**Planning Steps**

**Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations**

Provide an overview of the state’s M/SUD prevention (description of the current prevention system’s attention to individuals in need of substance use primary prevention), early identification, treatment and recovery support systems, including the statutory criteria that must be addressed in the state’s Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. In general, the overview should reflect the MHBG and SABG criteria detailed in “Environmental Factors and Plan” section.

Further, in support of the <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/> ,SAMHSA is committed to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Therefore, the description should also include how these systems address the needs of underserved communities. Examples of system strengths might include long-standing interagency relationships, coordinated planning, training systems, and an active network of prevention coalitions. The lack of such strengths might be considered needs of the system, which should be discussed under Step 2. This narrative must include a discussion of the current service system’s attention to the MHBG and SABG priority populations.

The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) has a mission to promote health and well-being by facilitating recovery for people whose lives have been affected by mental illness and substance use; supporting people with intellectual or developmental disabilities; and building resilience for all. The DBHDID vision is to:

* Expand the recovery-oriented system of care to address the opioid crisis and other substance use disorders;
* Support and promote the behavioral health and wellness of children and families involved with or at risk of involvement with the child welfare system;
* Mitigate adverse behavioral health outcomes exacerbated by the pandemic, natural and man-made all-hazards events, and racial inequity while preserving and enhancing the behavioral health safety network;
* Advance efficient and effective operations of state inpatient and residential facilities; and
* Assure a safe and adequate system of care for people with intellectual and other developmental disabilities.

Kentucky’s DBHDID current key priorities include:

* Increase access to behavioral health and intellectual disability services and supports;
* Improve quality of care in the behavioral health and intellectual disability service delivery system; and
* Reinforce a resilient, inclusive, and equitable organizational culture.

Kentucky’s DBHDID administers a comprehensive, community-based system of behavioral health care for adults with serious mental illness (SMI), children with severe emotional disabilities (SED) and their families, adults and youth with substance use disorders, and individuals with co-occurring mental health and substance use disorders. DBHDID is developing a statewide network of early intervention services and supports to address transition age youth and young people experiencing multiple behavioral health issues, including first episode psychosis. With guidance from SAMHSA’s *Strategic Plan: FY2019 - FY2023*, the DBHDID strives to further promote access to a full continuum of care for mental health and substance use disorders, and to provide necessary resources and data to assist community providers in local-level decision-making, including policies, program development and the provision of evidence-based practices. Kentucky is also working to enhance behavioral health crisis intervention programming across the state. DBHDID promotes the reality that access to a full continuum of care for mental health and substance use disorders advances the recognition that mental health and freedom from addiction is essential to overall health.

DBHDID is Kentucky’s designated State Mental Health Authority (SMHA) and Single State Agency for Substance Abuse Services (SSA), as well as the State Opioid Treatment Authority (SOTA). Per Kentucky Revised Statute (KRS) 194.030, DBHDID is designated as the primary state agency for developing and administering programs for the prevention, detection and treatment of behavioral health disorders (adults and children), including developing and administering treatment, rehabilitation, and recovery services for individuals with behavioral health disorders and developmental and intellectual disabilities. The Department receives state general funds allocated for the prevention and treatment of behavioral health (mental health and substance use) disorders in a biennial budget and is charged with administering the funds to achieve its service and quality goals.

DBHDID is part of the Cabinet for Health and Family Services (CHFS). CHFS is one of the largest agencies in state government, with nearly 8,000 full and part-time employees. Among other offices and councils, the following are also within this Cabinet:

Office of the Secretary (includes the Office of Data Analytics that manages Kentucky Health Information Exchange, Kentucky Health Benefit Exchange and Telehealth Services);

Office of the Ombudsman and Administrative Review;

Office of the Inspector General (Certificates of Need, Licensing and Regulation Authority);

Department for Public Health (Local and State Public Health Programs, Health Equity Branch, and Office for Children with Special Health Care Needs);

Department for Medicaid Services (Medicaid Authority, including Managed Care);

Department for Aging and Independent Living (Aging, Long-term Care, and Dementia Services); and

Department for Community-Based Services (Adult and Child Protection, Child Welfare, Public Assistance; Guardianship; Family Resource Centers);

<https://chfs.ky.gov/Pages/index.aspx>

Within DBHDID, there are five Divisions, including: Administration and Financial Management; Developmental and Intellectual Disabilities; Program Integrity; Substance Use Disorder; and Mental Health. As a result of a reorganization effective July 1, 2022, the previous Division of Behavioral Health was split into the Division of Substance Use Disorder and the Division of Mental Health. This reorganization occurred due to the expanded program growth in both of these areas, and both Divisions continue to work closely together.

