CHILD WELFARE WAIVER DEMONSTRATIONS
SUGGESTED SEMI-ANNUAL PROGRESS REPORT OUTLINE

Guidance: Waiver demonstration Terms and Conditions stipulate that progress reports must be submitted quarterly until implementation and then semi-annually thereafter. The Initial Design and Implementation Report (IDIR) and subsequent Quarterly Progress Reports Template should be used until the IDIR is fully approved. Thereafter, the Semi-Annual Progress Report Template should be submitted every six months throughout the project period, beginning 30 days after the first six months of implementation.

I. Overview

Provide a brief summary of major demonstration activities completed to date, as well of any significant evaluation findings. Summarize any major changes to the design of the demonstration or to the evaluation since the previous semi-annual report (NOTE: Any significant changes to the design of the proposed demonstration or evaluation must be approved by the Children's Bureau before they are implemented).

Sobriety Treatment and Recovery Teams (START)

Kentucky's START program has progressed well since implementing on 10/1/15, although there have been some challenges, as described below. In July 2017, the START Director, Tina Willauer, moved to a position with Children and Family Futures where, along with other functions, she will lead the training efforts for jurisdictions around the country wanting to implement the START model or strategies. Erin Smead has been promoted from Assistant Director to Director of the Kentucky START program, and Michelle Amann promoted from Kenton START Supervisor to START Assistant Director in January 2018. With staff transitions come challenges, as well as fresh perspectives, and the current START leadership have a strong commitment to the model and to doing quality work.

Four of the five START sites in Kentucky are now included in the Title IV-E Wavier: Jefferson, Kenton, Fayette, and Boyd. Daviess START is still part of a Regional Partnership Grant, which will conclude September 30, 2018, at which point that site will become a Waiver site. The evaluation team is working on the preliminary outcome study due in May, however, the teams appear to be doing well keeping children with their parents whenever it is safe and possible.

As of March 1, 2018, 373 cases have been referred to Jefferson START. Of those, 125 families were ineligible based on established program criteria and 8 families were not accepted due to START caseloads being at capacity. Among the remaining families, 168 were randomized to START in Jefferson County and 72 were randomized to usual services (this site utilizes "biased coin" randomization so that eligible families have increased odds of being assigned START). Of the 168 families randomized to START, 24 are not receiving services for several reasons, including: the family appeared eligible initially, but was later determined to be ineligible; the family moved out of the service area; or the family failed to attend initial staffing meetings

despite the START team's repeated attempts to engage. Of the 144 families enrolled in START in Jefferson County, 66 have completed baseline measures. Of the 72 families randomized to usual services, fourteen have completed baseline measures.

In Fayette County, which does not utilize random assignment, 35 cases have been referred to START since January 1, 2017. Of those, one family did not meet criteria and 8 families were not accepted due to caseloads being full. Twenty-six families were selected to receive START services. One family was initially accepted and later removed. Twelve families in Fayette County START have been enrolled in the evaluation and completed baseline measures.

Kenton County began using Title IV-E funds on July 1, 2017. Since then, fifty families have been referred to START and 23 families have been accepted into the program. Kenton County START became eligible for evaluation referrals in early October. Since that time, seven families have been referred to START. Of those, six were accepted into START and one has completed baseline measures. The local data collector is pursuing the remaining five families.

Boyd County also began using Title IV-E funds on July, 2017, and has accepted six new families since that time.

Kentucky Strengthening Ties and Empowering Families (KSTEP)

The Kentucky Department of Community Based Services (DCBS) implemented Kentucky's Title IV-E waiver program, Kentucky Strengthening Ties and Empowering Parents (KSTEP) on July 1, 2017. The implementation of KSTEP began in four pilot county sites: Carter, Greenup, Mason, and Rowan. There are eight DCBS teams involved in the program. Three of the teams are investigative only, three provide ongoing services, and two provide both investigative and ongoing services. There are two private in-home provider agencies, each covering two counties. Similarly, there are two contracted community mental health centers (CMHCs), one covering one county and one covering three counties. The CMHCs provide and ensure quick access to substance use disorder and mental health treatment for KSTEP families.

Attachment 1 demonstrates the KSTEP program referral information that is provided to families upon referral to the program.

KSTEP continues to progress well since implementation. As of March 7, 2018, 80 cases have been accepted between the four counties, serving 157 children. Since the involvement of those families with KSTEP, 137 children have remained in their home, eleven were placed with relatives and nine were placed in out of home care. Since implementation in July 2017, KSTEP has experienced ten unsuccessful closures and six successful closures.

There have been several changes regarding Evidence Based Practices (EBPs) and therapeutic models in use, as outlined below:

KSTEPs Initial Design and Implementation Report (IDIR) included a plan to utilize Adult Focused Family Behavior Therapy (AF-FBT) as one of four evidence based interventions. AF-FBT is an outpatient behavioral treatment aimed at reducing drug and alcohol use in adults along with common co-occurring problem behaviors such as depression, family discord, and school and work attendance problems. AF-FBT is being removed from Kentucky's EBP repertoire for multiple reasons.

When the AF-FBT intervention was selected, KSTEP had not made the decision to contract with CMHCs to deliver rapid access to substance use disorder treatment for KSTEP families. KSTEP participants are now receiving substance use treatment through contracts with two CMHCs. Therefore, it was determined to not be essential or realistic within the time frame to train the in-home providers and utilize this intervention.

Meetings were held with DCBS leadership, the KSTEP workgroup, and the Title IV-E waiver steering committee to discuss whether the in-home providers should be trained in AF-FBT. The workgroup decided to meet with the AF-FBT model purveyor, Dr. Brad Donohue, before making any decisions to take it out of the IDIR. Mr. Donohue was scheduled to come to Kentucky on October 26, 2017 to demonstrate this model and address whether Kentucky could train, implement, support, and maintain the model moving forward. However, on 10-13-17 after months of discussion with Mr. Donohue, he cancelled his visit stating his model is not appropriate for the target population and he is not in a position to train community providers. Additionally, he reported that FBT is not specific to opiate addiction. As previously outlined in the IDIR, Kentucky is in the midst of an opioid epidemic and led the nation in the use of prescription drugs for non-medical purposes in 2015, according to the Office of Drug Control Policy. In 2015, at least 485 people died in Kentucky from prescription drug overdoses. Medical examiners' records indicate the drugs most commonly found in these death cases were methadone, painkillers oxycodone and hydrocodone, alprazolam (Xanax), morphine, diazepam (Valium), and fentanyl.

Additionally, prior to selection of AF-FBT, both of KSTEPs in-home providers stated they offered family behavior therapy (FBT). However, it was discovered that neither agency was trained in the adult version of FBT. One agency previously trained their staff in the adolescent version, which is very similar to the adult version. This agency is also currently being trained in the adult version. They report they will have the capacity in the future to train AF-FBT. While unnecessary currently due to contracting with the two CMHCs and due to the purveyor believing AF-FBT to not be appropriate for the program, this could add to the potential for program growth in the future if anything changes.

As previously reported, Parent Child Interaction Therapy (PCIT) is another one of KSTEPs selected interventions. PCIT was originally selected because current in-home provider agencies indicated they were already being trained and could provide this intervention. The workgroup has since discovered that one of the in-home providers has trained staff in PCIT, but none of the clinicians trained to provide this intervention are located in the KSTEP pilot sites. This agency is no longer training staff in PCIT, but instead are training their staff in Child-Adult Relationship

Enhancement (CARE) skills. CARE skills is a trauma-informed modification of PCIT skills for general usage by non-clinical adults who interact with traumatized children and their caregivers. All staff with this agency are trained in CARE skills. KSTEPs other in-home provider has two staff going through the credentialing process to become certified in PCIT, and as a result will be able to train their staff in CARE skills. These two staff are still working toward their certification. However, if a KSTEP family has a child needing PCIT, in-home providers without PCIT trained clinicians can refer out for this service along with any other needed therapies.

As previously identified, it is neither feasible nor cost-effective for KSTEP to train and certify all in-home provider staff in PCIT. To become certified as a PCIT therapist, a graduate education is required with independent licensure or one has to be a third year doctoral student conducting clinical work under the supervision of a licensed mental health service provider. Therefore, it is much more practical to use CARE skills with the current in-home provider staff who have either a bachelor's or master's degree, or who may or may not be independently licensed. Utilizing CARE skills will provide the intervention with more long-term sustainability and is more practical based on current timeframes and expansion plan.

Additional changes regarding EBPs include adding additional funds to one of the in-home provider's contract in December 2017, to partner with DCBS to implement Motivational Interviewing (MI) training (one of the selected evidence based practices for the program) for the KSTEP program. Staff participating in the KSTEP pilot in the Northeast region of KY in Carter, Greenup, Mason, and Rowan counties will take part in MI training. Staff will receive a progression of trainings that will include basic or intro to MI and separate advanced trainings. Follow-up training and booster sessions will also be a part of the continuum of training sessions. MI will be integrated and incorporated through coaching and feedback sessions provided to supervisors and their staff. Coaching will include direct observation or review of tapes to identify strengths and weaknesses; discussion of actual observable behaviors; clarifying with probing questions; and active coaching through offering ideas and advice in such a way that the staff member can hear them, respond to them, and appreciate their value, as well as providing follow-up to monitor progress. Training will include discussion, videos, and experiential exercises and should be taught in MI style by a certified Motivational Interviewing Network of Trainers (MINT) trainer. If unavailable, the MI trainer should have a minimum of two years' experience training MI to large groups and be agreed upon with KSTEP program administrator. The in-home provider is currently in discussion with MINT trainer, Dr. William B. Webb, to begin this process. It should also be noted, a MINT trainer was secured initially and all staff completed introductory MI training. KSTEP initially collaborated with the Department for Behavioral Health, Developmental, and Intellectual Disabilities (DBHDID) to accomplish this through a joint request for proposals to bid out this training initiative. However, because the in-home providers and DCBS staff working with the KSTEP program are already implementing the tenets of MI, it was decided to build funding into one of the provider contracts and allow the provider to hire an MI trainer to provide advanced training and embedded coaching.

II. Demonstration Status, Activities, and Accomplishments

Provide a detailed overview of the status of the demonstration in the following areas:

A. Numbers and types of services provided to date. Note in particular the implementation status of any innovative or promising practices.

Sobriety Treatment and Recovery Teams (START)

The expansion of START in Jefferson County is considered to be in middle implementation and Fayette START is in early implementation. Kenton is currently at full implementation, though as they double the team, additional staff will need to be hired and trained, which will move them back into middle implementation of team formation and focus on learning the model so that it can be done with fidelity. Boyd is in early full implementation.

Each case that is selected to participate in the waiver goes through the following process. START cases participate in family team meetings where all members involved in the case, including service providers, meet to make shared decisions on the goals and progress of the case. Parents receive a behavioral health assessment within two days of enrollment in the START program. Referrals to service providers are based on the level of care identified by the behavioral health assessment and vary based on the needs of the parent. The types of individualized treatment can include but are not limited to residential treatment, in-patient, or outpatient rehabilitation. In addition, each family receives family mentor services. The family mentor makes weekly contact with the family and contributes to shared decision making. Program participants also receive at least a weekly home visit from their assigned DCBS worker. Program enrollment as of March 1, 2018 is as follows:

Jefferson County IV-E START Program	
Cases referred	373
Cases randomized to START	168
Cases randomized to services as usual	72
Cases not meeting eligibility criteria	125
Cases not selected due to full caseloads	8

Fayette County IV-E START Program	
Cases referred	35
Cases selected to participate	26
Cases not-selected to participate	9
Cases not meeting eligibility criteria	1
Cases not selected due to full caseloads	8

Kenton County IV-E START Program	
Cases referred	50
Cases selected to participate	23
Cases not-selected to participate	27
Cases not meeting eligibility criteria	12
Cases not selected due to full caseloads	15

Boyd County IV-E START Program	
Cases referred	7
Cases selected to participate	6
Cases not-selected to participate	0
Cases not meeting eligibility criteria	0

Kentucky Strengthening Ties and Empowering Families (KSTEP)

As of March 7, 2018, 83 referrals have been made to KSTEP. Three of these referrals did not meet criteria due to the age of the child or due to the case being in the ongoing function at the time of referral. Four referrals were accepted and assessments completed, however, were then closed due to the families not meeting the intensity level that would necessitate the risk of removal of a child from the home. Ten cases have been closed due to non-compliance, and in one case the family moved out of the service area. Six cases have been closed successfully, including successful completion of the program or the elimination of the need for a DCBS case. One hundred fifty-seven children have been involved in the program. Eleven children were placed with relatives and nine have entered out of home care (OOHC). One hundred thirty-seven children have been maintained in their homes.

KSTEP seeks to keep substance-affected families together whenever safely possible by providing immediate access to intensive in-home services (within 24 hours of referral). The in-home provider conducts a thorough substance use screening at first contact and assessment to determine if a parent is appropriate for a treatment recommendation and referral. If a parent meets American Society of Addiction Medicine (ASAM) criteria for treatment, they immediately present the parent with treatment options, per Medicaid guidelines, and assist the parent in arranging an intake appointment with one of KSTEPs contracted CMHCs based on the county where the participant resides or with a treatment provider of their choice. The contracted CMHCs ensure quick access to substance use treatment by providing the parent an appointment within forty-eight hours. If the parent chooses to not utilize the CMHC, the in-home provider ensures the selected treatment provider is able to serve the parent promptly. The in-home providers are available to provide transportation for the parent(s) to this and other appointments whenever needed. The in-home provider's role is critical to assist parents with addressing their substance use issues and helping parents engage in treatment as quickly as possible. The in-home providers and CMHCs are responsible for ensuring that KSTEP parents with substance use disorders are randomly drug screened according to program guidelines to

monitor compliance. The intensive case coordination provided by the in-home provider is intended to remove barriers to treatment engagement, to retain a parent in treatment, and to re-engage parents who may have stopped treatment. Treatment interventions include Cognitive Behavioral Therapy (CBT), Motivational Interviewing (MI), Child-Adult Relationship Enhancement (CARE) skills, and/or Parent Child Interaction Therapy (PCIT). The providers assess child safety, risk of future maltreatment, and teach parenting and other strategies to parents with a focus on improving family functioning and child wellbeing. In-home providers also identify and make referrals for counseling (if unable to provide this in the home) and for additional needs such as medication, housing, necessities, education, and employment. Some of the referrals made have been for psychotropic medication, higher education, food stamps, mental health counseling, and a home visiting program for pregnant mothers.

