Kentucky

UNIFORM APPLICATION
FY 2016 BEHAVORIAL HEALTH REPORT

COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 05/21/2013 - Expires 05/31/2016
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Center for Mental Health Services
Division of State and Community Systems Development

I: State Information

State Information

State DUNS Number

Number	927049767
Expiration Date	12/15/2018 12:00:00 AM

I. State Agency to be the Grantee for the Block Grant

Agency Name	Cabinet for Health and Family Services
Organizational Unit	Department for Behavioral Health, Developmental and Intellectual Disabilities
Mailing Address	275 East Main Street 4W-G
City	Frankfort
Zip Code	40621

II. Contact Person for the Grantee of the Block Grant

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III. State Expenditure Period (Most recent State exependiture period that is closed out)

From	7/1/2014
To	6/30/2015

IV. Date Submitted

NOTE: This field will be automatically populated when the application is submitted.

Submission Date	12/1/2015 11:48:08 PM
Revision Date	

V. Contact Person Responsible for Report Submission

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Footnotes:

II: Annual Report

MHBG Table 1 Priority Area and Annual Performance Indicators - Progress Report

Priority #: 1

Priority Area: Pregnant Women

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Educate and offer treatment services for pregnant women with substance use disorder.

Strategies to attain the goal:

It has been found that the CMHCs are not asking about pregnancy upon first contact. Additional education and close monitoring of the CMHCs will be performed to address this deficiency.

More than 25% of pregnant women in Kentucky smoke. Other than a national cessation hotline, there are no smoking cessation services in the state. The Division will work closely with the Department for Public Health to develop local programs and a statewide hotline.

A new statewide prevalence study for substance use during pregnancy is needed. Kentucky will let a Request for Proposal to update this study. The most recent was completed in 1990.

Residential services for pregnant women in Kentucky are scarce. The Commonwealth will continue to fund “Independence House,” a residential program for pregnant women.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Assure all Community Mental Health Centers are asking about pregnancy at first contact.

Baseline Measurement: 16%

First-year target/outcome measurement: 25%

Second-year target/outcome measurement: 30%

New Second-year target/outcome measurement*(if needed)*:

Data Source:

National prevalence estimates and an outdated state survey.

New Data Source*(if needed)*:

Description of Data:

1990 State Survey

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

The state survey used is from 1990; Kentucky must obtain more up-to-date information to more accurately determine client numbers.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: b Achieved é Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

Second Year Target: þ Achieved ¢ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved *(optional)*:

Required providers to track pregnancy status among clients through contracts and then monitored for compliance and also surveyed providers to illicit compliance/verifications by asking for their procedural policies.

Priority #: 2

Priority Area: Reduce consequences of underage drinking

Priority Type: SAP

Population(s): Other (Youth Aged 12 -20)

Goal of the priority area:

Reduce state 10th grade,
30 day binge drinking rate by at least 1% .

Strategies to attain the goal:

KY Incentives for Prevention (KIP) 2012 survey will be used as a baseline. KIP 2014 data will be used to measure outcomes.
Utilization of the Changing Social Norms and Policy protocol aimed at changing norms around acceptability of usage and limit availability of access in the following ways:
• Limiting social and retail access of alcohol to underage youth through establishment of Social Host Ordinances, or strengthening enforcement of these ordinances in counties where they already exist.
• Retail access strategies such as shoulder taps and compliance checks.
• Expanding and intensifying the “I Won’t Be the One” campaign – a large scale informational efforts at older adults about the legal and health consequences of providing alcohol to underage youth.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Implement local policies that target social access of alcohol to youth (social host & unruly gathering ordinances) in areas of identified need-as evidenced by high alcohol use by monors as reported on KIP survey

Baseline Measurement: 0

First-year target/outcome measurement: 3

Second-year target/outcome measurement: 4

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Regional Prevention Centers will report to the Division of Behavioral Health as local ordinances are created and KIP survey results will be evaluated.

