Service Array Index

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 and are geared toward facilitating access and visitation of non-custodial parents experiencing difficulty in 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 Child Support Enforcement (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 went live. 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 the following data in the intake database: gender, race, age, reason for calling, and participation in an IV-D case. 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 adding the grandparent/legal guardian option in the IV-D case types.

Through the end of 2021, 1,753 persons contacted the hotline for assistance related to access to and visitation with their child(ren). Child support paid the LAS $129,460.94 in calendar year (CY) 2021. Currently, there are no perceived barriers with 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 administers the state's Batterer Intervention Certification Program by enrolling providers, conducting training, monitoring providers, and maintaining the provider list. KCADV also accepts grievances regarding batterer intervention providers. Simone Marx (smarx@kcadv.org) is the program specialist at KCADV who works to coordinate the Batter's Intervention Program (BIP). Additional support staff include:

- Isela Arras, COO, iarras@kcadv.org
- Meg Savage, CLO, msavage@kcadv.org
- Lisa Gabbard, Leadership, lgabbard@kcadv.org

Certified providers deliver 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 (SUD) and mental health issues.

In 2021, three training events, attended by 24 potential providers**,** were held. Eight of the attendees became certified new providers. Based on the training barriers experienced during the COVID-19 pandemic, a virtual equivalent of the training aligning with 922 KAR 5:020 was created. The first online batterer intervention certification training was held in July 2021. KCADV also developed podcasts that

attendees listen to independently. They then use the KCADV certification site through Moodle to access all written and audio resources for each of the three days of training. This material includes podcasts, readings, and discussion boards (at least two per topic). For each podcast, KCADV offers a three-hour live session through Zoom, during which the presenter of the podcast will highlight the important points and other relevant information. There are five live sessions over the course of a month. All work associated with the training will account for 24 hours of training.

KCADV maintains the following in support of the BIP program:

- A provider site, Associations Management Online (AMO) that manages the provider lists, and contact information for providers, and allows for registration of the BIP certification training: members.kdva.org.
- A Moodle certification site with podcast episodes, assignments, and quizzes for virtual BIP certification: certification.kcdav.org.
- A quarterly provider list supplied to the Administrative Office of the Courts (AOC).

KCADV staff, Nick Davis (Anew Alternative-Frankfort), and Kilen Gray (Creative Spirits-Louisville), both BIP service providers, 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 a specific way and discusses how gender roles can get in the way of progress in groups. Nick Davis discusses the specifics of BIP service provision and the needs of the BIP participants.

COVID-19 continues to affect participant numbers and data collection. While the numbers served were lower in 2021 than in the past, participant numbers are back on the rise. Providers continue to face several challenges in terms of being able to faithfully execute their responsibility for this program and adherence to the regulations. This is based on the move from in-person to virtual groups.

Currently (and due in part to the effects of COVID-19 on the service delivery alterations), BIP providers specifically struggle with being able to:

- Shift their programs/groups to online spaces even though it was an approved service delivery process.
- Manage their own small private practices. Most BIP providers are very small practice practitioners and it's difficult for them to maintain the administrative structure of the program, such as documenting attendance for the course of 28 weeks and reporting routinely to the courts/DCBS.
- Engage with survivors appropriately and document referrals and engagement; and, perhaps more importantly,
- Engage with the courts. Because most interaction with clients, survivors, courts (and other referral sources) as well as with KCADV 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.
- Identify sub-standard service delivery practices because those who are benefitting from sub-standard services rarely report to KCADV their concerns at receiving superficial classes, deviating from a curriculum topic, or even at having to attend fewer classes than is required.

Throughout 2021, KCADV 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 the differences between BIP and anger management, how to inform judges about BIP, and other topics as requested. KCADV also shared training options to help with the transition to virtual groups. Some providers opted not to provide groups during the pandemic.

Batterer Intervention Program Data: 2021				
Category	**Male**	**Female**	**Other**	**Total**
Batterers Assessed*	**908**	**136**	**0**	**1,044**
Civil/DVO Referral	**417**	**110**	**0**	**527**
Criminal/Post-Conviction	**433**	**73**	**0**	**506**
Diversion	**121**	**17**	**0**	**138**
DCBS Referral	**155**	**26**	**0**	**181**
Self-Referred	**41**	**9**	**0**	**50**

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

2021 Selected statistics:

- The average assessment cost: $81.00
- The average cost per group session: $25.50
- One hundred thirty-three (133) total participants were referred for SUD outpatient treatment services
- Eight hundred forty-four (844) total participants earned less than $30,000 per year
- Four hundred eighty-eight (488) participants identified as Asian, Hispanic, or African American
- Four hundred thirty (430) participants ranged 18-29 in age

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). The CSAEP Board is an autonomous body within the Office of the Attorney General and exists as the sole organization in Kentucky with the statewide mission to prevent child sexual abuse. The organizational structure and duties of the CSAEP Board are set forth in KRS 15.900 to 15.940. Since its inception, the CSAEP 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. The mission of the CSAEP Board is to help provide for the safety of Kentucky's children by preventing child sexual abuse and exploitation through educating the public, funding innovative programs, and shaping public policy. 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 $219,417.02 in grants in 2020 (for state fiscal year (SFY) 2021). The amount awarded is the maximum amount that could be reimbursed to a grantee. Most grantees have not yet billed the full amounts awarded. The Trust Fund funded $195,653.69 to grantees in calendar year 2021.

Child Sexual Abuse Medical Exam Reimbursement: As shown in the chart below, $49,975.00 was funded to 15 Child Advocacy Centers as a partial reimbursement for 576 child medical sexual assault examinations at $75.00-100.00 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 2022 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 202**2**.

CAC NAME	**# OF EXAMS**	**GRANT AMOUNT**
BARREN RIVER	62	$5,400
BUFFALO TRACE	7	$650
CAC OF THE BLUEGRASS	160	$14,150.00
CUMBERLAND VALLEY	49	$3950
FAMILY & CHILDREN'S PLACE	52	$4,350
GATEWAY	14	$1275
GREEN RIVER	41	$3,500
HOPE'S PLACE	20	$1,625
JUDI'S PLACE	48	$4,125
KY RIVER	20	$1875
LAKE CUMBERLAND	56	$4,850
LOTUS	27	$2,475
NORTHERN KY	30	$0
PENNYRILE	15	$1,375
SILVERLEAF	5	$375

State/Regional Prevention Grants: The Board awarded $166,230.90 for regional and statewide awareness, prevention, and outreach programs for SFY 2022.

CHILD WATCH COUNSELING	$24,653.00
EXPLOITED CHILDREN'S HELP ORGANIZATION	$29,325.00
FAMILY NURTURING CENTER	$55,223.00
KENTUCKY KIDS ON THE BLOCK	$24,532.90
PREVENT CHILD ABUSE KENTUCKY	$32,465.00

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.

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.

Conference Grants: The Board reimbursed the following entities $2,110.75 in conference grants in 2021.

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

Other Grants: For SFY 2021, the board awarded medical reimbursement grants for 836 medical exams for child victims to 15 Children's Advocacy Centers 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 recognizes its responsibility of continuing to fund quality prevention programs with CSAEP monies and to continue to provide funding to the CACs to assist with the administrative costs associated with the child sexual abuse medical examinations conducted at the centers. The board will continue to award grant applications each year to meet its mission in serving child victims of 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. 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. 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 - Calendar Year 2021	
Service Category	**Number of Services Provided/Persons Served**
New children served	7,137
New caretakers served	4,592
Advocacy services: court, case management, referrals to services	103,478
Medical services: comprehensive forensic medical exam, general exam, follow up exams, referrals for further medical treatment	683
Forensic services: forensic interviews by CAC staff, forensic interviews hosted by the CAC for trained child welfare interviewers	5,878

Mental health services: individual, family and group treatment, mental health screening	11,500
New children staffed by KY MDTs	5,172
Total CAC cases seen through KY's MDTs in 2021	29, 614
Training programs conducted	772
Community partners trained	1,326
Community awareness events	788

CACs in Kentucky continually assess the quality of services available to Kentucky's families and communities through examination of Outcome Measurement System survey results. Responses from over 2,200 caregivers and investigative partners surveyed in 2021 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, 97.5% 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 feel like my daughter has been doing so much better since she came there and talked about what happened to her. I feel better too like I have a direction that makes me feel like we are going to get through this."

Responses from community partners showed 97% felt the CAC model fosters collaboration on the MDT, and 99% indicated clients served through the CAC also benefit from this team collaboration. CACs provide important resources that improve their ability to work. One community partner described her experience with her local CAC like this: "We work together to make sure victims are taken care of, feel supported and safe, and to protect their information. This is an area of our work that is so important, and it matters to me to see it handled so well."

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; and
- 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 federal fiscal year (FFY) 19-21 submitted December 21, 2018.

DCC is directly responsible for oversight of the CCAP, the tiered quality rating and improvement system, 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 programs 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 for Health and Family Services (CHFS/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).

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.

During CY 2021, an average of 20,382 children and 11,100 families received child care assistance program benefits. Of the total number of children receiving benefits, there was an average of 2,941 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 2021 were $104,555,696.

DCC contracts with the Kentucky Partnership for Early Childhood Services, 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 QRIS specialists;
- Twenty-one (21) quality coaches;
- Seventeen (17) technical assistance health/safety coaches;
- Eight training coaches; and
- Eight professional development coaches to ensure adequate supply of quality child care programs and services are available in each regional hub covering the Area Development District.

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. Child care report data collected through the Kentucky Integrated Child Care System (KICCS) assistance program is available to all 120 Kentucky Counties. Data reports compiled quarterly, annually, and ad hoc on request are available for state and federal reporting. Data analysis of data reports to support decision making, legislative, regulatory, and program improvements.

Effective October 1, 2017, child care application for eligibility determination transitioned to Benefind allows 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 to make educational and policy decisions.

Utilizing American Rescue Plan funding, DCC is working to launch a regularly updated data dashboard to provide the agency and its partners a snapshot of the child care landscape in Kentucky.

During CY 2021, Kentucky's CCAP experienced a 44.84% decrease in child enrollment. Families served numbers have decreased by more than 45.58%. This is a direct result of the COVID-19 pandemic.

The Kentucky workforce has greatly changed since the onset of the pandemic. Many people lost their jobs or chose to resign from their positions to stay home and care for their children. Child care providers are struggling to recruit and retain staff for the wages they are able to pay.

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 focused its efforts on sustaining existing child care programs. DCC used Coronavirus Aid, Relief, and Economic Security (CARES) Act funding to issue sustainment payments to all providers based on licensed capacity. DCC also amended its CCDF State Plan to pay providers based on enrollment not attendance and paid parental co-payments. DCC has also dedicated 85% of the funds received from the Coronavirus Response and Relief Supplemental Appropriations (CRRSA) Act to sustainment payments for providers. The remainder of the funds will be used to provide professional development and national background checks at no cost to providers and to implement a Family Child Care Network focused on increasing capacity especially in child care deserts as well as for children who are in foster care or placed with fictive kin.

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 beginning in October 2021 after the CRRSA

payments have concluded. These 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; and
- Building the supply of child care for underserved populations.

F. Children's Justice Act Grant

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

1. 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;
2. The assessment and investigation of cases of suspected child abuse-related fatalities and suspected child neglect-related fatalities;
3. The investigation and prosecution of cases of child abuse and neglect, including sexual abuse; and
4. 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, as well as provide expert testimony as needed. This is a necessary service to field staff, as many communities do not have forensically qualified medical personnel.

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

In 2021, the taskforce continued to fund an established grantee, the University of Louisville (UofL), Division of Pediatric Forensic Medicine (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.

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. Some key takeaways from 2021's continued project included:

- CAC employed MDT coordinators provided expert review of 3,313 reports between October 2019 and mid-June 2021. From January to June 2021, these CAC professional reviewed 902 reports for locally established intake criteria for MDT response and trauma informed, evidence-based services available through CACs as well as for trends of unmet community need.
- During months when CAC employed MDT coordinators actively reached out to MDT partner agencies to coordinate identified service needs for child abuse victims, the percentage of children receiving specialized services for which they qualified increased.
- Percent gains were observed for specialized services (forensic interviewing, victim advocacy, and mental health services) in all three locations.
- MDT coordinators identified potential barriers to efficient communication and utilized technology to assist in providing solutions. One example included routine use of email to communicate asynchronously and consistently with intake team supervisors and assigned investigative workers. Another example was use of a secure document for law enforcement agencies to indicate to other team members which agency had accepted a case for investigation when multiple agencies had been notified of an investigation.
- Through this project, CAC MDT coordinators increased their communication with DCBS personnel, including with the CI teams. Examples include attending virtual staff meetings, including the CI team in an MDT newsletter.
- CHFS entered an updated MOU Effective through 2024, demonstrating the recognition of the value of increasing collaborative efforts.

The taskforce also funded the Cultivating Youth Resilience Project to develop new web-based, synchronous, trauma-informed curriculum segregated into separate learning models to enhance the handling of child abuse cases in a manner which minimized additional harm to victims and their families. Survivors' Corner promotes survivor and trauma informed efforts to achieve impactful reform and lessen the effects of child abuse. The primary focus of the first quarter of the award period was developing the project plan and curriculum framework, brainstorming training best practices, and recruiting Survivor Leader Consultants to inform the curriculum based on their personal and professional experiences. In 2021, this project was able to begin by hiring three leader consultants who were all child abuse survivors from various backgrounds. These consultants held meetings regarding the handling and managing of child abuse cases, as well as creating documents needed for a successful curriculum.

In CY 2021, 64% of PFM forensic consultations involved children four years of age or younger. PFM saw a 33% increase of ingestions of illicit medication/substances, totaling 234.

For the CAC MEP, since moving into Phase 2 (active outreach/ coordination), Lotus (Graves County location) reviewed 244 reports received from CI, an increase of 9.4% from the same time-period in Phase 1. The Graves County MEP task force reviewed 197 reports. Lotus served 69 unduplicated victims and caregivers, and provided 660 services resulting from referrals for forensic, advocacy, and therapy services. Graves County saw an increase of 88% in forensic interviews. Between October 1, 2020, and June 9, 2021, Graves County MDT reviewed 96 cases, an increase of 63% from same time-period in Phase 1.

The taskforce has completed their annual strategic planning meeting and has voted to fund additional projects in 2022 relating to their strategic goals. The state will complete the annual application in 2022 with no foreseeable barriers. Meetings with the taskforce continue to be held in a virtual setting.

G. Children's Review Program

The Children's Review Program (CRP) is a program of 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; 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 based in the statewide office in Lexington, and working remotely across the state, alongside DCBS staff. To minimize the number of staff in offices and increase staff safety during the COVID-19 pandemic, many CRP staff worked hybrid schedules or remotely beginning in mid-March 2020 and continuing throughout 2021. Processes were developed that allowed CRP to continue to carry out its functions without interruption. Some CRP staff positions will continue to be remote or hybrid after the pandemic ends.

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 DCBS-committed children who are placed in OOHC.

As part of the assessment function, clinical reviewers assigned 11,725 levels (2,185 initials, 7,619 utilization reviews, 943 redeterminations, and 978 reassignments) from January – December 2021.

As part of the placement function, regional placement coordinators assisted in or were involved with 5,873 placements and made 345,565 referrals. Statewide placement office personnel facilitated or were involved in over 850 conference calls during 2021 (see additional details below).

After a brief pilot process in February 2021, CRP began completing QRTP assessments in March 2021 for a subset of eligible children, based on Cabinet-identified priorities. QRTP assessors completed 168 QRTP Referral Assessment and Recommendation reports between March 2021 and December 2021. Of the

168 assessments, 162 children were recommended for a QRTP placement, and six children were not recommended.

As part of the quality assurance function, CRP maintained data on 10,476 children committed to DCBS at some point in 2021, and program information on 198 private child-caring (PCC) and private child-placing (PCP) programs that operated in 2021, (62 residential treatment programs open at any point during the year; 97 therapeutic foster care programs; and 39 independent living programs). This information is continuously updated on an ongoing and as needed basis. In addition, in 2021, clinical reviewers identified 2,904 quality improvement issues related to the services provided to children 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. 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 Aetna SKY and other managed care organizations (MCOs), PCC/PCP providers, the Building Bridges Initiative (BBI), Family First Prevention Services Act (FFPSA), UK Innovation in Population Health Center (related to QRTP assessment implementation), and the Structured Decision-Making (SDM) project. CRP staff participate in utilization review committees in selected regions. CRP's regional placement coordinators are co-located with DCBS staff throughout the state. CRP also 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 are as accurate as possible based on both the child's medical needs and other issues/behaviors. In several DCBS regions, CRP is involved in ongoing collaborative meetings between DCBS and PCC/PCP staff, (i.e., the Southern Bluegrass Quality Care Provider meeting). A CRP staff person is actively involved in reviewing applications from programs applying to obtain a PCC/PCP agreement with DCBS.

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 continuous quality improvement (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 2021. CRP representatives also regularly attend the Alliance's quarterly OOHC Council meeting as community partners. CRP staff also lead a quarterly Quality Outcomes 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 provided several orientations to new agencies or new agency staff during the year (including The Home of Opportunities and Dreams (The HOOD)), and Nightlight

Foster Care Agency. In 2021, CRP provided phone consultations 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 behaviors, progress of, and services provided to children in their care. CRP staff also call programs about specific issues related to the completion of the ALP to improve a program's accurate reporting on this form. In addition, when making referrals, regional placement coordinators receive packets from DCBS staff to forward to potential placements. In February 2021, DCBS staff began utilizing a new system for notifying Regional Placement Coordinators of a placement referral request through a 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 the referral packets are incomplete or are missing important information, the regional placement coordinator will communicate with DCBS staff to get a more complete packet of information. The regional placement coordinators also provide detailed referral reason information, which supplements the packet provided by DCBS, and summarizes the child's issues and needs, when making these packets available to potential placements.

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. Consultative efforts draw on the wide range of clinical expertise among the staff of CRP, including assistance with service planning for children with severe emotional disabilities and for those with intellectual and developmental disabilities. In 2021, these efforts continued to include meeting with DCBS staff and providing data and feedback on child-specific and program-level quality improvement issues that were noted during utilization reviews, or by QRTP assessors during the assessment process. In addition, quality improvement information is made available to each PCC/PCP agency. CRP continues to revise the quality improvement system, as needed, to address DCBS concerns related to children in care and to communicate these concerns effectively to the PCCs/PCPs. For example, CRP worked with DCBS leadership in 2021 to identify new areas of focus for quality improvement related to DCBS' expectations for residential programs designated as QRTPs, (e.g., regarding the number of physical managements and seclusions utilized with children in these programs).

In 2021, 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 also worked with DCBS staff in the implementation and ongoing assessment of some PCC/PCP pilot programs, (e.g., Home of the Innocents CATS Program, Key Assets, Maryhurst).

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 (DPA), the 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. During early 2021, CRP began distributing information from central office to regional placement coordinators, about children whose placement had given a 14-day notice. This process has the potential to decrease placement crises as it enables regional placement coordinators to proactively communicate with DCBS staff about the situation.

In 2021, CRP completed 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).

For more than 10 years, CRP has also worked with UK to serve as an internship site for undergraduate psychology and social work students during the fall and spring semesters.

CRP's current annual budget is $3,714,334.