In addition to the substance use screening and assessment process, in-home providers complete a comprehensive range of screenings and assessments. Depending on the needs of the parent, these assessments evaluate the need for mental health, family violence, parenting, and family support services. They also utilize solution-based casework (SBC) to develop an action plan in partnership with the family. The in-home provider coordinates the SBC action plan with the DCBS service plan and CMHC treatment plan to ensure consistency across planning and service delivery processes. Case coordination provided by the in-home provider helps the family to act on plans and to coordinate all services.

KSTEPs in-home providers make regular home visits and work with families to identify and obtain resources the family may be eligible to receive, such as Medicaid and TANF. Furthermore, they work to ensure children can remain safely in their homes with flexible funding expenditures such as childcare, transportation, utilities, and other needed resources. Examples of expenditures include paying rent for a parent facing eviction, changing locks due to intimate partner violence, the purchase of a toddler bed, and baby monitors.

The in-home provider prepares a weekly progress report to DCBS and the CMHC substance use treatment provider provides a weekly report to the KSTEP provider that is incorporated into the report to DCBS. If a parent or child is attending counseling for mental health issues or family violence with another behavioral health provider, the in-home provider obtains a monthly written report from the provider and submits this to DCBS. DCBS has reported that this weekly report has been key to building the trust necessary to ensure success of the program by regularly addressing child safety and treatment needs of the family. In-home provider staff are doing well with ongoing assessment of child safety, identifying treatment needs, engaging family in substance use disorder treatment, evaluating presence of other individual and family needs, and collaborating with outside service providers.

KSTEPs in-home providers facilitate monthly family team meetings (FTMs) that include the family, involved DCBS social service workers (SSWs), and the behavioral health providers from CMHCs to facilitate collaborative efforts and decision making that includes all staff involved with the family.

B. Other demonstration activities begun, completed, or that remain ongoing (e.g., introduction of new policies and procedures, staff training).

Sobriety Treatment and Recovery Teams (START)

START (All Sites)

KY DCBS offers a START 101 training for selected staff including the DCBS workers, family mentors, and supervisors. This training is held for new staff and to remind all staff about fidelity to the program. All workers, mentors, supervisors, and service coordinators receive training on Motivational Interviewing (MI) to help with client engagement. START hosted two trainings and sent new staff to trainings available regionally. The supervisors and directors were trained on how to conduct practice sessions and receive ongoing coaching from an MI trainer. Practice sessions have been held in Jefferson, Kenton, and Boyd counties every four-six weeks. Practice sessions have not begun in Fayette due to the focus being on implementing the START model and building the team. The teams were also offered training on medication assisted treatment and overdose prevention. A training on recovery messaging was held in Lexington in May 2017. Most START staff also attended the annual Kentucky School for Alcohol and Other Drug Studies in July, which was an excellent opportunity to deepen their knowledge of substance use disorders and recovery.

Expansion meetings are held in Jefferson, Kenton, and Fayette counties with leadership from regional DCBS, DCBS central office, waiver evaluation staff, START program directors, START staff, and START supervisors. These high level meetings assist the program in moving forward and overcoming hurdles as they arise. The meetings also give the evaluation team an opportunity to discuss with DCBS the recruitment and referral of the control and experimental group cases, which is integral to the integrity of the evaluation. Monthly calls with the supervisors, program directors, and evaluation staff are held to review referral processes, admissions, and recruitment into the evaluation.

Direct line meetings and case reviews are also held each month at each site. Behavioral health providers, START staff, and the evaluator attend these monthly meetings where cases are reviewed for CPS and behavioral health progress, referrals and program numbers are discussed, and barriers to communication are addressed. These meetings provide a forum for direct line workers to examine the program thus far from their perspective and share thoughts and concerns with one another, getting input, and feedback from the program directors. START supervisors, as well as the evaluation team, also meet with various START teams in each county on an as needed basis to discuss the criteria and referral process to ensure it is working properly.

A statewide retreat was held in September for the supervisors, workers, mentors, and service coordinators from each site, with the next retreat planned for August of 2018. The focus was on evaluation, child welfare trends, and parent-child bonding. Statewide family mentor meetings are held quarterly to provide support for this unique role; another meeting was held March. Treatment providers had two cross-site calls this quarter to help support their function, and a statewide provider meeting is planned for May with a focus on Medicaid billing for START services and trauma-informed care.

START program directors are developing new practices on the ground to improve the case flow and referral process. Practice guidance related to medication assisted treatment was developed by the directors and shared with central office, where it is included with the standards of practice manual. The directors did a training for central office on this topic.

Jefferson START

The Jefferson County START site expansion has had some turnover, however, is now almost fully staffed with 7 workers and 8 mentors. Staff are currently in various stages of training, though they are far enough along to work with families and new cases are taken weekly to fill the open slots. Each four dyad team has a supervisor who has been in place since expansion occurred. Of the three service coordinator positions funded through a contract behavioral health agency, there are two filled. Additionally, Jefferson Substance Exposed Infant advisory meetings are held with the local community providers – methadone clinic, addiction treatment providers, doctors, DCBS, neonatologist, OB-GYN, hospital workers, etc.

Fayette START

Fayette START currently has one supervisor, four workers, three family mentors, and one service coordinator. Interviews are being conducted to fill the remaining family mentor position. Due to staff shortages throughout the agency, newly hired workers were recruited to START rather than experienced workers. The facilitator was promoted to supervisor, and due to the high number of staff vacancies, that vacancy is not being filled at this time. Discussions are being held with the contracted service provider to add a facilitator position to their contract. The service coordinator hired by the contracted treatment provider has been trained, approved by her licensure board, and is conducting assessments and case management.

To continue to support implementation of START in Fayette County, the START director, clinical director, and assistant director have been meeting monthly with DCBS management, central office leadership, and treatment provider management to continue ramping up the program. Monthly direct line meetings were implemented in February, including the directors, supervisor, workers, mentors, service coordinator, and behavioral health manager. DCBS leadership attend, when possible, to help support implementation. Ongoing training and

guidance on the model is provided by the directors during these meetings. Representatives from the evaluation team attend when possible to build buy-in for the evaluation.

START 101 and training on the data collection system was held for the whole team on January 20, 2017. Staff who were on board received MI training in November 2016 and June 2017. Due to staff turnover and new additions, most of the team still needs MI training. They will receive it through the local treatment provider with a number of staff attending training each quarter. The directors will begin coaching sessions with the staff this spring. Staff have also received training on the prevention of overdose and participated in a recovery messaging training in May 2017. The service coordinator and her manager conducted training for DCBS staff on addiction, including how to refer for an assessment, and is intended to build capacity throughout the entire office. They also trained the team on ASAM Patient Placement Criteria so that the team is aware of how treatment recommendations are made. The clinical director provided phone and in-person training for the service coordinator related to the functions of that position. The clinical director also consulted on the first five cases to help reinforce the model's quick access to the appropriate level of care. START 101 was conducted for the investigative teams in February 2018 in order to increase buy-in and referrals.

A START docket has been formed in the courtroom of one of the four family court judges in the county. The team and directors have met with the judge and her assigned attorneys and clerks in order to discuss processes and work through issues that have surfaced so far. The START directors presented about the START model to the entire court in October.

Kenton START

The START directors met with regional leadership for over a year to prepare for expansion of the Kenton START site under the waiver, which began in July 2017. Kenton has had a START team since 2007 and will now move from four worker/mentor dyads to eight dyads under two supervisors. The second supervisor was selected in May and began in July, promoting from a START worker position that she had held for three years. The first supervisor has been promoted to START assistant director and the hiring process is underway to find a replacement. A fifth worker has been moved to START under the first supervisor, but the additional three worker positions will not be filled until the new supervisor is in place so as not to overload the existing supervisor. A fourth family mentor has been hired, and recruiting and interviewing family mentor candidates is currently underway to fill the new four positions. New START staff have received START 101 training and participated in direct line meetings. A facilitator position is being developed through the CMHC, which provides contracted behavioral health services. Interviews will begin for that position in March 2018.

Boyd START

This site, which has been operational since 2010, is expanding from two to four worker/mentor dyads under the Waiver as of July 2017. Activities include expansion meetings, START 101 for new staff, and contract meetings. The team currently has four workers and two family mentors with recruitment under way to identify the additional two family mentors. A previous family mentor, who obtained her BSW while employed with START, is now the START Service Coordinator employed by the contracted treatment provider. This site is close to some of the KSTEP counties, and there has been some collaboration on topics such as medication assisted treatment and finding MAT providers who are willing to collaborate with child welfare.

Daviess START

This site has been operating since 2012 under a Regional Partnership Grant and will become a wavier site as of October 2018. The rigorous RPG outcome evaluation was designed by the same START evaluator who designed the waiver evaluation plan.

Kentucky Strengthening Ties and Empowering Families (KSTEP)

Program Updates

The KSTEP workgroup, comprised of contracted service providers, DCBS leadership, behavioral health representatives, and the evaluation team members continues to meet monthly. The Title IV-E waiver steering committee, comprised of KSTEP leadership, START leadership, DCBS leadership, and the evaluation team, continues to meet monthly. Direct Line meetings, comprised of KSTEP leadership, regional leadership, KSTEP providers, and DCBS supervisors also continues to meet monthly.

A phase workgroup was formed and met for the first time in February 2018. KSTEP experienced a change in phases prior to the submission of the last semi-annual report. At the request of the Title IV-E waiver steering committee, the previous program administrator was asked to add an additional fourth phase to the program. A workgroup was subsequently formed to create a document outlining the expectations for phase movement. Prior to finalization of the phase movement expectations, it was decided for the original three phases that had already implemented to be used rather than transitioning to the four phases prior to finalization. The phase movement (current phases) and phase movement expectation draft can be found in Attachments 2 and 3.

A MAT work group has also been formed in an effort to create a collaborative MAT partner listing. The workgroup met for the first time in February 2018. Goals of the workgroup include

reaching out to and inviting MAT providers that are currently utilized by KSTEP parents, and invite them to participate in direct line meetings to introduce providers to KSTEP, and to spread awareness of KSTEP MAT collaborative provider criteria. The criteria include communicating openly with CPS and the courts, receiving and responding to concerns, requiring drug testing and working toward discontinuation of illicit drug use, utilizing psycho-social treatment and recovery supports, billing Medicaid/insurance as appropriate, and implementing a policy to educate parents about safe storage, as adapted from START.

Contracts and budgets for the in-home providers and the CMHCs are also currently under review for changes for the upcoming state fiscal year. Each will run for two years from July 2018 to June 2020, instead of the one year they are currently running, from July 2017 to June 2018.

In September 2017, in-home providers and KSTEP leadership began monthly conference calls with SBC model purveyor, Dr. Dana Christensen. These calls allow coaching and consultation opportunities for KSTEP agency supervisors and front line staff to support the SBC implementation and certification process. Additionally, these calls provide staff the opportunity to ask practice questions and staff cases with involvement by the other in-home provider. SBC website implementation calls with Dr. Christensen's designee also began in September to track the work products the in-home provider staff are completing, skill acquisition, fidelity to the model, and certification of agency staff and supervisors. Conference calls have been moved to every six weeks, based on the current need of the program. Additionally, conversations have continued with Dr. Christensen, KSTEP leadership, and the Training Branch related to identifying and supporting future SBC training needs as the program expands. Currently, the training of the in-home providers as trainers of SBC is being explored.

KSTEP leadership provides consultation calls whenever requested or as needed to provide the entire KSTEP team the opportunity to staff cases. This has helped to troubleshoot problems and create consistent practice across sites, provide guidance, and problem solve issues as they arise.

The KSTEP referral and service framework (Attachment 4) was updated to include changes to the program since April. The KSTEP initial design included cases staying active with KSTEP when children were removed or placed with relatives. However, it was discovered this was not included in the program framework. This has now been added, along with guidance for the in-home provider agencies on quantity/quality of their contact with children when they are placed in out of home care or with a relative.

DCBS regional leadership, supervisory staff, and KSTEP leadership have begun to meet with the family court judges in the four counties served, to provide an update on program implementation.

Staff Training Updates

DCBS staff new to KSTEP will continue to receive a half-day review of SBC. DCBS adopted SBC as its service model in the mid 1990s and all DCBS SSWs are trained in SBC through a training partnership with Eastern Kentucky University (EKU). New in-home provider staff receive SBC training through the agency, as allowed through the purveyor.

Access and approval for new users to utilize the secure data collection website continues to be provided to all individuals required to input data into the site. Technical support is also provided as needed, to train new users how to navigate and use the site.

Additional funds were added to one of the in-home provider's contracts in December 2017, to partner with DCBS to implement MI training for the KSTEP program. Staff participating in the KSTEP pilot will take part in MI training. Staff will receive a progression of trainings that will include basic or intro to MI and separate advanced trainings. Follow-up training and booster sessions will also be a part of the continuum of training sessions. MI will be integrated and incorporated through coaching and feedback sessions provided to supervisors and their staff. Coaching will include direct observation or review of tapes to identify strengths and weaknesses; discussion of actual observable behaviors; clarifying with probing questions; and active coaching through offering ideas and advice in such a way that the staff member can hear them, respond to them, and appreciate their value, as well as providing follow-up to monitor progress. Training will include discussion, videos, and experiential exercises and should be taught in MI style by a certified Motivational Interviewing Network of Trainers (MINT) trainer. If unavailable, the MI trainer should have a minimum of two years' experience training MI to large groups and be agreed upon with KSTEP program administrator.

The in-home provider is currently in discussion with MINT trainer, Dr. William B. Webb, to begin this process. It should also be noted, a MINT trainer was secured initially and all staff completed introductory MI training. However, because the in-home providers and DCBS staff working with the KSTEP program were already implementing the tenets of MI, it was decided to build funding into one of the provider contracts and allow the provider to hire an MI trainer to provide advanced training and embedded coaching.

One of the in-home provider agencies is currently being trained in the adult version of FBT. They report they will have the capacity in the future to train AF-FBT. While unnecessary currently due to contracting with the two CMHCs and due to the purveyor believing AF-FBT to not be appropriate for the program, this could add to the potential for program growth in the future if anything changes.

The in-home provider agency not trained in PCIT or CARES, currently has two staff in the process of being trained in PCIT.

Central office KSTEP staff completed MAT training in March 2018, as provided by START leadership.

C. Challenges to implementation and the steps taken to address them.

Sobriety Treatment and Recovery Teams (START)

Jefferson START

The referral process continues to be an area of focus for START program directors since program implementation in October 2015. The Jefferson County START expansion for the waiver adjusted the target population from families with a substance exposed infants (SEI) to families with a child age 0-5. High turnover of investigative staff continues to be an issue, as well as a workforce of new investigative social workers, the initial source of START referrals. This has continued to cause the need for additional education in regards to START. There have also been new supervisors hired to supervise the investigative teams, so outreach has been needed.