The Division of Substance Use Disorder Director’s Office includes a broad dashboard of subject matter expertise. The Division Director, an Assistant Director, and several cross division program leaders including a Federal Grants Specialist, a Communications lead, the lead for Co-occurring Disorders/Integrated Care, and an administrative assistant are all included in the Division office.

The Division of Mental Health Director’s Office also includes a broad dashboard of subject matter expertise. The Division Director, an Assistant Director, several cross division program leaders, including Deaf and Hard of Hearing Services and Early Interventions for First Episode Psychosis are included in this Division. A Division budget specialist, a training program coordinator, and the block grant planner, as well as Behavioral Health Services Information System (BHSIS) staff are also included in this Division office.

DBHDID’s Division of Substance Use Disorder is comprised of the Director’s Office and two (2) Branches, including:

*Substance Use Prevention and Promotion Branch* – Oversees and supports programs across the state in the use of evidence-based prevention strategies to decrease risk factors and enhance protective factors and resilience, with the goal of reducing rates of substance use among residents of Kentucky. Prevention and Promotion Branch efforts focus on reducing or delaying the initiation of substances and related consequences.

*Adult Substance Abuse Treatment and Recovery Services Branch* – Oversees and supports the administration of community-based, outpatient and residential services for individuals with substance use disorders across the state. This Branch manages several statewide specialty programs for key SUD populations, (e.g., pregnant women; women with dependent children; medications for opioid use disorder; Veterans, Service Members, and their families), coordinates efforts to build a recovery-oriented system of care across the lifespan and provides guidance and technical assistance on the implementation of evidence-based practices across the Commonwealth.

The Substance Use Disorder Division also includes staff supporting the *Kentucky Opioid Response Effort (KORE)*, which primarily focuses on the administration of State Opioid Response (SOR) funds made available by SAMHSA. KORE is guided by the Recovery-Oriented System of Care Framework and strives to expand access to a full continuum of high quality, evidence-based opioid prevention, treatment, recovery, and harm reduction services and supports in high-risk geographic areas of the state.

DBHDID’s Division of Mental Health is comprised of the Director’s Office and three (3) Branches, including:

*Mental Health Promotion, Prevention and Preparedness Branch* – A newly created Branch that oversees and supports programs across the state to serve residents experiencing the most significant aspects of their behavioral health issues. Efforts in this Branch include the statewide 988 initiative, statewide disaster preparedness, crisis services, problem gambling and statewide suicide prevention. This Branch also includes a position that oversees programming for adults with SMI who are involved with the justice system in Kentucky. This programming involves Crisis Intervention Team (CIT) training for law enforcement officers across the state, collaboration with a community mental health center in Lexington, Kentucky, to provide jail triage services across the state, and collaboration with a community mental health center in Louisville, Kentucky, to assist individuals with SMI who are serving out or being paroled from the Kentucky State Reformatory. In addition, this Branch includes oversight of the KCCRT (Kentucky Community Crisis Response Team), a multidisciplinary team that is deployed during state emergencies and disaster situations.

*Children’s Behavioral Health and Recovery Services Branch* – Oversees the services and supports for children and youth across the state who have or are at-risk of developing behavioral health concerns and their families. This Branch works with community providers across the state to provide oversight and technical assistance regarding the delivery of a continuum of behavioral health care that includes early intervention, treatment and recovery service and supports. This Branch manages several statewide and regional initiatives including adolescent substance use prevention and treatment, high-fidelity wraparound services, youth and family peer support, early childhood mental health services, and others.

*Adult Mental Health Services and Recovery Branch* - Oversees the planning and implementation of mental health services for adults with serious mental illness across the state. This Branch provides training and technical assistance to providers regarding the delivery of an array of evidence-based practices that focus on treatment and recovery services and supports for adults with serious mental illness. Specific evidence-based practices include Assertive Community Treatment (ACT), Peer Support, Supported Employment, utilizing the Individual Placement and Support (IPS) model, and Permanent Supportive Housing. This Branch also includes statewide leadership for programming related to older adults with SMI, targeted case management for adults with SMI, liaisons to state psychiatric hospitals, Kentucky’s Projects for Assistance in Transition from Homelessness (PATH) coordination, and Olmstead coordination for adults with SMI.

Kentucky is divided into fourteen (14) geographic regions for the purposes of planning and providing publicly funded community mental health, substance use and prevention services.

