Kentucky

UNIFORM APPLICATION FY 2024 Mental Health Block Grant Report COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 06/15/2023 - Expires 06/30/2025 (generated on 11/29/2023 9.04.52 AM)

Center for Mental Health Services
Division of State and Community Systems Development

A. State Information

State Information

State Unique Entity Identification

Unique Entity ID LECJQDCLHVE5

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

First Name Katie

Last Name Marks

Agency Name Department for Behavioral Health, Development, and Intellectual Disabilities

Mailing Address 275 East Main Street 4W-F

City Frankfort

Zip Code 40621

Telephone 502-782-6106

Fax 502-564-5478

Email Address katie.marks@ky.gov

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

From 7/1/2022

To 6/30/2023

IV. Date Submitted

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

Submission Date

Revision Date

V. Contact Person Responsible for Report Submission

First Name Melissa

Last Name Runyon

Telephone 502-782-6238

Fax

Email Address Melissa.Runyon@ky.gov

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

Kentucky Behavioral Health Planning & Advisory Council

275 East Main Street, 4W-G, Frankfort, KY 40601

November 16, 2023

Odessa Crocker
Grants Management Officer
Division of Grants Management
Office of Financial Resources
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Rockville, MD 20857

Odessa Crocker,

I am writing on behalf of Kentucky's Behavioral Planning and Advisory Council to confirm that Council members have reviewed the Behavioral Health Reports for the Mental Health Block Grant and the Substance Use Prevention, Treatment and Recovery Services Block Grant. These reports provide required information on the federal funds expended during state fiscal year 2023.

Time was allocated to today's Council meeting to discuss the reports, including the data tables required for submission on December 1, 2023. The Department for Behavioral health, Developmental and Intellectual Disabilities welcomes recommendations and comments prior to and after submission of the 2024 Behavioral Health Reports.

Thank you for the continued support of community-based services for adults and youth with mental health, substance use, and co-occurring disorders. Our Council membership is honored to serve as advisors for planning in Kentucky.

Sincerely.

Sharon Darnell

Chair, Kentucky Behavioral Health Planning and Advisory Council

Cc: Melissa Runyon, Block Grant State Planner

Dutruell

B. Implementation Report

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

Priority #: 1

Priority Area: Adults with SMI

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Maintain a rate of 8% or less of psychiatric hospital discharges to a personal care home where the admission living arrangement was not personal care home

Objective:

To avoid an increase in the rate of adults, who did not already reside in personal care homes, being discharged to personal care homes from state-operated/contracted psychiatric hospitals.

Strategies to attain the goal:

The electronic medical records system utilized by state-operated/contracted psychiatric hospitals collects living arrangement at admission and discharge.

Maintain collaborative partnerships between the state-operated/contracted psychiatric hospitals and the CMHCs to facilitate referrals to community services.

Maintain contracts with CMHCs to provide evidence-based practices that assist individuals with SMI to live in the community: Assertive Community Treatment, Permanent Supportive Housing, Supported Employment and Peer Support services.

Provide training, technical assistance and fidelity monitoring to ensure most effective implementation of these evidence-based practices.

Provide technical assistance to the state-operated/contracted psychiatric hospitals and the CMHCs to address barriers to community placement.

Edit Strategies to attain the objective here: (if needed)

New Data Source(if needed):

| nual Performance Indicators to measu | re goal success |
|---|--|
| Indicator #: | 1 |
| Indicator: | Adults discharged from a state-operated/contracted psychiatric hospital to a personal care home where the admission living arrangement was not personal care home. |
| Baseline Measurement: | The SFY 2020 percentage of adults discharged from a state-operated/contracted psychiatric hospital to a personal care home where the admission living arrangement was not personal care home was at 5% = 267/5,278. |
| First-year target/outcome measurement: | By the end of SFY 2022, the percentage of adults discharged from a state-operated/contracted psychiatric hospital to a personal care home where the admission living arrangement was not personal care home will be maintained as less than 8%. This number will be calculated annually. |
| Second-year target/outcome measurement: | By the end of SFY 2023, the percentage of adults discharged from a state- operated/contracted psychiatric hospital to a personal care home where the admission living arrangement was not personal care home will be maintained as less than 8%. This number will be calculated annually. |
| New Second-year target/outcome measurem | ent(if needed): |
| Data Source: | |
| DBHDID Facility Data Set | |

Description of Data: Data report to show per State Fiscal Year (SFY): Report ID: COC_10-DC-LA_Not_From_PCH The total number of percentage of adults discharged from a state-operated psychiatric hospital to a personal care home where the admission living arrangement was not personal care home. The report is based on SFY (July 1 - June 30). This report is updated monthly. This report includes data for Central State Hospital, Western State Hospital, and Eastern State Hospital. New Description of Data:(if needed) Data issues/caveats that affect outcome measures: The electronic medical record system is the source of data. Technical issues that are unique to each facility's system sometimes occur. Troubleshooting technical issues with this system as they arise involves a third party vendor and a third party data management contract. In addition, this rate would be impacted if a significant or unusual change occurred to the total number of adults discharged in any single year.. It is expected that adults needing the levels of care described in this indicator are experiencing SMI. However, the specific data sets for both state-operated/contracted psychiatric hospitals and personal care homes are not required to have a specific SMI market. Personal care home admissions are required to have a diagnosis of mental illness that is expected to last at least two (2) years, and individuals must need assistance with daily living/personal care functioning. New Data issues/caveats that affect outcome measures: Report of Progress Toward Goal Attainment Achieved Not Achieved (if not achieved, explain why) First Year Target: Reason why target was not achieved, and changes proposed to meet target: How first year target was achieved (optional): In SFY 2022, there were 5,040 people discharged from state psychiatric hospitals who did not live in personal care homes upon admission. 214 of those were discharged to personal care homes for a total of 4.2%. Achieved Not Achieved (if not achieved, explain why) Second Year Target: Reason why target was not achieved, and changes proposed to meet target: How second year target was achieved: In SFY 2023 there were 5,304 people discharged from state psychiatric hospitals who did not live in Personal Care Homes upon hospital admission. Of those, 223 were discharged to Personal Care Homes for a total of 4.2%. Priority #: **Priority Area:** Early Serious Mental Illness/First Episode Psychosis **Priority Type:** MHS Population(s): **FSMI** Goal of the priority area: Increase access to evidence-based practices for individuals with early serious mental illness/first episode psychosis (FEP). Objective: Ensure rapid access to a prescriber for young people being admitted into Coordinated Specialty Care programs.

Strategies to attain the goal:

Utilize consultation from national experts in the field.

Provide training and technical assistance to all outpatient sites funded to provide Coordinated Specialty Care (CSC) to this population.

Convene biannual meetings with all key contacts from CMHCs, regarding this population, to provide technical assistance/education regarding CSC and the ESMI/FEP population.

Embed rapid access measures and rationale into CMHC contract deliverables for CSC outpatient funded sites.

| nual Performance Indicators to measu | g |
|--|--|
| | |
| Indicator #: | 1 |
| Indicator: | Young people will have access to available prescriber appointments within seven (7) days of admission into one of the eight (8) CSC programs. Young people served in CSC programs are not required to see a prescriber, but may choose to see a team prescriber, even if they do not wish to take medication. However, for ALL who choose to see a prescriber, rapid access is essential. Rapid access to care, including evidence-based medication management/education is a large part of the evidence base for CSC. |
| Baseline Measurement: | As of the third quarter of SFY 2021, eight (8) CSC funded programs had team prescribers identified to see young people upon admission into CSC programming. There were 54 new young people admitted into CSC programs, 35 of those new admissions saw the team prescriber within 7 days upon admission, resulting in a statewide total of 65% of new admissions into CSC programs seeing team prescribers within 7 days of admission. |
| First-year target/outcome measurement: | By the end of SFY 2022, the statewide total of new admissions into CSC programs seeing team prescribers within 7 days of admission will be 70 % of all new admissions who choos to see team prescribers. |
| Second-year target/outcome measurement: | By the end of SFY 2023, the statewide total of new admissions into CSC programs seeing team prescribers within 7 days of admission will be 75% of all new admissions who choose to see team prescribers. |
| New Second-year target/outcome measurem | ent(if needed): |
| Data Source: | |
| Department Periodic Penert (DDD) forms 1131 | |
| Department Periodic Report (DPR) form 1131 | H/CMHC Contract Reporting Requirement. Additional CSC site level data as needed. |
| | H/CMHC Contract Reporting Requirement. Additional CSC site level data as needed. |
| New Data Source(if needed): | H/CMHC Contract Reporting Requirement. Additional CSC site level data as needed. |
| · · | H/CMHC Contract Reporting Requirement. Additional CSC site level data as needed. |
| | H/CMHC Contract Reporting Requirement. Additional CSC site level data as needed. |
| New Data Source(if needed): Description of Data: | H/CMHC Contract Reporting Requirement. Additional CSC site level data as needed. this form on a quarterly basis. Data are collected from this form regarding prescriber access, |
| New Data Source(if needed): Description of Data: DPR Form 113H. All CMHC CSC sites submit in addition to all new admissions. | |
| New Data Source(if needed): Description of Data: DPR Form 113H. All CMHC CSC sites submit to | |
| New Data Source(if needed): Description of Data: DPR Form 113H. All CMHC CSC sites submit in addition to all new admissions. New Description of Data:(if needed) | this form on a quarterly basis. Data are collected from this form regarding prescriber access, |
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| New Data Source(if needed): Description of Data: DPR Form 113H. All CMHC CSC sites submit in addition to all new admissions. New Description of Data:(if needed) Data issues/caveats that affect outcome measurements. It is best practice for all young people exper regardless whether they take medications. Here | this form on a quarterly basis. Data are collected from this form regarding prescriber access, |
| New Data Source(if needed): Description of Data: DPR Form 113H. All CMHC CSC sites submit in addition to all new admissions. New Description of Data:(if needed) Data issues/caveats that affect outcome measurements. It is best practice for all young people exper regardless whether they take medications. Here | this form on a quarterly basis. Data are collected from this form regarding prescriber access, sures: iencing early signs of psychosis is to see a prescriber for education and consultation lowever, many young people choose to not see the prescriber. This indicator is intended to hoice will be taken into account as we calculate access rates. |
| New Data Source(if needed): Description of Data: DPR Form 113H. All CMHC CSC sites submit in addition to all new admissions. New Description of Data:(if needed) Data issues/caveats that affect outcome measurement of the company | this form on a quarterly basis. Data are collected from this form regarding prescriber access, sures: iencing early signs of psychosis is to see a prescriber for education and consultation lowever, many young people choose to not see the prescriber. This indicator is intended to hoice will be taken into account as we calculate access rates. |
| New Data Source(if needed): Description of Data: DPR Form 113H. All CMHC CSC sites submit in addition to all new admissions. New Description of Data:(if needed) Data issues/caveats that affect outcome measurement of the control | this form on a quarterly basis. Data are collected from this form regarding prescriber access, sures: iencing early signs of psychosis is to see a prescriber for education and consultation lowever, many young people choose to not see the prescriber. This indicator is intended to hoice will be taken into account as we calculate access rates. |
| New Data Source(if needed): Description of Data: DPR Form 113H. All CMHC CSC sites submit in addition to all new admissions. New Description of Data:(if needed) Data issues/caveats that affect outcome measurement of the choice of young people expering regardless whether they take medications. He honor the choice of young people, so that come the choice of young people with the choice of young people. New Data issues/caveats that affect outcome measurement of the choice of young people. Report of Progress Toward Good First Year Target: | sures: iencing early signs of psychosis is to see a prescriber for education and consultation lowever, many young people choose to not see the prescriber. This indicator is intended to hoice will be taken into account as we calculate access rates. e measures: al Attainment ed |
| New Data Source(if needed): Description of Data: DPR Form 113H. All CMHC CSC sites submit in addition to all new admissions. New Description of Data:(if needed) Data issues/caveats that affect outcome measurement of the control | sures: iencing early signs of psychosis is to see a prescriber for education and consultation lowever, many young people choose to not see the prescriber. This indicator is intended to hoice will be taken into account as we calculate access rates. e measures: al Attainment ed Not Achieved (if not achieved,explain why) |
| New Data Source(if needed): Description of Data: DPR Form 113H. All CMHC CSC sites submit in addition to all new admissions. New Description of Data:(if needed) Data issues/caveats that affect outcome means and it is best practice for all young people expering regardless whether they take medications. He honor the choice of young people, so that come is the composition of Progress Toward Good First Year Target: Report of Progress Toward Good First Year Target: Achieve Reason why target was not achieved, and characteristics. | this form on a quarterly basis. Data are collected from this form regarding prescriber access, sures: iencing early signs of psychosis is to see a prescriber for education and consultation lowever, many young people choose to not see the prescriber. This indicator is intended to hoice will be taken into account as we calculate access rates. The measures: al Attainment The Not Achieved (if not achieved, explain why) The anges proposed to meet target: |