START program directors and supervisors have offered continuous training and have developed materials to educate investigative staff on START criteria and the referral process. The START supervisors continue to meet with the investigative teams to reinforce the referral process and the new target population. Additionally, the supervisors presented on START at a region wide supervisor training and distributed material on the program and the referral process and plan to do another presentation with the addition of new investigative supervisors. A START referral form was requested by regional leadership in the hopes of increasing referrals and reducing the need for follow up questions. Many of the workers have begun using this form and the START supervisors will continue outreach to those workers and supervisors to ensure they are completing the form thoroughly to move the process forward.

Regional leadership reports that one potential barrier may be the higher number of reports investigative workers have been carrying due to staffing issues, and with a regional plan underway to attempt to resolve this issue, leadership believes this will allow staff to prioritize early identification of potential START cases. Regional data was shared and reviewed with regional leadership to assess the significant difference in potentially eligible cases versus the number referred for START services. Plans to meet with centralized intake are underway to revisit how cases should be flagged for investigative workers as being potential START cases. Additionally, regional leadership is proposing a specialized investigative team that would take reports with allegations of parental substance use and child maltreatment. START leadership is very supportive of this possibility and will work collaboratively with this team if this plan is implemented. There are currently ten investigative teams receiving START eligible cases.

Jefferson County continues to be impacted by leadership changes that have occurred. The service region administrator is detailed to the position, and there is a new service region administrator associate for the investigative unit. Staffing continues to be a challenge in Jefferson County. START has also been impacted by these workforce issues, as hiring of

investigative staff has needed to be a priority. There is currently one vacant worker position on the team that has been vacant for several months. Plans are underway to fill this position. All 8 of the 8 family mentor positions have been filled and all of the family mentors are carrying START cases.

All of the initial safety meetings for families in Jefferson START are facilitated by an experienced facilitator. Due to the need for all staff to assist with investigations, availability of staffing days/times has been limited, thus delaying START intervention for families. Regional leadership has agreed to repost an available position for another facilitator as a means to remedy this issue. Until that time the supervisors will continue to work with the current facilitator to problem solve this barrier.

Educating the members of the judicial system on the Title IV-E waiver had been a focus of the START program directors. Jefferson County family court had six newly elected judges, which necessitated an increase in Title IV-E and START education. The START supervisors and assistant directors had an opportunity to present on START and the waiver to the group of Jefferson family court judges. After this meeting, supervisors and the assistant director were also invited by the Jefferson County chief judge to present on START at a MAT information meeting for judges and other court personnel. Additionally, the START director and START assistant director presented at the statewide judicial symposium that was held in Jefferson County.

Fayette START

Fayette County began taking START cases in January 2017. As START caseloads have begun to build, workers continue to carry both START and non-START cases. As new START cases come in the team will need to move non-START cases to other ongoing teams to ensure availability for START cases. Materials were printed and distributed to investigative and hotline staff to ensure understanding of the early identification and referral process for START cases. The START supervisor continues to meet with the supervisors for the investigative teams to educate on START and the referral process. The supervisor recently presented information on START at a regional supervisor meeting. Ensuring that all eligible cases are referred continues to be a challenge. START directors have met with the investigative supervisors to follow up on the referral process, answer questions, and request feedback on how the process is going. County wide data on eligible cases was reviewed with leadership and numbers were compared to cases actually referred. The START supervisor continues to follow up on cases opened for services but not referred to START to troubleshoot. New investigative staff have come on board since implementation as well, so START directors held another START training for all investigative supervisors and staff, which allowed for discussion and feedback.

Ensuring that cases are being referred timely to generate a START family team meeting prior to court action or child placement decisions, has also been a focus for the START directors and the START supervisor. This has been an ongoing discussion with regional leadership and with the

courts. Several meetings have been held to include regional leadership, the START team, and the courts to discuss the court process for START cases thus far. One of the local family court judges oversees the START cases that are court active and holds a START docket for these families. The START directors also presented to the family court judge and the attorneys in her courtroom on the START model at their yearly retreat.

The region has also experienced staffing issues, which have impacted implementation. Three of the original workers hired for the team have moved from the team since implementation. Since then, one experienced worker remains on the team, and three workers were hired new to the agency and have recently completed their child welfare training, as well as training on the START model. There are now three family mentors on the team and interviews are underway to fill the fourth position.

Kenton START

Kenton County began taking START cases under the waiver in July 2017. A new supervisor has been hired for the team in preparation for expansion. The other START supervisor has now been hired as the assistant director for START. While the new supervisor is knowledgeable about START from her experience as a DCBS START worker, she is new to supervision. Regional leadership and the START directors continue to provide training, support, and coaching to support this transition. The other supervisor position has been posted and interviews are scheduled.

As the team has continued to build, two experienced START workers remain on the team, two workers were moved from other teams, and one new worker was hired, filling five of the eight vacancies. Another worker was hired and is currently doing investigations on a team that taking specific cases with allegations of parent substance use and child maltreatment. This worker has been identified to move to START once family mentors are in place for partnership. Recruitment efforts continue for family mentor candidates. Currently four of the eight positions are filled.

Kenton County has formed a specialized investigative team that accepts reports of families with allegations of parental substance use and child maltreatment. START is working collaboratively with this team to ensure that potential START cases are identified early and referred for START services. The supervisor and assistant director provided training for the team, and the START supervisor is following up closely on potential referrals. There appeared to be a discrepancy in the number of eligible reports and the number of START referrals so regional and START leadership met to review date for the region, as well as discuss any other potential barriers to receiving all eligible referrals.

Boyd START

Boyd County began taking START cases under the waiver in July 2017. Leadership changes in Boyd County have led to some changes on the START team, as the START supervisor was promoted and moved from her supervisor position. The new supervisor for the team is an experienced supervisor and is familiar with START, as a previous worker on the team. START directors continue to provide support for him in his new role and will provide coaching and guidance.

A fourth ongoing DCBS caseworker position was recently added to the team, as well as a fourth family mentor position. All four of those positions are currently filled. Due to the loss of three family mentors, for a period of time the team had no family mentors. Two family mentors have now been hired and have completed training and are serving families. One of the family mentors was a prior recipient of START services. Recruitment efforts remain underway to fill the other two vacant family mentor positions.

Kentucky Strengthening Ties and Empowering Families (KSTEP)

The ability to recruit and retain qualified staff to work at both a social work and case coordinator level has been difficult for all involved KSTEP service providers and DCBS. One in-home provider agency has retained two of six of the original coordinators. Recently, four additional coordinators have been hired. Four of the coordinators are full-time KSTEP coordinators and two are transitioning as KSTEP caseloads rise. This agency has not exceeded the maximum of nine per case load. The original two coordinators maintain a caseload of nine, however, the other coordinators are kept lower to ensure quality services are provided to the clients and families. The other in-home provider agency has four full-time coordinators and one part-time coordinator. There have been no issues maintaining a caseload of a maximum of nine cases. The CMHCs currently have full-time personnel in KSTEP coordinator positions.

DCBS staff turnover is an ongoing issue, however, the Northeastern Service Region Administrator, Shannon Hall, continues to practice a proactive approach in regards to employee retention. One of his areas of focus has been recruitment. The region has recently attended college job fairs at four local universities, yielding positive results. Mr. Hall advocated for approval from DCBS central office for funds to register and attend these type of events and approval was granted. Employment registers have improved by 25% as a result. In regard to retention, the region has put together a morale team. The morale team is currently working toward a May appreciation event for all Protection & Permanency staff, which will include food, prizes, networking, and training. Throughout the year the morale team also provides small gestures of appreciation, such as in April for child abuse prevention month, each staff received a small item of appreciation and a “thank you” card signed by all regional management. The region holds a yearly regional child abuse prevention conference free to all staff and

community partners. Two days of national speakers and workshops with free CEUs for social workers, nurses, counselors etc. are offered.

Staffing and turnover rate for the pilot counties:

- Carter County has twelve workers, two supervisors, and a turnover rate or 18% for 2018.
- Greenup County has nine workers, two supervisors, and a turnover rate of 9% for 2018.
- Mason County has ten workers, two supervisors, and a turnover rate of 11% for 2018.
- Rowan County has fourteen workers, two supervisors, and a turnover rate of 8% for 2018.

KSTEP has also experienced several programmatic staff changes throughout the planning and implementation stages of the demonstration project, including the loss of two Prevention Branch managers, the branch on which the KSTEP program is managed. New Prevention Branch manager, Jessica Brown, is now in place to supervise the KSTEP program administrative staff, as of March 2018. Ms. Brown is an asset in this position, as she has field experience with the other demonstration project, START. In October 2017 the program administrator, Susan Wilson, also left the program and the agency. Since that time previous KSTEP support staff and an interim program administrator have managed the program until a new program administrator can be seated in the position. Throughout staff changes Quality Assurance Branch manager, Tracy DeSimone, has managed the supervision of the program implementation. Ms. DeSimone has managed Kentucky's Title IV-E Waiver Program intermittently since January 2014, providing for a smooth transition and continuity during the staff changes discussed above.

The provision of evidence-based treatment approaches, including MI services, is a required activity of many grants in the state, as well as the most recent Opioid State Targeted Response (STR) Cures cooperative agreement between the Substance Abuse and Mental Health Services Administration (SAMHSA) and CHFS. The overall goal of the cooperative agreement is to create a self-sustaining infrastructure of MI trainers in the state while expanding access to persons trained and using MI with fidelity across the state.

It has been difficult to locate MAT providers who accept Medicaid. KSTEP has started a work group to develop a list of MAT providers based on criteria identified by START who communicate openly with DCBS and the judiciary, require drug testing and psychosocial treatment, receive and respond to concerns, and provide recovery support. MAT providers must also must bill Medicaid and other insurance and have a policy to educate parents about safe medication storage. Each KSTEP team in the four pilot counties have been very positive about the program. Thus far, 137 of 157 children involved in the program have remained at home with their parents.

Carter County

Carter County has referred 21 families to KSTEP. The site have been very positive about the program thus far. DCBS supervisors in this county report regularly, attend meetings with the family and the in-home provider, and describe communication between the in-home provider and substance use disorder treatment providers as excellent. Both supervisors recently participated in a meeting with the Carter County family court judge to provide an update on the pilot.

Greenup County

Greenup is the highest referring county with thirty families referred to KSTEP. One of the DCBS supervisors in this county has been a champion of both the SBC model and the KSTEP program. DCBS supervisors in this county report regularly, attend meetings with the family and the in-home provider, and describe communication between the in-home provider and substance use disorder treatment providers as excellent. A meeting with the Greenup family court judge has been scheduled to provide an update on the pilot. Both supervisors plan to be in attendance, as of all of the pilot county judges, the Greenup family court judge has been the most resistant toward KSTEP.

Mason County

Mason County has struggled the most in making KSTEP referrals. However, the site has now made fifteen referrals to date. DCBS supervisors in this county report regularly, attend meetings with the family and the in-home provider, and describe communication between the in-home provider and substance use disorder treatment providers as excellent. Both supervisors plan to participate in a meeting with the Mason County family court judge to provide an update on the pilot.

Rowan County

Rowan County is the most urban of the pilot counties and have made eighteen referrals to date. Rowan has had the largest number of referrals, with three cases, not meeting criteria for the program. This occurred early in implementation and is no longer an issue, as the investigative supervisor and staff are becoming more familiar with the program and the referral criteria. Rowan County struggled in January and February 2018 with referrals, with only one referral in those two months. However, overall investigations were low for the county during this time. One of the two Rowan county supervisors and the investigative supervisor attended an update meeting with their judges.

Recently concerns were brought forward during a direct line meeting, regarding a possible reduction in the amount of referrals to KSTEP. This would be a barrier to implementation if KSTEP eligible families are not being referred. Therefore, KSTEP leadership will begin to explore this concern and begin to look at this data as part of regular fidelity reporting. Previously, KSTEP central office staff developed a process to cross check eligible KSTEP cases against the master list of referrals to ensure that all eligible cases are being referred to the program. However, this cross-referencing was put on hold due to the previous program administrator leaving and no current case for concern. Implementing this process will be explored if there is any validity found with regard to referral reduction.

D. All demonstrations with a trauma focus (e.g., implementing trauma screening, assessment, or trauma-focused interventions) should report on each of the data elements listed below. For activities that are not being implemented as part of the demonstration, please indicate this with "N/A." If information is currently unknown, please indicate an approximate date that the data will be available.

- Target population(s) age range(s)
- Type of trauma screens used
- Number of children/youth screened for trauma
- Type of trauma/well-being assessments used[1]
- Number of children/youth assessed for well-being/trauma
- Type of trauma-focused evidence-based interventions (EBI's) used
- Number of children/youth receiving trauma-focused EBIs[2]
- Percentage of children and youth receiving trauma-informed EBIs who report positive functioning at follow up[3]
- Number of parents/caregivers:
  - Screened for trauma
  - Assessed tor trauma
  - Treated for trauma
- Number of clinicians trained in trauma-focused EBIs[4]

START is not a trauma-focused EBP. There are, however, elements of trauma informed care in the services provided to START participants. Seeking Safety and Helping Men Recover are the trauma-specific EBPs used by the behavioral health providers. In addition, individual therapy is provided for clients with trauma as needed.

KSTEP is also not a trauma-focused EBP; however, there are elements of trauma-informed care in the services provided to participants. Both of the in-home providers have been trained to provide Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). In-home providers will utilize trauma informed care with KSTEP recipients if clinically indicated or appropriately refer out to meet client needs. Additionally, as mentioned above the use of CARE skills by in-home

[1] Include any trauma and well-being assessments for which data is available.
[2] Include all children that have received any portion of the EBI(s).
[3] A jurisdiction may define "positive functioning" in any manner that is consistent with the definition used for the local evaluation of the waiver demonstration.
[4] This may include initial training and follow-up training.

providers includes a trauma education component to contextualize the use of these skills with the kinds of behaviors and problems exhibited by many traumatized children and their caregivers.

III. Evaluation Status

Provide a detailed overview of the status of the evaluation in the following areas:

Numbers of children and families assigned to the demonstration (including to any comparison/control groups if appropriate); note if current sample sizes differ significantly from original sample size estimates.

Major evaluation activities and events (e.g., primary and secondary data collection, data analysis, database development).

Challenges to the implementation of the evaluation and the steps taken to address them

A. Numbers of children and families assigned to the demonstration (including to any comparison/control groups if appropriate); note if current sample sizes differ significantly from original sample size estimates.