A Regional Board has been established pursuant to KRS 210.370-210.480 <https://apps.legislature.ky.gov/law/statutes/chapter.aspx?id=38158> as the planning authority for behavioral health programs in each region and these generally align with the Area Development Districts (ADD) throughout the state. County and municipal governments generally do not provide community behavioral health services. A Regional Board is an independent, non-profit organization that is governed by a volunteer board of directors that broadly represents stakeholders (including individuals with lived experience, and family members) and counties in the region. All agencies are licensed by the Cabinet for Health and Family Services as a “Community Mental Health Center.” In July 2023, four (4) of the Community Mental Health Centers merged to become the state’s largest behavioral healthcare organization. Four Rivers Behavioral Health (Region 1), the Pennyroyal Center (Region 2), LifeSkills, Inc. (Region 4) and Communicare, Inc. (Region 5), became a merged entity with a total of more than 1700 employees, serving 35 counties in the western part of Kentucky. The combined entity continues to operate under their regional names in their respective regions.



*Note of Clarification: Regions 9 & 10 were originally two different Boards but merged some years ago and are now counted as one region, thus there are a total of 14 Boards but they are represented with numbers 1 - 15.*

KRS 210.410 authorizes the Secretary of the CHFS to make state grants and other funding allocations to Regional Boards to provide, at a minimum, the following behavioral health services: Inpatient Services; Outpatient Services; Partial Hospitalization or Psychosocial Rehabilitation Services; Emergency Services; Consultation and Education Services; and Services for Individuals with an Intellectual Disability. Behavioral health services, including mental health services for adults and children, substance use disorder services for adults and adolescents, and services for individuals with co-occurring disorders are provided in county level clinics and a number of services may be provided off-site in homes, school and in other community locations. In addition to the clinics, there are fourteen (14) Regional Prevention Centers established to provide technical assistance and training on evidence-based prevention strategies. While the main focus is aimed at Primary Prevention for substance misuse, they also support some Secondary and Tertiary prevention strategies (using funds other than those set aside for Primary Prevention) when those activities directly support the Primary Prevention goals for each region identified through a comprehensive needs assessment. With its available resources of state general funds, block grant/other federal funds, and awarded agency funds, DBHDID contracts with the fourteen (14) private, not-for-profit CMHCs to provide services to citizens in all 120 counties of the state. These funds are awarded annually, and contracts may be modified throughout the year. The fiscal year of operation is July 1 through June 30. CMHCs are required to specifically describe their current systems of care for adults and children, including crisis care, and are required to report their plans for development regarding key system components, within an *Annual Plan & Budget* process. DBHDID is committed to working collaboratively with CMHCs to continuously enhance continuity of care, implementation of evidence-based practices and service effectiveness and accountability. DBHDID contracts with several CMHCs and a few other community-based, non-profit, entities to provide additional services to populations of focus. Examples of these include programming for Supported Employment, Supportive Housing, and specialized residential treatment for men, women, pregnant women and parents with dependent children, youth, and individuals with substance use disorders and individuals who experience homelessness.

DBHDID collects client-level data monthly, including fields for gender, race, and ethnicity from the following entities:

Fourteen (14) community mental health centers;

Two (2) state-owned psychiatric hospitals;

Two (2) state-contracted psychiatric hospitals;

Four (4) intermediate care facilities for individuals with intellectual disability; and

Two (2) non-profit agencies contracted to provide specialized services to individuals with substance use disorders.

Kentucky is not a racially diverse state with less than 16% identifying as a race other than white. There are currently no federally designated tribes present within the state. Despite the lack of statewide racial diversity, DBHDID has begun to identify and implement strategies to enhance access to and engagement with culturally responsive behavioral health services among marginalized and minoritized populations.

The Commonwealth is considered very diverse in culture from one area of the state to the other and there are great differences in income/wealth among residents across the state. According to 2022 population estimates from the Kentucky State Data Center, [Kentucky State Data Center – Empowering data users across the Commonwealth (louisville.edu)](http://ksdc.louisville.edu/) located at the University of Louisville, the population of Kentucky is 84% White alone, 8.3% Black or African American alone, 1.7% Asian alone, 2.3% Other, and 4.2% of Kentucky’s population report as Hispanic. According to the Small Income and Poverty Estimates (SAIPE) data report [SAIPE (census.gov)](https://www.census.gov/data-tools/demo/saipe/#/), as of 2021, approximately 16% of Kentuckians were considered impoverished.

