INTERIM JOINT COMMITTEE ON HEALTH, WELFARE, AND FAMILY SERVICES

Minutes of the Second Meeting of the 2019 Interim

June 3, 2019

Call to Order and Roll Call

The second meeting of the Interim Joint Committee on Health, Welfare and Family Services was held on Monday, June 3, 2019, at 1:00 p.m., in Room 154 of the Capitol Annex. Representative Kimberly Poore Moser, Co-Chair, called the meeting to order at 1:00 p.m., and the secretary called the roll.

Present were:

Members: Representative Kimberly Poore Moser, Co-Chair; Senators Julie Raque Adams, Danny Carroll, Julian M. Carroll, Denise Harper Angel, Alice Forgy Kerr, Stephen Meredith, and Max Wise; Representatives Danny Bentley, Tina Bojanowski, Adam Bowling, George Brown Jr, Tom Burch, Daniel Elliott, Deanna Frazier, Robert Goforth, Mary Lou Marzian, Melinda Gibbons Prunty, Josie Raymond, Steve Riley, Steve Sheldon, Nancy Tate, and Russell Webber.

Guests: Kristi Putnam, Deputy Secretary, Cabinet for Health and Family Services; Polly Ruddick, Director, Office of Homelessness Prevention and Intervention; Adrienne Bush, Executive Director, Homelessness & Housing Coalition of Kentucky; Officer Alejandro Zaglul, Community Paramedicine Unit, Lexington Police Department; Lili Lutgens, LCSW, Therapeutic Intervention Services; Steve Shannon, Executive Director, Kentucky Association of Regional MH-MR Programs (KARP); Christina Weeter, M.S.W., M.Ed., Director, Division of Student Success, Office of Continuous Improvement and Support, Kentucky Department of Education; Karen Bush, YMHFA Training Coordinator, Division of Student Success, Office of Continuous Improvement and Support, Kentucky Department of Education; Wendy Morris, Commissioner, Department for Behavioral Health, Intellectual and Developmental Disabilities, Cabinet for Health and Family Services; Phill Gunning, NAMI Lexington; Vestena Robbins, PhD, Executive Policy Advisor, Department for Behavioral Health, Intellectual and Developmental Disabilities, Cabinet for Health and Family Services; Christy Shuffett, New Beginnings, Bluegrass; Marc Kelly, Pathways Inc.; Stephanie Bates, Department for Medicaid Services, Cabinet for Health and Family Services; and Caitlin Szabo and Holly Whitaker, Homelessness and Housing Coalition.

LRC Staff: DeeAnn Wenk, Ben Payne, Chris Joffrion, Becky Lancaster, Sean Meloney, Dana Simmons, and Gina Rigsby.

Legislative Hearing on Executive Order 2019-286 - Reorganization of the Cabinet for Health and Family Services

Kristi Putnam, Deputy Secretary, Cabinet for Health and Family Services, was available for questions. A motion to accept Executive Order 2019-286 was made by Representative Bowling, seconded by Senator Raque Adams, and accepted by voice vote.

Approval of the Minutes of the January 23, 2019 Meeting

A motion to approve the minutes of the January 23, 2019 meeting was made by Senator Wise, seconded by Senator Meredith, and approved by voice vote.

"Free Care" State Program Amendment to Medicaid

Kristi Putnam, Deputy Secretary, Cabinet for Health and Family Services, stated that for several decades, Medicaid has played a critical role in providing school-based health services for students with an Individualized Education Program (IED). Kentucky education leaders have recognized the importance of having health and behavioral health clinicians on school campuses, yet funding for school-based health providers has been a challenge. Providing health services in the school setting can help address immediate health care needs, connect students to behavioral health services, and keep students learning.

On April 28, 2019, the cabinet submitted an amendment to its Medicaid state plan to allow for the payment of qualifying physical and mental health services. The Centers for Medicare and Medicaid Services (CMS) has 90 days to review and approve the state plan amendment. If approved, school districts can begin billing for medically necessary Medicaid-eligible services provided to any Medicaid enrolled child when available to all children at no charge starting in August 2019.

Districts across the Commonwealth will be able to leverage federal Medicaid funding to increase access to school-based health services such as comprehensive health screenings, certain mental health services, and diabetes and asthma management. If a school district decides to participate, it will be able to decide the specific services provided based on needs. In order for services to be reimbursable, the services must be provided by an appropriately licensed Medicaid provider.