New Data Source*(if needed)*:

Description of Data:

Regional Prevention Center reports as processed through the State Prevention System. Each Regional Prevention Center is required to enter data monthly E.g.number of evidence-based programs implemented, number of people reached, number of ordinances passed, number of people served through universal direct, indirect etc. Reports are generated from the system by the Prevention Branch Data Manager. The Prevention Branch is in the process of changing some of its program codes and revamping its data system. As soon as the revisions are made we will submit baseline data.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Variables in the Commonwealth beyond control, including no ordinaces/data in these locales.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: þ Achieved ¢ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:
During this reporting period, three social host ordinances were passed and a fourth was narrowly defeated. This brings the total number of ordinances in the Commonwealth to 24. Three responsible beverage server ordinances were passed, bringing the total number to 78. Two keg registration ordinances were passed during this reporting period, making a total of 10 in the Commonwealth. (source: The Kentucky Alcohol Prevention Enhancement site. http://www.kyprevention.com)

Second Year Target: þ Achieved ¢ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved *(optional)*:

Progress has continued during this reporting period, there are 28 social host ordinances and 13 KY communities with Keg Registration Ordinances in KY. There are 82 responsible beverage server ordinances in KY. (source: The Kentucky Alcohol Prevention Enhancement site. http://www.kyprevention.com)

Priority #: 3

Priority Area: Women with Dependent Children

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Escalate parents (women) with dependent children to priority population status.

Strategies to attain the goal:

Continued collaboration with the Kentucky Department for Community-Based Services (child protective services) in the sobriety treatment and recovery teams (START). Currently, there are six of fourteen regions throughout the state that provide family mentors (people in recovery) to team with child protective service workers to engage clients in services and keep children at home. These regions provide quick access to assessment and referral to the appropriate level of care. Kentucky would like to expand these services to at least one other region within FFY2014.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Expand the number of START programs in Kentucky

Baseline Measurement: 6

First-year target/outcome measurement: 6

Second-year target/outcome measurement: 7

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Kentucky Department for Community Based Services

New Data Source*(if needed)*:

Description of Data:

Because of a decrease in funding from child protective services, one of the currently implemented START programs is in danger of

folding. For federal fiscal year 2014, it is the intent of the DBH to first stabilize the current programs, and attempt to implement one additional program in another region within Kentucky.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Reductions in funding.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: þ Achieved ¢ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:
Program funding has been moved (non-grant) from the Division of Behavioral Health to the Division of Protection & Permanency; this goal is no longer relevant.

Second Year Target: þ Achieved ¢ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved *(optional)*:

Although the program is no longer funded through the Department for Behavioral Health, it was confirmed that the goals were achieved by the current program administrator in the child welfare agency.

Priority #: 4

Priority Area: Individuals with Substance Use Disorders and TB

Priority Type: SAT

Population(s): TB

Goal of the priority area:

Identify clients seeking treatment for substance use disorder who may currently have, or have in the past, had a tuberculosis diagnosis.

Strategies to attain the goal:

The Kentucky Department for Public Health (DPH) administers the tuberculosis control program in Kentucky. The Division of Behavioral Health will work in collaboration with DPH to share client diagnoses as they pertain to substance use disorder, or tuberculosis infection.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increased knowledge of clients with Substance Use Disorder with Tuberculosis

Baseline Measurement: 1.8 per 100,000

First-year target/outcome measurement: 1.8 per 100,000

Second-year target/outcome measurement: 1.5 per 100,000

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Cross-referencced with client data from the Kentucky Department for Public Health

New Data Source*(if needed)*:

Description of Data:

Client data pulled fro substance abuse clients with a secondary TB diagnosis.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

The Kentucky Division of Behavioral Health (DBH) seeks to share client data with the Kentucky Department for Public Health (DPH) in order to more accurately determine the number of clients in treatment for substance use disorder who have been, or currently are, being treated for Tuberculosis.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: þ Achieved ¢ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

Second Year Target: þ Achieved ¢ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved *(optional)*:

Priority #: 5

Priority Area: Individuals with Substance Use Disorders and HIV

Priority Type: SAT

Population(s): HIV EIS

Goal of the priority area:

For federal fiscal year 2014, as in years' past, the Commonwealth of Kentucky is not an HIV designated state. This performance indicator and priority area are not applicable.