According to a report from the Appalachian Regional Commission, an organization created as a partnership between several federal agencies to focus on 423 counties across Appalachia, Kentucky has higher mortality rates than the nation for several physical health conditions. Deaths from heart disease are at a rate 45% higher than the national rate. Deaths from cancer are at a rate 35% higher than the national rate. Deaths from chronic obstructive pulmonary disease (COPD) are at a rate 88% higher than the national rate. Deaths from diabetes are at a rate 32% higher than the national rate. [Kentucky Health Disparities and Bright Spots - Appalachian Regional Commission (arc.gov)](https://www.arc.gov/report/kentucky-health-disparities-and-bright-spots/)

CHFS and DBHDID are committed to addressing health disparities, particularly mitigating adverse behavioral health outcomes exacerbated by the pandemic, racial inequity, and other areas of inequity. DBHDID is a member of the Juvenile Justice Oversight Council, Juvenile Justice Advisory Board/subcommittee for Equity and Justice for All Youth, Differential Treatment Workgroup and the Disproportionality and Disparities standing committee of the State Interagency Council. The Treatment workgroup is currently analyzing statewide and regional program performance data, disaggregated by race, ethnicity, gender, and disability to determine if there are differences in access, use and outcomes. 988 implementation and suicide prevention efforts are focused on Black, Indigenous, and People of Color (BIPOC); the LGBTQIA, farm connected, military connected and rural, all of whom have greater risks of dying by suicide if they don’t receive appropriate behavioral health services. Providers are responsible for ensuring all staff participate in cultural responsiveness training regularly and that their policies and procedures do not discriminate but rather encourage inclusion of all citizens. Many CMHCs also focus on cultural responsiveness, and racial, ethnic, and sexual gender awareness in employee performance evaluation efforts and provide specific and detailed goals and objectives whenever deficits are identified.

During SFY 2020, a commissioner-level Executive Advisor was hired to work on racial equity within DBHDID. A Department-wide Racial Equity Action Plan was developed that focused on applying the principles of intersectionality and targeted universalism to the delivery of behavioral health services. It is anticipated that as data is disaggregated by race and actionable steps are taken within the Department, efforts will produce benefits beyond a spectrum inclusive of race and ethnicity and will include equitable outcomes for Kentuckians who represent the full spectrum of gender identity and sexual orientation. CHFS has held monthly panels to address racial equity since the summer of 2020. The Executive Advisor developed and presented a mandatory training for all supervisors and a mandatory training for all staff. In addition, a collaboration with Spalding University in Louisville resulted in training for up to 200 CMHC/state facility staff in Racial Trauma Therapy, with online modules and follow up coaching that allows certification in the Racial Trauma Therapy approach.

Additionally, the DBHDID data groups, consisting of DBHDID staff, CMHC staff, and data contractor staff worked to add relevant data points to the DBHDID client data set and to enhance existing client set data points. As a result, beginning on July 1, 2021, all CMHCs collect “gender identity” and “sexual orientation” data for all new clients. In addition, the “gender” category in the client data set for the CMHCs has been updated to be inclusive. Similar actions were taken to collect prevention data within the Prevention Data System.

DBHDID has authority for inpatient psychiatric care for the indigent and operates or contracts for several adult mental health inpatient facilities, as displayed in the table below. The majority of care in these facilities is provided with state general funds. Three (3) of the four (4) are Institutes for Mental Disease (IMD) designated facilities.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **State Hospital/Location** **Operation** | **ADC\*****SFY 2018** | **ADC\* SFY 2019** | **ADC\* SFY 2020** | **ADC\*****SFY 2021** | **ADC\* SFY 2022** |
| Western State Hospital/ HopkinsvilleState Operated | 115 | 112 | 107 | 112 | 116 |
| Central State Hospital/ LouisvilleState Operated | 58 | 54 | 51 | 46 | 48 |
| Eastern State Hospital/Lexington Contracted | 127 | 102 | 104 | 111 | 119 |
| Appalachian Regional Hospital (ARH) Psychiatric Center/Hazard Contracted | 54 | 57 | 55 | 61 | 71 |
| **TOTAL** | **354** | **325** | **317** | **330** | **354** |

 \*ADC = Average Daily Census

 Data Source: DBHDID Client Event Data/Report ID: FIS\_ADC\_YR

Kentucky Correctional Psychiatric Center (KCPC) is an inpatient psychiatric hospital, located within a correctional system complex, but operated by DBHDID. It primarily provides court-ordered inpatient evaluation for competency and criminal responsibility and treatment to restore competency to persons charged with a felony offense. When inpatient evaluation is unnecessary, KCPC facilitates outpatient competency evaluations through contracts for professional services with CMHCs. The facility’s average daily census in SFY 2022 was 25 people.

