KENTUCKY
GOVERNOR'S OFFICE OF
EARLY CHILDHOOD
READY TO GROW, READY TO LEARN & READY TO SUCCEED

Kentucky is Building Strong Foundations for Families

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Contents

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Introduction

The Building Strong Foundations for Families workgroup started discussions with a review of Kentucky's Early Childhood Fiscal Map, which was completed with support from Kentucky's Preschool Development [Planning] Grant (PDG). The fiscal map documented the nature and scope of early childhood resources flowing into Kentucky (with the exception of Medicaid funding). All told, at the time of the map's completion, Kentucky was marshalling at least $1.2 billion dollars annually into early childhood resources—noting again that this figure does not include Medicaid spending devoted to young children from the prenatal period forward.

The workgroup's conversations identified several programs for a first round of assessment. Of note, these programs represent the intersection of federal and state spending and included:

- Healthy Start Louisville
- Kentucky HANDS
- First Steps (Part C)
- Child Care Subsidies

The workgroup focused on the "warm hand offs" experienced within and across these programs during a child's first years of life. Put another way, the workgroup wanted to assess the nature and quality of transition experiences for mothers and babies. This focus was an opportunity to build upon additional work that was completed by Kentucky during the PDG wherein Kentucky developed a statewide Transitions to Kindergarten plan. One element of those transitions discussions was the identification of four transition points for young children, which included the transition home for a mother and new baby.

In sum, the workgroups planning phase focused Kentucky on the continuation of discussions initiated during the PDG, with a focus on expectant mothers, the natal experience, and the health and welfare of infants and toddlers. With guidance and input from Zero To Three, Kentucky developed the following goals for its Building Strong Foundations for Families work:

- Complete an inventory and needs assessment of policies, services, and data related to infants and toddlers.
- Increase equity of knowledge about and access to infant and toddler programs across the state.
- Enhance alignment and coordination of infant-toddler programs and services, at state and local levels.
- Enhance provider training and technical assistance, focused on equity and enhancing coordination of care.
- Examine issues related to different types of care for families and children living on the KY/ TN border

Programs of Interest

The study team examined three programs: Healthy Start, HANDS, and First Steps.

Healthy Start Louisville is funded through the Health Resources and Services Administration (HRSA) of the Maternal and Child Health (MCH) Bureau. Healthy Start was designed to (a) improve health outcomes related to pregnancy (from pre-to post-natal) and (b) address differences in maternal and child health outcomes across demographic groups.

Kentucky has one Healthy Start program operating in five zip codes in Louisville (40203, 40208, 40210, 40211, and 40212). This program has been in operation since 1998 and since that time has served more than 10,000 children (estimated, as of 2019)[1]. The zip codes were chosen because of poor maternal and child birth outcomes. The program's goal is to reduce infant mortality and adverse perinatal outcomes in urban West Louisville by providing services to help support African-American mothers, fathers, and their families through all stages of parenting: from preconception to pregnancy to postpartum and between pregnancies, and during a child's first 18-months of life.

Healthy Start works by enrolling and serving expectant mothers while they still are pregnant. Services include regular home visits and connections to other resources2 to support consistent use of prenatal care and healthy pregnancies. After birth, the program continues to work with and support the family until the baby turns two years of age. A variety of program staff work to ensure the whole family is served.

Healthy Start is administered through Louisville Metro Department of Public Health and Wellness and in partnership with the community councils of the Bridges of Hope, Ujima, and Northwest Neighborhood Places. These councils are comprised of residents of the areas served by the three Neighborhood Places so that those living in the Healthy Start areas participate in shaping services to meet the needs of each neighborhood. In addition, a Community Advisory Committee (CAC) provides feedback and input that shape program services, guide implementation of future services, and assist in the planning and facilitation of community and family events.

HANDS stands for Health Access Nurturing Development Services. Kentucky blends funding to provide the HANDS program in every county. Any family can participate but enrollment is limited to the pregnancy period or the first 90 days of the child's life.

HANDS is administered through local health departments and provides home visitation for new and expectant parents, through the first two years of the child's life. HANDS home visitors provide information and referrals to parents, based on their needs. Central to the HANDS approach are the beliefs that parents are the most important caregivers in a child's life and all parents will need guidance

[1] https://louisvilleky.gov/news/healthy-start-program-awarded-46-million

[2] Such as nutrition programs, parenting classes, health screenings and services, and fatherhood involvement.

or help at some point. Thus, HANDS home visitors are prepared to offer a variety of services to help parents adjust to having a new baby and meet the baby's needs through the first two years. An important aspect of this service is referrals to other community services for which the baby or family may be eligible.