Sobriety Treatment and Recovery Teams (START)

Jefferson County

As of March 1, 2018, 373 families have been referred to the START program in Jefferson County. Of these, 125 did not meet criteria for the program and 8 were not accepted due to START caseloads being at capacity. Of the 240 eligible families, 168 were randomized to START and 72 were randomized to the services as usual control group.

Of the 168 families randomized to START, 144 have received START services. Twenty-four families who were randomized to START are not receiving services for several reasons, including that the families were subsequently determined to be ineligible; the family moved out of the service area; or the family failed to attend initial staffing meetings (family team meetings) despite staff attempts at engagement.

Of those randomized to START, 66 families have consented to primary data collection and completed baseline measures in Jefferson County. Of the 72 families randomized to services as usual (control group), 14 families have completed baseline data collection. The evaluation team has worked closely with DCBS leadership in Jefferson County to improve recruitment of control group families for primary data collection, however, obstacles remain. Nevertheless,

permanency and safety data will be collected for all families who have been randomized, including those who were unable to be located for primary data collection.

Fayette County

In Fayette County, 35 families have been referred to the START program. Of these, 26 have been selected to participate. Eight families were not selected due to full caseloads and one family did not meet eligibility criteria. Of those 26, 24 are currently receiving services and two cases have been closed. At this time, twelve families have completed baseline measures for the evaluation and twelve are being pursued for baseline measures. No families have completed twelve month follow up measures, although four are currently being pursued for follow-up.

Kenton County

In Kenton County, fifty families have been referred to the START program and 23 were selected to participate. Of the 27 not selected to participate, twelve did not meet eligibility criteria and fifteen were not selected due to full caseloads. Seven families have been referred to the START program evaluation since the evaluation period began and six of are receiving services. Of these six, one family has enrolled in the evaluation by completing baseline measures.

Boyd County

In Boyd County, seven cases have been referred to the START program since July 1, 2017 and six cases were accepted.

Conclusion

The outcomes evaluation team will continue to work closely with START and DCBS leadership to assist with the improvement of program and evaluation recruitment in all four counties. A discussion of these activities is outlined in Section III C.

KSTEP

As of March 7, 2018, 83 referrals have been made to the program and only three of these referrals did not meet criteria due to the age of the child or due to an existing ongoing case with the family. Four referrals were accepted and assessments completed, however, were then closed due to the families not meeting the intensity level that would necessitate the risk of removal of a child from the home. Ten cases have been closed due to non-compliance and in

one case, the family moved out of the service area. Six cases have been closed successfully, including successful completion of the program or the elimination of the need for a DCBS case. One hundred fifty-seven children have been involved in the program. Initial examination of referral and enrollment data demonstrates that a sufficient amount of referrals are being made in the pilot counties to reach the estimated numbers to be served by the intervention.

B. Major evaluation activities and events (e.g., primary and secondary data collection, data analysis, database development).

Process Evaluation

The goals for the process evaluations for START and KSTEP continue to remain the same with an emphasis on automating some fidelity reporting for field staff. Communication and collaboration data from the previous reporting period have been shared with all program and partner staff at various direct line meetings. Data from the surveys are helping to provide insight into factors that may enhance collaboration and communication (internal and external) for both initiatives. Client satisfaction with surveys continue to be distributed to all participants as they exit KSTEP or START. Currently very few have been returned to the evaluation team, although the results are promising. Once sufficient sample size is obtained results will be reported to program staff on a more regular basis.

Hiring and Staffing-START

START staff training attendance/completion continues to be tracked through the Training Record Information System (TRIS). START staff (DCBS and EKU) dates of hire and dates of training initiation/completion are being tracked and reported as process/fidelity measures. The following chart describes the various positions, employer, required education and experience and the number hired as of 2/28/18.

Position	**Employer**	**Education/Experience**	**# on staff Jefferson**	**# on staff Fayette**	**# on staff Kenton**	**# on staff Boyd**
START family mentor	EKU	High school/equivalent, 3 yrs. experience	8 of 8	3 of 4	4 of 8	2 of 4

START caseworker	DCBS	Four-year degree-See START minimum work guidelines	7 of 8	4 of 4	5 of 8	4 of 4
START family services office supervisor	DCBS	Four-year degree, 2 yrs. related experience, See START minimum work guidelines	2 of 2	1 of 1	1 of 2	1 of 1
START assistant director (CPS)	EKU	Master's degree, 5 yrs. experience in child in child protective services	1	1	1	1
START assistant director (Behavioral Health)	EKU	Master's degree, 5 yrs. experience in behavioral health project management, training, consultation, and planning	1	1	1	1
START director	EKU	Master's degree, 10 yrs. experience in child welfare	1	1	1	1

In an effort to streamline recruitment and selection efforts and increase retention of START program staff, START leadership in coordination with the EKU administration made changes to the START family mentor job description and position posting information. The original job description read more as an administrative position and did not completely convey the nature of the work. The new descriptions and posting information have been approved by EKU human resources and are being used for the advertising and selection of new START family mentors. Recruitment efforts for family mentor vacancies are continuing to be discussed in monthly meetings at each site with open positions.

Data Collection-START IN Database and KSTEP/In-Home Services Database

The evaluation team continues to work closely with the developers responsible for updating the START-IN and KSTEP databases. This has included several refinements to improve functionality for both the evaluation team and end users including frontline workers and evaluation staff.

A new web-based data collection system has been developed, tested, and launched to capture inputs serving as a management information system for KSTEP. Revisions continue as needed during program implementation based on provider, DCBS, and evaluation staff needs. This has resulted in some minor updates to layout and functions, including the ability to query information easily for use in the evaluation.

Meeting Attendance-START

Regular internal and external communication is foundational to the START program. Members of the evaluation team continue to participate in various START meetings. These meetings are regularly occurring and serve a purpose in supporting the START teams and families. Regular meeting attendance by members of the evaluation team provides an ongoing platform for reviewing START fidelity and other process evaluation data with team members, behavioral health providers, and program administrators.

Meeting	Frequency	Stakeholders Involved	Purpose/Topics/Agenda Items
START supervisor meetings	Monthly by phone, once a year in person	START supervisors, START assistant directors, START director	Updates on START team staffing, HR related issues, trainings, START-IN, case related documentation, tips with staff for working with families (safe sleep, supporting relatives, etc.). Supervision direction and support on managing, leading and growing the team.
Direct line meetings	Monthly	All direct line staff, supervisors and regional management, START directors	Discussions of service delivery, communication, data, reviews, clarification of roles/protocols, case consults, and model fidelity
Jefferson County START expansion/steering group meetings	Every two months	Jefferson Co. START supervisors, START directors, DCBS service region administrator, DCBS central office, DCBS	Updates on implementation of START expansion in Jefferson County, identification of barriers, proposed solutions, and action steps.

		service region staff, evaluation team	
Fayette County START steering group meetings	Monthly	Fayette Co. START supervisors, START directors, DCBS service region administrator, DCBS service region staff, DCBS central office, evaluation team	Updates and planning on implementation of START in Fayette County, identification of barriers, proposed solutions, and action steps.
Kenton County START expansion/steering group meetings	Every two months, minimum	Kenton Co. START supervisors, START directors, DCBS service region administrator, DCBS service region staff, DCBS central office, evaluation team	Initial discussion and planning for implementation of START expansion in Kenton County, identification of barriers, proposed solutions, and action steps.
Boyd County START steering/contract meetings	Quarterly	Boyd Co. START supervisor, START directors, DCBS service region administrator and staff, evaluation team	Update and planning on implementation of START in Boyd County, identification of barriers, proposed solutions, and action steps.
START provider meetings	1-2 meetings per year	Behavioral health providers, START assistant directors, START director, START supervisors, DCBS service region administrators, DCBS central office and the evaluation team.	Updates, review of evaluation data, barriers and solutions, and training on behavioral health topics.
START statewide meeting Retreats	Annually	All START staff	Updates, professional development for staff.

Outcome Evaluation

Below are some specific activities and updates related to each evaluation site, in addition to a broad discussion regarding recent evaluation work.

START

Jefferson County

The current evaluation for Jefferson County includes 168 families randomized to START and 72 families randomized to usual services. Permanency and safety data will be collected for all of these families. With regard to primary data collection, as noted in Section II A, in Jefferson County 66 START families and fourteen control group families have consented to primary data collection and completed baseline measures. As of March 1, 2018, 36 START families have entered the window for twelve month follow-up. Of these, twenty-two (61%) have completed twelve month follow-up. Among the control group, seven families have entered the window for twelve month follow-up and two (28.5%) have completed follow up measures.

Fayette County

Only START families are recruited for primary data collection at this site. START program expansion in Fayette County is making good progress and 26 families have been referred to the program as of March 1, 2018. Of those, 26 met criteria for the program and 24 are currently receiving services. Two cases have been closed. At this time, twelve families have completed baseline measures and twelve are being pursued for baseline measures. No families have completed twelve month follow up measures, although four are currently being pursued for follow-up.

Kenton County

Only START families are recruited for primary data collection at this site. In this reporting period, one family completed baseline measures for the evaluation.

Boyd County

The evaluation team plans to include all eligible Boyd County START families in the larger outcome evaluation that will use administrative data. Therefore, in the final evaluation, START participants in Boyd County will be included with other START sites and subsequently matched to a comparison group using propensity score matching. However, during this reporting period, the team requested that it not be required to collect primary data at baseline and twelve months later for START families in Boyd County. This request was based on the anticipated minimal benefit of expanding primary data collection given Boyd County's low enrollment.

Conclusion

Throughout this reporting period, the evaluation team made efforts to train all START program staff on data entry, including through in-person trainings with the Boyd County sites in December of 2017 and in Fayette County in February of 2018. As staff changes continue to be the norm across sites and refreshers are needed even for long time staff, this will be an ongoing role in future reporting periods. Additionally, the Jefferson County data collector has developed a one-page guideline for data entry and has disseminated this to all START sites. The data collector also coordinates monthly email reminders and refreshers for START-IN procedures to assist teams in keeping up to date with data entry. Finally, the data collector shares expertise in these systems through being available to START supervisors, workers, and mentors for individual assistance by phone, email, and in person as needed.

The evaluation team research manager continues to conduct two check-in calls every month with the data collectors in order to discuss challenges and successes with regards to data collection and the progress of the evaluation at each site. Additionally, the evaluator, research manager, and Jefferson County data collector meet weekly to discuss ongoing issues and generate plans for improvement across sites. This period, the evaluation team also held an in-person training day to support the professional development of data collectors and to develop improved systems for monitoring the data collection and data entry at each evaluation site.

In Jefferson County, the data collector meets with the START supervisor, workers, and mentors on a weekly basis to collect respondent contact information and coordinate in-person meetings with respondents to inform them of the study opportunity. Evaluation team members also attend monthly direct line meetings whenever possible and network with partnered agencies (treatment facilities, inpatient facilities, recovery centers) to assist with respondent contact. A meeting for the Jefferson County site's expansion is held bi-monthly with child welfare administration where assistance in locating control group respondents is provided to the evaluation team by the service region administrative associate. This meeting also serves as an opportunity for the evaluation team to share progress with START and DCBS leadership and to generate new solutions and strategies for overcoming ongoing barriers to recruitment among other challenges.

In both Fayette and Kenton County, data collectors and other evaluation team members attend monthly direct line or steering meetings by phone or in-person as available. These meetings also serve as important opportunities for data collectors to touch base with supervisors and team members regarding evaluation referrals and opportunities to connect with potential participants. Also during this period, evaluation team members were able to combine the delivery of a START-IN training to Boyd County START team with participation in their monthly direct line meeting alongside their community partners.

Finally, the evaluation team began the process of preparing data for the interim evaluation report, due in May 2018. This report will include initial findings of the RCT in Jefferson County. On March 5, the evaluation team sent a data request for all Jefferson County experimental and

control group families to the DCBS Quality Control Analyst, and it is expected the team will have data files for analysis by mid-April.

KSTEP

The KSTEP evaluation plan that was reviewed by ACF, JBA, and the evaluation team in March 2017 has been submitted and approved by the University of Kentucky Institutional Review Board and the Cabinet for Health and Family Services Institutional Review Board. In preparation for submission of the interim evaluation report mentioned above, a preliminary examination of secondary data will occur and any preliminary findings reported to program staff.

Cost Analysis

An initial report on waiver expenses was provided by the Division of Administration and Financial Management (DAFM) to the evaluation team in during the reporting period. Expenses including salaries/wages, overtime, fringe benefits, travel, operating expenses, vendors/contractors, and indirect operating were included in the report. The evaluation team continues to work with DAFM and other program partners to interpret reported and/or additional cost associated with the waiver interventions.

C. Challenges to the implementation of the evaluation and the steps taken to address them.

START

Recruitment of participants for primary data collection continues to be a challenge in Jefferson County, despite ongoing attempts to develop new and improved systems for generating and processing referrals. Despite this, the evaluation team will continue to attend local and statewide meetings and participate in regular phone calls where new solutions are created and monitored. Existing strategies that will continue in the next reporting period include:

- Meetings between the data collector and START supervisors.
- Conference calls between START leadership and the evaluation team.
- Visits to CPS investigative teams by START supervisors and/or the evaluation team
- Use of a formal referral form.
- Attempting to improve data collector connections with potential participants through accompanying START mentors on family visits and developing relationships with treatment sites.

While these strategies have been implemented in previous periods of the evaluation, the team will continue to be used due to high turnover in Jefferson County, particularly among investigative teams, which are crucial to recruiting control group families. In addition to these strategies, the evaluation team will be analyzing county level data in an attempt to discern which families the current referral system may have missed and to identify additional strategies to improve recruitment.

In Fayette County, significant progress has been made in this reporting period with regards to establishing and effectively implementing evaluation procedures. Many challenges experienced in the past were ameliorated once the START team had settled into their new location and communication systems were improved. A significant development at this site has been that the data collector for the evaluation now works closely with the service coordinator to process referrals. This system works for both the START team and the evaluation team and has been a successful transition in terms of the quantity and timeliness of referrals.

For much of this reporting period, Kenton County has not been accepting new cases due to START caseloads being at capacity. In addition to this lull in evaluation activity, the evaluation team is aware of no current challenges. Beyond the data entry training provided this period, Boyd County has presented to specific needs or requests from the evaluation team. All sites are challenged by the demands of data entry and the evaluation team will continue to provide guidance, support, and resources to facilitate each team meeting these expectations.