Kentucky does not operate any state-funded inpatient facilities for children/youth under eighteen (18) years of age. There are currently 623 operational child psychiatric beds located in thirteen (13) hospitals that are geographically located in eight (8) of the fourteen (14) regions. *The 2021 Hospital Report cited below is the most recent data available.* Other residential care for children includes Psychiatric Residential Treatment Facilities (PRTFs), Private Child Care (PCCs) facilities and Therapeutic Foster Care (TFC) contracted by the Department for Community Based Services, Kentucky’s child welfare agency.

|  |
| --- |
| **Psychiatric Inpatient Utilization - Statewide - Children and Adolescents 0-17 Years of Age** |
| Calendar Year | Number of Hospitals | Total # Licensed Child/Adol Beds | Total # Child/Adol Beds in Operation | Total # Admissions | Total # Inpatient Days | Average Daily Census (ADC) | Average Length of Stay (ALOS) | Occupancy % |
| 2017 | 14 | 699 | 596 | 11,473 | 131,449 | 360 | 11.15 | 51.52% |
| 2018 | 13 | 700 | 596 | 11,098 | 124,190 | 340 | 11.52 | 48.61% |
| 2019 | 13 | 710 | 607 | 12,381 | 133,844 | 367 | 11.04 | 51.65% |
| 2020 | 13 | 714 | 613 | 9,720 | 127,074 | 347 | 13.04 | 48.63% |
| 2021 | 13 | 724 | 623 | 10,126 | 147,167 | 403 | 13.63 | 55.69% |
|  |  |  |  |  |  |  |  |  |

*Data Source: Office of Inspector General* [*https://www.chfs.ky.gov/agencies/os/oig/dcn/Pages/annualreports.aspx*](https://www.chfs.ky.gov/agencies/os/oig/dcn/Pages/annualreports.aspx)

The Office of Inspector General, an agency within CHFS, is the regulatory agency for licensing all health care facilities, day cares, long-term care facilities, and child adoption/child-placing agencies in the Commonwealth. The child welfare and juvenile justice agencies are the only state agencies authorized to take custody of children. Neither provider licensing, or “care, custody and control” of children are a function of the Kentucky Department for Medicaid Services (DMS) or DBHDID.

Kentucky has been applauded over the years for making a small amount of funding go a long way but the behavioral health system in Kentucky has traditionally been underfunded and unbalanced between community based services and inpatient/institutional care. Over the last decade, progress has been made to balance more funding from the residential/facilities side of the equation to enhance the community-based service continuum and increase community access. In addition, Kentucky has traditionally been near the bottom of state spending as rankings have ranged from 44th to 47th in recent years. Due in part to the increase of federal funding over the last few years Kentucky now ranks approximately 32nd in state spending according to SAMHSA. [Mental Health Spending By State Across the US - Drug Rehab Options (rehabs.com)](https://rehabs.com/explore/mental-health-spending-by-state-across-the-us/) This report also indicates that Kentucky provides services to 3.6% of the population and ranks lowest in the percentage of expenditures per client. However, costs associated with opioid use disorder and fatal overdose, such as costs of health care, substance use treatment, criminal justice, lost productivity, reduced quality of life, and the value of statistical life loss, are higher in Kentucky. According to a CDC report that highlighted the economic impact of the opioid crisis, Kentucky ranked fourth in highest economic impact. Kentucky’s combined per-resident costs from opioid use disorder (OUD) and its resulting deaths in 2017 was $5,491, including $3,007 for OUD deaths. Total state costs were nearly $24.5 billion, about $11.7 billion for OUD and $13.4 billion for OUD deaths.

The availability and funding of behavioral health services in Kentucky has seen some significant changes in recent years due to a variety of factors. Since the time of deinstitutionalization in the 1960s, Kentucky’s publicly funded services system for community based, non-residential, mental health and substance use has relied, almost solely, on a network of fourteen (14) Community Mental Health Centers (CMHCs) who provide a full continuum of behavioral health services to nearly four (4%) percent of the state’s population of nearly 4.5 million people. However, a number of changes have impacted the behavioral health delivery system, including the implementation of Medicaid managed care, implementation of the Affordable Care Act with a state-run health exchange and expanded Medicaid coverage, several approved Medicaid State Plan amendments, an expansion of the behavioral health provider network, and numerous new and amended state laws and regulations. Over the past few years, the COVID 19 pandemic forced behavioral health providers to rethink their methods of delivering service. All fourteen (14) CMHCs delivered services via telehealth during the pandemic, and several CMHCs developed creative ways to continue to safely provide in-person services as necessary and preferred. Many providers continue to provide hybrid service packages. The effects of the pandemic are still being analyzed for behavioral health care in Kentucky. Still, the CMHCs remain a strong and viable safety net provider for Kentucky citizens enrolled in Medicaid or other insurance plans, as well as those that are uninsured, underinsured or transitioning onto and out of insurance coverage.

The following offers a brief history of recent changes:

In November 2011, Kentucky transitioned its Medicaid program to managed care by initiating contracts with managed care organizations (MCOs) to provide services to Kentucky’s Medicaid enrollees. Behavioral health was included in the managed care model, which extended to all of Kentucky’s 120 counties. A new procurement process was initiated during SFY 2020 and as of SFY 2021, MCO contracts for six (6) managed care entities have been awarded. These MCOs include Aetna, Anthem, Humana, Molina, United Healthcare, and Wellcare.

