops and institutes, which incorporate components across the entire continuum of prevention. Participants are equipped with knowledge on primary prevention, risk factors, warning signs, and protective factors, which enhance the strength-based approach to prevention. Participants leave with tangible tools for working with children and families such as local and statewide community resources. Participants receive materials in addition to education. Training of the trainer institutes provides training materials, resources for future participants, and ongoing technical assistance. DCBS staff members are invited to attend or participate as co-presenters in many PCAK trainings. PCAK works with the TRC to ensure DCBS training credits are provided. This provides professional development opportunities for DCBS staff and encourages communities to align themselves with DCBS as a resource to assist in meeting local needs.

Train the Trainer offerings were provided through support from the Child Victims' Trust Fund to train 50 trainers from across the Commonwealth on the *Are They Good for Your Kids: Child Sexual Abuse Prevention* curricula. PCAK also worked with Step by Step, a local agency in Lexington to train three peers to provide this education to their peers. Individuals in the Step-by-Step program include single mothers ages 14-24. Through this partnership peers helped re-write this curriculum for the purpose of engaging their peers through presentations and discussions. The success of this program is credited to the mothers who worked with PCAK staff to develop this program from the very beginning as partners in this effort. Technical assistance is provided to ensure the longevity of this effort.

PCAK utilizes resources, materials, and technical assistance from the national affiliate Prevent Child Abuse America. This relationship provides access to best practices from sister chapters throughout the country. Additionally, PCAK has utilized resources and information from Child Welfare Information Gateway, Chapin Hall, Center for the Study of Social Policy, the Child Fatality and Near Fatality External Review Panel, and many others.

During 2023, trainings were offered locally, regionally, and statewide. PCAK provided training opportunities in each of the nine DCBS regions. Trainings often have a wide reach through statewide curriculum offerings and intentional offering of workshops in locations, which draw participants from surrounding counties. In 2023, PCAK served 2,386 participants, and provided 48 trainings.

PCAK 1-800-CHILDREN Parent Support Resource: The 1-800-CHILDREN parent support resource functions as a free parent support and referral service, which is available via phone, email, and the PCAK website. Funded by CBCAP, the 1-800-CHILDREN parent support resource line provides support to families to prevent incidents of abuse or neglect. Parents, caregivers, and the professionals offer support, encouragement, and information regarding local resources, which promote the safety and well-being of Kentucky children and families. The 1-800-CHILDREN parent support resource offers 24-hour

access via email and the web. PCAK staff answer calls 8:00a.m.-5:00p.m. Monday-Friday; during all other times, callers are referred to 1-800-4ACHILD to ensure 24-hour access to support via phone. Staff are trained to respond to caller concerns and have access to a wide variety of resources.

Additionally, new, or updated resources are provided to staff to ensue callers receive current resources and appropriate responses. When parents, caregivers, and professionals contact the 1-800-CHILDREN parent support resource, callers receive guidance in problem solving and referrals to the most appropriate resources in their local communities. Utilizing local social service providers for referrals not only connects callers with local and accessible resources, but also builds the community's capacity to care for Kentucky children and families. The 1-800-CHILDREN parent support resource also serves as an engagement tool to connect citizens interested in learning about being involved in child abuse and neglect prevention efforts. Volunteer opportunities, specific child abuse and neglect related resources, and other pertinent information is provided.

The 1-800-CHILDREN parent support resource interconnects PCAK programs and services with family service providers statewide. The 1-800-CHILDREN phone line is advertised at all PCAK trainings and is included on all PCAK resource materials. Professionals working with children and families can provide this information to the clients they serve. The 1-800-CHILDREN parent support resource serves as the point of contact for citizens to learn about programs, information, events, and volunteer opportunities, which affect child maltreatment prevention. DCBS frontline staff are encouraged to share the 1-800-CHILDREN parent support resource with parents and caretakers involved with the DCBS system and can be utilized as a component of safety and aftercare planning when appropriate.

- Approximately 273,414 pieces of material displaying 1-800-CHILDREN were distributed throughout the Commonwealth during 2023.
- Staff communicated information regarding 1-800-CHILDREN during 44 formal trainings and numerous presentations on various topics to a variety of audiences reaching 2,427 individuals.
- Staff were involved in 168 outreach opportunities reaching 11,516 individuals statewide.
- The 1-800-CHILDREN parent support resource continued to include toll-free and local calling, email services, and web-based resource materials.

Data regarding usage of the 1-800-CHILDREN parent support resource is tracked quarterly. Information captured includes number of calls received, the originating location for the call, type and number of referrals made.

Notable data from CY 2023:

- 108 calls were made to the 1-800-CHILDREN toll free parent support line.
- On average, the 1-800-CHILDREN toll free parent support line was utilized nine times per month.
- 23% of all callers were referred to DCBS.

Since the last reporting period, 1-800-CHILDREN parent support calls to the toll-free number continue to decline. This could indicate individuals utilizing the services are able to have their needs met through local, alternative means, including email, calls to the local resources such as 211 or utilization of KNECT.

PCAK places high value on the continuous quality improvement process and will continue analyzing 1-800-CHILDREN parent support resource data to ensure best practice.

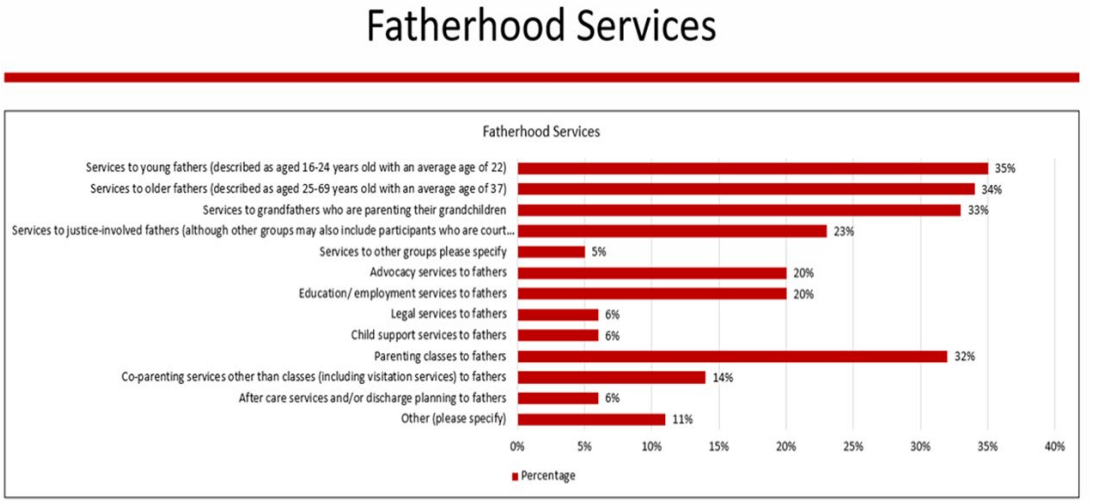
PCAK, Partners in Prevention: PCAK Partners in Prevention is a network of agencies, individuals, and businesses with coverage to the entire state. During 2023, PCAK had 316 Partners in Prevention (73 statewide partners and at least 2 partners in each of the 120 Kentucky counties). These partners reflected statewide coverage. The network consists of service providers such as volunteer groups, schools, hospitals, businesses, mental health providers, faith-based entities and other community organizations working to spread the message of child abuse prevention. Affiliates are involved in PCAK programming such as trainings and workshops, Self-Help, Parent Education and Support Groups, Child Abuse Prevention Month (CAPM), Kids Are Worth It!® Conference, Lean On Me Kentucky, as well as regional and community awareness campaigns. PCAK takes a targeted approach in contacting, meeting with, and formalizing partnerships with groups who will utilize the resources provided in a method increasing the development of awareness and prevention work across Kentucky.

PCAK staff and board members have identified targeted professions, associations or groups for targeted outreach and partnership to help collaboratively strengthen communities through resilient relationships, thereby preventing maltreatment. Intentional outreach was initiated with communities of faith, substance use disorder providers, parents with lived expertise, military families, western Kentucky representation, eastern Kentucky representation, diversity representation, and Latinx serving organizations, to name a few.

All partners are involved in work to bring awareness to child abuse and neglect by distributing and sharing PCAK prevention information throughout their region. Qualitatively, PCAK maintains relationships with each individual partner, offering technical assistance to help build greater capacity in meeting prevention program and awareness needs of partners. Conversation and observation find Partners are pleased with their experience through this network. Partners continue to assist PCAK in becoming a clearinghouse for CAPM ideas, seeking funding opportunities for prevention efforts that are well dispersed across the state, and continually brainstorming ideas and applying strategies to engage communities in each region.

Looking ahead to PCAK's work with partners across the state starting January 1, 2024, PCAK is excited to launch Regional Partner Meetings as an additional engagement opportunity and benefit for our partners. Allowing these formal times for engagement and brainstorming together will serve our Partners and Kentucky children and families better.

See the below chart indicating specific services provided to fathers by participant organizations.



Child Abuse Prevention Month: During National CAPM, PCAK provides leadership and technical assistance on awareness, education, and events to be held throughout the month. Efforts are funded through CBCAP, corporate and individual donations. PCAK collaborates with the state child welfare agency, community partners, professionals, parents, and caregivers to develop resources and materials. Awareness materials provide individuals with statewide information and services; and are made available through the PCAK website, trainings, and community meetings.

The 2023 CAPM campaign included the following activities:

- Via Gubernatorial Proclamation, April 2023 was declared Child Abuse Prevention month. Many communities across the state hosted proclamation ceremonies, engaging local elected officials such as mayors and judges, declaring April as CAPM. PCAK distributed local proclamation templates as a strategy to ensure consistent messaging throughout the state.
- On March 27, in conjunction with the Office of the Governor and First Lady Beshear, PCAK held a statewide kickoff to include a pinwheel planting attended by PCAK staff, PCAK board members, PCAK Partners in Prevention, state leadership/employees elected officials, and the public.
- Communities across the state held an array of events to include community proclamation ceremonies, pinwheel plantings, community informational events and trainings.
- There were 44 CAPM related events reported to PCAK in 2023.
- Staff developed CAPM resources available through the PCAK Information and Data Center. Resources included campaign ideas, templates for media outreach, event planning, faith-based materials, statistics and relevant data, tip sheets for parents and caregivers, suggestions for engaging communities in grassroots prevention efforts, home kits to be used to raise awareness at home, a scavenger hunt to help families to become familiar with local and state resources and a door decorating contest to engage individuals and organizations to participate during CAPM.
- Over 33,940 pinwheels were distributed across the Commonwealth.
- 571 pinwheel lapel pins distributed across the Commonwealth.
- Electronic announcements promoting child abuse prevention month and the availability of the online resources were distributed via social media, the PCAK webpage, and email distribution. There were 16,278 hits to the PCAK webpage during the campaign.
- 100% of Kentucky counties were engaged with PCAK in child abuse prevention month efforts.

- In advance of and during the month, 36,102 child abuse awareness materials were distributed across the state to local communities.
- During the 2023 campaign, the Facebook audience included 8,253 followers, 1,726 Instagram followers, and 3,767 Twitter followers. 33,034 users were reached during April 2023 on Facebook and 573 via Instagram.

Resources made available by CB and Prevent Child Abuse America were utilized in the development of the 2023 Child Abuse Prevention Month materials. Links to CB and other national organizations were provided on the PCAK website as resources to local communities. PCAK also benefits from affiliation with Prevent Child Abuse America and sister chapters throughout the country. This affiliation provides ideas and resources to strengthen Kentucky's efforts.

PCAK Awareness Tools: Using CBCAP funds, corporate and in-kind donations, PCAK provides an array of awareness tools throughout the year. Based on the varying learning styles of adults today, and the ways people receive information, awareness tools include brochures, electronic resources, as well as video**,** print and media campaigns. This group of resources has been coined the "PCAK Information and Data Center," a term reflecting the variety of media through which tools are distributed. Awareness tools serve to strengthen the ability of the public and professionals of the Commonwealth to gain knowledge regarding the issue of child abuse and neglect. CHFS staff and community partners are consulted regarding emerging trends in the field of child abuse and neglect prevention. This information assists in determining the content and topics of awareness materials offered by PCAK. These community partners, in conjunction with PCAK staff, provide ongoing review of materials to ensure the accuracy of the information available for distribution.

Examples of awareness tools available on these subjects include:

- 10 Things you can Do to Prevent Child Abuse! tip sheet is a general guide for anyone in the community to see something they can do to prevent child maltreatment.
- I make the world a better place sticker (English and Spanish).
- I matter sticker (English and Spanish).
- I'm wearing blue for child abuse prevention! Stickers.
- It's Okay to be myself sticker (English and Spanish).
- 10 Things Parents Need to Know About Internet Safety Parenting Slick.
- Abusive Head Trauma Parenting Slick.
- Managing Stress Parenting Slick.
- Understanding Childhood Trauma Parenting Slick.
- Preventing Child Sexual Abuse Card: Believe Children!
- Preventing Child Sexual Abuse Card: Learn the Signs of Grooming.
- Preventing Child Sexual Abuse Card: We Have To Talk About It!
- Preventing Child Sexual Abuse Guide.
- Three seconds is all it takes to prevent abusive head trauma postcard.
- What Should I Do? When A Child Talks About Child Sex Abuse Brochure.
- Why is my child acting out? Brochure.
- Lean On Me Kentucky Toolkit.
- 20 Lean On Me Kentucky cards.
- "Effective Fatherhood Engagement for Providers" tip sheet is a guide providers can use to assist fathers in being active in their kids' lives and the benefits of being active.
- "Are They Good for Your Kids?" brochure is a guide for caregivers introducing new friends, love

interests or other adults into their child's life. This brochure also comes in Spanish.

- "Are They Good for Your Kids?" postcard used to direct individuals to the child sexual abuse prevention interactive landing page.
- "Are They Good for Your Kids?" posters used to direct individuals to the child sexual abuse prevention interactive landing page.
- The Internet Safety Toolkit is an easy to comprehend guide for parents and caregivers to provide education on internet safety.
- "How to Prevent Childhood Drowning" tip sheet provides 20 tips to prevent childhood drownings. Also comes in Spanish.
- "Parenting Over 50" tipsheet used to support grandparents raising grandchildren as well as other caregivers over the age of 50.
- "We Can ALL Reduce the Risk of Child Sexual Abuse" brochure educates readers on the dynamics of child sexual abuse and prevention strategies.
- "How do I Choose a Safe Caregiver or Child Care Provider" Tip Sheet educates readers on the importance of choosing someone safe to care for their child.
- Healthy Development Informational Cards, reflecting tips for ages ranging from infancy to teenage children, demonstrate ways caregivers can support the healthy development of their children at any age.
- "As a Family, What Can We do to Reduce the Risk of Child Sexual Abuse" Tip Sheet educates families on ways to reduce the risk of child sexual abuse for the children in their lives.
- "Safety and Awareness for Everybody" tip sheet gives advice on having conversations with children regarding child sexual abuse. It is divided into different age groups. Also in Spanish.
- "When a Child Talks About Sexual Abuse…" Tip Sheet addresses how adults should react and respond to child sexual abuse disclosures.
- "Child Sexual Abuse Risk Reduction Protocol for Youth-Serving Organizations" is a guide designed for youth-serving organizations who are interested in adopting strategies to prevent child sexual abuse.
- "Home Safety Checklist: Ensuring Safe and Healthy Childhoods "is a checklist for parents to utilize to help keep their children safe from household dangers ranging from swimming pools to trampolines. Also comes in Spanish.
- Prevention Pals tip sheet utilized by caregivers on how to help children and youth understand home safety.
- Upstream Primary Prevention posters used to create awareness for primary prevention.

All resources are driven by needs identified within Kentucky and designed to meet the needs of parents and professionals. For instance, because abusive head trauma is the primary cause of physical abuse deaths in Kentucky, tools and awareness campaigns addressing this have been deemed critical. Also, current data shows increase in unintentional home injuries associated with medication storage and unsafe sleep practices of which are also included in this year's array of promoted materials. Two-hundred fifty (250) "Prevention Packs" were distributed across eastern KY with primary funding from the Berea College Appalachian Fund. "Prevention Packs" provided new caregivers with information on safe sleep, abusive head trauma, parental stress, choosing safe caregivers as well as a sleep sack to reiterate safe sleep practices. Providers receiving packages to distribute to clients also attended an informational session outlining one-on-one client interactions used to promote this education vs. simply providing clients with packages without guidance or instruction. In total 17,370 resources were distributed through the Prevention Pack effort in 2023.

PCAK works to ensure the online resources are available online at www.pcaky.org, to include electronic copies of all available brochures, parenting tip-sheets, and tools for involvement in awareness campaigns such as Pinwheels for Prevention or CAPM. The online Information and Data Center continues to be used widely throughout the state for ordering and downloading child abuse prevention resources: https://pcaky.org/information-data/digital-downloads/. Additional information is available on PCAK's YouTube channel.

Through a grant from the Child Victims Trust Fund, PCAK developed and launched an all-encompassing guide with our child sexual abuse prevention materials. The guide and corresponding assets were distributed to PCAK Partners in Prevention and other trainers across the state to ensure all interested received materials.