HANDS' goals include (a) healthy pregnancies and births; (b) healthy child growth and development; (c) healthy and safe homes; and (d) self-sufficient families.

First Steps is Kentucky's Individuals with Disabilities in Education Act Part C (Infant-Toddler) program. This program provides early intervention services to children with special health, learning, and developmental needs. To qualify for services a child must receive an assessment that documents the child is not typically developing in one or more domains such as communication, socio-emotional skills, or cognition. A child also is eligible if he or she is diagnosed with a condition that leads to a delay in development (e.g., Down Syndrome). It also is possible for a child to enroll based on a clinical assessment from a multidisciplinary team.

Once enrolled, services typically are delivered in the child's home or a related environment (such as a child care facility). At its core, services are focused on coaching the child's primary caregiver in creating an early learning environment that support the child's unique learning and developmental needs. First Steps services are available in each county and children are enrolled based on need, not income. Counties are grouped into districts (Point of Entry) to facilitate the screening, enrollment, and services processes.

Exhibit 1 presents an analysis of common program features including mission, services, and eligibility to establish cross-program alignment.

Exhibit 1. Comparison of Program Features

	Healthy Start	HANDS	First Steps
Mission	Reduce infant mortality	Support families in promoting • Healthy pregnancies and births • Healthy growth and development • Healthy, safe homes • Self-sufficient families	Provide supports and resources to help families and caregivers enhance children's learning and development.
Services	Home visiting, maternity education, prenatal education, developmental screenings and parenting classes and skills.	Voluntary statewide home visitation program providing assistance to parents during the prenatal period and until the child's third birthday.	Statewide early intervention system that provides services to children with developmental

			disabilities from birth to age 3 and their families.
Length of Services	Preconception and during a child's first 18 months of life	Enrolled during pregnancy or before a child is 90 days old until the child's third birthday	Birth to age 3
Funding Source	Health Resources & Human Services Administration (HRSA) Healthy Start Initiative: Eliminating Disparities in Perinatal Health.	Blended public funding through: 1. Maternal, Infant, and Early Childhood Home Visiting (MIECHV) 2. Medicaid reimbursement 3. Kentucky Tobacco Settlement	Blended private and public funding: • Family Share participation fee • Medicaid • Private health insurance • State First Steps funds • Federal Part C funds
Eligibility	African American mothers, fathers, and their families living in five zip codes in Urban West Louisville, from preconception and during a child's first 18-months of life	Families must be enrolled during pregnancy or before a child is 90 days old. Home visiting services are provided for parents facing multiple challenges (single parent status, low income, substance abuse, domestic violence, etc.)	First Steps serves children from birth to age 3 and their families. Child eligibility for the program is determined two ways: Developmental delay or established risk concern
Referral and Transitions Policies	Yes	Yes	Yes

What Did We Learn?

Kentucky's Guiding Principles for Transitions

Guiding Principles for transitions were developed to provide an overarching framing for the work of all early childhood systems partners. The following guiding principles are aligned with the Strengthening Families approach and presented in Kentucky's Transition to Kindergarten state plan.

- Transitions occur at different points in child development and provide opportunities to support future success. Kentucky has identified four critical points of transition that include; Prenatal to Home, Home to Early Care and Education, Prekindergarten to Kindergarten and Kindergarten to Third Grade. *Note: for the purposes of the Building Strong Foundations for Families project, the work group focused on the first transition.*
- Children and families are empowered by building on strengths to foster learning and development. Kentucky seeks opportunities to create, develop and maintain personalized partnerships with families.

- Transitions will be consistent and unified across all settings statewide. The transitions process is continually evaluated through multiple tools to build resiliency and utilize trauma-informed methods.
- Systems prioritize transitions as a key component of professional roles and responsibilities. Professionals will have the necessary tools and support to implement transition strategies.
- Successful transitions are the result of a collaborative, supportive team that represents the child, family, programs, schools and community. The team understands the role bias, racism, privilege and power can play in building a supportive team.
- Communication is responsive through engaging families and developing real understanding, reflecting a culturally sensitive environment that honors families and builds upon their strengths.