During 2021, a significant focus of the Cabinet has been on the continued implementation of FFPSA. Kentucky opted to be an early implementer of FFPSA in October 2019. It is a requirement of FFPSA that all children (excluding clearly defined exceptions) being considered for placement in a QRTP be evaluated within 30 days of placement to determine if congregate care is needed and appropriate. The assessment requires the use of an evidence-based, validated functional assessment tool to assess the strengths and needs of the child to help make this determination. Kentucky opted to use an abbreviated version of the Child and Adolescent Needs and Strengths (CANS) assessment as its functional assessment tool. The QRTP assessment must be conducted by a trained professional or licensed clinician who is not an employee of the state agency and who is not connected to, or affiliated with, any placement setting in which children are placed by the state. DCBS asked that CRP conduct the QRTP assessments. In June 2019, CRP submitted a proposal to DCBS for conducting the assessments and began working with DCBS on the logistics of completing the assessments, (e.g., developing a TWIST interface, developing a CANS algorithm relevant to Kentucky). There was a delay due to some unexpected issues related to QRTP definitions that had state and federal implications. In addition, DCBS worked with the Kentucky Department of Medicaid Services (DMS) during 2020 to establish a billing code that would allow the assessments to be reimbursed by Medicaid. DMS identified a QRTP assessment code in September and CRP was asked to resubmit their proposal for providing the assessments, taking this development into account. A revised proposal was submitted at the end of October. A letter of intent was provided by DCBS to CRP in November, with a plan to provide a signed contract to CRP in early 2021 and for CRP to begin implementation of the QRTP assessments two to four months after receipt of the signed contract. CRP continued to work on developing QRTP processes and procedures in collaboration with DCBS in preparation for implementation and began posting positions

related to the assessments in December. DCBS continued to educate DCBS staff, PCC/PCP providers, and judges in preparation for implementation.

The Cabinet has recently added specific performance indicators to PCC/PCP agreements. Although the Kentucky legislature did not approve the Cabinet's request in 2020 for funding to pursue performance-based contracting, it is hoped that performance indicator data will be used to evaluate and potentially reward programs' performance in the future. During 2021, CRP continued working with the PCC/PCPs to assure the validity of data collected to measure performance and analyzed the first full year of performance indicator data for FY 2020. CRP provides data on a regular basis to the PCC/PCPs so they can verify the accuracy of the data or make corrections as needed. FY 2019, FY 2020, and FY 2021 are considered "hold harmless" years for the PCC/PCPs so that they can better assess where they are on the measures and where they need to make improvements, in anticipation of future performance-based contracting. Report formats have been developed and provided to PCC/PCPs. During the coming year, CRP will continue to analyze performance indicator data and refine the format for reporting this data as needed 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. This will impact CRP in multiple ways, primarily related to CRP's level-of-care assessment function. CRP worked with DCBS staff to update the Application for Level-of-Care Payment (CRP-7) form and other forms that are referenced in the regulation. 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 and service needs. (Proposed changes to 922 KAR 1:360 were filed in January 2021 with planned implementation in July 2022.)

CRP assigns levels of care 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 (private child care placement, levels of care, and payment). Information used in the level assignments is provided by DCBS staff, the PCC/PCP, or through other sources. These levels represent the treatment and service needs of the child. The number of level assignments over the past five years are as follows: (Note: The table data has been updated to reflect a calendar year rather than a fiscal year).

Calendar Year	Total Reviews	Initials	Utilization Reviews	Redeterminations	Reassignments
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
2017	12,495	2,550	7,948	977	1,020

The number of level assignments increased each year from 2017 to 2018. During FY 2019, there was a decrease (3.9%) from the previous year, and in FY 2020 there was an additional 3.1% decrease. The number of level assignments decreased by another 6.8% from 2020 to 2021 and are now lower than the number of levels in 2017. Staff who assign levels of care (Clinical Reviewers) are required to maintain acceptable levels of inter-rater reliability, 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 2021, CRP's inter-rater reliability was .08.

During the last year, CRP has continued to work to collect IQ scores on children, especially those children who have been 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 746 IQ reports on 538 children currently committed to DCBS. In 2021, a total of 188 IQ reports (on 179 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 2021, CRP tracked 293 DCBS children who were identified as medically complex at some time during the year.

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

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. An effort is made to keep siblings together whenever appropriate. CRP staff were involved in 5,873 placements in 2021. This is an increase from 2020. In 2021, regional placement coordinators made 94,284 more referrals than in 2020. There have been some placement process changes based on guidance from DCBS that have likely contributed to this increase. The average number of referrals made for each placement increased from 45.1 to 58.8. There have been significant placement challenges associated with the COVID-19 pandemic, (e.g., lower residential bed capacity due to staffing shortages) that have likely contributed to the increase in the number of referrals made and the average number of referrals needed for each placement found.

Calendar Year	# of Referrals	# of Placements with RPC Involvement	Avg. # of Referrals per Placement
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
2017	309,279	6,111	50.6

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. In 2021, with QRTP implementation, regional placement coordinators also were able to refer based on whether a child is part of a particular population (pregnant, parenting, at risk for or victim of trafficking) and thus requires specialized services related to these issues. When placement options based on a referred child's age, level of care, etc. are identified, the regional placement coordinator shares information with DCBS staff about the types of EBPs and

other services each program offers to address the treatment needs of the child referred. CRP maintains a list of descriptions for the more than 80 EBPs reported as being used at some point by the PCC/PCP programs (48 are reported as currently being used by 89 programs) and updates these as needed. These descriptions 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 home 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. CRP routinely convenes conference calls to discuss and address complex cases, for decision making on locating placements that best meet the needs of DCBS children, and for clinical consultation. In 2021, CRP staff were involved in approximately 850 conference calls. This is a decrease from the 956 conference calls in 2020. 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.

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 who are at risk for disruption or decertification, or whose services have already been decertified by the MCO at their current placement. Decertification was not an issue in 2021 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 referrals for medically complex children. Currently, there are 182 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. 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 12 agencies with 37 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 treatment programs back into placement in Kentucky. CRP convenes conference calls as appropriate with DCBS staff, current out-of-state treatment providers, and others as needed, while the child is in the out-of-state 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 out-of-state placement had been gradually increasing. After a significant jump in 2018, the number of children placed in an out-of-state program sometime during the year leveled out in 2019. There were 25 children placed in out-of-state placement in 2020, compared to 31 in 2019. The number of children placed in out-of-state placement at the end of 2020 was eight, which is slightly lower than 2019 when there were 10 children placed in out-of-state treatment programs at the end of the year. In 2021, there were 19 children placed out-of-state. The number of children in out-of-state placement at the end of 2021 was 4, which is lower than 2020 when there were 8 children placed in out-of-state treatment programs at the end of the year.

Calendar Year	# Children Out-of-State During the Year	# of Children Out-of-State at End of Year
2021	19	4
2020	25	8
2019	31	10
2018	27	16
2017	15	6

CRP staff work closely with DCBS to address the needs of children diagnosed with developmental or intellectual disabilities, especially as they begin to transition out of care to ensure a smooth transition to the adult system. CRP has a consultant for developmental and intellectual disabilities who works with DCBS to help determine the most appropriate placements to meet the youth's needs. The consultant completed 33 written consultation reports in 2021. CRP staff may at times work with Supports for Community Living (SCL) programs to have them consider placing these youth under an individual placement agreement until SCL funding is available for the youth at 20.5 years of age. This may serve to reduce the number of transitions for the youth. CRP worked this year to compile a list that identified which SCLs fell into each category and shared this list with the Cabinet. From 2015 to 2017, the number of youth utilizing SCL services remained stable. The number of DCBS youth in SCL placements in 2020 remained almost the same as in 2019, at 104, and the number of youth placed with SCL providers at the end of the year was similar, at 75. The number of DCBS youth in SCL placements sometime during the

year in 2021 increased again, to 111, although the number of youth placed with SCL providers at the end of the year had decreased somewhat to 66 in 2021.

Calendar Year	# Youth in SCL During the Year	# of Youth in SCL at End of Year
2021	111	66
2020	104	75
2019	105	74
2018	92	74
2017	76	45

DCBS currently works with two different agencies that have 5S (specialized) residential programs for children with high intensity needs. CRP has been 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. These service reviews are provided to DCBS and to the programs. During 2021, CRP completed 147 service reviews for Maryhurst Specialized Services Program and 38 service reviews for Uspiritus Brooklawn Specialized Program for a total of 185. Service reviews are completed on a quarterly basis for each youth in the program. In 2021, there were 98 children who resided in these programs (80 in Maryhurst and 18 in Uspiritus). CRP has modified the reviews and aggregate reports to address requests from the programs and DCBS, such as tracking youth who have completed high school while in the program and tracking the average number of days for youth to complete the program. During 2020, in consultation with DCBS, both the individual and aggregate reports were revised, and it was decided that the individual reviews no longer needed to be sent to the programs or to DCBS. The aggregate reports are now 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.

<u>Qualified Residential Treatment Program Assessments:</u>
In March 2021, CRP began completing QRTP assessments for youth in the custody of DCBS who had been referred for residential care. Due to hiring challenges and other issues noted previously, assessments were completed for a subset of eligible children based on priorities identified by DCBS and expanded as possible, as additional Assessors were hired. Five assessors had been hired by the end of 2021. QRTP Assessors completed 168 QRTP Referral Assessment and Recommendation reports between March 2021 and December 2021. Of the 168 assessments, 162 children were recommended for a QRTP placement, and six children were not recommended; eight of the 168 assessments were reassessments, (i.e., an assessment of a child for whom a previous QRTP assessment had been completed). A portion of Assessor time spent completing assessments is Medicaid-billable and 156 of the QRTP assessments were able to be billed to Medicaid. The Medicaid-billable time represents more than 1,000 hours of records review, interviews, and assessment tool scoring (about 6.25 hours per assessment).

Calendar Year	**# Assessments Completed**	**# Assessments Recommending QRTP**	**# Assessments Recommending Against QRTP**
2021	**168**	**162**	**6**

Quality Assurance:
CRP receives quarterly or semi-annual reports from the PCCs/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 for level assignment information, they also note any concerns about a child's safety or the services he/she may or may not be receiving. These quality improvement issues are also tracked by program and a frequency report is provided to DCBS monthly. In 2021, 237 specific quality improvement issues were sent to DCBS (about 4 or 5 cases each week, on average). Clinical reviewers also identify program-level concerns to bring to the Cabinet's attention, (e.g., programs that consistently provides less than the required amount of individual counseling) or track concerns identified by the Cabinet, (e.g., data about the number of seclusions used in residential programs).

Quality improvement information is available to the PCC/PCPs online through the CRP web application. With the 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. In 2021, 2,901 quality improvement issues were recorded. The numbers remain 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, (e.g., modifying the description of quality improvement issues to provide clearer feedback to PCC/PCPs).

Calendar Year	# QI Issues Identified	# Utilization Reviews	% URs With Identified QI Issues
2021	2,901	7,619	38%
2020	3,645	8,577	42%
2019	3,924	8,529	46%
2018	3,913	8,287	47%
2017	3,652	7,948	46%

DCBS has a tracking system for children in private foster care, residential, and independent living placements. CRP receives a weekly download from DCBS, which is integrated into the CRP system, to ensure that placement information is as current and accurate as possible. In 2021, 16,063 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 43 programs designated as a QRTP at the end of 2021.

CRP staff work collaboratively with the PCC/PCP 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 characteristics that may be used in helping determine the most appropriate placement for a child. The performance indicator measure for therapeutic foster care is based on placement stability while the residential program performance indicator measure is focused on whether the reasons for a child's discharge from the program is positive, (e.g., the child moved to a less restrictive setting).

CRP provides the following reports to DCBS monthly: PCC Foster Home Occupancy Rates by Region, PCC Foster Home Occupancy Rates by Program, PCC Foster Home Occupancy Rates by County, PCC Foster Home Occupancy Rates by Region and County, Empty PCC Foster Homes, PCC Foster Care Medically Complex Foster Home Beds, Medically Complex Youth with Medically Complex Rating, Medically Complex Youth with Medically Complex Rating by MCO, Medically Complex Census, Private Medically Complex Foster Parents By Program, Private Medically Complex Foster Parents By Region, Medically Complex Children in Residential Care, Medically Complex Children in Non-medically Complex Homes, PCC Compliance Reports, Private Care Capacity and Occupancy Dashboard, Placement Stability Report, Residential Length of Stay Report, Level 3 Children in Residential Care, a Youth Medication Report, SCL Program Contact Information, and the Monthly Activity Dashboard, which includes current and trend data related to CRP's assessment, placement, and quality assurance functions.

CRP provides the following reports to designated DCBS staff on a quarterly basis: identifying foster parents who move between private agencies, comparative report, referral responses report, medically complex homes and placements report, PCC foster care homes with no history of placement or not current placement, EBPs currently used by PCC/PCPs, Total number of in-progress QRTP Assessments for the Quarter/Year, Total Number of QRTP Assessments Completed for the Quarter/Year, Total Number of Youths Recommended for QRTP for the Quarter/Year, Total Number of Youths not Recommended for QRTP for the Quarter/Year. Several additional reports are sent each quarter, providing data related to assessments not assigned due to insufficient Assessors. A QRTP report is also sent weekly to DAFM, in addition to a weekly Regional QRTP Report to QRTP Liaisons.

CRP communicates with DCBS and/or PCCs/PCPs on a daily and ongoing basis regarding data collection and other issues of concern. CRP made several database and web application changes in 2021 to make information more available to central office staff or to make data more understandable or useable. For example, the dates of a child's previous referrals were made viewable to central office staff, and PCC/PCP information related to EBPs was also made viewable. A parent placement field was added to the database to allow CRP to identify the initial admit date for a child of a committed youth.

In the last year, the number of level assignments decreased (6.8%) over the previous year (12,586 in 2020 and 11,725 in 2021). This continues to decrease from the previous years. Ongoing data will be needed to determine whether any of the 2020 decrease was related to fewer children entering DCBS custody due to consequences of the COVID-19 pandemic, (e.g., remote rather than in-person schooling). DCBS data indicates that there were 9,747 children in care at the end of 2018, 9,038 at the end of 2019, 9,193 at the end of 2020, and 8998 at the end of 2021. However, there has been an increase in the number of relative and fictive kin placements over these years and these types of placements do not require a level of care. In addition, it is noteworthy that there was a decrease in the number of children in residential care over the course of 2021, with 709 children in residential placement at the beginning of the year and 643 children placed in residential treatment programs at the end of the year. Based on QRTP assessments completed in 2021, most children placed in a residential program were determined to be appropriate for that placement (96% of children assessed were recommended for residential placement). There was also a decrease in residential capacity of 176 beds due to programs closing and to a decreasing number of beds available in individual programs. Some of this decrease was due to the COVID-19 pandemic and associated staffing issues. It is also likely the some of the decrease in residential beds occurred due to providers' awareness of DCBS' long-term focus on decreasing the number of children in residential programs.

CRP continued to support DCBS leadership over the past year in efforts to decrease the number of children experiencing placement instability. CRP has continued to provide two reports to the Cabinet on a monthly basis: one identifying children who moved from a PCP foster home within 30 days of placement with the agency; and the other showing the number of children with three or more placements in PCP foster care within the previous 90 days. DCBS has continued to follow up on cases identified in these reports. Performance indicator data for therapeutic foster care programs provides individual programs with information about placement stability and additional avenues for potential improvement in this area. Stability in residential care can be an issue as well. In 2021, nearly five percent of the QRTP assessments completed were reassessments. Reassessments often occurred due to the child disrupting their current QRTP placement. It will be important to continue to track the percentage of these reassessment cases going forward.

There continues to be many conference calls on children with complex placement and treatment needs. DCBS' central office has worked to involve regional leadership in problem solving before conference calls are scheduled and to streamline the processes in other ways, but not all regions have adopted these processes. The large number of complex cases drives the need for the high volume of calls. Although finding placement/treatment options for these children is the primary focus on most of the calls, conference calls are also convened to address questions or to reach consensus regarding placement or treatment recommendations and to explore ways to prevent disruption and ensure successful transitions.

The CRP Director was involved in mid-2021 in a Cabinet subcommittee that was re-started, to focus on improved treatment planning within the PCC/PCP community. CRP will continue to be involved in and support efforts related to improving treatment planning in the future as opportunities arise. CRP will continue to make adjustments to the referral process as needed to be consistent with the new QRTP assessment process and related Cabinet priorities (e.g., continuing efforts to integrate a trauma-informed perspective with placement referral narratives).

The number of placement referrals being made has nearly returned to the pre-pandemic level. The average number of referrals made per placement has also risen, compared to 2020, perhaps reflecting the increasing impact of the pandemic on staffing, program capacity, and waitlists for placement, and the need for regional placement coordinators to refer children multiple times in order to find placement. There appears to be a trend for fewer children to be placed in out-of-state facilities. This is likely due to a focus by DCBS on finding ways to meet children's needs in Kentucky and to fewer potential out-of-state placements being available.

There may be a positive trend developing related to quality improvement issues identified, with the percentage of utilization reviews completed that led to a quality improvement issue being identified decreasing from 46% in 2019, to 42% in 2020 and 38% in 2021. It is possible that this is related to an ongoing, overall focus by DCBS on some issues, (e.g., the importance of providing family therapy when children are in out-of-home care), to the intervention by DCBS staff regarding specific child concerns identified by CRP, to increased awareness and effort by individual programs to improve services provided to the children in their care, or to some combination of these factors. It will be important to continue to track quality improvement data to see if this trend continues, particularly as QRTP implementation expands.

The number of non-LOC or non-traditional treatment programs, including several pilots (e.g., Key Assets, Home of the Innocents CATS program), have been developed across the state. CRP will continue to

adapt workflows and procedures to support these efforts. CRP will continue to work with DCBS to address placement issues, (e.g., number of children placed out-of-state, and issues related to their return, addressing placement needs of children with complex placement and treatment needs, improving placement processes, etc.). CRP will continue to adjust the referral process as needed to be consistent with the new QRTP assessment process and related Cabinet priorities, (e.g., continuing efforts to integrate a trauma-informed perspective with placement referral narratives).

CRP will continue to work toward making the Provider Capacity and Occupancy Dashboard available to providers in the coming year through the CRP web application. CRP will revise both the CRP Monthly Activity Dashboard and the Provider Capacity and Occupancy Dashboard as needed in consultation with the Cabinet. During 2022, CRP will analyze Performance Indicator data for FY 2021 and provide the new data to PCCs/PCPs and the Cabinet, revising processes as needed in consultation with the Cabinet, in preparation for possible performance-based contracting in the future.

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).

1. 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.
2. PEMs have the same target population. PEMs are currently available in Jefferson and Daviess~~,~~ counties, and will be moved into an additional 11 rural areas in CY 2022. PEMs bring families, agencies, and community partners together to discuss barriers leading to educational neglect. Using a family strength approach, facilitators bring everyone together in the development of a plan to assist the family in eliminating barriers to school attendance and linking to community resources. Referrals are accepted from the school system. PEMs target school-aged children (ages 5-11) who are at risk of educational neglect. In 2021, 316 families received PEM services and 96% of 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 the area development districts (ADD)), 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 2021, IHBS served 364 families with 1,243 children. These numbers were lower due to the COVID-19 pandemic. In-home visits were conducted through virtual platforms or telephone calls between January and June 2021. Many families faced difficulties with accessing or utilizing technology. These barriers resulted in fewer families willing to accept services. In-home staff worked with families in overcoming barriers during the pandemic. As a result of the pandemic, families were provided an increased length in services beyond the average eight to 12 weeks. Many families faced unprecedented issues during the pandemic, such as loss of income, homeschooling, housing, and difficulty accessing available resources. North Carolina Family Assessment Scale (NCFAS)-G scores reflect an overall increase in family functioning. Once the pandemic ends, the number of families and children served are expected to increase.