With CBCAP support, a new movement inspired by Prevent Child Abuse Arizona and Casey Family Programs called, Lean On Me was launched in Kentucky in consultation with DCBS. A toolkit with videos and action steps, applicable to all Kentuckians was launched and utilized to promote being a mandatory supporter. A Community Supporter pledge was also created, and many notable figures have taken the pledge, including the Governor at the annual Pinwheel Planting press event. Twenty (20) postcard-sized cards have also been created and distributed, with the following messages:

- Accept Help
- Ask for Help
- Be Open to All Families
- Be Specific
- Be There
- Care About Kids
- Create Welcoming Spaces
- Explore All Solutions
- Keep Your Word
- Know Your Community
- Listen More; Talk Less
- Sharing is Caring
- Show Support
- Spread the Word
- Stay Positive
- Support Male Role Models
- Teach by Doing
- Understand Caregiving is Stressful
- Value Diversity
- We Are All Humans

The agency continued to work with CHFS, community partners, and when appropriate, national organizations, to stay abreast of current variables in the field of child abuse and neglect prevention in an on-going effort to maintain and expand our resources Trends continuing to emerge in 2023 include cyber safety, preventing unintentional home injuries, unintentional firearm injury prevention, supporting LGBTQIA+ children, child sexual abuse prevention, abusive head trauma, neglect prevention, grandparents raising grandchildren, working with children with special healthcare needs, trauma-informed care, building child and caregiver resiliency, child fatality/near fatality prevention and strengthening families through building protective factors.

Citizens and professionals are encouraged to utilize PCAK's awareness tools to educate and advance their knowledge as to the existence and impact of child abuse and neglect. The utilization of social media has proven to be advantageous for the agency, allowing PCAK to reach a multitude of citizens who may not have traditionally been familiar with the agency.

PCAK tracks baseline data regarding awareness tools requested and distributed. Included in this tracking system are the parties requesting materials, number of materials requested and distribution location. PCAK believes awareness promotes education, which, in turn, plays a relevant role in the reduction of incidences of child abuse and neglect. In 2023 over 77,058 pieces of materials were distributed across the Commonwealth designed to educate and promote awareness of child abuse and neglect. PCAK encourages the reproduction of this literature, many agencies make copies of the brochures and pamphlets sent to them by PCAK and distribute them to other local agencies and civic organizations. To assist in meeting this need, PCAK has developed printer friendly online versions of printed material.

Facebook/Meta changed the metrics able to be pulled for analysis. During 2022, there were over 9,800 visits to PCAK's Facebook business page (an increase of 145.8% as compared to CY 2022) and 407 new followers. Twitter/X impressions were 88,548 from 3,782 followers. Instagram followers grew by 125 new followers.

PCAK evaluates the *Information and Data Center* using tracking and distribution databases. Consumer satisfaction surveys and inferential statistics are utilized as well to determine the needs of consumers throughout the state:

The most requested informational brochures continue to address abusive head trauma and child sexual abuse prevention. Newer topics addressing the prevention of unintentional home injuries, water safety and fatherhood are also among those most requested.

The agency has a wide variety of resources available, and at times has difficulty meeting the demand. The agency is using technology to assist in providing this information in a more efficient and cost-effective means. This need has driven the PCAK agency goal to make the *Information and Data Center* Kentucky's premier source for child abuse and neglect prevention information. The Center informs Kentuckians via data, research findings, national and state trends and best practices; and will uses all media formats to inform the public of PCAK programs, trainings and child abuse prevention initiatives.

PCAK Fatherhood Initiatives: PCAK has provided community services and education geared toward greater engagement of fathers for over 17 years, particularly around child abuse prevention. The focus of PCAK efforts has been on improving outcomes for children by enhancing the engagement of fathers. PCAK strives to engage local and statewide partners in efforts to raise awareness on the importance of fathers in improving outcomes for children and the need for a cross-systems approach to enhancing the community's capacity to effectively engage fathers.

Partnerships cultivated in this effort to assist in the distribution of fatherhood training and resource materials. These partnerships have been particularly important as PCAK has been a leader to help create a statewide collaborative, the Commonwealth Center for Fathers and Families (CCFF), formerly identified as the Kentucky Fatherhood Initiative. CCFF is now a stand-alone 501(c)3 and our partnership with this newly formed organization continues.

The KY Department for Income Support and Child Support Enforcement Division works with CCFF and others to host the annual Fatherhood Summit. PCAK serves on the advisory committee for this event and will continue to do so in the coming year.

Thriving Families, Safer Children: Prevent Child Abuse Kentucky participates in the Thriving Families, Safer Children movement by working with DCBS, KY SEAT, the CCFF, the Kentucky Partnership for Families and Children and others to empower individuals and communities to support families to ensure they stay together without disruption. Through this movement, PCAK meets monthly with the Thriving Families Leadership team to promote this collaborative effort through Lean On Me Ky and other similar initiatives. PCAK received a grant from the W.K. Kellogg Foundation in conjunction with Prevention Child Abuse America to support this movement and lift the voices of individuals with lived experience as leaders. Activities include leadership academies for families and more. This effort has additionally provided leaders in this work the opportunity to learn from other states and groups working towards implementing parent engagement into their programming and leadership.

Lean On Me Kentucky: The Lean On Me Kentucky (LOMKY) movement reflects moving away from surveillance of parents towards a culture of support for families raising children. All levels of society can impact families by building protective factors and being a resource for caregivers to lean on before the need for child welfare involvement. Lean On Me Kentucky is purposefully mentioned throughout this report as this movement touches all aspects of our work with its purposeful focus on primary prevention. As mentioned previously, in conjunction with DCBS and the Governor's Office, LOMKY was launched in March 2023 and includes an array of resource tools. Post launch, PCAK partnered with WellCare, The Kentucky Chamber of Commerce, and many other associations and organizations to create awareness of this movement. A supplemental training was created to aid communities to better understand and communicate child welfare data in a manner that leads the public to action. This training was held three times and had 107 participants. Additionally, nine LOMKY trainings were held educating 386 individuals. Training evaluations showed 98% of training attendees better understand the need to reframe child maltreatment messaging and data, report a better understanding of primary prevention, and feel better prepared to support families prior to the need for child welfare involvement. Through partnerships with groups such as CCC, 27 LOMKY presentations were presented to 1,239 Kentuckians.

PCAK staff and DCBS leadership met with facilitation services hosted by the UofL Center for Family and Community Well-being to host a visioning session surrounding next steps for LOMKY in the coming years.

CC. Standardized Screening and Assessment

Project SAFESPACE was a five-year $2.5 million grant entitled *Promoting Wellbeing and Adoption after Trauma*. The grant was funded by CB. The grant ended September 29, 2018. At that time, DCBS initiated a contract with UofL to maintain one clinical consultant position through state funds, as well as the subcontract with Advanced Metrics to access the KIDnet system for web-based data entry of the functional assessments. Screening and assessment are fully integrated into the department's practice.

Screening and assessment are designed to enhance behavioral health services for children in OOHC through implementation of a continuum of evidence-based universal screening, functional assessment, outcome-driven case planning, treatment, and descaling of ineffective services. Screening and assessment occur statewide for children in OOHC.

The clinical consultant continues to collaborate with DBHDID and the DCBS Training Branch. During this reporting period, the implementation team continued to hold monthly steering committee meetings to drive the work forward and engage in collaborative decision-making. The clinical consultant regularly interfaces with community partners, including private providers, CMHCs, and other agencies (including the KPFC, The Praed Foundation, and Aetna Healthcare).

Standardized screening and assessment implementation includes a process for early identification of child trauma and behavioral health needs through standardized screening and assessment. DCBS frontline staff administer a compilation of screeners based on the child's age upon entry into OOHC, (e.g., Child Post Traumatic Stress Disorder (C-PTSD) Symptom Scale, CRAFFT, Strengths and Difficulties Questionnaire, Upsetting Events Survey, and Young Child PTSD Checklist). Screeners are specifically to be administered within ten business days of entry. For children seven years and older, the screener should primarily be informed by the child whereby information is solicited in a face-to-face interview. Screening is completed in Kentucky's CCWIS, whereby scores are tabulated and both detailed and summary reports are generated. The screening and assessment process expanded to include youth in in-home DCBS cases in all nine DCBS service regions in August 2023. This process was supported by the System of Care FIVE grant held by the DBHDID. In these cases, screeners are completed by the DCBS worker within 30 calendar days of an in-home case being opened. With parent permission, screeners are completed for all children in the home. If indicated, youth who "screen in" are referred for a Child and Adolescent Needs and Strengths (CANS) assessment.

Screening is designed to achieve standardized decision-making and give priority to those in need of behavioral health services, inform the provider about child and family needs, alert the child welfare worker as to the child's perception of experiences, engage caregivers and youth around assessment and treatment needs, and support leveling and placement.

Children identified as in need of a standardized clinical assessment receive a provider-completed CANS Assessment. Kentucky is currently using both the younger and older child versions of the CANS, (i.e., ages 0-4 and 5-17 years). The Kentucky CANS assesses six domains, 69 items for younger children, six domains, and 79 items for children ages five and older. Providers have 30 days to complete the initial CANS and then update the CANS every 90 days as long as the child/youth and family are receiving services from the agency. Providers complete the CANS in a web-based application that interfaces with CCWIS. Through an automated data push and pull between CCWIS and the CANS web-based application, child demographic information remains consistent across the systems ensuring data integrity. In return, high-level assessment information is communicated directly back to the DCBS frontline staff in the form of a report detailing significant areas of concern, strengths, change over time, recommended EBP, and intensity of service. This streamlined approach allows for efficient information sharing and aggregate data matching aligning child needs and treatment with child welfare outcomes. DCBS staff are trained to use CANS results to better understand clinically identified treatment needs and monitor progress. Assessment results are used to engage caregivers and youth, communicate with providers and partners, and to incorporate in case planning at the 90-day family team meeting.

Rates of compliance regarding completion of the screener and CANS assessment were analyzed for each region during CY 2023. The table below describes the number of children in OOHC requiring a screener (based on days in OOHC and age), the number of children screened, the number of children who needed a CANS assessment based on screener results, and the average amount of work days for screener completion.

Region	# Children Entered OOHC	# Children Screened	% Children Screened	Average Number of Days for Screener Completion	# Children Screened in for CANS	% Children Screened in for CANS
Eastern Mountain	376	359	95.48%	5.48	293	81.62%
Jefferson	361	305	84.49%	9.65	209	68.52%
Northeastern	361	315	87.26%	8.87	255	80.95%
Northern Bluegrass	622	478	76.85%	8.84	386	80.75%
Salt River Trail	536	335	62.50%	10.71	249	74.33%
Southern Bluegrass	493	355	72.01%	15.88	265	74.65%
The Cumberland	527	480	91.08%	9.655	331	68.96%
The Lakes	474	422	89.03%	12.705	299	70.85%
Two Rivers	755	567	75.10%	10.265	441	77.78%
Statewide	**4,505**	**3,616**	**80.27%**	**10.225**	**2,728**	**75.44%**

There continues to be a slight decrease in screener compliance, with 80.27% of youth entering OOHC receiving a screener in CY 2023. DCBS Leadership continues to report that high turnover rates and low staffing impact screener completion and timeliness.

Of the 846 screeners showing as past due, 208 of these youth have exited OOHC. Twenty-three (23) of these youth exited OOHC before their screeners were required to be completed. Table 2 highlights the youth with screeners that are showing as past due. Children aged seven and under are the most likely not to have a screener completed. More than 50% of past due screeners are for youth in this age group, of which more than 60% are age three and under.

Region	# Screeners Past Due	# Children Exited OOHC	# Children Exited OOHC before screener due date	Average Days in OOHC
Eastern Mountain	17	6	2	28.00
Jefferson	54	5	2	17.50
Northeastern	46	9	0	37.92
Northern Bluegrass	131	38	0	46.67
Salt River Trail	185	41	0	50.38
Southern Bluegrass	135	22	0	48.50
Cumberland	46	26	1	35.12
The Lakes	49	16	0	40.41
Two Rivers	183	45	0	45.16
Statewide	**846**	**208**	**23**	**44.30**

The following screeners are administered to children under five entering OOHC: Young Child PTSD Checklist (ages zero to six) and the Strengths and Difficulties Questionnaire (ages two and older). Children identified as needing an assessment receive a CANS assessment. The younger child CANS has a minimum of six domains and 69 items.

CANS Compliance: In 2023, more than 5,000 children received a CANS Assessment from a behavioral health provider. Nearly 13,000 CANS Assessments were completed in 2023. Of the CANS completed in 2023, 12.58% were completed for children ages 4 and younger. CANS compliance continues to be an area of focus. More than 93% of children placed in private child caring/placing agencies have received at least one CANS assessment. Conversely, nearly 70% of children placed in state foster homes, relative placements, or with fictive kin do NOT have a CANS assessment. There are many barriers to completion, including referrals needing to be made timely, foster families choosing non-CANS-trained providers, and the child's age (children under the age of five account for more than 40% of past due CANS).

In 2023, 904 referrals were sent to CMHCs for CANS assessments. Of these referrals, only 10.94% of CANS Assessments were completed. CMHCs have continued to report the following barriers to timely completion of the CANS: foster parents do not return phone calls to schedule intake appointments and CANS assessments, youth placed in foster homes move placements before they are seen, and foster parents take youth to providers who are not approved to complete CANS assessments. In 2023, 156 youth were referred to CANS trained independent/private providers. Only 15.38% of these youth received a CANS Assessment. Similar barriers exist for youth referred to private providers as those for CMHCs. A new referral procedure is in development so that referrals are sent automatically to agencies that are approved to complete CANS assessments for children in state foster homes, relative placements, or with fictive kin. This request remains in the development queue.

All children entering OOHC during the reporting period were targeted for screening. Any child identified through screening as needing a CANS assessment and served by a community mental health provider, independent provider, or a PCC/PCP agency should have received a CANS assessment.

Standardized screening and assessment was expanded to include youth receiving in-home services from DCBS in August 2023. The SOP related to this expansion is still in development. With funding from the SOC FIVE Grant held by DBHDID, staff from University of Louisville completed focus groups with behavioral health providers, child welfare staff, and regional liaisons. Additionally, the team from UofL conducted administrative data analysis.

The review of the administrative data regarding screening identified the following:

- Of youth who were screened, the dispersion by race is approximately the same.
- With regard to youth who met the clinical threshold for a CANS assessment, statistically significant differences between racial groups were found in 2018, 2019, 2021, and 2022.
- However, when assessing the percentage of youth, from 2019-2022 between two-thirds and three-quarters of youth in a known race category met clinical threshold for a CANS assessment.
- With regard to youth who met the clinical threshold for a CANS assessment, statistically significant differences between age groups were found in all four years.
- There was a significant change in the percent of youth aged 0-3 who met the clinical threshold for a CANS assessment (2018=27%, 2022=69%).
- Though the qualitative findings suggest screenings for youth aged 0-3 may not inform a case decision, findings from screening instrument data do not support this.

- Close to one-third of youth met the clinical threshold for a substance use assessment.

The review of the administrative data regarding assessment identified the following:

- 60% or greater of youth who met the clinical threshold received a CANS assessment for 2018 through 2020. This percentage decreased in 2022 to 48% of youth.
- This pattern held when delineating youth who received an initial CANS only compared with youth who received an initial and subsequent CANS assessment.
- Though statistically significant differences were found between race categories, no patterns emerged with regard to receipt of CANS assessment.
- Although screening for youth ages 0-3 increased between 2018 and 2022, this pattern was not observed for CANS completion.
- PCC and PCP agencies complete CANS assessments at a much higher rate when compared with CMHC agencies or independent and private providers. The pattern of declining completion of CANS assessments in 2022 held for provider agencies.

A summary of focus group findings with DCBS staff is included below:

- DCBS staff have a solid understanding of the purpose of the Screening process.
- A multi-pronged approach is used to gather information for the screening questions.
- Caseworkers use the information from the CANS report in varying ways including case planning.
- Communication and collaboration between DCBS and behavioral health providers varies by region and provider.
- DCBS liaisons assist in accessing and tracking information and play a critical role.
- Lack of buy-in to the screening and assessment process remains for some.
- DCBS staff have concerns about the quality of assessment and treatment by behavioral health providers.
- Contextual barriers to screening exist:
    - Screening of 0-5 age youth
    - Screening of youth with developmental delays
    - Timing of completing the screening instruments

A summary of focus group findings with behavioral health providers is included below:

- Clinicians are utilizing the CANS assessment to varying degrees.
- DCBS liaisons assist clinicians in accessing needed information.
- High compliance agencies provided valuable information on ways to effectively implement the CANS assessment.
- Yet, high compliance agencies also struggle with aspects of the assessment itself.
- Contextual barriers to CANS implementation exist:
    - Assessment of family and caregiver needs
    - Assessment of 0-5 age youth
    - Assessment of youth with developmental delays

Efforts will continue to focus on full integration into casework and treatment planning for DCBS staff. The clinical consultant will continue to provide at least monthly CANS training and support providers (CMHCs, PCP/PCCs, and independent providers) as they utilize the CANS. The clinical consultant also provides monthly CANS Refreshers for previously trained clinicians to receive additional training and support in using the CANS. The clinical consultant also works closely with DCBS regional liaisons to

ensure referrals are sent to CANS-trained providers promptly. The clinical consultant continues to engage additional providers so DCBS workers and families have more options for services.