In May 2013, the decision to expand Medicaid eligibility in Kentucky pursuant to the Affordable Care Act was announced, allowing individuals and families earning up to 138 % of the federal poverty line to enroll in an insurance plan. Kentucky created Kynect, an online health insurance marketplace to allow citizens to learn about and select health insurance plans, as well as access other public assistance benefits. This system allows Medicaid eligible individuals to sign up for coverage through the marketplace. Medicaid coverage for the expansion population began Jan. 1, 2014. By July 2022, total Medicaid/CHIP enrollment in Kentucky was up 172%, to more than 1.6 million people. That amounted to nearly 37% of all Kentucky residents covered by Medicaid. Nationwide, Medicaid enrollment was up 54% as of early 2022, and Kentucky’s 154% increase at that point was by far the highest in the nation. The growth was driven by Medicaid expansion as well as the COVID 19 pandemic (including the Families First Coronavirus Response Act, which paused Medicaid eligibility redeterminations throughout the COVID 19 public health emergency). According to the Kentucky Department for Medicaid Services, as of April 2023, there are 1,733,465 Kentuckians enrolled in Medicaid and of those 663,176 are enrolled as part of Medicaid expansion.

The Kentucky Department for Medicaid Services has had State Plan Amendments (SPAs) approved in recent years and this has resulted in the expansion of Medicaid benefits for clinical, rehabilitation and targeted case management services. Perhaps the most significant is the addition of coverage for services for substance use disorders. Historically, Kentucky was in the minority of states that did not have a Medicaid benefit for substance use treatment, except for pregnant women. Along with developing new behavioral health services through the Medicaid SPAs, the decision was made to expand the eligibility of professionals and organizations that are eligible to apply for and become Medicaid providers. Today the number of behavioral health providers who are able to seek reimbursement for Medicaid payment, through the MCOs, is growing steadily. There are a greater number of licensed professionals who may apply to become Medicaid providers, including, Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, Licensed Professional Clinical Counselors, Licensed Psychologists, Licensed Art Therapists, Certified Behavioral Analysts, and Licensed Clinical Alcohol and Drug Counselors. In addition, Registered Peer Support Specialist (for SUD services) was created as a new provider type by the Kentucky Board of Alcohol and Drug Counselors. This is in addition to Certified Peer Support Specialists with lived experience in substance use disorders who are certified as providers to provide services through various agencies. Several new licensure categories have been created including, Behavioral Health Services Organizations (BHSOs) and Multi-Specialty Groups (MSGs). A few services are limited in organizational categories (e.g., residential crisis units) but most services are open to all licensed professionals. A growing number of Federal Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Primary Care Providers are developing new or expanded behavioral health services. Furthermore, Kentucky has identified four (4) CMHCs to participate in a Certified Community Behavioral Health Clinic (CCBHC) demonstration to show effectiveness in the provision of comprehensive quality care reimbursed through a prospective rate based on historical costs. (Two additional CMHCs received separate SAMHSA CCBHC grants). CCBHCs are required to provide the following comprehensive scope of services: crisis mental health services; screening; assessment and diagnosis; outpatient mental health and SUD services; person centered treatment planning; primary care screening and monitoring of key health indicators; targeted case management; psychiatric rehabilitation; peer support, including family and youth; and community-based mental health care for members of the armed forces and veterans. With the many changes that have occurred in the behavioral healthcare system, the need for a significant number of new regulations has ensued.

Another catalyst for new legislation and regulatory changes has been the escalation of the overdose crisis in Kentucky. According to the Office of Drug Control Policy’s 2021 Overdose Fatality Report, more than 2,250 Kentuckians died from drug overdose in 2021 – an increase of 14.5% from the 1,965 resident deaths in 2020. Fentanyl was identified in 72.8% of those overdose deaths. While the COVID 19 pandemic has been a contributing factor, the increased presence of highly potent synthetic fentanyl within the drug supply is a significant driver in the rise of overdoses. Synthetic fentanyl is now found in a variety of substances including heroin, pressed pills, methamphetamine, cocaine, and benzodiazepines. As such, Kentucky continues to enhance access and availability of evidence-based practices, including overdose reversal medications, medications for opioid use disorder (MOUD), harm reduction strategies, strategies that support families with a loved one suffering from addiction, and public education, awareness. and stigma reduction. Such interventions are effective at reducing risk of overdose, improving treatment retention, and increasing the likelihood of long term recovery. The Kentucky Opioid Response Effort (KORE) is housed within DBHDID, and with the provision of SAMHSA’s State Opioid Response funding, KORE supports the implementation of high quality, evidence-based opioid and stimulant use prevention, treatment and recovery support programs and initiatives throughout the Commonwealth. All age groups have been affected by this epidemic and concerted efforts to support children and youth, including substance exposed infants, and children placed in out-of-home care due to substance use, overdose, or incarceration of parents, is a top priority. Additional funding has been made available to the Kentucky Office of Drug Control Policy to address heroin and opioid addition through Senate Bill 192. A portion of those funds are contracted to DBHDID for the provision of services, including services for substance exposed infants and their parents.