Mahak Kalra, Health Policy Director, Kentucky Youth Advocates, stated that schools are safest when children are most ready to learn and have access to quality, effective healthcare providers in school settings. There is so much that can be offered to students whether that is comprehensive health screening, therapeutic counseling, asthma prevention and treatment, school nurse services, as well as telehealth opportunities.

In response to questions by Senator Julian Carroll, Deputy Secretary Putnam stated that a school district would have the option to choose suspected drug use by a student as

one of the screening assessments. If a student shows the potential of doing harm to himself/herself and/or others through the behavioral assessments and screening for mental health, it would help the principal and/or the school superintendent respond quicker.

In response to questions by Senator Wise, Deputy Secretary Putnam stated that the Medicaid state plan amendment (SPA) to allow for the payment of qualifying physical and mental health services will be instrumental in allowing mental health professionals to become liaisons with staff in the school to deal with problems.

In response to questions by Representative Bojanowski, Deputy Secretary Putnam stated that the Medicaid state plan amendment funds for mental health services are the same as what is currently being offered in Jefferson County. Services can be provided to all students, but only services for Medicaid eligible students would be reimbursed by the federal government.

In response to questions by Representative Burch, Deputy Secretary Putnam stated that if a school district has a need for more mental health services as compared to physical health services, a school district could decide to focus more on mental and behavioral health services. School districts decide whether or not to participate in Medicaid services in schools and what services would best meet the needs of the students. If services are provided under an IEP, the school district currently has to provide those services under the Medicaid in schools program. The Medicaid SPA does not have to have an IEP as the medically necessary determination to receive services. Audits will be performed on what services are billed to and reimbursed by the Department for Medicaid Services (DMS).

In response to a question by Representative Bowling, Deputy Secretary Putnam stated that DMS will reimburse school districts for services, and then the school district will reimburse the provider whether they are hired by or contract with the school district.

In response to a question by Representative Moser, Deputy Secretary Putnam stated that nurses are a unique feature of Medicaid in schools. There needs to be a relationship between the school district and the local health department to provide a registered nurse (RN) in a school. Advanced registered nurse practitioners (APRNs) and physician assistants (PAs) can be reimbursed by DMS.

Representative Moser stated that having a school-based health center that is readily available to students is a cost-effective way to provide services.

Mental Health and Homelessness

Polly Ruddick, Director, Office of Homelessness Prevention and Intervention, stated that the community believes that a person should never have to change who they are to get what they need. In 2018, Fayette County's homeless system provided services to

over 1,300 individuals self-reporting a mental illness, about 26 percent of the Fayette County population. The number has doubled since 2017 and is likely underreported. Fayette County has been successful in effectively ending veteran homelessness and reducing overall and chronic homelessness because of a systematic shift to the Housing First program with no preconditions. In the Housing First program, fewer expectations and responsibilities are placed on the consumer and more are placed on the providers. In this program, consumers show reductions in substance use, crisis homeless services, hospital stays, incarceration days, and police interaction and have an increase in engagement in mental health treatment and recovery. Without the Housing First program, if a consumer is experiencing homelessness and has a mental illness, the following are responsibilities placed on the consumer to end their homelessness and start mental health recovery: (1) show up for all appointments with several appointments need to even establish care; (2) complete the paperwork on time; (3) voluntarily ask for help and assistance; and (4) come to the coalition for help, and then do what is requested.

For every $10 invested in Housing First, the community saves an average of $21.72. The average cost of $144,000 per year in crisis services for homeless individuals now costs $18,500. In Lexington in 2017, 112 individuals cost the city an estimated $16.4 million. Costs for the same individuals who received permanent housing dropped to $2 million which included all services. Kentucky can start to redevelop a mental health system that will actually provide positive outcomes for consumers by reducing costs on hospitals and acute care and reducing and ending mental illness within homelessness. Kentucky needs to develop a mental health block grant to fund Housing First model programs serving all individuals with mental illness, not just serious mental illness. All funding should be competitive and based solely on outcomes not outputs. Without providing the basic need of housing, individuals will continue to cycle through the system costing taxpayers hundreds of thousands of dollars each year per client. Kentucky needs to provide the housing capacity necessary for all individuals suffering from mental illness and homelessness.

The mental health system uses housing as leverage. All requirements must be met while wondering where to sleep, where to get food, and whether someone will attack you or steal your belongings all while fighting against yourself because you have no control over your malfunctioning brain. The current mental health system offers no solutions for permanent stabilization of basic needs prior to accessing treatment or recovery for those with a mental illness.