Barriers continue to exist related to referral practices and the use of non-CANS trained providers. Enhancements to the system have been requested but have yet to be funded. The clinical consultant will also devote time to case reviews to ensure quality screener and CANS completion.

With the findings from the review of the administrative data and focus groups, a collaborative decision was made between DCBS and UofL to expand UofL's contract to include data analysis in the future. The proposal includes adding additional support staff to support the screening and assessment process for youth in OOHC and those receiving in-home services from DCBS. If approved, the contract will go into place July 1, 2024.

DD. Rape Crisis Centers

Kentucky has 13 regional rape crisis centers (RCCs) which cover all 120 counties, and operate on a regional model, with each center covering anywhere from five to 17 counties. The ADD model was used as the template for RCC coverage. Kentucky's RCCs are governed by KRS 211.600-608 and 922 KAR 8:010. There are four configurations of the RCCs: independent RCCs (sexual victimization only), independent dual RCCs (sexual assault/CAC's), independent dual rape crisis and domestic violence center, and CMHC-based rape crisis program. All configurations are 501(c)(3) non-profits and have independent Boards of Directors that provide governance.

Kentucky's RCCs provide services to victims of all ages who have been sexually abused and/or assaulted. Additionally, the centers provide intervention services to the victim's family and friends to support the healing process of sexual victimization.

The following services are available at every RCC:

- 24-hour Rape Crisis Line. Call 1-800-656-HOPE (4673) to be connected to a local RCC.
- Counseling and support for survivor and for family and friends.
- Accompaniment and advocacy in hospitals, law enforcement settings, and other legal settings.
- Therapy services or professional referrals for therapy.
- Support groups or professional referrals to support groups.
- Referrals to appropriate community resources.
- Assistance with Crime Victims Compensation Fund claims.
- Prevention & Public Awareness Programming, presentations may be available on the following topics:
    - Green Dot in KY High Schools and Communities – evidence informed bystander intervention curriculum that has proven effectiveness in reducing rates of sexual violence perpetration, victimization, sexual harassment, and bullying.
    - It's My Space--evidence informed intervention designed to reduce dating violence and sexual harassment among middle school youth by highlighting the consequences of this behavior for perpetrators and increasing faculty surveillance of unsafe areas.
    - Dynamics of Sexual Violence.
    - Legal and Medical Aspects of Sexual Violence.
    - Dating Violence and/or Healthy Relationships.
    - Rape Awareness and Prevention.
    - Responding to Violence in Faith Communities.

- Sexual Harassment.
- How Family & Friends Can Help.
- Child Sexual Violence & Adult Survivors of Child Sexual Violence Consultation.
- Consultation for professionals working with survivors of sexual assault.
- In-service trainings for professionals.

RCCs receive funding from several sources to provide services, including CHFS. Data is collected and submitted through quarterly reports from each RCC to the program administrator at CHFS. Data collected includes demographics of victims served, crisis hotline calls, medical advocacy and assistance with the sexual assault forensic evidence exam, court advocacy information, crisis and long-term counseling, community education/professional trainings, and volunteer service hours.

Each RCC is a private 501(c)(3) agency and is encouraged to seek out additional revenue streams. RCCs receive their funding through subcontracts with each of the 13 regional RCCs. The cabinet has an MOU with Kentucky Association of Sexual Assault Programs (KASAP) to administer the funds that the cabinet receives for rape crisis work. The SFY 2024 contract includes state general funds in the approximate amount of $7.1 million, as a group, $1,151,981 in Family Violence Prevention and Services Act, American Rescue Plan Grant to Support Survivors of Sexual Assault from the ACF, $673,544 in Rape Prevention and Education funds from the CDC to Kentucky's DPH and passed on to DCBS for the implementation of primary prevention programming, including the nation's first evaluated, evidence informed bystander intervention program (Green Dot in KY High Schools) and $94,065 in Preventive Health and Health Services to further support primary prevention efforts. RCCs also write and receive several federal (i.e., Victim of Crime Act, Violence Against Women Act (VAWA), and Sexual Assault Services Program) and local grants (i.e. United Way, local fiscal government awards) that are not included in the contract with KASAP and are driven by each agency's Board of Directors' fundraising ability.

There are 13 RCCs strategically located in each of the 15 ADDs. These RCCs therefore are deemed regional RCCs and aim to serve victims and family members in each county of its respective ADD. RCCs serve an average of nine counties with some RCCs serving as many as 17 counties. DCBS contracts with KASAP, the member-based federally recognized state sexual assault coalition that represents the individual RCCs on issues related to all RCCs.

The RCCs work collaboratively with several partners to achieve the outcomes that they have experienced over the years. DCBS children and their caretakers make up 7.3% of the RCC new victims receiving services. Close work with DCBS frontline staff and RCC advocates and/or clinicians provides a critical link in the well-being of DCBS children who may be in out-of-home placements due to documented abuse or neglect. RCC advocates are also members of each county's multidisciplinary teams that staff child sexual abuse cases. This opportunity to connect with the legal guardians of children in care improves the overall outcomes of children navigating the long journey of healing after reporting or disclosing sexual abuse. Many representatives from other child-serving or victim-serving agencies sit on various RCC boards of directors, reflecting the core mission of most communities to stop abuse from happening to their children. Additionally, as part of their subcontract, each RCC has agreed to build and retain collaborative partnerships with culturally specific service agencies and other community partners to ensure that persons from marginalized communities have access to meaningful and relevant sexual assault services. These partnerships vary by region based upon availability. Some examples include collaborations with local LGBTQIA+ Pride organizations, collaborative forums focusing on people of color, provision of psychoeducational groups in substance abuse treatment programs,

activity on community task forces addressing immigrant/refugee populations, and many others. These activities are discussed and noted during annual program monitoring.

Rape Crisis Center Data: CY 2023	
Service Category	**Number of Services Provided/ Persons Served**
New victims served	3,244
New family & friends served	926
Legal advocacy services: court, case management, referrals to services	3,683
Medical advocacy services: sexual assault forensic exam (SAFE), follow up exams, referrals for further medical treatment	1,790
Crisis calls received	88,345
Counseling sessions provided	18,982
DCBS client total	396
Prevention/education sessions (including Green Dot in KY high schools)	5,073
Prevention/education participants (including Green Dot in KY high schools)	1,798,976
Volunteer hours	33,207

922 KAR 8:010 was updated by a committee of the KASAP Board in collaboration with DCBS staff and went into effect in October 2020. The KY Board of Nursing has approved a regulation change (in place since 1996) governing Sexual Assault Nurse Examiners (SANE) to permit the training and credentialing of pediatric/adolescent SANEs. Until this time, SANEs could only perform forensic examinations on children ages 14 and above. KASAP has traditionally been the only trainer of SANEs, however, is now collaborating with pediatricians serving in CACs to develop the didactic and clinical portions of SANE P/As, who will meet children and their families in hospital emergency departments, where the RCCs will dispatch advocates to meet them. Victims of chronic child sexual assault will still go the CAC and will be examined by a pediatrician. In addition, since the passage of the 2016 SAFE Act, RCC advocates are assisting law enforcement in reducing the backlog of rape kits by helping them notify victims.

Each RCC captures client feedback after services are completed. In the most recent iteration of the RCCs self-evaluation of advocacy and counseling services, Healing Voices 2012, the 13 RCCs demonstrated significant reduction in trauma symptoms by victims attending counseling services. The biggest reductions in trauma symptomology and increases in one's sense of empowerment were reported by clients attending ten or more counseling sessions. Likewise, advocacy services were reported to be similarly effective in reducing victims' negative experiences through the legal and medical advocacy services offered by RCCs.

Clients receiving services at RCCs say:

- "This place saved my life."
- "I feel so much better with everything. I cannot trust anyone usually and I feel safe with all the
- workers here they are helpful with everything. I would refer anyone here for treatment."
- "I am glad I finally took the step to come here & seek help & believe in the end it will help me."
- "This is my safe place. And, I'm getting more healthy."
- "The center always gives me help and hope."
- "I am ready to deal, heal and thrive!"

The regular trend seen within RCC data is an increase in services with either stagnant or decreasing funds to support the work required. There was some decrease in service provision during the 2020 calendar year due to the COVID-19 pandemic. However, all services were on the rise throughout 2021 and 2022. At the onset of the pandemic, RCC's quickly pivoted and developed systems to ensure service delivery could continue to the fullest extent possible via virtual platforms for many services and have maintained those systems in additional to face to face services when possible.

RCCs continue to improve their evidence base of effective services to victims of sexual crimes. One of the few coalitions focused on establishing and improving outcomes related to victims' services, KASAP and its 13 member organizations show commitment to and excellence in providing quality services to Kentucky's victims of sexual crimes.

EE. Safe Infants/Safe Haven

KRS 405.075, part of "The Representative Thomas J. Burch Safe Infants Act" provides that a person may leave a newborn infant less than 30 days old with an emergency medical services provider, police station, fire station, hospital, or participating place of worship. The Safe Infants Law states that the parent will not be criminally prosecuted for abandoning an infant less than 30 days old, if the baby is taken to one of the above-determined safe places and has not been physically abused or neglected after birth. The parent may voluntarily provide information about the baby. Within 30 days of infant abandonment, the parent may ask for return, and DCBS may provide services to the parent to help the family stay together and safe. After 30 days, the cabinet will begin the process of terminating the parental rights and making the child available for adoption. The statutory provisions afford parents a safe and anonymous option when they are unable to care for their newborn children. The provisions also help children obtain more timely permanency. The program's funding is included in Multiple Response, which is funded through SSBG and state funds.

The department's central office continues to receive requests for safe infant brochures and packets from community agencies. The requests are routed to the state Board of Emergency Medical Services (EMS) that compiles hospital packets and mails them to requestors. The department consistently receives requests for these packets from law enforcement, fire departments, and hospitals. Program information is available on https://chfs.ky.gov/agencies/dcbs/dpp/cpb/Pages/safeinfantsact.aspx. The website also contains a list of FAQs and a recently updated PowerPoint presentation by the state Board of EMS. Brochures have been translated to Spanish and were purchased for distribution to all universities, colleges, and DCBS offices across the state. In previous years, the cabinet's Office of Communications also issued a statewide press release regarding the details of the Safe Infants Act.

As a result of amendments to the Safe Infant Act in the 2016 legislative session, DCBS began working with partners at PCAK and Norton Children's Hospital to increase awareness of the program. DCBS and partners have consulted with Timothy Jaccard, founder/president of AMT Children of Hope Foundation in New York and is considered the father of the national safe haven initiative http://www.amtchildrenofhope.com/index.php. Mr. Jaccard has shared information and resources to include signage, hospital protocol manual, and access to his AMT Children of Hope Foundation hotline that helps pregnant and new mothers 24/7 who are considering a safe infant placement for their child. In collaboration with PCAK and Norton Children's Hospital, a hospital protocol was developed for utilization in hospitals across the state that includes appropriate signage to designate safe infant sites. DCBS continues to work with these agencies to finalize the materials.

In the 2016 legislative session, amendments were made to the Safe Infants Act by extending the relinquishment period from 72 hours to 30 days after birth. In addition, the amendment added participating places of worship to acceptable safe infant sites. KRS 405.075 was amended by the General Assembly to include the following language: "(5) A staffed police station, fire station, hospital, emergency medical facility, or participating place of worship may post a sign easily seen by the public stating that: "This facility is a safe and legal place to surrender a newborn infant who is less than 30 days old. A parent who places a newborn infant at this facility and expresses no intent to return for the infant shall have the right to remain anonymous and not be pursued and shall not be considered to have abandoned or endangered their newborn infant under KRS Chapters 508 and 530."

Program History (2002- 2023): There have been 75 safe infant incidents involving 76 infants since 2002. One incident involved a set of twins. Of the 76 infants, ten were delivered in the home, one was delivered in a hospital parking lot, 60 were delivered in the hospital, one left at an EMS station, two surrendered at a fire station, and one left in a Safe Infant Box. The infant delivered in the hospital parking lot was discovered at the hospital entrance. Neglect was substantiated, but the judge determined probable cause that the child was left with the intent to utilize the Safe Infant Act. Of the 76 infants, 56 have been adopted, four have pending TPRs or adoptions, 14 were returned to their parents, one child was placed with the maternal grandmother at the parents' request, and one intake was changed from Safe Infant to an abuse/neglect investigation.

The average length of time to TPR is approximately 6.9 months, with two months being the shortest amount of time and 13 months being the longest. In recent, years there has been ongoing litigation surrounding the Safe Infant Act resulting in the courts TPR/adoption process being prolonged. The average length of time for adoption to occur is approximately 5.68 months. One case from 2007 took 37 months for adoption to finalize, as the child was born with severe birth defects, and the adoptive parents waited for surgeries and medical interventions to occur prior to adoption.

All nine service regions in Kentucky have had at least one case involving safe infants. The number of Safe Infant Act incidents per region are as follows:

- Two Rivers: 32
- Southern Bluegrass: 9
- Northern Bluegrass: 5
- Jefferson: 6
- Northeastern: 6
- Salt River Trail: 6
- Cumberland: 5
- Eastern Mountain: 1
- The Lakes: 6

The ages of identified mothers in safe infant cases were 15, 17, 18, 22, 23, 24, 25, 26, 27, 28, 30, 33, 34, and 40. The ages of thirty-five mothers remain unknown. The infant gender breakdown has been 35 males and 41 females.

The breakdown of race and ethnicity of infants has been 32 White, 10 African American/Black, two Hispanic, one Indian, one Bosnian, seven Bi-racial, and 22 unknown/declined to disclose. Some children previously classified as unknown were reclassified as Bi-racial as additional information on accuracy was obtained.

The identified reasons cited for abandonment in safe infant cases included:

- had other kids and could not financially afford another,
- five infants were the product of rape,
- mother under age 18,
- already has one child and cannot handle a second one,
- cannot care for the child,
- an alternative to abortion,
- husband does not want the child,
- wants to give the child a better life,
- 15-year-old mother fearful the maternal grandfather would kill her,
- child had severe birth defects,
- mother experiencing homelessness,
- mother wanted to anonymously place child up for adoption,
- mother overwhelmed and afraid she will hurt the baby,
- mother concerned she'll be disowned by her family due to cultural issues,
- parents were undocumented immigrants afraid of deportation,
- baby will not be able to receive the medical care needed,
- One mother reported using the Safe Infants Act with a previous child, and
- Health issues identified of babies at adoption: asthma, lung disorder, difficulty walking, and severe deformity. Most surrendered infants were healthy with no issues.

Two cases were thought to be safe infants but were reversed after circumstances changed the outcome. One case was in the Southern Bluegrass service region, and the mother returned to claim the child, only to sign a voluntary TPR later. The other case was in Two Rivers service region. The mother and a relative returned to claim the child and request relative placement, however, there were concerns for neglect. An emergency custody order (ECO) was granted. There were nine cases in which the parent returned to claim the child within specified timeframes, one being the child's natural father.

One case was accepted as safe infant but was later determined not to fit the criteria but has since been corrected. This case was initially accepted as Safe Infant, however, the infant tested positive for illegal substance following the initial hospital exam. Following the receipt of this information these allegations were submitted to Central Intake as a substance-affected infant case and the Safe Infant case was closed. This case is still shows up in the data for Safe Infant as the original Safe Infant intake remains with the explanation of closure provided.

Situations that occurred that could have perhaps been avoided if the Safe Infants Act had been utilized include the following:

- 2007: Infant left in a shoebox in an unoccupied duplex, not a designated drop-off. One infant was delivered then placed on a doorstep, not an appropriate location.
- 2008: Infant placed in a plastic bag upon delivery at Bellarmine College. There were two additional fatalities that occurred in 2008 that could have been avoided if the mother had utilized the Safe Infants Law.
- 2009: An infant was left in a garbage receptacle immediately after delivery with toilet paper stuffed in the infant's throat.
- 2011: An infant was suffocated by the teenage mother, who was charged with homicide.
- 2013: An infant was left in a garbage can inside a department store in Louisville. The mother was charged with abuse of a corpse and tampering with physical evidence.

- 2014: A mother reportedly did not know she was pregnant, delivered her infant at home, and placed the infant in a garbage can. The infant survived and criminal charges were filed. Also in 2014, the remains of an infant were located on the property of a home in deplorable conditions where nine other children were removed, and the parents were charged with wanton endangerment.
- 2015: 1) Mother delivered a baby in a toilet. She put the child in a garbage bag and was going to put the child in a dumpster until someone intervened. The infant survived. 2) The second occurrence of 2015 included a 15-year-old mother that delivered at a local hospital while visiting her grandmother. Mother wrapped the child in linen and put the baby in a dresser drawer. The infant did not survive, and the mother was criminally charged.
- 2017: A deceased infant was located inside a bag on a busy neighborhood street in Lexington. The mother was never located.
- 2018: 1) Mother delivered the baby at home. The infant was deceased upon arrival to the hospital. The autopsy concluded that the child was born alive, but suggested multiple scenarios, including heat exposure, smothering/suffocation, and neglect. Due to this information, the cause of death was determined to be homicide. 2) A baby was found in a garbage bag outside of an apartment complex. The autopsy showed the baby had cranial bleeding and fractured ribs. The infant did not survive, and the mother was criminally charged.
- 2019: DCBS received a near fatality investigation regarding a newborn found in a toilet by EMS. The mother gave birth at home, claiming to be unaware of the pregnancy. The infant was birthed into the toilet (head down) and left there until EMS arrived. The infant was in critical condition upon arrival to the hospital.
- 2020: Mother gave birth in the bathtub at home. The baby was born alive, but the mother indicated the infant stopped breathing shortly after delivery. She held child for 30 minutes, cut the umbilical cord with scissors, placed in a plastic bag, and hid the body in a laundry basket. Due to excessive bleeding, mother was taken to the emergency room and doctors questioned whether she had given birth. She denied the pregnancy and denied giving birth. She did not inform anyone of the infant's whereabouts until approximately 5 pm the following day when she called law enforcement and admitted what happened.
- 2023: Pendleton County mother was brought into the ER by her father for bleeding. She did not disclose that she had given birth but later disclosed that she had given birth earlier that day and then fell asleep. She stated she did not want the baby. Law enforcement found the deceased infant wrapped in a blanket. It was later determined that the infant had been born alive.