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 continues 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. The addition of both the American Rescue Act funds and state general funds will allow for an expansion of the PEM program into several more rural counties; the addition of concrete support funds for families to allow children to reside more safely in their homes; and additional funds to eliminate the current waiting list for in-home services. 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.

Based upon positive outcomes, PEMs were expanded to at least 10 rural counties. PEMS deferred 96% of families from becoming involved with the child welfare system. In the coming year, State General Funds and ARPA funds will be used to sustain the PEM expansion, eliminate the waiting list, and provide concrete supports for families in each region beyond CY 2022. Discussions among DCBS leadership continue to occur regarding the prioritization of funding for prevention. Beginning in January 2022, concrete supports will be added to in-home services in an effort to keep more children safely in their homes.

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. FRIENDS also has encouraged Kentucky to apply to be a member of the Prevention Mindset Institute. That application will be submitted after the first of the year. There are barriers to additional expansions due to funding. Each regional network and collaborative partners bring data and issues to the network. Networks work to set priorities and allocate any funding available based upon those priorities. Increased awareness of child abuse/neglect issues is always a primary focus, especially during April, Child Abuse Awareness Month. Activities and information are targeted to issues identified in the community. Providers of in-home services participate in a CQI process to assist with improving services to families involved with CCC.

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 level. CSBG funds are allocated through CHFS. CHFS is responsible for administration, oversight, and allocation of the CSBG funds to eligible entities within Kentucky.

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, PPE, etc.). The funds expire December 29, 2022.

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.

CHFS filed an ordinary and emergency regulation change for KAR 6:010 on May 21, 2020, in response to HHS' CSBG Information Memorandum (1M) 2020-157, authorizing states to, "revise the income limit for eligibility ceiling from 125 to 200 percent of the federal poverty level 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.

On December 3, 2021, H.R. 6119, the "Further Extending Government Funding Act" was passed for continuing projects and activities of the Federal Government. Additionally, H.R. 6119 extended the state's authority to revise the income limit for eligibility from 125 to 200 percent of the federal poverty line (FPL) as authorized by the CARES Act. This extension applies to regularly appropriated CSBG and CSBG CARES funding. This extension does not apply to CSBG Disaster Supplemental funds. This extension is through February 18, 2022.

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 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. Community Action for Kentucky has provided training to the CAAs on case planning for CSBG services.

The 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 Kentucky

Revised Statutes (KRS) in chapters 45 and 273, and the applicable Kentucky Administrative Regulation (KAR) in Title 922 Chapters 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:

1. Individuals and families with low-income are stable and achieve economic security;
2. Communities where people with low incomes live are healthy and offer economic opportunity; and
3. 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 2 through module 4. 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 2, 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 Community Action for Kentucky on a quarterly basis. Community Action for Kentucky 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 information memorandum 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" (information memorandum 152). Module I is completed by the Cabinet and Modules II-IV will be completed by Community Action Kentucky, reviewed, and then submitted by the Cabinet. The complete Annual Report will be submitted to the federal government by March 30, 2022.

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 two 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 information memorandum 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 2021, the KCN collaborated with ~~a~~ new local program to build capacity through training and prepare to provide direct services in its counties. In 2021, the KCN also began the process of creating the 24th CASA program in Kentucky, CASA of the Appalachian Mountains (CAM) which filed for its 501©(3) in May 2021.

KCN is a statewide association. In 2021, there were 79 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. In 2021, in response to the COVID-19 pandemic, the KCN launched a COVID-19 workgroup, which meets monthly, to discuss both operational issues around COVID-19 and programmatic implications and solutions keep CASA services in place throughout court and school closures.

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), the Aetna Supporting Kentucky Youth (SKY) Governance and Training Task Force, and local family courts. KCN staff serves on an advisory committee for the Kentucky Victims Assistance Academy coordinated by the Kentucky Justice & Public Safety Cabinet and on the Prevent Child Abuse Kentucky Conference Advisory Council. KCN also serves on the Child Fatality Review Panel and Children's Justice Act task force. 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 programs experienced growth in volunteer advocates from 1,275 in 2020, to 1,302 in 2021, serving 3,758 dependent, abused, and neglected children in 2021. In 2021, 24 new volunteer advocates were trained.

In 2021, local CASA programs expanded to serve children in Lyon, Livingston, Trigg, Caldwell, Nicholas, Robertson, Jessamine, and Garrard Counties. KCN also began the start-up process to create a new program in Hazard, KY, which applied for National CASA Membership.

In 2021, KCN provided/facilitated over 30 virtual training opportunities for local CASA program staff and board. These trainings focused on board governance sustainability planning, performance measuremen,t and logic models and diversity, equity, and inclusion.

For FY 2021, KCN had a contract with the Justice and Public Safety Cabinet to administrator state CASA grant funds allocated by the Kentucky Legislature. This increased administrative function required KCN to adopt new policies and practices and bring on a grants specialist contractor to assist local programs

with financial and programmatic reporting responsibilities. The implementation of FFPSA, combined with the continued impact of the COVID-19 pandemic, resulted in a decrease in AOC petitions in 2021 in Kentucky. This reduces the appointments of CASAs in abuse, neglect, and dependency cases and the availability of CASA volunteers to serve on these cases.

The KCN developed a new growth plan in November 2021 that covers 2022-2023 and includes increasing the CASA program footprint into 34 new counties by the end of 2022, to be active in 100 counties in Kentucky by mid-2024. Barriers to increasing the CASA footprint are the 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. The COVID-19 pandemic has made organizing and development challenging and has slowed some of the pace due to the inability to meet in person. Another goal is to increase the number of total active volunteers to 1,500 by mid-2024, to provide CASA advocacy services to more children. Barriers to achieving increased volunteer numbers include improving retention strategies and raising awareness of CASA to attract new volunteers. Some volunteers were also reluctant to take new CASA cases during the COVID-19 pandemic. Additional barriers are around funding. The KCN has a request into the legislature to increase the two-year allocation to meet the growing needs of expansion.

K. Diversion/Intensive In-Home Services Program

Diversion program services are provided to TANF-eligible families with children ages five through 17 who are at risk of removal from their biological families, relatives, or finalized adoptive families. Services are also provided to those children who are in OOHC and have a plan to be returned to their families. The primary goals of the Diversion program are: 1) safely divert from OOHC children committed to DCBS or at risk of commitment and placement in OOHC, and 2) return children recently placed in OOHC but with in-home services, could be returned safely to their home. The program provides a timely (within 10 days of referral) initial clinical assessment by a staff person with a master's degree or higher in social work. The provider develops and implements an intervention plan to address the identified needs of the family. The family plan focuses on short-term needs and long-term sustainability of child safety. The TANF maintenance of effort (MOE) and title IV-B and IV-E funded program is available statewide.

An array of services is provided based on a comprehensive family assessment. The services must be family-focused and designed to keep children in the home without facing additional abuse or neglect. These services primarily include preservation and reunification, clinical assessments, therapeutic child support, parent development program, and crisis intervention. The provider works around the family's schedule and the diversion specialist is available to the family 24 hours a day, seven days a week.

The family service plan is developed within the first 30 days of entering the program. Program staff network and collaborate with community supports and resources such as community mental health centers (CMHCs), schools, faith-based services, housing, transportation, and medical services that can be utilized for sustained self-sufficiency. A wrap-around service delivery approach, including intervention and treatment plans, is then implemented. The family intervention can last up to six months or longer depending on the needs and progress of the family. Follow-ups are conducted at three months, six months, and one year after the family intervention to assess the success of the intervention.

In CY 2021, 438 families with 740 children were accepted into the Diversion program. Of the families accepted, 392 were considered to have successfully completed the service. In addition, 679 target children successfully completed the program, indicating a 92% success rate. Seventy-five percent (75%)

or more of children remaining home safely at closure and at six-month follow-up, is an outcome measure indicating services were successful.

Diversion Program Outcomes, CY 2021

	Families Accepted	Families Closed Complete	# of Target children at risk	# of children remained/ reunified home at closure	% of children completing services
Diversion	**366**	**318**	**613**	**562**	**92%**
Diversion Reunification	**72**	**74**	**127**	**117**	**92%**
Totals	**438**	**392**	**740**	**679**	**92%**

FFPSA requires services to families be provided using EBPs with scientific ratings of promising, supported, and well supported. As the program continues to build capacity for using supported and well-supported EBPs for SFY 2021, Functional Family Therapy (FFT) is indicated for youth with varied behavioral and emotional issues will be implemented. Diversion services are being assessed to build capacity to serve families and youth with more complex issues using additional EBPs such as Motivational Interviewing (MI) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).

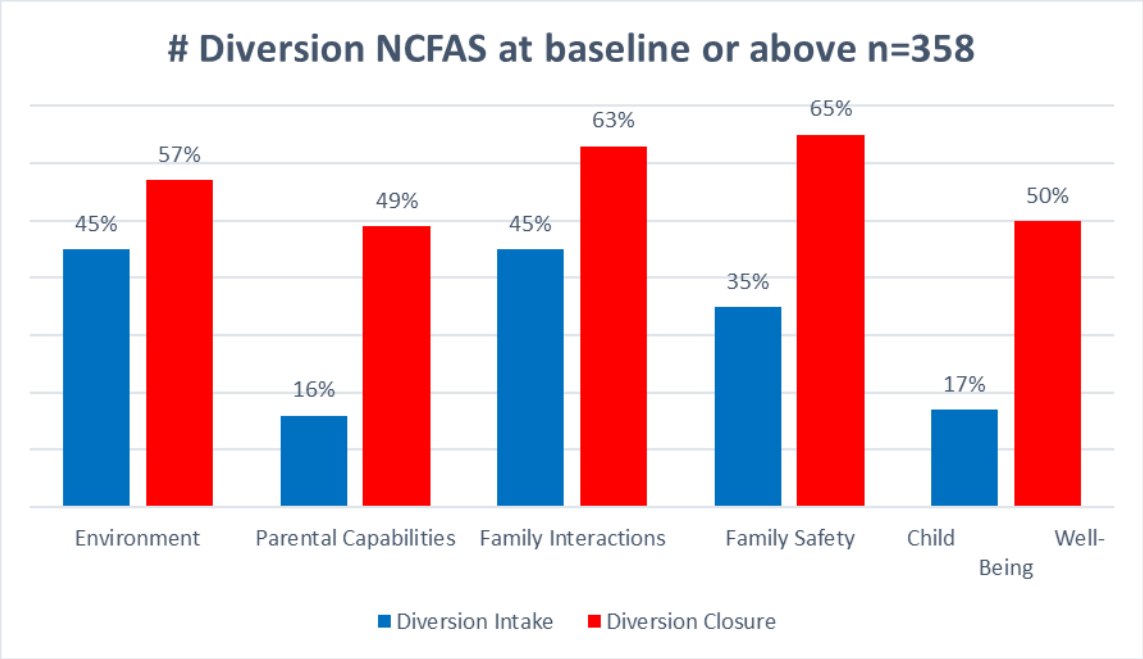
Public Consulting Group (PCG) has provided consultative and technical assistance to Kentucky in implementing FFPSA EBPs and developing a new data collection system to track statewide use of the EBPs as capacity is built in the use of supported and well-supported EBPs. Chapin Hall assisted Kentucky in developing CQI processes to ensure providers are utilizing EBPs to model fidelity and adhere to federal requirements for FFPSA.

Families and children who have completed Diversion services are 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 During CY 2021

3 Month Follow Ups	
Total # of Target Children with Follow-Up	**643**
Total # of Target Children in Home at Follow-Up	**611**
Percentage of Target Children in Home	**95%**
6 Month Follow Ups	
Total # of Target Children with Follow-Up	**625**
Total # of Target Children in Home at Follow-Up	**576**
Percentage of Target Children in Home	**92%**
12 Month Follow Ups	
Total # of Target Children with Follow Up	**676**
Total # of Target Children in Home at Follow Up	**595**
Percentage of Target Children in Home	**88%**

Families are assessed at intake and closure for family functioning using the NCFAS. Scores on environment, parental capabilities, family interaction, family safety, and child well-being range from -3 (serious problems), to 0 (adequate), to 2 (clear strength). To simplify the reporting of NCFAS scores at intake and closure, scores are dichotomized into adequate or better (a score of 0 to 2) or not (a score of -3 to -1). The percent of families completing Diversion services (represented by "n") in CY 2021 who scored adequate or better on each domain at intake and closure are presented below.



At intake, families scored the lowest on Parental Capabilities and Child Well-Being. The greatest gains were made in the same categories at closure. It is important to note that an increase in scores in Parental Capabilities (33%) normally correlates to an improvement in scores normally correlates to an improvement in scores in Family Safety (30%) and Child Well-Being (33%).

Diversion contracts were renewed in CY 2020 for another biennium beginning SFY 2020. As a result, service providers were able to continue accepting referrals and providing services with no disruption through the end of the year.

Due to implementation of FFPSA, program services are being assessed to build capacity to serve families and youth with more complex issues using EBPs such as FFT, MI, and TF-CBT.

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. The ECMHs provide trainings and consultations to early care and education programs at no cost. The goal is to build capacity of early care and education professionals in addressing social/emotional issues of young children, eventually decreasing the number of expulsions and referrals to the ECMHs.

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 the 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, the 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, the ECMH specialists conducted 3,001 consultations with early childhood professionals in 2021. ECMH specialists provided 335 trainings to a variety of early care and education personnel and other stakeholders. Finally, they participated in 1,685 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 (K-TAP) eligible families, not currently receiving cash payments, which are at or below the gross income limit for K-TAP for the appropriate family size. FAD is administered statewide and is funded by title IV-A, TANF.

Individuals do not apply for FAD but are screened for FAD eligibility when applying for K-TAP 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. Therefore, 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 on-going K-TAP 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, 2021 through December 31, 2021, an average of one family per month received a FAD payment. The average payment per family per month was $780.55. In CY 2021, FAD totaled 14 cases statewide, an average of 1 case per month and expenditures of $10,927.75.

No policy or procedural changes have been made to the FAD program during CY 2021. The Cabinet does not currently have plans to revise the program. There were no consultative efforts or technical assistance provided or received by a National Resource Center during CY 2021. In 2021, Kentucky was accepted into the Administration for Children & Families (ACF) "TANF Learning Community" (TLC). Kentucky's TLC project is called "Creating Virtual Case Management options for both Rural & Urban Populations in the Kentucky Works Program." ACF's overall project theme is called "Reimagining TANF Programs to Support Family Economic Independence and Mobility in a Post-Pandemic World." Kentucky TANF Administrators are working to find ways for TANF work participants to be given the opportunity to voluntarily and most important, safely, pursue self-sufficiency goals to overcome their barriers despite the worldwide crisis. The ACF TANF Learning Community project is from December 2021–December 2022.

DCBS DFS participated in the APHSA (American Public Human Services Association) "System Alignment Working Group for Children & Families" with a group of dedicated human services leaders and stakeholders across sectors, including parent representatives. The Working Group was tasked with identifying strengths and barriers in our current human services systems, opportunities for better system alignment, and to lay the foundations for a framework to effective human services alignment resulting in improved outcomes for young parents and their children. This work was featured in the December 2021 APHSA publication "Working Together – A Roadmap to Human Services System Alignment for Young Families."

N. Family Preservation Program

The Family Preservation Program (FPP) 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.

The FPP service array includes Intensive Family Preservation Services (IFPS) – for families with children at imminent and immediate risk of out-of-home placement; Family Reunification Services (FRS) – to help children in OOHC return to their families; and Families and Children Together Safely (FACTS) – for families with children at risk of out-of-home placement or returning from OOHC. 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. The 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.

FPP services are provided statewide in all 120 Kentucky counties through contracts with non-profit agencies. Regional management teams are comprised of DCBS staff, including the person responsible for screening all family preservation and reunification referrals, the service region administrator (SRA) or designee, the FPP supervisor, and the agency designee. This team determines any specialized FPP services and provides ongoing oversight of the services. FPP 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. FPP also networks with community partners including representatives from domestic violence shelters, family team meetings, drug task forces, IMPACT, mental health services, CACs, health departments, housing programs, and faith-based services.

FPP services provide a wide variety of family-centered, 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, FPP 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 services were successful. The table below indicates that up to 97% number of children at risk were maintained in their homes at closure.

Family Preservation and Reunification Services Continuum

Family Preservation and Reunification Services	Duration and Service Intensity	Outcomes
IFPS - Intensive Family Preservation Services **Referral Criteria:** Imminent risk of removal of child from home.	**Duration:** Average 4-6 weeks. **Service Intensity:** Intensive in-home services provided for 6-10 direct hours per week. **Caseload:** 2-4 families at a time **Age limit:** 0-17 years old	397 of 452 families completed services 789 of 814 children remained safely in the home (97%)
FRS - Family Reunification Services **Referral Criteria:** A plan to return a child home from OOHC.	**Duration:** Average 3-6 months (extensions are based on need and progress made) **Service Intensity:** Average minimum 3-8 direct hours per week. **Caseload:** Not to exceed 6 cases at a time. **Age limit:** 0-17 years old	493 of 570 families completed services 819 of 917 children remained safely in the home (89%)

FACTS - Families and Children Together Safely (preservation/reunification) **Referral Criteria:** Child at risk of removal from home or child in OOHC with a plan to be reunified with family.	**Duration:** Average 3-6 months (extensions are based on need and progress made). **Service Intensity:** Average minimum 3-8 direct hours per week. Intensity is determined based on the needs of family. **Caseload:** Not to exceed 6 cases at a time. **Age limit:** 0-17 years old	**FACTS Preservation** 1,034 of 1,255 families completed services 2,085 of 2,211 children at risk remained safely in the home (94%) FACTS Reunification 145 of 176 families completed services 244 of 278 children at risk remained safely in the home (88%).

From January 1, 2021, through December 31, 2021, there were 2,453 families with 4,220 children at risk of OOHC placement or reunifying from foster care participating in one of the FPP services (data retrieved March 31, 2022). Of those children, 3,937 were reunified with their families or remained home safely at closure, indicating an 93% success rate.

The following data shows the number of families and children served by service and the primary indicators of program goals to maintain children safely at home with the family and maintain permanency and stability in their living situations. A percentage rate of 80% or more of children remaining in the home indicates that the services were successful.

IFPS

- 452 families accepted
- 397 families completing services
- 814 children at imminent risk of placement
- 789 of 814 children remained safely in the home (97%)

FRS

- 570 families accepted
- 493 families completing services
- 917 children to be reunified
- 819 of 917 children safely returned to home (89%)

FACTS Preservation

- 1,255 families accepted
- 1,034 families completing services
- 2,211 children at risk
- 2,085 of 2,211 children at risk remained safely in the home (94%)

FACTS Reunification

- 176 families accepted
- 145 families completing services
- 278 children at risk

- 244 of 278 children at risk remained safely in the home (88%)

Families and children who have completed FPP services received follow-up 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.