Kentucky DBHDID has worked for several years to create a recovery-oriented system of care for individuals experiencing mental illness, substance use disorders, or co-occurring mental health and substance use disorders. DBHDID has partnerships with many organizations comprised of individuals with a wide variety of lived experience, including adults, young adults, transition age youth, parents, and family members, including the National Alliance on Mental Illness (NAMI) (Lexington and Louisville chapters), Kentucky Partnerships for Children and Families (KPFC), People Advocating Recovery (PAR), Young People in Recovery (YPR), Mental Health America of Kentucky (MHA-KY), and Bridgehaven (a nationally recognized therapeutic rehabilitation program for adults with SMI located in Louisville, KY), as well as other organizations dedicated to supporting recovery experiences for individuals. DBHDID is committed to having services available across the state that are evidence-based and specifically designed with input from those who benefit from the use of the services.

Kentucky has worked for many years to create a responsive crisis system of care for individuals with behavioral health challenges in need of care 24/7. DBHDID provides crisis services through contracts with the fourteen (14) CMHCs and utilizes a blended funding stream to support these services. The different regions provide crisis services in a variety of ways. Some regions have crisis stabilization units for overnight care, some have 23 hour crisis beds, some have mobile crisis units that travel for outreach, and others have robust walk-in services as needed. With the effects of the pandemic, statewide behavioral health crisis services have become even more relevant. As of July of 2022, Kentucky began implementation of the 988 initiative, and thirteen (13) of the fourteen (14) CMHCs participate in that effort. In addition, during a reorganization effective July of 2022, the KCCRT (Kentucky Community Crisis Response Team) oversight and operation was moved to the Division of Mental Health. This Team provides organized, rapid and effective response in the aftermath of a crisis event. The KCCRT (Kentucky Community Crisis Response Team), is Kentucky’s crisis response mechanism with regards to emergency and disaster situations, and which is comprised of a broad array of professional personnel including law enforcement, first responders, mental health professionals, public health workers, and many more. As a result of this reorganization, DBHDID also became the designated agency to apply for and administer federal behavioral health related disaster funds in the instance of a declared disaster with individual assistance designation. In light of Kentucky’s 2021 tornado outbreak in Western Kentucky and 2022 1,000-year flooding in Eastern Kentucky, the Department has applied for and administered more than $10 million in Crisis Counseling Program and Disaster Case Management funds from the Federal Emergency Management Agency in partnership with SAMHSA.

DBHDID collects data from Community Mental Health Centers and other funded providers on a monthly basis. This data supports DBHDID’s efforts to monitor client-level demographic and diagnostic statistics, service utilization, and staffing used to provide direct behavioral health services. This data (including service data for mental health, substance use and developmental/intellectual disabilities) is evaluated monthly and each data file is required to meet a set of accuracy, completeness, and timeliness standards. DBHDID uses this data as its source for federal Block Grant reports, National Outcome Measures (NOMS), Treatment Episode Data Set (TEDS), Client Level Data reporting (CLD), Uniform Data Reporting System (URS) and a variety of other uses, including SMHA/SSA Profiles and surveys. Kentucky has successfully reported CLD using the original MH-CLD methodology since the inception year. Similarly, Kentucky has successfully reported URS data since the inception year of 2002.

Daily, DBHDID collects data from its state-operated and state-contracted facilities for behavioral health, including two (2) state-operated psychiatric hospitals and two (2) state-contracted psychiatric hospitals. One (1) of the state-contracted psychiatric hospitals is located within a medical facility. Three (3) of the state psychiatric hospitals maintain data using the same electronic health record (EHR); the unit within a medical facility manages data with a similar EHR. The data collected from these systems by the DBHDID includes client level admission and discharge information and includes demographics, diagnostic, and living arrangement (housing) status at admission and discharge. This data is evaluated monthly according to facility utilization expectations and requirements. The DBHDID uses this data for internal operations and facilities management responsibilities.

