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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 (OCSE) and are geared toward facilitating access and visitation of non-custodial parents facing difficulty seeing their children due to issues such as poor 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 IV-D case participation status in the intake database. Race codes were revised to mirror the federal race codes and include *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*. If necessary, callers are referred to a partnering legal aid program located in the geographical area where they reside. Staff in CSE then receive the above data in addition to data regarding how the hotline served the caller. CSE has 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 has 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.

Total CSE expenses for CY 2022 were $60,383,700.85. The total caseload was 241,714. The total foster care cases were 8,415. Through the end of December 2022, a total of 1,421 persons contacted the hotline for assistance related to access and visitation with their child(ren). CSE paid LAS $124,324.00 in calendar year (CY) 2022. Currently, there are no perceived barriers to the Access and Visitation Hotline or the partnership with LAS.

B. Batterer Intervention Certification Program

On January 1, 2018, the Batterer Intervention Certification Program was moved from DCBS to the Kentucky Coalition Against Domestic Violence (KCADV). KCADV, now known as ZeroV, administers the state's Batterer Intervention Certification Program by enrolling providers, conducting training, monitoring providers, and maintaining the provider list. ZeroV also accepts grievances regarding batterer intervention providers. Nakela Cleveland (ncleveland@kcadv.org), program specialist at ZeroV, works to coordinate the Batterer Intervention Program (BIP). ZeroV also monitors complaints about batterer intervention practices if any are received. Additional support staff include:

- Isela Arras, COO, iarras@kcadv.org
- Simone Marx, Program Specialist, smarx@kcadv.org
- Meg Savage, CLO, msavage@kcadv.org
- Lisa Gabbard, Leadership, lgabbard@kcadv.org

Batterer intervention services are funded through the Cabinet for Health and Family Services (CHFS/cabinet) to allow for a meaningful investment in services to people who use violence to control their partners. In May 2022, CHFS awarded ZeroV $300,000 (an annual allocation) to support BIP. 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 BIP. The funding awarded to ZeroV by CHFS has helped the coalition correct the lack of information provided about BIP 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 software Client Progress Online (CPO), which tracks the progress of a participant through a BIP course products. The funding also allows more training opportunities for BIP 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) BIP providers in real-time. CPO allows referral sources such as DCBS and the court system to monitor the progress and attendance of BIP clients. ZeroV hopes that CPO will allow for more complete data, will no longer have to wait until the end of the year to be able to receive statistics, and will no longer have to rely on providers to complete their statistics and turn them into ZeroV. ZeroV will be able to retrieve their own data. 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 BIP 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.

Survivors who have a partner participant in BIP may experience misinformation or a lack of information about their rights. When survivors, judges, or attorneys do not understand what BIP 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.

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 Nakela Cleveland, Education, Change, and Accountability Program (EACP)/BIP Senior Program Specialist, to focus attention on strengthened skills (including through improved access to training) so providers can step into this pivotal role is of vital importance.

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 2022, four training events were attended by 14 potential providers and five certified providers. The COVID-19 shutdown that began in March 2020 caused in person trainings to be put on hold until ZeroV could find a way to ensure the quality of discussion and education that is required for a new provider to learn about working with people who have used violence to harm their partners. In early 2021, ZeroV created a virtual certification process to train new providers. Making the BIP Certification training virtual has allowed more practitioners to participate without taking off work to attend a three day in-person training.

In 2022, ZeroV's batterer intervention certification training was held four times. This training is the virtual equivalent of the training that corresponds with the regulations stated in 922 KAR 5:020. The coalition has developed 60–90-minute podcasts for independent listening. The participant then logs into the certification site, through Moodle, which allows participants to access all resources they will need to read and listen to for each of the three days of training. The material includes podcasts, readings, and discussion boards. For each podcast, ZeroV offers a three-hour live session through Zoom during which the podcast presenter will reviews the important points of the podcast and discusses other relevant information. Participants have five live sessions over the course of two weeks. All work associated with the training will provide 24 hours of training for new BIP providers.

With the requested regulation changes in 2023, this training will soon be 27 hours and will include two more topics: group facilitation and how to use CPO (entering clients, adding notes, and communicating with referral sources). Adding CPO to the certification training will allow ZeroV to train potential providers more efficiently to ensure earlier adoption of the skills. Potential providers can expediate their use of the database for the implementation of their BIP practice. ZeroV is also researching options for a more interactive and user-friendly platform to replace Moodle, such as Litmos or Blackboard.

ZeroV staff, Nick Davis (Anew Alternative), and Kilen Gray (Creative Spirits), both BIP service providers in Frankfort and Louisville, respectively, serve as the training faculty for BIP 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. Nick Davis discusses the specifics of BIP service provision and the needs of the BIP participants.

In addition to administration and training, ZeroV maintained the following in support of the BIP program during CY 2022:

- 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 BIP certification training.
- Implemented and maintained CPO and provided technical assistance to new and established users.
- Trained 81 providers to use CPO.
- A list of currently certified BIPs 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 BIP services, informational handouts that provide an overview about BIP to judges and DCBS

workers making referrals, the regulatory exclusion of anger management services, and guidance for ensuring that only Kentucky-certified BIP 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 BIP providers and referral sources across the state
- Processed 30 certification renewals
- Ensured that no one is practicing BIP services without being certified through the state.
- Sent two cease and desist letters
- Investigated one BIP provider complaint
- Provided quarterly BIP certification training in March, June, September, and December.
- Attended a meeting with the Fatality Review Board to inform members about the BIP program.
- Attended the Violence Against Women Act (VAWA) Symposium at the invitation of AOC staff, to offer an overview of the BIP program to over 50 participants.

The BIP program continues to struggle with provider data collection compliance. CY 2022 through the annual report shows BIP attendance is now on the rise after attendance being significantly affected by COVID-19 as the table below demonstrates:

Calendar Year	Number of Offenders Served
2018	2,436
2019	2,973
2020	818
2021	1,044
2022	1,245

Batterer Intervention Program Data: CY 2022				
Category	**Male**	**Female**	**Other**	**Total**
Batterers Assessed*	1,139	120	0	1259
Civil/DVO Referral	603	41	0	644
Criminal/Post-Conviction	554	56	0	610
Diversion	100	19	0	119
DCBS Referral	157	45	0	202
Self-Referred	51	7	0	58

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

BIP providers specifically struggle with:
- Shifting programs/groups from online to in-person spaces: COVID-19 allowed the option of attending virtually which allowed the participant not to have another stressor added to them like finding transportation. BIP participants are still utilizing virtual groups rather than in-person groups. The reason for the preference is that people who use harm can be affected by transportation barriers due to poverty.

- Managing their own small private practices: Most BIP providers are very small practice practitioners, and it is difficult for them to maintain the administrative structure of the program, such as consistently documenting attendance for the course of 30 weeks and reporting routinely to the courts/DCBS.
- Engaging with survivors consistently; appropriately document referrals and engagement; and, perhaps more importantly, engage with the courts: Because most interaction with clients, survivors, courts (and other referral sources), and ZeroV for reporting purposes is analog (most documents are only available in hard copy: assessments, reporting forms, templates for communicating with courts and other referral sources, applications for BIP, and renewal forms for certification.), it is very difficult to obtain a true accounting of the BIP program's efforts.

Sub-standard service delivery practices and lack of reliable documentation are difficult to root out because those who are benefitting from sub-standard services rarely report to ZeroV their concerns about receiving superficial classes, deviating from a curriculum topic, or even having to attend fewer classes than required.

Throughout 2022, ZeroV offered technical assistance to providers when needed. Technical assistance topics included: collaboration, shifting to virtual service provision, service requirements, COVID-19 Healthy at Work guidelines, changes in regulation, guidance regarding whether providers can bill insurance for BIP (and how to do so appropriately), guidance on differences between BIP and anger management, how to inform judges about BIP, and other topics as requested.

2022 statistics:

- Average assessment cost: $65.00
- Average cost per group session: $25.00
- Total participants referred for SUD outpatient treatment services: 186
- Total participants earning less than $30,000 per year: 1,001
- Participants who identified as Asian, Hispanic, or African American: 610
- Participants ranged 18-29 in age: 432

C. Child Victims' Trust Fund Board

In 1984, the passage of House Bill 486 established the Kentucky Child Sexual Abuse and Exploitation Prevention Board (CSAEP Board) 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 CANP 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 CSAEP Board is increasingly aware of the need for funding prevention programs that engage in community education and enhance public awareness. The CSAEP Board also supports 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 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.

The Board utilizes four committees to advance specific goals. They are:

- Marketing and Development Committee
- Grants Management Committee
- Strategic Planning Committee
- Operations Committee

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."

Because the reporting requirement is new, having become effective July 2022, the Board does not have a full year of data and information to present in the 2022 Report. However, 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 CSAEP 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, Daniel Cameron, 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 CVTF provides funding for regional and statewide prevention programs and reimbursement associated with the costs of medical examinations at CACs. The CVTF also provides for the education of professionals at conferences. The Trust Fund awarded $254,230.90 in grants in 2021, for state fiscal year (SFY) 2022. The amount awarded is the maximum amount that could be reimbursed to a grantee.

As shown in the chart below, $56,900.00 was funded to 15 Child Advocacy Centers as a partial reimbursement for 580 child medical sexual assault examinations at $100.00 per exam. While some portions of these exams are Medicaid billable, there are costs above the amount that can be billed to Medicaid. The Trust Fund awarded $88,000.00 for SFY 2023 which is the maximum amount that could be paid to medical grantees over the course of the fiscal year.

The chart below details the funding for medical exams for SFY 2022:

CAC NAME	# OF EXAMS	GRANT FUNDS EXPENDED
BARREN RIVER	69	$6,900.00
BUFFALO TRACE	10	$1,000.00
CAC OF THE BLUEGRASS	176	$17,600.00
CUMBERLAND VALLEY	26	$2,600.00
FAMILY & CHILDREN'S PLACE	33	$3,300.00
GATEWAY	22	$2,200.00
GREEN RIVER	33	$3,300.00
HOPE'S PLACE	20	$2,000.00
JUDI'S PLACE	57	$5,700.00
KY RIVER	25	$2,500.00
LAKE CUMBERLAND	55	$5,400.00
LOTUS	3	$300.00
NORTHERN KY	15	$1,500.00
PENNYRILE	25	$2,500.00
SILVERLEAF	11	$100.00

The Board awarded $131,811.98 for regional and statewide awareness, prevention, and outreach programs for SFY 2023, as follows:

CHILD WATCH COUNSELING	$24,493.00
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 uses the Safety Tools and Golden Rules program. Their curriculum delivers sexual abuse prevention education to pre-school and elementary school students in 13 counties in Western Kentucky, the Kentucky Boys and Girls Ranch, and older child-serving agencies by using age-

appropriate interactive discussion, activities, and videos. The program gives students an understanding of sexual abuse, ways to prevent it, and how to stop abuse already occurring.

Exploited Children's Help Organization will provide evidence-based prevention education to K-12 in both public and private schools in Louisville. It is anticipated that approximately 6,000 children and 3,500 adults who work with youth serving organizations, businesses, and volunteers engaged with children and youth will receive training.

The Family Nurturing Center uses the Stewards of Children training program (evidence-informed). The program is designed to educate 2,000 adults on how to prevent, recognize, and respond responsibly to child sexual abuse. The program was developed to meet the needs of youth-serving organizations, public agencies, schools, law enforcement, and parents. The program includes a unique motivational component that directly addresses reluctance to report and necessity of shared responsibility for every child. They will provide 195 Stewards of Children trainings in the Boone, Campbell, Grant, and Kenton counties.

The Kids on the Block Program provides school-based prevention services which increase public awareness about the problem of child abuse and equips children with the skills to recognize and report such abuse. Dynamic, interactive performances are provided using life size Kids on the Block puppets to educate children about child abuse and neglect. The puppets discuss their "personal stories" regarding both physical and sexual abuse. Following the presentation, the puppeteers are trained to address issues related to child abuse and answer questions from the children, so that children can clarify any information and gain additional insight into abuse. This program will reach 10,000 to 12,000 children in the area with 50 performances. At least two of the programs will be in each of the 15 area development districts (ADDs).

Prevent Child Abuse Kentucky (PCAK) has been able to gauge perceptions from the public on child sexual abuse prevention and occurrences through survey data collected by PCAK and with CVTF funding. They will conduct further analysis to identify demographics of individuals not receiving child sexual abuse prevention messaging. To prevent child sexual abuse from occurring, communities and individuals must believe child sexual abuse can be prevented as well as possess the tools needed to strengthen families. PCAK will promote existing and create new '*Are they good for your child*' sexual abuse prevention messaging via bus ads, digital ads, use of QR codes, and partner collaborations.

The Board reimbursed the following entities $2,110.75 in conference grants in 2022:

OVA/OAG, 2021 Victims Assistance Conference, June 2021	$750.00
Pennyrile Allied Community Services/Community Collaboration for Children, "*What We Don't Know Won't Hurt*" March 2021	$1,000.00
OAG STARK Conference, June 2021	$360.75

For SFY 2022, the Board awarded medical reimbursement grants for 855 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 CSAEP board has made good progress and continues to meet its mission. The board is in the process of strategic planning due to statutory changes during the 2022 legislative session. The board intends to use the committees previously mentioned to focus the work. The board will continue to award grant applications each year to meet its mission in serving child victims of child abuse, neglect, sexual abuse, and exploitation, as well as prevention efforts. The board is exploring avenues to increase fundraising to fund more prevention efforts and continues to support public policy efforts that prevent abuse to children.

D. Children's Advocacy Centers

In 1998, Kentucky adopted a statewide Children's Advocacy Center (CAC) network, which provides for one CAC in each of Kentucky's 15 Area Development Districts (ADD). 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 memorandum of understanding (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, include (1) the safety and protection for child victims of sexual abuse, and (2) accountability of the child sexual abuse service 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 the case management services associated with child abuse medical exams from the CVTF.

Children's Advocacy Center Data - CY 2022

Service Category	Number of Services Provided/Persons Served
New children served	7,584
New caretakers served	4,654
Advocacy services: court, case management, referrals to services	92,920
Medical services: comprehensive forensic medical exam, general exam, follow up exams, referrals for further medical treatment	783
Forensic services: forensic interviews by CAC staff, forensic interviews hosted by the CAC for trained child welfare interviewers	5,616
Mental health services: individual, family and group treatment, mental	8,580

health screening	
New children staffed by KY MDTs	5,754
Total CAC cases seen through KY's MDTs in 2021	33,699
Training programs conducted	967
Community partners trained	2,840
Community awareness events	743

CACs in Kentucky continually assess the quality of services available to Kentucky's families and communities through examination of Outcome Measurement System (OMS) survey results. Responses from over 2,100 caregivers and investigative partners surveyed in 2022 demonstrate the critical role CACs play in the investigative and healing processes. According to the survey results, 99% of caregivers reported that their questions were answered to their satisfaction. In addition, 98% of caregivers report that the CAC provided them with resources to support their child and respond to their needs in the days ahead. One community partner described her experience with her local CAC like this: "I appreciate that we have this resource in our community and I do not have to travel. My children seemed to be very at ease here despite a very stressful situation."

Responses from community partners showed 98% felt the CAC model fosters collaboration on the MDT, and 97% indicated clients served through the CAC also benefit from this team collaboration. Ninety-six percent agree that CACs provide important resources that improve their ability to work. One community partner described her experience with her local CAC like this: " Our multi-disciplinary team is very much a productive use of my time and effort. I am able to discuss cases with team members, receive insight and collaboration that allows me to serve our victims more effectively and capably."

E. 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 2021-23, 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.

During CY 2020, the primary focus of DCC was to sustain overall child care capacity during the COVID-19 pandemic. DCC filed several emergency regulations to impose stricter guidelines on providers to address the public health concerns related to COVID-19. DCC also amended its state plan to help alleviate the financial burden to all child care providers created by the many public health related executive orders.

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 are eligible to have their entire household income excluded from the CCAP application.

During CY 2022, 39,015 children and 22,319 families received CCAP benefits. Of the total number of children receiving benefits, there was an average of 2,994 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 2022 were $159,529,389.

DCC contracts with Child Care Aware of Kentucky (CCA), housed at the University of Kentucky (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, three 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
- Eight professional development coaches to ensure adequate supply of quality child care programs and services are available in each regional hub covering the ADD

DCC, through its CCR&R contract, works actively 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) Region IV office and contracted affiliates. DCC staff have also participated in several technical assistance opportunities and Peer Learning Groups (PLGs). KICCS (Kentucky Integrated Child Care System) helps DCC manage child care services in Kentucky and contains information on all the child care providers throughout Kentucky regulated by the Division of Regulated Child Care (DRCC). This system processes provider payments for CCAP, as well as helps track licensing and certification requirements for child care providers. This system also includes a provider portal for child care providers. Reports are compiled quarterly, annually, and ad hoc for state and federal reporting. Analyses of data reports are used to support 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.

During CY 2022, Kentucky's CCAP experienced a 22% increase in child enrollment. Families served numbers have increased by 26%. This is 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 is designated for sustainability payments that will be distributed to child care providers throughout the state. The funds will be distributed in nine payments totaling $49.6 million per payment cycle. The amount of each payment will vary based on the number of providers who apply and the tier for which they apply. There are three tiers, each with a wage requirement.

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

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

The second funding stream has also been dedicated to several other much-needed projects:

- Preschool Partnership Grants – This is a collaboration with the Kentucky Department of Education 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, 2022, 273 children (208 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 2022, 741 families (1,243 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, 2022, 28 providers are participating with a total of 349 slots. This is a decrease of one provider (32 slots) since the last reporting period.
- Provide facility repair grants. As of December 31, 2022, 906 awards have been issued.
- 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, 2022, 37 FCC grants were issued in 15 different counties

- Provide a grant match to businesses interested in opening on-site employee-based child care. As of December 31, 2022, three grants were awarded in two different counties.
- Provide a grant match to open new child care programs in child care deserts. As of December 2022, 27 grants have been issued to providers in 23 different counties identified as child care deserts.
- Update technology systems and provide new computers to child care programs through the state for enrollment, billing, and other business practices.

F. Children's Justice Act 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 taskforce grants are awarded after being reviewed and voted upon by the taskforce. 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 taskforce has allocated $82,500 annually to assist in determinations of abuse and neglect and to 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 and intended purpose and approved activities.

Beginning in late 2019, the taskforce funded the initial project the CAC proposed regarding CHFS sharing centralized intake (CI) notifications with CACs so that the center may be able to assist in identifying cases within the MDT's defined working protocol (cases fitting a specific criterion wherein the MDT has already determined a CAC-style joint investigation is necessary). This initial proposal and effort were to benefit children and families by allowing CAC to engage with children and families at a much earlier point in time, providing critical intervention, family advocacy, and therapeutic services more effectively. It was piloted in three Kentucky counties: Boone, Boyd, and Graves. This pilot program has provided the centers and CAC Kentucky with a window into the number of child abuse reports coming into centralized intake in the chosen counties to assess opportunities to provide services.

The CJA taskforce continued to fund CAC's project in 2020 and 2021, with 2021's focus on refining outcomes by child based upon response and service criteria.

In a report to the CJA Task Force in May of 2021, CAC Kentucky outlined the details and findings from the project, which uncovered that an estimated 15% of reports coming in through the Cabinet for Health and Family Services central intake system met criteria for the MDT response outline in local MDT protocols. Of these, CAC Kentucky also uncovered that only about half of the cases that met criteria received the full breadth of services outlined in the protocols. Although they have written agreements in place, many teams are not implementing the practices and procedures outlined by statute and their local protocols for investigating and serving child victims and their families.

Some of the challenges and barriers to implementing high functioning teams that rose to the surface during the pilot program include:

- The need to develop clear case criteria for MDTs
- The need for additional strategies and practical procedures for communication
- The need for skilled team facilitators
- The need for team coordinators

CAC Kentucky identified the need for training of CAC staff members to prepare them to address the above challenges and barriers within their local teams. The task force funded this project titled Strengthening Multidisciplinary Teams Training.

The task force also funded Validation of a Safety Culture Organizational Assessment in Kentucky Child Death Review Teams by the College of Public Health with the University of Kentucky (UK). The nature of Child Death Review (CDR) work is high-stress, and the result of this team-based work is of high-consequence. Despite the importance of understanding how CDR teams operate, there is limited research describing decision-making, team dynamics and individual stressors on CDR teams. Organizational assessments are used routinely to help teams to understand and identify areas of change within their decision-making, teamwork, and communication. The focus of this project was to draft a strategy for developing, administering, and validating a safety culture survey for CDR teams in Kentucky, aimed at helping them better understand the culture of their teams, identify areas of vulnerability in their culture and decision-making habits, and facilitate targeted quality improvement efforts to improve the outcomes of their work.