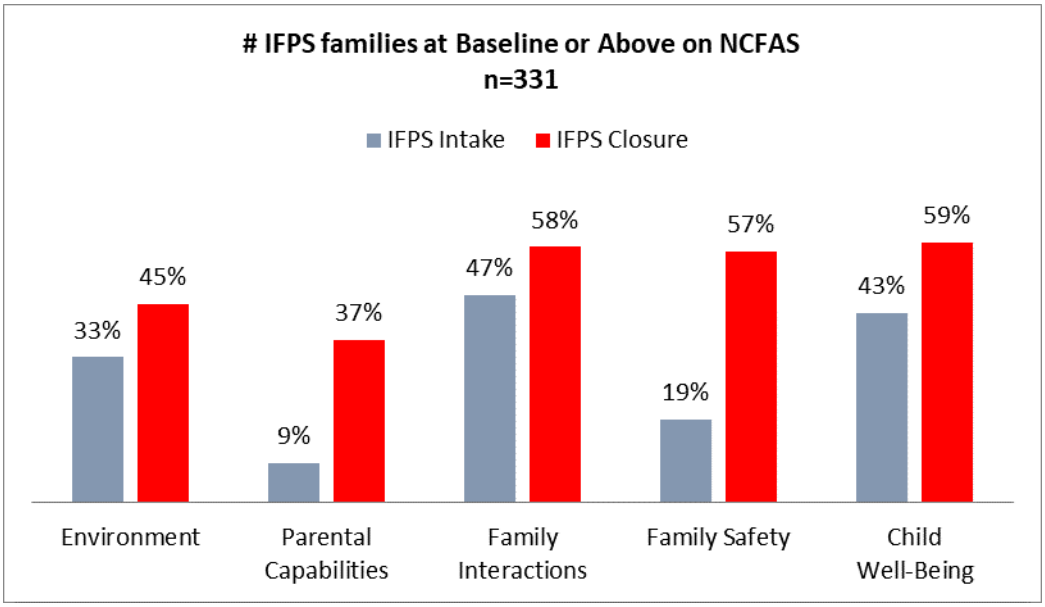
Follow-up Activity Completed from January 1, 2021 - December 31, 2021

6 Month Follow-Up	**IFPS**	**FRS**	**FACTS-P**	**FACTS-R**	**All FPP**
# Children at Risk	813	742	1,571	266	3,392
# Children at Risk in Home	722	652	1,460	235	3,069
% of Children at Risk in Home	89%	88%	93%	88%	91%
12 Month Follow-Up	**IFPS**	**FRS**	**FACTS-P**	**FACTS-R**	**All FPP**
# Children at Risk	1,165	563	1,406	200	3,334
# Children at Risk in Home	1,058	492	1,285	188	3,023
% of Children at Risk in Home	90.8%	87.4%	91.4%	94.%	90.7%

Families served are evaluated at intake, closure, and at interim for services extending beyond 45 days using the 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 IFPS (represented by "n") during CY 2021 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 2021



The chart above shows significant improvement that families made in the domains of Parental Capacity, Family Interactions, and Family Safety at the completion of IFPS services. Parental Capabilities domain is one of three domains namely, Parental Capabilities, Family Safety and Child Wellbeing, where families referred to FPP usually experience low scores ranging from moderate to serious problems. 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 (28%), Family Safety (46%), and Family Interactions (16%). An increase in scores in parental capabilities normally correlates to an improvement in scores in Family Safety and Child Well-Being. This shift in NCFAS scores indicates that incremental and impactful improvements can be measured during the IFPS intervention.

DCBS implemented FFPSA of 2018 (Public Law 115-123) in 2019. FFPSA makes changes to title IV-E of the Social Security Act allowing title IV-E funding to be utilized for prevention services to families of children who are at imminent risk of entering foster care. Through FFPSA, funding will be available for trauma-informed, 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.

FFPSA requires that preservation and reunification services be provided utilizing EBPs and trauma-informed services with a scientific rating of well-supported, supported, and promising as outlined in the Title IV-E Prevention Services Clearinghouse and in Kentucky's federally approved five-year IV-E Prevention Plan.

FPP was expanded in SFY 2019 to serve additional families and increase salaries of existing staff to aid in staff retention. This expansion served an additional 7% of families statewide, up to 30% more families for individual regions. FPP was expanded for a second time through SFY 2020, projected to serve an additional 23% of families. Funds were distributed by regional needs through analysis of the waitlist, OOHC numbers, substantiation rates, and re-entry rates. Expansions included an intentional focus on ensuring providers are trained in FFPSA EBPs and are providing them to fidelity to comply with federal

requirements for title IV-E reimbursement. Increased funding was allocated based on specific provider needs and needs of families.

Kentucky will have the opportunity to expand FPP further to serve more families and train further in FFPSA EBPs, through use of state general funds in CY 2022. During CY 2021 the state initiated a request for proposal process with FPP providers to further align with Family First service provision, to provide an opportunity to deliver these services, to increase flexible funding available to meet familial concrete needs from $500-1,000 per family, and to add 25% in additional funding. This would allow for service to additional families.

The following title IV-E EBPs are approved for use with family preservation and reunification services statewide: FFT, Homebuilders Model, MI, Multisystemic Therapy (MST), Parent-Child Interactional Therapy (PCIT), and TF-CBT. A Title IV-E State Prevention Plan amendment was approved to include expanded use of MI and use of High-Fidelity Wraparound.

All FPP programs currently report their data online using the In-Home Services Database and the Invoicing Portal within TWIST. 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 the reports that can be run. This has greatly improved the consistency of data reported statewide. The data collected is used to closely monitor service provision and to evaluate overall program improvement and quality assurance.

PCG has provided consultative and technical assistance to Kentucky in implementing FFPSA EBPs and developing a new data collection system to track statewide use of the EBPs as capacity is built in the use of supported and well-supported EBPs. In CY 2021, at the conclusion of PCG's contract, Sivic Solutions Group (SSG) was awarded the contract to provide consultative and technical assistance to Kentucky in implementing Family First. Chapin Hall has helped Kentucky develop CQI processes to ensure providers are utilizing EBPs to model fidelity and adhere to federal requirements for FFPSA.

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; and
- 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) for implementation. KCADV subcontracts with 15 domestic violence programs in the 15 area development districts across the state for direct service implementation regionally. The domestic violence programs provide shelter and related services to victims of domestic violence and their dependent children and are geographically distributed to be no more than 60 miles in distance from any state resident. The mission of the KCADV is to end intimate partner violence, promote healthy relationships, and engage communities through social change, economic empowerment, educational opportunities, and other prevention strategies. Funding for KCADV comes from the Family Violence Prevention and Services Grant, the state general funds, TANF, Kentucky Trust and Agency, and Social Services Block Grant (SSBG).

2021-Programing Additions and Highlights

- Transportation to services is problematic in many of the regions. Several shelters have obtained grant funds to begin mobile advocacy units to serve survivors with barriers to transportation.
- Several shelters maintain walk-in clinics in highly populated urban areas that are accessible by public transportation.
- Housing is a top priority, and KCADV administers three housing-specific grants that provide rental assistance to survivors totaling close to $1,602,340 in housing funds. KCADV also operates 84 units of tax credit housing.

- The Ion Center for Violence and Prevention implements the evidence-based Green Dot Violence Prevention Strategy in high school, college, and community settings. In a pilot study conducted by the CDC, the Green Dot Primary Prevention Program for teens lowered rates of power-based personal violence by 17-21% in schools with the program by a) equipping teens with skills and tools needed to safely intervene in situations of power-based personal violence amongst their peers and b) connecting them with resources that could help alleviate the impact of power-based personal violence, even through pandemic-related school closures and limitations in 2020-21. The Ion Center has been able to implement Green Dot programming in some capacity in 12 high schools, one college, and two communities throughout the Northern Kentucky and Buffalo Trace regions, reaching over 1,900 people through overview presentations and bystander trainings in the 2021 calendar year.
- The children and teen space in the Northern Kentucky shelter has been renovated by the Ion Center. The separate area for teens to have a space of their own in the shelter includes computers, games, comfortable seating, books, headphones, music, etc. This room has been helpful in allowing teens to relax, process their feelings, and given them a sense of belonging.
- GreenHouse 17 (GH17), located in Lexington, KY, is operating a farm to create an agriculture-based healing environment to meet the needs of victims as they strive to rebuild their lives as survivors. The vision for the farm is to become an economically self-sustaining program that provides a reliable source of revenue for the agency. The farm program applies a trauma-informed care model based on the therapeutic benefits of nature-based activity. This program has received several national and statewide awards. GH17 provides health and beauty products, as well as a flower community support agriculture (CSA) program.
- Local shelter programs continue to recruit, hire, and maintain bilingual professionals, including ASL, on their staff to ensure the ability to access, in person and/or by phone, interpreters for those clients with Limited English Proficiency (LEP). All shelters give clients with LEP "I Speak" cards to keep with them. These cards explain the requirement of organizations that receive federal funds to provide interpreters to ensure access of services they are funded to provide. The cards also give information regarding the right to an interpreter free of charge and information regarding how agencies and businesses should respond to people who are LEP. Additionally, programs have updated LEP policies to account for the provision of interpreters on virtual service delivery platforms.
- All programs are required to incorporate Meaningful Access (as outlined by the CHFS State Plan) into their Application for Funding submitted to KCADV. This means they have provided information about underserved populations in their application narrative and have addressed strategies for meeting the needs of those populations. They also discuss how notice about availability of these services is made available to survivors and stakeholders, how staff is trained to respond to diverse needs of survivors, and what policies and procedures their organizations must ensure or address non-discrimination.
- All KCADV member programs 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. Policies were reviewed and updated by KCADV staff so that all member programs have a standardized language access policy that also accounts for ASL interpretation needs. KCADV continues to provide technical assistance as they update those policies and practices to account for the virtual delivery of services.
- The Ion Center in Northern Kentucky continues an agreement with St. Elizabeth Healthcare. This provides crisis intervention and safety planning in their five emergency departments located across the northern Kentucky area, as well as staff on site at the St. Elizabeth Florence

Emergency Department. Staff and specially trained volunteers respond 24 hours a day, 365 days a year to victims of intimate partner violence and their non-offending loved ones. During the COVID-19 pandemic, services shifted to virtual and telephone. Staff returned to in-person accompaniment on 4/1/2021, and currently provide hybrid services, dependent on community COVID status. The Ion Center responds to requests for assistance from behavioral health units, intensive care units, oncology, and St. Elizabeth physician's offices for victims who identify DV as a secondary medical concern during treatment for other healthcare needs.

- KCADV 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. KCADV works with designated Peer Support Specialists who provide direct substance use treatment activities to survivors in member programs.
- KCADV completed a comprehensive needs assessment project coordinated by a community advisory board, with representation from a wide variety of stakeholders including underserved populations. The purpose of the needs assessment was to identify underserved populations, unmet needs, gaps in services, and other barriers survivors face. The findings suggested that survivors want, and need, services designed specifically to address their needs as survivors, (i.e., mental health, housing, and other poverty-related issues, and opportunities for community engagement). Additionally, survivors requested access to programming that allows them to have autonomy over their decisions and is compassionate to their anxieties. The findings from the needs assessment also highlighted the need for more opportunities with peer-led support Peer Support and community engagement. Survivors also expressed a need for survivor focused housing that would allow for community building amongst survivors. KCADV will be implementing these findings into our work via our organization's strategic plan. Additionally, these findings will influence the technical assistance our staff provide to our programs regarding shelter services and will assist KCADV and our member programs on being as more survivor-centered in our programming efforts as possible.
- KCADV operates an AmeriCorps state grant that deploys four AmeriCorps members to member programs to assist with shelter service delivery and address the economic needs of survivors affected by poverty.
- Selected statistics:
    - 2,770 people were served through emergency shelter services.
    - 8,432 people received group or individual counseling services.
    - 13,339 survivors received non-residential services through 15 member programs.
    - 61 men received domestic violence services.
    - 994 children received services.
    - 1,814 survivors who identify as African American, 726 who identify as Hispanic/Latino, 62 who identify as Asian, and 29 who identify as American Indian/Alaskan Native received domestic violence services.
    - 413 survivors who identify as lesbian, gay, bisexual, or transgender received services.
    - 415 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; and
- Self-sufficient families

R. Kentucky Center for School Safety

Kentucky schools focus on providing a warm culture and climate for both students and staff conducive to high levels of productivity and outstanding academic performance. Today, school safety is a daily issue that ranges from classroom management to school incident command for crisis situations. The Kentucky Center for School Safety (KCSS) staff is committed to providing training, resources, information, and research.

KCSS' belief is that school culture improves when a school-wide prevention plan consistently addresses the needs of all students to encourage a safe and healthy learning environment. The mission and scope of work for KCSS demanded that a statewide collaborative effort be undertaken. This collaborative partnership brings together a dynamic blend of experience and expertise in project management and the provision of training and technical assistance to education, human service and justice professionals, teacher preparation, applied research, electronic communication, and school and community needs assessment.

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, 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.

Throughout the year, KCSS is available to schools across Kentucky. KCSS, KDE, and KSBA collaborate to provide safe school assessments to any school in Kentucky. The voluntary assessment can enhance the school's learning environment by examining climate and culture. KCSS oversees and distributes safe schools' funds to each local school district, the Kentucky School for the Blind, and the Kentucky School for the Deaf. A safe school assessment is a service provided by the KCSS at no cost to the school or district. The KCSS staff takes great pride in being able to fully accommodate superintendents, principals, and other school personnel, as well as parents and community members whenever they contact the center for assistance.

Additionally, KCSS is working closely with all schools statewide to address training for gun violence, safety, and bullying for students and staff. Due to the increase of gun violence in the school system,

KCSS produced brochures to assist school staff to identify indicators of violence and areas of safety improvements. Current barriers to this initiative are fiscally based.

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. A statewide program, KCHIP collaborates with various organizations and agencies to ensure quality access to care for enrollees. KCHIP contracts with DCBS and Benefind to determine eligibility for potential enrollees. KCHIP also works closely with local health departments to provide age-appropriate screenings for enrolled children and with DPH to provide vaccines for eligible enrollees.

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 Affordable Care Act (ACA) requirements, children below 138% of the federal poverty level in the KCHIP Expansion Program were transitioned into Medicaid effective 1/1/2014. Per Centers for Medicare and Medicaid Services (CMS) direction and funding purposes, this group of children continues to be counted with the number of children served in the KCHIP Expansion Program. Per FFY 2021 final reports, 120,239 children were served during FFY 2021. 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 2021 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 twelve-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. 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. KCHIP's ongoing goals are to continue to increase retention efforts, maintain current level of outreach, and to continue to increase enrollment.

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 Eastern Kentucky University (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 78 educational programs in 51 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 14.7 years old. The largest age group of SAC in DCBS contracted programs is 16-year-olds with 17.3% of the population followed by 17 year-olds with 15.8%. The majority (69%) of DCBS KECSAC students are male. A significant number of DCBS children, 51%, are diagnosed with an educational disability that adversely affects learning. Emotional behavior disability is the category with the highest percentage at 37.7%. Other health impaired is the second highest percentage at 20.9%. Most children served in KECSAC programs, 75% identify as white. Black or African American is the second highest race category with 17% (overrepresentation).

The number of children and youth being served in department programs has continued to increase, while students in DJJ programs continue to decrease each year. In short, over the last 10 years students who were previously evenly split between DCBS and DJJ are now largely in DCBS programs. In addition, the overall number of children and youth decreased from around 11,000 students in 2020 to approximately 8,000 in 2021. The ongoing pandemic has played a role in the decrease in numbers of children served in KECSAC programs. It is expected that the number of DCBS children who utilize KECSAC programs may decrease over the coming years due to the implementation of Qualified Residential Treatment Program (QRTP) process. Not all KECSAC programs will meet the specific requirements of QRTP.

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 16 employees; 50% of the staff is parents that have raised, or are raising, children with behavioral health challenges and 50% 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, and
- United Partners in Kentucky.

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 childcare, 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 2021:

- Monthly e-newsletters disseminated to 2,500+.
- Virtual conference and workshop attendance: 1000+
- 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.

Over past five years, Kentucky leaders at DBHDID and DCBS have prioritized BBI as how PCPs, PCCs, behavioral health service organizations (BHSOs), and CMHCs need to do business. This effort has included trainings, regularly scheduled meetings, and coaching/consultation received by BBI National.

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. KYSF is a statewide, long-term initiative, with 10-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.

<u>Kentucky Youth Thrive</u> (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 2021 KYSF:

- Trained 34 individuals in hosting Parent Cafes due to the pandemic and pandemic restrictions. Towards the end of 2020, beginning of 2021 we created a training for online Parent Cafes.
- Trained 25 new Family Thrive Trainers due to the pandemic and pandemic restrictions.
- Trained 136 participants during a general Family Thrive training.
- To date with the CRRSA Project: 2868 early childhood professionals attended a Provider Café and 1785 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.

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. 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 has continued expansion of the KSTEP program into all counties of the Salt River Trail service region and all counties of the Cumberland service region. The full expansion is expected to be complete by the start of SFY 23. KSTEP seeks to (1) reduce the need for 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, KSTEP integrates substance abuse treatment services, child welfare practice, and family preservation services into an approach to deliver services that address the special needs of substance-affected families involved with the department.

From January 1, 2021, to December 31, 2021, KSTEP served 267 families and 532 children. Four additional referrals were assessment only. There were 21 additional referrals that were assessment only. Out of the 267 families serviced, four were closed due to alternative permanency being established, seven families chose to leave the program, 38 families were unable to meet program requirements, 10 families moved out of the service region, 32 finished successfully and 19 had other selected as a reason. The "other" selection was utilized for things like incomplete referrals. One hundred thirty-six (136) cases had the closure reason left blank indicating they are still open. The KSTEP program is designed to serve families for six-eight months, but services can be extended by approval of the KSTEP administrator.

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, Addiction Severity Index (ASI), and Parental Stress Index (PSI)). Secondary data, including case management/service delivery activities documented in the KSTEP database and outcomes including repeat maltreatment and placement in OOHC documented in CCWI, are also collected. The length of time a case remained open varied.

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. In Franklin, Spencer, and Trimble counties, the in-home providers will completing 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.

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. The American Rescue Plan Act of 2021, signed into law on March 11, 2021 (Public Law 177-2), allows clients applying for assistance with utilities such benefits. This additional funding enabled LIHEAP to offer a year-round program for both heating and cooling components. Heating subsidy began November 1, 2021. Income limits were adjusted to 150% 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/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 2021, for summer cooling subsidy and crisis; and 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. Trainings in 2021 were held virtually due to the COVID-19 pandemic.

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

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

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

A Program Compliance Review is conducted by CAK for each agency a minimum of one time during the contract period. It is the agency's responsibility to be available for and have documentation for CAKs review. Reviews are conducted through desk reviews.

Goals for LIHEAP are measured, in part, by the number of Kentucky's most vulnerable citizens served. During SFY 2021, 83,860 households received a heat subsidy, and 72,883 households received a cooling subsidy. Crisis component households totaled 72,596 for winter crisis and 50,049 in the summer crisis component of LIHEAP. Summer subsidy households totaled 72,883. APRA funding allowed for 39,491 for subsidy households served. Two hundred ninety-three (293) households were served by weatherization.

Y. Michelle P. Waiver Program

The Michelle P. Waiver is a home a community-based 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 Michelle P. Waiver 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 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

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 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.

KMCCSA meets bimonthly 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. Throughout 2021, the commission has 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 for 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, and 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 efficiently and effectively accomplish goals;
- 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 (EHDI) Program: Kentucky's EHDI Program oversees hearing screening at birth hospitals that deliver more than 53,000 births annually across the state. Ninety-eight percent (98%) 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 for the future. 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 2021, OCSHCN provided specialty medical services to 6,253 patients. Of the total number of patients seen, 77% had Medicaid/KCHIP, 21% had private insurance, and 2% had no insurance. OCSHCN accepted 2,174 new patients and discharged 3,160 patients; 47,012 visits were recorded.

During 2021, OCSHCN's EHDI program received 49,652 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, 2,640 failed on one or both ears. The total number of infants that passed the hearing screen was 47,012.