Strategies to attain the goal:

Not applicable.

Annual Performance Indicators to measure goal success

Priority #: 6

Priority Area: Suicide Prevention

Priority Type: MHP

Population(s): SMI, SED

Goal of the priority area:

All 14 Regional Boards will submit a Suicide Care in Systems Framework organizational readiness baseline assessment and a plan for systemic improvement of their suicide care.

Strategies to attain the goal:

Through contract and training/technical assistance offered to each Board, they will successfully meet the goal of improving their readiness and clinical protocols to improve the state's overall suicide rate among adults with SMI and children with SED.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Readiness Assessments and Care Plans Conducted & Created by the 14 Regional Boards

Baseline Measurement: 0

First-year target/outcome measurement: 14 Readiness Assessments submitted and approved

Second-year target/outcome measurement: 14 Suicide Prevention Care Plans submitted and approved

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Regional Boards will submit documentation to the Division of Behavioral Health and Division staff will review and approve (or work with the Board to adequately complete)

New Data Source*(if needed)*:

Description of Data:

Data will be submitted through contract required protocol

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

N/A

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: þ Achieved ¢ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:
All regions within the Commonwealth have conducted readiness assessments.

Second Year Target: þ Achieved ¢ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved *(optional)*:

•Kentucky law requires that public middle and high school teachers, principals and counselors receive two hours of suicide prevention training annually, and middle and high school students must receive suicide prevention information by September 1 annually. DBHDID provides technical assistance and resources for school staff and student training, including regional trainings around effective practices for schools and students, including evidence-based programs such as Lifelines, Signs of Suicide, More than Sad, LEADs curriculum, along with the promotion of the SAMHSA Toolkit for High School Suicide Prevention.
• As of 2015, Kentucky law requires behavioral health clinicians to take 6 hours of suicide assessment, treatment and management training. DBHDID hosted training for trainers in 2014 for the Assessing and Managing Suicide Risk training, which is on the Suicide Prevention Resource Center's Best Practice Registry. DBHDID supplies ongoing support for this training including trainer fees, materials and CEUs for clinicians who work with clients with mental health and/or substance use disorders including those with SMI and SED. DBHDID also supported two workshops on the Collaborative Assessment and Management of Suicidality in 2014 and anticipate further supporting future CAMS trainings.
• Kentucky has been involved in the Zero Suicide in Healthcare and Behavioral Health Care which is a system of care approach to reducing suicide for all populations. Kentucky currently has a SAMHSA grant with a strong focus on Zero Suicide for youth and young adult populations, however, our Zero Suicide initiative in Kentucky is aimed at health and mental health providers and organizations serving clients with mental health and/or substance use disorders including those with SMI and SED.
• The Suicide Prevention Consortium of Kentucky (SPCK – Live Long) was formed in 2014 to bring together various entities that are involved in suicide prevention and related efforts. DBHDID provided support and technical assistance to SPCK and to other groups and communities, including statewide needs assessments, funding, etc. in order to guide this group in efforts for various high risk groups including those with MH and SA issues and those with SED or SMI diagnoses, military and veteran and LGBTQ youth. From 2011 to 2014 DBHDID hosted trainings for providers of services to LGBTQ youth around culturally competent suicide care for this population.
• Kentucky has a large military and veteran population and their families with two Army bases, strong National Guard presence as well as Reserves. DBHDID partners with military and veteran organizations, those who serve these populations around multiple initiatives to reduce suicidal behaviors among these populations. DBHDID hosts annually Operation Immersion, Operation Headed Home for this population and those who provide services to this population, and Service Members, Veterans and Families (SMVF) suicide prevention implementation team which meets monthly with ongoing technical assistance from SAMHSA. This group is planning to merge with a similar SMVF substance use prevention implementation team in order to better braid or blend our efforts for the prevention of negative

outcomes such as suicide and substance abuse, for military, veterans and their families.