Adrienne Bush, Executive Director, Homelessness & Housing Coalition of Kentucky, stated that in Kentucky, the number of people homeless on the street or fleeing domestic violence decreased from 4,998 in 2014 to 3,688 in 2018. The number who self-report severe mental illness (SMI), has decreased from 1,075 in 2014 to 615 in 2018. People who have a mental illness represent 17 percent of the overall homeless population in Kentucky, down from 22 percent in 2014. However, the number of persons with SMI

remains essentially unchanged from 2017 to 2018. The implementation of the Housing First model 15 years ago has helped homeless service providers to make inroads into the challenges associated with SMI and homelessness. Housing First does not mean housing only or housing without consequences, but instead it is a recognition that it is at best difficult and at worst impossible to really address issues with people until they are in a stable place to live. In 2005, legislation was enacted to establish a pilot program in Louisville and the Lake Cumberland region that allows housing stabilization for people exiting out of institutions and the correction system including youth aging out of foster care. Over the past 4 years, the pilot program has served 142 individuals. In 2017, 73 percent of individuals have exited to a positive housing destination. In 2016, the pilot program was enacted to make it permanent and allow for expansion into other communities should funding become available. In 2019, House Bill 378 was enacted to address the needs of youth experiencing homelessness, but the ability for unaccompanied youth 16 and over to consent for shelter, housing, and mental health services was deleted from the legislation. The coalition urges the General Assembly to pass legislation to create a state Affordable Housing Tax Credit that would help private development of more affordable homes. It is nearly impossible to address homelessness without creating a housing environment where individuals with a mental illness can be successful.

In response to a question by Representative Burch, Ms. Ruddick stated that currently a client can decide what type of housing is best for them. The provider is responsible to honor a client's choice. Ms. Bush stated that she would not want to tell other communities what types of housing is needed. This should be driven by local needs and conditions.

Representative Brown stated that he was interested to know how to serve the mentally ill and homeless populations through the myriad of paperwork that has to be filled out.

In response to a question by Senator Danny Carroll, Wendy Morris, Commissioner, Department for Behavioral Health, Intellectual and Developmental Disabilities, Cabinet for Health and Family Services, stated that she would defer the discussion on reimbursement rates for personal care homes to the August 19th meeting.

In response to questions by Representative Moser, Ms. Ruddick stated that clients may disappear after discharge, and might not be found until they show up in jail or have another readmission into a facility. The Office of Homelessness Prevention and Intervention put out a request for proposal (RFP) to do a short, very transitional 90-day care program which would walk clients through every step of transition. The program was not funded because there is no housing available. The proposed mental health block grant would supply a place for someone to live and then allow the community to wrap around services in current programs.

In response to questions by Senator Raque Adams, Ms. Ruddick stated that her office works with private market landlords, developers, and the Affordable Housing Trust Fund in Lexington to help provide housing. The mental health block grant would be used to pay for private market housing.

Crisis Intervention Teams

Officer Alejandro Zaglul, Community Paramedicine Unit, Lexington Police Department, stated that every frontline police officer should be certified in crisis intervention teams (CIT) training to education responding officer on best practices for managing individuals in a crisis due to a mental illness or addiction. The benefits of the CIT training would be reduced use-of-force incident and more compassionate care for the consumer. The community paramedicine team include paramedics, police officers, and social workers who conduct follow-up intensive case management services to provide continuity of care and guidance navigating resources. Paramedicine teams help decrease dispatched calls by allowing police and EMS to address other emergency calls, help reduce emergency department admissions, reduce recidivism, and help individuals overcome barriers. A huge barrier for individuals is that Medicaid is not always reinstated when someone is released from a facility. Mobile crisis units are typically composed of police officers, paramedics, and qualified mental health professionals who conduct assessments on individuals in crisis and determine the most appropriate treatment action. Mobile crisis units can provide savings to a community by avoiding arrests and emergency department visits.

In response to questions by Representative Moser, Lieutenant Seth Lockard, Lexington Fire Department, stated that House Bill 106 from the 2019 Regular Session codified community paramedicine. Lexington's paramedicine team was funded through a 2-year federal Assistance to Fire Fighters grant.