Edit Strategies to attain the objective here:

| How socor | nd year target was achieved: | | |
|--|--|--|--|
| Of the to | _ | s during SFY 2023, 112 new admissions chose to see prescribers. Of these, 105 saw a | |
| Priority #: | 3 | | |
| Priority Area: | Children with SED | | |
| Priority Type: | iority Type: MHS | | |
| Population(s): | SED | | |
| Goal of the priorit | y area: | | |
| Increase access to | o evidence-based practices for chil | dren/youth with SED | |
| Objective: | | | |
| Increase the total | I number of children/youth with SI | ED who receive peer support services. | |
| Strategies to attain | n the goal: | | |
| served. Provide training a Specialists in the Provide awarenes Specialists in the Provide training a | and technical assistance to ensure workplace and how to appropriat ss activities and training regarding service delivery array. and technical assistance regarding | that CMHCs understand how to recruit, retain, and support Youth and Family Peer Support ely document and bill for services. Tresiliency and recovery principles and guidance in the process of fully including Peer Support the supervision of Peer Support Specialists. Courate coding procedures for reporting peer support services in client/event data set. | |
| (if needed) | attain the objective here: | | |
| Annual Perf | ormance Indicators to measu | are goal success | |
| Indicator # | # : | 1 | |
| Indicator: | | Peer support services for young people up to age 26, including those with SED. | |
| Baseline N | Baseline Measurement: Total number of young people up to age 26 who received Youth or Family Peer Support (individual or group) during SFY 2020 was 1,416. | | |
| First-year | First-year target/outcome measurement: Increase by .25% the total number of young people up to age 26 who receive Youth or | | |

Indicator #: Indicator: Peer support services for young people up to age 26, including those with SED. Baseline Measurement: Total number of young people up to age 26 who received Youth or Family Peer Support (individual or group) during SFY 2020 was 1,416. First-year target/outcome measurement: Increase by .25% the total number of young people up to age 26 who receive Youth or Family Peer Support services, from the CMHCs, during SFY 2022. At the end of SFY 2022, 1,420 young people should have received Youth or Family Peer Support services. Second-year target/outcome measurement: Increase by .25% the total number of young people up to age 26 who receive Youth or Family Peer Support services, from the CMHCs, during SFY 2023. At the end of SFY 2023, 1,424 young people should have received Youth or Family Peer Support services. New Second-year target/outcome measurement(if needed): Data Source: DBHDID Client/Event Data Set New Data Source(if needed): Description of Data: Description of Data: Data report to show the total number of young people up to age 26 served by the CMHCs, who received Youth or Family Peer Support

(individual or group peer support services). Report from AMART using the following filters: All MH served, statewide, in-region/out-of-

region, status 1, 2, & 3, ages 1 through 25, units of service client count, service codes 147,148,149,150.

| New Descriptio | n of Data:(if needed) | | | |
|--|--|---|---|---|
| Data issues/cav | eats that affect outco | me measures. | | |
| Due to the dat | a intricacies involved | in capturing all young | - | 26 who are served with Peer Support services, this indicator SED children served, but will also include young people in |
| New Data issue | s/caveats that affect o | outcome measures: | | |
| | | | | |
| Report of I | Progress Towar | d Goal Attainn | nent | |
| First Year Targ | get: | Achieved | | Not Achieved (if not achieved,explain why) |
| Reason why tar | get was not achieved, | and changes propos | ed to meet target: | |
| • | a rget was achieved <i>(o</i> 2, a total of 1,601 your | • | ge of 26 received ' | Youth and Family Peer Support services. The target was 1,420. |
| Second Year ⁻ | | Achieved | | Not Achieved (if not achieved,explain why) |
| | get was not achieved, | and changes propos | ed to meet target: | |
| | 3 | 3.01 | | |
| How second ye | ar target was achieved | d: | | |
| At the end of S | SFY 2023, 1,488 young | people receive Youth | or Family Peer Sup | port services. The target was 1,424. |
| | | | | |
| Priority #: | 4 | | | |
| Priority Area: | Primary Prevention | | | |
| Priority Type: | SAP | | | |
| Population(s): | PP | | | |
| Goal of the priority area | a: | | | |
| Reduce alcohol use an | d electronic cigarettes | s use among 10th grad | ders in Kentucky. | |
| Objective: | | | | |
| | n of harm of electroni | s signification in 10th ar | adore | |
| Increase the perception Decrease 30-day use o | | | auers. | |
| Strategies to attain the | goal: | | | |
| address electronic ciga 1.1.3 Conduct Reward 1.1.4 - Provide training 1.2.1 - Education pared | g and technical assistal arettes use. d/Remind type activiti g and technical assista nts about "host partie: | es with retailers relate nce to schools to sup or and the negative ps | mmunity organiza d to sale of electro port and enhance sychological effect | onic cigarettes to minors. early prevention screening and assessment of adolescents. s of alcohol consumption by adolescents. |
| 1.2.3 - Implement and | expand the "Keep a Li | d on It" strategy to red | duce youth access | Social Host Ordinances implementation and enforcement. to alcohol-to-go-sales. arly prevention screening and assessment of adolescents. |
| Edit Strategies to attain (if needed) | the objective here: | | | |
| —Annual Performa | ance Indicators to | measure goal succ | cess | |
| Indicator #: | | 1 | | |

Number of 10th graders, who participate in the KIP survey who report "great risk" or

Indicator:

| Baseline Measurement: | |
|--|---|
| | 2018 KIP survey results indicate that 42.8% of 10th graders, who participate in the KIP survey reported that using electronic cigarettes on a regular basis had moderate to great risk. During SFY 2020, 4,905 Kentucky residents, under the age of 21, received prevention services targeting tobacco use. |
| First-year target/outcome measurement: | The first year measure is a process measure based on total number of activities that address electronic cigarette use among youth as measured by data entered into the Prevention Data System (based on the 2018 KIP data analysis). First year measure for the block grant is to increase by 3% (to 5,052) the number of Kentucky residents, under the age of 21, who receive prevention services targeting tobacco use. |
| Second-year target/outcome measurement: | Increase by 2% the percentage of 10th graders, who participate in the 2023 KIP Survey, who report use of electronic cigarettes on a regular basis as "moderate' to "great risk". (44.8%) |
| New Second-year target/outcome measurem Data Source: | ent(<i>if needed</i>): |
| Kentucky Incentives for Prevention (KIP) Surve | ey: Kentucky's Prevention Data System |
| New Data Source(if needed): | |
| | |
| Description of Data: | |
| drugs (ATOD), as well as a number of factors districts (of the state's 173) completed the su | In Kentucky's largest source of data related to student use of alcohol, tobacco, and other related to potential substance use. In 2018, over 128,000 students representing 159 school urvey, and the information gathered provided an invaluable substance abuse prevention heir KIP results extensively for grand-writing purposes, prevention activities, and various |
| The Prevention Data System is Kentucky's rep by contract to enter the activities that they h | orting system for activities delivered by primary prevention providers. Providers are required ave delivered in their communities within 30 days of the end date of the activity. the cloud-HSA Block Grant reporting requirements related to primary prevention. |
| The Prevention Data System is Kentucky's rep by contract to enter the activities that they h | ave delivered in their communities within 30 days of the end date of the activity. the cloud- |
| The Prevention Data System is Kentucky's replay contract to enter the activities that they hased system provides data for various SAMI New Description of Data:(if needed) | ave delivered in their communities within 30 days of the end date of the activity. the cloud-HSA Block Grant reporting requirements related to primary prevention. |
| The Prevention Data System is Kentucky's rep by contract to enter the activities that they h based system provides data for various SAM | ave delivered in their communities within 30 days of the end date of the activity. the cloud-HSA Block Grant reporting requirements related to primary prevention. |
| The Prevention Data System is Kentucky's replay contract to enter the activities that they hased system provides data for various SAMI New Description of Data:(if needed) Data issues/caveats that affect outcome means | ave delivered in their communities within 30 days of the end date of the activity. the cloud-HSA Block Grant reporting requirements related to primary prevention. Sures: the next iteration scheduled to occur in the fall of 2021. (the 2020 KIP survey did not occur |
| The Prevention Data System is Kentucky's rep by contract to enter the activities that they h based system provides data for various SAMI New Description of Data:(if needed) Data issues/caveats that affect outcome measure. The KIP Survey is conducted biannually, with | ave delivered in their communities within 30 days of the end date of the activity. the cloud-HSA Block Grant reporting requirements related to primary prevention. Sures: the next iteration scheduled to occur in the fall of 2021. (the 2020 KIP survey did not occur eximately 6 months post administration. |
| The Prevention Data System is Kentucky's rep by contract to enter the activities that they h based system provides data for various SAMI New Description of Data: (if needed) Data issues/caveats that affect outcome measurements of the KIP Survey is conducted biannually, with due to the pandemic). Data is available approximately. | ave delivered in their communities within 30 days of the end date of the activity. the cloud-HSA Block Grant reporting requirements related to primary prevention. Sures: the next iteration scheduled to occur in the fall of 2021. (the 2020 KIP survey did not occur eximately 6 months post administration. |
| The Prevention Data System is Kentucky's rep by contract to enter the activities that they h based system provides data for various SAMI New Description of Data: (if needed) Data issues/caveats that affect outcome measurements of the KIP Survey is conducted biannually, with due to the pandemic). Data is available approximately. | ave delivered in their communities within 30 days of the end date of the activity. the cloud-HSA Block Grant reporting requirements related to primary prevention. Sures: the next iteration scheduled to occur in the fall of 2021. (the 2020 KIP survey did not occur eximately 6 months post administration. measures: |
| The Prevention Data System is Kentucky's rep by contract to enter the activities that they h based system provides data for various SAMI New Description of Data:(if needed) Data issues/caveats that affect outcome measurements. The KIP Survey is conducted biannually, with due to the pandemic). Data is available approved. New Data issues/caveats that affect outcome | ave delivered in their communities within 30 days of the end date of the activity. the cloud-HSA Block Grant reporting requirements related to primary prevention. Sures: the next iteration scheduled to occur in the fall of 2021. (the 2020 KIP survey did not occur oximately 6 months post administration. measures: al Attainment |
| The Prevention Data System is Kentucky's rep by contract to enter the activities that they h based system provides data for various SAMI New Description of Data: (if needed) Data issues/caveats that affect outcome measurements and the KIP Survey is conducted biannually, with due to the pandemic). Data is available approved the Data issues/caveats that affect outcome measurements are considered by the Data issues/caveats that affect outcome measurements are considered by the Data issues/caveats that affect outcome measurements are considered by the Data issues/caveats that affect outcome measurements are considered by the Data issues/caveats that affect outcome measurements are considered by the Data issues/caveats that affect outcome measurements are considered by the Data issues/caveats that affect outcome measurements are considered by the Data issues/caveats that affect outcome measurements are considered by the Data issues/caveats that affect outcome measurements are considered by the Data issues/caveats that affect outcome measurements are considered by the Data is a con | ave delivered in their communities within 30 days of the end date of the activity. the cloud-HSA Block Grant reporting requirements related to primary prevention. Sures: the next iteration scheduled to occur in the fall of 2021. (the 2020 KIP survey did not occur eximately 6 months post administration. measures: al Attainment ed Not Achieved (if not achieved,explain why) |
| The Prevention Data System is Kentucky's rep by contract to enter the activities that they h based system provides data for various SAMI New Description of Data: (if needed) Data issues/caveats that affect outcome measurements. Data is available approved the pandemic. Data is available approved to the pandemic. Data is available approved to the pandemic. Progress Toward Good First Year Target: Reason why target was not achieved, and characteristics. | ave delivered in their communities within 30 days of the end date of the activity. the cloud-HSA Block Grant reporting requirements related to primary prevention. Sures: the next iteration scheduled to occur in the fall of 2021. (the 2020 KIP survey did not occur eximately 6 months post administration. measures: al Attainment ed |
| The Prevention Data System is Kentucky's rep by contract to enter the activities that they h based system provides data for various SAMI New Description of Data: (if needed) Data issues/caveats that affect outcome measurements. Data is available approved the pandemic. Data is available approved to the pandemic. Data is available approved to the pandemic. Progress Toward Good First Year Target: Reason why target was not achieved, and characteristics. | Attainment ed Not Achieved (if not achieved,explain why) surges proposed to meet target: e of 21 received tobacco prevention services. The target was 5,052. |
| The Prevention Data System is Kentucky's rep by contract to enter the activities that they h based system provides data for various SAMINEW Description of Data: (if needed) Data issues/caveats that affect outcome measurements of the KIP Survey is conducted biannually, with due to the pandemic). Data is available approved the pandemic of Progress Toward God First Year Target: Reason why target was not achieved, and characteristics. Achieved the pandemic of | ave delivered in their communities within 30 days of the end date of the activity. the cloud-HSA Block Grant reporting requirements related to primary prevention. Sources: the next iteration scheduled to occur in the fall of 2021. (the 2020 KIP survey did not occur oximately 6 months post administration. measures: al Attainment ed |