Priority #: 7

Priority Area: Adults with SMI who reside in Personal Care Homes

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Assist adults with SMI to move from living in a Personal Care Home (PCH) to an integrated community setting

Strategies to attain the goal:

Further develop services and supports to allow adults with SMI to move from PCHs to community housing of their choice.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of Adults with SMI who move from a PCH to an integrated community residence

Baseline Measurement: Estimated 2,000 persons with SMI currently residing in PCHs

First-year target/outcome measurement: 200 Adults with SMI will move from a PCH to an integrated community residence

Second-year target/outcome measurement: 200 (additional) Adults with SMI will move from a PCH to an integrated community residence

New Second-year target/outcome measurement*(if needed)*:

Data Source:

The Division of Behavioral Health will strictly monitor this along with an independent monitor

New Data Source*(if needed)*:

Description of Data:

There are identified individuals that will be priority -provided by P&A

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

N/A

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ○ Achieved ○ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:
Protection & Advocacy Interim Settlement Agreement with the CHFS established a goal of transitioning 100 individuals from PCH between October 1, 2013 and October 1, 2014, with 200 additional to move by October 1, 2015 and 300 additional to move by October 1, 2016, for a total of 600. Systems change activities and funding was initiated in January 2015 and progress escalated in June – September 2014. For the time period of October 1, 2013 – October 1, 2014, 56 individuals transitioned into the community with a revised goal of 244 to move by October 1, 2015. Housing capacity and funding is limited and local EBP services are slow to reach fidelity.

How first year target was achieved *(optional)*:

Second Year Target: ○ Achieved ○ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved *(optional)*:

A data tracking tool was implemented in January 2015 to allow for a more comprehensive approach in identifying individuals with SMI who reside in personal care homes and who are in need of “in-reach” services to assist them in transitioning into the community. As of October 27, 2015, 1,366 persons were referred and of those, 691 (51%) were deemed ‘inaccessible’ for various reasons (e.g., eligibility, refusing services or unable to locate). Consequently, the CMHCs are working with an active caseload of 675 individuals and have successfully transitioned or diverted a total of 282 persons from personal care homes into various community settings. Progress toward goal attainment has been steadily escalating throughout SFY 2015. State funds and Block grant and have been utilized to support the use of four identified evidence based practices (EBPs) necessary to support individuals in the community, including:
Assertive Community Treatment (ACT); Peer Support Services; Supported Employment; and Supported Housing. Ten (10) of sixteen (16) established ACT teams have attained passing fidelity scores. Peer Support services have not been implemented as readily due to delayed training and availability of a qualified workforce. Supported Employment (IPS model) has grown steadily with three (3) sites achieving “exemplary” fidelity, seven (7) at “good” fidelity with two (2) at “fair” fidelity. Housing assistance in the form of vouchers is reaching capacity with 120 current recipients and a capacity of 150 total vouchers, but individuals associated with the settlement agreement remain a priority for receipt of vouchers.

Priority #: 8

Priority Area: Youth with co-occurring SED and Substance Use Disorders (SUDs)

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Increase the number of youth with co-occurring mental health and substance use disorders that recieve services from the Regional Boards.

Strategies to attain the goal:

Utilize newly developed funding streams to enhance provider competence to screen, assess and treat youth with co-occurring MH and SU disorders. Utilize E BPs for youth with SUDs- 7 Challenges, Cannabis Youth Treatment (CYT), Motivational Interviewing, MET-CBT, Adolescent Community Reinforcement Approach (ACRA)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of youth with identified SED and Substance Use Disorders

Baseline Measurement: Baseline Year - No date

First-year target/outcome measurement: 150

Second-year target/outcome measurement: 250 (Additional)

New Second-year target/outcome measurement*(if needed)*:

Data Source:

MHSIP data set used by the Department and the 14 Regional Boards

New Data Source*(if needed)*:

Description of Data:

Data will show how many individuals served by diagnostic category and services type.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

data currently available provides some detail to estimate current service numbers but diagnostic and services category type and actual numbers of youth with SED and youth with SUDs is available separately, but not a reliable count of youth with co-occurring.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: þ Achieved ¢ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

Second Year Target: þ Achieved ¢ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved *(optional)*:

In SFY 2014, there were 168 served and in SFY 2015, there were 269 youth with co-occurring mental health and substance use disordered served.