A noticeable trend is that most of the cases are from the Two Rivers Service Region. It appears that region is well-trained at assessing mothers-to-be and working with their local hospitals to counsel them with all options, including the Safe Infants Act. Additionally, most of the safe infants were born in the hospital and relinquished to hospital officials upon delivery.

The cabinet will continue to send information to requesting parties to maintain awareness of the program and work with community partners to educate and raise awareness for the program.

FF. Safety Net

Safety Net is a short-term intervention program that provides services to former recipients of TANF cash assistance who are no longer eligible for assistance due to failure to comply with participation requirements or reaching their 60-month lifetime limit of receipt. The goal of Safety Net is to prevent

out-of-home placement of children in these families. The program is funded through title IV-A and services are administered statewide.

Services are designed to assist families in developing the skills necessary to manage their home, family relationships, and prevention of home disruption. Activities include assessment of the family and home; problem solving; and intervention in crisis situations, including utility shutoffs or insufficient food, clothing, housing, employment, etc. Referrals to community resources may also be made to meet any immediate needs the family may have.

Staff from DFS notify DPP staff when a family is no longer eligible for TANF cash assistance due to failure to comply with participation requirements or reaching their 60-month lifetime limit of receipt. Within 15 days, DPP staff contacts the family to arrange a home visit to complete an assessment. After the completion of the assessment, DPP staff may help the family develop a plan of action and refer the family to community resources to assist in meeting any unmet needs of the family. If financial assistance is needed and the family is at or below 200% of the federal poverty level, the family may receive up to $635 for over a four-month period within the 12-month period following discontinuance. These benefits are used to meet basic needs such as shelter, food, clothing, or utilities.

Each service region is allocated a specific amount of Safety Net funds. A monthly log containing the name of the family, the purpose and amount of expenditure, names of families denied, and the resources utilized is maintained in each local office. In addition to the monthly log, DPP workers document how Safety Net prevented out-of-home placements and family instability. A copy of the regional log, invoices, receipts, and checks issued are submitted each month to DAFM.

During CY 2023, 12 families received Safety Net services. DPP's "Safety Net Tally" report and statewide for CY 2022, a total of $4,990.10 was spent on Safety Net services. This data shows an increase from the previous calendar year; in CY 2022, 14 families received Safety Net services for a total of $6,748.61 according to DPP's Safety Net Tally report.

During 2020, the CHFS Division of General Accounting conducted an Auditor of Public Accounts (APA) Audit of all TANF funded programs, including Safety Net. The 2020 APA Audit uncovered numerous areas needing improvement with the Safety Net program.

The APA Audit "Record of Control Weakness or Noncompliance" noted the following issues with the Safety Net program:

- Fayette County and Jefferson County did not perform assessments on potentially eligible individuals. In total for FY 2020, Fayette County had 61 potential Safety Net cases and Jefferson County had 347 potential cases. There was no evidence an assessment was performed for the potentially eligible families.
- The total payments from all counties on DPP's Safety Net Tally was $14,768. However, the state's accounting system total payments were $16,263, a difference of $1,495 for FY 2020. There is no explanation for the variance and no reconciliation performed between the two systems.
- There are two travel documents totaling $28 in the state's accounting system coded to Safety Net. Travel expenses are not allowable.
- For one Safety Net case out of 26 cases, CHFS paid $652; however, CHFS is only allowed to pay $635 per family, a difference of $17.

The APA Audit stated, “CHFS did not have internal controls in place to review Safety Net program eligibility requirements and make sure expenditures were for allowable costs”. Therefore, “CHFS was not in compliance with eligibility requirements for the Safety Net program. By not documenting the assessment of potentially eligible cases, individuals may not have received the Safety Net funds although they were eligible. Also, by overpaying in one case and paying for unallowable travel costs, funds available to help eligible individuals were reduced.”

The APA Auditors recommended that CHFS:

- Evaluate the eligibility requirements for Safety Net contained in the State Plan.
- Develop and implement internal control procedures to ensure compliance with Safety Net program eligibility requirements; and
- Review expenditures to ensure only allowable costs are charged to the Safety Net program.

Internal discussion among both DPP and DFS continues for Safety Net program improvement. No data/evaluation was conducted during CY 2023 for Safety Net. No consultative efforts or technical assistance was provided or received by the National Resource Center during CY 2023. There have been no changes in policy or practice during CY 2023. The cabinet intends to continue to provide Safety Net services for families who lose TANF benefits to prevent out-of-home placement of children and to assist the family in maintaining stability.

GG. Sobriety Treatment and Recovery Teams (START)

The Kentucky Sobriety Treatment and Recovery Teams (START) is an intensive intervention model for parents struggling with substance use and families with young children involved with the child welfare system that integrates SUD and recovery services, family preservation, community partnerships, and best practices in child welfare and SUD 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.

The key components of START are:

- Specially trained CPS worker and a family mentor share a caseload of families with co-occurring parental substance use and child maltreatment where at least one child is five or younger.
- The family mentor brings real-life experience to the team and is a recovering person with at least two years of recovery and previous CPS involvement. The mentor is rigorously screened, trained, and supervised to provide START families with both recovery coaching and help navigating the CPS system.
- Reduced caseloads for the START team of 15 families per worker/mentor pair.
- Integration between CPS, SUD treatment providers, and community partners by addressing differences in professional perspectives.
- 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 use treatment and close collaboration among CPS and service providers.
- Shared decision-making among all team players, including the family.
- Collaboration with community partners, SUD 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 use, mental health, and trauma; and
- Extensive program evaluation to indicate and document the program achievements and challenges.

Specific objectives are to reduce recurrence of child abuse/neglect; provide comprehensive support services to children and families; provide quick and timely access to SUD 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.

Kentucky START is based on the successful and nationally recognized START program that originated in Cleveland, Ohio. Kentucky began implementing START in 2007 and has modified and evolved the model to fit the needs of Kentucky families. State and federal funding is currently used to fund the program in seven counties: Kenton, Campbell, Boone, Jefferson, Boyd, Daviess, and Fayette. Due to positive outcomes and as part of Kentucky's title IV-E waiver demonstration project, START was expanded. Jefferson County and Kenton County added a second START team, and a team was implemented in Fayette County. Boyd County also began taking cases under the title IV-E waiver in July 2017. Daviess began taking cases under the waiver in July 2018. The title IV-E waiver ended September 30, 2019. In addition, in 2018, DCBS received funding for START to add two additional sites, in Campbell and Boone Counties through the Substance Abuse and Mental Health Services Administration (SAMHSA) funding from Kentucky Opioid Response Effort (KORE).

In 2006, Kentucky DCBS sought to improve the system of care serving families with co-occurring child maltreatment and SUDs by investing $2 million TANF maintenance of effort (MOE) funds annually into the Substance Abuse Initiative. A regional partnership grant was awarded to the DCBS in October 2012 to fund the expansion of the START program into Daviess County. This grant provided $2.5 million dollars over a five-year period.

The funds for SUD treatment are disseminated through contracts with six CMHCs: Centerstone, NorthKey, Kentucky River Community Care (KRCC), Pathways, New Vista, and Mountain Comprehensive Care Center. In five of these CMHC sites, a START program was established (NorthKey provides services for three sites, including one existing site and the two newer sites). In the sixth region, KRCC established the Solutions program which is a SUD treatment program serving women in the following counties: Breathitt, Knott, Letcher, Wolfe, Lee, and Owsley and serving men in Letcher, Lee, and Perry counties. With the expansion of Medicaid in Kentucky and a benefit to cover SUD services, DCBS was able to use less TANF MOE and title IV-E waiver funds for SUD treatment services. START requires CMHCs to bill all behavioral health services to Medicaid before using other funding. A process is in place for CMHCs to request funds for services that are not Medicaid or insurance billable. The START director and assistant directors oversee the approval of these funds when requested.

Kentucky became an early implementer of FFPSA in October 2019. START is one of the prevention services in Kentucky's FFPSA plan. START is rated as a supported practice on the Title IV-E Prevention Services Clearinghouse as an EPB. START is now a national model, being implemented in several jurisdictions across the nation. Kentucky utilizes title IV-E reimbursement for eligible families, as well as state general funds.

During CY 2023, START served 291 families, 496 adults, and 568 children. These numbers are broken down by county below:

County	Families Served	Children Served	Adults Served
Boone	20	50	41
Boyd	64	113	103
Campbell	26	41	49
Daviess	34	69	50
Fayette	63	121	95
Jefferson	40	74	70
Kenton	42	94	84
Pendleton	2	6	4
Total	**291**	**568**	**496**

In addition to direct services to families, START leadership and evaluation developed one manuscript in 2023:

Hall, M. T., Hardy, G. C., & Brooks, A. J. (under review). Methamphetamine use, substance use treatment complexity, and child welfare outcomes.

START also made two national presentations:

Hall, M. T., Hardy, G. C., & Bryant, S. E. (2023). *COVID-19 and fidelity to the Sobriety Treatment and Recovery Teams model.* Presented at the 27th Society for Social Work and Research Annual Conference. Phoenix, AZ.

Hall, M. T. (2023, December 12). *Kentucky's Sobriety Treatment and Recovery Teams & the Title IV-E Prevention Services Clearinghouse.* Presented to the Parent Partner Learning Collaborative's Evaluating Parent Partner Programs for Clearinghouse Readiness. Online.

In addition, the evaluation team and START leadership have continued documenting possible changes to START-IN that would improve data collection and evaluation.

In the Summer of 2022, the SDM® tool, an evidence-based tool created by Evident Change, was implemented by DCBS. The SDM® tool has restructured the way in which new reports are accepted, classified, and measured. Additionally, the tool is a key component of the new assessment process that rates families and children across values of well-being. The tool is being utilized throughout the intake and investigation process by staff across the state, including START sites. During the Summer of 2023, additionally pay increases occurred for DCBS staff. The results of which are being seen in many locations, as evidenced by, improving staffing levels. However, there are still areas that struggle to recruit and retain staff, notably in Jefferson County, Campbell County, Boone County, and Kenton County. START operates in all of these locations and continues to see reduced staffing.

The National Sobriety Treatment and Recovery Teams entity, managed through Children and Family Future (CFF), has developed an ongoing certification process for the review and certification of individual START sites. Certification is based upon adherence to the Essential Components and Fidelity

Standards of START. Effective September 2022, certification was awarded to Kentucky START's Jefferson, Kenton, and Boyd sites. Each of the three sites completed an annual review update in September 2023 to remain in compliance with the certification requirements.

Additionally, during this review period there was a new revised policy from the Executive Branch regarding telecommuting and hybrid work schedules for the commonwealth. Beginning in September 2022, the Governor issued new policy that mandated Executive Branch employees who work a hybrid schedule to be in the office three days a week, with the option to telecommute up to two days a per week. START has adopted a comparable protocol, requiring START family mentors to also work at least three days per week in the office with up to two days per week working remotely. All necessary field work is expected to be completed in-person regardless of hybrid scheduling.

DCBS executive leadership, in April 2022, made an announcement that there would be pay grade enhancements for DCBS employees with the hope to retain staff and be able to recruit new employees for the commonwealth. DCBS staff within designated classifications received a one-time pay adjustment that brought them up to 90% of the mid-point salary of their pay grade. This resulted in significant pay increases for most DCBS staff, including START DCBS supervisors and social workers.

Additionally, there continues to be a focus on developing consistent practice guidelines around substance exposed infants and how to address Neonatal Abstinence Syndrome (NAS). START leadership is involved in the state's plan of safe care to ensure compliance with CAPTA requirements.

In 2023, Kentucky START leadership received technical assistance from National START Training and Technical Assistance (TTA) from CFF. Three early adopters, and founding members, of the model (Jefferson, Kenton, and Boyd counties) were recognized as Certified Affiliates of the National START Model, with four counties moving toward full fidelity to fully orient the leadership team, support fidelity monitoring and certification in the remaining START counties and provide Kentucky with nation resources. This effort will continue into the next biennium. Kentucky START is also part of a national learning collaborative through CFF with other START sites across the nation and has participated in a workgroup focused on racial equity.

All START sites participate in both a process evaluation and an outcome evaluation. The process evaluation regularly monitors fidelity to the START model. Specifically, sites are evaluated on how quickly: (1) families are referred to START; (2) the first family team meeting is conducted; (3) adults are assessed by the drug treatment provider. Other process outcomes, such as retention and intensity of treatment, are regularly assessed.

In July 2023, the START evaluation team completed a fidelity report for all START sites. This represents data collected through December 2022. Major highlights include:

- 90% of referrals overall (whether they were accepted or not) were received within 14 calendar days, and about 98% of referrals met this threshold in 2022.
- START's goal is to conduct the first FTM within four calendar days of the referral. The percentage of families meeting the goal of four calendar days has increased every year since 2016, with a rate of over 80% in 2022 (the last year of complete data) and an all-time average of roughly 64%.
- Of all adults, over two-thirds met the goal of being assessed withing 4 calendar days. When we look at just focal adults – one person from each family – the percentage increases to 82.9%, meaning over 80% of families have at least one adult meeting the goal.

- For all treatment types, 78% of all START adults met the goal, compared to 84% of intensive outpatient (IOP) clients.
- 67% of all adults (and 75% of focal adults) completed the timeline between the date CPS initiated the investigation and the completion of the fourth treatment session (goal of 60%) in 38 calendar days.
- The average case length across all sites and years is 15.5 months, and about a month longer (16.5 months) for 2022, (most recent year for complete data).
- Across all sites and years, almost two-thirds of cases end with children remaining or being reunited with their parents. Another 26% end with children being placed with relatives, meaning 90% of families have children residing with parents or other family. Only 10% of START families have ended with parental rights being terminated.

START leadership has regular contact with regional leadership for each site to provide any updates, address challenges and to collaboratively support direct supervisors for the START teams. This will continue during the next review period with a focus on challenges specific to each site. High turnover of frontline staff, supervisors, and family mentors is a barrier in many sites. Additionally, a lack of referrals when eligible families exist is another concern. Education is provided throughout the sites to ensure that staff know when a family is appropriate to refer to a START team.

START teams' leadership have also been involved at a statewide level in racial equity work. This was a focus during the statewide START meeting and work is being done in each region around equity. START behavioral health providers through KORE and START leadership also participated in racial equity trainings during this review period. Additionally, there was a study published during this period that found Black children in START had higher rates of reunification and lower rates of repeat maltreatment than Black children served in traditional child welfare casework, as well as White children in START. Equity work will be a continued area of focus during the upcoming review period, as START intends to incorporate more members into the regional racial equity work groups.

Staffing issues have continued to be a challenge across multiple sites during this review period. A primary focus of this review period was on rebuilding teams. START leadership continues to consult with each region to assess the need for child welfare workers on START, as well as recruitment of family mentors. During the review period, several new social workers and two family mentors were onboarded into START. Unfortunately, START also saw several family mentors and social workers leave the program. Most of the family mentors who departed moved on to other opportunities (i.e. completed degree and became START social worker), which is a valued characteristic within the program.

Ensuring referrals are made to START with a shift to statewide Central Intake continues to pose a challenge. There was a process in place at each site to flag "potential" START referrals for investigative staff. However, this practice has drifted within the agency requiring START FSOS's and leadership to create localized systems of tracking and monitoring. START leadership has maintained communication with intake leadership to assess for consistency as well as ensuring regional processes to notify START supervisors of potential referrals in order to follow up with investigative workers. One additional shift within DCBS involved piloting a new AR program in two regions, both with a START site. Alternative Response is transforming the way in which incoming allegations/reports are classified and disposed. Under AR lower risk neglect, including some SUD allegations, will be responded to by staff but not under official investigation. Therefore, unless staff find more substantial safety risks within the home, cases under the AR track will not have a finding of neglect. DCBS leadership continues to explore the potential

use of persons with shared lived experience in the AR program. START will continue to support this. DCBS leadership intend to expand AR statewide by the end of 2025.

HH. Social Services Block Grant (SSBG)

SSBG is funded through title XX of the Social Security Act (SSA). States can consolidate several programs into a single grant under SSBG. Federal grant awards for each state are determined by a statutory formula based on the state's population. States have the flexibility to determine what services will be provided, who is eligible to receive the services, and how funds are to be distributed.

Services are available statewide and are directed at one or more of the five national goals:

- Achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency.
- Achieving or maintaining self-sufficiency, including reduction or prevention of dependency.
- Preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests, or preserving, rehabilitating, or reuniting families.
- Preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care; and
- Securing referral or admission for institutional care when other forms of care are not appropriate or providing services to individuals in institutions.