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. In light of Kentucky selecting 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

Aetna Better Health of Kentucky was awarded the contract to provide a single MCO for children in state custody, former foster youth, and adopted youth receiving subsidy in 2020. Service provision launched for SKY on January 01, 2021. Children and youth in 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. SKY offers evidenced-based, trauma-informed practices and wraparound service provision to approximately 28,000 members. The level of care management services provided by the care coordination teams will be tailored to meet the needs of each individual SKY member. The team will also provide the following services to:

- 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 serves all 120 counties and nine DCBS service regions. SKY has approximately 28,000 members in every county across Kentucky. SKY collaborates across the Commonwealth in terms of resources and service provision to members and stakeholders. Aetna has long-standing relationships with the healthcare community and SKY has ensured the addition of additional partnership in the child welfare specific arena, as well. This assists in ensuring 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. Quarterly CORE meetings facilitated by DCBS include the following divisions and departments across CHFS: DAFM, DPP, DSR, DFS, Commissioner's Office, Training Branch, DJJ, DMS, DBHDID, CCWIS team, technical applications and assistances, and Aetna Better Health of Kentucky. This group keeps CHFS 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 that meets monthly to plan the CORE agenda and to tackle any challenges or concerns related to programming or roll out. Various workgroups inform CORE and address topic-specific needs in the SKY work and partnership. These entail infrastructure and technology, medically complex population, practice and policy, training, communications, and DJJ youth. These groups range from meeting weekly to monthly to ad hoc dependent upon need. SKY hosts various connector, data sharing, and inclusive meetings including a quarterly Governance Council with DCBS and cabinet-wide representation, as well as ad hoc meetings, a training collaborative charged with meeting training gap needs across stakeholder groups, a formal partnership with KYA to bring stakeholders together. KYA already partners with Casey Family Programs and collaborates with many 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 DCBS and DJJ staff at a frontline case management level for heightened collaboration. SKY also holds provider meetings where DCBS is engaging on reduction of barriers, and ensuring supports to remediate gaps in service coverage. This directly speaks to service array and problem solving around service desserts and offering choice of treatment and service provider when able to consumers. DCBS staff and other stakeholders have had the opportunity to participate in a plethora of trainings hosted and/or supported via SKY.

DCBS' standards of practice (SOP) language continues to be 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 children in federal and state waiver services additionally. Previously, contracted nurses completed these services. Since then those contracted nurses through OCSHCN have been employed with DCBS and serve as nurse consultant inspectors within the service regions to support the medically complex work and service array and have also taken over the role of visiting medically complex youth in waiver programs rather than DMS taking on this role, for optimal service provision.

Family Connect provides an online application for resource families to access the SKY online portal to schedule appointments, and review claims and services provided, as well as direct online messaging with case managers. Four of the nine service regions have Family Connect processes in their regions. The goal is to have all nine on board by the end of CY 2022.

CC. 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/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, 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 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.

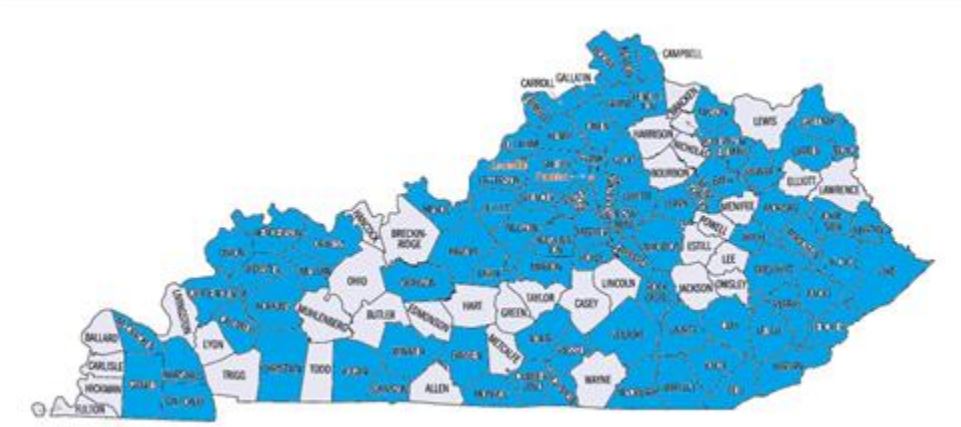
The conference is funded through CBCAP, grants, sponsorships, and private/corporate donations. The conference is planned collaboratively between PCAK staff and a diverse advisory committee representing a variety of disciplines (including legal, public health, mental health, substance abuse, community 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 25th Annual Kids Are Worth It!® Conference was held virtually via ZOOM, due to the COVID-19 pandemic. The event launched on August 30th with a free pre-conference institute focusing on the racial wealth gap simulation. This function was attended by 125 individuals. Separate from the pre-conference simulation, participants were able to attend up to seven workshops from a selection of 14 offerings, three keynote sessions, and 134 exhibits. Beginning with the racial wealth gap simulation on

August 30th, through the conclusion of the final workshop on September 30th, the virtual Kids Are Worth It!® Conference served 457 participants.

Participants from 85 counties (identified in the Kentucky map below), across all nine DCBS service regions were present; representing 71% of Kentucky counties.

2021 KAWI Participant Representation Map



**Participant counties of work are highlighted in blue.*

Evaluation Summaries: Participants were provided the opportunity to complete an overall conference evaluation. Sixty-eight (68) evaluations were received, accounting for a 16% response rate. The percentages below represent those who indicated they were either *Extremely Satisfied* or *Satisfied* with the categories below:

Please rate your overall experience:	**2019 Overall Responses**	**2020 Overall Responses**	**2021 Overall Responses**
a. Conference as a whole	100%	95%	96%
b. Registration process	98%	94%	94%
c. Workshop choices	96%	94%	95%
d. Keynote sessions	96%	92%	95%
e. Networking opportunities	96%	N/A	N/A

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

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

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:

- *"Always get useful information from Kids Are Worth It! Conferences."*
- *"The available amount of resources offered and shared, as well as, community partners in collaboration."*
- *I liked the keynotes and all the sessions I signed up for. Dr. Currie is always informative, and I liked the session on suicide prevention, but all were great!"*
- *"The visuals used by the speakers, and the materials available as a resource."*
- *"Resources for families to prevent child abuse/child sexual abuse."*
- *"Virtual training turned out better than I anticipated. In fact, I loved how spread out it was over the month. Really helped with client scheduling. I was impressed with the material. Thank you."*
- *"Each one of the speakers and exhibitors were very knowledgeable about what they were teaching. There was a really good selection of main conference topics as well."*

Self-Help, Parent Education, and Support Groups: Services are available in every service region and served 98 counties (of 120) in the state in 2021. Subcontractors are required to utilize the evidence-based Nurturing Parenting curricula along with administration of the parallel Adult-Adolescent Parenting Inventory (AAPI) pre and posttest. 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 have been implemented 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 715 families began a parent education and/or parent support program with one of the 17 providers during 2021. In this period, PCAK subcontractors provided 8,834 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 2021, 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 posttest 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 2021 noted the following outcomes:

- Among those parents that have completed the program, there is an upward trend of positive impact of parenting skills and program satisfaction.
- Parent protective factors increased, and maltreatment risk factors decreased after program completion.
- Participants reported increased awareness of local resources and support networks after program completion.
- Almost all participants reported some negative childhood experience.

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:

Adverse Childhood Experiences: Understanding and Responding to Toxic Stress: Fifty-nine (59) percent of Kentuckians report experiencing at least one adverse childhood experience (ACE), 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 explores 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.

Bounce 101: Intro to ACEs and Trauma-Informed Practices: People face many stressors that can have a life-long impact on their ability to thrive. Yet it is possible to foster resilience, equipping people with the tools to effectively respond to adversity and bounce back. This interactive workshop supports this goal by increasing understanding of the lifelong impact of ACEs and building individual and organizational skill to nurture resilience. You will complete practical exercises designed to encourage trauma-informed approaches to serving your clients.

Bounce 102: Building Trauma-Informed People: This interactive follow-up session to Bounce 101 takes participants deeper into practical strategies that help build resilience in individuals and organizations. The learning outcomes include:

- Articulate the resilient behaviors your organization needs to thrive.
- Discuss barriers to building resilience.
- Discuss ways to overcome barriers to building resilience.
- Write ways your organization can build a culture of resilience.

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 affect 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 KYSF 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.

Abusive Head Trauma: Kentucky statute requires education on the identification and prevention of abusive head trauma. In partnership with experts in child maltreatment, PCAK has developed curricula to meet the needs of a variety of professionals impacted by this legislation.

Preventing Child Maltreatment Death: A Community Effort: Everyone has a role to play in keeping children safe and ensuring children reach their full potential. Through lecture and group work, participants are empowered to act to end the tragedy of child death and near death at the hands of those charged with caring for them.

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.

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 Messages: Promoting Action for the Prevention of Child Sexual Abuse: The way in which individuals talk about social problems affects how people understand their causes and solutions. Everyone has beliefs and values that are used to help 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 PCAK that there is work to do regarding child sexual abuse and its prevention. PCAK wants its messages to promote action and move individuals to intervention and prevention. This workshop will summarize the work already completed around reframing child sexual abuse messaging in Kentucky, as well as the importance of adequate message frames moving forward. Participants will leave with an understanding of proper framing for difficult topics, and the tools to create new appropriate messages for difficult social issues, specifically child sexual abuse.

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

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

The Connection between Intimate Partner Violence and Child Maltreatment: Intimate partner violence affects 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 intimate partner violence, how children are impacted by the violence, and techniques for preventing child maltreatment when working with families impacted by intimate partner violence.

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.

New, online trainings:

Electronic Crimes Against Children: How to Educate, Monitor, and Communicate Internet Safety: Whether you are a professional working to protect children or you 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, PCAK will work to update this training annually. Special thanks to 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 partnered with DCBS for 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 presenters, Chelsea Harrod and Sydney Lawson, from the Child Protection Branch, DCBS.

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. In light of 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 protecting children from abuse and neglect and 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. 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 2021, 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 2021, PCAK served 2,182 participants and provided 32 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. 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 83,151 pieces of material displaying 1-800-CHILDREN were distributed throughout the Commonwealth during 2021.
- Staff communicated information regarding 1-800-CHILDREN during 26 formal trainings and numerous presentations on various topics to a variety of audiences reaching 3,203 individuals.
- Staff were involved in 27 outreach opportunities reaching 1,312 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. Some notable data from January 1, 2021, to December 31, 2021, includes:

- 151 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 13 times per month.
- On average, 70.05% of all callers were referred to DCBS.

Since the last reporting period, 1-800-CHILDREN parent support calls to the toll-free number have remained stable. 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 2021, PCAK had 250 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.

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. Data from this survey will be made available during CY 2022.

PCAK Child Abuse Prevention Month: During national child abuse prevention month, PCAK provides leadership to a statewide public education and awareness campaign to promote child abuse and neglect prevention. 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 2021 child abuse prevention month campaign included the following activities:

- Via Gubernatorial Proclamation, April 2021 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 March 26, in conjunction with the Office of the Governor and First Lady Beshear, PCAK held a statewide kickoff to include a pinwheel planting on the Capitol Lawn. The pinwheel planting was private to PCAK staff and elected officials to adhere to CDC guidelines for COVID-19.
- Communities across the state held an array of events to include community proclamation ceremonies, pinwheel plantings, and virtual events on ZOOM/Facebook to adhere to CDC guidelines for COVID-19.
- There were 82 Child Abuse Prevention Month related events reported to PCAK in 2021.
- 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, and suggestions for engaging communities in grass roots prevention efforts.
- Over 42,382 pinwheels were distributed across the Commonwealth.
- There were 1,611 pinwheel lapel pins distributed across the Commonwealth.
- There were 202 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 37,822 hits to the PCAK webpage during the campaign.
- Targeted announcements were also sent to DCBS staff, educators, mental health professionals, childcare providers, law enforcement officials, health departments, and legal professionals.
- 100% of Kentucky counties were engaged with PCAK in child abuse prevention month efforts.
- In advance of and during the month, 20,422 child abuse awareness materials were distributed across the state to local communities.
- During the 2021 campaign, there were 515 new Facebook likes, 73 new Twitter followers, and 3,569 reaches on Instagram.

Resources made available by the Children's Bureau were utilized in the development of the 2021 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:

- "Ages and Stages: A Parent's Guide to Discipline" brochure designed to educate individuals on child development and keys to effective discipline.
- The "Hold Them, Hug Them, Love Them But Never Shake a Baby" brochure has been replaced by "Understanding Abusive Head Trauma & Safe Sleep Practices." This brochure also comes in Spanish.
- "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.
- The Internet Safety Toolkit is an easy to comprehend guide for parents and caregivers to provide education on internet safety.
- "Preventing Child Neglect" brochure defines neglect and educates the reader on how to recognize and respond to neglect.
- "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.
- "Coping with Crying" Tip Sheet educates parents on ways to deal with baby's crying, in effort to reduce stress and acting out in harmful ways, reducing pediatric abusive head trauma.
- "Selecting the Right Summer Camp" Tip sheet educates parents on the questions to ask prior to enrolling their child in any summer camp or youth serving organization activity.
- "When a Child Talks About Sexual Abuse…" Tip Sheet addresses how adults should react and respond to child sexual abuse disclosures.
- Child Sexual Abuse Risk Reduction Protocol for Youth-Serving Organizations" is a guide designed for youth-serving organizations who are interested in adopting strategies to prevent child sexual abuse.
- "Home Safety 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 is for children to understand home safety
- Upstream Primary Prevention posters used to create awareness for primary prevention.

All resources are driven by needs identified within Kentucky and designed to meet the needs of parents and professionals. For instance, because abusive head trauma is the primary cause of physical abuse deaths in Kentucky, tools and awareness campaigns addressing this have been deemed critical. In addition, research has shown the reality that many children each year are abused by their parent's love interest or their caregiver, which deemed it necessary to have a resource to help parents make these decisions.

PCAK has worked 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/

Through a grant from the Child Victim's Trust Fund, PCAK developed and launched "Are They Good for Your Kids?" campaign including an infographic, postcard and posters directing the public to an interactive webpage focused on child sexual abuse prevention. The campaign included bus advertisements, social media advertisements and press conference. This campaign had over 1.2 million impressions

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

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. Trends continuing to emerge in 2021 include internet safety, human trafficking, child sexual abuse prevention and the way it is communicated to the public, evidence-based prevention, pediatric abusive head trauma, prevention/awareness programs targeted to

children, parenting strategies, grandparents raising grandchildren, trauma-informed care, building child and parent resiliency, child fatality prevention, and strengthening families through building protective factors. PCAK works collaboratively with community partners to promote systems improvements by creating tools to support multi-tiered prevention of abusive head trauma for parents provided by birth hospitals, healthcare professionals, and home-visiting programs. Staff have also collaborated with medical professionals, childcare providers, parenting programs, early child home visiting programs and other agencies towards revising new and existing materials to reflect research in messaging and prevention strategies.

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 2021, over 28,725 pieces of materials, with 234 downloads, were distributed across the Commonwealth designed to educate and promote awareness of child abuse and neglect. PCAK encourages the reproduction of this literature, many agencies make copies of the brochures and pamphlets sent to them by PCAK and distribute them to other local agencies and civic organizations. To assist in meeting this need, PCAK has developed printer friendly online versions of printed material. During 2021, Facebook (Meta) changed the metrics able to be pulled for analysis. During 2021, there were 5,133 visits to PCAK's Facebook business page and 802 new followers. Twitter followers grew to 3,754. Instagram followers grew to 1,426. There were 58,980 hits to the PCAK website.

PCAK evaluates the resource library 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, child sexual abuse prevention, and the role of every person to report suspected child abuse and neglect. They are, "Understanding Abusive Head Trauma & Safe Sleep Practices," which reflects the intentional focus within PCAK and other advocacy organizations in addressing high instances of abusive head trauma in Kentucky; "Preventing Child Sexual Abuse", reflecting PCAK's statewide focus on child sexual abuse prevention; and "What Everyone Should Know about Child Abuse", reflecting the need for education of what to look for and how to report.
- 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. https://pcaky.org/information-data/child-maltreatment-and-data-statistics/.

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 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. 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. PCAK also provides opportunities for locally and nationally recognized presenters to teach community partners and providers best practices in working with and serving fathers.

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. During 2021, CCFF applied for 501c3 status and continued work on the strategic plan outlining goals for promoting statewide positive fatherhood involvement.

CCFF hosted the 2021 Kentucky Fatherhood Summit virtually due to COVID-19 restrictions. The summit was delivered to 256 individuals, including summit attendees, presenters, CCFF members, and volunteers. Participants indicated their profession and county of work during the registration and evaluation processes. The professions included representatives from state government, mental health, law enforcement, education, corrections, non-profit organizations, faith-based organizations, and other community social service providers. Participants represented 63 of 120 Kentucky counties and six other states (AL, CA, DC, FL, GA, IN).

PCAK continues to play a vital role in statewide fatherhood work. Two PCAK staff members currently serve as executive officers for CCFF and is involved on several subcommittees including network and fund development, special events, communications, and legislative inclusion. PCAK's leadership with fatherhood efforts helps to promote healthier childhoods across the Commonwealth.

DD. Standardized Screening and Assessment

Project SAFESPACE was 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 KID net system for web-based data entry of the functional assessments. Screening and assessment is fully integrated into the Department's practice.

Screening and assessment is 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 occurs 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 bi-monthly steering committee meetings to drive the work forward and engage in collaborative decision-making. The clinical consultant regularly interfaces with community partners, including private providers, CMHCs, and other agencies (such as CASA).

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 PTSD (Post Traumatic Stress Disorder) Symptom Scale, CRAFFT, Strengths and Difficulties Questionnaire, Upsetting Events Survey, and Young Child PTSD Checklist). Screeners are specifically to be administered within 10 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 service regions through the System of Care FIVE grant held by the Department for Behavioral Health, Developmental and Intellectual Disabilities. This process will expand to two more service regions in early 2022 with the goal of eventual statewide expansion.

Screening is designed to achieve standardized decision-making and give priority for 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 needing 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 to be used to engage caregivers and youth, communicate with providers and partners, and incorporated 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, 2021-December 31, 2021). The table below describes the

number of children in OOHC, the number of children screened, and the number of children who needed a CANS assessment based on screener results.

Region	# Children Entered OOHC	# Children Screened	% Children Screened	# Children Screened in for CANS	% Children Screened in for CANS
Eastern Mountain	326	310	99.04%	249	79.55-%
Jefferson	382	328	87.70%	237	63.37 %
Northeastern	402	327	82.78%	250	63.29%
Northern Bluegrass	700	537	77.27%	439	63.17-%
Salt River Trail	666	478	72.21%	367	55. 44%
Southern Bluegrass	609	470	77.69 %	325	53.72 %
Cumberland	607	579	97.97%	419	70.90 %
The Lakes	631	610	97.91%	451	72.39%
Two Rivers	894	802	92.18%	610	70.11%
Total	5217	1441	86.06%	3347	65.27%

There has been a slight decrease in screener compliance in 2021. Leadership continues to explore reasons for this, including DCBS staffing issues/turnover, training concerns, and implementation drift.

In the table below, screener compliance is reported monthly for children who were in OOHC for more than 10 days during 2021. Screener and CANS compliance continue to increase.