Priority #: 9

Priority Area: Prescription Drug Use among Adults and Youth

Priority Type: SAP

Population(s): Other (Youth ages 12- 18 Adults 20-24)

Goal of the priority area:

Reduce the misuse of prescription drugs by adults and youth

Strategies to attain the goal:

Utilizing the Changing Social Norms and Policy protocol, focus on environmental strategies that aim to change norms around acceptability of usage and limit availability of access. Regions that are concentrating on prescription drugs will concentrate their efforts primarily on:
• Correcting three (3) youth misperceptions about prescription drugs - that they are: 1.) safer than street drugs, 2.) less addictive than street drugs, 3.) OK to share among friends and family
• Safe storage and disposal of prescription drugs
• Support for new Kentucky legislation which licenses pain clinics and mandates the use of the Kentucky All Scheduled Prescription Electronic Drug Reporting (KASPER) system for all doctors in the state
• Conducting large scale informational efforts directed at parents, caregivers and prescribers of prescription drugs

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Reduce misuse of prescription drugs

Baseline Measurement: Incidence of misuse as reported on NSDUH survey and the KIP survey for youth

First-year target/outcome measurement: 5% decrease in misuse

Second-year target/outcome measurement: 8% decrease in misuse

New Second-year target/outcome measurement*(if needed)*:

Data Source:

NSDUH survey and the KIP survey for youth

New Data Source*(if needed)*:

Description of Data:

The National Survey on Drug Use and Health (NSDUH) is an annual nationwide survey involving interviews with approximately 70,000 randomly selected individuals aged 12 and older.
Every even-numbered year, the Kentucky Division of Behavioral Health, with the support of the Governor's Office of Drug Control Policy and the Federal Center for Substance Abuse Prevention, jointly sponsor the KIP survey to assess the extent of alcohol, drug, and

tobacco use among 11 to 18-year-olds throughout Kentucky, and to evaluate the impact of prevention efforts aimed at reducing substance use.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

There are no data issues. Data may show as skewed as the NSDUH is a smaller sample.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: þ Achieved ¢ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

Second Year Target: þ Achieved ¢ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved *(optional)*:

Priority #: 10

Priority Area: IVDUs - Intravenous drug users

Priority Type: SAT

Population(s): IVDUs

Goal of the priority area:

All 14 Community Mental Health Centers to screen for IV drug use upon initial contact.

Strategies to attain the goal:

Continued education and monitoring of client intake data. In addition, Kentucky shall work with the CMHCs to encourage them to follow the NQF Standard of Care regarding Withdrawal Management; specifically, “Supportive pharmacotherapy should be available and provided to manage the symptoms and adverse consequences of withdrawal, based on a systematic assessment of the symptoms and risk of serious adverse consequences of the withdrawal process.” Kentucky will accomplish this by increasing detox services so that there is a minimum of one medically supported detox center in each of the 14 regions; more where population or geography requires.

Kentucky will continue to strive to follow the NQF Standard of Care regarding pharmacotherapy: “Pharmacotherpy should be recommended and available to adult patients diagnosed with opioid dependency and without medical contraindications.” CMHCs should be required to recommend MAT when appropriate, and affordable MAT options need to be increased to provide services to indigent residents.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increased number of clients screened for IV drug use at initial contact.

Baseline Measurement: 50%

First-year target/outcome measurement: 70%

Second-year target/outcome measurement: 80%

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Kentucky Opioid Replacement Therapy Outcome Study (KORTOS)

New Data Source*(if needed)*:

Description of Data:

Client data collected through KORTOS

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Kentucky's addicted follow what seems to be the national norm in that the Opiod prescription drug users, when faced with no available source, turn to IV heroin use, which then shows a disproportionate number of users.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: þ Achieved ¢ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

Second Year Target: þ Achieved ¢ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved *(optional)*:

Footnotes:

III: Expenditure Reports

MHBG Table 3 - MHBG Expenditures By Service.