KSTEP

A primary challenge for the outcome evaluation for KSTEP is the delayed implementation of the intervention. Having only begun implementation July 1, 2017, there will be limited data to analyze for the upcoming interim evaluation report and those limitations will continue into the final analysis given current time restraints and smaller than desired sample size. The evaluation team has recently been able to uncover and work through several issues related to data quality that will be resolved prior to the final analysis as a result of interim report completion.

IV. Significant Evaluation Findings to Date

Summarize any significant process, outcome, or cost evaluation findings available to date. (NOTE: Evaluation findings may also be presented in a separate report or addendum to the semi-annual progress report prepared by the jurisdiction's evaluator).

START Fidelity Outcomes

The evaluation team regularly conducts a close review of initial fidelity indicators both statewide and for each START site. Indicators of START fidelity include referrals to start occurring within ten days of the initial CPS report, completing the first family team meeting within three business days of the referral, quick access to treatment, and intensity of treatment. These outcomes are examined annually, at minimum, and are often shared through both individual county level meetings and statewide meetings with START staff, leadership, and community providers. Fidelity outcomes were last assessed in September 2017. Although no fidelity outcomes were analyzed or disseminated during this reporting period, the evaluation team has plans to attend both a statewide provider meeting in May of 2018 and the annual statewide START retreat in August of 2018, where an updated fidelity report will be presented.

V. Recommendations and Activities Planned for Next Reporting Period

Describe major demonstration and evaluation activities that will be started, continued, or discontinued during the subsequent reporting period. Highlight any recommendations for changes to the design and implementation of the demonstration or evaluation based on challenges encountered during the current or prior reporting period, or based on evaluation findings to date (please see earlier caveat about securing prior approval from the Children's Bureau).

START

Implementation and expansion of a second START team will continue in Jefferson County with the following activities to occur during the next reporting period:

- Fill the eighth worker position and then remain fully staffed.
- START will continue to provide training to new staff members that have recently joined the team. Continue to fill START caseloads with START cases. This will also require close monitoring of any non-START cases remaining with the team as to make room for new START cases.
- MI practice sessions will continue to be held with the team as a follow up to the initial Motivational Interviewing training. Staff who have not yet had introduction to MI will be sent to regional trainings.
- The START supervisors and directors will receive advanced MI coaching on how to lead practice sessions with the START teams and will continue to help the team practice their use of these engagement skills.
- Following the statewide Judicial Symposium convening in Louisville, the START team will continue to meet and follow up with Jefferson County judges in order to build a positive relationship and work more collaboratively.
- Continued education for Jefferson START staff on MAT for opioid dependence. This adjunct to psychosocial treatment is misunderstood by many workers and will continue to be an area of focus during monthly meetings, case consults, and trainings. Ongoing training and coaching around MAT aims to educate them about the various medication

options, how they work, how to monitor their use, and how to work with the providers of MAT. Jefferson County has high rates of heroin and prescription drug abuse so this is a critical area of focus. The directors will continue to support the team in putting together a list of collaborative MAT providers.

- The START-IN database has been recently updated and moved to a new and improved format. Monitoring of the system and provide staff training and support on the new and improved system.
- Continued monthly case review sessions with START staff, providers, supervisors, and directors. A transition into a less frequent case review format will occur once the team is more established and ready to make this transition.
- Continued START direct line, steering, and advisory group meetings.
- Continue to work with regional leadership on improving referrals from investigative units by providing education, reminders, and support around referrals.

The planning and implementation of a new START team in Fayette County will continue with a goal of fully staffing the team and continuing to serve START families. Below are the activities for the next reporting period:

- Fully staff the START team-continue to interview until the last family mentor position is filled.
- Provide training to new staff members as the team builds to capacity (to include; MI; family mentor mini academy; START 101; cross training- introduction to CPS and introduction to substance use disorders, addiction and recovery; START overview for bluegrass staff; START IN; NCFAS and others as needed.
- New START staff (service coordinator, supervisor, workers, mentors) to shadow DCBS staff in Fayette. Peer to peer cross-site visits will also be set up for new Fayette START staff to visit existing START sites to observe START in full operation.
- Clarification about the START facilitator position, its role, and responsibilities. The person who had been filling this role was promoted to another position in the agency. The steering group will continue to discuss this matter and explore options to hire this position through a contracted agency.
- Continue to invite the Fayette DCBS service region administrative associates (for the investigative teams) to join the START steering team meetings. This is a good forum to continue to discuss how to help effect practice change with regard to in-home service plans, safety planning with families who have substance use disorders, and to continue to support the development of START and the overall practice change anticipated in Fayette.
- Continued contact with the local judges to discuss START model and overall practice with regard to families with substance use disorders. START directors will provide training for family court judge and attorneys at their upcoming conference.
- The evaluation team will continue to be part of the steering group and will begin involvement in direct line meetings to discuss evaluation with the team.

- Continue to serve families and build START caseloads. Due to vacancies on the team and training needed for new staff, capacity issues to accept new START cases have been an issue.
- Continue to develop and monitor the plan to build START caseloads and transition non-START cases from the team as START caseloads grow.
- Continue conducting direct line meetings with the START team and build the participant group to include other service providers to promote community collaboration and increase service array, as the team becomes more established.
- Continue monthly case reviews.

Implementation and expansion of a second START team will move forward in Kenton County with the following activities to occur during the next reporting period:

- Continued planning and expansion meetings with the Kenton steering group, held monthly with regional leadership, START directors, and local CMHC.
- Recruitment of staff for supervisor, facilitator, workers, and family mentors for the new team.
- Continue to work with NorthKey/local CMHC to expand behavioral health staffing as START caseloads increase. Continue recruitment efforts for family mentor positions and continue with the hiring process as new applicants become available.
- Set up training, shadowing, and peer to peer site visits at other START sites for new START staff to include supervisor, workers, family mentors, and any new behavioral health staff.
- Begin to review and further refine any needed protocols for referral, case acceptance, and service delivery.
- Continue to discuss and plan for FTM facilitator for START. Work with contracted agency to coordinate hiring, supervision and roles for this position.
- Continue regular MI practice sessions with the START team.

START services in Boyd County will continue with the following activities to occur during the next reporting period:

- Fully staff the START team. Two more family mentor vacancies need to be filled.
- Provide training to the new supervisor, worker, and mentors on the new START-IN system.
- Continue to arrange peer support and guidance to family mentors from family mentors at other START sites.
- Training for the team and direct line participants on MAT. Opiates are a primary drug of abuse in Boyd County.
- Continue direct line and steering meetings, case review at direct line, and MI practice with the team every four-six weeks.
- Continue to develop a list of collaborative MAT providers, including discussions about how to improve communication.

Process Evaluation

Process evaluation activities will include further refinement of fidelity reporting and data cleaning from START-IN. Client satisfaction data will be examined and reported to program staff during the next reporting period.

Outcomes Evaluation

With an evaluation interim report expected in May of 2018, the evaluation team plans to work toward analyzing initial outcomes for Jefferson County and disseminating preliminary results in the next period. Additionally, updated fidelity outcomes will be shared with START providers at a statewide meeting in May, and again with START teams and leadership at a statewide program retreat in August of 2018. These reports will include updates to fidelity monitoring provided in past presentations, as well as any new outcomes that have been generated as a result of the interim evaluation report or other analyses conducted up to that time. In addition to sharing outcomes, the evaluation team takes the opportunity to listen to feedback from stakeholders regarding the evaluation process and to generate new ideas or strategies for improving how the evaluation is conducted.

Cost Analysis

START cost analysis data will continue to be tracked and reported. The evaluation team continues to work with DAFM. Average cost per case will be calculated where possible. Expenses for these staff will need to be appropriated accordingly to determine actual waiver-related costs.

KSTEP

KSTEP will continue implementation and program support in the four pilot counties. The KSTEP workgroup and waiver steering committee will continue to explore expansion into the remaining eleven counties in this region. This will be accomplished by analyzing evaluation data and ongoing feedback from DCBS and KSTEP service providers.

- In-home providers will continue to build their caseloads and will hire additional staff to provide coverage as caseloads rise.
- Continue providing consultation and technical assistance to counties participating in KSTEP to address obstacles and difficulties encountered in practice. Make adaptions to service framework and program when needed.
- Advance and support relationships and collaboration between DCBS and in-home providers by seeking ongoing feedback and making regular site visits to meet with all service providers in KSTEP counties to encourage engagement, collaboration, and further implementation.

- Continue to provide training to KSTEP staff on MAT for opioid dependence. Further knowledge and practice in area of opioid dependence by supporting MAT. MAT workgroup to grow a list of collaborative MAT providers.
- Finalize the four program phases and criteria for moving through the phases. Continue the phases workgroup to complete this, present final product to the KSTEP workgroup and then to the steering committee for approval. Update framework with changes.
- Plan to provide additional SBC introductory trainings to expansion counties with goal of building training capacity by utilizing in-home provider staff currently undergoing SBC certification process to co-train with Dr. Christensen. This will occur during expansion and the last step will be training on their own. Dr. Christensen has suggested this as the process to build training capacity. Once he determines that an individual provider can train on their own, the provider will be able to train other in-home providers as the program expands.
- KSTEP will continue to train pilot staff in MI to include DCBS leadership, supervisors, SSWs, case managers, contracted private agency staff, community mental health professionals, specialists, trainers, facilitators, and program assistants. The desired outcome is to ensure that DCBS and behavioral health providers are using a shared approach with families. Providing MI skills supports staffs' ability to ready families for treatment, enhances providers' ability to engage the family in treatment and increases the likelihood that the treatment will be meaningful and effective with the family. Through training, staff will gain the skills and resources necessary to effectively implement and improve MI.
- Develop requests for proposals to contract with additional service providers as the program expands.
- Continue monthly workgroup, steering, and direct line meetings.
- Continue to build online KSTEP training for DCBS staff to introduce program and to educate staff on the model and referral process.
- Develop expansion plan and invite leadership from identified expansion counties to KSTEP meetings.
- During expansion, facilitate staff training through peer-to-peer site visits between new staff and staff from pilot sites experienced with the program.
- Hire a new KSTEP program administrator, along with additional KSTEP central office staff to assist with KSTEP duties and expansion.
- Continue contacts with judiciary in pilot region to build these relationships and to address program strengths and barriers.
- Continue to invite evaluation team to direct line and monthly workgroup to address evaluation plan and data collection needs.
- Submit semi-annual reports twice a year with next report due in October 2018.

Process Evaluation

Process evaluation activities for KSTEP will continue to focus on implementation efforts and the refinement and assessment of key fidelity indicators. Client satisfaction survey data will be examined and reported during the next reporting period.

Outcomes Evaluation

Matching criteria for PSM will continue to be refined as more data are collected from KSTEP participants. A preliminary examination of other outcome variables will occur in preparation for the interim evaluation report and shared with program and partner staff during their direct line and committee meetings.

Cost Analysis

KSTEP service data will be provided by each in-home provider agency and CMHC for KSTEP families/clients served. Expenses will be determined using client event data per worker and verified by invoices for contracted services. Other expenses will continue to be tracked and reported by DAFM and included in the interim and final evaluation reports where possible.

VI. Program Improvement Policies

Provide a brief description of the two child welfare program improvement policies (one new, one existing) that were noted in the waiver Terms and Conditions (see Section 2.3). The new policy must be implemented within three years of the waiver demonstration application. Include any relevant information that illustrates that the agency has implemented the new policy within this time frame (e.g., copy of agency policy, program instruction, Legislative Bill or Amendment etc.).

As reported in Kentucky's waiver application, the agency will be implementing the following Child Welfare Program Improvement Policies, as identified in section 1130(a)(3)(C) of the Social Security Act.

The new policy that DCBS will implement is as follows:

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

DCBS has identified three primary initiatives that will have a positive impact on the use of congregate care placements and ensure that are only utilized when appropriate.

1. **Medicaid expansion** across Kentucky will directly contribute to an increase the community capacity to provide evidence based practices that address child and

adolescent internalizing and externalizing symptoms that can contribute to safety concerns and lead to congregate care placements. Additionally, Medicaid expansion has made it possible for thousands of parents to access behavioral health services to address their own needs and enhance their capacity to provide a safe and stable home for their children.

2. DCBS continues the process of revising agreements with private child placing (PCP) and private child caring (PCC) agencies to include **performance based contracting** that aligns with child permanency and well-being outcomes established in the Child and Family Service Reviews (CFSR). As agencies are held accountable for not only providing a safe placement for children in congregate care, but ultimately for stepping them down to a lower level of care, the reliance on these higher levels of residential care will decrease in both frequency and duration.
3. Project SAFESPACE (Screening & Assessment for Enhanced Service Provision to All Children Everyday) is a federally funded initiative targeted at enhancing behavioral health services for children in out-of-home care. Through standardize screening, Project SAFESPACE provides a mechanism for child welfare workers to proactively identify child trauma and behaviors. Upon identification of behavioral health needs, the provider completed standardized assessment allows for treatment planning, progress monitoring, and aggregate data collection to support reconfiguration of the service array. Assessment results and therapeutic recommendations feed directly back to Kentucky's SACWIS creating enhanced communication and greater efficiency. Project SAFESPACE is designed to increase placement stability, support appropriate levels of care, and move children to permanency more quickly. Project SAFESPACE has implemented in all service regions throughout the state. The Project SAFESPACE grant ends at the close of FFY 2018.

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

1. Establishment of specific programs to prevent foster care entry or provide permanency: The establishment of one or more of the following programs that are designed to prevent infants, children, and youth from entering foster care or to provide permanency for infants, children and youth in foster care:
    a. A comprehensive family-based substance abuse treatment program.

Attachment 1. KSTEP Program Referral Information

Kentucky Strengthening Ties and Empowering Parents (KSTEP)
Program Referral Information

Why is KSTEP the program for me?

- A report has been made and there is evidence to support that substance use issues present a high risk of harm to my child(ren) and there is a chance they may be removed from my home.
- This program is my opportunity to receive treatment and assistance in keeping my children safe and in my home.

What can I expect from being in KSTEP?