Inadequate Treatment Options for Individuals with Intellectual Disabilities and Mental Health Disorders

Lili Lutgens, LCSW, Therapeutic Intervention Services, stated that the three types of residential facilities include family homes or residences under the Supports for Community Living (SCL) waiver program, psychiatric facilities (202A) for individuals with acute psychiatric problems necessitating a higher standard of care, and intermediate care facilities (ICF-ID) for people with intellectual disabilities (202B). The 202A psychiatric facilities and 202B ICF/ID facilities are not designed to be permanent residences, but instead are used when individuals need a higher level of care than the community can provide. Individuals with both intellectual disabilities and mental illness can present with unique challenges that make them unsafe to remain in the community whether living in residences with family or in SCL residential placements.

Kentucky Revised Statute 202B excludes individuals with mild intellectual disabilities to be placed in an ICF/ID. The ICF/IDs also will not take individuals presenting

with significant psychiatric problems. Individuals with acute or chronic mental health issues such as suicidal or homicidal ideation are often turned away from psychiatric facilities that are not equipped to handle the ID population. The end result is that individuals at risk of harm to self and/or others remain in the community. The cost for their care is picked up by ambulance services, the police, or jails. This is an issue throughout the state and likely even worse in rural communities that lack resources.

KRS 202A does not expressly prevent the entry of individuals with intellectual disabilities into psychiatric facilities, but most the facilities are not geared to treat these individuals. Psychiatric staff determine the symptoms of mental illness are behavioral and, therefore, inappropriate for treatment in a psychiatric facility. Psychiatric facilities typically do not employ behavior analysts even though applied behavior analysis would be useful to the facility population as a whole.

The SCL program offers several residential options to participants including family home providers, staffed residences, and group homes. Placements typically have one staff person per every three participants. The SCL program does provide for exceptional supports, a higher rate of pay for residential services for participants of higher acuity, but this is capped at twice the regulatory rate. Once an SCL residential agency accepts a participant, it must keep the participant until another SCL provider agrees to accept the participant resulting in a significant loss of money and dangerous individuals left in the facility for long periods of time.

Kentucky lacks adequate residential resources for individuals with intellectual disabilities and mental illness. Individuals remain in the community even when they present a risk of harm to self or others putting the individuals, personnel working with them, and the public at risk.

Leah Campbell, Executive Director, Pillar and Board Member, Kentucky Association of Private Providers (KAPP), stated that KAPP conducted a survey of 43 residential providers that reported 79 percent of these residential providers had called 911 in the last 12 months because of a resident who was at risk of harm to self or others. Residential providers cannot afford to accept individuals in any kind of significant crisis situation. The average unreimbursed cost that residential providers incur is over $35,000 per week when a facility has an individuals in crisis. Referrals were turned down by 88 percent of the residential providers who participated in the survey due to the unreimbursed cost. Residential providers cannot discharge or terminate services to an individual with significant mental illness in a crisis situation.

In response to questions by Representative Goforth, Ms. Campbell stated that residential providers are reimbursed $175 per day per client. Ms. Lutgens stated that the SCL program does provide for exceptional supports, a higher rate of pay for residential

services for participants of higher acuity, if a residential provider can prove a resident is in crisis, but it is capped at twice the regulatory rate. Ms. Campbell stated that the extra reimbursement could pay for additional staff or extra behavioral providers to address a specific situation.

Representative Moser stated that the statutes need to be changed to allow individuals to be placed into a 202B facility for a short-term period of time when someone is in imminent risk to self or others.

Mental Health Waiver

Steve Shannon, Executive Director, Kentucky Association of Regional Mental Health-Mental Retardation Programs (KARP), stated that KARP is an association of 10 Community Mental Health Centers (CMHCs) which are the behavioral health public safety net. For the past 53 years, the CMHCs have helped Kentuckians in all 120 counties access needed mental health, substance use disorders, and intellectual and developmental services and supports. The CMHCs serve and support approximately 180,000 individuals annually, employ over 8,000 individuals including direct support professionals, therapists, accountants, and physicians, and have more than 300 voluntary board members.

The Cabinet for Health and Family Services administers six home and community based services (HCBS) 1915 (c) waivers that serve individuals who are aging, have physical disabilities, have brain injuries, have intellectual and developmental disabilities, and are ventilator dependent. HCBS waivers help provide different services that allow those who need care to receive services in their homes or communities. Adults who are severely mentally ill (SMI), adults with substance use disorder (SUD), and children with a serious emotional disturbance (SED) are not included and have never been included in the HCB waivers. The Medicaid State Plan has a robust behavioral health benefit, but does not provide some vital services. Kentucky should consider a Medicaid waiver or state plan amendment (SPA) to provide needed services to adults with SMI such as supportive housing and supported employment and to take advantage of Kentucky's Federal Medical Assistance Percentage (FMAP) which has a 29/71 federal match.