Expenditure Period Start Date: 7/1/2014 Expenditure Period End Date: 6/30/2015

Service	Unduplicated Individuals	Units	Expenditures
Healthcare Home/Physical Health			$0
Specialized Outpatient Medical Services			$0
Acute Primary Care			$0
General Health Screens, Tests and Immunizations			$0
Comprehensive Care Management			$0
Care coordination and Health Promotion			$0
Comprehensive Transitional Care			$0
Individual and Family Support			$0
Referral to Community Services Dissemination			$0
Prevention (Including Promotion)			$0
Screening, Brief Intervention and Referral to Treatment			$0
Brief Motivational Interviews			$0
Screening and Brief Intervention for Tobacco Cessation			$0
Parent Training			$0
Facilitated Referrals			$0
Relapse Prevention/Wellness Recovery Support			$0
Warm Line			$0
Substance Abuse (Primary Prevention)			$0
Classroom and/or small group sessions (Education)			$0
Media campaigns (Information Dissemination)			$0
Systematic Planning/Coalition and Community Team Building(Community Based Process)			$0
Parenting and family management (Education)			$0

Education programs for youth groups (Education)			$0
Community Service Activities (Alternatives)			$0
Student Assistance Programs (Problem Identification and Referral)			$0
Employee Assistance programs (Problem Identification and Referral)			$0
Community Team Building (Community Based Process)			$0
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental)			$0
Engagement Services			$0
Assessment			$0
Specialized Evaluations (Psychological and Neurological)			$0
Service Planning (including crisis planning)			$0
Consumer/Family Education			$0
Outreach			$0
Outpatient Services			$0
Evidenced-based Therapies			$0
Group Therapy			$0
Family Therapy			$0
Multi-family Therapy			$0
Consultation to Caregivers			$0
Medication Services			$0
Medication Management			$0
Pharmacotherapy (including MAT)			$0
Laboratory services			$0
Community Support (Rehabilitative)			$0
Parent/Caregiver Support			$0
Skill Building (social, daily living, cognitive)			$0
Case Management			$0

Behavior Management			$0
Supported Employment			$0
Permanent Supported Housing			$0
Recovery Housing			$0
Therapeutic Mentoring			$0
Traditional Healing Services			$0
Recovery Supports			$0
Peer Support			$0
Recovery Support Coaching			$0
Recovery Support Center Services			$0
Supports for Self-directed Care			$0
Other Supports (Habilitative)			$0
Personal Care			$0
Homemaker			$0
Respite			$0
Supported Education			$0
Transportation			$0
Assisted Living Services			$0
Recreational Services			$0
Trained Behavioral Health Interpreters			$0
Interactive Communication Technology Devices			$0
Intensive Support Services			$0
Substance Abuse Intensive Outpatient (IOP)			$0
Partial Hospital			$0
Assertive Community Treatment			$0
Intensive Home-based Services			$0
Multi-systemic Therapy			$0

Intensive Case Management			$0
Out-of-Home Residential Services			$0
Children's Mental Health Residential Services			$0
Crisis Residential/Stabilization			$0
Clinically Managed 24 Hour Care (SA)			$0
Clinically Managed Medium Intensity Care (SA)			$0
Adult Mental Health Residential			$0
Youth Substance Abuse Residential Services			$0
Therapeutic Foster Care			$0
Acute Intensive Services			$0
Mobile Crisis			$0
Peer-based Crisis Services			$0
Urgent Care			$0
23-hour Observation Bed			$0
Medically Monitored Intensive Inpatient (SA)			$0
24/7 Crisis Hotline Services			$0
Other (please list)			$0
Total			$0

Footnotes:

This is not a required table and Kentucky does not collect data in these categories. Therefore, KY does not submit information for this table.

III: Expenditure Reports

MHBG Table 4 - Set-aside for Children's Mental Health Services

State Expenditures for Mental Health Services		
Actual SFY 2008	Actual SFY 2014	Estimated/Actual SFY 2015
$9,483,648	$10,246,212	$9,563,569

States are required to not spend less than the amount expended in Actual SFY 2008. This is a change from the previous year, when the baseline for the state expenditures was 1994.