Month	Screener Compliance	% Screened In	CANS Compliance
January	**96.41%**	**69.00** %	**63.95**%
February	**96.44 %**	**72.32-%**	**59.22** %
March	**97.07 %**	**70.16-%**	**63.95**%
April	**96.52 %**	**68.46%**	**64.20**-%
May	**97.27 %**	**70.43-%**	**64.59**-%
June	**96.53 %**	**70.51-%**	**68.86**%
July	**96.57 %**	**70.55%**	**61.80**-%
August	**96.52 %**	**70.92%**	**64.58-%**
September	**95.68%**	**70.96%**	**65.17-%**
October	**95.67 %**	**71.20%**	**64.89-%**
November	**94.91 %**	**70.96 %**	**64.80-%**
December	**92.44%**	**71.01%**	**64.58-%**

Discrepancies exist between the two data tables due to differences in available reports. One is a cumulative report and includes children who may have been placed in OOHC for a short time (less than 10 days) and never received a screener. Two is based on point in time data and only includes children in OOHC at the time of the report.

The following screeners are administered to children under five entering OOHC: Young Child PTSD Checklist (ages 0-6) and the Strengths and Difficulties Questionnaire (ages 2 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: CANS compliance continues to be an area of focus for the department. More than 90% of children placed in PCC/PCP 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 not being made timely, foster families choosing non-CANS trained providers, and the age of the child (young children not being served by agencies). During this reporting period, the clinical consultant has been better able to track referrals for CANS assessments for children in these placement types. Of 1076 referrals made to CMHCs in 2021, only 281 (26.12%) of the CANS were completed. In 2021, 213 children were referred to CANS trained private/independent providers, who completed 56 assessments (26.29%). A new referral procedure is in development so that referrals are sent automatically to agencies who are approved to complete CANS assessments for children in state foster homes, relative placements, or with fictive kin.

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.

The department implemented SOP 4.26.3 Standardized Screening and Assessment for Children in Out of Home Care in 2019. This SOP details the procedures for screening and assessment. No new policies or practices pertaining to screening were implemented during 2020 or 2021.

Evaluation activities were not included in the contract between DCBS and University of Louisville. Formal evaluation activities with UofL ended in September 2019.

Efforts on full integration into casework and treatment planning continue. The clinical consultant will continue to provide at least monthly CANS trainings 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 in a timely manner. 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 not yet been 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

The 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, multidisciplinary team involvement, 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 2021 contract includes state general funds in the approximate amount of $ 4.7 million, as a group, $544,315 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 $97,025 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 Area Development Districts (ADD). 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 10% 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.

Rape Crisis Center Data: Calendar 2021	
Service Category	**Number of Services Provided/Persons Served**
New victims served	4,748
New family & friends served	945
Legal advocacy services: court, case management, referrals to services	2,495
Medical advocacy services: sexual assault forensic exam (SAFE), follow up exams, referrals for further medical treatment	1,587
Crisis calls received	3,589
Counseling sessions provided	18,988
DCBS client total	485
Prevention/education sessions (including Green Dot in Kentucky high schools)	4,593
Prevention/education participants (including Green Dot in Kentucky high schools)	4,949,402
Volunteer hours	45,690

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 age 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 10 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 continue to the fullest extent possible via virtual platforms for many services and have maintained those systems in additional to face to face services when possible. The shift to virtual platforms for educational programming has radically increased the number of participants in that area as well.

The 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 KY'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 the baby's abandonment, the parent may ask for the baby's 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 is funded through SSBG and State General 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 downloadable 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 offers assistance 24 hours per day/7 days per week to pregnant and new mothers 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."

History (2002- 2021)

- There have been 60 safe infant incidents involving 61 infants since 2002 (one incident involved a set of twins).
- Of the 61 infants, 10 were delivered at home, one was delivered in the hospital parking lot, and 49 were delivered in the hospital.
- The infant delivered in the hospital parking lot was discovered to have been left at the hospital entrance. Neglect was substantiated, but the judge determined probable cause that the child was left with the intent to leave the child according to the Safe Infant Act.
- Of the 61 infants, 48 have been adopted, one has a pending TPR, and 11 were returned to their parents.
- Average length of time to TPR is 6.88 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, and it appears this is the exception to the remainder of the data. In this case, the child was born with severe birth defects, and the adoptive parents were waiting for the child's surgeries and medical interventions to occur prior to adoption.

- There are nine service regions in Kentucky, and each region has had at least one case involving safe infants. The number of Safe Infant Act incidents per region are as follows: Two Rivers: 23, Southern Bluegrass: 7, Northern Bluegrass: 5, Jefferson: 5, Northeastern: 6, Salt River Trail: 5, Cumberland: 3, Eastern Mountain: 1, and The Lakes: 5.
- Ages of mother (if able to identify): 15, 17, 18, 22, 23, 24, 25, 26, 27, 28, 30, 33, 34, 40, as well as 31 unknowns.
- Infants - Males and Females: 27 males and 33 females.
- Races of infants: 26 Caucasian, 8 African American, 2 Hispanic, 1 Indian, 1 Bosnian, 1 bi-racial, and 22 unknown/declined to disclose.
- Reasons cited for abandonment, if identified: 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 y/o mother was afraid that the maternal grandfather would kill her if he found out about the baby; child had severe birth defects; mother was homeless; mother reported that she 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; child born with birth defects; parents are illegal immigrants and afraid if deported due to the new administration; and the 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; severely deformed infant. Most infants are healthy with no problems.

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, and the mother and relative returned to claim the child and request placement with a relative; however, there were neglect concerns, and an emergency custody order was granted. There were nine cases in which the parent returned to claim the child within specified timeframes, one of these was the natural father.

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

- An infant left in a shoebox in March 2007; however, it was left at an unoccupied duplex, and this is not a designated place.
- An infant was also delivered and placed on a doorstep; the child was not considered Safe Infant because the child was not left at an appropriate location.
- An infant was placed in a plastic bag upon delivery at Bellarmine College.
- In 2009, an infant was left in a garbage receptacle immediately after delivery; toilet paper was stuffed in the infant's throat.
- In 2011, an infant was suffocated by the teenage mother, who was subsequently charged with homicide.
- In 2013, an infant was left in a garbage can inside a department store in Louisville. The mother was initially charged with abuse of a corpse and tampering with physical evidence.
- In 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 are pending. 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.

- In 2015, there were two incidents in which Safe Infant could have been utilized. The first occurred in January: Mother delivered the 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. The second occurred in July: Mother (age 15) delivered the baby at a local hospital while visiting her grandmother who was hospitalized. 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.
- In November 2017, a deceased infant was located inside of a bag on a busy neighborhood street in Lexington. The mother was never located.
- In 2018, there were two incidents in which the Safe Infants Act could have been utilized. The first occurred July: 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. The second occurred in December. 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.
- In 2019, DCBS received a near fatality investigation regarding a newborn found in a toilet by EMS. The mother gave birth at home, claiming that she was unaware of the pregnancy. The infant was apparently birthed into the toilet (head down) and left there until EMS arrived. The infant was in critical condition upon arrival to the hospital.
- In February 2020, a Grant County mother gave birth in the bathtub at home at 10 am. The baby was born alive, but the mother indicated the infant stopped breathing shortly after delivery. She held him for 30 minutes, cut the umbilical cord with scissors, placed him in a plastic bag, and hid him in a laundry basket. Due to excessive bleeding, she 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.

A noticeable trend is that most of the cases are from the Two Rivers 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 notifies 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.

From January 1, 2021, through December 31, 2021, three families received Safety Net services. This was an average of $798.20 per month. DPP's "Safety Net Tally" report and statewide for CY 2021, a total of $1,568.14 was spent on Safety Net services. This data shows a rapid decline from the previous calendar year: in CY 2020, 31 families received Safety Net services for a total of $9,578.42 according to DPP "Safety Net Talley" report. DPP's "Safety Net Tally" report is incomplete and does not contain data for the entire state. These figures do not contain data from Jefferson Region (Louisville) or Southern Bluegrass Region (which contains Lexington) for the entire CY 2020.

There have been no changes in policy or practice during CY 2021. The Cabinet intends to continue to provide Safety Net services for families who lose TANF benefits to prevent out-of-home placement of children and to assist the family in maintaining stability. No consultative efforts or technical assistance was provided or received by the National Resource Center during CY 2021.

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:

1. 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.
2. 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.
3. There are two travel documents totaling $28 in the state's accounting system coded to Safety Net. Travel expenses are not allowable.
4. 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.

DPP has been instructed to create a corrective action plan (CAP) to resolve the audit’s findings of weakness or noncompliance. 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. In CY 2021, DPP and DFS continue to review the Safety Net program for potential changes to both service delivery and record keeping for upcoming years.

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 5-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 Promising 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.

These numbers are broken down by county below.

County	Families Served	Children Served	Adults Served
Boone	**37**	**69**	**69**
Boyd	**55**	**103**	**90**
Campbell	**32**	**44**	**57**
Daviess	**41**	**87**	**64**
Fayette	**78**	**108**	**117**
Jefferson	**104**	**194**	**203**
Kenton	**81**	**179**	**148**
Pendleton	**2**	**2**	**3**
Total	**429***	**786**	**750***

***Note: One case transferred from Kenton County to Fayette County. It is counted under both counties individually but is only counted once in the total.**

Overall, START served 429 families, 786 adults, and 750 children. In addition to direct services to families, and expansion of the program, START leadership and evaluation team provided two peer reviewed manuscripts in 2021.

Publications:

1.) Hall, M. T., Kelmel, A. B., Huebner, R. A., Walton, M. T., & Barbee, A. P. (2021). Sobriety Treatment and Recovery Teams for families with co-occurring substance use and child maltreatment: A randomized controlled trial. *Child Abuse & Neglect*, 114, Advance online publication. https://doi.org/10.1016/j.chiabu.2021.104963

This study, which took place in Jefferson County, is the first randomized controlled trial of START. The START OOHC rate was seven percentage points lower than families receiving usual services. Although the rate of OOHC was not significantly different between START and usual services, the relative differences were meaningful, and this is the third study showing lower rates of OOHC among START relative to usual services. Additionally, the START reunification rate in Jefferson County was higher than the overall U.S. average despite notable risk factors among START families.

2.) Hall, M. T., Walton, M. T., Huebner, R. A., Higgins, G. E., Kelmel, A. B. & Lorenz, D. (2021). Sobriety treatment and recovery teams for families with co-occurring substance use and child maltreatment: A propensity score-matched evaluation. *Children and Youth Services Review*, 131, Advance online publication. https://doi.org/10.1016/j.childyouth.2021.106256

This study used propensity score matching and tested whether START saw better outcomes than usual child welfare services within 12 months of the index maltreatment event. Children in families receiving START were less likely to be placed in OOHC than children in families receiving usual services, and of children who were placed in OOHC, a higher percentage of those receiving START were reunified with their caregivers, though differences were not statistically significant. Rates of subsequent maltreatment were higher among children in families receiving START than those in families receiving usual services, perhaps due to increased surveillance relative to usual services.

Additionally, there continues to be a focus on developing consistent practice guidelines in the area of 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. START's evaluation team completed a fidelity report for all START sites which represents data collected through May 2021. Another fidelity review will occur in 2022.

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.

Staffing issues have continued to be a challenge across multiple sites during this review period. The START director and DSR director held monthly meetings to assess for staffing and other challenges across sites. A big focus of this review period was rebuilding teams, through consultation with each region to assess the need for child welfare workers on START as well as recruitment of family mentors. START leadership arranged for several trainings including methamphetamines and stimulant use disorders and trauma informed care for all START staff. New staff have also been trained in MI, and the clinical director continues to provide regular MI coaching sessions to staff. START teams and START leadership have been involved at a statewide level in racial equity work. Equity work in each region will be a continued area of focus during the upcoming review period

II. Social Services Block Grant

SSBG is funded through title XX of the Social Security Act. 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 2021 Data	
SSBG Service	**Number of Clients Served**
Adult/Domestic Violence Protection	**114,569**
Child Protection	**395,804**
Home Safety Services	**4,607**
Juvenile Services	**2,680**
Residential Treatment	**422**

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, there were 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.

There was a focus in 2020 on training staff in EBPs, particularly with the implementation of FFPSA within child welfare. Solutions staff were trained in MI. Two staff were also trained in PCIT and working towards certification. Additionally, one staff member was trained in adolescent community reinforcement approach (ACRA) for transitional age youth up to and including 25 years of age. There was an initiative to provide joint training for DCBS staff and Solutions staff aimed at increasing knowledge and skill base for working with clients. Some of the training included a two-day Motivational Interviewing training, Dialectical Behavior Therapy training, and mastering DSM-5 differential diagnosis.

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.

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 21 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.

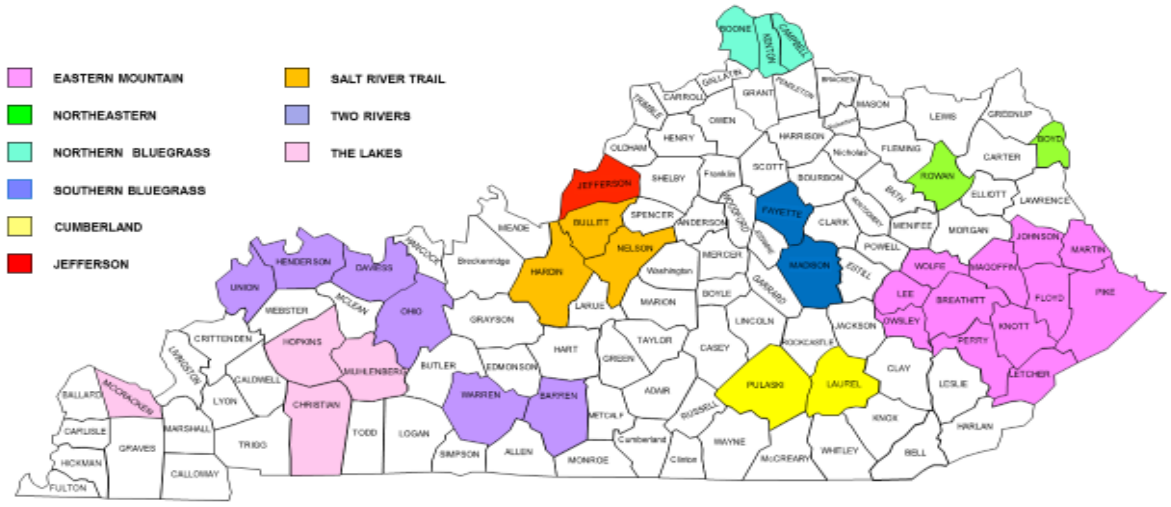
The TAP approach includes the following key practices:

- 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 2021, 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 2021 Service Map by DCBS Service Region



Targeted Assessment Program Opioid Use Disorder Project:
In 2019, DCBS addressed Kentucky's opioid crisis by expanding TAP, initiating the Targeted Assessment Program Opioid Use Disorder Project (TAP OUD) through an MOU between DBHDID and DCBS. Funded by SAMHSA Grant 1H79TI081704, this TAP expansion is one of three DCBS projects supported by a Kentucky State Opioid Response (SOR) grant through KORE. The purpose of KORE is to increase access to evidence-based treatment, reduce unmet treatment need, and reduce opioid-related overdose deaths by supporting the implementation of a full continuum of high-quality, evidence-based opioid prevention, treatment, and recovery support services.

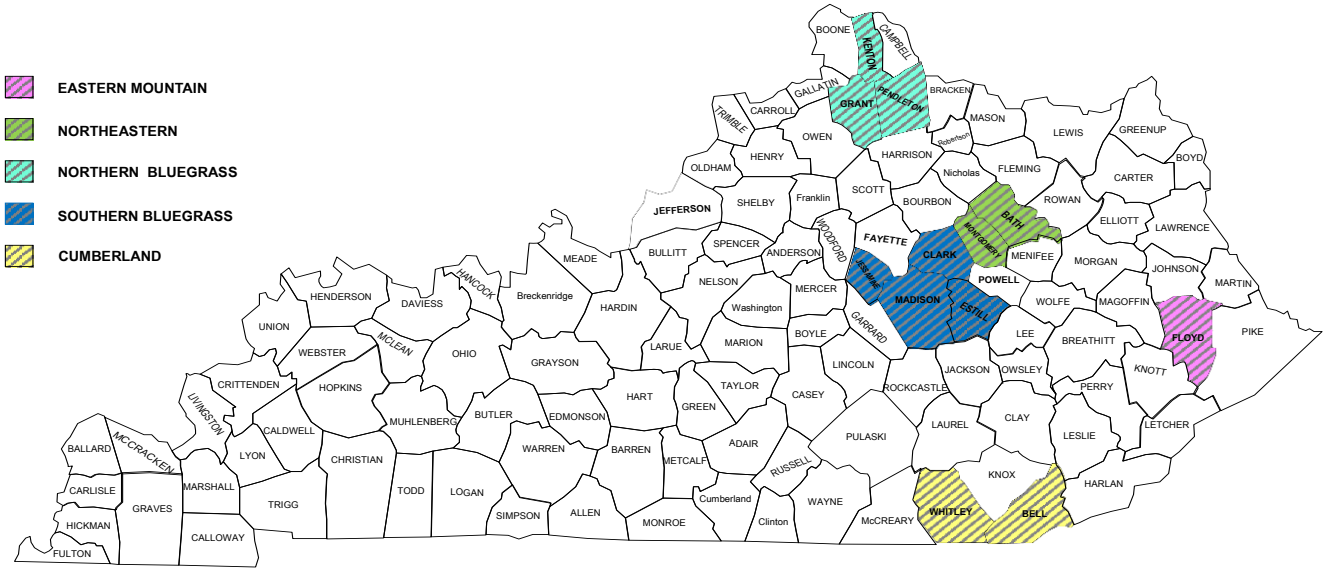
TAP OUD relies on a strong state/university partnership and the ability to efficiently replicate implementation to expand TAP services in counties with the highest Kentucky Overdose Index Scores (2017) in the Jefferson, Northern Bluegrass, Northeastern, Southern Bluegrass, Eastern Mountain, and Cumberland service Regions (see map below). This includes five counties that already had TAP services (Fayette, Floyd, Jefferson, Kenton, and Madison) and 10 additional counties (Bath, Bell, Clark, Estill, Grant, Jessamine, Montgomery, Pendleton, Powell, and Whitley). The target population is low-income

parents served by DCBS with or at risk for opioid use disorders. TAP OUD's goals include increasing participant engagement, reducing barriers to treatment, increasing access to evidence-based treatment, (e.g., Medications for Opioid Use Disorder, (MOUD)**,** community services, and increasing treatment retention).

Initially a two-year contract (FY 2019-2020), the KORE grant was renewed in FY 2021 for an additional year, with the potential for another no-cost extension through FY 2023 when approved by SAMHSA. With funding limitations in mind, DCBS and TAP OUD formed a sustainability committee to discuss potential complementary funding to sustain the project post-KORE. At DCBS' request, TAP OUD in CY 2021 explored Medicaid funding 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 conduct a cost-benefit analysis, to determine the feasibility of this option. As part of this analysis, a retrospective study is being conducted to determine potential billable services currently provided by TAP OUD staff. Results of this cost-benefit analysis will be presented to the TAP OUD/DCBS sustainability committee.