SSBG services are used to support, in whole or in part, the state mandated social services programs administered by DCBS. When feasible, services are purchased through written agreements with service providers throughout the state. The following is a list of providers contracted to provide services for adult protection, child protection, residential services (for juveniles), and training: DJJ, EKU, ZeroV, Seven Counties/Centerstone, and UofL.

TWIST captures the number of clients receiving SSBG services. This data is evaluated every six months and is used in reporting to LRC. Additional reports are submitted to the federal government annually. TWIST data reflects an increase in child protective services each year, indicating the continuing need for child welfare services statewide.

State Fiscal Year 2023	
SSBG Service	**Number of Clients Served**
Adult/Domestic Violence Protection	96,303
Child Protection	327,709
Home Safety Services	3,016
Juvenile Services	1,349
Residential Treatment	340

Adult protection provides protective services to adults designed to prevent and remedy abuse, neglect, or exploitation; increase employability and/or self-sufficiency; or prevent inappropriate placement, (e.g., investigate complaints of abuse, provide supportive services, or counseling).

Child protection provides children and their families with services designed to prevent or remedy abuse, neglect, or exploitation, (e.g., identification of children at risk; investigation of reports of abuse, neglect, or dependency; removal of the child from the home when necessary; or information and referral services).

Home safety services provides services to prevent the removal or repeat maltreatment of a child, or to maintain an adult's safety in the home or community, (e.g., arranging for community agencies to provide help with day-to-day household tasks; instructing and assisting with meal planning; nutrition; budgeting; or general household management).

Juvenile services provide children and their families with services designed to prevent or remedy abuse, neglect, or exploitation, and to help prevent the youth's future involvement with the juvenile or criminal justice system, (e.g., interaction with courts on behalf of juveniles; counseling; psychological testing and/or psychiatric consultation; or utilization of appropriate resources).

Residential treatment services provide a comprehensive treatment-oriented living experience, in a 24-hour residential facility for juvenile offenders committed to CHFS or DJJ. These services are provided through a written agreement with DJJ.

Staff training provides ongoing training for DCBS staff that addresses the skills and knowledge base necessary to carry out their duties regarding services provided by the SSBG programs.

II. Solutions

Kentucky River Community Care (KRCC)/Solutions is an intensive treatment and support program serving Breathitt, Knott, Lee, Letcher, Owsley, Perry, and Wolfe counties that works intensively with clients to address substance use, mental health, intimate partner abuse, and/or other victimization issues. Solutions initially served only female clients, however, expanded services to serve males in several of the counties using the same model. Solutions' approach is through a trauma-informed perspective. Additionally, in several of the counties there is transitional housing for both men and women where clients are in a safe and supportive environment in which to enhance their recovery. The majority of the project's clients are parents who are DCBS clients with the goal of keeping children in the home and/or reuniting children with their parents.

Participants in the program receive group, family, and individual therapy for both SUDs and other behavioral health issues. They can earn a GED, learn employment and interview skills, and develop parenting skills. The program considers the unique history of women in the area and includes TI practices. All programs implemented through Solutions are evidence-informed practices such as using Seeking Safety and Nurturing Parenting programs. Solutions has been able to provide onsite supervision for parents, which has been beneficial. Participants are transported to the treatment services as needed.

The program also provides case management/case coordination and advocacy services to assist clients in accessing domestic violence shelter services; legal services; medical services, including psychiatric care; safe and sober housing; education and employment; and services for their children. Solutions staff members also provide onsite parenting classes for the clients. The staff participates in family treatment team meetings, case collaboration meetings, and ongoing case reviews. DCBS and the courts are provided weekly progress reports on referred clients.

Having stable housing, while receiving support services, strengthens families in moving them towards reuniting with their children. Two additional recovery houses opened in Lee County in 2020. One provided a stable environment for pregnant and parenting women to assist in the recovery process, and another for adult men. The objective for adding the transitional housing options for is to offer support by providing a safe and structured atmosphere to build a foundation for lifelong recovery.

During the COVID-19 pandemic, CMHCs adapted their response to individuals with an SUD. Solutions began offering different platforms for families to receive services including virtual platform and in-person with precautions. In 2021, two additional recovery houses that opened. One house was opened in Perry County for men and the other house opened in Breathitt County for women. These houses provide a safe and structured foundation while clients are receiving services.

Two additional recovery houses opened in Lee county; one for pregnant and parenting women needing a stable environment to assist in the recovery process; and another transitional recovery house for adult men in Lee County. The objective for adding the transitional housing options for both men and women is to support them by providing a safe and structured atmosphere where they can build a foundation in lifelong recovery. Having stable housing while receiving support services strengthens families in moving them towards reuniting with their children.

Starting in 2007, $2 million of TANF MOE funds were provided each year and allocated into contracts with CMHCs that provide services for Solutions. In 2020, there was an improved process to streamline the ability to utilize flex funds to reduce barriers for families to keep children in their home. Flex funds are discretionary dollars that can assist families with the goal of keeping children in the home or for reunification. As a result, Solutions had developed a process where when a family is referred for an assessment that they will be seen the very same day for them to access treatment service quickly, which could prevent a child removal. The Solutions program is now supported through state general funds. Solutions operates in Breathitt, Lee, Perry, Owsley, Knott, Wolfe, and Letcher counties.

Strategies are continually being examined and implemented to refine the quality of services provided to clients, with the ultimate goal of improving their health and welfare and creating a safe/supportive family unit. During 2023, referral processes both within Solutions/New Directions and DCBS have been reviewed, resulting in more-timely referral information and immediate access to treatment services. This has been an ongoing endeavor with slow but steady progress. Another area of ongoing progress has been the utilization of wrap around funds. The approval process for these funds has been working efficiently (an area for improvement in prior years), but this service continues to be under-utilized. Concerted efforts have been underway to improve the utilization of wrap around funding for clients in need. There was an increase in wrap around funding this year, however, it is hypothesized that the need continues to outpace requests for services. Reminders from clinicians and workers continues to be emphasized.

In 2023, a New Directions program was established in Breathitt County. It is provided by the Solutions staff, with separate service delivery. This has provided the opportunity for couples in the process of regaining or maintaining custody of their children to receive treatment and work toward their common goal. There is also the opportunity for conjoint counseling to help strengthen the parent dyad. Additionally, this year approval was received for the use of discretionary funding to purchase calendars and therapeutic work books to assist clients with the development of structure and recovery skills. Feedback on this has been positive.

To ensure that clinicians and support staff remain current in best practice service delivery, numerous trainings were approved and attended in 2023. Commensurate with a prior agreement, some trainings included staff from both KRCC and DCBS. CY 2023, trainings included:

- Seeking Safety training
- Beginner Motivational Interviewing training

- Intermediate Motivational Interviewing training
- Nurturing Parenting training

In addition to the above evidence-based trainings, other trainings were attended to enhance treatment of co-morbid mental health issues and staff self-care. These were not billed to the grant but were beneficial to program delivery. Additional trainings included:

- The Compass Center CEU Retreat June 10 and 11, 2023
- Annual Mental Health and Substance Use Treatment Conference, October 19, 2023

As a result of trainings in 2023, Solutions and New Directions programs had enhanced parenting education for clients.

Attendance in the programs remained lower than expected or hoped for. Competition in the region has resulted in increased client choice and many clients choose programs that contain Medication for Opioid Use Disorder (MOUD). MOUD has been incorporated into the Perry County outpatient office where the Perry County New Directions is held. It is hoped this program will be expanded to other regions and help boost enrollment. Attendance at Perry County New Directions and Breathitt Solutions has remained constant. There was a slight increase in referrals to Letcher Solutions, however, a significant decrease in referrals to the Knott County Solutions to the point there were zero clients by the end of the year. Efforts have been underway to increase marketing and referrals, but this remains an area for continued attention. Discretionary funding approved for treatment onset to enhance engagement and retention is available but under-utilized. Strategies for increasing referrals continue to be explored.

Overall, the program content of both Solutions and New Directions continues to be solid and based in best practice. Staff for the most part have been consistent and have considerable knowledge and skill in the treatment and support of individuals with substance use and co-occurring mental health disorders.

JJ. Targeted Assessment Program (TAP)

Kentucky's Targeted Assessment Program (TAP) provides intensive services to parents involved in the state's child welfare and TANF systems. Over the past 20+ years DCBS has collaborated with UK to provide TAP services. The TAP model co-locates professional targeted assessment specialists (TAS) in public assistance and child protective services offices in Kentucky counties designated by DCBS.

TAP helps participants overcome barriers to self-sufficiency, stability, and family safety through a holistic and multidimensional approach, enhancing DCBS capacity to respond effectively to the families it serves. The TAP model includes comprehensive assessment addressing (1) substance use; (2) mental health; (3) intimate partner violence victimization; (4) learning disabilities and deficits; (5) parental protective factors; (6) unmet basic needs and other structural barriers to service engagement; and (7) parental and family strengths. TAP staff prepare participants for treatment, "frontload" services and support, refer them to community-based services and treatment programs, and facilitate their follow-through with referrals and services. By using a trauma-informed, strength-based approach, TAP partners with the DCBS and other community providers to keep families together and meet safety, permanency, and well-being outcomes for parents and children.

TAP interventions help the department to increase participant engagement, service access, and treatment retention and completion. The clinical expertise and evidence-based interventions provided by TAP supports DPP efforts to improve engagement with participants and families presenting with

multiple risk factors. In response to the unique challenges facing Kentucky's low-income parents, TAP services are individualized and intensive. Due to the flexibility of the TAP model, TAP staff can go where they are needed and help participants become increasingly empowered and competent in meeting their needs and caring for their families.

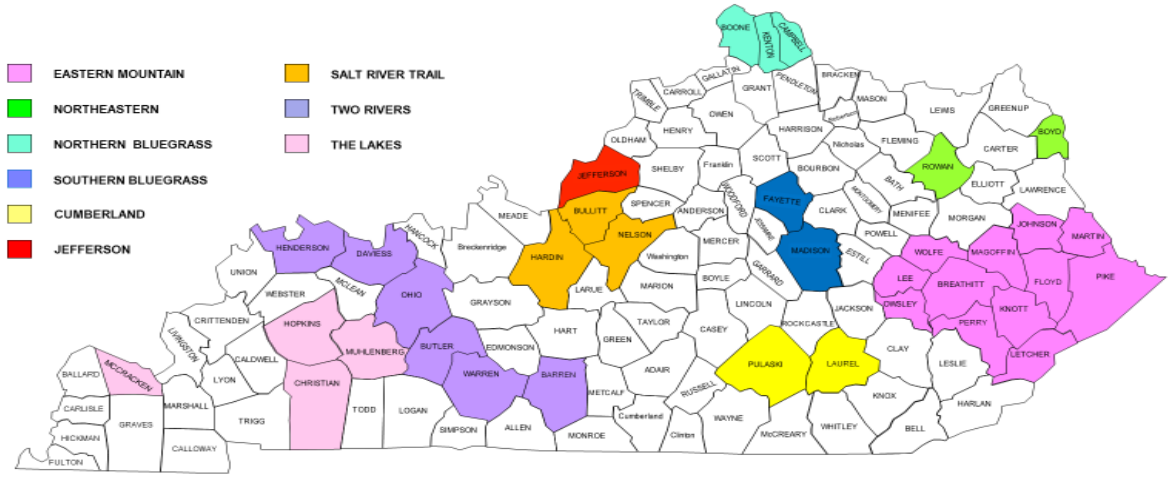
TAP is supported through TANF funds. Eligibility criteria includes receipt of TANF benefits or TANF-eligibility with a family income at or below 200 percent of the FPL. Parents referred by DPP must have a child in the home or a plan for reunification. There must be at least one dependent child in the home. If the child(ren) has been removed, there must be a plan for reunification in place. This can be concurrent with another permanency goal.

The TAP approach includes the following key practices:

- Co-location with DCBS
- Strong collaboration and communication with DCBS and other community partners
- Strength-based engagement with parents, with persistent outreach
- Holistic assessment of barriers and strengths
- Individualized service plan created with each parent in consultation with the referring/current case worker
- TI and strength-based interventions
- EBPs, such as MI
- Pretreatment to resolve internal barriers to service engagement and provide ongoing education and support
- Intensive case management and supportive services to resolve external barriers and encourage progress

In FY 2023, TAP co-located assessors at DCBS DFS and DPP offices in 35 of 120 counties: Barren, Boone, Boyd, Breathitt, Bullitt, Butler, Campbell, Christian, Daviess, Fayette, Floyd, Nelson, Hardin, Henderson, Hopkins, Jefferson, Johnson, Kenton, Knott, Laurel, Lee, Letcher, McCracken, Madison, Magoffin, Martin, Muhlenberg, Ohio, Owsley, Perry, Pike, Pulaski, Rowan, Union, Warren, and Wolfe. Six TAP positions also have field supervisor responsibilities. The principal investigator, program director, associate director, and program evaluator are located at UK in Lexington. The program's service map according to DCBS service region is presented below:

Targeted Assessment Program, CY 2023 Service Map by DCBS Service Region



During FY 2023, TAP facilitated or participated in 37 advisory council meetings and 206 planning and implementation meetings with DCBS staff. In addition, TAP facilitated five local community selection committee meetings to fill staff vacancies. TAP provided DCBS consultations for referred participants as well as cases not referred to the programs. TAP also provided 11,950 case consultations to DCBS for participants and 2,128 case consultations for non-TAP participants. In collaboration with DCBS, staff participated in FTMs to engage and support families during DPP case planning, case management, and case closures – bringing together various partners in case planning and shared decision-making. TAP assessors participated in 731 FTMs during the fiscal year. When needed, they coordinated and facilitated these meetings. The sharing of information and expertise is an invaluable part of case planning to improve outcomes. Such collaborations strengthen communication between DCBS and TAP and ultimately enhance services for families.

TAP continued to utilize its web-based data collection system during FY 2023. The current system includes: 1) a baseline assessment of barriers to self-sufficiency, family stability, and safety; and 2) a case closure assessment of participant progress, including: a) readiness to change; b) safety; c) work readiness/skills; d) parenting; e) access to services; and f) overcoming barriers to self-sufficiency and safe parenting. Securely housed on a UK server, the confidential data (with participant identifiers encrypted) are used for reporting, program evaluation, and quality improvement. The UK TAP and TAP OUD evaluation protocol (Protocol Number 44783) was approved by the UK Medical IRB for the period January 6, 2023, through January 5, 2024 – and undergoes periodic revision, as needed.

During FY 2023, TAP completed 1,854 baseline assessments for participants referred by DCBS divisions and other sources. Referrals to TAP (n=2,480) continue to be primarily from DCBS DPP (82%, n=2,025) and DCBS DFS (16%, n=403). Compared to the previous fiscal year, DFS referrals increased by 65%.

Of the 1,854 TAP participants receiving baseline assessments during FY 2023, more than half (66%, n=1,227) were assessed at baseline with two or more targeted barriers. Mental health and substance use were the most prevalent barriers, with almost three-fourths (79%) reporting mental health and

nearly half (48%) reporting substance use as barriers to self-sufficiency, family safety and stability. In addition, 46% reported intimate partner violence victimization.

In 2024, TAP received a request from the DPP to continue to study the prevalence of barriers to self-sufficiency and safety among participants across multiple fiscal years. In FY 2023, 1,854 TAP participants received a baseline assessment. The percent of TAP participants with barriers assessed at baseline are presented graphically below. Mental health has consistently been the most prevalent barrier across all years – remaining fairly steady since FY 2014 (71%), until reaching a high in 2023 (79%). In contrast, the percent of participants assessed with a substance use barrier has varied over the past decade – ranging from a high of 63% in FY 2021 to a low of 48% in FY 2023. The percent of participants with an IPV barrier increased slightly between FY 2022 (45%) and FY 2023 (46%). Lastly, the percent of participants with learning problems which includes educational deficiencies has decreased over time, ranging from a high of 32% in FY 2014 to a low of 22% in FY 2023.

DPP also requested a summary of Protection and Permanency involvement and child welfare outcomes among assessed TAP participants discharged between July 1, 2022, and June 30, 2023 (n=1,979). Case closure data are used for all measures. It is important to note that TAP and DPP case closures have separate timelines. As presented below, of the 1,979 assessed participants who terminated TAP services during FY 2023, more than three-quarters of participants (76%; n=1,500) had DPP involvement.

Targeted Assessment Program Opioid Use Disorder Project: In 2019, DCBS chose to address Kentucky's opioid crisis by expanding TAP through the TAP OUD Project as part of DCBS' participation in KORE. Targeted Assessment Program Opioid Use Disorder Project (TAP OUD). The project was supported by KORE through a SAMHSA Grant (1H79TI081704) through June 30, 2023, and DCBS determined TAP OUD services would be supported with TANF funds in FY 2024.