Footnotes:

III: Expenditure Reports

MHBG Table 7 - Maintenance of Effort for State Expenditures on Mental Health Services

Total Expenditures for SMHA		
Period (A)	Expenditures (B)	$\frac{\text{B1(2013) + B2(2014)}}{2}$ (C)
SFY 2013 (1)	$20,505,083	
SFY 2014 (2)	$20,508,187	$20,506,635
SFY 2015 (3)	$20,508,271	

Are the expenditure amounts reported in Column B "actual" expenditures for the State fiscal years involved?

SFY 2013	Yes	X	No	
SFY 2014	Yes	X	No	
SFY 2015	Yes	X	No	

If estimated expenditures are provided, please indicate when actual expenditure data will be submitted to SAMHSA: _____

Footnotes:

Kentucky Behavioral Health Planning & Advisory Council
Mary Singleton, Chair Sherry Sexton, Vice Chair Gayla Lockhart, Secretary
275 E. Main Street, 4WG, Frankfort, Kentucky 40621

November 19, 2015

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road Room 7-1109
Rockville, Maryland 20857

Dear Ms. Simmons:

In accordance with the *CMHS Block Grant Report*, I am writing on behalf of Kentucky's Behavioral Health Planning & Advisory Council to confirm that our Council members have reviewed the 2015 Behavioral Health Report. Our Council dedicated time at today's quarterly council meeting to review a draft copy to solicit comments before the December 1st due date.

Thank you for the continued support of mental health and substance use treatment and prevention block grant funds. Our Council membership is honored to serve as advisors for planning in Kentucky.

Sincerely,

Mary Singleton

Mary Singleton
Chair, Kentucky Behavioral Health Planning & Advisory Council

Cc: Michele Blevins

EXECUTIVE SUMMARY
Unified Community Mental Health and Substance Abuse Prevention and Treatment Block Grant Implementation Report for FFY 2015 Funds

Please note that no Executive Summary is required/able to be loaded into the electronic web application but is provided by KDBHDID for informational purposes.

This document contains Kentucky's year-end report on the expenditure of federal mental health and substance abuse treatment and prevention funds for State Fiscal Year 2015. These are Title XIX funds that are awarded on a non-competitive basis to all U.S. states and territories that submit required application and reporting. These funds are intended to strengthen the publicly funded behavioral health systems of care for adults and youth across the Commonwealth. The application and required reporting is submitted by the state's designated authority for both mental health and for substance abuse prevention and treatment, the Kentucky Department for Behavioral Health, Intellectual and Developmental Disabilities (DBHDID) in compliance with Public Law 102-321.

Historically, the federal Center for Mental Health Services and the Centers for Substance Abuse Prevention and Treatment, within the Substance Abuse and Mental Health Services Administration (SAMHSA) have had markedly different planning and application processes, as well as different reporting requirements and timeframes. In recent years, SAMHSA has encouraged states to complete a "unified" application and reporting format. The funds continue to be awarded separately but states are strongly encouraged to participate in joint planning to transform their behavioral health system into one that is fully integrated. A detailed timetable for application and reporting is included at the end of this summary.

SAMHSA requires that Block Grant funds be directed toward four purposes: (1) To fund priority treatment and support services for individuals without insurance or who cycle in and out of health insurance coverage; (2) To fund those priority treatment and support services not covered by Medicaid, Medicare or private insurance and that demonstrate success in improving outcomes; (3) To fund universal, selective and targeted prevention activities and services; and (4) To collect performance and outcome data to determine effectiveness and to plan the implementation of new services. States are instructed to include in their plan the efforts made toward the transition of block grants for these four purposes.

Block Grant funds may only be used to carry out the activities identified in the state's approved plan; to evaluate programs under the plan; and to plan, administer and educate stakeholders regarding services and supports under the plan. The majority of the block grant funds are allocated to Kentucky's fourteen Regional Behavioral Health Boards (the Community Mental Health Centers) that provide a full array of mental health and substance abuse prevention and treatment services. Federal limitations on administrative costs and maintenance of effort requirements are met. A certain percentage of the state's mental health funding must be set aside for children's services, and a certain percentage of substance abuse funding must be set aside for prevention activities. Kentucky generally exceeds these minimum requirements.