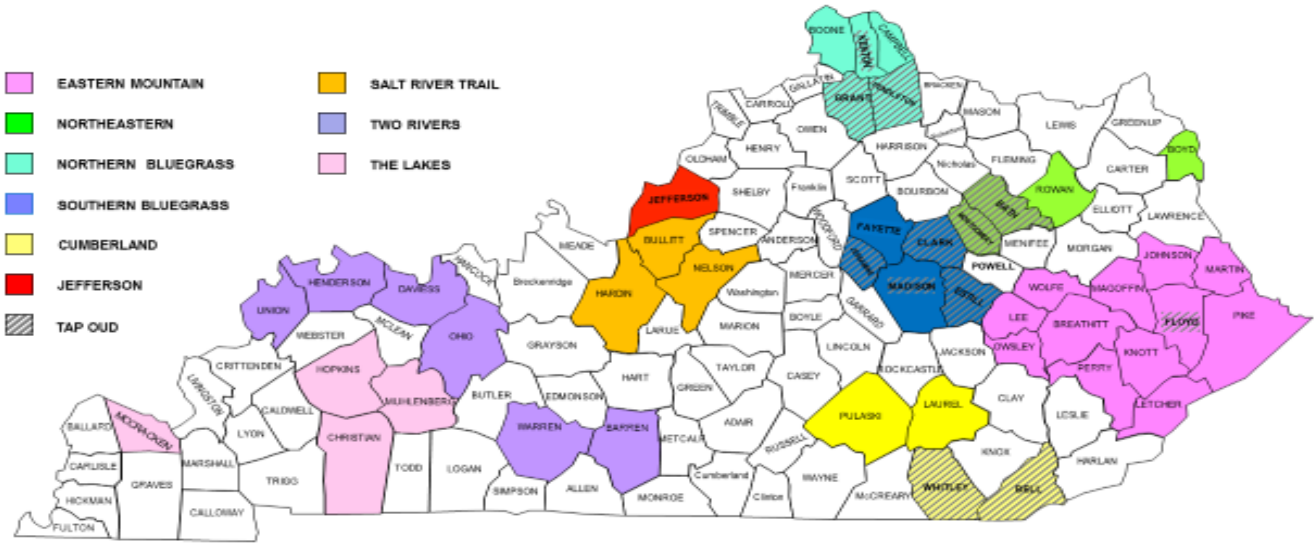
In 2021, through consultation with DCBS leadership and DBHDID KORE, the scope of work was modified, and it was determined that 12 TAP OUD assessors would be co-housed in the following state-selected counties, including three counties with existing TAP services (Floyd, Kenton, and Madison), and nine new counties (Bath, Bell, Clark, Estill, Grant, Jessamine, Montgomery, Pendleton, and Whitley). Three assessor positions also have field supervisor responsibilities. The TAP OUD principal investigator, project director, and project evaluator are located at UK in Lexington. The TAP OUD project's service map according to DCBS service regions is presented below:

Targeted Assessment Program Opioid Use Disorder Project (TAP OUD)
CY 2021 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 2021 is presented below.

TAP and TAP OUD Project
CY 2021 Service Map by DCBS Service Region



Fiscal Year 2021 TAP and TAP OUD Data
During FY 2021, TAP and TAP OUD facilitated or participated in 57 advisory council meetings (34 TAP; 23 TAP OUD) and 288 planning and implementation meetings (180 TAP; 108 TAP OUD) with DCBS staff. In addition, TAP and TAP OUD facilitated 8 local community selection committee meetings (4 TAP; 4 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 2021, TAP/TAP OUD provided 10,916-case consultations to DCBS (8,899 TAP; 2,017 TAP OUD) for participants and 2, 210 case consultations (1,712 TAP; 498 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 2021, TAP/TAP OUD assessors participated in 1,101 (864 TAP; 237 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, TAP and TAP OUD continued to utilize its web-based data collection system. The current system includes: 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 March 8, 2021, through March 7, 2022. 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 362 TAP OUD participants, 191 6-month follow-up GPRAs, and 128 discharge GPRAs.

During FY 2021, TAP and TAP OUD respectively completed 1,675 and 506 baseline assessments for participants referred by DCBS divisions and other sources – for a total of 2,181. Referrals to TAP (n=2,312) continue to be primarily from DPP (92%, n=2,118) and DFS (6%, n=150). Compared to the previous fiscal year, DFS referrals decreased (-57%), while DPP referrals increased (+7%). Most referrals to TAP OUD (n=657) were also from DPP (93%, n= 611) and DFS (6%, n=39. Becoming fully staffed enabled an overall referral increase of +329% over FY 2021.

Many of the 2,181 TAP and TAP OUD participants receiving baseline assessments during FY 2021 were found to have multiple barriers. Indeed, 66% (n=1,099) 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 (72%) reporting mental health and more than half (57%) reporting substance use as barriers to self-sufficiency and family safety. In addition, 45% reported intimate partner violence victimization. Of the 506 TAP OUD participants completing a baseline assessment, 84% (n=427) were assessed with two or more barriers. Mental health and substance use barriers were also the most prevalent, with more than three quarters of those assessed reporting mental health (85%) and substance use (81%) barriers. In addition, 44% reported intimate partner violence victimization at baseline.

Assessors also completed 2,589 (n=2,265 TAP; n=324-TAP OUD) case closure reports for participants who terminated TAP and TAP OUD services during the FY. Of these terminating participants, 70% (n=1,812[1]) had received a baseline assessment. Notably, many TAP participants were assessed with multiple barriers. Among terminating TAP participants who received an assessment (n=1,705), mental health and substance use were the most prevalent of the four targeted barriers, with almost three-fourths (73%) of those assessed self-reporting mental health as a barrier and more than half (56%) reporting substance use as a barrier to self-sufficiency and family safety. In addition, over a third (38%) reported intimate partner violence victimization. Nearly two-thirds (n=1,045; 61%) of those assessed prior to termination were found to have two or more barriers, with almost a quarter (n=383; 22%) assessed with three or more barriers. Among terminating TAP OUD participants who received an assessment (n=14), almost three-fourths (71%) of those assessed reported substance use as a barrier. More than fifty percent (51%) reported mental health problems, and 29% reported intimate partner victimization.

<u>COVID-19 Pandemic Impact</u>**:** 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

[1] Terminating participants may have been referred or assessed prior to FY 2020.

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 state of emergency, Kentucky Works Program (KWP) participants continued to receive "Good Cause" exemptions, with voluntary participation. Further, Family Support staff reported their ability to screen for the need for TAP services was limited by the closure of schools and other child-relating programs. Pandemic-related DCBS staff turnover also impacted TAP and TAP OUD utilization. These trends began to shift later in the year. TAP and DPP reported increased pandemic-related intimate partner violence, mental health symptoms, and substance use. Unfortunately, pandemic restrictions made it more difficult for families to access and benefit from needed services.

Evaluation: Assessors completed 2,589 case closure reports for participants who terminated TAP and TAP OUD services during FY 2021, including 2,265 TAP case closures and 324 TAP OUD case closures. Of the 2,589 total terminating participants, 71% (n=1,608[2]) of TAP participants and 63% (n=204) of TAP OUD participants had received a baseline assessment. Terminating TAP participants who received an assessment had an average duration of services of 36 weeks. Terminating TAP OUD participants who received an assessment had an average duration of services of 32 weeks.

Of the 1,606 terminating TAP and TAP OUD participants who were assessed, nearly nine out of every 10 (89%) showed improvement in accessing needed services. Among terminating participants who received an assessment, progress in overcoming major barriers to self-sufficiency, stability, and safety was rated (from No Progress to A Lot of Progress) by assessors as:

- 87% of terminations identified with Mental Health as a barrier made progress
- 87% of terminations with Substance Use as a barrier made progress
- 86% of terminations with Intimate Partner Violence as a barrier made progress

In addition, progress overcoming basic needs barriers among terminating assessed participants was rated by assessors as:

- 87% of termination with children's basic needs barriers made progress
- 86% of terminations with parenting difficulties as a barrier made progress
- 85% of terminations with child care difficulties made progress
- 82% of terminations with social/family relationship problems made progress
- 81% of terminations with lack of housing as a barrier made progress
- 77% of terminations with difficulty obtaining work made progress
- 68% of terminations with transportation difficulties made progress

[2] Terminating participants may have been referred or assessed prior to FY 2021.

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

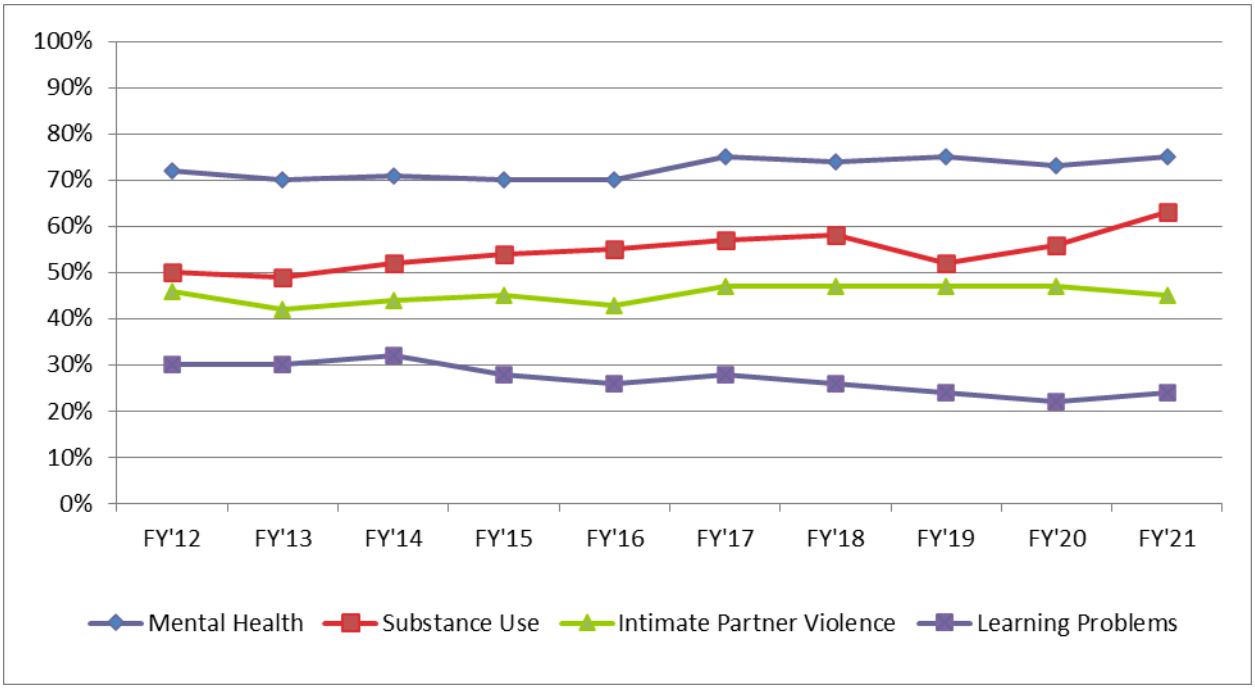
	Assessed Participants Terminating TAP and TAP OUD with Identified Barrier		
	TAP	**TAP OUD**	**Total**
Mental Health	**n=1,148**	**n=161**	**n=1,309**
Any Progress, (i.e., a little, some, moderate, a lot)	992 (86%)	146 (91%)	1,138 (87%)
A Little Progress	214 (18%)	35 (22%)	249 (19%)
Some Progress	344 (30%)	34 (21%)	378 (29%)
Moderate Progress	354 (31%)	67 (42%)	421 (32%)
A Lot of Progress	80 (7%)	10 (6%)	90 (7%)
No Progress	156 (14%)	15 (9%)	171 (13%)
Substance Use	**n=895**	**n=165**	**n=1,060**
Any Progress, (i.e., a little, some, moderate, a lot)	769 (86%)	147 (89%)	916 (86%)
A Little Progress	153 (17%)	25 (15%)	178 (17%)
Some Progress	216 (24%)	23 (14%)	239 (23%)
Moderate Progress	311 (35%)	66 (40%)	377 (36%)
A Lot of Progress	89 (10%)	33 (20%)	95 (10%)
No Progress	126 (14%)	18 (11%)	122 (12%)
Intimate Partner Violence	**n=564**	**n=69**	**n=633**
Any Progress, (i.e., a little, some, moderate, a lot)	490 (87%)	61 (89%)	551 (87%)
A Little Progress	90 (16%)	11 (16%)	101 (16%)
Some Progress	128 (23%)	17 (25%)	145 (23%)
Moderate Progress	203 (36%)	26 (38%)	229 (36%)
A Lot of Progress	69 (12%)	7 (10%)	76 (12%)
No Progress	74 (13%)	8 (11%)	82 (13%)
Learning Problems	**n=158**	**n=24**	**n=182**
Any Progress, (i.e., a little, some, moderate, a lot)	79 (50%)	18 (75%)	97 (53%)
A Little Progress	32 (20%)	5 (21%)	37(20%)
Some Progress	27 (17%)	10 (42%)	37 (204%)
Moderate Progress	18 (12%)	3 (12%)	21 (12%)
A Lot of Progress	2 (1%)	0 (0%)	2 (1%)
No Progress	79 (50%)	6 (25%)	85 (47%)

	Assessed Participants Terminating TAP and TAP OUD with Identified Barrier		
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=51**	**n=498**
Any Progress, (i.e., a little, some, moderate, a lot)	361 (81%)	40 (78%)	401 (81%)
A Little Progress	90 (20%)	13 (25%)	103 (21%)
Some Progress	107 (24%)	11 (22%)	118 (24%)
Moderate Progress	110 (25%)	11(22%)	121 (24%)
A Lot of Progress	54 (12%)	5 (9%)	59 (12%)
No Progress	86 (19%)	11 (22%)	97 (19%)
Problems with Social/Family Relationships	**n=372**	**n=23**	**n=395**
Any Progress, (i.e., a little, some, moderate, a lot)	320 (86%)	20 (87%)	340 (86%)
A Little Progress	85 (23%)	6 (26%)	91 (23%)
Some Progress	145 (36%)	5 (22%)	149 (38%)
Moderate Progress	77 (21%)	7 (30%)	84 (21%)
A Lot of Progress	13 (3%)	2 (9%)	15 (4%)
No Progress	52 (14%)	3 (13%)	55 (14%)
Transportation	**n=311**	**n=34**	**n=345**
Any Progress, (i.e., a little, some, moderate, a lot)	216 (70%)	19 (56%)	235 (68%)
A Little Progress	87 (28%)	11 (32%)	98 (28%)
Some Progress	73 (24%)	3 (9%)	76 (22%)
Moderate Progress	43 (14%)	5 (15%)	49 (14%)
A Lot of Progress	13 (4%)	0 (0%)	13 (4%)
No Progress	95 (30%)	15 (44%)	157 (32%)
Problems Obtaining Work	**n=291**	**n=42**	**n=3**
Any Progress, (i.e., a little, some, moderate, a lot)	226 (78%)	29 (69%)	255 (77%)
A Little Progress	57 (20%)	10 (24%)	67 (20%)
Some Progress	67 (23%)	5 (12%)	72 (22%)
Moderate Progress	60 (21%)	8 (19%)	68 (21%)
A Lot of Progress	42 (14%)	6 (14%)	48 (14%)
No Progress	65 (22%)	13 (31%)	78 (23%)
Parenting	**n=388**	**n=32**	**n=420**
Any Progress, (i.e., a little, some, moderate, a lot)	330 (85%)	29 (91%)	359 (85%)
A Little Progress	76 (20%)	7 (22%)	83 (20%)

	Assessed Participants Terminating TAP and TAP OUD with Identified Barrier		
Some Progress	108 (28%)	11 (34%)	119 (28%)
Moderate Progress	125 (32%)	7 (22%)	132 (31%)
A Lot of Progress	21 (5%)	4 (13%)	25 (6%)
No Progress	58 (15%)	3 (9%)	61 (15%)
Legal Problems	**n=166**	**n=16**	**n=182**
Any Progress, (i.e., a little, some, moderate, a lot)	132 (80%)	12 (75%)	144 (79%)
A Little Progress	26 (16%)	3 (19%)	29 (16%)
Some Progress	54 (33%)	5 (13%)	59 (32%)
Moderate Progress	32 (19%)	3 (19%)	35 (19%)
A Lot of Progress	20 (12%)	1 (6%)	21 (12%)
No Progress	34 (20%)	4 (25%)	38 (21%)
Basic Needs for Children	**n=137**	**n=20**	**n=157**
Any Progress, (i.e., a little, some, moderate, a lot)	120 (88%)	17 (85%)	137 (87%)
A Little Progress	22 (16%)	4 (20%)	26 (17%)
Some Progress	45 (33%)	4 (20%)	49 (31%)
Moderate Progress	42 (31%)	7 (35%)	49 (31%)
A Lot of Progress	11 (8%)	2 (10%)	13 (8%)
No Progress	17 (12%)	3 (15%)	20 (13%)
Physical Health	**n=129**	**n=7**	**n=136**
Any Progress, (i.e., a little, some, moderate, a lot)	124 (91%)	6 (86%)	130 (91%)
A Little Progress	32 (25%)	1 (14%)	39 (29%)
Some Progress	39 (30%)	4 (58%)	58 (42%)
Moderate Progress	31 (24%)	1 (14%)	26 (19%)
A Lot of Progress	7 (5%)	0 (0%)	1 (1%)
No Progress	20 (16%)	1 (14%)	13 (9%)
Child Care	**n=72**	**n=5**	**n=77**
Any Progress, (i.e., a little, some, moderate, a lot)	59 (82%)	4 (80%)	63 (82%)
A Little Progress	18 (25%)	1 (20%)	19 (25%)
Some Progress	22 (31%)	1 (20%)	23 (30%)
Moderate Progress	13 (18%)	0 (0%)	13 (17%)
A Lot of Progress	6 (8%)	2 (40%)	8 (10%)
No Progress	13 (18%)	1 (20%)	14 (18%)
Providing Enough Food	**n=44**	**n=4**	**n=48**
Any Progress, (i.e., a little, some, moderate, a lot)	40(91%)	2 (50%)	42 (88%)
A Little Progress	6 (14%)	0 (0%)	6 (13%)
Some Progress	11 (25%)	1 (25%)	12 (25%)
Moderate Progress	14 (32%)	1 (25%)	15 (31%)
A Lot of Progress	9 (20%)	0 (0%)	9 (19%)
No Progress	4 (9%)	2 (50%)	6 (12%)

Fiscal Year 2012-2021 Barrier Prevalence**:** In 2021, TAP received a request from DPP to continue to study the prevalence of barriers to self-sufficiency and safety among participants across multiple fiscal years. The percent of TAP and TAP OUD participants with barriers assessed at baseline is presented graphically below. Of the 1,750 assessments completed in FY 2020, 96 were for TAP OUD participants and 1,654 were for TAP participants. In FY 2021, of the 2,181 assessments completed, 506 were for TAP OUD participants and 1,675 were for TAP participants. Mental health has consistently been the most prevalent barrier across all years – remaining steady between FY 2012 (72%) and FY 2021 (75%). In contrast, the percent of participants assessed with a substance use barrier has increased since FY 2012, with the most recent increase to 63% in FY 2021 (up from 56% in FY 2020). The percent of participants assessed with an intimate partner violence barrier decreased slightly to 45% in FY 2021, down from 47% in FY 2020. Lastly, the percent of participants screened with learning problems and deficiencies has varied year to year, ranging from a high of 32% in FY 2014 to a low of 22% in FY 2020, increasing slightly to 24% in FY 2021.