In its Transition to Kindergarten state plan, Kentucky also identified Key Components of smooth transitions, which were:

- Collaborative approach – engage all stakeholders
- Family partnership – foster positive relationships between children, families and schools
- Communication – clear, consistent and meets family needs
- Higher intensity strategies, offered over time
- Transition planning across systems
- Alignment across systems – standards, assessments, curricula

These Guiding Principles and Key Components were helpful for the creation of an informal rubric for analyzing focus group and interview data. To wit, when reviewing parent and staff feedback, the study group sought to identify the following themes in the responses:

- Are programs developing personalized partnerships with families?
- Are transitions, or hand-offs, consistent across programs and across locations?
- Are transition experiences included in routine planning for and evaluation of services?
- Are staff trained in and supported in their transition work?
- Are staff providing the nature and level of communication that parents need to promote and ensure child health and well-being?
- Are transitions facilitated by collaborative and supportive teams that are grounded in equity-supportive practices?
- Does there appear to be good alignment across programs, such that the transition from one service to the next does not represent a shift in expectations or requirements?

Strengths

The feedback received from parent focus groups (see Appendix A) led to the following conclusions regarding program strengths. First, parents believe that services are **high quality**, facilitated by a **trained and professional staff**. Part of what makes services high-quality is the family-centered approach. Program staff provide family coaching, helping parents not only to understand child

development but also build self-sufficiency. Staff also function as **connectors and navigators** for other community resources, so that parents and families can (potentially) access additional resources for which they may qualify.

Second, the services are valuable not simply for the content delivered but also because of the **support provided for parents who experience isolation**. Further, it is important to understand that isolation is not necessarily a function of an urban or rural location—parents in urban zip codes in Louisville also reported feelings of isolation.

Finally, based on feedback received from program staff and leadership, programs appear to be **leveraging their resources and connections well**. In addition, the **concept of "transitions" or warm hand-offs already is part of program code**. This is to say, program staff across all three programs speak to the expectation that they will assist families in connecting with other programs and services.

Challenges

Staff feedback helped illuminate the challenges that programs face in fully executing their services. First, staff speak of **high case loads** in some communities. High case loads cause stress and burn-out among staff and may contribute to turnover in program staffing. In addition, high case loads can create drag on the turn-around time between recognizing a need and being able to fully assist the family in meeting that need.

There also are challenges in **finding qualified staff** in some communities. This is especially true for specialized or clinical staff who work with children with special healthy, learning, or development needs. Staff and parents spoke to the reality of having to travel to Louisville, Lexington, or out-of-state to access services needed for their children. Finally, in some programs and some communities, there still is a **tendency to work in silos** such that program staff across programs are not making the most of collaborations and coordinated services. Staff recognize the value of collaborations but also note that with high case loads, the coordination of services takes time and energy that may not be available to them.

Findings from Focus Groups and Interviews

Starting Services

As regards parents entering services at their first eligibility or opportunity, parents noted the need for an **easier application process**. Because there is **no universal application**, parents would at times need to complete multiple applications for the different services for which they were referred. It also was possible that applications would need to be submitted in hard copy form in different locations, adding to the burden experienced by parents, who often were caring for one or more young children.

This stated, simply being referred to a program or service was not necessarily sufficient to ensure enrollment. Parents spoke to the necessity of **trust and scheduling** when considering whether or not to

work with a new program. Parent word-of-mouth is a popular means of communicating about services, both in positive and negative terms. Thus, a parent may decide not to enroll in a service because there was a lack of trust in the agency or program team, or because the parent felt discriminated against or disrespected by a service provider. A parent also may decide that the family schedule was too full to enroll in another service. While not all parents were working, all parents were caring for at least one young child (and often more) and also juggling other responsibilities. Thus, while a service may be helpful for the family, family scheduling and commitments may prevent its use.

Accessibility is another issue and in stating this, there is a distinction between availability and accessibility. Services may be available to parents but that does not necessarily mean that they are accessible. Accessibility centers on issues such as transportation, the days and times that services are offered, and the ability to manage family and child care demands. Accessibility is perhaps heightened in communities where services are not local; the family would need to travel to another community, county, or even state in order to participate. Numerous parents spoke to the demands of child care as an accessibility issue, and noted that tele-services that were provided in response to COVID-19 at times created an opportunity to participate that they had not yet had. Families with more than one young or home-bound child need to confirm child care or the ability to bring all children with them to appointments. Not all service providers would allow multiple children during a visit, especially during COVID. Not all families had access to consistent, affordable, and trusted child care.

It is important to note that while the programs are generally accessible with regard to income (this is to say, income is not a basis for need when considering eligibility), there are cut-offs regarding when a parent can enroll. For example, the HANDS program requires families to enroll either during pregnancy or within the first 90 days of the child's life. This program design allows programs to provide services during critical periods. However, it raises the need to **build awareness of enrollment cut-off times** to make sure families don't miss out on services.