The task force funded a project from the University of Kentucky Pediatric Forensic Medicine's (UK PFM), Program Safe and Healthy Children and Families. UK PFM has taken a novel approach to assessing child maltreatment, utilizing an interdisciplinary approach to complete medical and psychosocial assessments of families to better understand the totality of the violence experienced by the family. Understanding the unique experiences of the family, especially other family violence and intimate partner violence is critical in preventing further maltreatment and adverse consequences for children and their caregivers. Gaining a better understanding of the risk factors can help drive Kentucky's policy, prevention, and intervention efforts. This proposal involved providing interdisciplinary evaluations of child maltreatment and neglect, provide and strengthen multidisciplinary team meetings across the UK PFM service region, and provide education and training to frontline workers.

In 2022, the taskforce continued to fund an established grantee, the University of Louisville (UofL) PFM. The PFM program is 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 CY 2022, PFM had 1,062 new incidents. This is a 17% decrease from CY 2021. The majority, 61% (646) in 2022, of consultations involve children four years of age or younger. PFM also provides consultation on fatalities and near fatalities, as well as cases of ingestions of illicit medications/substances. PFM reported in CY 2022, a continued significant increase of ingestions of illicit medication/substances, totaling 374. This is a 60% increase from CY 2021.

For the CAC Strengthening MDTs Training, national expert Cathy Crabtree developed and delivered a training program and follow-up resources for Kentucky's CACs. Held in May 2022, all 15 of Kentucky's CACs engaged in this training program. Training participants provided positive feedback regarding the impact of the training. Utilizing knowledge gained from the training, Kentucky's CACs are developing written plans to improve the effectiveness of their local teams, ultimately improving the system response for abused children.

UK's College of Public Health Validation of a Safety Culture Organizational Assessment in Kentucky Child Death Review (CDR) Team was encouraged to rescope the initial project proposal regarding the first phase. This shift involved being focused on the development of a CDR-specific organizational assessment but not to include any collections using this instrument at the local CDR team level. Challenges for the project included schedule constraints and lack of relevant research in this area.

Key learning points for the project included:

- A more in-depth understanding of CDR teams was essential to creating an organizational assessment that would yield actionable data to improve team culture, habits, and decision-making. Learning points around Kentucky CDR teams:
    - CDR teams are more ad-hoc and temporary than originally conceptualized, and membership in these teams is largely fluid
    - There is significant variability in the operations of CDR teams by county: in operations, output of reviews, and team thinking
    - CDR team culture appears to be highly driven by the team leader (coroner), which perhaps contributes to variability between teams
- State-level stakeholders described several challenges to CDR team operations, data dissemination, and eventual systems change:
    - Fear of conflict within teams and repercussions for member agencies
    - Secondary stress and trauma for team members doing reviews
    - Fear of judgment from external parties (state, media, public perception)
    - Concerns about review effectiveness and ultimate change

UK PFM Program Safe and Healthy Children and Families reported success. UK PFM proposed three main goals to meet the tenets of the Task Force's federal mandates.

Goal number one of the project sought to provide interdisciplinary evaluations of child maltreatment and neglect that inform risk evaluation, needs of the family and civil and criminal legal proceedings. Objectives met related to goal one of this project are listed below:

Quarter	Number of Children/ Families Served	Number of Medical Evaluations Provided	Number of Referrals for services	Number of Counseling Interventions Provided
Jan-Mar 2022	188	179	257	91
April-June 2022	192	163	276	99
Total	**380**	**342**	**533**	**190**

Additionally, PFM licensed clinical social workers (LCSW) provided services to 23 non-offending caregivers from January 01, 2022 – June 30, 2022, which included individual counseling services and crisis intervention. As PFM transitions to its new facilities next year, this portion of the program will continue to grow. Currently, PFM LCSWs must share provider space with other divisions for counseling services and such space is a commodity within the healthcare setting.

Goal number two of this project was to provide and strengthen MDT meetings across the UK PFM service region to enhance collaboration and communication of necessary stakeholders to provide safety for child victims of maltreatment and hold perpetrators accountable.

MDT meetings have continued in the Southern Bluegrass, Northern Bluegrass, and Cumberland Regions of the State which were in existence prior to the beginning of this project. The Northeastern MDT team has now been established and will hold its first meeting in July 2023. PFM was able to use existing relationships with DCBS workers in the area to collaborate with key DCBS leadership in the region to bring together law enforcement and prosecution to join PFM and DCBS in bimonthly meetings to discuss and review current cases.

Sexual abuse MDTs have existed across Kentucky for many years and have demonstrated the power of collaboration of disciplines: increased prosecution and offender accountability, improved communication amongst disciplines, and increased service provision for victims and families. PFM wants to ensure the same outcomes are seen in cases involving physical abuse and neglect which accounted for 79% of the cases seen by PFM providers during this funding cycle.

Goal number three of the project was to provide education and training to frontline workers. Kentucky struggles to hire and retain frontline staff in child protection. PFM has worked with DCBS administrators to recertify the DCBS core curriculum created by PFM already in use with Cumberland, Northern Bluegrass, and Southern Bluegrass regions. Low staff numbers, changes to what was previously known as The Academy (for new hires to the Protection and Permanency (P&P) Branch of DCBS) and a significant overhaul to the intake process for child abuse and neglect referrals have slowed the progress on this goal more than expected when this project began. However, work will continue for this portion of the project if/when funding is provided again. DCBS investigators, children, and families all benefit when frontline workers are provided with evidence-based education regarding child physical abuse, neglect, and sexual abuse. Families and children are provided with safety and services and workers can feel confident and supported in the tough decisions they must make.

G. Children's Review Program

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 out-of-home care (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. (Note: To minimize the number of staff in offices and increase staff safety during the COVID-19 pandemic, many CRP staff moved to remote or hybrid work. Processes have been developed that allow CRP to continue to carry out its functions without interruption. In addition, DCBS has approved fully remote work for staff completing QRTP assessments and for staff assisting with out-of-home placements, including after the pandemic.)

CRP is funded through title IV-E and State General Funds. CRP has four primary functions: LOC assessment, placement, QRTP assessment, and quality assurance, 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 11,322 levels (2,286 initials, 7,141 utilization reviews, 763 redeterminations, and 1,132 reassignments) from January – December 2022. As part of the QRTP assessment function, QRTP Assessors completed 598 QRTP Referral Assessment and Recommendation reports between January and December 2022. Of the 598 assessments, 552 children were recommended for a QRTP placement, and 46 children were not recommended.

As part of the quality assurance function, CRP maintained data on 10,537 children committed to DCBS at some point in 2022. Please note this is likely an overestimate of the number of actively committed children, as children released from DCBS custody whose status was not updated in the TWIST data are integrated into CRP's web application monthly. CRP also maintained program information on 177 PCC and PCP programs operating in 2022. Forty-four (44) residential treatment programs were open at any point during the year, 96 therapeutic foster care programs, and 36 independent living programs. This information is continuously being updated. CRP staff, primarily clinical reviewers and QRTP assessors, identified 2,929 quality improvement issues related to the services children received while in OOHC. CRP's functions are directed by the contract with DCBS and through ongoing contact with DCBS at many levels throughout the year. This includes monthly meetings with DCBS' central office staff, including the director and/or assistant directors in the Division of Protection and Permanency (DPP). There are also weekly virtual meetings between CRP placement staff and DCBS' Clinical Services Branch staff to discuss complex cases involving children with challenging treatment or placement needs. Since November 2022, CRP statewide placement staff have been joining daily priority placement meetings initiated by DCBS central office staff to discuss children placed in, or at risk of being placed in nontraditional settings such as DCBS offices, hotels, hospital emergency departments. In addition, CRP maintains ongoing communication with DCBS central office staff between meetings. CRP participates in committees and meetings as invited by DCBS. In the last year, this has included but not been limited to meetings involving SKY and other managed care organizations (MCOs), PCC/PCP providers, the Building Bridges Initiative (BBI), New Allies/Youth Villages, FFPSA, UK Innovation in Population Health Center (related to QRTP assessment implementation), and the SDM® project.

CRP placement staff participate in utilization review committees in selected DCBS regions. CRP also has designated staff who work closely with the DCBS Medical Support Section 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. Multiple CRP staff attend the quarterly Southern Bluegrass Quality Care Provider meeting. Regional Placement Coordinators are involved in collaborative meetings in Northern Bluegrass, Northeastern, 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 provides an opportunity to plan and track quality improvement activities, however, did not occur in 2022. CRP representatives also regularly attend the Alliance's quarterly OOHC council meeting 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 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 types for children in residential programs. CRP is in frequent communication with the PCCs/PCPs for issues of data collection, level assignment, placement, QRTP assessment, and general consultation. For PCC/PCP programs that have questions or 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 to new agencies or new agency staff during the year. During 2022, orientation training was provided to one agency, Abbey Hill. 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 were sent to programs and posted on the CRP website in preparation for the transition to the new level system on July 1. 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. DCBS frontline staff continue to utilize a system for notifying regional placement coordinators of a placement referral request through the TWIST Placement Workbasket. Regional placement coordinators 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 frontline worker is incomplete or is missing important information, the regional placement coordinator will communicate with the DCBS frontline worker to get a more complete packet of information. When making these packets available to potential placements, regional placement coordinators 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 in psychiatric hospitals and psychiatric residential treatment facilities (PRTFs), it is important that CRP staff maintain relationships with psychiatric hospitals, PRTFs, and MCOs. CRP tracks children in psychiatric hospitals through a census report generated by CRP and updated and returned to CRP by the hospitals on a weekly basis. In addition, CRP on a weekly basis continues to supplement the census report by obtaining information from the hospitals and MCOs on an ongoing basis 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 goals for children with significant treatment needs who are being referred for placement in a residential treatment program. In March 2022, based on DCBS guidance, CRP terminated its contract with a psychologist who had provided specific assistance with service planning for children with intellectual and developmental disabilities. DCBS' plan was for CRP to provide this assistance through the QRTP assessment process instead. 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 utilization reviews (URs) or by QRTP assessors during the assessment process. In addition, quality improvement (QI) 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. For example, based on DCBS' focus on aligning data gathering with federal priorities and language, CRP began tracking the number of involuntary confinements reported by providers in the progress reports submitted as part of URs, and a new QI category was added for this in early 2023, and adjusted the definition of physical managements to include assists when identifying QI issues in this category. In August, based on DCBS needs, CRP also began gathering information related to projected discharge dates for children from ALPs completed by residential treatment programs. New fields were then added to the CRP web application, and clinical r enter this information as part of every UR for a residential treatment program. The information is compiled monthly and provided to DCBS leadership.

During CY 2022, CRP continued to work with DCBS on 5S (specialized services) programs for children with high intensity needs. CRP facilitates conference calls on referrals and placements for children in these programs and, at the request of DCBS, reviews records of children in these programs to report to DCBS how well the programs are providing the expected services. CRP staff have worked in the past with DCBS staff on 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 2022.

CRP routinely convenes telephone conference calls and 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. Calls 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 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, and/or family members. DCBS also implements disruption consultations 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's regional placement coordinators are involved in these efforts and will continue to support the Cabinet in addressing the issue of 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 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 the last 90 days or who have moved within their first month of entering an OOHC placement, is also provided to DCBS leadership monthly to aid in addressing placement stability issues.

In 2022, CRP continued a process started in 2021 of completing data requests for DCBS, (e.g., residential bed decreases and program closures, length of stay in residential programs) as well as for the Children's Alliance, (e.g., the average number of placements for children in residential care), and multiple providers, (e.g., the number of children who moved to a foster care program from a residential setting). In 2022, CRP communicated information from 1,650 14-day notices to regional placement coordinators. CRP completed numerous data requests for DCBS regarding QRTP staff lists, referral responses, children in PCC placements with low reported IQ scores, autism spectrum disorder (ASD) diagnosis, or intellectual or developmental disability, and programs providing Dialectical Behavior Therapy (DBT). Data requests fulfilled for the Children's Alliance addressed questions related to the number of children assigned a level two or three in the new level system, and multiple provider referrals to, and discharges from specific programs.

For more than ten years, CRP has also worked with UK, EKU, and Capella University to serve as an internship site for undergraduate psychology and social work students during the fall and spring semesters.

During 2022, 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 needed and appropriate. CRP began completing QRTP assessments in March 2021 and expanded the number of assessments in 2022 as additional QRTP assessors were hired. 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 the federal FFPSA legislation.

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 2022, CRP continued working with the PCC/PCPs to assure the accuracy of data collected to measure performance and analyzed the second as well as the third full year of performance indicator data. FY 2021 data was analyzed early in 2022 and FY 2022 data was analyzed in December 2022. CRP provides data on a regular basis to PCC/PCPs so that the

programs can verify the accuracy of the data or make corrections as needed. Report formats have been developed and performance indicator data was provided to PCC/PCPs each quarter during FY 2022 for their review. Each year since FY 2019 has been considered a "hold harmless" year for the PCC/PCPs, and future years will continue to be so 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.

DCBS leadership worked during 2021 on the process of changing the administrative regulation that defines levels of care (922 KAR 1:360; Private child care placement, levels of care, and payment), to move from a five-level system to a three-level system. Proposed changes to 922 KAR 1:360 were filed in January 2022 and the new level of care system was implemented on July 1, 2022. Implementation of the three-level system has impacted CRP in multiple ways, primarily related to CRP's level-of-care assessment function. Significant changes to the CRP database, web application, and system-generated forms and communication were completed by CRP's programmer to ensure that level-related processes could be carried out within required parameters once the transition occurred. CRP worked with DCBS central office staff to update the Application for Level-of-Care Payment (CRP-7) form and other forms that are referenced in the 922 KAR 1:360 regulation and use of these new forms also began on July 1, 2022. The CRP-7 is submitted by PCC/PCPs at regular intervals for each child in their program, to identify the child's progress and treatment issues and service needs.

CRP has four primary functions: level-of-care assessment, placement, QRTP referral assessment, and quality assurance, 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.

Number of Level Assignments over the Past Five Years:

CY	Total Levels	Initials	Utilization Reviews	Redeterminations	Reassignments
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
2018	13,518	2,941	8,287	1,233	1,057

* 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 2018 to 2022 (a 3.9% decrease in 2019, an additional 3.1% decrease in 2020, and a 6.8% decrease from 2020 to 2021). This trend continued in 2022, with a 3.4% decrease in the number of levels assigned in 2022 compared to 2021. 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

inter-rater reliability of .50 (half a level from the mean) or less. In fiscal year 2022, CRP's inter-rater reliability (IRR) was .19.

During the last year, CRP has continued to work to collect IQ scores on children, especially those described as low functioning or developmentally delayed by DCBS or placement staff. This information is used in determining the most appropriate placement and treatment options for these children. CRP currently maintains 721 IQ reports on 520 children currently committed to DCBS. In 2022, a total of 223 IQ reports (on 201 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 Level-of-Care Assessment Unit monthly to aid in this. In 2022, CRP tracked 334 DCBS children who were identified as medically complex at some time during the year. The level of care 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.

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 regional placement coordinators are responsible for assisting DCBS staff in locating placements that best meet a child's needs. CRP's database identifies placement options based on the child's age, level of care, 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 identification. An effort is made to keep siblings together in placement whenever appropriate. CRP staff were involved in 5,005 placements in 2022, a significant decrease from 5,873 in 2021. However, continuing a trend started in 2021, placement coordinators made 111,435 more referrals in 2022 than in 2021, an increase of approximately 32%. The average number of referrals made for each placement increased from 58.8 to 91.31, an increase of about 55%. 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
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

2018	369,604	5,055	73.1

In addition, CRP provides information to DCBS staff about placement options for referred children, so that 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, level of care, etc. are identified, the regional placement coordinator shares information with the DCBS frontline worker about the types of evidence-based practices 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 evidence-based practices reported as being used at some point by the PCC/PCP programs (48 evidence-based practices are reported as currently being used by 93 programs) and updates these as needed. During 2022, a new staff type was added for PCC/PCP staff to help clarify when clinical staff, versus only the treatment director, were able to provide a particular evidence-based practice. Descriptions of EBPs are provided to DCBS so that they can be posted on the DCBS website.

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 how they compare to other similar programs in various areas including safety and permanency. In addition, the regional placement coordinators 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. The regional placement coordinators 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.

CRP statewide placement staff, in addition to the regional placement coordinators, 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, regional placement coordinators 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. 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 2022, CRP staff were involved in approximately 796 conference calls. This is a decrease from the 850 conference calls CRP staff were involved in, in 2021; the Clinical Services Branch revised the process and criteria for scheduling conference calls in June, and this change may account for some of the decrease. For conference calls on children 16 and over, independent living coordinators may be invited to participate to ensure the region follows appropriate steps to prepare children for transitioning out of care. Guardianship staff are invited to participate in conference calls on youth over the age of 18 who may need these services as they get closer to transitioning out of care.

In November 2022, DCBS central office staff initiated virtual daily priority placement meetings to discuss children currently in (or at risk of being in) non-traditional placement settings, (e.g., DCBS offices, hotels, hospital emergency departments). CRP statewide placement staff join these meetings daily to provide

updates on placement searches and other relevant information. During 2022, the head of the placements unit also 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.

Due to the number and characteristics of children in DCBS custody who are placed in psychiatric hospitals, it is important that CRP staff maintain relationships with psychiatric hospitals, PRTFs, and MCOs. CRP tracks children in psychiatric hospitals and PRTFs through a census report generated by CRP to be updated and returned to CRP by the hospitals on a weekly basis. In addition, CRP supplements the census report by obtaining information from the hospitals, PRTFs, and MCOs on an ongoing basis to be proactive in placement efforts with the goal of beginning discharge planning at the time of admission. CRP maintains and utilizes lists for children with complex needs and/or are in hospitals to effectively communicate with DCBS' Clinical Services Branch on challenging cases and updates these lists, as needed, to meet the changing demands of managed care. These lists are also used to track children 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 in 2022 because hospitals were not pursuing decertification while Kentucky was under a state of emergency.

As part of the placement process, CRP works closely with the MCOs. Some of the MCOs are willing to put additional services in place for children to help move them to or maintain them in less restrictive or more community-based settings, including moving children back to Kentucky from out-of-state placements. CRP also routinely interfaces with SKY and other MCOs about children with complex needs to discuss whether these types of additional services would be available to support a child in Kentucky before out-of-state placement is considered. CRP works with the MCO, potential placing agencies, and DCBS to determine placement options and the additional services that would be needed to support the child once placed.

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 ensure appropriate placement referrals for medically complex children. Currently, there are 169 homes on the list. 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 any medically complex children who are placed in non-medically complex homes.

Regional placement coordinators 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 IL 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 (see table below). The number of children in OOS placement at the end of 2022 was 15, which is a significant increase from 2021 when there were 4 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 1,039 at the beginning of 2022 to 966 at the end of the year, a 7.6% change. Note: CRP does not have access to data about the number of PRTF beds). An additional column has been added to the table below to begin tracking the number of referrals made for OOS placements each year, based on staff reports that this number has also increased significantly. (Note: 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 (individualized education programs, psychological evaluation reports, treatment plans, etc.) that is often required by OOS treatment facilities.

Number of Children Referred for OOS Placement by CY

CY	# Children Out-of-State During the Year	# of Children Out-of-State at End of Year	# of Children Referred for OOS Placement
2022	25	15	71
2021	19	4	
2020	25	8	
2019	31	10	
2018	27	16	

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 DCBS system to assure a smooth transition to the adult system. CRP staff may at times work with supported 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 fairly 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.

Calendar Year	# Youth in SCL During the Year	# of Youth in SCL at End of Year
2022	101	70
2021	111	66

2020	104	75
2019	105	74
2018	92	74

DCBS worked during 2022 with two different agencies, Maryhurst and Uspiritus Brooklawn, that have specialized (5S) residential programs for children with high intensity needs. CRP has continued to be involved in helping determine children's appropriateness for placement in these specialized services programs and has facilitated conference calls to discuss related referrals and placements. CRP staff also review the records of these programs to determine if agreed upon services have been provided. During 2022, CRP completed 152 service reviews for Maryhurst Specialized Services Program and 14 service reviews for Uspiritus Brooklawn Specialized Services Program for a total of 166 service reviews. (Note: Uspiritus programs, including the Brooklawn 5S program, were closed for intake in July 2022 by DCBS and children in the 5S program were transitioned to new placements by the end of October; the last Uspiritus Brooklawn 5S service review was completed in September). Service reviews are completed on a quarterly basis for each youth in these programs. In 2022, there were 97 different children who resided in these programs (88 in Maryhurst and 9 in Uspiritus). 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 the Maryhurst and Uspiritus 5S programs through the CRP web application.