Prevention process measures are recorded through Kentucky’s web-based Prevention Data System (PDS). The PDS is patterned after CSAP’s Minimum Data Set to collect information related to the type of primary prevention services used to reduce and prevent substance use disorders among the residents of the Commonwealth. Information is collected on:

* Implementation of strategies based on community needs assessment and selected for that specific population’s needs
* Delivery of prevention services, including collaborations with schools, businesses, government agencies and individuals, policy changes, and curricula implementation,
* Use of the six CSAP strategies of information dissemination, education, alternative activities, community based processes, environmental, and problem identification, and referral strategies
* Identification of the demographic composition of population served, including number served, age, gender, race, ethnicity, and whether part of high-risk population.

The Prevention Data System is maintained by Substance Use Prevention and Promotion Branch staff. Reports are developed in conjunction with Regional Prevention Center (RPC) Directors and other special projects of the Branch. Reports are reviewed monthly by Branch staff collaboratively with the RPC staff.

The reports give RPC Directors the ability to evaluate activities and effectiveness at the county level, and information is used to plan for future activities; as well, for state staff to track progress towards attaining work plan objectives. The Regional Prevention Centers are required by contract to enter data on their substance use disorder prevention efforts on a monthly basis. The PDS data is used in the compiling of Kentucky’s annual SAPT Block Grant Report. The system is also used for the collection of mental health promotion and prevention and suicide prevention efforts in the state.

The Kentucky Incentives for Prevention (KIP) survey is the primary data source used to set block grant priorities and track outcomes for Substance Use Disorder Prevention. The KIP survey is implemented biannually in a majority of Kentucky’s 172 school districts, and provides data on substance use, risk and protective factors, mental health, suicide, and school safety on the county or school district level for grades 6,8,10, and 12. It is a population-level survey, meaning that all students present on the dates of administration in the identified grade levels would participate, compared to a randomized sample survey. This type of administration provides a broader applicability for Kentucky’s diverse culture pockets and ensures that local school districts have access to their data for grant applications as well as identifying local needs and relevant strategies.

The KIP survey is modeled after the National Monitoring the Future Survey. During the last survey period (2021), 93,812 students from 127 school districts across the state participated in the KIP Survey. This new survey represents a new cohort of students. Prior to the COVID 19 pandemic the KIP Survey was implemented in even numbered years. However, due to the pandemic, the survey could not be administered in 2020. Recently, as a result of Kentucky legislation which required active versus passive consent for participation, the 2023 administration was paused to ensure that processes could be developed that align with the state statute’s requirement for parental consent for all health and wellbeing surveys administered in Kentucky schools. The next administration is now, tentatively, planned for the fall of 2024. Kentucky also utilizes usage rates through the National Survey on Drug Use and Health (NSDUH), which is implemented annually among randomly selected youth aged twelve (12) and older, and the Youth Risk Behavioral Survey System (YRBSS). The most recent administration of the YRBS in Kentucky occurred early in 2023 prior to the enactment of the consent legislation. The NSDUH data allows for tracking general usage rates among youth ages 12-17 on an annual basis. NSDUH also provides much needed adult data which is used to set priorities for the over seventeen (17) population. YRBSS is implemented every two (2) years in odd numbered years and provides state level consumption data. With this broad approach to data collection, plus additional local surveys and data, Kentucky’s substance use and mental health preventionists complete thorough needs assessments to guide their community-level efforts.

Kentucky hosts three (3) data-related standing teams that involve state and community partners. Each team plays a key role in defining data elements, defining processes to ensure accurate, complete, and timely data collection, and defining indicators and measures of quality. Contributions from all three (3) teams lead to successful implementation of data collection, issue resolution, and measure development.

BHDID Data

**DUG**

*Use*

**JCIC**

*Collection*

**QMOT Quality**

**Q**

The Data Users Group (DUG) is comprised of DBHDID staff and contracted data managers. This team provides recommendations and direction for the collection, analysis, architectural design & structure, use of data and information relevant to desired outcomes management across the Department. The team evaluates issues related to data collection, data analysis, data quality, data architecture and structure that support the provision of quality services and explores areas for improvement.

The Joint Committee for Information Continuity (JCIC) is comprised of department staff and IT representatives from the fourteen (14) CMHCs and other contracted providers. This team makes recommendations concerning information management to the Department. The committee facilitates the development of data-related contract items between the Department and CMHCs. As a central function, the committee provides direction and assistance in the continued development of the information system to manage a public behavioral health system.

The Quality Management & Outcomes Team (QMOT) is comprised of the quality assurance officers from the fourteen (14) CMHCs. This team provides direction for the collection of information relevant to desired outcomes, methods of measurement, and design of processes for continuous outcomes management across the Department. The team evaluates outcomes that support the provision of quality services and explores areas for improvement.