- The first 1-2 weeks of the program, you and your family will go through several assessments and meetings so that the KSTEP provider can ensure you have all the appropriate services to keep your child(ren) safe in your home. This will be a very busy time.
- If you need help with transportation for appointments, your KSTEP provider will help arrange transportation.
- You will have random drug screens to determine if you are substance-free. If you need help paying for these screens, your KSTEP provider will assist you with this. At first, you will be drug screened weekly but as you progress in treatment, the fewer screens you will have.
- Based on your individual needs, you may be referred to an outside treatment provider for treatment. This may include detox, IOP (intensive outpatient), inpatient, residential or MAT (medication assisted treatment).
- KSTEP recognizes MAT as an evidence based approach with the greatest long-term success for opioid dependent patients. Individuals participating in MAT have to agree to sign a release of information to allow KSTEP access to all of their MAT provider records in order to assess progress and compliance. You will be encouraged to use an MAT provider on our collaborative list and cannot use a physician with current disciplinary orders against them. Additionally, you will have to participate in clinical/counseling services as a part of MAT.
- You will have to submit to routine prescription counts and provide verification of prescription if prescribed medication of any type.
- Your KSTEP provider will work with you on your goals that will include keeping your child(ren) safely in your home. The KSTEP provider will do all they can to find treatment providers and schedules that meet your needs. They will also help you overcome barriers that have prevented past success.
- KSTEP providers will use a strength and solution based approach. This means knowing what is working or has worked for you and what your strengths are so we can build on to them. You can also expect lots of celebration when things go right!

What are my expectations in KSTEP?

- You will be expected to participate fully in the program which includes:
    - Being available for all appointments, both in home and in the community,
    - Having a consistent way to be contacted and answer or return calls promptly,
    - Signing releases for all providers involved to share information,
    - Following all safety plans that are put into place including supervision and safe sleeping,
    - Going for random drug screens and providing adequate test samples when called, and
    - Following through with all recommendations made for you and your family.
- Most importantly, in order for this program to work, you will need to be open in your communication with your providers and work on the new plans and skills that you learn to keep you and your family safe. The providers cannot truly help you if they are not aware of all of the issues and problems you need help with. **By signing below, I acknowledge that my DCBS worker has reviewed this form with me and I understand the program expectations.**

_____	_____
Participant Signature	Date
_____	_____
Participant Signature	Date
_____	_____
DCBS Worker Signature	Date

Attachment 2. KSTEP Referral and Service Framework

Kentucky Strengthening Ties and Empowering Parents (KSTEP)

Referral and Service Framework

KSTEP is an in-home service offered to families with an open protection and permanency (P&P) investigation, with children at moderate to imminent risk of entering out-of-home care (OOHC), based on the DCBS assessment and documentation tool (ADT). KSTEP is for families experiencing substance abuse risk factors known to be precursors to child abuse and neglect. In order to be eligible for KSTEP families must also have at least one child, under age ten (10), residing in the home. Additionally, the family must reside in a county designated as a demonstration site and agree to participate in the program. KSTEP services will be delivered by private agency contractors that will utilize evidenced based and promising research practices according to the California Evidenced Based Clearinghouse (CEBC).

KSTEP will focus on expanding programs offered by existing service providers already operating in communities across Kentucky, particularly in those counties/regions identified to have the greatest need of services. KSTEP will also fill a gap in prevention and preservation services to meet the needs of families requiring longer-term (up to eight months), and more risk-specific interventions. Through participation in KSTEP, families will demonstrate increased capacity to safely care for their children, experience improved social and emotional wellbeing, and will be less likely to experience subsequent maltreatment or OOHC episodes.

DCBS investigative social worker can make a referral to KSTEP at any time during investigative process.

KSTEP Eligibility Requirements:

1. Child(ren) at moderate to imminent risk of removal from the home.
2. At least one household child is under age ten (10).
3. Parental substance abuse is a primary feature affecting child safety.
4. The family did not have an ongoing DCBS case at the time the investigation was received.
5. The investigation will result in the case being opened for ongoing services.
6. The family is preferred to be a Medicaid recipient or to carry private insurance accepted by the provider agencies (all other situations accepted on a case by case basis).

DCBS assessment and referral to KSTEP	The DCBS investigative social services worker (SSW), in consultation with their supervisor, identifies a KSTEP eligible family (the referral may take place any time during the investigation). Referrals to KSTEP outside of the DCBS investigative process will not be accepted, i.e., no referrals will be accepted after DCBS has completed their investigation. **All KSTEP referrals must include case transfer to ongoing services**. **Best practice is to make the referral from the family home.** The SSW will discuss making a referral to KSTEP with the family and obtain signed releases (forms 1A & 1B). The SSW will contact the KSTEP in-home provider agency to make the referral. The DCBS SSW completes their investigation and paperwork, addressing safety issues in the prevention plan or case plan for safety during the investigation, including information on court involvement and KSTEP consultation and support.
DCBS must flag all KSTEP cases in TWIST	There is a checkbox/flag in TWIST on the case management screen that indicates that the case is KSTEP. This box must be checked for outcome measurement purposes and to ensure that all KSTEP cases are flagged appropriately. The flag is not unchecked once the family completes services or is no longer involved in the program.
Referral paperwork to/from KSTEP in-home Provider Agency	The SSW will provide the KSTEP in-home provider agency with information that outlines the reason for referral and basic demographics or contact information from the DCBS Case Summary Referral Form. Additional details about the referral can be provided by phone or email. **CARTER & GREENUP Counties** **Ramey or Re-Group-** Eva Staggs (Intake Coordinator) during business hours 8am-5pm: 606-547-4386 On-call after 5 and on weekends: 606-547-6879 Email: regroup@rameyestep.com **MASON & ROWAN Counties** **KVC-** Phone: 859–254–1035 On call number for after hours and weekend referrals: 606-755-0161 Email: gatewayreferrals@kvc.org Jessica Bayless (Director) Email:jbayless@kvc.org Phone: 606-371-4002 The KSTEP in-home provider agency will take the information and complete a referral form for the SSW and will email or scan it back to

	them within 24 hours of accepting the referral. The KSTEP in-home provider agencies are contractually obligated to accept all referrals; however, if the KSTEP in-home provider agency declines the referral they must provide a written explanation documenting this to the referring SSW and to the KSTEP program administrator. The SSW will forward to the KSTEP in-home provider agency the documents bulleted below within three (3) days of the provider referral (all documents will be sent electronically, if feasible): • Information about allegations of substance use and/or family violence to include prior criminal charges and their disposition. This should include any charges that may indicate risk of safety to the family or to the KSTEP in-home provider agency. The SSW will notify the KSTEP in-home provider agency of immediate threats to child safety and any known threats to SSW/KSTEP in-home provider safety. • Prior substantiated allegations including but not limited to physical abuse to child by parent, domestic or family violence, and neglect where substance use/abuse or family violence was a contributing risk factor. • Copy of P&P prevention plan, case plan and/or court orders • A copy of the Case Summary Face Sheet, with correct and updated case member demographic and relationship information. • Release of Information forms 1A & 1B signed by the family. The KSTEP in-home provider agency should accept the referral verbally or in writing upon receipt of the phone call by the SSW when the referral is made. KSTEP in-home providers should not wait 3 days for the paper copies of the above information to be sent to them before acceptance of the referral. The above information should be provided verbally or in writing via email when SSW makes the referral. The KSTEP in-home provider agency can decline the referral if they discover an unidentified or undocumented safety concern that would be likely to place their staff in physical danger during their initial face-to-face meeting with the family or during their assessment of the family.
Family notification and engagement	SSW discusses the referral to KSTEP and provides: • A description of KSTEP in-home services and supports that will be provided. • The name of the KSTEP in-home provider agency • Review and discuss the Program Referral Information form and have the family sign the form, acknowledging their SSW has reviewed the form with them and their understanding of the expectations of the program. • An explanation of how participation will benefit the family and potential consequences of nonparticipation, i.e., participation is necessary to reduce risk and ensure child safety. Substance use

	treatment services will be expedited and they will have a substance use treatment coordinator who will work with the KSTEP in-home provider. Drug testing will be paid for by the program. Financial assistance is available to prevent removal. Successful participation and progress will likely result in closure of the P&P case (after risk is reduced) and may avert the need to file a court petition, or avoid further court interventions, such removal of child(ren) and placement in out-of-home care (foster care). Families should be informed that participation in KSTEP services has the potential to greatly benefit the family and may reduce the likelihood of future contact with P&P.
KSTEP in-home provider meets parent w/in 24 hours of receipt of referral	KSTEP in-home provider screens parent(s) or caretakers residing in the home using ASAM criteria. Refers immediately to CMHC (Pathways or Comprehend) or other appropriate treatment provider for treatment, if screening and/or referral information warrants. KSTEP in-home provider will explain services to the family, schedule time(s) to assess the family, make other referrals to appropriate treatment providers, arrange drug testing, have the family sign release forms and review DCBS prevention/safety plan, case plan, and/or court orders with the family. KSTEP in-home provider then follows-up with DCBS on the first contact with the family and status.
Community Mental Health Center (CMHC) Pathways-Greenup, Carter & Rowan Comprehend-Mason	CMHC assesses parent(s), child, and caretakers within 48 hours of referral by KSTEP in-home provider. KSTEP in-home provider transports parents/caretaker to assessment. CMHC ensures that initial treatment recommendations are shared verbally or in writing with DCBS & the KSTEP in-home provider agency, within (24) hours of the assessment. CMHC ensures that the first treatment appointment will occur within (48) hours of the verbal treatment recommendations that are shared with DCBS & KSTEP in-home provider agency and ensures that KSTEP clients will be given top priority in Pathways and Comprehend's Utilization Management process. CMHCs will use the KSTEP Services Approval Protocol when clients without Medicaid need services or when their MCO will not authorize or recertify.

KSTEP initial family team meeting (FTM)	Within six (6) working days, but no later than fourteen (14) days of KSTEP referral and acceptance, KSTEP in-home provider will convene a family team meeting (FTM). KSTEP in-home provider will coordinate a date, time, and place for the meeting by obtaining a few possible days/times from family, DCBS, and CMHC (Pathways and Comprehend) and will schedule the meeting with all. DCBS and the substance use treatment provider are to attend the initial and subsequent FTMs. If the referring SSW or CMHC substance use treatment coordinator cannot be at this meeting, they are to find someone else from their agency, such as supervisor or coworker, to represent them in the meeting. KSTEP in-home providers ensure that FTMs are held, at a minimum, every thirty (30) working days thereafter.
Substance disorder assessment/referrals to treatment, case management, transportation	**Early engagement in treatment is crucial to success of KSTEP.** KSTEP in-home providers will be hands on and will provide a warm hand-off to any outside referrals, such as substance use disorder treatment, mental health, or intimate partner violence treatment services. This means the KSTEP in-home provider will take clients to assessments or accompany them. They will also attend any scheduled meetings with treatment providers and maintain regular contact with other providers involved in the case. KSTEP in-home providers will ensure that transportation is not a barrier to services by providing transportation or arranging it for the parent if there is none available. This will be particularly true for initial and follow-up appointments. However, they will not be expected to provide daily transportation to treatment until the case closes. They should work with the family on individual and family level plans to ensure that transportation to appointments occurs.
Medically Assisted Treatment	Medication Assisted Treatment (MAT)-A variety of medications are used to complement substance use treatment for different types of substance use disorders including tobacco, alcohol, and opioids. MAT increases retention in treatment, decreases illicit opioid use, decreases criminal activities, decreases drug-related HIV and Hepatitis-C, decreases pregnancy related complications, and reduces maternal cravings and fetal exposure to illicit drugs. MAT is designed to stabilize patients and may include provision of medications such as methadone or buprenorphine in conjunction with supportive services such as medical, nursing, psychiatric, counseling, vocational services, peer services, and case management. It is an evidenced based approach with the greatest likelihood of long-term success for opioid addicted patients. **When using a MAT facility, it must be ensured the MAT facility is willing to honor releases of information and collaborate with DCBS and KSTEP in-home providers.** MAT facilities or doctors must not have current disciplinary orders against them. KYs buprenorphine regulations require regular drug screens, pill counts, and other measures to prevent medication abuse, but contain loopholes doctors can exploit. Patients must participate in "behavioral modification" such as counseling or 12-step

	programs, ~~but~~ however~~,~~ the rules ~~don't~~ do not say how often, so it can vary from several times a week to less than once a month. In addition, if patients fail drug screens, it is up to doctors to use "appropriate clinical reasoning" to support changes in treatment such as increased screening or more frequent visits.
KSTEP case plan, family agreement and action plan	The KSTEP in-home provider will utilize Solution Based Casework (SBC) tenets to develop the family agreement (family case plan) within six (6) working days of referral. It will align with the DCBS identified safety concerns and the prevention/safety plan, be solution focused, strengths based, and developed collaboratively with the family. The family agreement will be developed to focus on the overarching goals of the case and will include family and Individual level objectives. Family objectives will be specific to the childcare tasks that are at risk (e.g. supervision, environmental dangers, nutrition, medical care etc.). The individual objectives will be specific to the caretaker patterns of personal behavior that is threatening the ability of the caretakers to ensure the safety and well-being of their children (e.g. criminal behavior, anger management, substance abuse, emotional stability, and sexual behavior). The KSTEP in-home provider completes the family agreement and provides a copy is to the SSW. The SSW ~~who~~ should incorporate the objectives of the KSTEP in-home provider case plan into the DCBS case plan. If there is a concern regarding the appropriateness of the objectives, the SSW should immediately contact the KSTEP in-home provider to share their concerns so both parties can work together to reach a consensus or seek assistance from their respective administrative leadership. Once the family agreement is completed, the KSTEP in-home provider will immediately begin to work with the family on developing an action plan for each identified objective listed in the family agreement. The action plan will also include ways for the KSTEP in-home provider and the family to assess and measure progress in ensuring safety session by session. Specific strategies should be included for documenting and celebrating what the parent is learning in treatment and how they are applying it and practicing it through the week. Tasks on the action plan will change almost every session, as they are small steps that will need to be adjusted and improved as the family is learning how to change their behavior. The action plan will include the step-by-step actions for all involved parties to take to reach their goals within a specified time, as well as relevant goal tracking criteria. Challenges and barriers to change are to be expected, however, the KSTEP in-home provider and the SSW will always be tracking the basic safety of the home and be assessing for dynamic changes in the family that threaten the safety of the children.
KSTEP and DCBS communication and information sharing	Open Cases- As long as the KSTEP case remains open, the SSW will maintain communication with the KSTEP in-home provider agency, share pertinent information, and participate in meetings including a monthly joint meeting (FTM) or phone conferences to receive updated reports and information.