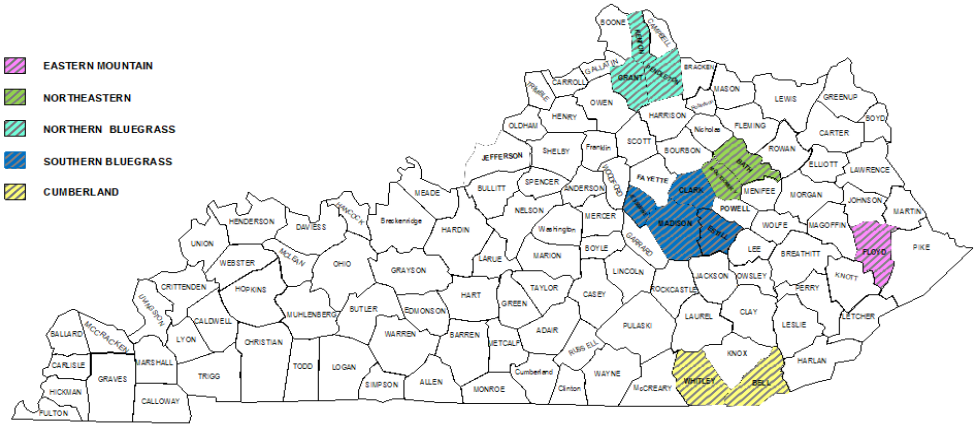
TAP OUD engages parents from both the public assistance and child welfare systems in services that help overcome multiple barriers, increase access to services, achieve and maintain permanency, and improve self-sufficiency by utilizing evidence-based approaches such as MI and strengths-based case management. Services provided include assessment, pretreatment, referral, and follow-up services focused on substance use and co-occurring barriers such as mental health and IPV, as well as other barriers impacting low-income families. Parental/family strengths and protective factors are also assessed. TAP OUD assists vulnerable families so children can be cared for in their own homes by increasing the engagement, retention, and recovery maintenance of parents with opioid and/or stimulant use disorders and co-occurring disorders. Harm-reduction strategies are discussed with participants and TAP OUD can distribute Narcan to those who accept it. TAP OUD also provides consultation and training to DCBS case managers and case workers as requested to enhance professional skills related to OUD and other substance use disorders. TAP OUD establishes multidisciplinary advisory councils in each county/region to assist in program planning, staff hiring, ongoing support and input to ensure efficiency and continuous improvement, and to identify and address systemic service gaps. TAP OUD provides (at minimum) monthly updates to the DCBS referral source.

To be eligible for TAP OUD services, participants must be: 1) low-income parents with/at-risk for opioid and/or stimulant use disorders and co-occurring disorders; and 2) receive or are eligible for TANF/Kentucky Transitional Assistance Program benefits - with at least one dependent child and a family income at or below 200% of the federal poverty level. In addition to meeting income requirements, DPP clients must have a child in the home or a plan for reunification. Most participants

are referred by DCBS case managers and case workers; however, community partners may also refer parents for these intensive services.

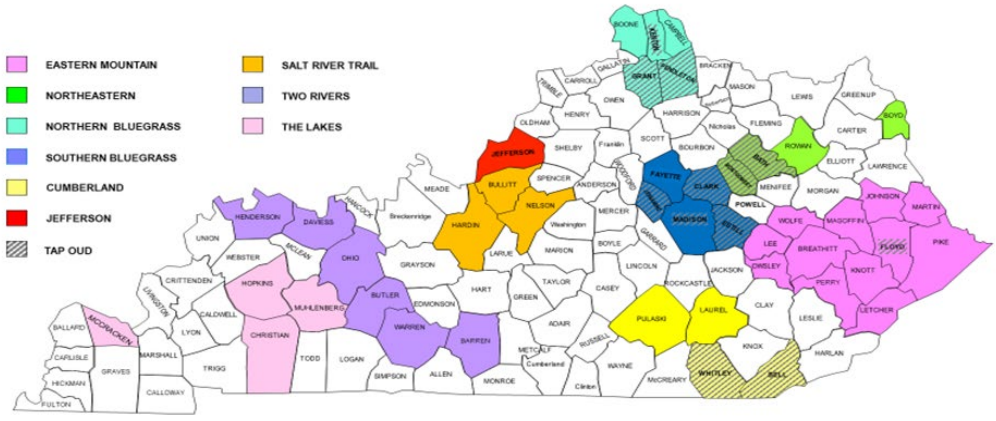
TAP OUD services were implemented in 12 state-selected counties with the highest Kentucky Overdose Index Scores (2017) - Floyd, Kenton, Madison, Bath, Bell, Clark, Estill, Grant, Jessamine, Montgomery, Pendleton, and Whitley. Nine counties had never had TAP services prior to this expansion. Three counties already had TAP services but were able to enhance service provision through TAP OUD.

Targeted Assessment Program Opioid Use Disorder Project (TAP OUD) FY 2023 Service Map by DCBS Service Region



A combined map showing the 44 Kentucky counties served by TAP and/or the TAP OUD project in CY 2023 is presented below:

TAP and TAP OUD FY 2023 Service Map by DCBS Service Region



FY 2023 TAP and TAP OUD Data: TAP OUD assessors completed 705 case closure reports for participants terminating services during FY 2023. Of the 705 participants with closed cases, 83% (n=583)

had received a baseline assessment. Terminating participants may have been referred or assessed before FY 2023. Prior to case closure, the duration of TAP OUD services averaged 33 weeks.

Of the 583 assessed TAP OUD participants whose cases were closed, 98% showed improvement in accessing services to overcome major barriers to self-sufficiency, stability, and safety:

- 95% with mental health barriers made progress
- 97% with substance use barriers made progress
- 96% with intimate partner violence barriers made progress
- 69% of participants with learning problem barriers showed progress

In addition, TAP OUD participants whose cases were closed made progress overcoming barriers to basic needs:

- 98% with challenges providing enough food for themselves and their families made progress
- 100% with childcare difficulties made progress
- 100% with social/family relationship problems made progress
- 94% with parenting difficulties as a barrier made progress
- 95% with children's basic needs barriers made progress
- 89% with lack of housing as a barrier made progress
- 80% with transportation difficulties made progress
- 78% with difficulty obtaining work made progress

In 2024, TAP OUD received a request from DPP to continue to examine the prevalence of barriers to self-sufficiency and safety among participants across multiple fiscal years. The percent of TAP OUD participants with barriers assessed at baseline by fiscal year were: FY 2020 (n=96), FY 2021 (n=506), FY 2022 (n=543), and FY 2023 (n=546). Mental health, combined with substance use, have alternately been the most prevalent barriers across all years – rising from TAP OUD's inaugural year (FY 2020) and remaining steady between FY 2021 and FY 2023. In contrast, the percent of participants assessed with IPV has risen steadily, with the most recent increase to 55% in FY 2023 (up from 29% in FY 2020). After an initial increase, the percent of participants with learning problems which includes educational deficiencies has declined slightly - at 31% in FY 2021, 29% in FY 2022, and 25% in FY 2023.

The percent of TAP OUD participants with unmet basic needs at baseline is substantial and has risen steadily in past years - from 63% in FY 2021 to 68% in FY 2022 and 73% in FY 2023. The most identified unmet basic needs in FY 2023 were finding money to cover expenses, transportation, housing, legal problems, and difficulty getting along with family. These have constituted the top three unmet needs in all four fiscal years.

DPP also requested an examination of opioid use trends among TAP OUD participants from FYs 2020-2023. The percent of TAP OUD participants self-reporting opioid use during the three months prior to baseline is presented in the figure below. In FY 2023, the use of most drugs has declined markedly since FY 2020, although in FY 2023, intravenous (IV) substance use, and use of other opioids increased slightly.

The percent of TAP OUD participants self-reporting opioid use in their lifetime are presented below. Compared to FY 2022, participants in FY 2023 reported slight decreases in lifetime use of Oxycontin, buprenorphine, heroin, other opioids, and methadone. IV substance use remained unchanged in this period. In general, the lifetime uses of all drugs have declined relatively steadily since FY 2020.

In 2024, DPP also requested a summary of Protection and Permanency involvement and child welfare outcomes among assessed TAP OUD participants discharged between July 1, 2022, and June 30, 2023 (n=546). Case closure data are used for all measures. It is important to note that TAP and DPP case closures have separate timelines. As presented below, of the 583 assessed participants who terminated TAP OUD services during FY 2023, most (89%; n=521) had DPP involvement. Prevention efforts were successful for 175 families (34%) whose children were never removed. In addition, 28% of cases remained open at the time the TAP OUD case was closed, with 146 families making progress toward reunification.

In response to a request from DPP to survey assessors about the types of DPP cases referred during FY 2023, TAP OUD surveyed 12 assessors located in five DCBS service regions. TAP OUD assessors reported that slightly less than one-half (48%) of their caseloads involved out-of-home cases, with the possibility of reunification. Of in-home cases, on average, nearly one-third (30%) were deemed high-risk for removal while 22% were low-risk. This will continue to be monitored in subsequent surveys.

Evaluation: TAP assessors completed 2,239 case closure reports for participants terminating services during FY 2022. Of the 2,239 total terminating participants, 70% (n=1,558[2]) of TAP participants had received a baseline assessment. Prior to termination, duration of service averaged 35 weeks.

Of the 1,558 terminating TAP participants assessed, nearly nine out of every ten showed improvements in accessing services to overcome major barriers to self-sufficiency, stability, and safety:

- 87% with mental health barriers made progress
- 89% with IPV barriers made progress
- 84% with substance use barriers made progress

Of the 754 total terminating TAP OUD participants, 78% (n=590[3])received a baseline assessment. Prior to termination, the duration of service averaged 35 weeks for TAP OUD participants. Of the 754 terminating TAP OUD participants assessed, 95% showed improvement in accessing services to overcome major barriers to self-sufficiency, stability, and safety:

- 90% with mental health barriers made progress
- 90% with substance use barriers made progress; and
- 87% with intimate partner violence barriers made progress

Progress ratings for each identified barrier are presented in the table below. The number of participants with a specific identified barrier is reported as well as progress made. This pattern is repeated for each barrier. No progress was rated if a participant did not engage or became disengaged, refused or was resistant to services, or if the participant could no longer be contacted. Further, if services did not exist or were not available, (e.g., waitlists) or if the focus of pre-treatment and/or service coordination was to address other barriers or basic needs, (e.g., housing), there may have been no progress in overcoming certain identified barriers. Participants who moved to a non-TAP and TAP OUD county or who were unable to be contacted were rated by assessors on the last contact before termination.

[2] Terminating participants may have been referred or assessed prior to FY 2022.
[3] Terminating participants may have been referred or assessed prior to FY 2022.

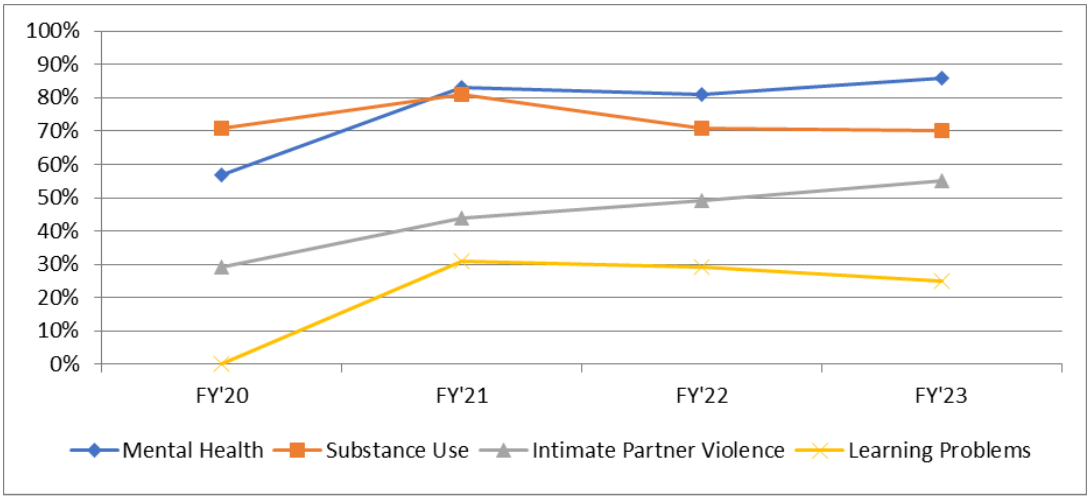
Progress in Overcoming Barriers to Self-Sufficiency, Stability, and Safety among Participants Terminating TAP and TAP OUD FFY 2023	Assessed Participants Terminating TAP and TAP OUD with Identified Barrier		
	TAP	TAP OUD	Total
Mental Health	**n=1,448**	**n=483**	**n=1,909**
Any Progress, (i.e., a little, some, moderate, a lot)	1,281 (89%)	461 (95%)	1,742 (91%)
A Little Progress	298 (21%)	137 (28%)	435 (23%)
Some Progress	367 (25%)	129 (27%)	496 (26%)
Moderate Progress	417 (29%)	145 (30%)	562 (29%)
A Lot of Progress	199 (14%)	50 (10%)	249 (13%)
No Progress	167 (11%)	22 (5%)	189 (9%)
Substance Use	**n=976**	**n=378**	**n=1,354**
Any Progress, (i.e., a little, some, moderate, a lot)	859 (88%)	366 (97%)	1,225 (90%)
A Little Progress	183 (19%)	126 (33%)	309 (23%)
Some Progress	217 (22%)	67 (18%)	284 (21%)
Moderate Progress	290 (30%)	99 (26%)	389 (29%)
A Lot of Progress	169 (17%)	74 (20%)	243 (18%)
No Progress	117 (12%)	12 (3%)	129 (9%)
Intimate Partner Violence	**n=666**	n=226	**n=892**
Any Progress, (i.e., a little, some, moderate, a lot)	603 (91%)	217 (96%)	820 (92%)
A Little Progress	129 (19%)	83 (37%)	212 (24%)
Some Progress	152 (23%)	49 (22%)	201 (23%)
Moderate Progress	191 (29%)	48 (21%)	239 (27%)
A Lot of Progress	131 (20%)	37 (16%)	168 (19%)
No Progress	63 (9%)	9 (4%)	72 (8%)
Learning Problems	**n=209**	n=172	**n=381**
Any Progress, (i.e., a little, some, moderate, a lot)	133 (64%)	50 (69%)	183 (48%)
A Little Progress	64 (31%)	35 (49%)	99 (26%)
Some Progress	39 (19%)	8 (11%)	47 (12%)
Moderate Progress	19 (9%)	6 (8%)	25 (6%)
A Lot of Progress	11 (5%)	1 (1%)	12 (3%)
No Progress	76 (36%)	22 (31%)	98 (26%)
Difficulty Meeting DCBS Requirements	**n= 598**	**n=275**	**n=873**
Any Progress, (i.e., a little, some, moderate, a lot)	527 (88%)	259 (94%)	786 (90%)
A Little Progress	139 (23%)	104 (38%)	243 (28%)
Some Progress	116 (20%)	54 (20%)	170 (20%)
Moderate Progress	133 (22%)	60 (22%)	193 (22%)
A Lot of Progress	139 (23%)	41 (15%)	180 (21%)
No Progress	71 (12%)	16 (6%)	87 (10%)
Housing	**n=535**	n=230	**n=765**
Any Progress, (i.e., a little, some, moderate, a lot)	444 (83%)	205 (89%)	649 (85%)
A Little Progress	108 (20%)	75 (33%)	183 (24%)
Some Progress	131 (25%)	61 (26%)	192 (25%)
Moderate Progress	123 (23%)	34 (15%)	157 (20%)
A Lot of Progress	82 (15%)	35 (15%)	117 (15%)
No Progress	91 (17%)	25 (11%)	116 (15%)

Progress in Overcoming Barriers to Self-Sufficiency, Stability, and Safety among Participants Terminating TAP and TAP OUD FFY 2023	Assessed Participants Terminating TAP and TAP OUD with Identified Barrier		
Problems with Social/Family Relationships	**n=422**	**n=133**	**n=555**
Any Progress, (i.e., a little, some, moderate, a lot)	363 (86%)	133 (100%)	496 (89%)
A Little Progress	95 (23%)	72 (54%)	167 (30%)
Some Progress	140 (33%)	41 (31%)	181 (33%)
Moderate Progress	89 (21%)	19 (14%)	108 (19%)
A Lot of Progress	39 (9%)	1 (1%)	40 (7%)
No Progress	59 (14%)	0 (0%)	59 (10%)
Transportation	**n=382**	**n=116**	**n=498**
Any Progress, (i.e., a little, some, moderate, a lot)	266 (70%)	93 (80%)	359 (72%)
A Little Progress	99 (26%)	52 (45%)	151 (30%)
Some Progress	102 (27%)	28 (24%)	130 (26%)
Moderate Progress	47 (12%)	9 (8%)	56 (12%)
A Lot of Progress	18 (5%)	4 (3%)	22 (4%)
No Progress	116 (30%)	23 (20%)	139 (28%)
Problems Obtaining Work	**n=362**	**n=130**	**n=492**
Any Progress, (i.e., a little, some, moderate, a lot)	290 (80%)	102 (78%)	392 (80%)
A Little Progress	65 (18%)	37 (28%)	102 (21%)
Some Progress	70 (19%)	27 (21%)	97 (20%)
Moderate Progress	81 (23%)	20 (15%)	101 (21%)
A Lot of Progress	74 (20%)	18 (14%)	92 (19%)
No Progress	72 (20%)	28 (22%)	100 (20%)
Parenting	**n=457**	**n=138**	**n=595**
Any Progress, (i.e., a little, some, moderate, a lot)	389 (85%)	130 (94%)	519 (87%)
A Little Progress	94 (21%)	64 (46%)	158 (26%)
Some Progress	134 (29%)	38 (28%)	172 (29%)
Moderate Progress	118 (26%)	28 (20%)	146 (25%)
A Lot of Progress	43 (9%)	0 (0%)	43 (7%)
No Progress	68 (15%)	8 (6%)	76 (13%)
Legal Problems	**n=192**	**n=85**	**n=277**
Any Progress, (i.e., a little, some, moderate, a lot)	155 (81%)	83 (98%)	238 (86%)
A Little Progress	41 (21%)	45 (53%)	86 (31%)
Some Progress	42 (22%)	20 (24%)	62 (22%)
Moderate Progress	38 (20%)	15 (18%)	53 (19%)
A Lot of Progress	34 (18%)	3 (3%)	37 (13%)
No Progress	37 (19%)	2 (2%)	39 (14%)
Basic Needs for Children	**n=229**	**n=99**	**n=328**
Any Progress, (i.e., a little, some, moderate, a lot)	206 (90%)	94 (95%)	300 (91%)
A Little Progress	32 (14%)	34 (34%)	66 (20%)
Some Progress	59 (26%)	26 (26%)	85 (26%)
Moderate Progress	74 (32%)	27 (27%)	101 (31%)
A Lot of Progress	41 (18%)	7 (7%)	48 (15%)
No Progress	23 (10%)	5 (5%)	28 (8%)
Physical Health	**n=187**	**n=26**	**n=213**