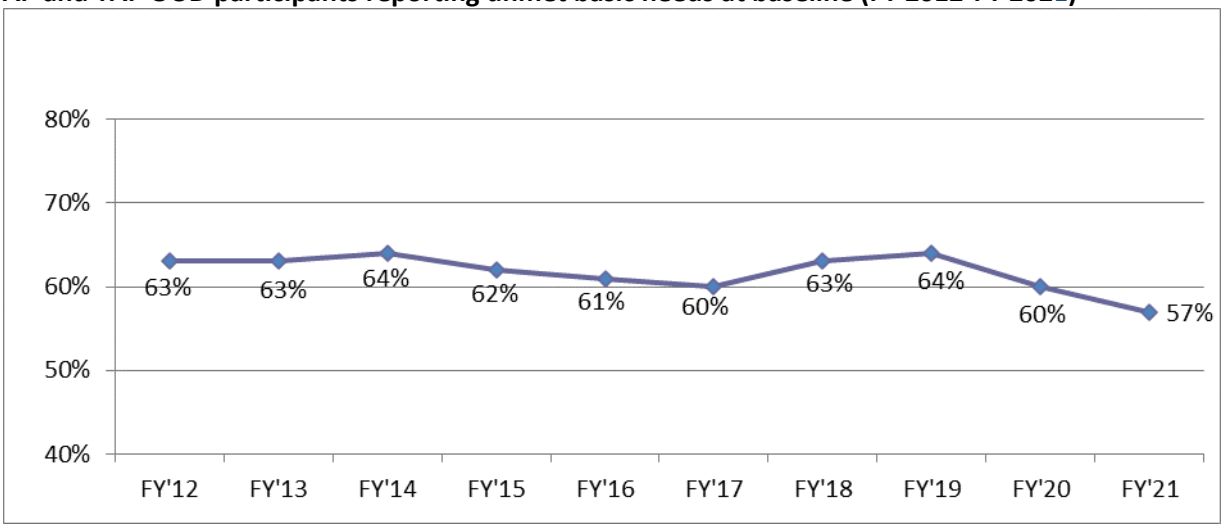
Percent of TAP and TAP OUD participants assessed with barriers to self-sufficiency and safety at baseline (FY 2012 – FY 2021)[3]



The percent of TAP and TAP OUD participants assessed with unmet basic needs barriers from FY 2012 through FY 2021 is also presented graphically below. The percent of participants assessed at baseline with unmet basic needs has varied since FY 2012, with a high of 64% in Fiscal Years 2014 and 2019, and a low of 57% in Fiscal Year 2021. The most identified unmet basic needs reported by participants in FY 2021 were finding money to cover expenses, transportation, social support (social/family relationships), and legal problems. This is consistent with previous years.

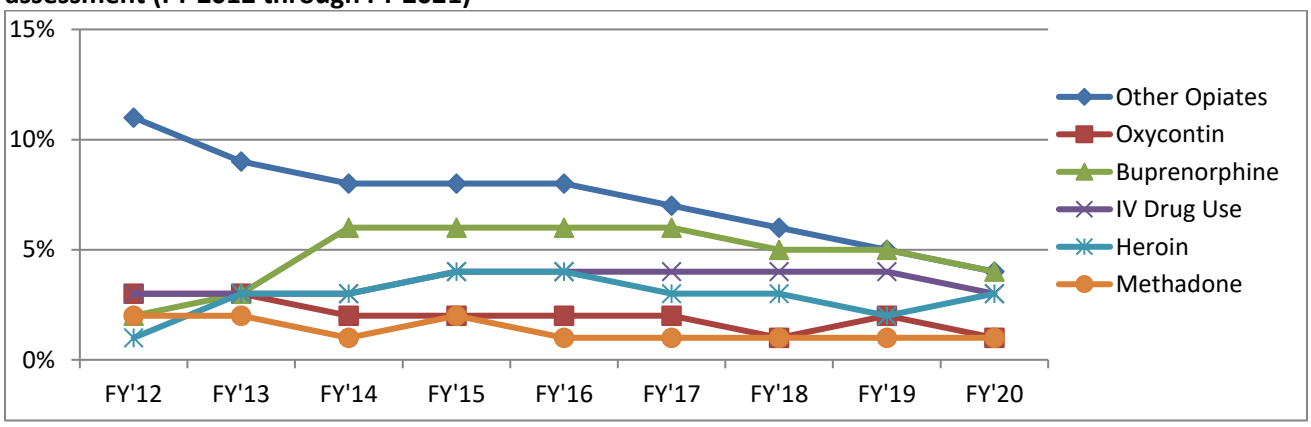
[3] TAP OUD services were not initiated until FY 2020

TAP and TAP OUD participants reporting unmet basic needs at baseline (FY 2012-FY 2021)[3]



In 2022, TAP received a request from DPP to continue to examine opioid use trends among participants from FY 2012 through FY 2021. The percent of TAP and TAP OUD participants self-reporting opioid use at baseline assessment in the previous three months is presented in the figure below. Compared to FY 2020, during the three months prior to the baseline assessment, use of heroin, other opiates, and IV drugs increased in FY 2021. Use of Oxycontin, Buprenorphine, and Methadone was consistent with the previous year. It important to note that TAP OUD did not initiate services until FY 2020. Of the 22,730 baselines completed between FY 2012 and FY 2021, 22,128 and 602 were completed by TAP and TAP OUD assessors, respectively.

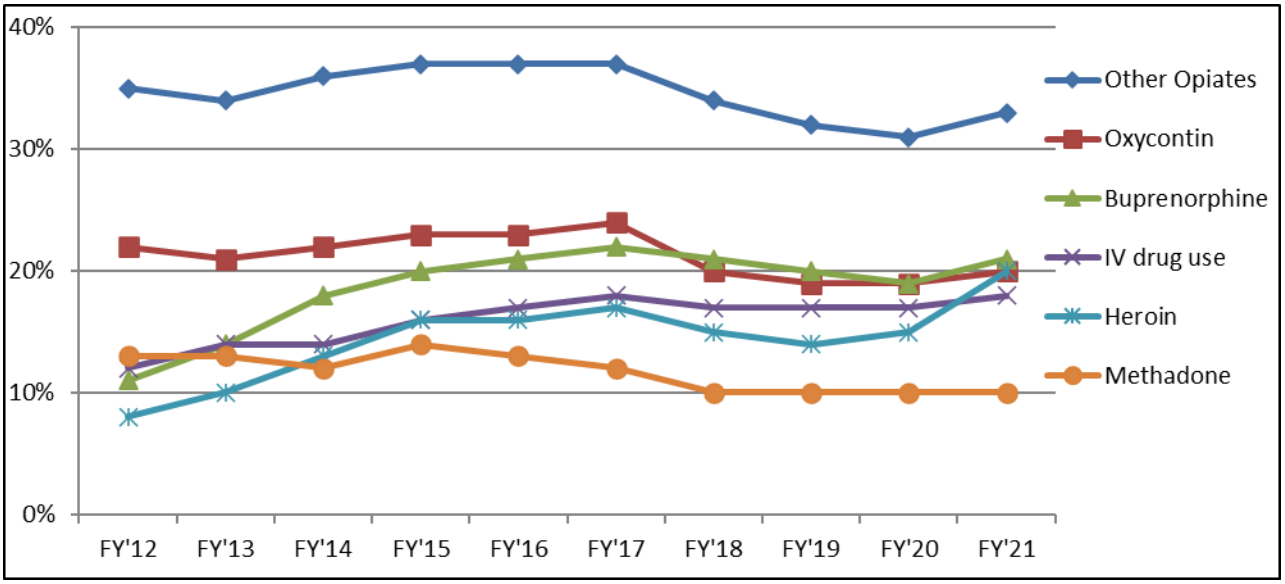
Percent of TAP and TAP OUD participants self-reporting opioid use 3 months before baseline assessment (FY 2012 through FY 2021)[3,4,5]



The percent of TAP and TAP OUD participants self-reporting opioid use in their lifetime is presented below. Compared to FY 2019, participants served in FY 2020 reported decreased use of Buprenorphine and other opiates, while heroin use increased. Reported OxyContin, Methadone, and IV drug use was consistent with the previous year.

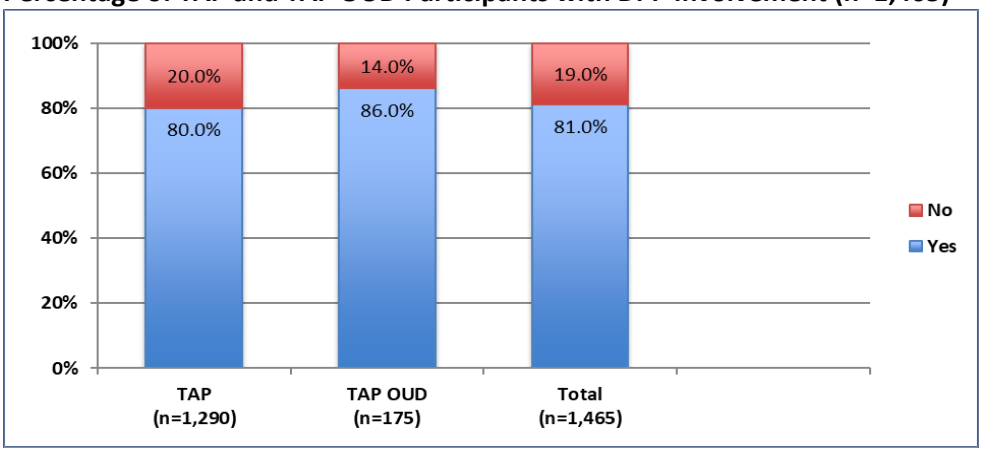
[3] TAP OUD services were not initiated until FY 2020
[3] TAP OUD services were not initiated until FY 2020
[4] Use of IV drugs and heroin was reported by 3% of participants in FY 2020 and 4% of participants in FY 2021
[5] Use of Oxycontin and Methadone was reported by 1% of participants in both FY 2020 and FY 2021

Percent of TAP and TAP OUD participants (n=20,549) self-reporting lifetime opioid use at baseline assessment (FY 2012 through FY 2021)[3]



DPP Involvement and Outcomes**:** At the request of DPP, TAP also summarizes Protection and Permanency involvement and child welfare outcomes among TAP and TAP OUD participants who had completed a baseline assessment and were discharged from the TAP or TAP OUD program between July 1, 2020**,** and June 30, 2021 (n=1,812). Case closure data is used for all measures. It is important to note that TAP/TAP OUD case closure and DPP case closure have separate timelines. As presented below, of the 1,812 assessed participants who terminated TAP (n=1,608) or TAP OUD (n=204) services during FY 2021, around four of every five participants (%; n=1,465) had DPP involvement. Specifically, 80% (n=1,290) of TAP participants had DPP involvement, and % (n=175) of TAP OUD participants had DPP involvement.

Percentage of TAP and TAP OUD Participants with DPP Involvement (n=1,465)



The table below presents the DPP case status for participants at the time of TAP or TAP OUD termination. More than one category may be selected by assessors when completing the case closure

[3] TAP OUD services were not initiated until FY 2020

instrument. As shown below, of those involved with DPP while receiving TAP or TAP OUD services (n=1,465), 290 families (20%) were reunified, with 172 DPP cases closed and 118 DPP cases open for monitoring and support. In addition, prevention efforts were successful for 515 families (35%) whose children were never removed; 14% of those cases remained open, with 206 families making progress toward reunification.

DPP Case Status among TAP and TAP OUD Participants (n=1,465)[6]

	Number and percent of participants who reported status		
	TAP (n=1,290)	**TAP OUD (n=175)**	**Total (n=1,465)**
Open working towards reunification	438 (34%)	49 (28%)	487 (33%)
Open for monitoring and support; children never removed	190 (15%)	16 (9%)	206 (14%)
Closed children never removed	282 (22%)	27(15%)	309 (21%)
Open for monitoring and support; family reunified	99 (8%)	19 (11%)	118 (8%)
Closed family reunified	139 (11%)	33 (19%)	172 (12%)
Closed custody not returned to parent	93 (7.0%)	19 (11%)	112 (8.0%)
Open goal changed to adoption, legal custodianship, planned permanent living arrangement, or other form of TPR	49 (4%)	12 (7%)	61 (4%)
Closed parental rights terminated (TPR)	7 (<1%)	0 (0%)	7 (<1%)

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 2021, the Clinical Services branch manager attended the quarterly meetings of the Statewide Steering Committee on Trauma-Informed Care. These quarterly meetings are hosted at the UK Center on Trauma and Children and are facilitated by staff at UK and DBHDID. Due to the COVID-19 pandemic, these meetings are now 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.

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

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. In the past, one of the challenges of this program was although it was set up to be at a lower level of care than an acute psychiatric admission, the five MCOs in the state do not have agreements to refer participants into this program, which provides the TF-CBT as well and a highly supportive environment. In 2021, Kentucky implemented the SKY specialized Medicaid benefit for children in state custody, which lessened the barrier associated with MCOs. This program ceased operations during the early part of 2021. It is reported that it was related to staffing – specifically the loss of the program director.

The UK Center on Trauma and Children operates the Child and Adolescent Trauma Treatment and Training Institute (CATTTI Clinic http://www.uky.edu/CTAC/CATTTI). 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 (http://www.riskingconnection.com/rc_about.php). 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.

MM. Work Incentive Program

The Work Incentive Program (WIN) was created as a result 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 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.

No new policy or practice was implemented during CY 2020. From January 1, 2021, through December 31, 2021, an average of 76 WIN payments were issued per month for a CY total of $117,780.00. No consultative efforts or technical assistance was provided by a National Resource Center during CY 2021. The Cabinet is currently researching plans to revise the program.

During 2020 and 2021, DFS participated in the Southeast Cohort for Young Parents & Families, convened by the nonprofit group Third Sector. Through focus groups, surveys, and data analysis, a finding of this project gleamed TANF supportive services are being under-utilized. DFS also participated in the American Public Human Services Association's (APHSA) "System Alignment Working Group for Children & Families," with a group of dedicated human services leaders and stakeholders across sectors, including parent representatives. The Working Group was tasked with identifying strengths and barriers in our current human services systems, opportunities for better system alignment, and to lay the foundations for a framework to effective human services alignment resulting in improved outcomes for young parents and their children. This work was featured in the December 2021 APHSA publication "Working Together – A Roadmap to Human Services System Alignment for Young Families."

In 2021, Kentucky was accepted into the Administration for Children & Families (ACF) "TANF Learning Community" (TLC). Kentucky's TLC project is called "Creating Virtual Case Management options for both Rural & Urban Populations in the Kentucky Works Program." ACF's overall project theme is called "Reimagining TANF Programs to Support Family Economic Independence and Mobility in a Post-Pandemic World." Kentucky TANF Administrators are working to find ways for TANF work participants to be given the opportunity to voluntarily and most important, safely, pursue self-sufficiency goals to overcome their barriers despite the worldwide crisis. The ACF TANF Learning Community project timeline is from December 2021 through December 2022.

The number of WIN cases decreasing is an ongoing trend. Prior to the pandemic, in CY 2019, there was an average of 249 WIN payments issued per month, for a total of $388,440.00. In CY 2018, there was an average of 354 WIN payments issued per month, for a total of $552,890.00. The number of WIN cases decreased to 76 for CY 2021.

The COVID-19 crisis hit Kentucky in March 2020. Family Support services previously provided in-person at local DCBS offices moved to online or telephone-based services. Some of the most vulnerable citizens

may have been unable to access services due to the lack of a phone or internet access. Further analysis is needed to determine how to increase usage of the WIN program.

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 of prisoners.

Y-NOW collaborates with the local school system (Jefferson County Public Schools), family and juvenile court, Neighborhood Places, CHFS, Seven Counties Services, Probation & Parole, and other agencies involved with children of prisoners. 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 17 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.

<u>Outcomes</u>

- 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); and
- To improve family relationships (and support system).

MUW Indicators/Outcomes	New Matches (in 2021)	Sustained Matches
75% demonstrate an improvement in school performance (grades, suspensions, attendance)	***	82%
85% report improvement in family relationship (stability, communication, no runaways, etc.)	***	90%
75% have no new arrest and/or out of control behavior	93 % 93%	88% 90%

75% will not initiate any (or any new) contact with family/juvenile court 80% pass to the next grade	***	92%
MUW Indicators/Outcomes	**2021/2022 FALL CLASS**	**ALL Y-NOW PARTICIPANTS (2004-2021)**
% Achieve academic success (improvement)	***	---
% Pass to next grade	***	---
% Missing less than 10 days of school	23 %	---
# Graduated middle school	**	317
# Graduated high school and/or earn GED	**	213
# Currently enrolled in elementary/middle/high school	31	210
# 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 limitations with tracking and access to youth data, youth past high school cannot be tracked.
* *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 graduates the program in July 2022 thus program data will not be completed until after graduation. Data in report spans from October 2021-December 2021.

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. Due to the available program space at Safe Place, less youth were enrolled in the 2021 class to allow for appropriate social distancing during in-person group meetings. The Fall 2020/21 class began with 16 participants, with 15 youth graduating the program. The Fall 2021-22 class began in October 2021 with 15 youth participants.

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 which will occur in April 2022.

During the 10-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 10-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

2017	• 16-year-old youth leader is featured speaker at YMCA Safe Place Services Together 4Teens Breakfast • A second class of Y-NOW was added in the spring of 2017. • The case manager resigned in June, requiring the director to step in and manage the Spring 2017/18 class of Y-NOW. • The end of November Y-NOW finally was able to reach full employment. • 299 youth have completed the three-day retreat. Of the 299 youth, 269 youth completed the 12 or 10-month follow-through program. 88% of youth who should have graduated HS have (or received a GED).
2018	• The inaugural spring class graduated in January 2018 with 23 youth. • 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. • To-date 387 youth have completed the three-day retreat. Of the 387 youth, 331 youth completed the 12 or 10-month follow-through program. • Youth leader was nominated and won a Youth Character Award, which includes scholarship money for college.
2019	• Y-NOW alumni from 2014-15 class is featured speaker as YMCA Safe Place Services Together for Teens Breakfast. Same youth went on to give invocation in 2019 annual Mayor's Breakfast. • Staff re-established Y-NOW alumni event in August. Over 40 alumni, mentors, and family members gathered at Safe Place to reconnect, eat and play games. • To-date 434 youth have completed the three-day retreat. Of the 434 youth, 372 youth completed the 12 or 10-month follow-through program. • Three Y-NOW youth (two alumni and one current participant) won Youth Character Awards, which includes scholarship money for college. • Out of the 203 Y-NOW alumni who should have graduated high school, 186 have graduated on time; meaning 92% of alumni have graduated high school on time.
2020	• 2019-2020 Spring alumni spoke at 2020 YMCA Annual Campaign kick-off; same youth was stated to share her story at the 2020 Safe Place Services Annual Together 4 Teens Breakfast. • The 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. • Due to COVID-19 preventing the kickoff for Spring 2020-21 cohort, along with reduction in funding, the program returned to one Y-NOW class a year and the Spring case manager position was terminated. The Y-NOW volunteer recruitment specialist position was also eliminated. • Staff hosted a drive-thru graduation in July celebration for the youth and mentors in the 2019-20 Fall cohort. • 44 current Y-NOW participants or program alumni were successfully promoted from 5th grade, 8th grade or graduated high school. • In October 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. • To date 396 youth have graduated from the Y-NOW program since 2004.
2021	• A volunteer mentor was selected as the 2021 Volunteer of the Year. Another volunteer mentor was selected as the 2021 Joyce Skees Memorial honoree. Award will be received in 2022. • The program has experienced staff turnover thus the program has a newly formed team. The Volunteer Recruitment Specialist/ Case Manager joined in July 2021 and the Y-NOW Director joined in October 2021. • 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. • To date, 411 youth have graduated from the Y-NOW program since 2004.