| Indicator #: | 2 | | | |
|--|--|--|--|--|
| Indicator: | Number of 10th graders, who participate in the KIP survey, who report past 30-day use of alcoholic beverages. | | | |
| Baseline Measurement: | 2018 KIP survey results indicate 16.8% of 10th graders answered that they consumed alcohol, on at least 1 occasion, in the past 30 days. SFY 2020 data reports 4,688 youth, under the age of 19, received prevention services targeting underage drinking. | | | |
| First-year target/outcome measurement: | The first year measure is a process measure based on the total number of activities that address underage drinking use among youth as measured by data entered into the Prevention Data System (based on the 2018 KIP data analysis). First-year measure for the block grant will increase by 3% (to 6,149) the number of youth, under the age of 19, receiving prevention services targeting underage drinking. | | | |
| Second-year target/outcome measurement: | Decrease by 1% (to 16.5), the number of 10th graders that report having consumed alcohol on at least 1 occasion, in the past 30 days. | | | |
| New Second-year target/outcome measureme | ent(if needed): | | | |
| Data Source: | | | | |
| Kentucky Incentives for Prevention (KIP) Surve | ey; Kentucky's Prevention Data System | | | |
| New Data Source(if needed): | | | | |
| | | | | |
| Description of Data: | | | | |
| based system provides data for various SAME New Description of Data:(if needed) Data issues/caveats that affect outcome meas | HSA Block Grant reporting requirement related to primary prevention. Sures: | | | |
| The KIP Survey is conducted biannually, with due to the pandemic). Data is available appro | the next iteration scheduled to occur in the fall of 2021 (the 2020 KIP Survey did not occur oximately 6 months post administration. | | | |
| New Data issues/caveats that affect outcome | measures: | | | |
| | | | | |
| — Report of Progress Toward Goa | al Attainment | | | |
| | _ | | | |
| First Year Target: Achieve | ed Not Achieved (if not achieved,explain why) | | | |
| First Year Target: Achieve Reason why target was not achieved, and cha How first year target was achieved (optional): | ed Not Achieved (if not achieved,explain why) anges proposed to meet target: | | | |
| First Year Target: Achieved Reason why target was not achieved, and cha How first year target was achieved (optional): During SFY 2022, 11,103 people under the age | nges proposed to meet target: e of 19 received alcohol related prevention services. The target was 6,149. | | | |
| Reason why target was not achieved, and cha How first year target was achieved (optional): During SFY 2022, 11,103 people under the age | Not Achieved (if not achieved,explain why) anges proposed to meet target: e of 19 received alcohol related prevention services. The target was 6,149. Not Achieved (if not achieved,explain why) | | | |
| First Year Target: Achieve Reason why target was not achieved, and cha How first year target was achieved (optional): During SFY 2022, 11,103 people under the age Second Year Target: Achieve | Not Achieved (if not achieved,explain why) anges proposed to meet target: e of 19 received alcohol related prevention services. The target was 6,149. Not Achieved (if not achieved,explain why) | | | |