Progress in Overcoming Barriers to Self-Sufficiency, Stability, and Safety among Participants Terminating TAP and TAP OUD FFY 2023	Assessed Participants Terminating TAP and TAP OUD with Identified Barrier		
Any Progress, (i.e., a little, some, moderate, a lot)	158 (84%)	24 (92%)	182 (85%)
A Little Progress	60 (32%)	12 (46%)	72 (34%)
Some Progress	55 (29%)	10 (38%)	65 (30%)
Moderate Progress	32 (17%)	2 (8%)	32 (16%)
A Lot of Progress	11 (6%)	0 (0%)	11 (5%)
No Progress	29 (16%)	2 (8%)	32 (15%)
Child Care	**n=82**	**n=22**	**n=104**
Any Progress, (i.e., a little, some, moderate, a lot)	70 (86%)	22 (100%)	92 (88%)
A Little Progress	20 (25%)	4 (18%)	24 (1%)
Some Progress	15 (18%)	10 (45%)	25 (24%)
Moderate Progress	20 (25%)	5 (23%)	25 (24%)
A Lot of Progress	15 (18%)	3 (14%)	18 (17%)
No Progress	12 (14%)	0 (0%)	12 (18%)
Providing Enough Food	n=65	**n=60**	**n=125**
Any Progress, (i.e., a little, some, moderate, a lot)	57 (88%)	59 (98%)	42 (88%)
A Little Progress	14 (22%)	19 (32%)	33 (26%)
Some Progress	15 (23%)	14 (23%)	29 (23%)
Moderate Progress	16 (25%)	21 (35%)	37 (30%)
A Lot of Progress	12 (18%)	5 (8%)	17 (1%)
No Progress	8 (12%)	1 (2%)	9 (12%)

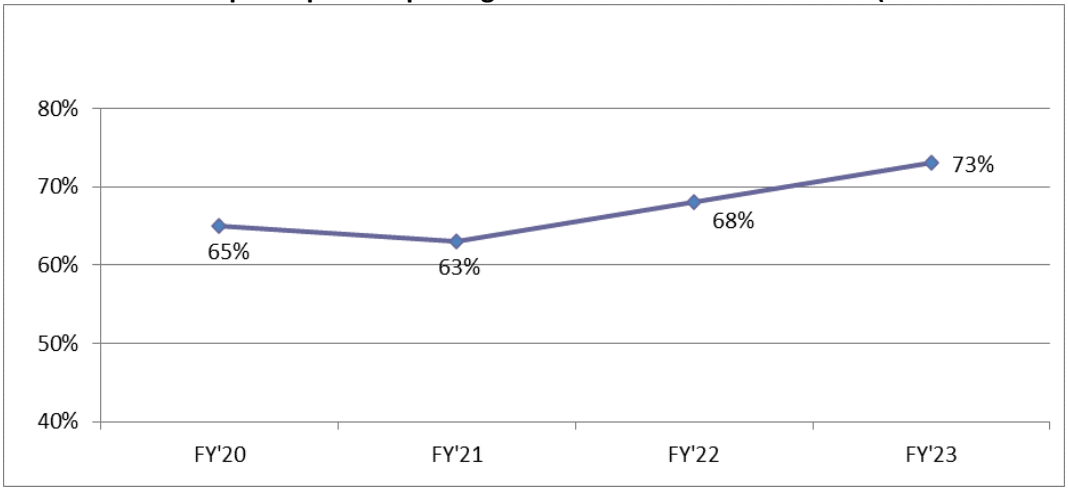
Fiscal Year 2020-2023 Barrier Prevalence: In 2024, TAP OUD received a request from DPP to continue to examine the prevalence of barriers to self-sufficiency and safety among participants across multiple fiscal years. The percent of TAP OUD participants with barriers assessed at baseline are presented graphically below by fiscal year: FY 2020 (n=96), FY 2021 (n=506), FY 2022 (n=543), and FY 2023 (n=546). Mental health, combined with substance use, have alternately been the most prevalent barriers across all years – rising from TAP OUD's inaugural year (FY 2020) and remaining steady between FY 2021 and FY 2023. In contrast, the percent of participants assessed with intimate partner violence has risen steadily, with the most recent increase to 55% in FY 2023 (up from 29% in FY 2020). After an initial increase, the percent of participants with learning problems which includes educational deficiencies has declined slightly – at 31% in FY 2021, 29% in FY 2022, and 25% in FY 2023.

Percent of TAP and TAP OUD participants assessed with barriers to self-sufficiency and safety at baseline (FY 2013 – FY 2023)



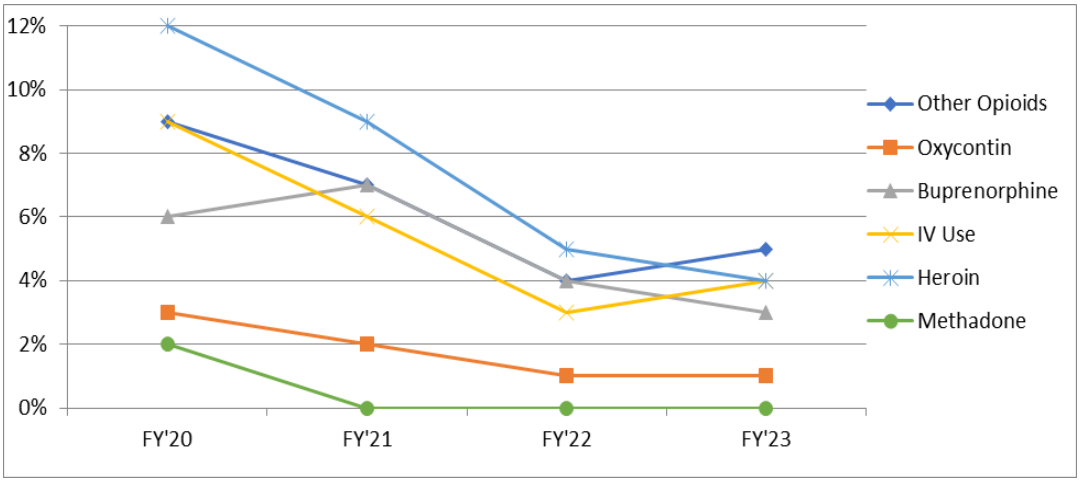
The percent of TAP OUD participants with unmet basic needs from FY 2020 through FY 2023 are also presented graphically below. The percent of participants with unmet basic needs at baseline is substantial and has risen steadily in past years - from 63% in FY 2021 to 68% in FY 2022 and 73% in FY 2023. The most identified unmet basic needs in FY 2023 were finding money to cover expenses, transportation, housing, legal problems, and difficulty getting along with family. These have constituted the top three unmet needs in all four fiscal years.

TAP and TAP OUD participants reporting unmet basic needs at baseline (FY 2020-FY 2023)



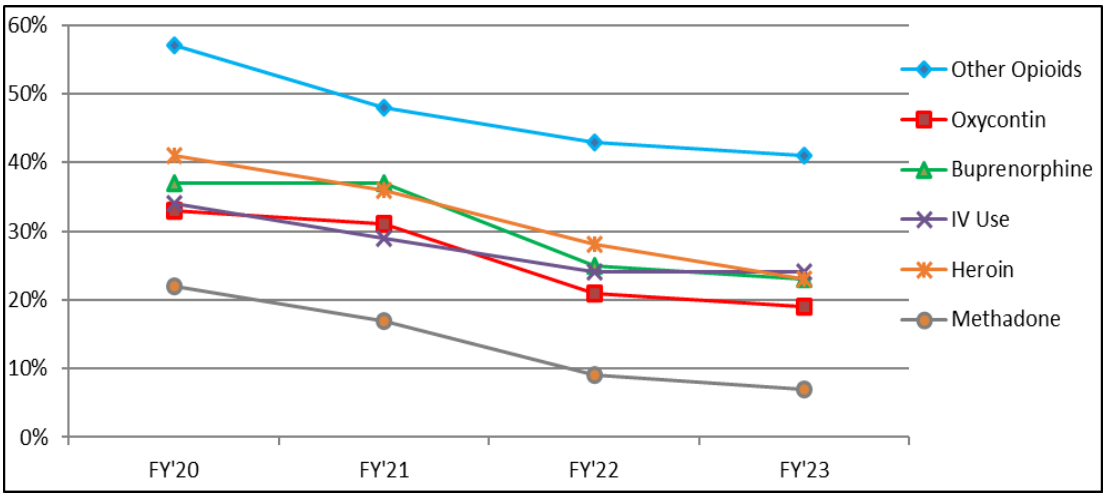
DPP also requested an examination of opioid use trends among TAP OUD participants from FY 2020 through FY 2023. The percent of TAP OUD participants self-reporting opioid use during the 3 months prior to baseline is presented in the figure below. In FY 2023, the use of most drugs has declined markedly since FY 2020, although in FY 2023, IV substance use, and use of other opioids increased slightly.

Percent of TAP OUD participants self-reporting opioid use 3 months before baseline assessment (FY 2020-2023)



The percent of TAP OUD participants self-reporting opioid use in their lifetime are presented below. Compared to FY 2022, participants in FY 2023 reported slight decreases in lifetime use of Oxycontin, buprenorphine, heroin, other opioids, and methadone. IV substance use remained unchanged in this period. In general, the lifetime uses of all drugs have declined relatively steadily since FY 2020.

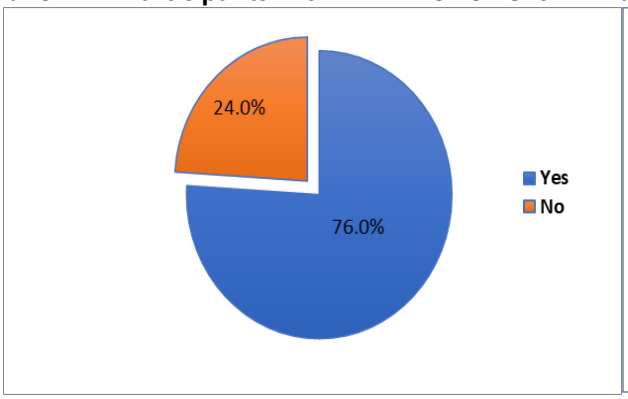
Percent of TAP OUD participants self-reporting lifetime opioid use at baseline assessment (FY 2020-FY 2023)



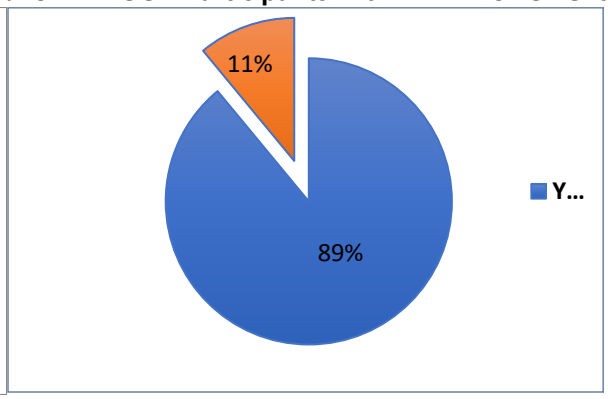
DPP Involvement and Outcomes: DP also requested a summary of Protection and Permanency involvement and child welfare outcomes among assessed TAP participants discharged between July 1, 2022, and June 30, 2023 (n=1,979). Case closure data are used for all measures. It is important to note that TAP and DPP case closures have separate timelines. As presented below, of the 1,979 assessed participants who terminated TAP services during FY 2023, more than three-quarters of participants (76%; n=1,500) had DPP involvement.

DPP also requested a summary of Protection and Permanency involvement and child welfare outcomes among assessed TAP OUD participants discharged during FY 2023 (n=546). Case closure data are used for all measures. It is important to note that TAP OUD and DPP case closures have separate timelines. As presented below, of the 583 assessed participants who terminated TAP OUD services during FY 2023, nearly nine of every ten (89%; n=521) had DPP involvement.

% of TAP Participants with DPP Involvement



% of TAP OUD Participants with DPP Involvement



The table below presents the DPP case status for participants at the time of TAP OUD case closure. More than one category may be selected by assessors when completing the case closure instrument. As shown, of those involved with DPP while receiving TAP OUD services (n=521), 90 families (17%) were reunified - with 59 DPP cases closed and 31 DPP cases remaining open for monitoring and support.

Prevention efforts were successful for 175 families (34%) whose children were never removed. In addition, 28% of cases remained open at the time the TAP OUD case was closed, with 146 families making progress toward reunification.

DPP Case Status	Number of Participants Reporting Status	Percent of Participants Reporting Status
Closed; family reunified	59	11%
Closed; parental rights terminated (TPR)	4	1%
Closed; custody not returned to parent	68	13%
Closed; children never removed	124	24%
Open for monitoring and support; family reunified	31	6%
Open for monitoring and support; children never removed	51	10%
Open; working towards reunification	146	28%
Open; goal changed to adoption, legal custodianship, planned permanent living arrangement, or other form of TPR (termination of parental rights)	48	9%

Statewide Training: During FY 2023, TAP and TAP OUD continued to work with the Opioid Response Network (ORN) Technical Assistance (TA) Consortium to access staff training opportunities. As previously reported, ORN sponsored MI training for all staff, including MI training via coaching circles conducted by

ORN contractor, Jeremy Bayard, in November 2022. In March and April 2023, TAP and TAP OUD assessors attended a *Language Matters* training to further strengthen their ability to provide recovery-oriented, strength-based, and participant-centered services. The training was sponsored by the Southeast Addiction Technology Transfer Center. In May 2023, TAP OUD staff completed six hours of targeted case management continuing education training as required by Kentucky administrative regulations. This training was provided by Speak with Confidence, LLC.

Strengthening Families: TAP and TAP OUD support DPP efforts to keep families together by mitigating barriers negatively impacting children and screening participants for the following KYSF protective factors: parental resilience, social connections, concrete support in times of need, knowledge of parenting/child development, social and emotional competence of children/nurturing and attachment. By strengthening these protective factors and supporting efforts to provide a stable home environment, assessors collaborate with parents to prevent removal of their children or re-entry into a Cabinet placement. If children are removed, assessors work to facilitate prompt reunification, and ensure that all reasonable efforts have been made when reunification is not possible. TAP/TAP OUD also partners with DCBS and other community providers to enhance safety, permanency, and well-being outcomes for parents and children.

Referral Impact: In FY 2023, referrals to TAP and TAP OUD (n=3,166) continued to be primarily from the DPP (84%; n=2679) and DFS (14%; n=430). Compared to FY 2022, referrals from Family Support increased by 62%, primarily as the result of COVID-19 exemptions ending. Referrals decreased overall and continued to be impacted by DCBS staff shortages in most service regions, as well as increased TAP staffing concerns. After more than two decades of relative stability, the program began experiencing a high level of staff turnover during the fiscal year, with five employees resigning between July 1, 2022, and June 30, 2023, to take better-paying positions.

KK. Trauma-Informed Care

Trauma-informed (TI) care is an approach toward engaging providers, agencies, and systems with the goal of recognizing that every person encountered may have trauma exposure and may present with trauma symptoms, and the role that trauma may play in an individual's life. One of the first key aspects of this approach seeks to change the paradigm from one that asks, "What's wrong with you?" to one that asks, "What has happened to you?" Most consumers of behavioral health services have experienced at least one traumatic event in their lives.

During 2023, the Clinical Services Branch manager attended the quarterly meetings of the Statewide Steering Committee on Trauma-Informed Care. These quarterly meetings are hosted by the UK Center on Trauma and Children and are facilitated by staff at UK and DBHDID. Agenda items involve training and resource building surrounding trauma informed practice. The steering committee consists of representatives from DPH, early childhood development, school systems, mental health professionals, correctional systems, medical professionals, disability rights advocates, sexual assault prevention advocates, and domestic violence prevention advocates. The committee allows for additional collaboration with community partners, as well as offering additional information gathering and distribution.