	When a DCBS case is transferred from investigation to ongoing, either the investigative or the ongoing SSW will notify the KSTEP in-home provider agency. If possible, both SSWs will participate in the first FTM after an ongoing SSW is assigned. The KSTEP in-home provider agency will schedule subsequent FTMs a minimum of every thirty (30) days following the initial FTM and will provide the SSW, substance use treatment provider, and other involved services providers no less than seven (7) days' notice to attend each FTM held on an open case. When not feasible to provide 7 days-notice, the KSTEP in-home provider agency will notify the SSW and treatment provider as soon as possible. The SSW will notify the KSTEP in-home provider as soon as possible if a court petition is filed involving a family receiving KSTEP services. The KSTEP in-home provider and substance treatment KSTEP coordinator will make court appearances as requested. Closed Cases- Consistent with DCBS policy, after risk is reduced, DCBS may decide to close the DCBS case. When this occurs, they will notify the KSTEP in-home provider who will also close the KSTEP case at that time.
KSTEP Services Phase 1: Engagement & service planning by KSTEP in-home provider	Two (2) face to face contacts with the family are required every seven (7) days. Face to face contacts should include approximately 5-10 hours a week with the family. Amount of hours spent face to face with the parent(s)/child(ren) is to be clearly documented in weekly progress reports provided to DCBS. 50% of the weekly contacts will occur in the home. Any missed contacts by the family through cancellations or failure to meet will be documented in the weekly report to DCBS. Phase 1 should last approximately one (1) month. Random drug testing to occur once (1x) per week during Phase 1. Verify safety of each child at every contact-if there are any new safety issues identified that DCBS is not aware of, the KSTEP in-home provider will immediately notify SSW and/or their supervisor via phone call and through a follow up email to ensure documentation of these concerns. Case planning will occur during this phase and will include both formal and informal services. There are non-negotiables in the case plan: federal and state laws, agency policies, and court orders. The case plan must be in written form signed by the parents, DCBS, KSTEP in-home provider, and the child and family team members involved. The KSTEP in-home provider will provide a copy of the plan to the parents, members of the child and family team, and DCBS.

	The American Society of Addiction Medicine (ASAM) screener will be administered within 24 hours (first contact with parent). A child safety screening, Parenting Stress Index (PSI), Addiction Severity Index (ASI), North Carolina Family Assessment Scale (NCFAS), and biopsychosocial will be administered to the parent(s) within fourteen (14) days of receipt of referral. Based upon the completed assessments and in consultation with parents, referrals are provided to appropriate KSTEP and/or community interventions at this appointment. The NCFAS will be repeated with the family at 3-month intervals and at referral closure. The PSI & ASI will be repeated with the family at 4 months and at referral closure. The biopsychosocial should include targeted assessments for substance use disorders, mental health, family violence, etc. Co-occurring conditions will be addressed through counseling and behavioral therapies (in combination with medications, if necessary). These referrals will be made by providers if identified in their assessment if DCBS has not already made a referral. The KSTEP in-home provider maintains regular collateral contacts with the family's substance use disorder treatment providers, other clinical providers, community partners, and informal family supports. These contacts are to be documented in the weekly progress report provided to DCBS. Regular/consistent contact is also maintained with the SSW.
KSTEP Services Phase 2: Accessing services, achieving abstinence, meeting parental responsibilities	Two (2) face to face contacts with the family are required every 7 days. Face to face contacts with the family are estimated to be 5-10 hours during this phase. Amount of hours spent face to face with parent(s)/child(ren) is to be clearly documented in weekly progress report provided to DCBS. Phase 2 should last no less than 90 days. Random drug testing should occur weekly. Verify the safety of each child at every contact. KSTEP in-home providers will immediately notify SSW and/or their supervisor via phone call of any safety issues that arise, and follow up with an email to ensure documentation of these concerns. Frequent and regular collateral contacts are expected with substance treatment providers, other clinical providers, community partners, and informal family supports. These contacts are to be documented in weekly progress report provided to DCBS. Regular/consistent communication is required with the SSW.

KSTEP Services Phase 3: Recovery & other life skills, education/employment, increased responsibility for children	The KSTEP in-home provider will continue to provide support. Phase 3 should last approximately 1-2 months. Random drug testing should occur no less than twice (2x) per month Weekly face to face contact with the family is required. Face to face contacts: 2-10 hours a month during this phase. Collateral contacts as needed documented in weekly progress report provided to DCBS.
KSTEP Services Phase 4	The KSTEP in-home provider will continue to provide support, but reduce engagement. Phase 4 should last approximately 1-2 months. Random drug testing should occur no less than once (1x) per month. Monthly face to face contact with the family is required. Face to face contacts: 1-8 hours a month during this phase. Collateral contacts as needed documented in weekly progress report provided to DCBS.
KSTEP Services Phase Movement	Phase movement will be determined by the progress the family has made in lowering their risk level through collaboration and consensus of the entire KSTEP team. This includes DCBS, KSTEP in-home provider, and substance treatment provider. Termination of services is determined by the family's progress on goals identified in the family agreement and action plans, administration of the NCFAS, ASI, and PSI to determine progress in critical domains, and a family team meeting where an aftercare plan will be developed. This decision should also be through collaboration of entire KSTEP team. A family can return to a previous phase if there is a relapse, new safety threat, new instance of maltreatment, etc. Phase movement will be decided collaboratively between the family, DCBS, and the KSTEP in-home provider.
Payment to assist KSTEP families with immediate needs and short-term stressors	$500 in waiver funds, per family, per DCBS referral, may be used for payment of goods/services to keep children from entering out of home care, i.e., household needs, transportation, etc. Transportation should not be a barrier for KSTEP families to access services/treatment. Funds should also be accessed for other things that would prevent OOHC placement. **These funds cannot be used to pay for drug screens.** Whenever a KSTEP in-home provider utilizes funds for a family this should be documented in the weekly progress reports to DCBS.

In-home KSTEP Service Coordinators will not carry more than nine (9) cases.	Carrying more than 9 cases could result in barriers to engagement with KSTEP families. This would be particularly true if there are cases containing children in multiple households, causing the KSTEP in-home provider to visit several homes to satisfy the visitation requirement for a single case.
KSTEP contact standards for OOHC/relative placement	The KSTEP in-home provider will have a minimum of two (2) weekly face to face contacts with parent(s), 50% of the weekly contacts will occur in the home with the parent. The KSTEP in-home provider will have a minimum of one (1) weekly face to face contact with children. The amount of time spent face to face with children is to be documented in the weekly progress report provided to DCBS. The KSTEP in-home provider can supervise and facilitate parental visitation.
KSTEP contact standards for residential substance abuse treatment	The KSTEP in-home provider is to have weekly telephone contact with client, treatment provider, and/or KSTEP CMHC coordinator when one or both parents are in residential treatment to address substance use disorders.
Substance use relapse	Whenever a KSTEP parent or child caretaker tests positive or admits to substance relapse, the CMHC substance use treatment provider (Pathways or Comprehend) will immediately notify the KSTEP in-home provider and SSW. • KSTEP in-home provider will visit the parent in the home on date notified of positive screen or admission of alcohol or other drug use. • An FTM should be scheduled without delay by the KSTEP in-home provider whenever a substance use relapse occurs. • After a relapse, the KSTEP in-home provider will re-establish weekly contact, if the frequency had been reduced to bi-weekly.
Special standards for contact	Contact standards may change when a parent/caretaker is: • Graduated and not re-entering treatment • In out of region treatment • Trial home visit-return to weekly contact • Re-engagement in treatment
Problem resolution	When a SSW identifies a problem with decision-making or actions taken by the contracted KSTEP in-home provider agency or substance use treatment provider, the following steps may be taken towards resolution. • DCBS will meet with the substance use treatment provider, KSTEP in-home provider and/or provider supervisor, program manager or agency administration; and • DCBS will inform KSTEP Program Administrator of the issue.
KSTEP monthly family team meetings	After the first FTM, additional FTMs should be held, at a minimum, each calendar month.

	Any other providers serving the family or individuals that the family identifies as support systems, will also be invited to join FTMs by the KSTEP in-home provider. The substance use treatment provider coordinator is also required to attend the FTM. The family agreement completed by the KSTEP in-home provider & the family will serve as the first FTM form. The second FTM should also serve as case planning meeting for DCBS. Additional FTMs are to be held as needed for crises such as relapse, changes in treatment, ~~and~~ placement moves, and within thirty (30) days of referral closure. DCBS is not precluded from holding additional FTMs; however, if DCBS does convene an FTM, the KSTEP in-home provider and substance use treatment providers should be invited.
Drug testing	Phase I-Weekly random drug testing Phase II-Weekly random drug testing Phase III-Twice monthly drug testing Phase IV-Monthly random drug testing In the event of relapse, drug testing will return to weekly unless otherwise determined by KSTEP in-home provider & DCBS in conjunction with substance use treatment providers. Drug testing can be requested more frequently at the discretion of the KSTEP in-home provider, DCBS, and substance treatment providers. This should occur through collaboration and consultation between all service providers and DCBS.
American Society of Addiction Medicine (ASAM) screener and criteria	KSTEP in-home provider will screen all KSTEP parents at first contact (within twenty-four hours of referral receipt) using the ASAM criteria. If a parent(s) meet criteria for treatment, they will immediately arrange an intake appointment with one of KSTEPs contracted CMHCs or another appropriate provider (i.e., MAT) based on the county where the participant resides.
NCFAS tools/assessment	The KSTEP in-home provider agency will complete NCFAS within fourteen (14) working days of receipt of referral. Administration of the NCFAS is required again at three (3) months if the referral remains open and every three (3) months thereafter. Administration of the NCFAS is required prior to closure of the KSTEP case.

Addiction Severity Index (ASI)	The KSTEP in-home provider agency will complete ASI within fourteen (14) working days of receipt of referral. Completion of the ASI is required again at 4 months and at closure of the KSTEP case.
Parenting Stress Index (PSI)	The KSTEP in-home provider agency will complete PSI within fourteen (14) working days of receipt of referral with scoring based on family's initial status. Completion of the PSI is required again at 4 months and at closure of the KSTEP case.
Family moves	If a family is receiving KSTEP services and they subsequently move out of an eligible pilot county (Carter, Greenup, Mason or Rowan), the KSTEP in-home provider will determine whether they can continue to provide services to the family. If they are unable to continue to provide services, the KSTEP in-home provider will notify the SSW and close the family's case after the family has officially moved/relocated. They will work with the family to develop a plan for them to continue treatment services in their new location prior to case closure.
Closure of referral by KSTEP in-home provider	As part of any planned case closure, the KSTEP in-home provider creates an aftercare plan and makes referrals to any recommended services or resources in the plan. The KSTEP in-home provider schedules an FTM with the family, the SSW, and all involved treatment providers. The SSW attends, reviews the plan, and coordinates the content with any aftercare plan that DCBS may create. If possible, the KSTEP in-home provider and DCBS SSW create a single, comprehensive aftercare plan. The KSTEP in-home provider will provide 30 days advanced notice of any planned service closure to DCBS. Reasons for closure can include~~,~~ but are not limited to a family moving to a county outside of the KSTEP in-home provider's service area, or a family becoming unresponsive to the KSTEP in-home provider agency's contact attempts for thirty (30) days or more. Prior to any closure for unresponsiveness, the KSTEP in-home provider and SSW will exhaust alternate strategies for engaging the family, including court involvement. These will be outlined in the weekly progress report and case closure summary.
Children in OOHC, relative, or fictive kin placement	If any/all children in the home are removed, placed in foster care, with relatives or fictive kin through a change of custody or temporarily through a prevention plan, the KSTEP in-home provider will continue to work with the family in an attempt to facilitate reunification more quickly. Provider visits with children in OOHC, relative, or fictive kin placement

	• At a MINIMUM should occur once every month • Should occur more frequently if the children remain in their county of residence • Should occur more frequently if clinically indicated • Efforts should be made to complete joint visits with the parent and child together, such as when the parent is visiting, etc. to assess, identify and provide for any parenting needs, family functioning needs, etc.
Contact notes KSTEP in-home providers	KSTEP in-home providers must complete weekly contact notes and these are to be audited randomly by the KSTEP in-home provider supervisor on a monthly basis. These notes should include but not be limited to: safety assessment, family and individual level progress, barriers, and how barriers are being addressed. Notes should also include dates/times of contacts with the family, referrals, and collateral contacts (including drug screens/treatment progress). The KSTEP in-home provider agency will request monthly written updates on progress from providers (other than the substance use provider) working with child or family, and summarize that information in contact notes. Additionally, any missed appointment(s) by the parent(s)/caretaker(s) and/or child(ren) should be documented with reasons for non-attendance. Expenditures of any funds and the amount for the family should also be included in contact notes when they occur. Weekly reports will be due to SSW, their supervisor, and the KSTEP Administrators by noon on Mondays for the previous week. KVC contact notes should be submitted to Interim KSTEP Administrator, Jennifer.Thornhill@ky.gov and Re-Group contact notes should be submitted to Interim KSTEP Administrator, Annette.Riley@ky.gov.
Contact notes from the substance use treatment providers Pathways & Comprehend	Substance use treatment providers are to complete a weekly report that has been provided to them by KSTEP Program Administrator. This report is to be provided to the KSTEP in-home provider (weekly). The report can be submitted in person or electronically.
KSTEP evaluation data KSTEP in-home providers	KSTEP in-home providers to input applicable case data on a weekly basis into the KSTEP database. KSTEP in-home provider supervisors are to review data monthly for completion and accuracy.
KSTEP evaluation data substance use treatment providers Pathways & Comprehend	Substance use treatment providers are to input applicable case data on a weekly basis into the KSTEP database when the database is operational for their use. Additionally, once the weekly contact form is loaded into the database they can complete it there for KSTEP in-home providers to review.
KSTEP documentation of participation in services	Releases of information are to be completed by KSTEP in-home providers at the initial meeting with the family, and then reviewed and revised as needed at subsequent FTMs.