CRP communicates with DCBS and/or PCC/PCPs on a daily and ongoing basis regarding placement referrals for children, clinical consultation, and other issues of concern.

Qualified Residential Treatment Program 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 2022. Hiring challenges associated with the COVID-19 pandemic that were present in 2021 continued in 2022, but six QRTP assessors were able to be added during the year. This brought the total number of full-time assessors to ten (one assessor hired in 2021 moved to a part-time position in October that provides only clinical supervision and consultation), leaving two unfilled positions. Due to the number of assessors available and challenges associated with the assessment processes, assessments were initially completed for just a subset of eligible children (those who were title IV-E eligible), based on priorities identified by DCBS. Assessments were expanded in April 2022 to all children placed in QRTPs, as additional assessors were hired. QRTP assessors completed 598 QRTP Referral Assessment and Recommendation reports between January and December 2022. Of the 598 assessments, 552 (92.3%) children were recommended for a QRTP placement, and 46 children (7.7%) were not recommended; 81 of the 598 assessments (13.5%) 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 percentage of reassessments in 2021 (4.8%, or 8 of 168 assessments). Reassessments occur when a child disrupts their current QRTP placement and is referred for placement with another QRTP, 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.

Multiple components of the assessment process, (e.g., interview scheduling, Medicaid billing documentation requirements, the process of obtaining previous treatment records for review, the report-writing process) were more time-consuming than initially anticipated, impacting the number of assessments that could be completed. CRP has worked with DCBS Central Office leadership to streamline the assessment process while maintaining the quality of the reports.

A portion of assessor time spent completing assessments is Medicaid-billable and 440 of the QRTP assessments completed in 2022 (73.6%) were able to be billed to Medicaid. This is lower than the 92.8% of assessments (156 of 168 assessments) that were able to be billed to Medicaid in 2021. This decrease is related to changes in assessment procedures and processes decided on in consultation with DCBS leadership to increase the number of assessments that could be completed. For example, it was recommended that fewer historical records be reviewed, and that fewer attempts to schedule interviews be made. As a result, fewer cases in 2022 met the five-hour minimum set by the Kentucky Department of Medicaid Services for billing of QRTP assessments. Medicaid-billable time in 2022 represents more than 2,600 hours of records review, interviews, and assessment tool scoring (a little less than four and a half hours per assessment on average).

CY	# Assessments Completed	# Assessments Recommending QRTP	# Assessments Recommending Against QRTP
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 2022, assessors brought 17 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.

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. These 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 2022 these specific issues of concern have been emailed on a weekly basis to DCBS. In 2022, 344 specific QI issues were sent to DCBS, averaging six to seven cases each week.

Since the implementation of QRTP assessments, QI concerns identified during the assessment process have also been communicated to DCBS. Clinical reviewers identify 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 (e.g., identification of physical management concerns was expanded based on cabinet guidance related to a child's age).

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 3,913 QI issues in 2018, 3,924 issues in 2019, 3,645 issues in 2020, and 2,901 in 2021. In 2022, 2,929 QI issues were recorded. These numbers are most meaningful when considered as a percentage of the total number of URs completed. The percentage of URs for which a QI issue was identified in 2018 and 2019 remained between 46-47%, then decreased in 2020 to 42%, and again in 2021 to 38%, (see table below). In 2022, the percentage of URs for which a QI issue was identified increased again, to 41%. Overall, the percentage remains consistently high, even though the PCC/PCPs have access to the information and are encouraged to use it for their own quality improvement purposes.

CRP continues to monitor and adjust the system as necessary. In 2022, this included discussions with the department's central office staff to verify CRP reviewers are identifying issues in ways consistent with expectations related to the transition to the three-level system, (e.g., QI issues related to the number of individual therapy services provided).

Calendar Year	# QI Issues Identified	# URs	% URs With Identified QI Issues
2022	2,929	7,141	41%
2021	2,901	7,619	38%
2020	3,645	8,577	42%
2019	3,924	8,529	46%
2018	3,913	8,287	47%

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 placement information is as current and accurate as possible. In 2022, 15,938 PCC tracking records were reconciled with information in the CRP web application.

During 2021, information regarding QRTP designation for residential treatment programs was added to the CRP database, as well as information about which programs were able to provide specialized services for specific populations identified by DCBS (pregnant or parenting youth and youth who were at risk for, or victims of trafficking). This information is added or updated as needed. There were 40 programs designated as a QRTP at the end of 2022.

Based on changes to demographic information in DCBS documentation and in TWIST, information about children's sexual orientation and gender identification was added to the CRP database during 2022. CRP works closely with the PCC/PCP providers through their association, the Children's Alliance of Kentucky, to improve outcomes for children in the custody of DCBS. As noted above, the Children's Alliance Stakeholders CQI meeting, and the CRP quarterly Quality Outcomes for Children Council meeting provide opportunities to plan and track quality improvement activities.

During 2022, CRP made some additional data available to DCBS central office staff, (e.g., making summary numbers available on web application pages identifying children placed out of state, in SCLs, in detention, etc.). A continuing focus of 2023 will be to further enhance web application processes to provide information more readily and effectively to CRP and DCBS Clinical Services Branch staff for decision-making regarding children facing placement challenges. This will include a particular focus on adding information to the web application pages related to children who have specialized placement and treatment needs. 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.

CRP currently maintains paper charts for children in OOHC but recognizes the need to move to electronic records to increase the safety, security, and efficient accessibility of case information as CRP carries out its various functions. CRP has begun exploring the costs and processes involved in moving to a digital storage and retrieval system and will continue these efforts in the coming year.

The TWIST LOC, placement, and QRTP workbaskets allow DCBS frontline staff to submit documents to CRP more efficiently and provides a mechanism for communication from CRP to the DCBS frontline worker through the pend back function when documentation submitted is not sufficient in some way. With few exceptions, DCBS workers seeking an initial level-of-care assignment for a child utilize TWIST to submit this request and the placement workbasket is being used for most placement referrals. However, use of the pend back function in the placement workbasket is still being refined, and parameters for use of this function in the LOC and QRTP workbaskets have not yet been established. Regional placement coordinators have worked to make sure that their written feedback in the pend back function conforms to cabinet IT requirements, to allow data gathering from the feedback. CRP will continue working with unit staff and the Cabinet to utilize the pend back function as effectively as possible.

During 2022, the QRTP workbasket continued to list children who had been placed in a QRTP (based on DCBS frontline staff's entry of placement information in TWIST) to alert CRP of the need for an assessment. Modifications of the QRTP workbasket requested by DCBS were not completed during 2022. These changes were implemented at the beginning of 2023 and CRP will provide feedback about needed changes and continue working with DCBS on how to utilize the workbasket most effectively.

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 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. CRP will also work to improve information received on progress reports from PCC/PCPs. This will involve CRP's collaboration with the Eastern Kentucky University (EKU) Training Resource Center (TRC) staff to launch an updated training through TRIS (Training Resource Information System) on how to best complete the new ALP form that PCC/PCPs submit for URs. QRTP unit staff will continue to develop relationships with psychiatric hospitals to increase the 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. One option would be to add data related to QRTP assessments to this dashboard.

Late in 2022, CRP analyzed performance indicator data for FY 2022 and provided the new data to PCCs/PCPs and the Cabinet. 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 review by the PCC/PCPs to help inform programs of treatment/service issues related to the new three-level system, or about areas of increased DCBS focus related to QRTP implementation. It is anticipated that the QI information CRP collects in the coming year will include data relevant to QRTP criteria, (e.g., QI concerns related to interventions and practices by PCCs/PCPs not reflective of a trauma-informed care approach; QI concerns related to lack of family engagement or family therapy provided by PCCs/PCPs), to complement the Cabinet's reviews of QRTPs. QI data will also support DCBS in tracking whether an increased number of treatment services are being provided to children identified as having significant treatment needs in the new three-level system, an important objective of the transition to the new system. CRP will continue to work with the Cabinet to meet any other data needs in this area.

CRP has continued to assess the information collected from PCCs/PCPs related to the EBPs utilized. 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 such as Key Assets. CRP will continue to work with DCBS to address placement issues, (e.g., the increasing number of children referred and placed OOS and issues related to their return, addressing placement issues related to children in non-traditional placements and tracking these placements if needed, 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 be consistent with the QRTP assessment process

and related Cabinet priorities, (e.g., continuing efforts to integrate a trauma-informed perspective with placement referral narratives as well as to highlight children's treatment needs, progress, and strengths).

The number of QRTP assessments will continue to increase during 2023, due to the final assessors being hired. The changes in the QRTP workbasket allow DCBS frontline staff 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 the most appropriate referrals, using approved referral processes consistently, and on 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 for the number of residential placements and the length of residential placements to decrease over time, and for the number of successful and stable step-downs from residential programs to increase. It is hoped that the QRTP assessment process will contribute to this outcome, by identifying earlier the treatment issues and placement needs of children who may require residential placement. Recent guidance provided by the DMS regarding billable activities that are part of the QRTP assessment process, is expected to increase the number of hours billed per assessment.

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 level-of-care assessment, placement, QRTP assessment, and quality assurance functions. CRP's annual budget for FY 2023 is $4,197,569.46. CRP will continue to communicate with and work with DCBS to meet other needs as they arise in 2023.

H. Community Collaboration for Children, Community-Based Child Abuse Prevention, and Promoting Safe and Stable Families

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 families who are struggling with other issues. 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 2022, 526 families received PEM services and 96% 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. Each region has an established regional network whose membership requires representation from DCBS, CCC service providers, early childhood councils, family resource and youth service centers (FRYSCs); health departments, mental health service providers, court officials, domestic violence shelter representatives, other child and family serving prevention agencies, community leaders including the faith community, and local citizens including parents. A regional network is a community-based collaborative 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. Needs of the region are discussed and DCBS data is shared, as well as community partner data. Regional networks are a unique component of the program and fulfill the statewide network requirement of the CBCAP program instructions.

In 2022, IHBS served 597 families with 1,154 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.

The DCBS Training Branch provides training for agencies who provide IHBS and was developed to reflect all CBCAP and DCBS requirements, as well as promote strengths-based principles for family engagement. CCC vendors participate in quarterly statewide meetings and an annual orientation. CCC employs one parent leader as an effort to increase parent involvement and build leadership skills. The CCC parent leader serves on the National Parent Advisory Council with FRIENDS, the CBCAP federal resource center.

CCC's work on the Child and Family Services Plan (CFSP) is an ongoing task with direct services and federal mandates. CCC collaborates with various agencies including DPH, early childhood, mental health, faith-based communities, and education, among others. CCC in-home services staff continue to provide Ages and Stages Questionnaire, social and emotional screening to all children under the age of five and a half years. Having these tools helps to identify children in need of services for further prognoses. Increased use of data to identify needs or gaps in service has been encouraged to assist the regional networks with planning. CCC is included in the new in-home services data collection system. Access to better data collection and analysis has contributed to progressive improvements in service planning, delivery, and outcomes.

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 will continue to focus on IHBS, regional networks, and PEMs across the state. PEM programs will continue in 14 counties, with continued efforts to identify additional funding sources for program expansion. Funds from ARPA will be used to sustain the PEM expansion, funds to decrease wait lists, and to provide concrete supports to families in each region in CY 2023 and beyond. CCC in-home services will continue in the geographic location, as described above. In-home services continue to be the most effective and in demand services for prevention of abuse and neglect. Regional network collaborations continue to be critical, as with funding limitations, creative solutions, and a decrease in duplication of services are needed. PEMs were expanded to ten additional counties in CY 2022 because of prevention state general funds and CBCAP funding through the ARPA. Discussions, among DCBS leadership, continue to occur regarding the prioritization of funding for prevention.

The FRIENDS National Resource Center provided technical assistance regarding service array. In addition, FRIENDS also hosts a variety of webinars and assistance with the CBCAP grant available to all CBCAP grantees. Kentucky applied, was approved, and participated in both the Prevention Mindset Institute and the Poverty Institute. Current efforts include the development of a logic model, and the participation of statewide parent groups to be in the Building Effective Parent/Practitioner Collaboration (BEPC) training.

I. Community Services Block Grant

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 federal poverty line (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 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 Continuing Resolution (CR) passed with language extending the use of the 200% FPL for CARES and CSBG FY 2021, FY 2022 and FY 2023 funds that are released during the CR. On January 6, 2023, the Office of Community Services (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 FYs 2022-23.

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 of Kentucky 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.

The Office of Community Services (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 (ROMA 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, 2023.

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. The Division for Administrative and Financial Management (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

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 CASA programs, for CY 2022, the KCN collaborated with a new local program to build capacity through training and prepare to provide direct services in its counties. KCN also created two new programs. CASA of the Appalachian Mountains (CAM) became a full member of National CASA and KCN in June 2022. In December 2022 start-up paperwork was submitted for a new CASA program in the 21st Judicial District, CASA of the Gateway Region.

KCN is a statewide association. In 2022, there were 85 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. KCN has two standing workgroups that formed in 2021 and include The Equity Workgroup and The Performance Measurement/Data Workgroup. KCN provides significant training and holds two signature training events twice a year: Volunteer Coordinator Training and a Training of Facilitators (TOF).

In 2022 the KCN launched a new Board Governance Initiative. 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 serves on several statewide advisory committees and workgroups which include the CAN Prevention Board, Children's Justice Act Task Force (CJA), Judicial Commission on Mental Health Workgroup/DNA Subgroup and the Judicial Engagement Workgroup. KCN also works collaboratively with the state association for Children's Advocacy Centers and other service providers in conference calls and meetings, participating in trainings, information, and data sharing.

Statewide CASA maintained volunteer advocates numbers from 1,302 in 2021, to 1,239 in 2022, serving 3,538 dependent, abused, and neglected children in 2022. Three hundred twenty-eight (328) new volunteer advocates were trained statewide in 2022. KCN provided or facilitated over 30 virtual and in-person training opportunities for local CASA program staff and board. These trainings focused on board governance, a new executive director, sustainability planning, performance measurement, logic models, and diversity, equity, and inclusion.

During 2022, local CASA programs expanded to serve children in Allen, Simpson, Clay, Perry, Leslie, Letcher, and Knott Counties. KCN also began the start-up process for the new CASA of the Gateway in Rowan, Bath, Morgan, and Menifee Counties.

The implementation of FFPSA combined with the continued impact of the COVID-19 pandemic resulted in another year of significant (about 25%) decrease in AOC petitions in 2022 in Kentucky. The gap between substantiations and petitions narrowed in 2022 versus prior years. This reduced CASA appointment for abuse, neglect and dependency cases and increased the availability of CASA volunteers to serve on these cases. KCN issued its 2023 Biennial Report on February 1, 2022, detailing the impact

that the federal families first legislation is having on the state's child welfare system. CASA programs and volunteers report seeing a lack of availability of prevention services when referrals are made, as well as a lack of available quality providers. There has also been a significant impact on volunteer retention over the past two years due to turnover with frontline social workers.

KCN adopted a new growth plan in January 2022 for CYs 2022-2024 including increasing the CASA program footprint to be active in 100 counties in Kentucky by mid-2024. Barriers to increasing the CASA footprint are the total 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. Community support can be a barrier to establishing and creating new local programs and boards, as can apprehension and judicial interest on having CASA in a particular jurisdiction.

Another goal is to increase the number of total active volunteers to 1,500 by mid-2024, to expand the advocacy population served. Barriers to achieving increased volunteer numbers include improving retention strategies and raising awareness of CASA to attract new volunteers. Some volunteers were reluctant to take new CASA cases during the COVID-19 pandemic.

K. In-home Services and family preservation

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 strength-based 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. The lower scores on the NCFAS form the basis for goal development using evidence-based intervention strategies with a scientific rating of well-supported,

supported, and 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, 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 the services were successful. From January 1, 2022, through December 31, 2022, there were 2,123 families with 3,936 children at risk of OOHC placement or reunifying from foster care participating in one of the FPP services. The table below indicates that 3,631 of those children were reunified with their families or remained home safely at closure indicating a 92% success rate.

Family Preservation and Reunification Services Continuum, CY 2022

Service Type	Referral Criteria	Details	Outcomes
Family Preservation Services (FPS)	*Moderate to imminent risk* of removal of child from home.	**Duration:** 1-6 months for 3-10 direct hours per week **Caseload:** 2-6 families at a time **Ages:** 0-17 years old	2,123 of 2,624 families completed services
Family Reunification Services (FRS)	*Immediate to Moderate risk cases* with a plan to return a child home from out-of-home care.	**Duration:** Average 3-6 months intervention meetings; 1x/week for 3-8 direct hours based on family needs **Caseload:** Not to exceed six cases at a time. **Ages:** 0-17 years old	3,631 of 3,936 children remained safely in the home (92%)

<u>Family Preservation and Reunification Services (FPRS)</u>

- 2,624 families accepted
- 2,123 families completing services
- 3,936 children at imminent risk of placement
- 3,631 of 3,936 children remained safely in the home (92%)

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.

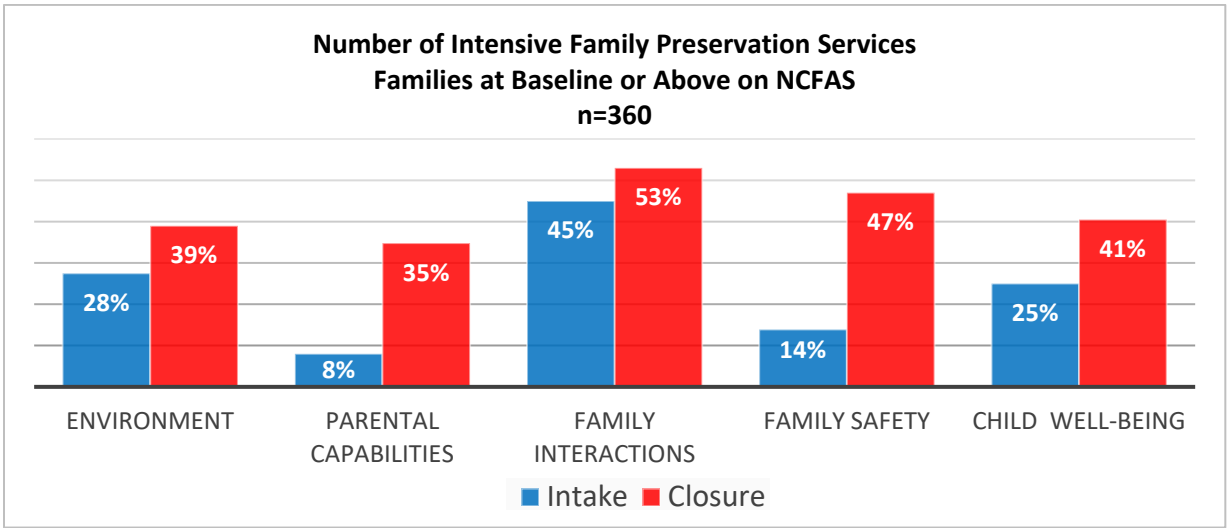
Follow- up Activity Completed CY 2022

Six Month Follow-Up	FPS	FRS	All FPRS
# Children at Risk with Follow-Up	2,005	438	2,443
# Children at Risk in Home at Follow-Up	1,835	397	2,232
% of Children at Risk in Home at Follow-Up	92%	91%	91%
12 Month Follow-Up	**FPS**	**FRS**	**All FPRS**
# Children at Risk with Follow-Up	2,465	522	2,987
# Children at Risk in Home at Follow-Up	2,226	456	2,682
% of Children at Risk in Home at Follow-Up	90%	87%	90%

Families served are evaluated at intake, closure, and at interim for services extending beyond 45 days using the North Carolina Family Assessment Scale (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 2022, 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.

NCFAS Scores at Intake and Closure CY 2022



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 (27%), Family Safety (33%) 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 IFPS intervention.

DCBS has implemented the federal Family First Prevention Services Act (Family First) of 2018 (Public Law 115-123). Family First makes changes to Title IV-E of the SSA, 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 trauma-informed (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, 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 In-Home Services 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 trauma-informed 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 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

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 16 ECMH specialists across the state located at regional 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 Community Early Childhood Councils (CECC) 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 regional inter-agency councils (RIACs) and District Early Intervention Committees (DEICs).