| riority Type: SAT population(s): PWDC and of the priority area: Simultaneously protect infants who are affected by prenatal substance use and support mothers and families in their capacity to provide care for infants following britty/hospital discharges. Simultaneously protect infants who are affected by prenatal substance use and support mothers and families in their capacity to provide care for infants following britty/hospital discharges. Bijective: Create a model of Plan of Safe Care (PDSC) that meets the Child Abuse Prevention Treatment Act (CAPTA) requirements, is multi-disciplinary and intended to bupport the mother and infant prior to and after discharge from the hospital. Iterategies to attain the goal: Identify services and supports to be provided to the mother and infant, and delineate who is responsible for ensuring that the mother is aware of accesses needed survices and supports. Recognize the importance role of trauma and adverse childhood experiences in this population. Stabilize the nonther in the post-partial predict and provide angingm supports for possible parenting and a safe home environment for the infant. Create opportunities to reduce adverse childhood experiences for the infant, thereby improving long-term outcomes, and reducing the risks of repeating the cycle of substance use as they grow into their teenage years. Idi Strategies to attain the objective here: I noticator #: Indicator #: Indicator #: Indicator #: Indicator #: Indicator #: As of the end of STY 2023, there are seven (7) POSC sites to serve PWWDC with SUDs. At the end of STY 2023, one (1) additional Community Mental Health Center (CMHC) will become a POSC site. New Second-year target/outcome measurement: At the end of STY 2023, one (1) additional Community Mental Health Center (CMHC) will become a POSC site. New Data Source; Opicid STR Table 82 (KORE funding and CMHC contract reporting requirement); Annual Statement of Revenues and Expenditures. New Data Source; In readed); Data issues/caveats that | riority #: 5 | i | | | |
|--|---|--|--|--|--|
| pulation(s): PWWDC all of the priority area: imultaneously protect infants who are affected by prenatal substance use and support mothers and families in their capacity to provide care for fants following birth/hospital discharges. glective: reate a model of Plan of Safe Care (POSC) that meets the Child Abuse Prevention Treatment Act (CAPTA) requirements, is multi-disciplinary and itended to support the mother and infant prior to and after discharge from the hospital. rategies to attain the goal: lentify services and supports to be provided to the mother and infant, and delineate who is responsible for ensuring that the mother is aware of creases needed services and supports. ecognize the important role of trauma and adverse childhood experiences in this population. Intalize the mother in the post-partition period and provide ongoing supports for positive parenting and a safe home environment for the infant, reate opportunities to reduce adverse childhood experiences for the infant, thereby improving long-term outcomes, and reducing the risks of opportunities to reduce adverse childhood experiences for the infant, thereby improving long-term outcomes, and reducing the risks of opportunities to reduce adverse childhood experiences for the infant, thereby improving long-term outcomes, and reducing the risks of speating the cycle of substance use as they grow into their teenage years. It is Strategies to attain the objective here: Readed At the end of SFV 2021, there are seven (7) POSC sites to serve PWWDC with SUDs. First-year target/outcome measurement: At the end of SFV 2022, one (1) additional Community Mental Health Center (CMHC) will become a PoSC site. New Second-year target/outcome measurement (if needed): Data Source: Opioid STR Table 82 (KDRE funding and CMHC contract reporting requirement): Annual Statement of Revenues and Expenditures. New Data Source(if needed): Description of Data: The total number of POSC sites within Community Mental Health Centers (CMHCs). New Description of Dat | iority Area: | Pregnant Women/Women with Dependent Children who have Substance Use Disorders | | | |
| cal of the priority area: imultaneously protect infants who are affected by prenatal substance use and support mothers and familias in their capacity to provide care for frants following birth/hospital discharges. bipective: create a model of Plan of Safe Care (POSC) that meets the Child Abuse Prevention Treatment Act (CAPTA) requirements, is multi-disciplinary and intended to support the mother and infant prior to and after discharge from the hospital. rategies to attain the goal: dentify services and supports to be provided to the mother and infant, and delineate who is responsible for ensuring that the mother is aware of cressors needed services and supports. leagnages the important role of trauma and adverse childhood experiences in this population. Itabilize the mother in the post-partum period and provide ongoing supports for positive parenting and a safe home environment for the infant. Ireate opportunities to reduce adverse childhood experiences for the infant, thereby improving long-term outcomes, and reducing the risks of expeating the cycle of substance use as they grow into their teenage years. Its Strategies to attain the objective here: Inneceded) —Annual Performance Indicators to measure goal success Indicator: Plan of Safe Care (POSC) implimentation Baseline Measurement: As of the end of SFY 2021, there are seven (7) POSC sites to serve PWWDC with SUDs. At the end of SFY 2022, one (1) additional Community Mental Health Center (CMHC) will become a POSC site. Second-year target/outcome measurement: At the end of SFY 2023, one (1) additional Community Mental Health Center (CMHC) will become a POSC site. New Second-year target/outcome measurement: At the end of SFY 2023, one (1) additional Community Mental Health Center (CMHC) will become a POSC site. Data Source: Opicid STR Table 82 (KORE funding and CMHC contract reporting requirement); Annual Statement of Revenues and Expenditures. New Data Source(if needed): Data Issues/caveats that affect outcome measures: Expected outco | iority Type: | SAT | | | |
| imultaneously protect infants who are affected by prenatal substance use and support mothers and families in their capacity to provide care for fants following birth/hospital discharges. Jective: Treate a model of Plan of Safe Care (POSC) that meets the Child Abuse Prevention Treatment Act (CAPTA) requirements, is multi-disciplinary and attended to support the mother and infant prior to and after discharge from the hospital. Jean of Safe Care (POSC) that meets the Child Abuse Prevention Treatment Act (CAPTA) requirements, is multi-disciplinary and attended to support the mother and infant prior to and after discharge from the hospital. Jean of Safe Care (POSC) that meets the Safe Safe Safe Safe Safe Safe Safe Saf | ppulation(s): | PWWDC | | | |
| spective: reate a model of Plan of Safe Care (POSC) that meets the Child Abuse Prevention Treatment Act (CAPTA) requirements, is multi-disciplinary and intended to support the mother and infant prior to and after discharge from the hospital. rategies to attain the goal: dentity services and supports to be provided to the mother and infant, and delineate who is responsible for ensuring that the mother is aware of cossess needed services and supports to be provided to the mother and infant, and delineate who is responsible for ensuring that the mother is aware of cossess needed services and supports to posture and supports for postive parenting and a safe home environment for the infant, reate apportunities to reduce adverse childhood experiences for the infant, thereby improving long-term outcomes, and reducing the risks of appealing the cycle of substance use as they grow into their teenage years. It is trategies to attain the objective here: Indicator: | oal of the priority area | : | | | |
| Treate a model of Plan of Safe Care (POSC) that meets the Child Abuse Prevention Treatment Act (CAPTA) requirements, is multi-disciplinary and intended to support the mother and infant prior to and after discharge from the hospital. Treategies to attain the goal: dentify services and supports to be provided to the mother and infant, and delineate who is responsible for ensuring that the mother is aware of screense needed services and supports. Secognize the important role of trauma and adverse childhood experiences in this population. Stabilize the mother in the post-partum period and provide ongoing supports for positive parenting and a safe home environment for the infant, thereby improving long-term outcomes, and reducing the risks of expeating the cycle of substance use as they grow into their teenage years. It is strategies to attain the objective here: Indicator: Plan of Safe Care (POSC) implementation Baseline Measurement: As of the end of SFY 2021, there are seven (7) POSC sites to serve PWWDC with SUDs. First-year target/outcome measurement: At the end of SFY 2022, one (1) additional Community Mental Health Center (CMHC) will become a POSC site. Second-year target/outcome measurement: At the end of SFY 2023, one (1) additional Community Mental Health Center (CMHC) will become a POSC site. New Second-year target/outcome measurement(if needed): Data Source: Opioid STR Table B2 (KORE funding and CMHC contract reporting requirement); Annual Statement of Revenues and Expenditures. New Data Source(if needed): Description of Data: (If needed) Data issues/caveats that affect outcome measures: Expected outcome measure for the 2 year period equals nine (9) total POSC sites by the end of SFY 2023. | | | prenatal substance use and support mothers and families in their capacity to provide care for | | |
| rategies to attain the goal: dentify services and supports to be provided to the mother and infant, and delineate who is responsible for ensuring that the mother is aware of ccesses needed services and supports. Ecognize the important role of trauma and adverse childhood experiences in this population. tabilize the mother in the post-partum period and provide ongoing supports for positive parenting and, a safe home environment for the infant, treate opportunities to reduce adverse childhood experiences for the infant, thereby improving long-term outcomes, and reducing the risks of eperating the cycle of substance use as they grow into their teenage years. It strategies to attain the objective here: Indicator #: Indicator #: Indicator: Plan of Safe Care (POSC) implementation Baseline Measurement: As of the end of SFY 2021, there are seven (7) POSC sites to serve PWWDC with SUDs. At the end of SFY 2022, one (1) additional Community Mental Health Center (CMHC) will become a POSC site. Second-year target/outcome measurement: At the end of SFY 2023, one (1) additional Community Mental Health Center (CMHC) will become a POSC site. New Second-year target/outcome measurement(if needed): Data Source: Opioid STR Table 82 (KORE funding and CMHC contract reporting requirement); Annual Statement of Revenues and Expenditures. New Data Source(if needed): The total number of POSC sites within Community Mental Health Centers (CMHCs). New Description of Data: (if needed) Data issues/caveats that affect outcome measures: Expected outcome measure for the 2 year period equals nine (9) total POSC sites by the end of SFY 2023. | ojective: | | | | |
| dentify services and supports to be provided to the mother and infant, and delineate who is responsible for ensuring that the mother is aware of coesses needed services and supports. cocognize the important role of trauma and adverse childhood experiences in this population. tabilize the mother in the post-partum period and provide ongoing supports for positive parenting and a safe home environment for the infant. reate opportunities to reduce adverse childhood experiences for the infant, thereby improving long-term outcomes, and reducing the risks of experienting the cycle of substance use as they grow into their teenage years. it Strategies to attain the objective here: meeded!) —Annual Performance Indicators to measure goal success Indicator #: Indicator: Plan of Safe Care (POSC) implimentation Baseline Measurement: As of the end of SFY 2021, there are seven (7) POSC sites to serve PWWDC with SUDs. First-year target/outcome measurement: At the end of SFY 2022, one (1) additional Community Mental Health Center (CMHC) will become a POSC site. Second-year target/outcome measurement: At the end of SFY 2023, one (1) additional Community Mental Health Center (CMHC) will become a POSC site. New Second-year target/outcome measurement(if needed): Data Source: Opioid STR Table B2 (KORE funding and CMHC contract reporting requirement); Annual Statement of Revenues and Expenditures. New Data Source(if needed): Description of Data: The total number of POSC sites within Community Mental Health Centers (CMHCs). New Description of Data: The total number of POSC sites within Community Mental Health Centers (CMHCs). New Description of Data: Expected outcome measure for the 2 year period equals nine (9) total POSC sites by the end of SFY 2023. | | | | | |
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| Indicator #: 1 Indicator: Plan of Safe Care (POSC) implmentation Baseline Measurement: As of the end of SFY 2021, there are seven (7) POSC sites to serve PWWDC with SUDs. First-year target/outcome measurement: At the end of SFY 2022, one (1) additional Community Mental Health Center (CMHC) will become a POSC site. Second-year target/outcome measurement: At the end of SFY 2023, one (1) additional Community Mental Health Center (CMHC) will become a POSC site. New Second-year target/outcome measurement/(if needed): Data Source: Opioid STR Table B2 (KORE funding and CMHC contract reporting requirement); Annual Statement of Revenues and Expenditures. New Data Source(if needed): Description of Data: The total number of POSC sites within Community Mental Health Centers (CMHCs). New Description of Data: The total number of POSC sites within Community Mental Health Centers (CMHCs). New Description of Data: The total number of POSC sites within Community Mental Health Centers (CMHCs). New Description of Data: The total number of POSC sites within Community Mental Health Centers (CMHCs). New Description of Data: The total number of POSC sites within Community Mental Health Centers (CMHCs). New Description of Data: The total number of POSC sites within Community Mental Health Centers (CMHCs). | ccesses needed servic lecognize the importal tabilize the mother in reate opportunities to | es and supports. nt role of trauma and adverse the post-partum period and o reduce adverse childhood ex | e childhood experiences in this population. provide ongoing supports for positive parenting and a safe home environment for the infant. xperiences for the infant, thereby improving long-term outcomes, and reducing the risks of | | |
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| Baseline Measurement: As of the end of SFY 2021, there are seven (7) POSC sites to serve PWWDC with SUDs. First-year target/outcome measurement: Second-year target/outcome measurement: At the end of SFY 2023, one (1) additional Community Mental Health Center (CMHC) will become a POSC site. At the end of SFY 2023, one (1) additional Community Mental Health Center (CMHC) will become a POSC site. New Second-year target/outcome measurement(if needed): Data Source: Opioid STR Table B2 (KORE funding and CMHC contract reporting requirement); Annual Statement of Revenues and Expenditures. New Data Source(if needed): Description of Data: The total number of POSC sites within Community Mental Health Centers (CMHCs). New Description of Data:(if needed) Data issues/caveats that affect outcome measures: Expected outcome measure for the 2 year period equals nine (9) total POSC sites by the end of SFY 2023. | Indicator #: | | 1 | | |
| First-year target/outcome measurement: At the end of SFY 2022, one (1) additional Community Mental Health Center (CMHC) will become a POSC site. Second-year target/outcome measurement: At the end of SFY 2023, one (1) additional Community Mental Health Center (CMHC) will become a POSC site. New Second-year target/outcome measurement(if needed): Data Source: Opioid STR Table B2 (KORE funding and CMHC contract reporting requirement); Annual Statement of Revenues and Expenditures. New Data Source(if needed): Description of Data: The total number of POSC sites within Community Mental Health Centers (CMHCs). New Description of Data:(if needed) Data issues/caveats that affect outcome measures: Expected outcome measure for the 2 year period equals nine (9) total POSC sites by the end of SFY 2023. | Indicator: | | Plan of Safe Care (POSC) implmentation | | |
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| become a POSC site. New Second-year target/outcome measurement(if needed): Data Source: Opioid STR Table B2 (KORE funding and CMHC contract reporting requirement); Annual Statement of Revenues and Expenditures. New Data Source(if needed): Description of Data: The total number of POSC sites within Community Mental Health Centers (CMHCs). New Description of Data:(if needed) Data issues/caveats that affect outcome measures: Expected outcome measure for the 2 year period equals nine (9) total POSC sites by the end of SFY 2023. | First-year target | /outcome measurement: | | | |
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| The total number of POSC sites within Community Mental Health Centers (CMHCs). New Description of Data:(if needed) Data issues/caveats that affect outcome measures: Expected outcome measure for the 2 year period equals nine (9) total POSC sites by the end of SFY 2023. | New Data Sourc | e(if needed): | | | |
| New Description of Data:(if needed) Data issues/caveats that affect outcome measures: Expected outcome measure for the 2 year period equals nine (9) total POSC sites by the end of SFY 2023. | Description of D | ata: | | | |
| Data issues/caveats that affect outcome measures: Expected outcome measure for the 2 year period equals nine (9) total POSC sites by the end of SFY 2023. | The total numb | er of POSC sites within Comm | nunity Mental Health Centers (CMHCs). | | |
| Expected outcome measure for the 2 year period equals nine (9) total POSC sites by the end of SFY 2023. | New Description | of Data:(if needed) | | | |
| | Data issues/cave | eats that affect outcome meas | sures: | | |
| New Data issues/caveats that affect outcome measures: | Expected outco | me measure for the 2 year pe | riod equals nine (9) total POSC sites by the end of SFY 2023. | | |
| | New Data issues | /caveats that affect outcome | measures: | | |