Three waiver or state plan amendment alternatives to leverage the federal match are the 1115 waiver, 1915(c) waiver, and the 1915(i) state plan amendment which can work like a waiver. The 1115 waiver is the broadest type of waiver available to state Medicaid agencies. Under a waiver program, a state can waive certain Medicaid program requirements allowing the state to provide care for people who might not otherwise be eligible under Medicaid. Some waivers allow states to target services to people who need long-term services and supports. The SCL and Michele P. waivers could serve as a model for a 1915(c) waiver for adults with SMI. Existing state general fund dollars would need to be used to leverage federal dollars for these new waivers.

In FFY 2015, the cost of all 1915(c) waivers in all states and D.C. was approximately $44.7 billion. Colorado, Connecticut, Massachusetts, and Montana spent almost $53 million on 1915(c) waivers that targeted adults with SMI. The 1915(i) waiver allows a state to design service packages targeted to people with specific needs including special services for individuals with a mental illness or substance use disorder. The twelve states currently with a 1915(i) SPA are Wisconsin, Oregon, Nevada, Iowa, Louisiana, Florida, Indiana, Connecticut, Wyoming, Montana, Texas, and Maryland.

House Bill 447 was filed during the 2019 Regular Session that would direct the cabinet to submit waivers, waiver amendments, or state plan amendments necessary to provide support employment and supportive housing services to adults who have a severe mental illness. Unfortunately, the bill failed to be enacted.

Social determinates of health are conditions in the environment that affect an individual's health. Two variables that negatively impact health are housing instability and lack of employment. The waivers discussed today can provide adults with SMI access to more stable housing and employment services thereby decreasing Medicaid spending on emergency rooms and unnecessary hospitalizations. If adults with SMI cannot access necessary services and supports, they will access more costly services such as emergency rooms, local jails, and homeless shelters. Kentucky must do better for the individuals who need services.

Grant Updates

A. Kentucky Advancing Wellness and Resilience Education (AWARE) Project

Christina Weeter, M.S.W., M.Ed., Director, and Karen Bush, YMHFA Training Coordinator Improvement and Support, Division of Student Success, Office of Continuous Improvement and Support, Kentucky Department of Education, stated that in 2014, the Kentucky Department of Education (KDE) received a Project Advancing Wellness and Resilience Education (AWARE) five-year grant from the Now is the Time initiative awarded by the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. The KDE used the grant to train adults on responding to mental health issues when interacting with school-aged youth, connect children, youth, and families who may require support to appropriate mental health services, and implement Youth Mental Health First Aid (YMHFA) in state and local training programs. The School Climate Transformation Grants (SCT) and AWARE can support the goals of the School Safety and Resiliency Act (2019 Senate Bill 1). Recommendations are due June 2019 to the State Interagency Council (SIAC) Social Emotional Health Task Force. Over 4,400 First Aiders were certified through the YMHFA training that resulted in almost 15,000 mental health referrals by the First Aiders.

In the Fall of 2018, KDE was awarded the SCT grant, and in the Spring 2019, KDE was awarded a second Project AWARE grant that included three new pilot districts in

Bullitt County, Henderson County, and Warren County. AWARE and SCT grants will support Trauma-informed Practices for Educators (TIPE) learning collaboratives, training to support the integration of mental health referral pathways and cultural competency into Positive Behavior Interventions and Supports (PBIS), Youth Mental Health First Aid (YMHFA), and a single state management team to ensure ongoing alignment and coordination of both projects.

Some features of Project AWARE 2019 are state and local collaborative partnerships, comprehensive plan for school and community-based mental health services, and coordinated mental health referral, services, and follow-up for youth and their families. The five goals for Project AWARE 2019 are: (1) increase the mental health awareness and literacy of school staff, administrators, parents, agency partners and community members who interact with school-aged youth by training individuals to respond effectively to youth mental health needs; (2) increase statewide capacity and sustainability of the school and behavioral health treatment workforces to implement and integrate trauma-informed principles into practice; (3) increase access to evidence-based behavioral health services and supports in each partner school district; (4) enhance resiliency among school-age youth by integrating and implementing social-emotional learning skills into the general education curricula and increase family and student engagement; and (5) increase access and use of school-based mental health promotion, prevention, early intervention and treatment strategies by creating or enhancing a proactive multi-tiered system of support (MTSS) in schools, which integrates academic, positive behavior, and mental supports to meet the needs of students.