In addition to direct services provided to young children and their families, ECMH specialists conducted 2,708 consultations with early childhood professionals in 2022. ECMH specialists provided 265 trainings to a variety of early care and education personnel and other stakeholders. Finally, they participated in 1,543.50 hours of early childhood meetings including CECCs, DEICs, CCC regional networks, and FRYSCs.

M. Family Alternatives Diversion

Family Alternatives Diversion (FAD) is a diversion program for self-supporting families or families who could be self-supporting if short-term needs are met. FAD provides short-term temporary assistance to stabilize families and maintain self-sufficiency as an alternative to applying for ongoing cash assistance. FAD is available to Kentucky Transitional Assistance Program (KTAP) eligible families, not currently receiving cash payments, which are at or below the gross income limit for KTAP for the appropriate family size. FAD is administered statewide and is funded by Title IV-A, TANF.

Individuals are screened for FAD eligibility when applying for KTAP by local field staff. If it is determined a family could benefit from FAD, the family is given the opportunity to choose to receive either FAD or ongoing cash assistance. To receive FAD payments, all short-term needs must be verified. Once expenses are verified, payments may be issued to either a vendor or vendor and applicant.

Families eligible for FAD may receive up to $1,300 to pay for verified short-term needs. The types of benefits provided include assistance with transportation, child care, shelter, utility costs, or employment related expenses. FAD has a three-month eligibility period and is not considered cash assistance. FAD does not count towards the 60-month lifetime receipt of TANF cash assistance. FAD may not be received more than once in a 24-month period and is limited to twice in a lifetime. Receipt of FAD payment excludes the benefit recipient from receiving ongoing 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 FAD, additional services or referrals should be offered including Supplemental Nutrition Assistance Program (SNAP), Medicaid, child care assistance, child support, and employment services.

From January 1, 2022, through December 31, 2022, an average of two families per month received a FAD payment. The average payment per family per month was $1,262.94. In CY 2022, FAD totaled 19 cases statewide, an average of two cases per month and expenditures of $15,155.23. The number of FAD cases increased slightly from 14 cases in 2021 to 19 cases in 2022. With local offices providing in-person services again, citizens who may have been unable to access services due to the lack of a phone or internet access are now able to meet with workers face to face, it is thought the increase will continue. Over 50% of the families received the payment in the last quarter of 2022 after local offices offered in person services again.

During 2022, there were proposed changes to FAD regulations and policy. FAD will be updated to FAST (Family Assistance Short Term). FAST Payments can be made for up to $2,600 during a three-month period and can only be received once in 12 months but is not limited to twice in a lifetime. The approved changes have a planned release date of June 2, 2023.

Kentucky has obtained approval for policy/regulation changes to modernize KTAP and TANF related programs which include FAD to FAST. With these changes in place, Kentucky expects the usage of the program will increase and will assist more citizens, as the income limits and benefit amounts have increased.

N. Family First Prevention Services

The Family Preservation and Reunification Services (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 level 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 evidence-based practice (EBP) interventions and an in-home intervention using a strength-based approach to working with families. Families served are evaluated at intake, closure, and interim for services extending beyond 45 days using the NCFAS and other evidence-based clinical assessments. This provides a comprehensive assessment of family functioning and determines service needs.

Eligible families are referred by DCBS frontline staff and referrals are screened and approved by a designated DCBS regional staff person. Families are evaluated using the NCFAS and other clinical assessments to provide a comprehensive assessment of family functioning and determine service needs. Lower scores on the NCFAS form the basis for goal development using evidence-based intervention

strategies which bear a scientific rating of well-supported, supported, or promising on the Title IV-E Prevention Services Clearinghouse.

FPRS services are provided statewide in all 120 Kentucky counties through contracts with non-profit agencies. In 2022, the agency served 110 families, with 87 cases served through closure. Of the closed cases, 55 cases closed with the children remaining in the home at closure, 14 children were removed from the home, and 18 cases were listed “Other” that were closed due to moving out of the service area, refusal to complete services or no contract, or cases were opened but no longer met criteria for the evidenced based practice.

DCBS collaborated with Chapin Hall to administer the Kentucky Provider Community Readiness Assessment Survey. Survey results were analyzed in the selection of Evidence-Based Practices to include on Kentucky’s Five-year Prevention Plan. Those EBPs included Functional Family Therapy, Homebuilders, MI, Multi-systemic Therapy, Parent-Child Interactional Therapy, Sobriety Treatment and Recovery Teams, and Trauma-Focused Cognitive Behavioral Therapy. Capacity growth was indicated in all domains analyzed by the survey. The overall themes raised in the justification assessing the extent to which key indicators of capacity relevant to a trauma-informed approach exist include the readiness of the provider’s infrastructure, training of staff on trauma-informed care, and the engagement of clients in practice.

Common themes were raised in assessing the capacity in which the implementation and use of EBPs exist. These include the adequacy and availability of financial resources; the accessibility of resources, such as staff training plans and coaching beyond initial EBP training; and the integration of staff or teams to guide the use, implementation, or sustainability of EBPs. The common themes raised in the justification assessing the extent to which key indicators of capacity relevant to the use of data and evidence in a CQI process include the logistics and planning for CQI in the organization, how CQI is supported by the organization through dedicated CQI staff or teams, automation of an information management system, the use of case reviews in monitoring performance, and CQI processes in place to monitor performance.

In CY 2022, activities to support capacity growth identified in the Community Readiness Assessment Survey continued. For a trauma-informed (TI) approach, contractual requirements to deliver services in a trauma-informed manner, staff completion of trauma-informed care training, and implementation of policies and procedures to ensure practice occurs in a trauma-informed manner continued. In January of 2023, a third pilot began in Southern Bluegrass service region with KVC Kentucky. Additionally, a Five-Year Prevention Plan Amendment was approved in December 2021, adding Intensive Care Coordination Using High-Fidelity Wraparound (HFW) and expanded use of MI. MI was approved for use in all three EBP categories: in-home skill-based parenting, mental health, and substance use, and for use by child welfare workers. A second Five-Year Prevention Plan Amendment was approved in September 2022, adding Intercept® as an evidenced-based practice (EBP). Intercept® is an EBP through Youth Villages. CY 2022, Intercept® is piloting in Cumberland, Southern Bluegrass, and The Lakes Service Regions.

In CY 2022, DCBS continued to collaborate with Chapin Hall with the continuation of Family First Continuous Quality Improvement (CQI) infrastructure, CQI processes, case reviews, and data use. The Measurement Framework continues with implementing and evaluating Family First prevention services, including capacity, reach, fidelity, and outcomes. Framework activities occurring in CY 2022 includes identifying capacity needs from the DCBS Survey that occurred in CY 2021, and the focus group with contracted providers, facilitated by Chapin Hall in CY 2022, implementation of a broader Continuous

Quality Infrastructure, and the development of the ad hoc Reach report. The broader CQI infrastructure includes continued quarterly case reviews, for one year, exploration and integration of CFSR items relevant to Family First, formalizing an improvement process for case review that captures strengths and needs during debriefings with providers, prevention branch attendance at monthly CQI specialist's meetings and regional CFSR review outcome meetings on items relevant to Family First CFSR items. DCBS worked with TWIST on streamline the Prevention Service Referral draft and the integration of the SDM Tool Draft. Another broader CQI infrastructure item is the creation of the ad hoc Reach report in advance of a Reach Dashboard that will assess each Family First Prevention Services.

The ad hoc Reach report will identify trends from the Family First case reviews and see cases reflected in the data. The ad hoc Reach report provide assessment of children eligible, actual children referred, gatekeeper and provider response to referrals, EBP referred/received, disaggregated by race, ethnicity, age, region to access for capacity and trends in data. There remains continued discussion with Department of Service Region (DSR) CQI specialist on second level case reviews.

DCBS' partnership continued with Dr. Brandy Kelly Pryor of BKP Strategies, DBHDID, and the System of Care (SOC) Five grant. In SFY 2022, Dr. Kelly Pryor completed the Race and Equity Audit. The purpose of the audit was to assess the design and implementation of the Family First Prevention Safe Act (FFPSA), ensure cultural responsiveness, and avoid disproportionality and disparity in services. Moreover, Dr. Kelly Pryor facilitated a small workgroup on the Racial Equity Impact Assessment (REIA) including the Five Whys to Implementation Practices at the January 2022 Family First Quarterly Stakeholder meeting. Dr. Kelly Pryor completed the qualitative pieces of the assessment but was unable to incorporate recommendations into the FFPSA CQI process and building capacity within staff to review data that may be indicative of disparate outcomes. Dr. Kelly Pryor will draft a scope of work to share outcomes from REIA in new contract in SFY 2023.

A data sharing agreement was not finalized until December 2022, and the data was shared in February 2023. The Internal Review Board (IRB) approval occurred in February 2023. An anticipated findings report of the audit following the data analysis will occur in CY 2023.

A second Five-Year Prevention Plan Amendment was submitted in March 2022, adding Intercept® as an EBP. Intercept® is an EBP through Youth Villages. CY 2022, Intercept® is piloting in Cumberland, Southern Bluegrass, and The Lakes service regions. The submission was approved in September 2022. A third Five-Year Prevention Plan amendment is in draft to include Kentucky Strengthening Ties and Empowering Parents (KSTEP) as an EBP for transitional claiming, to expand the definition for candidates for foster care to include children who have come to the attention of the child welfare agency, and child welfare workers utilizing MI as an EBP.

DCBS received an additional $20 million appropriation of state general funds to be utilized for prevention services in SFY 2022. In CY 2021, DCBS began the planning and contracting process to expand the KSTEP program into the entire Salt River Trail and Cumberland service regions, in addition to increasing flexible funding to meet concrete needs from $500 to $1,000 per family. Additionally, the agency received $10,000,000 in funding for SFY 2023, and an additional $10,000,000 in funding for SFY 2024 with the agency's biennium budget for utilization with Family First programs.

Kentucky received a grant award in the amount of $7.9M to support Family First implementation. This grant funding was originally going to be used to support expansion of Family Preservation Program (FPP). However, in CY 2021 with the Consolidated Appropriations Act granting 100% federal

reimbursement to states for Family First EBPs through 9/30/2021 and the department receiving a $20 million appropriated in state general funds for Family First through state fiscal year 2022, this was no longer a need for these funds. Instead, a portion of these funds was used to support Qualified Residential Treatment Program (QRTP) implementation in the form of stipends to QRTP providers who were struggling financially because of pandemic related challenges including staffing. The remaining balance of these FFTA funds is $6,519,207 and these must be used by 9/30/2025, understanding this is 100% federal funding and cannot be used for services for which a Title IV-E claim will also be submitted. Beginning October 1, 2026, the federal reimbursement for Title IV-E prevention will increase to the state's FMAP rate, which will be roughly 72% in Kentucky (based on current FMAP rate). Similarly, Kentucky received a federal certainty grant, granted to former waiver demonstration states. The current amount of this grant is $3,003,300. This grant amount can be adjusted based on the state's Title IV-E claiming, but it must be used by 9/30/2026. It can also be used to support implementation of Family First services.

FFTA and certainty grant funds are one time funding. Therefore, there must be a plan for sustainability of any expansions funded utilizing these funds. With additional state general fund appropriations supporting Family First prevention program expansion in this budget biennium (FPP and KSTEP), these funds could be used to support further expansion in state fiscal years 2024 and 2025. This would leave the department well positioned when the federal reimbursement for Title IV-E prevention services increase on October 1, 2026. Another option for the funds may for the expansion of community response if the evaluation demonstrates positive outcomes. This option is dependent upon a future plan to amend the Title IV-E prevention plan. Finally, a third option would be to use these funds as flex funds to help support any Family First programming that does not have flex funding specifically built into EBPs.

O. Family Resource and Youth Service Centers

The Family Resource and Youth Service Centers (FRYSCs) 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 the 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 the Kentucky Coalition Against Domestic (KCADV), now known as 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, the state general funds, TANF, Kentucky Trust and Agency, and Social Services Block Grant (SSBG).

2022 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. In CY 2022, over $85,000 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. 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.

- Housing is a top priority, and KCADV administers three housing-specific grants that provide rental assistance to survivors totaling close to $1,410,419 in housing funds. ZeroV also operates 84 units of tax credit housing.
- In 2022, 35 domestic violence advocates completed 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 work.
- In October, ZeroV signed a Memorandum of Understanding 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 KCADV will utilize the findings to implement improved services to survivors and discuss altering the physical environments.
- Beginning in June 2022, ZeroV worked to migrate all DPMs to a uniform database for client service recording and reporting. This will help to streamline data collection and reporting practices, ensure more accurate and complete service reporting, allow ZeroV to better assist DPMs with data collection and entry, and allow ZeroV to pull statewide statistics with ease and expediency.
- 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. 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.

- DOVES, 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.
- 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 taskforces 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:

- 3,241 people served through emergency shelter services
- 7,403 people received group or individual counseling services
- 12,805 survivors received non-residential services through 15 member programs
- 1,013 men received domestic violence services through programs
- 2,264 children received services from programs
- 1,814 survivors who identify as African American, 808 who identify as Hispanic/Latino, 54 who identify as Asian, and five who identified as American Indian/Alaskan Native received domestic violence services from KCADV programs
- 397 survivors identified as lesbian, gay, bisexual, or transgender received services
- 395 survivors had 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:

- Healthy pregnancies and births
- Healthy child growth and development
- Healthy, safe homes
- Self-sufficient families

R. Kentucky Center for School Safety

The Kentucky Educational Collaborative for State Agency Children (KECSAC) assists local education agencies to provide and assure high-quality educational support services through a collaborative delivery system involving KDE, the Department of Juvenile Justice (DJJ), community-based services, mental health services, developmental disabilities and addiction services, and private and public child and youth care programs. KECSAC provides administrative services, professional development, and leadership in an efficient and cost-effective manner that complies with state education reform initiatives and other applicable state and federal mandates. KECSAC provides a comprehensive evaluation of the delivery of educational services to state agency children including the administrative process, service delivery, program monitoring, and outcomes.

On July 13, 2018, Governor Bevin issued an executive order reorganizing various education boards and councils. The Governor abolished Center for School Safety (KRS 158.442 and KRS 158.443) then recreated it and reconfigured the KCSS Board of Directors. The KCSS Board of Directors was reduced

from 12 members to 11 members. DCBS is no longer a required member. The board disbanded on 7/03/2018.

Other board of directors' members represent circuit court, Division of Mental Health, school superintendents, KDE, DJJ, Kentucky Education Support Personnel, Kentucky Association of School Councils, school principals, school boards, school bus drivers, and teachers. Changes implemented by the Executive Order will have minimal fiscal impact. The board will see a reduction in size, which could lead to nominal savings.

S. Kentucky Children's Health Insurance Program

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 the 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 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 2022 CAHPS surveys indicate that overall utilization of health services by KCHIP recipients continues to remain 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 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.

T. Kentucky Education Collaboration for State Agency Children

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 DJJ, CHFS, and DBHDID. All monies come from state general funds.

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, KDE, and the College of Education at EKU.

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.

Currently, KECSAC operates 74 educational programs in 50 school districts across Kentucky. Thirty-six (36) 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.

KECSAC-funded state agency educational programs provide funding to students between the ages of five and 21. The current 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.

The number of children and youth being served in department programs has slightly decreased, while students in DJJ programs have increased. As predicted last year, 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.

U. Kentucky Partnership for Families and Children, Inc.

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 22 employees; approximately 70% of the staff is parents that have raised, or are raising, children with behavioral health challenges and approximately 33% 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 is partnering with DBHDID and DCBS on Kentucky's System of Care FIVE grant that focuses 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
- Children's Justice Act Task Force
- System of Care FIVE Grant Management and Implementation Team

- Kentucky Partnership for Youth Transition
- Transition Age Youth Launching Realized Dreams
- 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, Surviving Challenging Behaviors, Better Understanding ADHD/bipolar disorder/etc., Bridges Out of Poverty, 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 2022:

- Monthly e-newsletters disseminated to 2,500+.
- Virtual conference and workshop attendance: 1,000+
- Children's Mental Health Awareness Day: 90+
- Resource requests: 500+

Many DCBS contracted PCPs and PCCs are embracing and implementing BBI, which utilizes System of Care values and principles including family-driven and youth-driven care. The philosophy is that children grow better in families and, when possible, in their home communities.

A theme that emerged during 2022 is the emphasis on families of origin being included on system and program level decision-making. The 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.

KPFC has created three KPFC peer support centers in three different regions of the state. These peer support centers offer peer services in a flexible and creative manner. New data shows peer services work best when provided by a peer-run/family-run organization. This allows peer support specialists to provide services needed to meet the needs of their customers and does not solely focus on what is billable.

Currently, KPFC peer support centers are in Cumberland, Two Rivers, The Lakes, Salt River Trail, Northeastern, and Eastern Mountain service regions. DCBS is the largest referral source to the KPFC Peer Support Centers. The Peer Support Centers also provide individual peer services, group peer services, SMART recovery groups, Nurturing Parenting Program, various trainings, etc.

Barriers for effective/maximum service delivery for this program include the inability to bill Medicaid, the need for office space in various locations across the state, and finances to support peer support positions, building alliances with service providers and community members.

V. Kentucky Strengthening Families

Kentucky Strengthening Families (KYSF) represents a multi-disciplinary partnership of over 20 national, state, local, public, and private organizations dedicated to embedding six research-based protective factors into services and supports for children and their families. Supporting families is key strategy for promoting school readiness and preventing 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.

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 Coronavirus Response and Relief Supplemental Appropriations (CRRSA) Act funding from the Division of Child Care to help support child care professionals during the COVID 19 pandemic. This grant ended June of 2022. KYSF is a statewide, long-term initiative, with ten-year goals.

Family Thrive (across the lifespan) Protective Factors include:

- 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 (Age Nine-Transitional Age Adult)

- 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 332 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.

The new social and emotional consultant is working to create a new system for accurately collecting data across the state, to include active trainers, new trainers that participate in the training of trainers, and number of trainings.

In 2022 KYSF:

- Trained 32 individuals in hosting Parent Cafés due to the pandemic and pandemic restrictions
- Trained 55 new Family Thrive Trainers due to the pandemic and pandemic restrictions
- Trained 260 participants during a general Family Thrive training
- To date with the CRRSA Project: 3,949 early childhood professionals attended a Provider Café, and 2,075 early childhood professionals attended a Trauma-Informed Care and Resiliency training
- 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 is working with an Epidemiologist with the Department for Public Health to create a statewide evaluation system in REDCap to collect pre-and post-training data, including a 3- and 6-month post training follow-up on all programming under the Initiative. Post training data will measure the impact KYSF programming has on parents/caregivers and professionals on reducing Adverse Childhood Experiences (ACEs) to increase the well-being of children and families. 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.

W. Kentucky Strengthening Ties and Empowering Parents (KSTEP)

The cabinet implemented Kentucky Strengthening Ties and Empowering Parents (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 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.

KSTEP was a title IV-E waiver demonstration project initiative, until the waiver ended on September 30th, 2019. The program was sustained through general state funds and FFPSA reimbursement. KSTEP launched in July 2017 in Carter, Greenup, Mason, and Rowan counties within the department's Northeastern Service Region. KSTEP expanded to Bath, Montgomery, Fleming, and Lewis in 2019, and Boyd, Lawrence, Elliott, Morgan, Menifee, Robertson, and Bracken in 2020. Through a grant provided by Kentucky Opioid Response Effort (KORE), KSTEP was able to expand into Spencer, Trimble, and Franklin counties of the Salt River Trail Service Region in 2021.

The cabinet continued expansion of the KSTEP program into all counties of the Salt River Trail Service Region and western counties of the Cumberland Service Region (Shelby, Oldham, Bullitt, Anderson, Breckinridge, Grayson, Hardin, Larue, Marion, Meade, Nelson, Washington, Woodford, Pulaski, McCreary, Russell, Casey, Taylor, Wayne, Green, Adair, Clinton, and Cumberland counties) through general state funds and FFPSA reimbursement in 2022.

From January 1st, 2022, to December 31st, 2022, KSTEP serviced 401 families and 565 children. Two-hundred twenty-seven (227) cases closed in 2022. Of the 227 cases that were closed in 2022, 94 cases closed due to successful completion, ten cases closed due to alternative permanency being established, nine cases closed due to assessment only, 30 cases closed due to the family choosing to leave services prior to completion, 40 cases closed due to the family being unable to meet program requirements, nine cases closed due to the family moving out of the service area, 31 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 four 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 2022 was $9,104.00. The current average cost per child in OOHC is $59,027.00. By utilizing programs like KSTEP that prevent children from entering OOHC, there is a cost savings of almost $50,000 per child.

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, ASI, PSI). 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 IBM SPSS software, including repeated measure mean comparisons across different administrations of the tests, and descriptive analyses for some KSTEP families.