| How first year target was achieved (optional) | ı . |
|--|--|
| | r: HCs with Plans of Safe Care Sites. The target was eight (8). |
| Second Year Target: Achiev | ved Not Achieved (if not achieved,explain why) |
| Reason why target was not achieved, and ch | anges proposed to meet target: |
| How second year target was achieved: | |
| At the end of SFY 2023, there are 10 CMHCs | with Plans of Safe Care sites. The target was 9. |
| | |
| rity #: 6 | |
| rity Area: Persons Who Inject Drugs | |
| rity Type: SAT | |
| ulation(s): PWID | |
| l of the priority area: | |
| duce the outbreak of Hepatitis by increasing the a | availability and awareness of Syringe Services Programs (SSPs) statewide. |
| ective: | |
| onitor and increase the number of Syringe Service | s Programs across the state. |
| tegies to attain the goal: | |
| eeded) | uro anal success- |
| Annual Performance Indicators to measu | ire goal success |
| Indicator #: | 1 |
| Indicator: | The number of syringe services programs (SSPs) in place across the state. |
| Baseline Measurement: | At the end of SFY 2021 there are 74 SSPs across the state. |
| First-year target/outcome measurement: | At the send of SFY 2022, there will be one (1) additional SSP in the state. This is a comparison across consecutive years. |
| Second-year target/outcome measurement: | At the end of SFY 2023, there will be one (1) additional SSP in the state. This is a comparison across consecutive years. |
| New Second-year target/outcome measurem | nent(if needed): |
| Data Source: | |
| The Kentucky Department for Public Health S Coalition, and DBHDID. | Surveillance data, Kentucky Office of Drug Control Policy (ODCP), Kentucky Harm Reduction /Pages/kyseps.aspx |
| https://chfs.ky.gov/agencies/dph/dehp/hab/ | |
| https://chfs.ky.gov/agencies/dph/dehp/hab/ New Data Source(if needed): | |
| | |

| SFY 2023 is 76 SSPs in Kentucky. New Description of Data:(if needed) | |
|---|-------|
| New Description of Data.(if needed) | |
| Data issues/caveats that affect outcome measures: | |
| SSPs have existed and been studied extensively in the United States since 1988. The SSPs are community-based programs that provide access to sterile needles and syringes free of cost, facilitate safe disposal of used needles and syringes, and other safe injection education. the SSPs in Kentucky also provide linkages to critical services and programs including substance use disorder treatment programs, overdoes prevention education, screening, care and treatment for HIV and viral hepatitis, prevention of mother-to-child transmission, hepatitis A and B vaccination, screening for other sexually transmitted diseases and tuberculosis, partner services and other medical, social and mental health services. In direct response to Senate Bill 192, enacted during the 2015 regular legislative session, the Department for Public Health has published guidelines for local health departments implementing harm reduction and syringe exchange programs. NO SABG FUNDS WILL BE USED TO SUPPORT THE SSPs. | |
| New Data issues/caveats that affect outcome measures: | |
| | |
| Report of Progress Toward Goal Attainment | |
| First Year Target: Achieved In 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): At the end of SFY 2022, there are 82 Syringe Services Programs in Kentucky. The target was 75. | |
| Second Year Target: Achieved In 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: At the end of SFY 2023, there are 83 Syringe Services Programs in Kentucky. The target was 76. | |
| rity #: 7 | |
| rity Area: Individuals who receive Substance Use Disorder services and have or are at risk for Tuberculosis (TB). | |
| rity Type: SAT | |
| ulation(s): TB | |
| I of the priority area: | |
| prove data collection of individuals with or at risk of TB who receive services for SUD. | |
| ective: | |
| sure all clients presenting for substance use disorder services are adequately screened for TB. | |
| tegies to attain the goal: | |
| ntinue partnering with the Kentucky Department for Public Health and the CMHCs to improve data collection definitions and screening prof TB. sure that CMHCs are systematically screening for TB among individuals receiving services for SUDs. fer CMHCs technical assistance in updating and improving their policies and procedures regarding TB screening and referral. | ocols |
| Strategies to attain the objective here: needed) | |
| | |
| Annual Performance Indicators to measure goal success | |

Indicator #:

| Indicator: | Screen persons who present for substance use services at the fourteen (14) CMHCs for TB. |
|---|---|
| Baseline Measurement: | At the end of SFY 2021, all 14 CMHCs have submitted written policies regarding screening all individuals seeking services for SUDs for TB. However, at the end of SFY 2021, CMHCs do not have written procedures outlining specific methods of screening and subsequent referrals, including written procedures of how staff will be trained to follow the written policies/procedures. |
| First-year target/outcome measurement: | At the end of SFY 2022, four (4) of the CMHCs will submit written procedures detailing the process for TB screening and subsequent referral as indicated, for all individuals seeking services for SUDs, to include staff training processes and training curriculum that ensures effective and consistent implementation of policies and procedures. |
| Second-year target/outcome measurement: | At the end of SFY 2023, two (2) additional CMHCs will submit written procedures detailing the process for TB screening and subsequent referral as indicated, for all individuals seeking services for SUDs, to include staff training processes and training curriculum that ensures effective and consistent implementation of policies and procedures. |
| New Second-year target/outcome measureme | ent(if needed): |
| Data Source: | |
| Submission of TB-related procedures, includi | ing training processes and curriculum, by CMHCs, through the Plan and Budget process. |
| New Data Source(if needed): | |
| Description of Data: | |
| At the end of SFY 2023, six (6) CMHCs will have indicated, to include staff training and training | ve submitted written procedures regarding TB screening and subsequent referral as ng curriculum. |
| New Description of Data:(if needed) Data issues/caveats that affect outcome meas | ures: |
| N/A | |
| New Data issues/caveats that affect outcome | measures: |
| | |
| Donard of Donard T | .l. Attainmant |
| Report of Progress Toward Goa | _ |
| First Year Target: 🔽 Achieve | Not Achieved (if not achieved,explain why) |
| | |
| Reason why target was not achieved, and cha | nges proposed to meet target: |
| How first year target was achieved (optional): At the end of SFY 22, there are 10 (ten) CMHCs | s with written, approved, policies regarding screening for tuberculosis among individuals |
| Reason why target was not achieved, and cha How first year target was achieved (optional): At the end of SFY 22, there are 10 (ten) CMHCs receiving substance use disorder services. The Second Year Target: | s with written, approved, policies regarding screening for tuberculosis among individuals target was 4 CMHCs. |
| How first year target was achieved (optional): At the end of SFY 22, there are 10 (ten) CMHCs receiving substance use disorder services. The Second Year Target: | s with written, approved, policies regarding screening for tuberculosis among individuals target was 4 CMHCs. Not Achieved (if not achieved,explain why) |
| How first year target was achieved (optional): At the end of SFY 22, there are 10 (ten) CMHCs receiving substance use disorder services. The | s with written, approved, policies regarding screening for tuberculosis among individuals target was 4 CMHCs. Not Achieved (if not achieved,explain why) |

Priority #: 8

Priority Area: Adults with SMI

Priority Type: MHS
Population(s): SMI

Goal of the priority area:

Maintain a rate of 8% or less of psychiatric hospital discharges to a personal care home where the admission living arrangement was not personal care home.

Objective:

To avoid an increase in the rate of adults, who did not already reside in personal care homes, being discharged to personal care homes from state-operated/contracted psychiatric hospitals.

Strategies to attain the goal:

The electronic medical record system utilized by state-operated/contracted psychiatric hospitals collected living arrangement at admission and discharge.

Maintain collaborative partnerships between the state-operated/contracted psychiatric hospitals and the CMHCs to facilitate referrals to community services.

Maintain contracts with CMHCs to provide evidence-based practices that assists individuals with SMI to live in the community: Assertive Community Treatment, Permanent Supportive Housing, Supported Employment and Peer Support services.

Provide training, technical assistance and fidelity monitoring to ensure most effect implementation of these evidence-based practices.

Provide technical assistance to the state-operated/contracted psychiatric hospitals and the CMHCs to address barriers to community placement.

Edit Strategies to attain the objective here: (if needed)

| Indicator #: | 1 | |
|---|--|--|
| Indicator: | Adults discharged from a state-operated/contracted psychiatric hospital to a personal cahome where the admission living arrangement was not personal care home. | |
| Baseline Measurement: | The SFY 2020 percentage of adults discharged from a state-operated/contracted psychiatri hospital to a personal care home where the admission living arrangement was not personal care home was at 5% = 267/5,278. | |
| First-year target/outcome measurement: | By the end of SFY 2022, the percentage of adults discharged from a state- operated/contracted psychiatric hospital to a personal care home where the admission living arrangement was not personal care home will be maintained as less than 8%. This number will be calculated annually. | |
| Second-year target/outcome measurement: | By the end of SFY 2023, the percentage of adults discharged from a state- operated/contracted psychiatric hospital to a personal care home where the admission living arrangement was not personal care home will be maintained as less than 8%. This number will be calculated annually. | |
| N | | |
| New Second-year target/outcome measurem | nent(if needed): | |
| | ent(if needed): | |
| New Second-year target/outcome measurem Data Source: DBHDID Facility Data Set | ent(if needed): | |
| Data Source: DBHDID Facility Data Set New Data Source(if needed): | ent(if needed): | |
| Data Source: DBHDID Facility Data Set New Data Source(if needed): Description of Data: | | |
| Data Source: DBHDID Facility Data Set New Data Source(if needed): Description of Data: Data report to show per State Fiscal Year (SF | Y): Report ID: COC_10-DC-LA_Not_From_PCH scharged from a state-operated/contracted psychiatric hospital to a personal care home | |
| Data Source: DBHDID Facility Data Set New Data Source(if needed): Description of Data: Data report to show per State Fiscal Year (SF' The total number of percentage of adults diswhere the admission living arrangement wa The report is based on SFY (July 1 - June 30). | Y): Report ID: COC_10-DC-LA_Not_From_PCH scharged from a state-operated/contracted psychiatric hospital to a personal care home s not personal care home. This report is updated monthly. | |
| Data Source: DBHDID Facility Data Set New Data Source(if needed): Description of Data: Data report to show per State Fiscal Year (SF' The total number of percentage of adults diswhere the admission living arrangement wa The report is based on SFY (July 1 - June 30). | Y): Report ID: COC_10-DC-LA_Not_From_PCH scharged from a state-operated/contracted psychiatric hospital to a personal care home s not personal care home. | |
| Data Source: DBHDID Facility Data Set New Data Source(if needed): Description of Data: Data report to show per State Fiscal Year (SF' The total number of percentage of adults diswhere the admission living arrangement wa The report is based on SFY (July 1 - June 30). The report includes data for Central State Holes | Y): Report ID: COC_10-DC-LA_Not_From_PCH scharged from a state-operated/contracted psychiatric hospital to a personal care home s not personal care home. This report is updated monthly. | |
| Data Source: DBHDID Facility Data Set New Data Source(if needed): Description of Data: Data report to show per State Fiscal Year (SF' The total number of percentage of adults diswhere the admission living arrangement wa The report is based on SFY (July 1 - June 30). | Y): Report ID: COC_10-DC-LA_Not_From_PCH scharged from a state-operated/contracted psychiatric hospital to a personal care home s not personal care home. This report is updated monthly. | |