Several foster care providers and residential providers throughout the state continue to work toward training therapists in Trauma Focused-Cognitive Behavioral Therapy (TF-CBT). TF-CBT has proven to be effective in helping participants learn new skills to help process thoughts and feelings related to

traumatic life events; manage and resolve distressing thoughts, feelings, and behaviors related traumatic life events; and enhance safety, growth, parenting skills, and communication. Previously, one psychiatric hospital in the state offers a 16-week program, where youth are patients of the hospital and can complete a standardized curriculum for TF-CBT. This inpatient TF-CBT program is no longer operating due to chronic staffing issues and problems with recruiting and retaining appropriately qualified therapists.

The UK Center on Trauma and Children operates the Child and Adolescent Trauma Treatment and Training Institute (CATTTI Clinic). CATTTI provides in-depth trauma assessments and training for providers on how to best serve and treat children that have experienced traumatic events – including those that are clients of DCBS.

DCBS currently collaborates with private agencies that are working with trauma-informed curricula or milieu models. Two large private residential and foster care agencies are currently implementing the Risking Connections trauma-focused program. There are significant costs associated with implementation of this program, which continues to be a challenge both for the agencies that are currently using the program, as well as for those who would like to use this model in the future. Additionally, while the Risking Connections model works well, there are subgroups of child welfare clients that tend to have a poor response to Risking Connections.

ZeroV has changed the training curriculum for all victim advocates working in shelters and non-residential sites. The new curriculum was developed by the National Center on Domestic Violence, Trauma, and Mental Health. Adopting a trauma-informed approach to domestic violence advocacy means attending to survivors' emotional and physical safety. Just as the advocates help survivors to increase their access to economic resources, physical safety, and legal protections, using a trauma-informed approach means that they also assist survivors in strengthening their own psychological capacities to deal with the multiple complex issues that they face in accessing safety, recovering from the traumatic effects of domestic violence and other lifetime abuse, and rebuilding their lives. It also means ensuring that all survivors of domestic violence have access to advocacy services in an environment that is inclusive, welcoming, de-stigmatizing, and that does not re-traumatize.

Kentucky is experiencing a placement crisis which has evolved into children boarding in county offices. When clinical services branch staff are involved in these cases, it is often the case that referral materials are not written in TI and person-centered language. When referral materials are revised and written in a trauma-informed manner, placement is then identified in many cases.

LL. Work Incentive Program (WIN)

The Work Incentive Program (WIN) was created because of a study conducted by Manpower Demonstration Research Corporation (MDRC). The findings of this study indicated income supports proved to be more effective than case management in helping individuals stay off welfare and remain self-sufficient. WIN is a work expense reimbursement program. Eligible recipients receive a monthly payment to cover any work-related expense for a period up to 12 consecutive months. WIN assists families transitioning off public benefits by enabling the family to achieve or maintain self-sufficiency. WIN also promotes family stability, preventing out of home care placement of children.

WIN is available statewide to eligible KTAP recipients whose KTAP case discontinues with earnings. Eligible WIN recipients may receive a monthly work expense reimbursement payment. Work expenses may include transportation costs, clothing necessary for work food, etc. WIN income is considered a

reimbursement and therefore is excluded when determining eligibility in SNAP or Medicaid. WIN is funded by title IV-A.

To be eligible for WIN, the individual must be discontinued from KTAP with earnings; be employed; have a work expense; have a child in the home; be a resident of Kentucky; and have total gross earned and unearned income at or below 200% of the FPL. Individuals may only receive WIN once in a lifetime. Additionally, they may not waive receipt of WIN to receive WIN later. If the individual no longer meets WIN requirements or reapplies for KTAP, WIN payments will stop even if months are remaining in the eligibility period. Effective November 2012, payments for WIN were generated from the Online Tracking Information System (OTIS). The first payment for WIN is automatically issued once a K-TAP case with earnings is discontinued. For the remaining months, the recipient receives a form to verify eligibility that must be completed and returned to the local office to continue to receive the WIN payment.

During 2022, DFS proposed changes to WIN regulations and policy, brought on by the discussion of TANF modernization. The changes update the $130 monthly payment amount to $200 and would allow up to 12 months of cumulative payments, instead of the nine consecutive months previously allowed. This is the first time the payment changed since 1996. The changes to WIN were approved and became effective March 1, 2023. This extension of 12 cumulative months is expected to allow WIN eligible individuals more time to transition from public assistance to employment, promoting job retention with less financial turmoil while tapering off their assistance.

From January 1, 2023, through December 31, 2023, an average of 96 WIN payments were issued per month with a total of 1,153 payments and $216,390.00 dollars for CY 2023. This is up from CY 2022, when the average was 82 monthly payments with a total of $127,920.00 for the year. WIN payments increased in the last three months of 2023; however, further analysis is needed to determine how to continue the increased usage of the WIN program. No consultative efforts or technical assistance was provided by a National Resource Center during CY 2023.

MM. Y-NOW Mentoring Program

YMCA Safe Place Services is a social service branch of the YMCA of Greater Louisville. Beginning in 1974, the YMCA Safe Place Services has touched the lives of thousands of teens and their families by providing emergency shelter, outreach, family mediation, and mentoring services. YMCA Safe Place Services' mission is to accept, affirm, and advocate for teens and families in crisis through programs that empower youth to reach their full potential in spirit, mind, and body.

Y-NOW, the mentoring component of YMCA Safe Place Services, has been working with unique populations of youth since 1996, including both middle and high school students, Hurricane Katrina evacuees, youth who are at-risk of dropping out, youth transitioning from eighth to ninth grade, children with incarcerated parents, and children affected by the opioid crisis.

Y-NOW collaborates with the local school system, Jefferson County Public Schools (JCPS), family and juvenile court, Neighborhood Places, CHFS, Seven Counties Services, Probation & Parole, and other agencies involved with children with parents experiencing incarceration or with history of substance abuse. The program service area is Greater Louisville metro.

All services are offered free of charge to the youth and family. Funding for the Y-NOW Mentoring program comes from Metro United Way (MUW), Louisville Metro Government, and other local organizations and individuals.

For the past 18 years, Y-NOW has worked almost exclusively with youth who have a parent experiencing incarceration. In 2023, Y-NOW received KY state Opioid Abatement grant funding. Although most of the youth Y-NOW has served experienced some type of substance abuse in the home already, with the new grant, Y-NOW has expanded to officially work with youth who have history of substance abuse in the home. The trauma to a child of having a parent experiencing incarceration or substance abuse in the home has been likened to experiencing the death of a loved one, but the grief that the child experiences often goes unnoticed and unacknowledged. It is common for them to exhibit anxiety, shame, fear, sadness, and guilt. In addition, these inward battles present themselves in anti-social behaviors that have resulted in an alarming profile: These children are at an increased risk of anxiety, depression, aggression, truancy, substance abuse, attention disorders, and poor scholastic performance. Studies indicate that children of prisoners are more likely to become incarcerated themselves one day. The goal of Y-NOW is to break the cycle of substance abuse and incarceration.

Outcomes:

- To increase the success of youth in school.
- To prevent or reduce the use of physical violence against others in the community, home, and school.
- To prevent or reduce the risk of delinquency and involvement in the court system(s).
- To improve family relationships (and support system)

MUW Indicators/Outcomes		2023 Participants	Sustained Matches
75%	demonstrate an improvement in school performance (grades, suspensions, attendance)	80%	82%
85%	report improvement in family relationship (stability, communication, no runaways, etc.)	76%	90%
75%	have no new arrest and/or out of control behavior	88%	88%
75%	will not initiate any (or any new) contact with family/juvenile court	88%	90%
80%	pass to the next grade	100%	92%

MUW Indicators/Outcomes	2021/2022 Fall Class	All Y-NOW Participants (2004-2023)
% Achieve academic success (improvement)	83%	---
% Pass to next grade	100%	---
% Missing less than 10 days of school	64%	---
# Graduated middle school	10	332
# Graduated high school and/or earn GED	---	215
# Currently enrolled in elementary/middle/high school	25	**
# Enrolled in 2- or 4-year college or technical school, or in Armed Forces	**	**
# Graduated 2- or 4-year college or technical school, or completed Armed Forces commitment	**	**

** Data represented for Fall 22-23 cohort (started October 2022 and graduated July 2023) and Spring 23-24 cohort (started April 2023 and graduated January 2024)*

*** Due to limitations with tracking and access to youth data, the program does not have the capacity to track youth past high school.*

Volunteer Recruitment/Training: A volunteer training for mentors before the program officially kicks off. This training covers the policies of the program, volunteer expectations, details best practices when working with their mentee and their family and goes over possible scenarios the volunteer may encounter during the program. This year the volunteer training was offered in-person as well as the YMCA child abuse training being virtual. Staff were utilized from different program areas, as well as long time program volunteers to serve as retreat volunteers this year.

Youth Referrals/Youth Enrollment: Youth referrals primarily come from area school counselors, therapists, and families. While referrals are accepted all year long, youth recruitment and enrollment process increase two months prior to each retreat kick-off (February - March for the Spring cohort and August – September for the Fall cohort). Phone calls are made to youth who meet the requirements of the program and express an interest in joining the community. The Y-NOW case manager conducted enrollment sessions where the youth was introduced to the program, completed the registration, signed a commitment to the program and set their educational and personal goals for the program. The Fall 2022-2023 class began in October 2022 with 16 youth participants attending camp, and 14 youth graduated the program. The Spring 2023-2024 class began in April 2023 with 13 youth participants attending camp, and 11 youth graduated the program.

Caregiver/Guardian/Parents: Case managers reach out to referrals and start scheduling and conducting individual caregiver meetings two to three months before the kick-off retreat. These meetings are completely centered on the caregiver's availability and needs; meetings are typically conducted with the case manager at either Safe Place or the family's home. Meeting with the caregiver individually allows the case manager to explain the program and paperwork in detail, answer any questions the caregiver may have, and establish a relationship between the caregiver and case manager – which has been very beneficial for the program. The parent/caregiver enrollment includes registration forms, release of information forms, and waivers. Case managers continue to conduct bi-monthly phone calls with caregivers throughout the follow-through program, and provide additional support and resources as needed to caregivers, youth, and families.

Youth/Mentor Retreat: The retreat launches the group experience for the cohort, mentors, and staff. It builds the group's trust, sense of unity, and community and It includes a variety of guided group conversations and experiential activities designed to have the youth take a look at what's getting in the way of them being successful and begin to develop an action plan for their future (particularly around their education). A curriculum-based three-day kickoff camp retreat occurred in April 2023. At the conclusion of camp, the youth were paired with mentors during a pairing ceremony.

One-to-One Mentoring Match: Each youth receives a weekly contact from a thoroughly screened and trained volunteer mentor to receive support and work on their goals. Mentors attend three mentor-only meetings in which training topics are presented, the topic for the first mentor only was ACEs. Mentors also discuss highlights and challenges related to their mentoring journey. As a response to mentors sharing their experiences, guidance and recognition is provided by staff and meeting participants. Lastly, case managers provide direct support to mentors; contact with mentors occurs at least monthly.

Ten-month Follow-Through Program: Group meetings take place at least twice monthly. Youth and mentors attend the group meetings together. Meetings include a meal and a structured curriculum topic. Participants practice decision-making, leadership, accountability, and remedying mistakes. Curriculum topics include anger management, educational goals, diversity, human sexuality, grief and loss, budgeting, social media and internet safety, college and career readiness, and the criminal justice system. Some group meetings include volunteer guest speakers. Additionally, in December youth participated in a holiday party in which the families were invited and Y-NOW hosted a 12-hour lock-in that included activities such as swimming, crafts, team games, sports, and karaoke. Youth previously worked on planning committees to suggest activities, decorations, and food for the holiday party and lock-in. Both cohorts of youth also planned a community service project. which occurred in April 2022, the Y-NOW community filled care packages for children in the hospital and young adults experiencing homelessness. The Fall 2022-2023 cohort conducted a neighborhood cleanup, then used the skills they learned from our budgeting curriculum, to buy animal food and toys to donate to No Kill Louisville. The Spring 2023-2024 cohort joined the Hope Buss by preparing fresh food to be cooked and donated to families in need.

During the ten-month cohort case managers remain in contact with each youth to support youth as needed. The case managers provide support to youth at least monthly either at school or home. Case managers collaborate with school personnel and community service providers to advocate for youth.

Sustained Relationships/Youth Leaders: At the conclusion of the program, youth are celebrated for keeping their ten-month commitment with a graduation ceremony. Upon graduation, youth can continue participation on two levels. Alumni gatherings/reunions are offered annually for the youth and mentors to come back together and catch up. Many youth and mentors continue to work together once they have graduated, however Y-NOW currently lacks the capacity to fully engage alumni with ongoing support. Youths who take part in training and meet all criteria can serve as a youth leader for the next program.

Key Accomplishments Over the Past Five Years

2019	• 2014-15 Y-NOW alumni was featured speaker at YMCA Safe Place Services Together for Teens Breakfast and delivered the invocation at the annual Mayor's Breakfast. • 40 alumni, mentors, and family members gathered at Safe Place to reconnect, eat, and play games at the re-established Y-NOW alumni event. • 434 youth completed the three-day retreat, of which 372 completed the follow-through program. • Two Y-NOW youth alumni and one active participant won Youth Character Awards, and scholarships. • 92% of alumni (186 out of 203) graduated high school on time.
2020	• 2019-2020 Spring alumni spoke at 2020 YMCA Annual Campaign kick-off and 2020 Safe Place Services Annual Together 4 Teens Breakfast. • 2019-2020 Fall cohort suspended in-person group meetings and moved to a virtual platform due to the COVID-19 pandemic. • Staff created and delivered care packages to each youth several times before the class graduated in July. • COVID-19 and a funding decrease prevented the kickoff for Spring 2020-2021 cohort, and the program returned to one class a year. • Spring case manager and Y-NOW volunteer recruitment specialist positions were

	eliminated during COVID-19. • Drive-thru graduation celebration held for the 2019-2020 Fall youth and mentors. • 44 active Y-NOW participants or program alumni were successfully promoted from elementary, middle, and high schools. • Staff kicked off the 2020-2021 Fall class with a seven-hour retreat at the Republic Bank Foundation YMCA. 16 youth were paired with mentors for this class. Of the youth enrolled in the program, approximately 83% are living at or below the poverty level, 67% are performing poorly in school, and 13% have been held back a year in school. The majority of Y- NOW participants identify as non-white. • A Y-NOW alumnus was the youngest recipient of a YMCA Youth Character Award. • 396 youth graduated from the Y-NOW program since 2004.
2021	• Volunteer mentors were selected as the 2021 Volunteer of the Year and as the 2021 Joyce Skees Memorial honorees. • Volunteer recruitment specialist/case manager joined in July and the Y-NOW director joined in October. • Emphasis on mentorship and relationship building drives the program, but some people may be excluded due to the expenses of transporting youth and outing costs. To combat this barrier case managers, inform mentors of free or low-cost activities in the community. Y-NOW also received donated tickets for the Frazier History Museum for youth and mentors to attend. • Y-NOW returned to in-person programing. • 411 youth graduated from the Y-NOW program since 2004.
2022	• Y-NOW had four active volunteer youth leaders throughout the Fall cohort. Youth leaders support Y-NOW youth participants and serve as positive role models. Four youth leaders were each awarded a $2,500 college scholarship. The scholarship will assist the youth leaders with achieving their educational and career goals. • From the most recent graduating class two youth alumni became youth leaders and will serve as role models for the upcoming class that begins in October 2022. • Mentors are a vital component of Y-NOW; unfortunately, due to a lack of mentors, the Spring 2022-2023 cohort did not launch. The youth that were enrolled in the Spring 2022-2023 cohort began the program in October 2022. To keep these five youth engaged in Y-NOW over the summer, case management services began, and the youth met as a group with staff once per month. The introduction and final meetings were held at YMCA Safe Place. The remainder of the meetings were fun community outings. • COVID-19 presented a challenge as staff, youth, and volunteers were unable to attend group meetings due to contracting the virus. • 423 youth graduated from the Y-NOW program since 2004.
2023	• Y-NOW had three active youth leaders throughout both cohorts in 2023. Youth leaders are graduates of the program, who volunteer their time coming back to support new youth participants and serve as positive role models. • A Y-NOW graduate from 2021 has been selected to be a speaker at the next Together 4 Teens luncheon. This youth will also participate in Safe Place's 50th anniversary marketing campaign. • Mentors are a vital component of Y-NOW; Unfortunately, due to lack of mentors, the Fall 23-24 cohort did not launch. The youth that were enrolled in the Fall 23-24 cohort will be a part of the Spring 24-25 class. The case manager still provided case management to both youth and their families that were enrolled but pushed to the next spring class.

	• The Y-NOW Mentoring Program received the KY state Opioid Abatement grant funding, which has allowed us to expand the program criteria for youth served. This also allows us to teach a substance abuse class to participants. Most of our previous Y-NOW participants were affected by both incarceration and substance abuse in the home already. With the new grant, the youth can qualify for the program with either a parent with history of incarceration or substance abuse. • Y-NOW experienced some change in staffing this year, with the case manager being promoted to interim director but still providing case management. A volunteer recruitment specialist was hired to help combat the shortage of mentors we've had in the past. The case manager position is posted, to be filled when an appropriate candidate is identified. • To date, 448 youth have graduated from the Y-NOW program since 2004.