The KSTEP evaluation outline has been drafted for submitting the Family First state plan amendment. For Franklin, Spencer, and Trimble counties, the in-home providers also completed initial baseline and six month follow up assessment for clients with Opioid Use Disorder (OUD) as part of the Government Performance and Results Act (GPRA) collection requirements for KORE funding.

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 will be 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.

X. 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. ARPA was signed into law on March 11, 2021, (Public Law 177-2), allowing clients applying for utility assistance with energy assistance benefits. This additional funding enabled LIHEAP to offer a year-round program for both heating and cooling components. Heating subsidy began November 1, 2022. 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 ACF's, Office of Community Services (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 150% PFL for 2022, for summer cooling subsidy and crisis; 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. Changes occurring in the FFY 2022 performance measures report include expenditures for ARPA funding.

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 affected by recent tornadic activity and flooding. The 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 2022, 62,668 households were served in heating subsidy; 68,102 households were served in the cooling subsidy component. Crisis component households served totaled 77,171 for winter crisis and 24,077 in the summer crisis component of LIHEAP. Summer subsidy households served totaled 68,102. ARPA funding allowed for 26,084 for winter subsidy households served. APRA funding also allowed for 13,226 summer crisis households to be served. Four hundred thirty (430) households were served by weatherization.

Y. 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. 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.

Michelle P. Waiver 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.

SCLs are private agencies that contract with the state, Medicaid, and private families to provide services to people with physical and mental disabilities.

During CY 2022, there were 10,302 unique members who had a paid claim for MPW services. There were 4,650 active members under the age of 21 and 5,652 active members 21 and over.

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.

Z. Multidisciplinary Commission on Child Sexual Abuse

The Kentucky Multidisciplinary Commission on Child Sexual Abuse (KMCCSA), staffed by the Office of the Attorney General, 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.

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.

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 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 Attorney General's Office who shall be appointed by the Attorney General; one Commonwealth's attorney who shall be appointed by the Attorney General; 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 children's advocacy center who shall be appointed by the Governor; one physician appointed by the Governor; and one former victim of a sexual offense or one parent of a child sexual abuse victim who shall be appointed by the Attorney General. 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.

In the fall of 2015, KMCCSA presented the revised MDT protocol at the PCAK Conference, the Kentucky Victim Assistance Conference, and the 17th Annual Ending Sexual Assault and Domestic Violence Conference. In addition, KMCCSA collaborated with the Kentucky Association of CACs and the regional CACs to present training on the protocol across the state. All local MDTs were asked to submit a revised local protocol by April 1, 2016. Since then, KMCCSA has reviewed and approved the protocols from nearly all local MDTs. Local MDTs continue to update their protocol to the newly revised model that was effective January 2016. The commission met and completed an updated and revised model protocol to be more user friendly that will assist local MDTs to add guidance in their protocol to be more specific to the counties they serve. The commission is in the process of submitting the final draft of the updated model protocol to ensure that all Local MDTs can have access to start utilizing the new updated model. KMCCSA has no monies, per se. The Attorney General's Office pays administrative fees incurred when this board meets.

AA. Office for Children with Special Health Care Needs

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 six satellite clinics. The agency's website is located at https://chfs.ky.gov/agencies/ccshcn, where a directory of services and provider lists programs available in all areas of the state. OCSHCN provides services for the following: audiology services, clinical services, autism spectrum disorder, cardiology, cerebral palsy, cleft lip and palate, craniofacial anomalies, neurology, telehealth, ophthalmology, orthopedics, otology, scoliosis, transitioning to adulthood, supplemental services or care coordination, case management, social services, nutrition, therapy services, language interpretation, additional diagnostic and treatment services, First Steps point of entry, hemophilia treatment centers, family support services, family to family health information center, Spanish-speaking support groups, folic acid distribution, provider support, and 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 97 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. 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 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, State Interagency Council (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.

Early Hearing Detection and Intervention 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: Hemophilia Treatment Centers (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 2022, OCSHCN provided specialty medical services to 7,025 patients. Of the total number of patients seen, 71% had Medicaid/KCHIP, 19% had private insurance, and 11% had no insurance. OCSHCN accepted 2,063 new patients, permanently discharged 94 overage patients, but 2,441 were eligible to return; 28,851 visits were recorded.

During 2022, OCSHCN's EHDI program received 49,488 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, 1,453 failed on one or both ears. The total number of infants that passed the hearing screen was 46,824.

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.

BB. Supporting Kentucky Youth

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. 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 out of home care 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 core meeting which is 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 group has a smaller subset known as the Command Center which meets monthly to plan the core agenda and to address any challenges related to programming or roll out. 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. 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:

- Develop a statewide provider network for the Kentucky SKY populations with 24-hour emergency access and crisis services
- Provide 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
- Provide access to trauma-informed services, including physical health, mental health and substance use disorder treatment, dental care, social services, and wraparound services

Aetna will also develop collaborative relationships with stakeholders who support the Kentucky SKY population. The MCO will, for example, provide 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. DCBS staff and other stakeholders have had the opportunity to participate in a plethora of trainings hosted and/or supported via SKY.

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. Department for Medicaid Services is in an integral part of the continual communication and helping to vet through technical and contractual processes and needs.

CHFS believes this Medicaid managed approach is responsive to feedback from foster and adoptive parents, foster youth, providers, advocates, and CHFS staff. CHFS is committed to the partnership with Aetna and will oversee Aetna's performance to ensure improved health outcomes and coordinated access to physical and behavioral health care services. SOP language has been, and is still in process, of being updated to reflect the myriad of changes to include SKY partnership language. DCBS' SOP surrounding medically complex children has been updated to reflect that SKY nurses will also assist with service provision and complete monthly care plans. DMS will assist with consultations for children in federal and state waiver services additionally. Nurse consultant inspectors within the service regions to support the medically complex work and service array. They have also began taking on the responsibility for visiting medically complex youth in waiver programs rather than DMS taking on this role for optimal service provision.

SKY in alignment with FFPSA and Child Welfare Transformation initiatives, will strengthen cabinet support to families in crisis and promote ongoing transformation of Kentucky's child welfare system.

CC. Prevent Child Abuse Kentucky

Prevent Child Abuse Kentucky (PCAK)'s mission is 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).

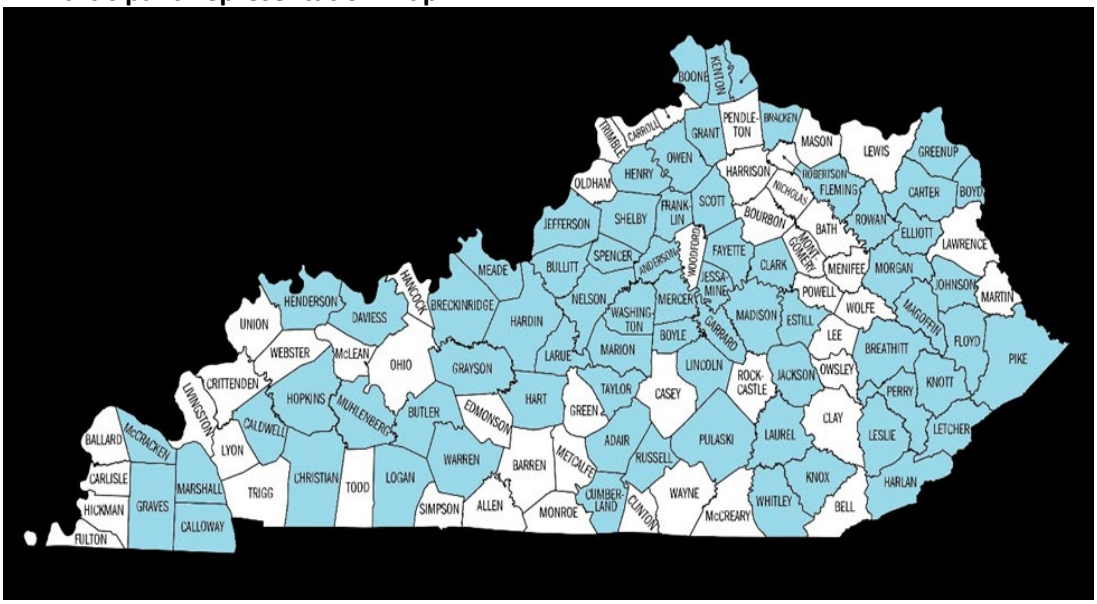
PCAK works closely with CHFS personnel to ensure the goals and services provided under its programs are aligned closely with the overall CFSP. All subcontractors, who are local community agencies, are required to implement evidence-based parent education and support group services. All subcontractors 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; and fatherhood 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 Kids Are Worth It!® 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 26th Annual Kids Are Worth It!® conference was held at the Galt House in Louisville, KY on September 10-11, 2022. This function was attended by 459 individuals. Participants were able to attend up to six workshops from a selection of 30 offerings, two keynote sessions, and 23 exhibits. Participants from 76 counties (identified in the Kentucky map below), across all nine department service regions were present, representing 63% of Kentucky counties.

2022 KAWI Participant Representation Map*



*Participant counties of work are highlighted in blue.

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 6.7% 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
a. Conference as a whole	100%	95%	96%	94%
b. Registration process	98%	94%	94%	97%
c. Workshop choices	96%	94%	95%	87%
d. Keynote sessions	96%	92%	95%	85%
e. Networking opportunities	96%	N/A	N/A	N/A

As a result of attending the conference:	2019 Overall Responses	2020 Overall Responses	2021 Overall Responses	2022 Overall Responses
a. I am better prepared to prevent child abuse and neglect.	96%	94%	92%	100%
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%

c. I learned a new skill, which will assist me in my work to improve outcomes for children and families.	96%	95%	96%	97%
d. I was able to network with community partners.	91%	N/A	N/A	N/A

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:

- *"Keynote luncheon and the trainers in my sessions."*
- *"Choices of workshops."*
- *"The workshops were very informative. I also noticed how a majority of the workshops had a connection to mental health and well-being. I had not noticed this at a previous conference prior to COVID."*
- *"Very well organized and wonderful staff running the whole event, thank you. Loved the venue. Hope next year we go back to the Galt House. Keynotes were all inspiring."*
- *"I attended sessions that are different from my typical choices and I liked the ability to learn new things."*

Self-Help, Parent Education, and Support Groups: Services are available in every service region and served 89 of 120 counties in the state in 2022. 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 1,266 families began a parent education and/or parent support program with one of the 15 providers during 2022. In this period, PCAK subcontractors provided 12,892 duplicated incidents of service.

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 2022, 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 2022 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
- 99.8% of respondents shared their facilitator/ leader was "really helpful" or "helpful" to them
- 66% 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

Additional support in 2022 allowed for the coordination of three separate Train the Trainer nurturing parenting curricula offerings encompassing the general Nurturing Parenting Program, Nurturing Fathers Program, and Nurturing Program for Families in Substance Abuse Treatment and Recovery. Five separate two-day trainings were held in coordination with Nurturing Parenting Facilitators, Carol Lapin and Karen Feldmanis with Home of the Innocents. These trainings occurred between April 20 and June 22, 2022. In total, 66 individuals attended from 29 counties. While attendees declared their work

county, most participants covered multiple counties, and all participants collectively covered the nine department service regions.
When surveyed three months after the facilitator trainings, participants indicated:

- 80% were very confident in their knowledge of the program content and materials
- 80% were extremely confident or very confident in facilitating the program
- 60% were currently facilitating the program they were trained to facilitate earlier in the year
- Participants facilitating programs indicated utilizing the AAPI Assessment and In-Person meetings
- 100% of respondents indicated wanting information on future facilitator trainings or other TOT opportunities

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.

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.

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 Adverse Childhood Experiences 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. Trauma-informed 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.

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 the Kentucky State Police.

From Report to Court: Knowing How to Report and What to Expect During COVID-19: PCAK has partnered with the Kentucky Department for Community Based Services to bring you a unique training to help understand what to expect from the reporting process during the COVID-19 pandemic. Learn how to recognize child abuse and neglect on a virtual platform and what steps Child Protective Service intervention entails. Special thanks to our presenters, Chelsea Harrod and Sydney Lawson, from the Child Protection Branch, The Cabinet for Health and Family Services.

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 trauma-informed 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.

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. 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, Twitter).

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 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. 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.

All PCAK educational workshops and institutes focus on preventing maltreatment before it ever occurs as well as protecting children from abuse and neglect by supporting families, so children reach their full potential. Professionals are empowered to act when recognizing indicators of child maltreatment and to incorporate practices to enhance community and family protective factors to prevent occurrences from ever happening in the first place. As an a statutorily appointed member on the Kentucky External Child

Fatality and Near Fatality Review Panel, PCAK utilizes experienced staff to provide accurate data on trauma, risk factors, and the protective factors that can prevent fatalities and near fatalities. Workshops on preventing abusive head trauma and the communities' role in preventing child maltreatment deaths broaden participants' understanding of the issue. Participants learn about PCAK resources and services including the annual Kids Are Worth It!® Conference, written and electronic materials, parent support programming, additional training opportunities, and technical assistance for agencies wishing to incorporate child abuse prevention into their programs. 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, the National Center for Child Death Review, and many others.

During 2022, 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 2022, PCAK served 2,427 participants and provided 44 trainings. PCAK staff continues to be active on the KYSF leadership team and can integrate these concepts into other PCAK training curricula. PCAK staff continue to work with those who have implemented KYSF into their work to ensure these efforts continue.

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 82,110 pieces of material displaying 1-800-CHILDREN were distributed throughout the Commonwealth during 2022.
- 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 monthly. Information captured includes number of calls received, the originating location for the call, type and number of referrals made.

Notable data from CY 2022:

- 126 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 11 times per month
- Over 70% of all callers were referred to DCBS

Since CY 2021, 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, and the web-based service directory.

PCAK places high value on the CQI process and will continue analyzing 1-800-CHILDREN parent support resource data to ensure parents have access to high quality support via phone, email, and the web.

PCAK, Partners in Prevention: PCAK Partners in Prevention is a network of agencies, individuals, and businesses with coverage to the entire state. During 2022, PCAK had 269 partners in prevention. These partners allowed for 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, Kids Are Worth It! Conference, 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.

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 Child Abuse Prevention Month 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.

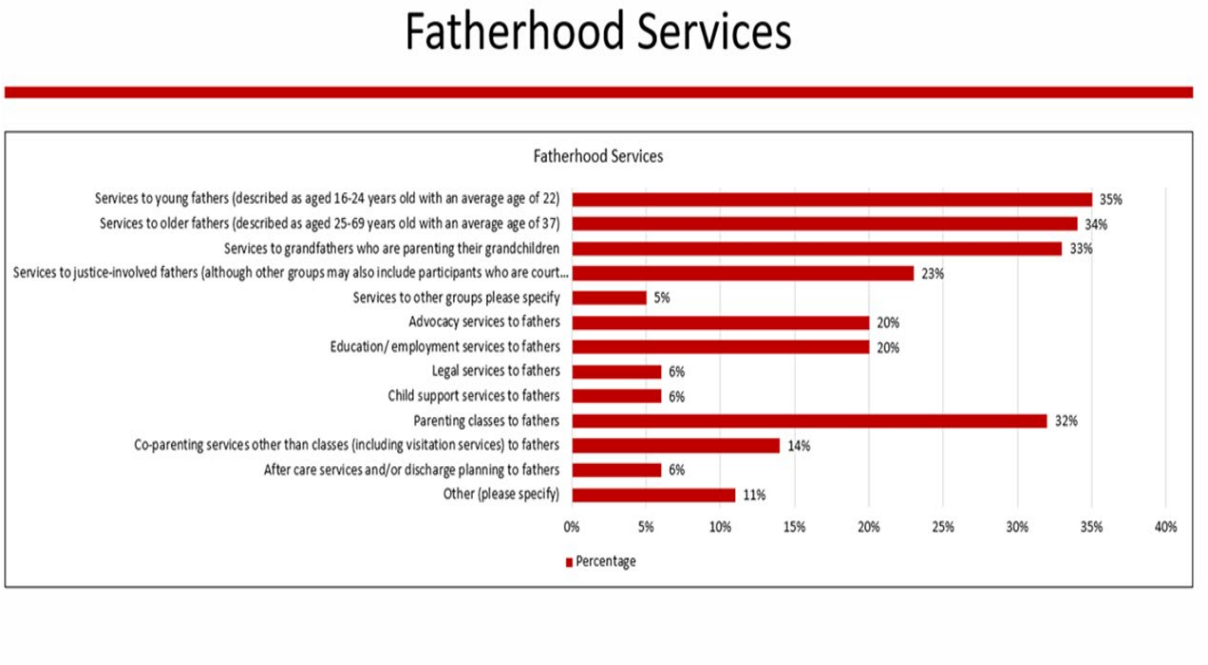
PCAK staff and board members have identified targeted professions, associations or groups for targeted outreach and partnership to help collaboratively strengthen communities through resilient relationships,

thereby preventing maltreatment. Intentional outreach was initiated with communities of faith, substance use disorder providers, parents with lived expertise, and military families, to name a few. As a part of the agency's quality improvement efforts, PCAK staff initiated a plan to examine existing partnership efforts. PCAK staff assembled a workgroup who examined existing practices on an ongoing basis. This group's strategic plan included increased partner engagement via regional partner meetings, quarterly updates via electronic newsletters and emails, and allowing partner conversations from these initiatives to drive next steps in developing appropriate prevention resources for the state. Due to the ongoing COVID-19 pandemic, no in-person partner meetings were held in 2021. To replace the invaluable feedback PCAK received from partners during these meetings, PCAK launched a partner survey to assess partnerships throughout the state. This survey, created in partnership with the University of Louisville Center for Families and Community Well-Being covered prevention services, the impacts of COVID-19, and services for fathers. The survey was finalized at end of CY 2021. During CY 2021, PCAK in partnership with the UofL Center for Families and Community Wellbeing launched a statewide survey covering primary prevention services, the impacts of COVID-19, and services for fathers. 24/7 responses were received and found that most providers (85 to 90%) surveyed work for agencies that connect families to support, treat parents as vital to their children's growth, empower parents to act on their own behalf, among other highly researched practices found to strengthen families and prevent maltreatment.

Additional outcomes include the following:

- 37% provide primary prevention programs for the public.
- 36% provide programs that enhance community awareness of maltreatment prevention and shared responsibility.
- 41% provide emergency support for parents 24 hours a day.
- 90% agree that COVID had an impact on their agency and clients.
- 55% of providers indicated that COVID had an impact on their mental health, 41% indicated an impact to their physical health and 47% indicated an impact to their personal relationships.

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



PCAK Child Abuse Prevention Month: During National Child Abuse Prevention Month, 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 2022 Child Abuse Prevention Month campaign included the following activities:

- Via Gubernatorial Proclamation, April 2022 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 Child Abuse Prevention Month. PCAK distributed local proclamation templates as a strategy to ensure consistent messaging throughout the state.
- On April 11, 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 89 Child Abuse Prevention Month related events reported to PCAK in 2022.
- Staff developed Child Abuse Prevention Month 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 39,290 pinwheels were distributed across the Commonwealth.
- 2,220 pinwheel lapel pins distributed across the Commonwealth.
- 140 yard signs 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 11,327 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, 56,219 child abuse awareness materials were distributed across the state to local communities.
- During the 2022 campaign, the Facebook audience included 8,194 followers, 1,688 Instagram followers, and 3,762 Twitter followers. 33,034 users were reached during April 2022 on Facebook and 573 via Instagram. Twitter posts had 20,561 impressions over the month of April.

Resources made available by the Children's Bureau and Prevent Child Abuse America were utilized in the development of the 2022 Child Abuse Prevention Month materials. Links to the Children's Bureau 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:
- "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" tip sheet 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.
- Upstream Primary Prevention posters used to create awareness for primary prevention. "Home
- Safety Check List: 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.

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. New this year, 846 "Prevention Packs" were distributed across the state with primary funding from the Kentucky Safety Prevention Alignment Network. "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.

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 Child Abuse Prevention Month. 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/.

YouTube: https://www.youtube.com/user/PCAKY
Website: https://pcaky.org/training/educational-videos-and-webinars/

Through a grant from the Child Victim's Trust Fund, PCAK launched "Safety and Awareness for Everybody?" campaign including a video and tip sheet on body safety and how/when to talk to children and youth about healthy child sexual development. This campaign also included an online training component. As part of the "Are They Good for Your Kids? campaign which launched in 2021, existing postcards and posters directing the public to an interactive webpage focused on child sexual abuse prevention continued. The campaign included bus advertisements, social media advertisements and press conference at Greyline Station in Lexington. This campaign had over five million impressions across the Commonwealth in 2022.