contract. In addition, this rate would be impacted if a significant or unusual change occurred to the total number discharged in any single year. It is expected that adults meeting the levels of care described in this indicator are experiencing SMI. However, the specific data sets for both state-operated/contracted psychiatric hospitals and personal care homes are not required to have a specific SMI marker. Personal care home admissions are required to have a diagnosis of mental illness that is expected to last at least 2 years, and individuals must need assistance with daily living/personal care functioning. New Data issues/caveats that affect outcome measures: Report of Progress Toward Goal Attainment Not Achieved (if not achieved, explain why) Achieved First Year Target: Reason why target was not achieved, and changes proposed to meet target: How first year target was achieved (optional): During SFY 2022, there were 5,040 people discharged from state psychiatric hospitals who did not live in personal care homes. Of those, 214 were discharged to personal care homes, for a total of 4.2%. Achieved Not Achieved (if not achieved, explain why) Second Year Target: Reason why target was not achieved, and changes proposed to meet target: How second year target was achieved: In SFY 2023, there were 5,304 people discharged from state psychiatric hospitals who did not live in Personal Care Homes upon admission. Of these, 223 were discharged to Personal Care Homes for a total of 4.2%. Priority #: Early Serious Mental Illness/First Episode Psychosis **Priority Area: Priority Type:** MHS Population(s): **FSMI** Goal of the priority area: Increase access to evidence-based practices for individuals with early serious mental illness/first episode psychosis (FEP). Objective: Ensure rapid access to a prescriber for young people being admitted into Coordinated Specialty Care (CSC) programs. Strategies to attain the goal: Provide training and technical assistance to all outpatient sites funded to provide Coordinated Specialty Care (CSC) to this population. Utilize consultation from national experts in the field. Convene biannual meetings with all key contacts from CMHCs regarding this population to provide technical assistance/education regarding CSC and the ESMI/FEP population. Embed rapid access measures and rationale into CMHC contract deliverables for CSC outpatient funded sites. Edit Strategies to attain the objective here: (if needed) Annual Performance Indicators to measure goal success Indicator #: Indicator: Young people will have access to available prescriber appointments within seven (7) days of admission into one of the eight (8) CSC programs. Young people served in CSC programs are not required to see a prescriber, but may choose to see a team prescriber, even if they do not wish to take medication. However, for ALL who choose to see a prescriber, rapid

access is essential. Rapid access to care, including evidence-based medication

Troubleshooting technical issues with this system as they arise involves a third party vendor and a third party data management

| | management/education is a large part of the evidence base for CSC. |
|---|---|
| Baseline Measurement: | As of the third quarter of SFY 2021, eight (8) CSC funded programs had team prescribers identified to see young people upon admission into CSC programming. There were 54 new young people admitted into CSC programs, 35 of those new admissions saw the team prescriber within 7 days upon admission, resulting in a statewide total of 65% of new admissions into CSC programs seeing team prescribers within 7 days of admission. |
| First-year target/outcome measurement: | By the end of SFY 2022, the statewide total of new admissions into CSC programs seeing team prescribers within 7 days of admission will be 70 % of all new admissions who choose to see team prescribers. |
| Second-year target/outcome measurement: | By the end of SFY 2023, the statewide total of new admissions into CSC programs seeing team prescribers within 7 days of admission will be 75% of all new admissions who choose to see team prescribers. |
| New Second-year target/outcome measurem Data Source: | ent(if needed): |
| Department Periodic Report (DPR) form 1131 | H/CMHC Contract Reporting Requirement. Additional CSC site level data as needed. |
| New Data Source(if needed): | |
| Description of Data: | |
| DPR form 113H. All CMHC CSC sites submit t to all new admissions. | this form quarterly. Data are collected from this form regarding prescriber access, in addition |
| New Description of Data:(if needed) | |
| Data issues/caveats that affect outcome mean | sures: |
| regardless whether they take medications. H | iencing early signs of psychosis is to see a prescriber for education and consultation lowever, many young people choose to not see the prescriber. This indicator is intended to hoice will be taken into account as we calculate access rates. |
| New Data issues/caveats that affect outcome | measures: |
| | |
| Dan aut of Duanus - Taylor I Co | al Attainment |
| Report of Progress Toward Go | _ |
| First Year Target: Achiev | Not Achieved (if not achieved,explain why) |
| Reason why target was not achieved, and cha | anges proposed to meet target: |
| How first year target was achieved (optional) During SFY 2022, there were 96 new young pedays, for a total of 77%. | : eople admitted to CSC programs. Of those 96 new admissions, 74 saw a prescriber within 7 |
| Second Year Target: Achiev | Not Achieved (if not achieved,explain why) |
| Reason why target was not achieved, and cha | anges proposed to meet target: |
| | |
| How second year target was achieved: | |
| Of the total admissions to CSC teams during within 7 days for a total of 94%. | SFY 2023, 112 new admissions chose to see a prescriber. Of these, 105 saw a prescriber |
| | |

Priority #: 10

Priority Area: Children with SED

Priority Type: MHS
Population(s): SED

| Goal of the priority area: |
|---|
| Increase access to evidence-based practices for children/youth with SED. |
| Objective: |
| Increase the total number of children/youth with SED who receive Peer Support services. |
| Strategies to attain the goal: |

CMHCs with Transition Age Youth specialized programming are required by contract to have Peer Support services available to children/youth being served.

Provide training and technical assistance to ensure that CMHCs understand how to recruit, retain and support Youth and Family Peer Support Specialists in the workplace and how to appropriately document and bill for services.

Provide awareness activities and training regarding resiliency and recovery principles and guidance in the process of fully including Peer Support Specialists in the service delivery array.

Provide training and technical assistance regarding the supervision of Peer Support Specialists.

Provide technical assistance to CMHCs regarding accurate coding procedures for reporting Peer Support services in client/event data set.

Edit Strategies to attain the objective here: *(if needed)*

| Indicator #: | 1 |
|---|--|
| Indicator: | Peer support services for young people up to age 26, including those with SED. |
| Baseline Measurement: | Total number of young people up to age 26 who received Youth or Family Peer Support (individual or group) during SFY 2020 was 1,416. |
| First-year target/outcome measurement: | Increase by .25% the total number of young people up to age 26 who receive Youth or Family Peer Support services, from the CMHCs, during SFY 2022. At the end of SFY 2022, 1,420 young people should have received Youth or Family Peer Support services. |
| Second-year target/outcome measurement: | Increase by .25% the total number of young people up to age 26 who receive Youth or Family Peer Support services, from the CMHCs, during SFY 2023. At the end of SFY 2023, 1,424 young people should have received Youth or Family Peer Support services. |
| New Second-year target/outcome measurem | nent(if needed): |
| Data Source: | |
| | the CMHCs |
| Data Source: Client/Event Data Set used by DBHDID and t | the CMHCs. |
| Client/Event Data Set used by DBHDID and t | the CMHCs. |
| Client/Event Data Set used by DBHDID and t | the CMHCs. |
| Client/Event Data Set used by DBHDID and to New Data Source(if needed): | the CMHCs. |
| Client/Event Data Set used by DBHDID and to New Data Source(if needed): | the CMHCs. |
| Client/Event Data Set used by DBHDID and to New Data Source(if needed): Description of Data: Data report to show the total number of you services in each respective state fiscal year (in the content of the content | ung people up to age 26 served by the CMHCs, who received Youth or Family Peer Support includes counts for individual and group peer support services) Report form AMART using de, in-region/out-of-region, status 1, 2, & 3, ages 1 through 25, units of service client count |
| Client/Event Data Set used by DBHDID and to New Data Source(if needed): Description of Data: Data report to show the total number of you services in each respective state fiscal year (if the following filters: All MH served, statewick service codes 147,148,149 150. | ung people up to age 26 served by the CMHCs, who received Youth or Family Peer Support includes counts for individual and group peer support services) Report form AMART using |
| New Data Source(if needed): Description of Data: Data report to show the total number of you services in each respective state fiscal year (if the following filters: All MH served, statewice) | ung people up to age 26 served by the CMHCs, who received Youth or Family Peer Support includes counts for individual and group peer support services) Report form AMART using |
| Client/Event Data Set used by DBHDID and to New Data Source(if needed): Description of Data: Data report to show the total number of you services in each respective state fiscal year (in the following filters: All MH served, statewick service codes 147,148,149 150. | ung people up to age 26 served by the CMHCs, who received Youth or Family Peer Support includes counts for individual and group peer support services) Report form AMART using |
| Client/Event Data Set used by DBHDID and to New Data Source(if needed): Description of Data: Data report to show the total number of you services in each respective state fiscal year (if the following filters: All MH served, statewick service codes 147,148,149 150. | ung people up to age 26 served by the CMHCs, who received Youth or Family Peer Support includes counts for individual and group peer support services) Report form AMART using de, in-region/out-of-region, status 1, 2, & 3, ages 1 through 25, units of service client count |

| | First Year Ta | rget: | ✓ Achie | eved | | | Not Achieved (if not achieved,explain why) | |
|--|---|---|---|---|--|---|---|------|
| | Reason why ta | arget was not achie | ved, and c | hanges propo | sed to meet t | target: | | |
| | How first year target was achieved (optional): During SFY 2022, 1,601 young people under the age of 26 received Youth or Family Peer Support services. The target was 1,420. | | | | | | | |
| | During SFY 202 | 22, 1,601 young pe | ople under | the age of 26 | received You | th or Fa | nily Peer Support services. The target was 1,420. | |
| | Second Year | Target: | ✓ Achie | eved | | Not Achieved (if not achieved,explain why) | | |
| | Reason why ta | arget was not achie | ved, and c | hanges propo | sed to meet t | target: | | |
| | How second y | ear target was ach | eved: | | | | | |
| | At the end of | SFY 2023, 1,488 yc | ung people | e received You | ıth or Family F | Peer Su | port. The target was 1,424. | |
| | | | | | | | | |
| Priority | <i>t</i> #: | 11 | | | | | | |
| Priority | Area: | Primary Preventio | า | | | | | |
| Priority | туре: | SAP | | | | | | |
| Popula | tion(s): | PP | | | | | | |
| Goal of | the priority are | ea: | | | | | | |
| Reduc | e alcohol use a | nd electronic cigar | ette use am | nong 10th gra | ders in Kentu | cky. | | |
| Objecti | ve: | | | | | | | |
| | | on of harm of elect use of alcohol by 1 | _ | | | | | |
| Strateg | ies to attain the | e goal: | | | | | | |
| 1.1.2 - addres 1.1.3 1.1.4 - 1.2.1 - 1.2.2 - 1.2.3 - | Provide trainin ss electronic cig Conduct rewar Provide trainir Educate paren Provide trainir Implement and | garettes use. Ind/remind type action Ing and technical as Its about "host part Ing and technical as Its expand the "Keep | vities with I sistance to ies" and th sistance to a Lid on It | retailers relate schools to su e negative ps community c ' strategy to re | ed to sale of e pport and enl ychological et oalitions to ex educe youth a | ganizati electroni hance e ffects o xpand S access t | igarette use. ons to update school and community smoke-free police c cigarettes to minors. arly prevention screening and assessment of adolescer alcohol consumption by adolescents. ocial Host Ordinances implementation and enforcement of alcohol-to-go sales. rly prevention screening and assessment of adolescent | nts. |
| Edit Str | _ | n the objective he | e: | | | | | |
| —An | nual Perform | nance Indicators | to meas | ure goal su | ccess | | | |
| | Indicator #: | | | 1 | | | | |
| | Indicator: | | | | | | articipate in the KIP survey who report "great risk" or ettes "some days but not every day?". | |
| | Baseline Meas | urement: | | reported tl During SFY | hat using elec | ctronic o Kentuck | that 42.8% of 10th graders, who participate in the KIP sigarettes on a regular basis had moderate to great risk y residents, under the age of 21, received prevention | |
| | First-year targ | et/outcome measu | rement: | - | | • | ss measure based on total number of activities that ad youth as measured by data entered into the Prevention | |

Data System (based on the 2018 KIP data analysis). First year measure for the block grant is to increase by 3% (to 5,052) the number of Kentucky residents, under the age of 21, who

Increase by 2% the percentage of 10th graders, who participate in the 2023 KIP Survey, who

report use of electronic cigarettes on a regular basis as "moderate' to "great risk". (44.8%)

receive prevention services targeting tobacco use.