Project AWARE 2019 will serve 37,556 students through universal, targeted, and direct intervention. Through the provision of training and other supports, the project will impact 375 school administrators, 3,292 school staff, and over 1,000 parents and community members.

In response to a question by Representative Gibbons Prunty, Ms. Bush stated that Marshall County did implement the PBIS framework for several years and had positive results.

B. Youth with Severe Mental Illness, Taylrd 2.0

Wendy Morris, Commissioner, Department for Behavioral Health, Intellectual and Developmental Disabilities, Cabinet for Health and Family Services, stated on March 31, 2019, Kentucky was awarded a $1 million Transition Age Youth Launching Realized Dreams (TAYLRD) 2.0 grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. TAYLRD aims to positively impact the lives of Kentucky's 16 to 25 year olds who have, or are at risk of developing behavioral health challenges by improving access to high-quality, culturally and developmental appropriate supports and services across the Commonwealth.

Studies show that 50 percent of individuals who will develop mental health disorders show symptoms by age 14 and 75 percent of mental health conditions develop by age 24. This data underscores the importance of acting early. Unfortunately, too many of these cases go undetected and untreated and intervention only happens when a crisis occurs. The length of time between onset of symptoms and intervention has a dramatic impact on long-term outcomes. Longer times between symptoms and intervention result in unconscionable rates of suicide, school drop-out, homelessness, juvenile and criminal justice system involvement, and unemployment resulting in both great personal and social costs. Studies also show that we are able to prevent or at least mitigate the effects of mental illness and allow individuals to live fulfilling, productive lives in the community.

The Adverse Childhood Experiences (ACE) Study found that the risk for later chronic health conditions and risky health behaviors rises as the number of ACEs increase. According to America's Health Rankings, Kentucky is in the top 10 states for ACEs, with 27 percent of its children having experienced two or more stressful or traumatic events on a list of 10. With over a quarter of the state's children experiencing 2 or more events that have both short and long term impact, Kentucky must invest in prevention and early intervention. From the prenatal period into early adulthood, there are many opportunities to support the mental health of Kentucky's children, youth, and young adults. Promotion and prevention interventions operate to strengthen protective factors and to reduce exposure for risks. Risk factors can occur at multiple levels, including biological, psychological, family, community, and cultural levels.

Kentucky received two federal grants to support implementation of the TAYLRD initiative. The first grant cycle will end later in 2019, while TAYLRD 2.0 was funded in March 2019 and will run until March 2024. TAYLRD funded programs in the Pathways region (Boyd and surrounding counties) and Centerstone Region (Jefferson and surrounding counties). TAYLRD 2.0 will fund new programs in the Kentucky River region (Perry and surrounding counties) and the Communicare region (Hardin and surrounding counties). The program at Hardin County will focus on youth with military experience, and the program at Perry County will focus on homeless youth. The main features of the TAYLRD initiative are more public awareness of signs and symptoms for serious behavioral health challenges facing young people and the developmentally appropriate responses to those challenges; increased outreach and engagement to youth, young adults, and their families by service providing agencies; and improved access to services for young adults that meet cultural and linguistic needs.

In partnership with the CMHCs and other partner agencies, TAYLRD uses a drop-in center approach to behavioral health care to increase the possibility that young people will receive the right services at the right time. Kentucky has opened TAYLRD Drop-in Centers across the Commonwealth. The centers are youth friendly, safe, with appealing

spaces, designed by youth and young adults that have computer labs, snacks, board games, video games, pool tables, washers and dryers and more where youth and young adult can hang out, work on personal goals, develop their assets, and gain access to resources like peer support, case management, therapy, medication if needed, education, employment, and housing supports. The TAYLRD Louisville Drop-in Center was featured as a best practice model for improving housing and reducing homelessness among youth and young adults in the April issue of Focal Point, a nationally-recognized publication of the Pathways Research and Training Center at Portland State University that conducted a national webinar on their model.

Vestena Robbins, PhD, Executive Policy Advisor, Department for Behavioral Health, Intellectual and Developmental Disabilities, Cabinet for Health and Family Services, was available for questions.

Adjournment

There being no further business, the meeting was adjourned at 3:19 p.m.