Through CBCAP support, a new movement inspired by Prevent Child Abuse Arizona and Casey Family Programs called, Lean On Me was developed for Kentucky and in consult with DCBS. Using primary prevention frameworks on moving prevention upstream, reframing the lens of responsibility for maltreatment prevention and more, nine focus groups were held in each DCBS service region from May 26 through July 7, 2022. One hundred ten (110) participants attended focus groups representing community members, program participants and staff members of PCAK Partner in Prevention agencies. Participants represented diverse experiences, cultures, and backgrounds. One session, hosted by the Nest in Lexington was provided solely in Spanish for their Spanish speaking clients and community members.

Themes emerged through the narratives shared during these groups and through Survey Monkey anonymous responses collected are as follows:

- Reduce stigmas associated with needing support (ex: services, mental health supports, parent education classes, etc.)
- Decrease barriers to access services and programs provided to community members
- Ask if help is needed and be specific in your offering of assistance to families having a tough time
- Ensure services are inclusive and accessible to all families in need of support, regardless of language spoken, background, abilities, income level, or employment status
- Support families in your community through modeling behaviors, mentoring, volunteering, and donating (physical goods or monetary gifts)
- Advocate for additional safe, happy, healthy, and low-cost community centers, child care facilities, grocery stores, medical facilities, and community supports in your neighborhoods

Using the work previously completed by Prevent Child Abuse Arizona, social norms science and focus group outcomes, the Lean On Me Kentucky toolkit was created and includes videos, training resources, a pledge, action cards and action steps all individuals can take to support families prior to abuse or neglect ever occurring. Mahan Multimedia was contracted to create the toolkit, videos and media included in this movement. Planning for a 2023 statewide launch to occur during Child Abuse Prevention Month occurred throughout the year.

The agency will continue 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 ongoing effort to maintain and expand resources. Starting in October, PCAK staff have connected with Community for Collaborations groups at regional levels to ensure collaborative members know of materials available to them as well as gain insight into their training and resource needs related to primary prevention. Trends continuing to emerge in 2022 include internet safety, preventing unintentional home injuries, human trafficking, child sexual abuse prevention and the way it is communicated to the public, evidence-based prevention, abusive head trauma, prevention/awareness programs targeted to children, parenting strategies, neglect prevention, grandparents raising grandchildren, children with special healthcare needs, trauma-informed care, building child and parent 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 2022, over 43,103 pieces of materials were distributed across the Commonwealth designed to educate and promote awareness of child abuse and neglect. We received 1,636 pages views on PCAK's Digital Download tool, with many Kentuckians accessing these resources in April 2022. 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 developed printer-friendly online versions of printed material.

Facebook (Meta) changed the metrics able to be pulled for analysis. During 2022, there were 4,658 visits to PCAK's Facebook business page and 397 new followers. Twitter impressions grew to 129,002 from our 3,757 followers. Instagram followers grew by 148 new followers. There were 60,531 hits to the PCAK website.
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 15 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.

PCAK seeks to address the engagement of fathers through awareness, education, trainings, and community events. Staff have developed specific curricula to address the importance of fatherhood engagement. These trainings highlight the importance of involving fathers in children's lives, addressing all outcomes in the areas of safety, permanency, and well-being. These trainings are provided in various settings, and in partnership with agencies such as public health, local government, etc. In 2022, two trainings were provided by staff serving 49 participants. Similarly, PCAK staff have also been engaged in community events promoting the value of father engagement. These events include activities such as community baby showers, social media posts, and fatherhood celebrations.

Through corporate and foundation support over 20 mini grants were awarded to community agencies in support of their work to develop, implement or strengthen father engagement programming and community engagement events. Each participating agency received trainings, support, and technical assistance to aid in their overall father engagement work. The Commonwealth Center for Fathers and Families was contracted to provide capacity grants to organizations working to develop and strengthen grassroots fatherhood programming. Additionally, a tip sheet, "Effective Fatherhood Engagement for Service Providers" was created and distributed to 244 individual service providers across the state. A new project aimed at supporting families impacted by "Shiftwork" was launched. This new project aims to help employers and service providers understand the impact a shiftwork schedule can have on the well-being of a family. Launched in December 2022 a training event was held and included an emphasis on shiftwork and fathers. Experts from the Lexington Leadership Foundation provided training to 38 individuals.

Through partnership and contracts with fatherhood expert consultants two toolkits were created helping to (1) identify and address implicit bias when working with fathers in the child welfare system and (2) promising practices aimed at father engagement. Implementation for distribution, training, evaluation, and technical assistance are in process.

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

On October 11-12, 2022, CCFF, the KY Department for Income Support and Child Support Enforcement Division hosted the 2022 Kentucky Fatherhood Summit virtually and in-person. The Summit was delivered to 325 registered attendees representing 12 states across the nation and 66 Kentucky Counties. An additional 10,211 justice involved individuals were able to watch sessions through "Watch Parties" hosted at Kentucky correctional facilities. PCAK's executive director presented a session at this event while staff hosted an exhibitor table sharing information about PCAK's programs and services. PCAK serves on the advisory committee for this event and will continue to do so in the coming year. This event also provided the opportunity for Kentucky leaders to meet with national leaders from the Department of Health and Human Services. PCAK was able to summarize Kentucky efforts and highlight projects funded by CBCAP funding, grants projects received from Kentucky funders by PCAK and more. The Commonwealth Center for Fathers and Families through contract and with support from PCAK's partnership created the KYDAD Academy and Speaker's Bureau. In result of this effort, 19 fathers from 13 counties received training in empowerment strategies and self-advocacy.

PCAK continues to play a vital role in statewide fatherhood work. Through contract with the Center for Family and Community Wellbeing, housed in the UofL Kent School of Social Work surveys were distributed statewide to service providers and government agencies for the purpose of collecting data on existing programs conducting father engagement work, programing specific to fathers, utilization of programs while also identifying service gaps. This information is being transferred to a statewide website/resource directory site for practitioners, fathers and researchers and will be housed at www.kentuckydads.com. Additionally, a statewide survey was distributed across the state seeking father input to help inform needed services and support specific to fathers in Kentucky. This partnership

also includes meta-analysis on existing fatherhood research to better identify ways in which Kentucky can strengthen father engagement practices at the micro, mezzo, and macro levels. PCAK's leadership with fatherhood efforts helps to promote healthier childhoods across the Commonwealth.

DD. 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 the Children's Bureau. 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 bimonthly 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 (Kentucky Partnership for Families and Children, 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 (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. While screening is required for children entering OOHC, it may be completed for any child served by DCBS. During this reporting period, the screening and assessment process has been expanded to youth in in-home DCBS cases in two additional service regions through the System of Care FIVE grant held by the DBHDID. This process is now in place in four of Kentucky's nine service regions, with plans to expand statewide in CY 2023.

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. 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 this reporting period (January 1, 2022-December 31, 2022). 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	# Children Screened in for CANS	% Children Screened in for CANS	Average Number of Days for Screener Completion
Eastern Mountain	273	267	97.8	210	78.65	6.31
Jefferson	354	307	86.72	233	75.90	14.94
Northeastern	402	350	87.06	277	79.14	12.42
Northern Bluegrass	718	628	87.47	495	78.82	9.99
Salt River Trail	623	400	64.21	299	74.75	16.28
Southern Bluegrass	503	351	69.78	274	78.06	15.21
Cumberland	526	502	95.44	316	62.95	10.56
The Lakes	514	496	96.50	360	72.58	10.37
Two Rivers	711	636	89.45	489	76.89	13.14
Total	**4,624**	**3,937**	**85.14**	**2,953**	**75.01**	**12.08**

There has been a slight decrease in screener compliance in 2022. DCBS leadership has expressed that high turnover rates and low staffing have significantly impacted screener completion and timeliness. Many new workers have been hired and need additional training and guidance on screener completion. The clinical consultant continues to work with the regions on additional training opportunities.
Of the 710 screeners showing as past due, 232 of these youth have exited OOHC. Twenty-three (23) of these youth exited OOHC before their screeners were required to be completed. The table below highlights youth with screeners that are showing as past due. Children ages 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	7	6	1	20.00
Jefferson	49	24	2	32.63
Northeastern	53	18	1	49.17
Northern Bluegrass	91	27	1	35.70
Salt River Trail	233	73	10	25.48
Southern Bluegrass	155	30	3	48.57
Cumberland	27	19	3	23.11
The Lakes	18	7	0	22.71
Two Rivers	77	28	2	36.32
Statewide	**710**	**232**	**23**	**33.12**

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 2022, more than 5,300 children received a CANS Assessment from a behavioral health provider. Of the CANS completed in 2022, 14.73% 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 2022, 632 referrals were sent to CMHCs for CANS assessments. Of these referrals, only 22.94% 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 2022, 192 youth were referred to CANS trained independent/private providers. Nearly 30% of these youth received a CANS assessment (29.17%). 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.

No new policies, practices or evaluation activities pertaining to screening were implemented during 2022, however, efforts on full integration into casework and treatment planning continue. The clinical consultant will continue to provide CANS trainings at least monthly and support providers (CMHCs,

PCP/PCC agencies, 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 the use of 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.

EE. 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 Area Development District 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 2022 contract includes state general funds in the approximate amount of $ 7.1 million, as a group, $574,199 in rape prevention and education funds from the Center for Disease Control to 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 Kentucky 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, 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 7.5% 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 2022

Service Category	Number of Services Provided/ Persons Served
New victims served	4,624
New family & friends served	1,061
Legal advocacy services: court, case management, referrals to services	3,191
Medical advocacy services: sexual assault forensic exam (SAFE), follow up exams, referrals for further medical treatment	2,503
Crisis calls received	3,202
Counseling sessions provided	18,225
DCBS client total	435
Prevention/education sessions (including Green Dot in KY high schools)	2,073
Prevention/education participants (including Green Dot in KY high schools)	2,420,420
Volunteer hours	38,963

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 has been some decrease in service provision during 2020 due to the COVID-19 pandemic, however all services increased in 2021. At the onset of the pandemic, RCC's quickly pivoted and developed systems to ensure service delivery could fully continue possibly via virtual platforms for many services and have maintained those systems in additional to face to face services

when possible. The shift to virtual platforms for educational programming has radically increased the number of participants in that area as well.

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.

FF. 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 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 and posters are available on https://chfs.ky.gov/agencies/dcbs/dpp/cpb/Pages/safeinfantsact.aspx. The website also contains a list of Frequently Asked Questions 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 CHFS' 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 who is the 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- 2022):

- There have been 67 safe infant incidents involving 68 infants since 2002. One incident involved a set of twins.
- Of the 68 infants, ten were delivered in the home, one was delivered in a hospital parking lot, 56 were delivered in the hospital, and one was surrendered at a fire station. 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 68 infants, 48 have been adopted, five have pending TPRs or adoptions, 14 were returned to their parents, and one child was placed with the maternal grandmother at the parents' request.
- Average length of time to TPR is approximately 5.7 months, with three months being the shortest amount of time and 13 months being the longest.
- Average length of time for adoption to occur is approximately 5.68 months. One of the cases 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. There are currently two cases from May 2022 awaiting adoption dates. There has been an increase in length of time from birth to adoption for these cases due to court delays.
- 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: 24
    - Southern Bluegrass: 9
    - Northern Bluegrass: 5
    - Jefferson: 6
    - Northeastern: 6
    - Salt River Trail: 6
    - Cumberland: 5
    - Eastern Mountain: 1
    - The Lakes: 6
- Ages of identified mothers: 15, 17, 18, 22, 23, 24, 25, 26, 27, 28, 30, 33, 34, 40. Thirty-one (31) mother's ages remain unknown.
- Gender of infants: 31 males, 37 females.
- Race of infants: 26 Caucasian, 9 African American/Black, 2 Hispanic, 1 Indian, 1 Bosnian, 1 bi-racial, and 30 unknown/declined to disclose.
- Identified reasons cited for abandonment:
    - 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 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.
- 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 Southern Bluegrass and the mother returned to claim the child, only to sign a voluntary TPR later. The other case was in Two Rivers. The mother and a relative returned to claim the child and request relative placement, however, there were concerns for neglect. An emergency custody order 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.

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.

GG. 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 sixty-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 2022, 14 families received Safety Net services. DPP's "Safety Net Tally" report and statewide for CY 2022, a total of $6,748.61 was spent on Safety Net services. This data shows an increase from the previous calendar year: in CY 2021, three families received Safety Net services for a total of $1,568.14 according to DPP's Safety Net Tally report.

During 2020, the CHFS Division of General Accounting conducted an 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.

During CY 2021, DCBS utilized the results of the APA Audit of TANF-funded programs to research options for improvement of all TANF programs, including Safety Net. There have been no changes in policy or practice during CY 2022. The Cabinet intends to continue 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. No consultative efforts or technical assistance was provided or received by the National Resource Center during CY 2022.

HH. Sobriety Treatment and Recovery Teams

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 SAMHSA funding from 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 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 2022, START served 370 families, 676 adults, and 619 children. These numbers are broken down by county below:

County	Families Served	Children Served	Adults Served
Boone	38	81	71
Boyd	66	125	103
Campbell	41	68	71
Daviess	34	69	47
Fayette	71	118	105
Jefferson	65	105	119
Kenton	51	104	96
Pendleton	4	6	7
Total	**370**	**676**	**619**

In addition to direct services to families, START leadership and evaluation published two peer-reviewed manuscripts in 2022**:**

Hall, M. T., Hardy, G. C., & Bryant, S. E. (2022). COVID-19 and fidelity to the Sobriety Treatment and Recovery Teams model. *Journal of Studies on Alcohol and Drugs.* https://doi.org/10.15288/jsad.22-00082

Hall, M. T., Hardy, G. C., Golder, S. G., Huebner, R. A., McNeil, A. J., & Walton, M. T. (2022). Substance use and other factors associated with child welfare case duration: Looking beyond out of home care. *Child & Family Social Work, 28*(1), 136-146. https://doi.org/10.1111/cfs.12948

The evaluation team has also continued work on a study focused on medication for opioid use disorder (MOUD) among START families. This study is a follow-up to the 2016 MOUD study completed. In addition, the evaluation team and START leadership have continued documenting possible changes to START IN that would improve data collection and evaluation. Lastly, the evaluation team worked with START staff to enhance the quality of the data housed in START-IN by filling in missing data and rectifying discrepancies. This was a multi-step project, which consisted of filling in missing data on families, adults, children, and other areas important for program 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.

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 of 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 of 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. START leadership is involved in the state's plan of safe care to ensure compliance with CAPTA requirements.

Technical assistance and consultation were provided regularly by the Children's Bureau and the National Center on Substance Abuse and Child Welfare (NCSACW) during the regional partnership grant periods. START has worked closely with both entities who were extremely helpful in supporting the growth and sustainability of START in Kentucky. Kentucky has received support from PCG and SSG around title IV-E prevention claiming and from Chapin Hall to support the CQI process for EBP fidelity monitoring.

Kentucky START is also part of a national learning collaborative through Children and Family Futures 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 June of 2022, the START evaluation team completed a fidelity report for all START sites. This represents data collected up through April of 2022. Major highlights of the report are presented here, and the full report is available from the evaluation team. START aims to receive referrals within 14 calendar days of the DCBS intake. As shown in the table below, over 90% of referrals overall were received within 14 calendar days, and over 95% of referrals met this threshold in the first portion of 2022. Please keep in mind that 2022 data were not complete at the time the fidelity report was assembled, so the total numbers will be smaller than preceding years.

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 family mentors were onboarded into START. Ensuring referrals are made to START with a shift to statewide central intake has been a challenge. There was a process in place at each site to flag potential START referrals for investigative staff and with a shift to statewide system, a new plan had to be developed. 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 to follow up with investigative workers.

II. Social Services Block Grant

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, KCADV, 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.

Calendar Year 2022 Data	
SSBG Service	**Number of Clients Served**
Adult/Domestic Violence Protection	93,702
Child Protection	346,509
Home Safety Services	3,258
Juvenile Services	1,506
Residential Treatment	281

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.

JJ. Solutions

Kentucky River Community Care/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 trauma sensitive 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 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.

KK. Targeted Assessment Program

Kentucky's Targeted Assessment Program (TAP) provides intensive services to parents involved in the state's child welfare and TANF systems. For the past 22 years, the DCBS has collaborated with UK Kentucky 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.

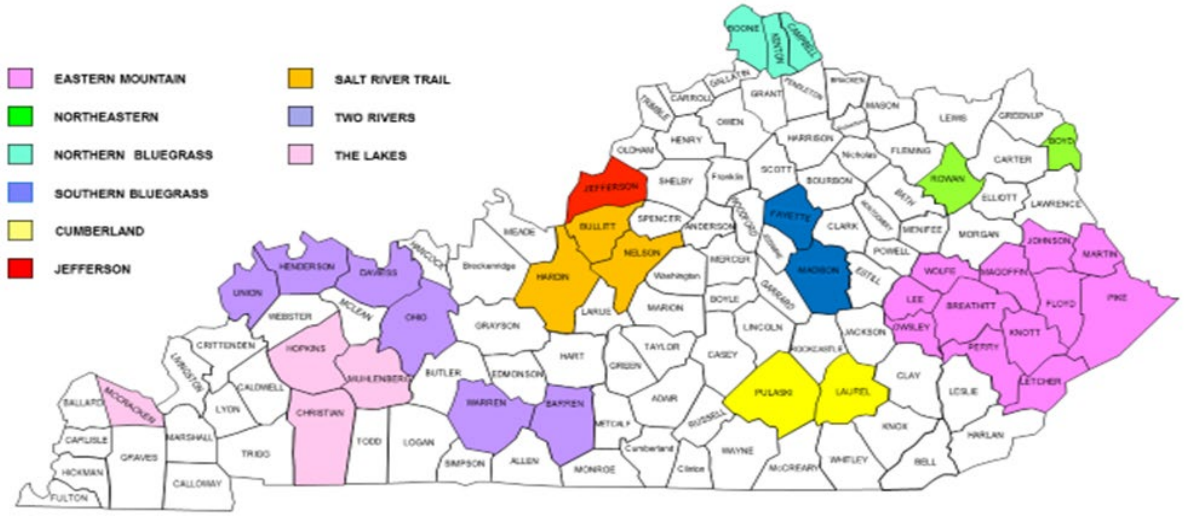
TAP is supported through TANF funds. Eligibility criteria includes receipt of TANF benefits or TANF-eligibility with a family income at or below 200 percent of the federal poverty level. Parents referred by DPP must have a child in the home or a plan for reunification. There must be at least one dependent 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
- Trauma-informed 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 CY 2022, TAP co-located assessors at DCBS DFS and DPP offices in 35 of 120 counties: Barren, Boone, Boyd, Breathitt, Bullitt, 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, 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 2022 Service Map by DCBS Service Region



Targeted Assessment Program Opioid Use Disorder Project: In 2019, as part of its participation in Kentucky's Opioid Response Effort (KORE), the Department for Community Based Services (DCBS) contracted with the University of Kentucky Center on Drug & Alcohol Research (CDAR) to implement the Targeted Assessment Program Opioid Use Disorder Project (TAP OUD). With federal funding from the Substance Abuse and Mental Health Services Administration (Grant 1H79TI081704) administered through KORE, 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,

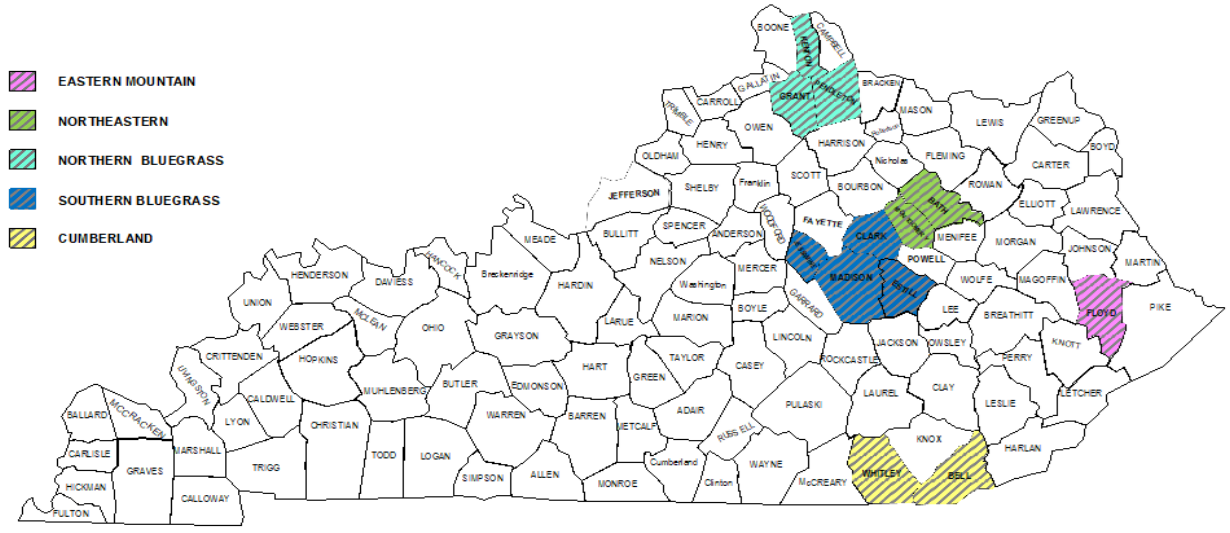
Jessamine, Montgomery, Pendleton, and Whitley. Three assessor positions also have field supervision responsibilities. The TAP OUD Principal Investigator, Project Director, and Project Evaluator are located at the University of Kentucky in Lexington. When KORE funding ends on June 30, 2023, DCBS has determined TAP OUD services will be supported with TANF funds. At the request of DCBS, TAP OUD continues to explore the possibility of potential service reimbursement through Medicaid as a potential complementary funding source - reviewing Medicaid regulations and meeting with representatives of the Kentucky Medical Services Foundation (KMSF) and the UK Office of Healthcare Finance to determine the feasibility of this option.