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Second-year target/outcome measurement:

| Kentucky Incentives for Prevention (KIP) Sur | vey, Kentucky's Prevention Data System |
|---|---|
| New Data Source(if needed): | |
| | |
| Description of Data: | |
| accessibility of electronic cigarettes in the delectronic cigarettes. Once the survey data district-specific results, and depicting come the KIP Survey, conducted every other year drugs (ATOD), as well as a number of factor districts (of the state's 173) completed the tool for these communities. Districts utilized other needs related to program planning. The Prevention Data System is Kentucky's ruby contract to enter the activities that they | student perceptions about the health dangers of electronic cigarettes and perceived community. The 2018 Survey included the addition of several new questions related to are gathered and analyzed, each participating school district receives a report outlining parisons to the region, state and (when available) the rest of the country. It is Kentucky's largest source of data related to student use of alcohol, tobacco, and other rest related to potential substance use. In 2018, over 128,000 students representing 159 school survey, and the information gathered provided an invaluable substance abuse prevention their KIP results extensively for grant-writing purposes, prevention activities, and various exporting system for activities delivered by primary prevention providers. Providers are required have delivered in their communities within 30 days of the end date of the activity. The cloud-MHS Block Grant reporting requirements related to primary prevention. |
| New Description of Data:(if needed) | |
| | |
| Data issues/caveats that affect outcome me | asures: |
| New Data issues/caveats that affect outcom | ne measures: |
| Report of Progress Toward Go | pal Attainment |
| First Year Target: 🔽 Achie | eved Not Achieved (if not achieved,explain why) |
| Reason why target was not achieved, and c | hanges proposed to meet target: |
| How first year target was achieved <i>(optiona</i> | n- |
| | of 21 received tobacco prevention services. The target was 5,052. |
| Second Year Target: | eved Not Achieved (if not achieved,explain why) |
| Reason why target was not achieved, and c | hanges proposed to meet target: |
| | |
| How second year target was achieved: | |
| | who reported use of electronic cigarettes as "moderate" to "great risk" on the Kentucky to 62.1%. This is a 45% increase. The target was 2%. |
| | |
| Indicator #: | 2 |
| ndicator: | Number of 10th graders, who participate in the KIP survey, who report past 30-day use of alcoholic beverages. |
| Baseline Measurement: | 2018 KIP survey results indicate 16.8% of 10th graders answered that they consumed alcohol, on at least 1 occasion, in the past 30 days. SFY 2020 data reports 4,688 youth, under the age of 19, received prevention services targeting underage drinking. |
| First-year target/outcome measurement: | The first year measure is a process measure based on the total number of activities that address underage drinking use among youth as measured by data entered into the Prevention Data System (based on the 2018 KIP data analysis). First-year measure for the block grant will increase by 3% (to 6,149) the number of youth, under the age of 19, |

receiving prevention services targeting underage drinking.

| | on at least 1 occasion, in the past 30 days. |
|--|--|
| New Seco | nd-year target/outcome measurement(if needed): |
| Data Sour | ce: |
| Kentucky | Incentives for Prevention (KIP) Survey; Kentucky's Prevention Data System. |
| New Data | Source(if needed): |
| | |
| Descriptio | n of Data: |
| drugs (AT districts (tool for the other need The Prevent | urvey, conducted every other year, is Kentucky's largest source of data related to student use of alcohol, tobacco, and other COD), as well as a number of factors related to potential substance use. In 2018, over 128,000 students representing 159 schoo of the state's 173) completed the survey, and the information gathered provided an invaluable substance abuse prevention nese communities. Districts utilize their KIP results extensively for grant-writing purposes, prevention activities, and various related to program planning. Sention Data System is Kentucky's reporting system for activities delivered by primary prevention providers. Providers are required to enter the activities that they have delivered in their communities within 30 days of the end date of the activity. The cloudstern provides data for various SAMHSA Block Grant reporting requirements related to primary prevention. |
| New Desc | ription of Data:(if needed) |
| | |
| Data issue | s/caveats that affect outcome measures: |
| | urvey is conducted biannually, with the next iteration scheduled to occur in the fall of 2021 (the 2020 KIP Survey did not occur |
| due to th | urvey is conducted biannually, with the next iteration scheduled to occur in the fall of 2021 (the 2020 KIP Survey did not occur e pandemic). Data is available approximately 6 months post administration. issues/caveats that affect outcome measures: |
| due to th | e pandemic). Data is available approximately 6 months post administration. issues/caveats that affect outcome measures: |
| due to th | e pandemic). Data is available approximately 6 months post administration. issues/caveats that affect outcome measures: of Progress Toward Goal Attainment |
| New Data Report First Year | e pandemic). Data is available approximately 6 months post administration. issues/caveats that affect outcome measures: of Progress Toward Goal Attainment |
| New Data Report First Year Reason wh | e pandemic). Data is available approximately 6 months post administration. issues/caveats that affect outcome measures: of Progress Toward Goal Attainment Target: Achieved Not Achieved (if not achieved, explain why) |
| New Data Report First Year Reason wh | e pandemic). Data is available approximately 6 months post administration. issues/caveats that affect outcome measures: of Progress Toward Goal Attainment Target: Achieved Not Achieved (if not achieved, explain why) ny target was not achieved, and changes proposed to meet target: |
| New Data Report First Year Reason wh How first y During SF | e pandemic). Data is available approximately 6 months post administration. issues/caveats that affect outcome measures: of Progress Toward Goal Attainment Target: Achieved Not Achieved (if not achieved, explain why) ny target was not achieved, and changes proposed to meet target: year target was achieved (optional): |
| New Data Report First Year Reason wh How first Year During SFY Second Y | e pandemic). Data is available approximately 6 months post administration. issues/caveats that affect outcome measures: of Progress Toward Goal Attainment Target: Achieved Not Achieved (if not achieved, explain why) ny target was not achieved, and changes proposed to meet target: year target was achieved (optional): (2022, 11,103 people under the age of 19 received alcohol related prevention services. The target was 6,149. |
| New Data Report First Year Reason wh How first y During SFY Second Y Reason wh | e pandemic). Data is available approximately 6 months post administration. issues/caveats that affect outcome measures: of Progress Toward Goal Attainment Target: Achieved Not Achieved (if not achieved, explain why) ny target was not achieved, and changes proposed to meet target: year target was achieved (optional): (2022, 11,103 people under the age of 19 received alcohol related prevention services. The target was 6,149. Year Target: Achieved Not Achieved (if not achieved, explain why) |
| Report First Year Reason wh How first y During SFY Second Y Reason wh How secon | e pandemic). Data is available approximately 6 months post administration. issues/caveats that affect outcome measures: of Progress Toward Goal Attainment Target: Achieved Not Achieved (if not achieved,explain why) by target was not achieved, and changes proposed to meet target: year target was achieved (optional): 2022, 11,103 people under the age of 19 received alcohol related prevention services. The target was 6,149. Year Target: Achieved Not Achieved (if not achieved,explain why) The target was not achieved, and changes proposed to meet target: |
| Report First Year Reason wh How first y During SFY Second Y Reason wh How secon | e pandemic). Data is available approximately 6 months post administration. issues/caveats that affect outcome measures: Of Progress Toward Goal Attainment Target: |
| New Data Report First Year Reason wh How first y During SF Second Y Reason wh How secon The perce Kentucky | e pandemic). Data is available approximately 6 months post administration. issues/caveats that affect outcome measures: Of Progress Toward Goal Attainment Target: |
| Report First Year Reason wh How first y During SFY Second Y Reason wh How secon The perce Kentucky | e pandemic). Data is available approximately 6 months post administration. issues/caveats that affect outcome measures: of Progress Toward Goal Attainment Target: Achieved Not Achieved (if not achieved,explain why) ny target was not achieved, and changes proposed to meet target: year target was achieved (optional): (2022, 11,103 people under the age of 19 received alcohol related prevention services. The target was 6,149. Year Target: Achieved Not Achieved (if not achieved,explain why) ny target was not achieved, and changes proposed to meet target: Ind year target was achieved: entage of Kentucky 10th graders who reported consuming alcohol on at least one occasion in the past 30 days, on the Incentives for Prevention (KIP) Survey, fell from 68% to 13%, which is a 22.6% decrease. The target was a 1% decrease. |
| Report First Year Reason wh How first y During SFY Second Y Reason wh How secon | e pandemic). Data is available approximately 6 months post administration. issues/caveats that affect outcome measures: of Progress Toward Goal Attainment Target: Achieved Not Achieved (if not achieved,explain why) by target was not achieved, and changes proposed to meet target: year target was achieved (optional): 2022, 11,103 people under the age of 19 received alcohol related prevention services. The target was 6,149. Year Target: Achieved Not Achieved (if not achieved,explain why) by target was not achieved, and changes proposed to meet target: Ind year target was achieved: entage of Kentucky 10th graders who reported consuming alcohol on at least one occasion in the past 30 days, on the Incentives for Prevention (KIP) Survey, fell from 68% to 13%, which is a 22.6% decrease. The target was a 1% decrease. |

Goal

Simultaneously protect infants who are affected by prenatal substance use and support mothers and families in their capacity to provide care for infants following birth/hospital discharges

Objective:

Create a model of Plan of Safe Care (POSC) that meets the Child Abuse Prevention Treatment Act (CAPTA) requirements, is multi-disciplinary and

intended to support the mother and infant prior to and after discharge from the hospital.

Strategies to attain the goal:

Identify services and supports to be provided to the mother and infant, and delineate who is responsible for ensuring that the mother is aware of, and accesses needed services and supports.

Recognize the important role of trauma and adverse childhood experiences in this population.

Stabilize the mother in the post-partum period and provide ongoing supports for positive parenting and a safe home environment for the infant. Create opportunities to reduce adverse childhood experiences for the infant, thereby improving long-term outcomes, and reducing the risks of repeating the cycle of substance use as they grow into their teenage years.