	KSTEP in-home provider agency will provide the SSW, supervisor, and KSTEP Administrators with weekly documentation of client progress in writing in a format agreed upon by DCBS.
KSTEP direct line meetings	These meetings are currently scheduled to occur on the first Tuesday of the month. These meetings will begin as monthly meetings, but the frequency may be reduced by the program administrator as the project progresses. This meeting will consist of KSTEP in-home providers and/or their supervisors, the SSW's and/or their supervisors, SRAAs, and KSTEP Program Administrator and/or other central office staff. Other community service providers involved in these cases should be notified by the KSTEP in-home provider of these meetings and encouraged to attend. The meeting will be held in Rowan County. This is a working meeting to address service delivery, collaboration and communication, data reviews for program improvement and evaluation, clarification of roles and protocols, case consults, and fidelity to the model.
KSTEP coaching & mentoring consultations	KSTEP in-home provider agency supervisors will provide coaching and mentoring for supervisees no less than monthly, and other consults to be requested as needed.
KSTEP team meeting/staff meeting	KSTEP in-home providers will hold a monthly all KSTEP staff meeting. These are to be separate from individual coaching and mentoring sessions and provide the opportunity for reviewing processes and procedures, problem-solving, disseminating information, and sharing information in order to address case coverage in the event of illness or other leave by a KSTEP staff.
Tracking and reporting KSTEP expenditures	For financial and accounting purposes as well as for the cost-analysis portion of the KSTEP IV-E waiver evaluation, DCBS staff must track their time applied to working with families receiving waiver services by using time code: HZZFES

KSTEP Indications for Phase Movement

Please also Refer to Child Safety Indicators Questions & Considerations that include: (Current & Prior Maltreatment, Protective Capacity, Cognitive & Emotional Characteristics, Response to Crisis, Susceptibility to Violence, Information from Collaterals, Informal Community Supports, Social Environment, Child Strengths, Home Environment, Basic Needs, Caregiver/Child Interaction, Caregivers Willingness to Change)

PHASE I *(Approximately one month)* **Engagement & Service Planning** • **Screening/Assessment** • **Service Planning** • **Admission to Treatment & Other Services**	
TREATMENT ISSUE	**INDICATIONS FOR PHASE MOVEMENT**
Alcohol and drug use	Parent completes assessment and accepts treatment referral
Alcohol and drug use	Elimination of alcohol and other drug withdrawal symptoms
Co-occurring disorders Psychotic, anxiety, mood, or personality disorders Suicidal thoughts	Identify acute mental crises
Basic living concerns	Identify basic food, clothing, shelter, and safety needs
Financial concerns	Identification of financial issues
Threats to personal safety	Identify concerns regarding living situation
Lack of transportation	Identification of transportation needs
Pregnancy	Identify need for prenatal care
Childcare needs	Identify childcare needs
PHASE II (90 Days) • **Accessing Services** • **Achieving Abstinence** • **Meeting Parental Responsibilities**	
TREATMENT ISSUE	**INDICATIONS FOR PHASE MOVEMENT**
Alcohol & Drug Use	Maintaining Abstinence Regular Treatment attendance

	Utilization of recovery supports-Sponsor, self-help, group members. Starting to identify triggers Greater insight into substance abuse and dependency
Alcohol and drug use	Acknowledge substance use as a problem and evidence motivation to change through actions and treatment participation Parent will begin to identify the impact of substance use on parenting Parent is currently in compliance with service plans.
Continued abuse of substances (e.g., alcohol, opiates, cocaine)	Demonstrated changes in life circumstances to prevent relapse Begin relapse prevention planning Discontinue opioid and other drug use Discontinue alcohol use
Medical concerns Chronic diseases (e.g., diabetes, hypertension, seizure disorders, cardiovascular disease)	Establish ongoing care for chronic conditions
Infectious diseases (e.g., HIV/AIDS, TB, hepatitis B and C, sexually transmitted diseases)	Care for infectious diseases
Co-occurring Disorders Psychotic, anxiety, mood, or personality disorders Suicidal thoughts	Use of psychiatric medication if applicable that may have a secondary effect on cravings and drug use

	Individual cognitive behavioral counseling Stress management and coping skills
Pregnancy	Prenatal care
Parenting	Parent is able to identify parenting deficits and strengths and is working on parenting goals. Parent able to achieve one or more parenting goals.
Visits with Children	Parent is consistent in visits with children if not in their care
Establishing trust and feeling of support	Interaction with treatment providers
Therapeutic relationship	Attendance at counseling sessions Building a working alliance
Addressing myths about Treatment	Focus on treatment goals
Motivation and readiness for change	Engagement in treatment process
Ambivalent attitudes about substance use	Acknowledge uncertainness about addiction as a problem
Avoidance of counseling (noncompliance) Negative relationships with staff Inadequate treatment or medication dosage Negative attitude about treatment Involuntary discharge	Lifestyle changes and addressing substance use related issues
Emergence of family problems (e.g., traumatic family history, divorce, other problem situations)	Increased responsibility for children
Legal problems	Resolution of, or ongoing efforts to solve, legal problems
Criminal charges	Absence of illegal activities
PHASE III (1-2 months) • **Sobriety & Other Life Skills** • **Increased Responsibility for children's needs**	
Alcohol & Drug Use	Parent has Maintained a sustained period of Abstinence Continuous Treatment with meaningful participation

	Following relapse prevention plan and able to self-report relapse Developing relationships with recovering role models/mentors Increased involvement in drug free activities, recovery support systems, sober relationships Utilization of recovery supports-Sponsor, self-help, group members Applying 12-Steps in daily life Lack of ambivalence about substance use as a problem Fewer episodes of relapse
Medical concerns Chronic diseases (e.g., diabetes, hypertension, seizure disorders, cardiovascular disease)	Compliance with treatment for chronic diseases
Infectious diseases (e.g., HIV/AIDS, TB, hepatitis B and C, sexually transmitted diseases)	Compliance with treatment Improved health status
Co-occurring Disorders Psychotic, anxiety, mood, or personality disorders Suicidal thoughts	Use of psychiatric medication if applicable that may have a secondary effect on cravings and drug use Compliance & active participation in individual or group counseling Stress management and coping skills
Financial concerns	Stable source of income
Education & Employment	Expanded involvement in employment and/or education
Parenting	Parent is able to identify parenting deficits and strengths

	and is working on parenting goals. Parent able to achieve one or more parenting goals.
Visits with Children	Parent is consistent in visits with children if not in their care and demonstrating increased parenting responsibility during visits
Threats to personal safety	Stabilization of living situation
Lack of transportation	Resolution of transportation needs
Childcare needs	Resolution of childcare needs
Legal problems	Resolution of, or ongoing efforts to solve, legal problems
Criminal charges	No criminal or legal involvement
PHASE IV (1-2 months) **Support & Reduced Engagement** • **Solidifying Gains** • **Accomplishing Concrete Goals** • **Anticipating Future Challenges**	
Alcohol & Drug Use	Maintaining Abstinence Continuous Treatment with meaningful participation Following relapse prevention plan and if in aftercare participating in aftercare services and working with a specific relapse prevention plan Continued Utilization of recovery supports-Sponsor, self-help, group members Applying 12-Steps in daily life Engaged in sober relationships and activities
Medical concerns	Continued Compliance with treatment for chronic diseases

Chronic diseases (e.g., diabetes, hypertension, seizure disorders, cardiovascular disease)	
Infectious diseases (e.g., HIV/AIDS, TB, hepatitis B and C, sexually transmitted diseases)	Continued Compliance with treatment Improved health status
Co-occurring Disorders Psychotic, anxiety, mood, or personality disorders Suicidal thoughts	Established ongoing care for co-occurring disorder
Basic living concerns	Satisfaction of basic food, clothing, shelter, and safety needs
Financial concerns	Stable source of income
Education & Employment	Expanded involvement in employment and/or education
Parenting	Parent is able to identify parenting deficits and strengths and is working on parenting goals. Parent able to achieve two or more parenting goals. Family Problem Solving
Threats to personal safety	Stabilization of living situation
Lack of transportation	Resolution of transportation needs
Childcare needs	Resolution of childcare needs
Legal problems	Resolution of, or ongoing efforts to solve, legal problems
Criminal charges	No criminal or legal involvement

Attachment 4. KSTEP Draft Phase Expectations

KSTEP Draft Phase Expectations

	KSTEP Provider	Client
Phase 1- Orientation Stabilization, and Engagement *Approximately 1-2 months	□ Minimum of 2- Face to Face contacts with the family every 7 days □ Contacts are 5-10 hours per week □ 50% of contacts in home □ Initial A&D Assessment with recommendations within 24 hrs of referral using ASAM criteria □ ASI completed □ PSI completed □ NCFAS completed □ Initial FTM within 6-14 working days- Inviting all involved providers □ Family Agreement and initial Action Plan created □ Follow-up FTM within 30 days of initial (possible phase change here) □ At least once weekly verbal and written updates to DCBS SSW □ All KSTEP phase changes are made at FTMs and are a collaboration of all providers	□ Signs informed consents, participation agreements, and all releases of information for intake and assessment in the KSTEP program with the KSTEP Coordinator □ Provide honest and complete information during the intake and assessment process □ Shows movement from Pre-Contemplation/Contemplation Stage of Change to Contemplation/Preparation Stages of Change; Able to recognize the need for change in maintaining safety of the children and verbalize a desire for change though still may fear change or feel change is too difficult □ Agrees to and engages in recommended level of treatment for substance abuse and/or mental health based on assessments □ Random drug screens at least once weekly □ Consistent engagement in treatment and KSTEP services as evidenced by attending at least XX% of appointments and providing adequate (generally 24 hr) notice of need to cancel/re-schedule □ Actively engage in completion of a Change Plan through Family Team Agreement and Action Plan(s) to improve safety and wellbeing of the child(ren) □ Maintain regular contact/visitation with child(ren) if applicable and necessary □ Participate in the development of and follow all safety plans put into place
Phase 2- Acquisition of Skills and Resources to Overcome Safety Issues *Approximately 2-3 months	□ Minimum of at least 2- Face to Face contacts with the family every 7 days □ Contacts are 5-10 hours per week □ 50% of contacts in home	□ Movement through the Preparation Stage of Change into the Action Stage of Change; learning and practicing new skills and behaviors to manage safety issues and problems.

	• Reviews of progress based on Action Plan, ILOs, FLOs, and tasks. • At least once weekly verbal and written updates to DCBS SSW • Consistent contact with treatment providers for coordination of care and progress updates • FTMs are held at least every 30 days- all providers invited • Update NCFAS every 3 months and ASI/PSI every 4 months • All KSTEP phase changes are made at FTMs and are a collaboration of all providers	• Demonstrate active learning and open communication with all providers on what is working/not working and if changes need to be made to Action and Safety Plans. Not allowing setbacks to deter progress but use as a learning tool to modify tasks/skills as needed. • Random drug screens at least once weekly- screens should be clean or show decreasing levels. If lapse/relapse occurs, each case will be addressed individually with all providers and considerations such as if new safety plan was implemented to keep child(ren) safe, time frames/amount used, ability/willingness to ask for help, honesty, etc. will be discussed. Lapse/Relapse does not necessarily mean starting over but it could. • No new substantiated DCBS referrals • Attendance in XX% of all KSTEP and recommended service appointments. • Reported positive participation in treatment activities and service appointments. • Consistent contact/visitation with child(ren) to maintain bonds and begin practicing positive parenting. Child(ren) may still be out of home. • Observable demonstrations of attempts to implement new safety/parenting/life skills to meet safety, permanency, and well-being needs of the child(ren). Acceptance of adjustments/new skills as needed. • Active attainment and positive utilization of available community supports and resources (insurance, SNAP, reliable transportation, etc) • Identify a plan and begin to implement steps toward long term financial stability. • Develop stable child caring plan • Obtain safe, stable housing • Identify and begin to establish a positive support system. This

		includes positive, sober peer and family support as well as encouraged participation in self-help groups including but not limited to SMART Recovery, Celebrate Recovery, AA/NA, etc. - Identify and address all safety issues and implement any safety plans needed as described in Action Plan(s') Tasks
Phase 3- Consistent Application of Skills and Resources to aid in Maintained Safety of Child(ren) and Recovery *Approximately 1-3 months	- At least 1 weekly Face to Face contact with family - Contacts total at least 2-10 hours per month. - Provide weekly written progress reports to DCBS worker and verbal contact as needed. - Reviews of progress based on Action Plan, ILOs, FLOs, and tasks. - Consistent contact with treatment providers for coordination of care and progress updates - FTMs are held at least every 30 days- all providers invited - Update NCFAS every 3 months and ASI/PSI every 4 months - All KSTEP phase changes are made at FTMs and are a collaboration of all providers	- Remain in the Action Stage of Change with potential movement into Maintenance Stage in some areas; shows consistency in applying new behaviors to ensure safety and manage problems and ability to recognize and adjust skills as needed while still utilizing help from providers as needed. - No new substantiated DCBS referrals - Random drug screens are completed at least 2x per month- screens should be clean or show decreasing levels. If lapse/relapse occurs, each case will be addressed individually with all providers and considerations such as if new safety plan was implemented to keep child(ren) safe, time frames/amount used, ability/willingness to ask for help, honesty, etc. will be discussed. Lapse/Relapse does not necessarily mean starting over but it could. - Attendance in XX% of all KSTEP and recommended service appointments. - Reported positive participation in all treatment activities and service appointments. - Reach level of proficiency with new safety/parenting/life skills that all involved parties have confidence of safety of the child(ren) - Children are in the home full time so that the parent(s) has the ability to demonstrate effective and safe parenting skills while still receiving ample support from providers.

		▯ Demonstrating independence in stabilizing the family unit and ability to seek out needed resources on their own effectively. May still require assistance of KSTEP provider occasionally. ▯ Consistent use of positive and sober network including family and peers as well as encouraged attendance in self-help groups.
Phase 4- Maintenance and Aftercare Planning *Approximately 1-2 months	▯ At least 1- Face to Face contact per month. ▯ Contacts total 1-8 hours per month ▯ Provide weekly written progress reports to DCBS worker and verbal contact as needed. ▯ Reviews of progress based on Action Plan, ILOs, FLOs, and tasks. ▯ Consistent contact with treatment providers for coordination of care and progress updates ▯ FTMs are held at least every 30 days- all providers invited ▯ Update NCFAS and ASI/PSI at discharge. If last update was within 30 days of discharge, only complete a new assessment if there is a relevant documented change ▯ Establish a discharge date through collaboration of all providers ▯ Develop a thorough Aftercare Plan and make all necessary referrals and ensure follow-up appointments are made.	▯ Remain in the Action Stage with movement to Maintenance stage of change in all areas. ▯ No new substantiated DCBS referrals ▯ Random drug screening at least 1x per month. Screens should be clean. Any use will be evaluated in an FTM by all providers to determine plan of action. ▯ Attendance in XX% of all KSTEP and recommended service appointments. ▯ Reported positive participation in all treatment activities and service appointments. ▯ A thorough and viable Relapse Plan is in place ▯ Completion of all Action Plan tasks and resolution of all concerns identified on the Family Agreement regarding safety and well-being of the children. ▯ Ongoing demonstration of proficient use of safety/parenting/ life skills resulting in resolution of all safety, permanency, and well-being concerns for the child(ren). ▯ Consistent use of positive and sober network including family and peers as well as encouraged attendance in self-help groups. ▯ Demonstrates full capacity to function independently or with assistance of natural supports and maintain family safety and stability without the aid or assistance of the KSTEP provider