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 motivational interviewing 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 intimate partner violence, 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, DCBS Division of Protection and Permanency (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.

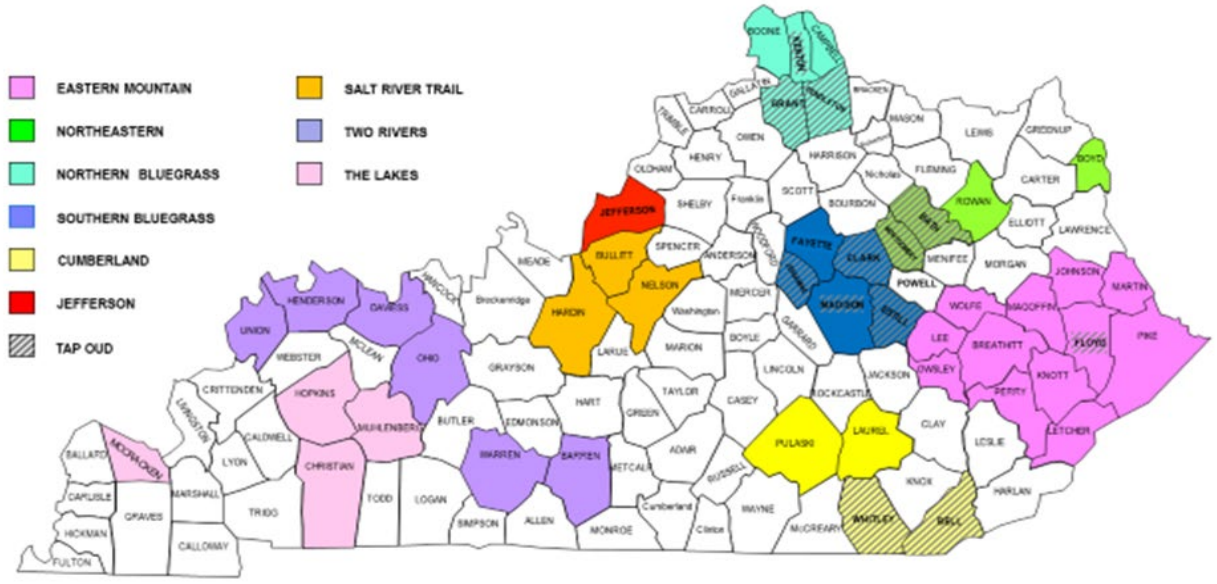
TAP OUD’s service map is presented below:

TAP Opioid Use Disorder Project (TAP OUD) CY 2022 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 2022 is presented below:

TAP and TAP OUD Project CY 2022 Service Map by DCBS Service Region



Fiscal Year 2022 TAP and TAP OUD Data: During FY 2022, TAP and TAP OUD facilitated or participated in 63 advisory council meetings (37 TAP; 26 TAP OUD) and 364 planning and implementation meetings (214 TAP; 113 TAP OUD) with DCBS staff. In addition, TAP and TAP OUD facilitated 9 local community selection committee meetings (8 TAP; 1 TAP OUD) to fill staff vacancies. TAP and TAP OUD provide consultations to DCBS staff for participants who have been referred to TAP/TAP OUD as well as cases not referred to the programs. During FY 2022, TAP/TAP OUD provided 10,916-case consultations to DCBS (12,112 TAP; 3,660 TAP OUD) for participants and 2,975 case consultations (2,367 TAP; 608 TAP OUD) for non-TAP/TAP OUD participants.

In support of and in collaboration with DCBS, TAP and TAP OUD staff participated in family team meetings to engage and support the family in the DPP case planning, case management, and case closure processes. Family team meetings bring together parents, families, other significant adults, and child welfare and other professionals for collaborative case planning and shared decision-making. During FY 2022, TAP/TAP OUD assessors participated in 1,394 (1,102 TAP, 292 TAP OUD) family team meetings statewide. In some counties, TAP/TAP OUD coordinated and facilitated these meetings. All collaborations strengthen communication between DCBS and TAP/TAP OUD and enhance services for families. The sharing of information and expertise is an invaluable part of case planning to improve outcomes.

During the FY 2022, TAP and TAP OUD continued to utilize web-based data collection systems. The current systems include: 1) a baseline assessment instrument to assess barriers to self-sufficiency, family stability, and safety among individuals referred; and 2) a case closure instrument to determine participant progress, including: a) readiness to change; b) safety; c) work readiness and work skills; d) parenting; e) access to services; and f) overcoming barriers to self-sufficiency and safe parenting. The data are confidential, with participant identifiers encrypted, and are stored on a secure server at UK. The data are used for participant reports and aggregated data tables for program evaluation and quality improvement. The UK TAP and TAP OUD Evaluation protocol (Protocol Number 44783) was approved by UK's Medical Institutional Review Board (IRB) for the period February 8, 2022, through February 7, 2023, and undergoes periodic revision as needed. In addition to the baseline and case closure, TAP OUD participants receive the Center for Substance Abuse Treatment (CSAT) Government Performance and Results Act GPRA Client Outcome Measures – also administered electronically. In FY 2021, TAP OUD assessors completed baseline GPRAs on 364 TAP OUD participants, 255 six-month follow-up GPRAs, and 287 discharge GPRAs.

During FY 2022, TAP and TAP OUD respectively completed 1,787 and 543 baseline assessments for participants referred by DCBS divisions and other sources – for a total of 2,330. Referrals to TAP (n=2,516) continue to be primarily from DPP (86%, n=2,176) and DFS (10%, n=244). Compared to the previous fiscal year, DFS referrals increased (+63%), while DPP referrals decreased (-3%). Most referrals to TAP OUD (n=694) were also from DPP (97%, n= 673) and DFS (3%, n=21). During the fiscal year, DFS referrals decreased (-46%) while DPP referrals increased (+8%).

Many of the 2,330 TAP and TAP OUD participants receiving baseline assessments during FY 2022 were found to have multiple barriers. Indeed, 64% (n=1,139) of TAP participants were assessed at baseline with two or more targeted barriers. Mental health and substance use were the most prevalent barriers, with almost three-fourths (74%) reporting mental health and more than half (52%) reporting substance use as barriers to self-sufficiency and family safety. In addition, 45% reported intimate partner violence victimization.

Of the 543 TAP OUD participants completing a baseline assessment, 78% (n=425) were assessed with two or more barriers. Mental health and substance use were the most prevalent barriers, with more than three-fourths of those assessed reporting mental health (81%) barriers and almost three-fourths (71%) reporting substance use barriers. In addition, 49% reported intimate partner violence victimization. The most common unmet basic needs among assessed participants (n=543) included: not enough money to meet the family's expenses (59%), transportation (56%), housing (35%), and difficulty in family relationships (33%).

COVID-19 Pandemic Impact: TAP and TAP OUD service provision continued to be impeded during CY 2021 by the COVID-19 pandemic. On March 16, 2020, TAP and TAP OUD suspended in-person contact with participants due to social distancing protocols from CHFS in response to the COVID-19 pandemic. Responding to state of emergency cabinet requirements, TAP and TAP OUD staff continued their temporary remote work schedules through May 2021, using telephone and video conferencing for participant sessions, family team meetings, and meetings with DCBS and other community partners Some participants had limited access to technology, which affected contact and engagement in services; however, this improved over time as assessors assisted participants in accessing federal/state funding to increase technology access. When essential to service provision, assessors had in-person contact with participants only when it was essential to service provision, practicing social distancing, wearing masks, and meeting outside. TAP and TAP OUD also facilitated staff selection committee meetings and candidate interviews using Zoom. Due to DCBS facility capacity restrictions, assessors and field supervisors worked remotely, typically reporting to their DCBS office one day per week. Virtual service delivery and collaboration practices were temporarily reinstituted as state positivity rates began to rise in July 2021, with TAP and TAP OUD staff having in-person contact with participants as safe and appropriate.

During the COVID-19 state of emergency, DFS Kentucky Works Program (KWP) participants continued to be granted "COVID-19 Good Cause" exemptions, with participation voluntary. Combined with DCBS DFS staff limited ability to screen clients for TAP services, this resulted in a significant decrease in DFS referrals to TAP/TAP OUD in CY 2020-2022. In preparation for the end of the good cause exemption effective November 1, 2022, TAP and TAP OUD collaborated with DFS to offer services to those nearing the end of their lifetime TANF benefits. Record-level DCBS staff turnover also impacted TAP and TAP OUD referrals and utilization. In April 2022, DPP initiated SDM, an approach to child protective services that uses clearly defined and consistently applied decision-making criteria for screening for investigation. SDM reduced the number of cases accepted by DPP and in turn, impacted referrals to TAP/TAP OUD.

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[1]) 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 10 showed improvement in accessing services to overcome major barriers to self-sufficiency, stability, and safety:

- 87% with mental health barriers made progress
- 89% with intimate partner violence barriers made progress
- 84% with substance use barriers made progress

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

Of the 754 total terminating TAP OUD participants, 78% (n=590[2])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

As noted previously, 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.

Progress in Overcoming Barriers to Self-Sufficiency, Stability, and Safety among Participants Terminating TAP and TAP OUD FFY 2022	**Assessed Participants Terminating TAP and TAP OUD with Identified Barrier**		
	TAP	**TAP OUD**	**Total**
Mental Health	**n=1,148**	**n=457**	**n=1,309**
Any Progress, (i.e., a little, some, moderate, a lot)	992 (86%)	410 (90%)[3]	1,138 (87%)
A Little Progress	214 (18%)	110 (24%)	249 (19%)
Some Progress	344 (30%)	122 (27%)	378 (29%)
Moderate Progress	354 (31%)	142 (31%)	421 (32%)
A Lot of Progress	80 (7%)	36 (8%)	90 (7%)
No Progress	156 (14%)	47 (10%)	171 (13%)
Substance Use	**n=895**	**n=461**	**n=1,060**
Any Progress, (i.e., a little, some, moderate, a lot)	769 (86%)	417 (90%)	916 (86%)
A Little Progress	153 (17%)	95 (21%)	178 (17%)
Some Progress	216 (24%)	90 (19%)	239 (23%)
Moderate Progress	311 (35%)	162 (35%)	377 (36%)
A Lot of Progress	89 (10%)	70 (15%)	95 (10%)
No Progress	126 (14%)	44 (10%)	122 (12%)
Intimate Partner Violence	**n=564**	n=186	**n=633**
Any Progress, (i.e., a little, some, moderate, a lot)	490 (87%)	162 (87%)	551 (87%)
A Little Progress	90 (16%)	45 (24%)	101 (16%)
Some Progress	128 (23%)	49 (26%)	145 (23%)
Moderate Progress	203 (36%)	43 (23%)	229 (36%)
A Lot of Progress	69 (12%)	25 (14%)	76 (12%)
No Progress	74 (13%)	24 (13%)	82 (13%)

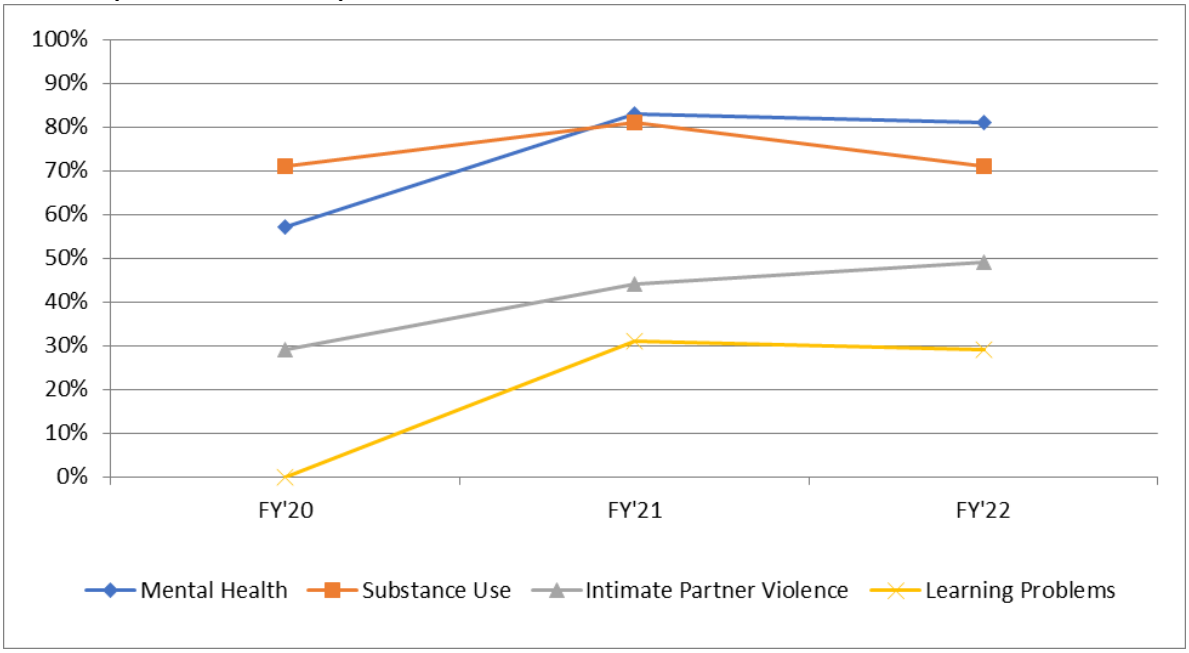
[2] Terminating participants may have been referred or assessed prior to FY 2022.
[3] Values under each barrier represent the percent of participants making any progress with the identified barrier. Any progress includes a little, some, moderate, and a lot of progress.

Progress in Overcoming Barriers to Self-Sufficiency, Stability, and Safety among Participants Terminating TAP and TAP OUD FFY 2022	Assessed Participants Terminating TAP and TAP OUD with Identified Barrier		
Learning Problems	**n=158**	n=65	**n=182**
Any Progress, (i.e., a little, some, moderate, a lot)	79 (50%)	52 (80%)	97 (53%)
A Little Progress	32 (20%)	26 (40%)	37(20%)
Some Progress	27 (17%)	18 (28%)	37 (204%)
Moderate Progress	18 (12%)	7 (11%)	21 (12%)
A Lot of Progress	2 (1%)	1 (1%)	2 (1%)
No Progress	79 (50%)	13 (20%)	85 (47%)
Difficulty Meeting DCBS Requirements	**n=432**	**n=53**	**n=485**
Any Progress, (i.e., a little, some, moderate, a lot)	368 (85%)	41 (77%)	409 (84%)
A Little Progress	112 (26%)	16 (30%)	128 (26%)
Some Progress	101 (23%)	13 (24%)	114 (24%)
Moderate Progress	127 (29%)	11 (21%)	138 (28%)
A Lot of Progress	40 (7%)	2 (2%)	30 (6%)
No Progress	64 (19%)	12 (23%)	76 (16%)
Housing	**n=447**	n=188	**n=498**
Any Progress, (i.e., a little, some, moderate, a lot)	361 (81%)	153 (81%)	401 (81%)
A Little Progress	90 (20%)	39 (21%)	103 (21%)
Some Progress	107 (24%)	43 (23%)	118 (24%)
Moderate Progress	110 (25%)	40 (21%)	121 (24%)
A Lot of Progress	54 (12%)	31 (16%)	59 (12%)
No Progress	86 (19%)	35 (19%)	97 (19%)
Problems with Social/Family Relationships	**n=372**	n=96	**n=395**
Any Progress, (i.e., a little, some, moderate, a lot)	320 (86%)	84 (87%)	340 (86%)
A Little Progress	85 (23%)	33 (34%)	91 (23%)
Some Progress	145 (36%)	37 (38%)	149 (38%)
Moderate Progress	77 (21%)	12 (13%)	84 (21%)
A Lot of Progress	13 (3%)	2 (2%)	15 (4%)
No Progress	52 (14%)	12 (13%)	55 (14%)
Transportation	**n=311**	n=102	**n=345**
Any Progress, (i.e., a little, some, moderate, a lot)	216 (70%)	76 (75%)	235 (68%)
A Little Progress	87 (28%)	43 (42%)	98 (28%)
Some Progress	73 (24%)	20 (20%)	76 (22%)
Moderate Progress	43 (14%)	10 (10%)	49 (14%)
A Lot of Progress	13 (4%)	3 (3%)	13 (4%)
No Progress	95 (30%)	26 (25%)	157 (32%)
Problems Obtaining Work	**n=291**	n=103	**n=3**
Any Progress, (i.e., a little, some, moderate, a lot)	226 (78%)	75 (73%)	255 (77%)
A Little Progress	57 (20%)	27 (26%)	67 (20%)
Some Progress	67 (23%)	20 (19%)	72 (22%)
Moderate Progress	60 (21%)	13 (13%)	68 (21%)
A Lot of Progress	42 (14%)	15 (15%)	48 (14%)
No Progress	65 (22%)	28 (27%)	78 (23%)
Parenting	**n=388**	n=135	**n=420**

Progress in Overcoming Barriers to Self-Sufficiency, Stability, and Safety among Participants Terminating TAP and TAP OUD FFY 2022	Assessed Participants Terminating TAP and TAP OUD with Identified Barrier		
Any Progress, (i.e., a little, some, moderate, a lot)	330 (85%)	118 (87%)	359 (85%)
A Little Progress	76 (20%)	38 (28%)	83 (20%)
Some Progress	108 (28%)	37 (27%)	119 (28%)
Moderate Progress	125 (32%)	31 (23%)	132 (31%)
A Lot of Progress	21 (5%)	12 (9%)	25 (6%)
No Progress	58 (15%)	17 (13%)	61 (15%)
Legal Problems	**n=166**	n=76	**n=182**
Any Progress, (i.e., a little, some, moderate, a lot)	132 (80%)	63 (83%)	144 (79%)
A Little Progress	26 (16%)	25 (33%)	29 (16%)
Some Progress	54 (33%)	24 (32%)	59 (32%)
Moderate Progress	32 (19%)	12 (16%)	35 (19%)
A Lot of Progress	20 (12%)	2 (3%)	21 (12%)
No Progress	34 (20%)	13 (17%)	38 (21%)
Basic Needs for Children	**n=137**	n=66	**n=157**
Any Progress, (i.e., a little, some, moderate, a lot)	120 (88%)	56 (85%)	137 (87%)
A Little Progress	22 (16%)	19 (29%)	26 (17%)
Some Progress	45 (33%)	12 (18%)	49 (31%)
Moderate Progress	42 (31%)	23 (35%)	49 (31%)
A Lot of Progress	11 (8%)	2 (3%)	13 (8%)
No Progress	17 (12%)	10 (15%)	20 (13%)
Physical Health	**n=129**	n=35	**n=136**
Any Progress, (i.e., a little, some, moderate, a lot)	124 (91%)	29 (83%)	130 (91%)
A Little Progress	32 (25%)	10 (29%)	39 (29%)
Some Progress	39 (30%)	10 (29%)	58 (42%)
Moderate Progress	31 (24%)	8 (23%)	26 (19%)
A Lot of Progress	7 (5%)	1 (3%)	1 (1%)
No Progress	20 (16%)	6 (17%)	13 (9%)
Child Care	**n=72**	n=16	**n=77**
Any Progress, (i.e., a little, some, moderate, a lot)	59 (82%)	15 (94%)	63 (82%)
A Little Progress	18 (25%)	4 (25%)	19 (25%)
Some Progress	22 (31%)	3 (19%)	23 (30%)
Moderate Progress	13 (18%)	5 (31%)	13 (17%)
A Lot of Progress	6 (8%)	3 (19%)	8 (10%)
No Progress	13 (18%)	1 (6%)	14 (18%)
Providing Enough Food	**n=44**	n=32	**n=48**
Any Progress, (i.e., a little, some, moderate, a lot)	40(91%)	31 (97%)	42 (88%)
A Little Progress	6 (14%)	9 (28%)	6 (13%)
Some Progress	11 (25%)	1 (3%)	12 (25%)
Moderate Progress	14 (32%)	17 (53%)	15 (31%)
A Lot of Progress	9 (20%)	4 (13%)	9 (19%)
No Progress	4 (9%)	1 (3%)	6 (12%)

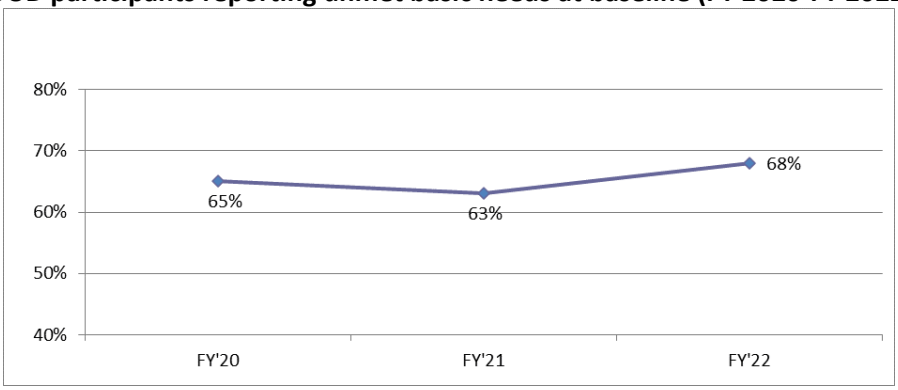
Fiscal Year 2020-2022 Barrier Prevalence**:** In 2023, TAP OUD received a request from the DCBS Division of Protection and Permanency (DPP) to continue to examine the prevalence of barriers to self-sufficiency and safety among participants across multiple fiscal years. The percent of TAP OUD participants with barriers assessed at baseline are presented graphically below by fiscal year: FY 2020 (n=96), FY 2021 (n=506), FY 2022 (n=543). 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 2022. In contrast, the percent of participants assessed with intimate partner violence has risen steadily, with the most recent increase to 49% in FY 2022 (up from 29% in FY 2020). Lastly, the percent of participants with learning problems and deficiencies, after an initial increase, has remained relatively stable – at 31% in FY 2021 and 29% in FY 2022.