Unfortunately, another aspect of service delivery that was acknowledged by parents and staff was **community and family safety**. A number of participants spoke to safety concerns that might affect service providers, related to issues such as community violence or substance use disorders. While not the fault of parents and staff, this is an important confounding factor that needs to be consider when families are enrolling for services.

Referrals and Connections

Several themes emerged when parents and staff were asked to reflect on the ability to connect to additional resources and services, several themes emerged. The first theme spoke to the value of **coordinated case work**. In short, it was important for programs **not to compete** with each other to provide services to families. Rather, staff and families could benefit from **streamlining paperwork** and **reducing confusion about what different programs and services offered**. This process, of course, could be driven by staff across agencies, provided they had the buy-in and time necessary to coordinate

services. As noted above, high case load demands may prevent this level of coordination from taking place.

Participants again noted accessibility issues when asked if referrals were helpful and led to additional services. While it was evident that referrals were being made, families also had to consider whether services were local or easily accessible with their available transportation. In addition, for some families, the burden of scheduling or managing care for multiple young children could be significant and could reduce their availability to engage in additional services. Finally, as noted earlier, there also was the issue of trust and whether or not enrolling in another service would be a safe decision for the family.

These issues raise the question of **how many services are too many for one family?** Conventional wisdom might suggest that a lack of services is a pervasive need. The feedback received during these family sessions suggested that, at times, service "overload" might be a limiting factor. Coordinated case management may be an adequate response for helping families prioritize and manage service participation.

Graduating Out of Services

The last type of hand-off or transition that parents and staff spoke to was graduation from infant and toddler services into whatever form of services came next. Several significant challenges were identified. The first was referred to as "**The Cliff**," or that point at which a trusted service provider can no longer provide services. While additional or follow-on service may be available for a family, what some families had to reconcile was the loss of an ally or trusted advocate who had been a part of the family's life, through the provision of services, for a critical time in their child's life. In speaking to this need, parents and staff spoke to the socio-emotional support that was provided and which may heretofore be underestimated in its importance.

Transitioning across services also may bring **paradigm shifts** as parents and child learn new routines, rules, and expectations regarding the nature, tone, or frequency of services. For example, children and families who transition from First Steps into the state's Part B services, provided through the public schools, are transitioning from home-based, coaching-focused, services to classroom-based services. This shift can be an adjustment for children and families alike.

There also may be **gaps in services** that result from regulations around when children are to graduate services and when they can start receiving the next service. For example, if a child is graduated from First Steps in the late spring because he or she has reached their age limit for services, that child may need to wait until the fall to begin the next set of services that are provided through the school system.

Next Steps

Kentucky now is poised to take additional steps to support the health and well-being of expectant mothers, mothers, and infants and toddlers. Recommendations include:

1. **Commission a deeper study into health care needs and accessibility**, inclusive of prenatal and postnatal care options as well as access to pediatric, developmental, and emotional or mental health. The study could be informed by a family engagement advisory group.
2. **Invest in Bright Spots**. There are many promising and successful practices already occurring across the Commonwealth, facilitated by experienced and talented professionals. We recommend Kentucky invest in practices and services already shown to be successful in the state and commission its home-grown experts to provide guidance and mentoring.
3. **Systematically address workforce needs.** Kentucky, like many other states, needs new strategies to refresh and maintain its workforce pipeline. Workforce development is a major systems issue; our recommendation is to ensure representatives for expectant mothers, mothers, and infants and toddlers participate in state-level planning and conversations.
4. **Shared professional development.** Each major service and office provides or requires professional development. We recommend developing a system and process for professionals to participate in trainings across sectors, to broaden their knowledge and skills and enhance their inter-disciplinary approaches for working with mothers and children.
5. **Develop protocols and supports for transitions.** Each of the programs examined has requirements or guidance around transitions that directly relate to expectant mothers, mothers, and infants and toddlers. Our recommendation is to ensure there is a unified approach to transitions across programs and services, supported by shared professional development.
6. **Offer virtual or telehealth services.** The COVID-19 pandemic created an opportunity to learn if or how telehealth services could be beneficial to mothers and children. Our findings suggest that telehealth can be useful in some situations, but not all. Our recommendation is to ask programs and services to provide a telehealth or virtual option for services, when it does not interfere with or erode the quality of services or outcomes.

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