The plans required by the block grant must address all activities and funding that build systems of care for individuals with behavioral health care needs, not just those supported by Block Grant funds. Therefore, the data in this report and the Uniform Reporting System (URS) Tables includes services provided with all available funds, including Medicaid, other federal grants, locally obtained funds, and appropriations from the Kentucky General Assembly.

The planning process required by the federal agency also provides an opportunity to present it for formal review by a panel of stakeholders, the Kentucky Behavioral Health Planning & Advisory Council. Parents, family members, and consumers are well represented on the Council (51%), and we believe that the state's publicly funded behavioral health system is stronger because of their involvement, ideas, and comments. There are currently new members being added to the Council to more fully represent consumers and family members affected by substance use disorders.

As a result of the required planning process for the funding application for which this implementation report is submitted, the table below represents the *State Priorities* for Kentucky's publicly funded behavioral healthcare system that were created in the FFY 2014-2015 grant cycle.

STATE PRIORITIES	
1	Ensure access to behavioral health services and supports across the Commonwealth.
2	Ensure availability of high quality (science based) services and supports for all consumers of the publicly funded behavioral healthcare system.
3	Promote holistic, integrated physical and behavioral health services/supports, utilizing bi-directional models, across Kentucky's publicly funded healthcare system.
4	Reduce health disparities and premature death among individuals with behavioral health disorders.

5	Maintain focus on addressing the behavioral healthcare needs of targeted populations, including:
	• Persons who have mental health or substance abuse disorders and are:
	  ➢ Pregnant;
	  ➢ Diagnosed with HIV/AIDS;
	  ➢ Intravenous drug users;
	  ➢ Diagnosed with tuberculosis;
	  ➢ Adolescents; or
	  ➢ Parents with dependent children.
	• Adults with Severe Mental Illness
	• Children/youth with Severe Emotional Disturbance; or
	• Individuals with co-occurring mental health and substance use disorders.

6	Further develop evidence-based substance abuse prevention and mental health promotion and prevention activities across the Commonwealth.
7	Further develop behavioral health services and supports for adults with SMI and children/youth with SED who are involved with the juvenile and criminal justice systems.
8	Expand behavioral health (mental health and substance abuse) prevention and treatment services to military personnel, veterans and their families.
9	Enhance the knowledge and skills of behavioral health providers and others that could/do lend support to citizens with behavioral health disorders (first responders, correctional officers, courts, employers, human service agencies, etc.).
10	Increase the utilization of data to drive planning, treatment and coordination of the publicly funded behavioral healthcare system.

States are required to develop Goals, Strategies and Performance Indicators to address each of these priorities and to report on the state's progress towards the goals and objectives annually. The detailed reporting of progress is provided in Table 1 of this document. Additionally, states are required to provide detailed expenditure data in formatted Tables. Some of the tables are required and some are optional.

The FFY 2014-15 block grant application/plan was submitted on September 1, 2013 for the two year period of October 1 2013-September 30, 2015. Kentucky also submitted an abbreviated funding application based on the plan in the interim year (September 1, 2014) and this document is the year two report. The table below shows the timelines with which states must comply. Kentucky submitted its plan for FFY 2016-21017 on September 1, 2015.

Application for FFY	Two Year Plan Due	Abbreviated Funding Application	Plan is for the Period of	Implementation Reports Due	Reporting Period
2014	9/3/2013		10/1/13-9/30/15	12/1/15	7/1/13-6/30/14
2015		9/1/2014	10/1/14-9/30/15	12/1/16	7/1/14-6/30/15
2016	4/1/15-9/1/2015		7/1/15-6/30/17	12/1/17	7/1/15-6/30/16
2017		9/1/2016	10/1/16-9/30/17	12/1/18	7/1/16-6/30/17

Note: Reporting for SYNAR is due by December 31.