Percent of TAP and TAP OUD participants assessed with barriers to self-sufficiency and safety at baseline (FY 2013 – FY 2022)



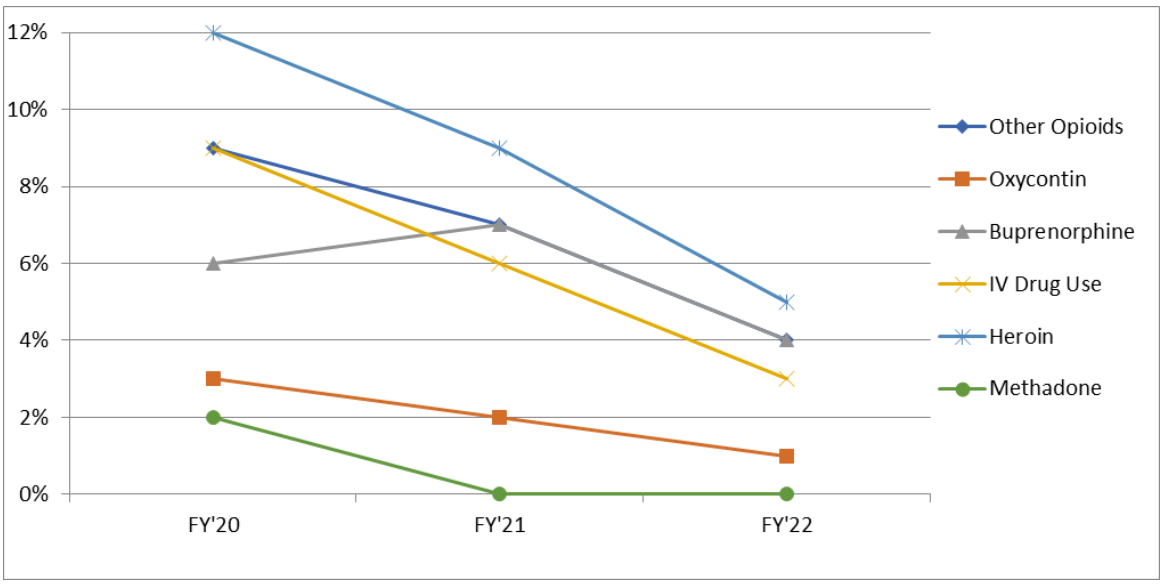
The percent of TAP OUD participants with unmet basic needs from FY 2020 through FY 2022 are also presented graphically below. The percent of participants with unmet basic needs at baseline is substantial and has varied only slightly, from 65% in FY 2020 to 63% in FY 2021 and 68% in FY 2022. The most identified unmet basic needs in FY 2022 were: finding money to cover expenses, transportation, housing, and difficulty getting along with family. These have constituted the top three unmet needs in all three fiscal years.

TAP and TAP OUD participants reporting unmet basic needs at baseline (FY 2020-FY 2022)



DPP also requested an examination of opioid use trends among TAP OUD participants from FY 2020 through FY 2022. The percent of TAP OUD participants self-reporting opioid use during the 3 months prior to baseline is presented in the figure below. Compared to FY 2020, the use of heroin, other opioids, and IV drugs decreased visibly in FY 2021, with the use of Oxycontin and methadone declining less markedly. The use of buprenorphine increased during this time. These same trends were evident from FY 2021 to FY 2022 except for buprenorphine – which decreased. Between FY 2020 and FY 2022, TAP OUD assessors completed 1,145 baseline assessments.

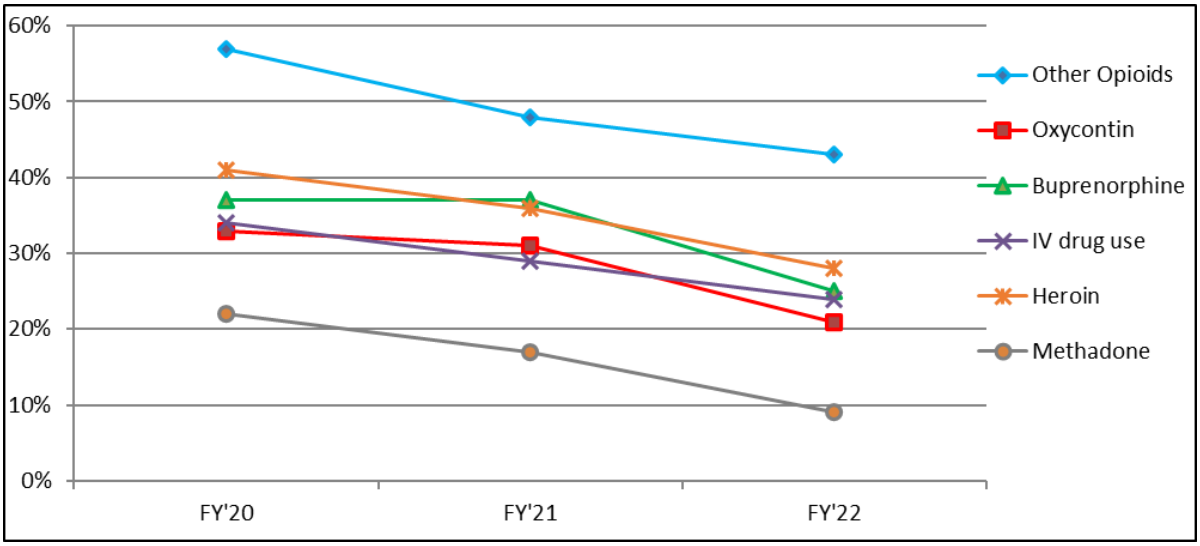
Percent of TAP OUD participants self-reporting opioid use 3 months before baseline assessment (FY 2020-2022)[4]



The percent of TAP and TAP OUD participants self-reporting opioid use in their lifetime is presented below. Compared to FY 2021, participants in FY 2022 reported decreased lifetime use of Oxycontin, buprenorphine, heroin, other opioids, methadone, and IV drugs.

[4] Use of Methadone was reported by 0.2% of participants in FY 2021 and 0.04% of participants in FY 2022

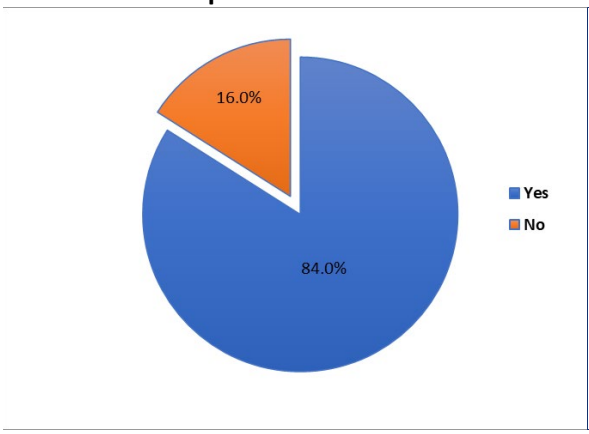
Percent of TAP OUD participants self-reporting lifetime opioid use at baseline assessment (FY 2020-FY 2022)



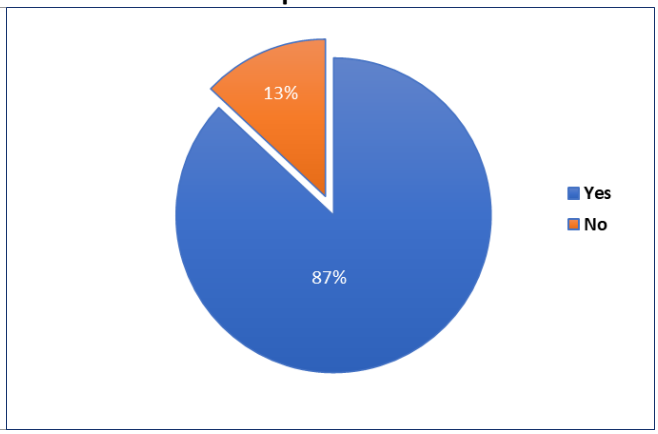
DPP Involvement and Outcomes**:** DCBS Division of Protection and Permanency (DPP) requested a summary of Protection and Permanency involvement and child welfare outcomes among assessed TAP participants discharged during FY 2022 (n=1,558). Case closure data are used for all measures. It is important to note that TAP and DPP case closures have separate timelines. As presented below, of the 1,558 assessed participants who terminated TAP services during FY 2022, more than four of every five participants (84%; n=1,316) had DPP involvement.

DCBS Division of Protection and Permanency (DPP) also requested a summary of Protection and Permanency involvement and child welfare outcomes among assessed TAP OUD participants discharged during FY 2022 (n=590). 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 590 assessed participants who terminated TAP OUD services during FY 2022, nearly nine of every ten (87%; n=518) 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 and TAP OUD termination. As shown, of those involved with DPP while receiving TAP OUD services (n=518), 109 families (21%) were reunified - with 80 DPP cases closed and 29 DPP cases remaining open for monitoring and support. Prevention efforts were successful for 171 families (33%) whose children were never removed. In addition, 26% percent of cases remained open, with 133 families making progress toward reunification.

DPP Case Status among TAP and TAP OUD Participants	Number and percent of participants who reported status		
	TAP (n=1,316)[5]	**TAP OUD (n=518)**	**Total (n=1,465)**
Open working towards reunification	376 (29%)	133 (26%)	487 (33%)
Open for monitoring and support; children never removed	178 (14%)	58 (11%)	206 (14%)
Closed children never removed	349 (27%)	113 (22%)	309 (21%)
Open for monitoring and support; family reunified	92 (7%)	29 (6%)	118 (8%)
Closed family reunified	169 (13%)	80 (15%)	172 (12%)
Closed custody not returned to parent	113 (9%)	60 (12%)	112 (8.0%)
Open goal changed to adoption, legal custodianship, planned permanent living arrangement, or other form of TPR	36 (3%)	50 (10%)	61 (4%)
Closed parental rights terminated (TPR)	10 (1%)	8 (2%)	7 (<1%)

Substance Use Disorder Identification and Referrals in Human Services Project: TAP was one of 41 key informants invited to participate in the *Substance Use Disorder (SUD) Identification and Referrals in Human Services Project* funded by the ACF's Office of the Assistant Secretary for Planning and Evaluation (ASPE). This project, implemented by JBS International, sought to identify and resolve barriers to parental SUD identification and treatment referrals within the four human services program areas – TANF, child welfare, domestic violence, and Head Start. Information collected from content experts will be used to identify and expand policies and practices to enhance SUD identification, treatment access, and recovery supports for individuals in need. In addition, JBS conducted a literature review to develop the paper, *"Framing Human Services Programs as Paths to Substance Use Disorder Treatment: Identifying Obstacles and Moving Forward"* submitted to ASPE in September 2021.

As part of the next phase of this project, Barbara Ramlow, TAP Director, was invited to serve on a federal expert TANF panel for a 2-day virtual meeting held September 21–22, 2021, "*The Time Is Now: Systematically Identifying Human Service Program Recipients Affected by Substance Misuse and Referring Them to Treatment and Recovery Services"*. The goal of this meeting, hosted by JBS International on behalf of ASPE, was to provide information to DHHS leadership on removing barriers to systematic and consistent implementation of appropriate and effective substance misuse identification, treatment referrals, and collaborative and supportive practices within the four human services program areas. Ms. Ramlow was also invited to do a presentation on TAP, which was selected to be highlighted as the innovative TANF program on the first day of the meeting, and to submit a brief paper about the

[5] More than one category may be selected by assessors when completing the case closure instrument

program**.** Ms. Ramlow presented *Temporary Assistance to Needy Families (TANF) Program Innovation: Kentucky's Targeted Assessment Program* on September 21, 2021. The resulting manuscript, titled **"***Partnering with Low Income Parents and Human Service Programs to Increase Substance Use Treatment Engagement: Kentucky's Targeted Assessment Program" and* authored by Barbara Ramlow, Kimberly Releford, Megan Dickson, Terry Stratton, and Carl Leukefeld, was submitted to ASPE in September 2022.

ASPE published *Identifying and Supporting Human Service Participants with Substance Use Disorders: Roundtable Summary*, authored by Annette Waters, Robin Ghertner, Pamela Baston, and Kathleen Meyers on March 28, 2022. TAP was highlighted in this paper. ASPE also published *Challenges to Identifying and Supporting Human Services Participants with Substance Use Disorder*, authored by Annette Waters, Robin Ghertner, Pamela Baston, and Kathleen Meyers on May 27, 2022.

LL. Trauma-Informed Care

Trauma-informed 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 2022, 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. Due to the COVID-19 pandemic, these meetings were held virtually via a meeting hosting application. 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 TF-CBT, which is a specific mode of cognitive behavioral therapy. 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.

KCADV 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.

During 2022, it has become apparent there is a need to increase field staff's knowledge of and ability to use trauma-informed concepts and language. 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 trauma-informed and person-centered language. When referral materials are revised and written in a trauma-informed manner, placement is then identified in many cases.

MM. Work Incentive Program

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 nine consecutive months. WIN assists families transitioning off welfare 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 funded by title IV-A. WIN is available statewide to eligible K-TAP recipients whose K-TAP case discontinues with earnings. Eligible WIN recipients may receive a monthly work expense reimbursement payment for $130 for up to nine consecutive months. 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.

To be eligible for WIN, the individual must be discontinued from K-TAP 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 federal poverty level. 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 K-TAP, WIN payments will stop even if months are remaining in the eligibility period. Effective November 2012, payments for WIN are 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 CY 2022, an average of 82 WIN payments were issued per month for a CY total of $127,920.00. No consultative efforts or technical assistance was provided by a National Resource Center during CY 2022. The Cabinet is currently researching plans to revise the program.

During 2022, Division of Family Support 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 currently allowed. The changes to WIN were approved and is effective March 1, 2023.

Kentucky has obtained approval for policy/regulation changes to modernize KTAP and TANF related programs including WIN, beginning in March 2023. With these changes in place, we expect usage of the WIN program will increase. The extension of 12 cumulative months will allow WIN eligible individuals transition from public assistance to their employment, promote job retention with less financial turmoil while tapering off their assistance.

The number of WIN cases has slightly increased from 2021, as individuals are transitioning back into the workforce. Currently for CY 2022 the average was 82 monthly payments with a total payment amount of $127,920.00 for the year. In CY 2021 there was an average of 76 WIN payments issued per month, for a total of $117,780.00 for the year. Which is still considerably less than prior years before the COVID-19 pandemic, in CY 2019, there was an average of 249 WIN payments issued per month, for a total of $388,440.00 Program data demonstrated no updates to benefit amounts since 1996, whereas the dollar has decreased in value due to inflation.

NN. Y-NOW Children of Prisoners Mentoring Program (YMCA Safe Place Services)

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, and children with incarcerated parents.

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 incarcerated parents. The program service area is the Greater Louisville metro area.

All services are offered free of charge to the youth and family. Funding for the Y-NOW Children of Prisoners Mentoring program comes from Metro United Way, 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 incarcerated. The trauma to a child of having an incarcerated parent 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: children of incarcerated parents 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 that cycle.

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	**NEW MATCHES (FALL 2021/22)**	**SUSTAINED MATCHES**
• 75% demonstrate an improvement in school performance (grades, suspensions, attendance)	67%	82%
• 85% report improvement in family relationship (stability, communication, no runaways, etc.)	75%	90%
• 75% have no new arrest and/or out of control behavior	83%	88%
• 75% will not initiate any (or any new) contact with family/juvenile court	83%	90%
• 80% pass to the next grade	100%	92%
MUW Indicators/Outcomes	**2021/2022 FALL CLASS**	**ALL Y-NOW PARTICIPANTS (2004-2021)**
% Achieve academic success (improvement)	67%***	---
% Pass to next grade	100%***	---
% Missing less than 10 days of school	---	---
# Graduated middle school	5***	322
# Graduated high school and/or earn GED	---	215
# Currently enrolled in elementary/middle/high school	15**	225
# 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	---	__*

*Due to COVID-19 & virtual school, Y-NOW did not have access to youth's grades, attendance, & suspensions for Fall 2020/2021.
** The Fall 2021/2022 class data in this report spans from October 2021-July 2022 which is the ten-month period of this cohort.
***The Fall 2021/2022 class data in this report represents the youth that began the class in October 2021 & graduated the program in July 2022.

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. To decrease barriers Y-NOW staff transported some of the youth to the enrollment sessions. The Fall 2021/22 class began with 15 participants, with 12 youth graduating 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: A curriculum-based three-day kickoff camp retreat occurred in October 2021. Before camp began the youth and adults underwent COVID-19 testing. Y-NOW staff provided transportation for some youth to get tested. 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 look at what is getting in the way of them being successful and begin to develop an action plan for their future (particularly around their education).

A fair amount of time is spent building trust and creating a safe and supportive community so that the youth can begin to talk about what it is like to have an incarcerated parent. The youth also do a high ropes course. Mentors usually join the group at the retreat Saturday morning and staff for the rest of the weekend. At the conclusion of camp, the youth are 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. Face-to-face meetings are strongly encouraged, but virtual meetings are acceptable when needed for COVID-19 safety reasons. Mentors attend three mentor-only meetings in which training topics are presented, the topic for the first mentor only meeting in November 2021 was Adverse Childhood Experiences (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. Youth also planned the community service project occurred in April 2022, the Y-NOW community filled care packages for children in the hospital and young adults experiencing homelessness. 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

2018	• 23 youth graduated from inaugural spring class • 14-year-old youth leader is featured speaker as YMCA Safe Place Services Together for Teens Breakfast • Director retired, fall case manager was promoted to director and new Fall case manager was hired. • 387 youth completed the three-day retreat, of which 331 youth completed the follow-through program. • Youth leader won a Youth Character Award and scholarship
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 2020-21 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 2019-20 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 2020-21 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 2 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.