| Edit | Strategies | to at | tain the | objective | here |
|-------|------------|-------|----------|-----------|------|
| (if n | reeded) | | | | |

| | 1 | | | | |
|--|---|--|--|--|--|
| Indicator: | Plan of Safe C | are (POSC) implementation | | | |
| Baseline Measurement: | As of the end | of SFY 2021, there are seven (7) POSC sites to serve PWWDC with SUDs. | | | |
| First-year target/outcome measure | At the end of become a POS | SFY 2022, one (1) additional Community Mental Health Center (CMHC) will SC site. | | | |
| Second-year target/outcome meas | surement: At the end of become a POS | SFY 2023, one (1) additional Community Mental Health Center (CMHC) will SC site. | | | |
| New Second-year target/outcome | measurement(if needed): | | | | |
| Data Source: | | | | | |
| Opioid STR Table B2 (KORE fundir | ng and CMHC contract rep | porting requirement, Annual Statement of Revenues and Expenditures. | | | |
| New Data Source(if needed): | | | | | |
| Description of Data: The total number of POSC sites within the Community Mental Health Centers. | | | | | |
| The total number of 1 obe sites w | | tal Health (enters | | | |
| | , | tal Health Centers. | | | |
| New Description of Data:(if needed | | tal Health Centers. | | | |
| New Description of Data:(if needed | | tal Health Centers. | | | |
| | d) | tal Health Centers. | | | |
| Data issues/caveats that affect out | ccome measures: | e (9) total POSC sites by the end of SFY 2023. | | | |
| Data issues/caveats that affect out Expected outcome measure for th | ccome measures: e 2 year period equals nin | | | | |
| Data issues/caveats that affect out Expected outcome measure for th | ccome measures: e 2 year period equals nin | | | | |
| Data issues/caveats that affect out Expected outcome measure for th New Data issues/caveats that affect | ccome measures: e 2 year period equals ninct outcome measures: | e (9) total POSC sites by the end of SFY 2023. | | | |
| Data issues/caveats that affect out Expected outcome measure for th New Data issues/caveats that affect Report of Progress Tow | ccome measures: e 2 year period equals ninct outcome measures: | e (9) total POSC sites by the end of SFY 2023. | | | |
| New Data issues/caveats that affect Report of Progress Tow First Year Target: | ccome measures: e 2 year period equals ninct outcome measures: eard Goal Attainme | e (9) total POSC sites by the end of SFY 2023. ent Not Achieved (if not achieved,explain why) | | | |
| Data issues/caveats that affect out Expected outcome measure for the New Data issues/caveats that affect Report of Progress Tow First Year Target: Reason why target was not achieve | ccome measures: e 2 year period equals nine ct outcome measures: ard Goal Attainme Achieved ed, and changes proposed | e (9) total POSC sites by the end of SFY 2023. ent Not Achieved (if not achieved,explain why) | | | |
| Data issues/caveats that affect out Expected outcome measure for the New Data issues/caveats that affect Report of Progress Tow First Year Target: Reason why target was not achieved | ccome measures: e 2 year period equals nine ct outcome measures: ard Goal Attainme Achieved ed, and changes proposed (optional): | e (9) total POSC sites by the end of SFY 2023. ent Not Achieved (if not achieved,explain why) d to meet target: | | | |
| Data issues/caveats that affect out Expected outcome measure for the New Data issues/caveats that affect Report of Progress Tow First Year Target: Reason why target was not achieved At the end of SFY 2022, there are 1 | ccome measures: e 2 year period equals nine ct outcome measures: ard Goal Attainme Achieved ed, and changes proposed (optional): | e (9) total POSC sites by the end of SFY 2023. ent Not Achieved (if not achieved,explain why) d to meet target: | | | |
| Data issues/caveats that affect out Expected outcome measure for the New Data issues/caveats that affect Report of Progress Tow First Year Target: Reason why target was not achieved At the end of SFY 2022, there are 10 | come measures: e 2 year period equals nine et outcome measures: ard Goal Attainme Achieved ed, and changes proposed (optional): 0 (ten) CMHCs with Plan o | ent Not Achieved (if not achieved,explain why) d to meet target: f Safe Care sites. The target was 8. Not Achieved (if not achieved,explain why) | | | |

| Priority #: | 13 |
|-------------|----|
|-------------|----|

Priority Area: Persons Who Inject Drugs

Priority Type: SAT

Population(s): PWID

Goal of the priority area:

Reduce the outbreak of Hepatitis by increasing the availability and awareness of Syringe Services Programs (SSPs) statewide.

Objective:

Monitor and increase the number of Syringe Services Programs across the state.

Strategies to attain the goal:

Collaborate with the Office of Drug Control Policy, the Harm Reduction Coalition, and the Kentucky Department for Public Health to educate communities about the benefits of syringe services programs.

Encourage the increase of local ordinances to create local syringe services programs.

Edit Strategies to attain the objective here:

| (if | ne | ed | ed) |
|-----|----|----|-----|
|-----|----|----|-----|

| Annual Po | erformance | Indicators | to | measure | goal | success- |
|-----------|------------|-------------------|----|---------|------|----------|
|-----------|------------|-------------------|----|---------|------|----------|

Indicator #:

Indicator: The number of syringe services programs (SSPs) in place across the state.

Baseline Measurement: As of the end of 2021, there are 74 SSPS across the state.

First-year target/outcome measurement: At the end of SFY 2022, there will be one (1) additional SSP in the state. This is a comparison

across consecutive years.

Second-year target/outcome measurement: At the end of SFY 2023, there will be one (1) additional SSP in the state. This is a comparison

across consecutive years.

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

Data Source:

The Kentucky Department for Public Health Surveillance data, Kentucky Office of Drug Control Policy (ODCP), Kentucky Harm Reduction Coalition, DBHDID.

https://chfs.ky.gov/agencies/dph/dehp/hab/Pages/kyseps.aspx

New Data Source(if needed):

Description of Data:

The Kentucky Department for Public Health monitors the number of SSPs statewide and also posts to their website the days/hours of operation for each program. The ODCP and the Kentucky Harm Reduction Coalition and DBHDID work to educate individuals and communities about the cost, benefits, myths and best practice guidelines for initiating and maintaining SSPs. The target for the end of SFY 2023 is 76 SSPs in Kentucky.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

SSPS have existed and been studied extensively in the United States since 1988. The SSPs are community-based programs that provide access to sterile needles and syringes free of cost, facilitate safe disposal of used needles and syringes and other safe injection education. The SSPs in Kentucky also provide linkages to critical services and programs including substance use disorder treatment programs, overdose prevention education, screening, care and treatment for HIV and viral hepatitis, prevention of mother-to-child transmission, hepatitis A and B vaccination, screening for other sexually transmitted diseases and tuberculosis, partner services and other medical, social and mental health services.

In response to Senate Bill 192, enacted during the 2015 regular legislative session, the Department for Public Health has published

| | guidelines for local health departments implementing harm reduction and syringe exchange programs. NO SABG FUNDS WILL BE USED TO SUPPORT THE SSPs. | | | | | | |
|----------------------|--|---|---------------|---|--|--|--|
| | New Data issu | ues/caveats that affec | ct outcome | e measures: | | | |
| | | | | | | | |
| | Report of | Progress Tow | ard Go | al Attainment | | | |
| | First Year Ta | arget: | Achiev | ved Not Achieved (if not achieved,explain why) | | | |
| | Reason why t | arget was not achiev | ed, and cha | anges proposed to meet target: | | | |
| | - | r target was achieved SFY 2022, there were | |): • Services Programs in Kentucky. The target was 75. | | | |
| | Second Yea | r Target: | Achiev | ved Not Achieved (if not achieved,explain why) | | | |
| | Reason why t | arget was not achiev | ed, and cha | anges proposed to meet target: | | | |
| | | | | | | | |
| | | rear target was achie | | ge Services Programs. The target was 76. | | | |
| | At the end o | 1 31 1 2023, there were | e os synnigi | e Services Programs. The target was 70. | | | |
| | | | | | | | |
| Priority | | 14 | aiva Cubata | ance Hea Disorder consists and have are so strick for Tubersules (TD) | | | |
| Priority Priority | | SAT | eive Substa | ance Use Disorder services and have or are at risk for Tuberculosis (TB). | | | |
| _ | tion(s): | TB | | | | | |
| - | the priority a | | | | | | |
| | | | h or at risk | of TB who receive services for SUDs. | | | |
| | | ion of marviduals wit | II OI at IISK | Of the wild receive services for 3005. | | | |
| Objectiv _ | | | | | | | |
| Ensure | e all clients pre | senting for substance | e use disor | rder services are adequately screened for TB. | | | |
| Strateg | ies to attain th | ie goal: | | | | | |
| for TB. Ensure | that CMHCs a | are systematically scre | ening for 1 | for Public Health and the CMHCs to improve data collection definitions and screening protocols TB among individuals receiving services for SUDs. mproving their policies and procedures regarding TB screening and referral. | | | |
| Edit Str | _ | in the objective here | | | | | |
| —An | nual Perforr | mance Indicators t | to measu | re goal success— | | | |
| | Indicator #: | | | 1 | | | |
| | Indicator: | | | Screen persons who present for substance use services at the fourteen (14) CMHCs for TB. | | | |
| | Baseline Mea | surement: | | At the end of SFY 2021, all 14 CMHCs have submitted written policies regarding screening all individuals seeking services for SUDs for TB. However, at the end of SFY 2021, CMHCs do not have written procedures outlining specific methods of screening and subsequent referrals, including written procedures of how staff will be trained to follow the written policies/procedures. | | | |
| | First-year targ | get/outcome measure | ement: | At the end of SFY 2022, four (4) of the CMHCs will submit written procedures detailing the process for TB screening and subsequent referral as indicated, for all individuals seeking services for SUDs, to include staff training processes and training curriculum that ensures effective and consistent implementation of policies and procedures. | | | |
| | Second-year t | target/outcome meas | urement: | At the end of SFY 2023, two (2) additional CMHCs will submit written procedures detailing | | | |

the process for TB screening and subsequent referral as indicated, for all individuals seeking services for SUDs, to include staff training processes and training curriculum that ensures effective and consistent implementation of policies and procedures. New Second-year target/outcome measurement(if needed): Data Source: Submission of TB-related procedures, including training processes and curriculum, by CMHCs, through the Plan and Budget process. New Data Source(if needed): **Description of Data:** At the end of SFY 2023, 6 CMHCs will have submitted written procedures regarding TB screening and subsequent referral as indicated, to include staff training processes and training curriculum. 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 **✓** Achieved First Year Target: 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): At the end of SFY 2022, 10 (ten) CMHCs had written, approved policies for screening for tuberculosis among individuals receiving substance use disorder services. The target was 4. **✓** Achieved Not Achieved (if not achieved, explain why) Second Year Target: Reason why target was not achieved, and changes proposed to meet target: How second year target was achieved: At the end of SFY 2023, all 14 CMHCs have written, approved policies regarding screening for TB among individuals receiving SUD services. The target was 6 CMHCs.

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| Footnotes: | |
|------------|--|
| | |

C. State Agency Expenditure Report

Footnotes:

MHBG Table 3 - Set-aside for Children's Mental Health Services

This table provides a report of statewide expenditures for children's mental health services during the last completed SFY States and jurisdictions are required not to spend less than the amount expended in FY 1994.

Reporting Period Start Date: 7/1/2022 Reporting Period End Date: 6/30/2023

| Statewide Expenditures for Children's Mental Health Services | | | | | |
|--|----------------------|--------------------------------|--|--|--|
| A Actual SFY 1994 | B Actual SFY 2022 | C Estimated/Actual SFY 2023 | Please specify if expenditure amount reported in Column C is actual or estimated | | |
| \$3,832,010 | \$8,966,538 | \$8,416,600 | Actual Estimated | | |

| If <u>estimated</u> expenditures are provided, please indicate when <u>actual</u> expenditure dat | a will be submitted to SAMHSA: |
|---|--------------------------------|
| States and jurisdictions are required not to spend less than the amount expended in | n FY 1994. |
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C. State Agency Expenditure Report

MHBG Table 6 - Maintenance of Effort for State Expenditures on Mental Health Services

This table provides a report of expenditures of all statewide, non-Federal expenditures for authorized activities to treat mental illness during the last completed SFY.

Reporting Period Start Date: 07/01/2022 Reporting Period End Date: 06/30/2023

| A Period | B Expenditures | C <u>B1 (2021) + B2 (2022)</u> 2 |
|-----------------|-------------------|--|
| SFY 2021 (1) | \$20,557,212 | |
| SFY 2022 (2) | \$20,557,982 | \$20,557,597 |
| SFY 2023 (3) | \$20,564,621 | |

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

| SFY 2021 | Yes | Χ | No |
|----------|-----|---|----|
| SFY 2022 | Yes | Χ | No |
| SFY 2023 | Yes | Χ | No |

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

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| Footnotes: | |
|------------|--|
| | |